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2005 SENATE HUMAN SERVICES

SB 2366

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2366

Senate Human Services Committee

❑ Conference Committee

Hearing Date February 7, 2005

Tape Number	Side A	Side B	Meter #
1	x		1700-end
		x	00-3837
Committee Clerk Signature	Cathy Hinard		

Minutes:

Chairman Lee opened the public hearing on SB 2366. All members were present.

Senator Gary Lee, District 22, was a sponsor of this bill, which relates to the practice of physical therapy. See attached testimony (Attachment 1)

Testimony in favor of SB 2366

Jack McDonald introduced several people who would testify in favor of the bill.

Dr. Shelley Killen, teacher at the University of Mary with their Physical Therapy and Occupational Therapy, and board certified physician practicing physical medicine and rehabilitation at St. Alexius. See written testimony (Attachment 2)

Kevin Axtman, practicing physical therapist and serving his second term on the North Dakota State Examining Committee for Physical Therapists. See written testimony (Attachment 3)

Chairman Lee: Why would you want to have all of this in law instead of administrative rules.

Axtman: We spent a lot of time on our rules and we found we were stuck, mainly because of the definitions and things that were in our practice act. We're at a point where other professions are asking for updates of our definitions, because we tend to be attacked, in terms of our current definitions. They're 1959 definitions that we're currently using, very outdated and does not reflect what's happening in the state.

Chairman Lee: I don't have a problem with the updating of the definitions and all, but I'm thinking about some of the specifics of practice. Let me give an example. I'm a real estate agent and all of the updates for my profession are in law; I think that's stupid, I think they should be in rule through the real estate commission who knows more about what's going on all the time and ultimately sets the classes that are required. Why would you not want those kind of specifics to be in rule; why would you want to give up a little flexibility by changing it from rule to statute?

Axtman: It does make it clearer, a lot of our guidelines are still in rule and will continue to be in rule.

Sen. Lyson: The problem between your group and the chiropractors is manipulation, can you help me out here? It appears from some of the things that I've received, that your group, that there only a few in North Dakota that have the training and education to be able to do this.

Axtman: As you get into manual therapy and specifically manipulation, mobilization and manipulation, they're semantics, and it depends on what term you want to use. Depending on what school of thought you have, there's a spectrum going from a grade one to a grade five. Grades one and two are used for pain, threes and fours to regain motion, five, it you really need to gain motion, to go beyond their current range. In speaking for myself, if I have a shoulder that

is frozen, and if I want to get it unstuck, if I couldn't use grade 5s, I'm basically saying I can't work with you anymore.

Sen. Lyson: Why isn't the level five recognized by the American Medical Association?

Axtman: Because the way it's written, we are reimbursed.

Sen. Lyson: Why isn't it recognized, why haven't you gone to them to get this recognized?

Axtman: Because right now since they do not break it down, because of the schools of thoughts and the differing ways in which they measure it. It differs between the schools of thought in what they use for grading scales. So they do not break it down.

Sen. Dever: What educational experience or what allows you the ability to do that when other therapists are not. By what standard do you move from one step to another?

Axtman: Graduating from a physical therapy school. The testing essentially gives you the minimal requirements to practice. We do have ongoing continuing education that is required of all therapists within the state of North Dakota. Some therapists go on to specialize in those areas. Physical therapists around the state may be specialists in pediatrics, burn therapy, geriatrics, orthopedics, manual therapy. So depending on what direction they go in their current practice.

Sen. Dever: So that would be a matter of education, not experience?

Axtman: Correct.

Sen. Lyson: I'm trying to get my arms around your level five mobilization. That's a term that you guys have phrased, is that right? It hasn't been phrased by the American Medical Association or the Chiropractic Association.

Axtman: It's a phrase that may schools use. It's not just from physical therapy that use that phrase.

Sen. Lyson: But it's not recognized by the American Medical Association.

Axtman: They don't break it down specifically into that, they just use mobilization and manipulation in their current definition.

Chairman Lee: The American Medical Association doesn't regulate either physical therapy or chiropractors, so they wouldn't necessarily have one.

Dr. Killen: We're talking about a CPT code that's used for billing. And, yes, the AMA comes forward with CPT codes. Those CPT codes are used across the continuum. MDs, DOs, chiropractors, physical therapists, occupational therapy, anybody, even massage therapists, if they are going to be covered, use these same codes. So the definitions are not broken down that specifically; it is a manipulation and mobilization code. So the AMA does not break it down into levels, its just one set code and they are very broad codes. They do have some regulation with the DOs or osteopathic physicians who it is definitely a part of their practice and training, to do all of these types of manipulations no matter what the grade is.

Sen. Lyson: How much training do they do in intern to be able to do a level five mobilization?

Chairman Lee mentioned that there is no either/or with some of these issues, there are overlapping procedures with several standards of practice, one of which would be regulated by one professional standard of practice and the same kind of work is being done by some other medical professional. They might both be doing the same kind of thing, but each is regulated by their own members. In this case we're talking about physical therapists and chiropractors, but it doesn't mean that there is one procedure that is mutually exclusive to one profession or the other. They both might be doing similar things, but each is regulated by their own board.

Dr. Kellen: Correct. I could easily walk into my office today and use the same code for the manipulation.

Mary Jo Wagher, President of the North Dakota Physical Therapy Association. She works as a physical therapist for MeritCare Health Systems in Fargo and has been a practicing physical therapist for 20 years.

Ms. Wagher is in favor of this bill because it better reflects the current practice of physical therapy today. The language in the current physical therapy act dates back to the 1950s and the current interpretations have been stretched to their limits. The basic premise of physical therapy as a profession has remained unchanged over the years. The depth and breath of our training has progressed and some of the treatment approaches currently used are not even in existence in the 1950s. However, manual therapy and manipulation has been a part of the physical therapists scope of practice all of those years. We're not looking here to change any way the scope of our practice, in particular related to physical therapy. Currently, over one half of all accredited school of physical therapy in the United States graduate physical therapists with a doctorate degree and the remainder with masters. This is currently a progression from the bachelors program offered in 1977. In the year 2020, all accredited schools will offer doctorate degrees as mandated by our national physical therapy association. Currently, physical therapists have the opportunity to gain recognition by specialty certification in many areas as mentioned earlier, by passing specialty examinations from the American Physical Therapy Association. That would be one way to demonstrate proficiency in the use of manual therapy and manipulation by completing that specialty exam. In North Dakota, physical therapists are required by law to provide evidence of continuing education activity.

Ms. Wagner went on to talk about physical therapy organizations.

Sen. Brown: I see you have prescription authority on page 3 line 5, is that something new?

Wagher: That would be referring to the technique of ianitophresen, which is an electrical way of inducing a topical medication into the skin. That's something that wasn't in existence back in 1977 when I graduated, but it is something that we have used as a treatment modality for several years. It's in our standard of practice.

Chairman Lee: Just to make perfectly clear, they're not changing any of your current practice act, you're just updating the language and definitions in this bill. There's nothing that you're asking to do new in here beyond what you're already doing.

Killen: Correct.

Sen. Brown: This might be an example of what you brought up earlier, that it might be better in rule than in state law and a better description like she just gave of a prescription might be better than just saying 'prescription.'

Chairman Lee: Be careful what you ask for, putting all this in law instead of in rule.

Killen: I would need to trust Jack McDonald and our national association, whose model is what the practice act is modeled after.

Chairman Lee: Here's the difference: when we pass this law, it's there until we change it again. But if you see, as part of your standards of practice, that there are things that you're doing since you were in school, right now, you can go to administrative rules, and you can have those rules changed so that they can keep up with your practice and what's changing year by year. Whereas you have to get the majority of the House and the Senate and the Governor to all think

it's a fine idea if you change things by law. You're going to have a lot less flexibility to change things if they're in law.

Jeff Schmidt, physical therapist from Fargo: I'm a manual therapist and I use my hands a lot. It's all under the CPT code of manual therapy, that's how we bill it out. We do this because it's effective and we're educated in it. There are continuing education classes that we can attend and I have attended, and I feel comfortable doing this. It is reimbursed and it is not exclusive to one profession. It is not solely chiropractic or solely physical therapy, osteopathic.

Jack McDonald, passed out attachments 4 (letter from Dr. Philip Johnson), attachment 5 (proposed amendment) and attachment 6 (current law and rules for physical therapists).

Mr. McDonald mentioned that the legislature has made the rules and regulations process considerable more difficult and time consuming to the point where I'm not entirely sure whether it not easier to get legislation passed than it is to get administrative rules and regulations. The other thing that has happened that the Attorney General's office has heighten its sense of scrutiny of the rules and regulations and particularly have emphasized the point that any rule or regulation has to have a basis or a sounding in state law. So, in other words, to pass a definition, we do have to provide for the prescriptive authority within state law. So what we have tried to do in our definitions and in our act we have enlarged a bit so that we can have a basis of law to go into and do the rules and regulations. I can assure you that we have not tried to make the law any wordier or any more cumbersome that we feel we really have to in order to do our rules and regulations.

Mr. McDonald went over the amendments. He met with over 15 boards to come up with the amendments. Some amendments were also requested by the Attorney General's office to make the bill read a little better and meet HIPAA worked with Bill Peterson and requirements. We

Mike Mullen. He stressed that the CPT codes that are currently in use and the CPT code that the physical therapists are now practicing, is the definition of manual therapy that you see on the third item on page 2 line 7 of my amendments. That is the exact one that is used in North Dakota by Blue Cross Blue Shield and all major hospitals, by Medicare and Medicaid. It's the one that allows physical therapists to bill for manual therapy. Within that manual therapy is the full range that you heard discussed today, the level one through five. The CPT code does not say that this is level one, this is level two, etc., and it does not require that for the billing procedure. So you just bill for what you do in manual therapy--whether you do a level one or level two, or some other type of manual therapy, you just simply bill for manual therapy. He went on to discuss other changes.

If there's a feeling that physical therapists are practicing outside their expertise, there are avenues to take care of that and they can lose their license. A complaint can be filed with their board or civil action can be taken.

Testimony in opposition to SB 2366

Jeff Askew, President of the North Dakota Chiropractic Association. See written testimony (Attachment 7)

Chairman Lee: At the end of you testimony, you're saying that you don't want the physical therapists interfering with your practice law, but you're trying to interfere with theirs. You talk about massage therapy, which has significantly less instruction that PTs, so don't blow that off. And you're also saying that, you're talking about providers with little or no training, and I think that we would all agree, that PTs are certainly above the level of 'little or no training' even in the

issues we're talking about here, so I have some concerns with the way you've addressed a couple of these issues in your testimony and I'm allowing you a chance to respond.

Askew: I'm not sure I understand your question about massage therapists.

Chairman Lee: That was a comment from me and irrelevant because massage therapist have a whole lot less instruction, they don't get a bachelor's degree, they don't get a master's or a doctorate. That's a trade as far as I'm concerned.

Askew: My comment was more relating the fact that they do use the term manipulation and mobilization in their curricula and just the use of the term does not mean that they can expand it to include whatever that word might entail.

Chairman Lee: But they're regulated by their board. There's going to be overlap with some of these procedures. On the one hand, you're saying you appreciate the language being added that doesn't overlap into your standards of practice, and yet you're looking to overlap into the PTs standard of practice when there are people who are on their board, physicians as well as PTs, who are very anxious that the quality of people licensed by their board is at a very high level, the same as the board who regulates chiropractors is anxious to make sure the people in your profession are doing high quality for the people they serve.

Askew: I did not mean to imply that physical therapists had little or no education.

Chairman Lee: But you said that in your testimony.

Askew: I meant it to be specifically applied to the area of the level five mobilization or the chiropractic manipulation that thrusts high velocity low amplitude thing we talked about. It is our understanding that there is none of that training in the basic physical therapy degree and in the advanced degree it would be minuscule by world standards. Compared to levels of education

that we got through our years of school to perform very specifically do that one thing. The experience we get to maintain that level of proficiency, I think the comparison is pretty dramatic.

Chairman Lee: But you're telling me then that you don't think the board that regulates PTs is capable of determining what kind of criteria for education and training and experience are required in order for them to perform level five work. That you should be able to determine what they do that the physicians and physical therapists on that board can't do that?

Askew: I don't think that nurses would intend to try to let their board of examiners determine when they're ready to prescribe medications, without any input from the medical board.

Chairman Lee: They do, and there's no input from the medical board. The board of nursing and we've spent a ton of time in this committee talking about the Nurse Practice Act, but the board of nursing totally regulate nursing. That doesn't mean that there's not an opportunity for advice to be provided but, but nursing licenses, for example, a nurse that has prescriptive practice authority is regulated entirely by the board of nurses and the initial educational requirements are put in place are entirely the responsibility of the board of nursing. We've had a lot of experience with boards of various professions. These boards of professionals who regulate their profession, nobody knows more about that profession, nobody knows more about chiropractors than chiropractors, nobody knows more about nurses than nurses. There's always input from other professionals with what's going on, but each board regulates its own profession. We've had this discussion with nurses and nurse anesthetists. You bet there's input from the physicians because the anesthesiologists are regulated by the board of medical examiners and the CRNAs are regulated by the board of nursing. So they'll all here telling us the same kind of things that you and the PTs are telling us today. But it's the same kind of situation, where there are services that

require a high level of skill and training and that people's physical well-being is being affected by what's going on. But each profession regulates its own, and the board of nursing licenses the CRNAs who have their additional education but provide anesthesia the same as the physicians who are anesthesiologists. I'm trying to sort out why chiropractors think they should have a sort of all or nothing thing that another profession with its own licensing board, has addressed and will continue to address because that profession is slightly different.

Askew: I'm not implying that our board should have any jurisdiction over physical therapists--it was not my intent in this testimony. More to the point, we as a concerned group, who have been practicing this technique for 108 years with manifold times the training that has been presented here as a possible entry level performing this. With all of our experience doing this, we have concerns that there is a health hazard for people in the state, and not only that, but to the entity of manipulation itself, there are a lot of benefits to it, but those benefits are based on being done by highly proficient people. Ninety-four percent of manipulations in the United States are being done by chiropractors. We come from a position of authority in expertise in passing out a warning without any kind of parameters on what can be done. There is a possibility that people with little or no training could be doing this. If only a tiny of PTs have training in this level five mobilization it seems like the law is a bit premature. It would be like us trying to expand our scope of practice to include spinal surgery, because we think its an area that people might be interested in.

Chairman Lee: But your board would determine what kind of credentials would be needed, if indeed, that were something you were seeking. Wouldn't you agree that your board wouldn't say

go ahead and do spinal surgery. They would determine what kind of education and credentialling was needed.

Askew: I would be surprised if our board set 100 hours of education as the level we needed to do that and the legislature wouldn't listen to some input from the people who have been doing surgery for 100 years.

Chairman Lee: You bet.

Askew: That's were our concern is coming from. If our board would set a threshold too low we would expect to hear some screaming about it and that's what's going on here. We think the threshold is way too low.

Chairman Lee: So the only concern you have is the Level five; the rest of the bill is fine for you with the amendments?

Askew: Yes

Senator Dever asked a question about the frozen shoulder that was given as an example earlier and what would happen with that person. Mr. Askew did not answer the question directly.

Chairman Lee asked a question to the group of PTs: Do you now have certain educational requirements for doing level five work comparable to what the CRNAs have to do with the board of nursing?

Dr. Jodi Rollen, head of the physical therapy department at the University of Mary answered the question: Much of our program is about the inside of every inch of the body. By the time these students get to the end of their entry level education, they know, intricately, the inside workings of joints, how it moves, and how they can move it. We have added manipulation (level five) to our curriculum. From our accreditation body, there is now a manipulation

handbook and we have in our university, Steve Ziegler, who does teach that, he's a certified manual therapist in McKenzie. We have the foundation, and whether these students go right out and do manipulation, I rather doubt it, they will be working under someone who knows how to do it. One student spent six months additional training to do manipulation. Whenever a student wants to specialize, they received additional training and work under someone already practicing.

Chairman Lee: Does the board of physical therapy require a certain amount of hours for level five. Is there additional educational requirement for someone performing level five manipulation before they're permitted to do it?

Axtman: Bottom line is that it would be up to that individual to prove competency.

Chairman Lee: To the employer or to the board?

Axtman: To the board. Also the employer.

Chairman Lee: If I were a PT and have worked under someone for a certain amount of time, how do I prove competency? Do I have to demonstrate something or have a signoff from the person I'm working under. How do I demonstrate competency?

Axtman: It's a personal responsibility, to be able to prove competency.

Chairman Lee: I understand that, but how do I prove competency? How does the board know I'm capable of doing that. I'm trying to figure out that this level five activity is something that, I'm not doubting the fact that the training is good, I'm also concerned about the chiropractors point that we may have people that don't have specialty training in that, how does the board determine that somebody is competent of any specialty area in PT?

Axtman: Whether they've done continuing education and they've had certification with it. There is specialty certification within our own profession: manual therapy certification, orthopedic certification, sports certification. So there are those processes within the profession.

Chairman Lee: That would be similar to surgical nurses, nurse anesthetists, advance practice nurses.

Killen: And that is reported to the board every two years. All continuing education is reported to the board.

Sen. Dever: Is this spelled out in the bill or somewhere else

Axtman: No. You wouldn't require a certification, but there are other ways to do it. There are the certification processes but other than the continuing education you can get and then report to the board.

Axtman: I kind of liken it to dentists and doctors, they get their entry level MD degree and go out and do one year internship, and take their test and they're licensed doctors. And then they go on to their specialties. That's what our education is, we get our entry level degree and then go on to get the specialty. Can someone come to them when they don't have their specialty? Yes, but we are required to refer that person on to a person with that specialty. So we didn't want our law to be limiting to say that physical therapists couldn't do this, because there are many physical therapists that can do it, and other states as well.

Chairman Lee: But in order to do level five work, is there a certification required by the board?

Killen: No.

Sen. Dever: How do you delineate between who's qualified to do this and who isn't?

Killen: You put your certification thing in a frame and put it on your wall.

Sen. Dever: You're saying that you need additional training in order to do it.

Chairman Lee: The rules of your board require that if you just have your degree and have not gotten the specialty certification that they have to be referred on?

Killen: Yes.

Chairman Lee: We're trying to sort this out.

Killen: We thought we might have taken care of that when we did the language for the bill, that we cannot practice beyond our level of expertise. So therefore, if someone came to me needing level five manipulation, I would refer them to someone who did this. That's an ethical principle of our organization.

Sen. Brown: The comparison was used to a physician that wants to go onto a specialty, it's my understanding that if a person coming out of medical school wants to be a surgeon, they must go back to school to be one, then recognized in that field and certified.

Chairman Lee closed the public hearing on SB 2366. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2366

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 7, 2005

Tape Number	Side A	Side B	Meter #
3	X		3,385-5400
Committee Clerk Signature	Cathy Minard		JH

Minutes:

Chairman Lee opened the meeting to discuss SB 2366.

Senator Dever- Should this bill have a fiscal note, since they are creating a board?

Chairman Lee- No, they already have a board in place, just want the language changed.

Senator Brown- It sounds like the physical therapists might want to come up with a compromise with the chiropractors first.

Chairman Lee- We need to keep in mind that each profession has a board that regulates what they can and cannot do. There will be some overlap because they do a lot of things similar to one another.

Senator Lyson- It boils down to the level 5 therapy.

Chairman Lee- Jack McDonald would put forth a proposal that would indicate education requirements and certification that would be required for level 5. Its the same type of procedure that nurses use in their profession.

Senator Brown- A few years ago, the chiropractors came in and wanted to change their practice pattern, but the physical therapists objected to it. The bill was eventually killed, how is that different from this?

Chairman Lee- One profession can't regulate what another profession does. A lot of the time the issue boils down to money. Perhaps the two groups can reach a consensus. I sent an e-mail Keith Bjerke from NDSU who worked out issues between the landscape architects and the architects. He has the experience in bringing groups together.

Senator Lyson- The prescription issue still bothers me a little bit.

Chairman Lee- The only reason that is in the rules is because there is a particular medication which is administered topically. Maybe it is too broad.

Senator Brown- It doesn't seem like that should be in the statute.

Senator Warner- There must be somewhere in the code where it says what chiropractors can prescribe and what nurse practicioners can prescribe.

Senator Dever- The physical therapists acknowledge there is a difference in training, but don't have a way to prove they have it.

Chairman Lee- It will be important for them to come up with definite criteria.

Senator Dever passed out a handout making reference to the Board of Counselor Examiners, Ch. 43-47.

Senator Lyson- Could they still be licensed under the part that says "families?"

Chairman Lee- Yes, but they would have to take 5 more classes. Its going to take a lot of convincing to get the two groups together to get things worked out.

Chairman Lee closed the meeting on SB 2366. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **SB 2366**

Senate Human Services Committee

❑ Conference Committee

Hearing Date February 8, 2005

Tape Number	Side A	Side B	Meter #
2	x		1,700-2086
Committee Clerk Signature			

Minutes:

Chairman Lee reopened discussion on SB 2366. All members were present.

Jack McDonald, submitted a proposed amendment. (Attachment 1)

He explained the changes which are also in his written testimony. He also gave a copy to the chiropractors, who are looking at it.

Discussion ended on SB 2366. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2366

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 14, 2005

Tape Number	Side A	Side B	Meter #
1		x	1740-end
2	x		00-550
Committee Clerk Signature			

Minutes:

Chairman Lee reopened discussion on SB 2366. All members were present.

Jack McDonald, Passed out a proposed amendment (Attachment 1).

Chairman Lee: Everything is the same in here as was originally proposed with the exception of the highlighted stuff on page 3.

Jack McDonald: That's correct, we've changed this section several times, but this is the latest version.

Chairman Lee: So it would call for the board, in rule, establishing the requirement for somebody at each level, including level five?

McDonald: Yes. We've made every change that we could that have been asked of us. The amendment you just read off said that our board will require that each licensee will provide the board with evidence of competence in the various elements of the therapy they practice. Then the board can determine the satisfactory competency level pursuant to that one section of the law

43-26.1-03 that's already in the bill itself and that provision says that we have to establish these different levels of competency. We've gone as far as we can go short of allowing the chiropractors themselves to set what the levels of training should be. That has to be left with the board of physical therapy. But we've acknowledged every single other thing we've gotten. What we've done is exactly what they asked for.

Chairman Lee: I'm looking at a suggested amendment from the North Dakota Chiropractic Association. (Attachment 2)

McDonald: That's already in there.

Senator Warner moved for adoption of the McDonald amendment, seconded by Senator Lyson

The committee took some time to look at the century code. Mr. McDonald offered that it wouldn't be in the century code because they would be creating a new section of law.

Chairman Lee: It's my recollection that the purpose of the bill was to create a new section that restated everything that currently kind of scattered, wasn't that the original purpose?

McDonald: Yes.

Chairman Lee: You do have in your testimony, in your book, there should be chapter 43-26. Physical therapist current statute.

Sen. Dever: Do the current rules address the point of controversy (level five manipulation)?

McDonald: No, they do not.

Chairman Lee: So that would be the only change from...where I'm headed for here is is that the only area of contention? You've answered the other questions. The other things in here are just

pulling together and cleaning up and putting into a new statute the current law and rules regarding physical therapy and level five manipulation.

McDonald: Yes, but the board does not have now any method to certify separately beyond the granting the of the physical therapy degree and then the physical therapists themselves getting advanced work. Any system to certify the manipulation level is shaded. That would be entirely new.

Sen. Dever: If we took that out altogether, it's where we're at now.

Chairman Lee: Correct, and if the bill fails, we also where we're at now because everything already is in law. We're not letting them do anything they not already doing. Right?

McDonald: Yes. We think that's a good provision, however, and I guess I'd say we'd like to see that provision in the law at this stage. We think it's good that we do develop these things and set those out and encourage you to include those in the amendment.

Chairman Lee: I have a note from Blue Cross Blue Shield. They had a concern on page 3 lines 11-13: (read from bill). It seems that this language does not fit within the first part of the C paragraph. They're suggesting to end line 11 with a period and delete lines 12 and 13.

McDonald: The Attorney General brought up that same point. On our amendments have addressed this concern. It relates just to physical therapists.

Sen. Dever: I have a question for Ken Tupa. I'm looking at your proposed amendment (attachment 2). Is it the position of your organization that no physical therapist should be allowed to do that?

Tupa: It's not a position that we would restrict that so no physical therapist could perform that level five manipulation. Our concern is with that competencies that may or may not be proved to

the board and the some PTs may be competent to do it, to my understanding there are about two or three that can do it, but that the vast majority don't necessarily have those competencies, in our opinion, and cannot go into that high level of manipulations.

Dever: As I read your amendment, it leads me to believe that nobody, no physical therapist should be allowed to do that. I'm looking for some kind of delineation between those that have had the extra training.

Tupa: It's our opinion that the competencies that could be proved or the courses or certifications that could be shown that a PT may or may not have in order to perform this level of manipulation are significantly different that the education and training that a chiropractor has had to perform these. And given that concern, the amendment would restrict that performance by physical therapists unless they could demonstrate the competency that we feel would be equivalent to our education.

Chairman Lee: Have you had a chance to visit with your association about this shaded amendment and whether or not with the competency requirements that would be determined by the board that something like that would be satisfactory?

Tupa: Are we talking about page 3 line 12-26?

Chairman Lee: Yes.

Tupa: Yes, we have looked at this and don't feel that it really gets us much beyond where we are now. How is competency defined? Would the board just say anything and everything is as it currently is is approved competency, therefore, physical therapists would be able to provide any level of manipulation as they would currently now, if it were determined by the board? Our

question is, what is competency? This doesn't really move us beyond that because we still have that question--what is competency?

Sen. Lyson: What do we have with chiropractors, what is the length of training that they need to be able to do this?

Tupa: I do. I have copies of it. (passed around one copy)

Chairman Lee: I don't know if we're competent to determine if the board of chiropractors requirements about competency are good or not.

Sen. Lyson: I would still like to see how much training they have compared to the physical therapist I talked with this weekend who said they wouldn't even try to do this.

Chairman Lee: But they're not doing it.

Sen. Lyson: I understand that, but it doesn't mean that they couldn't and that's my problem.

Tupa: We had 550 hours specific to high level manipulation and over 1000 hours with respect to diagnostic component.

Chairman Lee: What we need in addition to that is a copy of the physical therapists training and the definition, so we're comparing apples to apples. Do chiropractors have confidence in their board that the Board of Chiropractic is able to professionally and appropriately set rules for the professional requirements for chiropractors? Are the chiropractors confident about their own board?

Tupa: I believe they are.

Chairman Lee: Well, then, do they not have confidence in the board of physical therapists, that those people, as professionals, would also be concerned about the professional level of education and training that would be required in that profession?

Tupa: I think if you look at the education and training of chiropractors, we've drawn this information from their program, and I think that when a chiropractor is licensed, it's inherent in the program that they have this level of program and training and education. In terms of demonstration of education from the physical therapists perspective, we're not so sure what that is. I don't know what it is, I guess I'm not sure what they're training and hours is.

Chairman Lee: But I'm back to my original question about if you trust your own board, don't you trust other professional boards to also require appropriate training. Both professions have a place in health care in North Dakota. Tell me why this is different from the anesthesiologists telling the CRNs what they can do? How is this different? I know I'm putting you on the spot here, and the answer is it's not.

Tupa: If we're dealing with a specific bill from last session SB 2413 or 2402, the issue there was supervision and that sort of thing which was a little different than this issue.

Chairman Lee: Except the Board of Medical Examiners regulates anesthesiologists and the Board of Nursing regulates nursing, and the nurses set up criteria for whatever their specialties are to make sure that somebody's health isn't being endangered. The doctors regulate themselves in the same way. We have seen overlapping areas of care. This is the same, we have chiropractors doing this kind of work and physical therapists doing this same kind of work, but I have a hard time see that one profession is purposely trying to come in and be concerned about this, I don't have a problem with that, but beyond saying that the Board of Physical Therapists are going to be setting up rules to determine competency and making sure members of their own profession don't do this if they're not qualified, I would assume that the chiropractors do the same thing. They would not let a certain people do a certain level of competency in a specialty

area if they weren't qualified. My general philosophical point here is isn't favoring one profession or another, I'm trying very hard to be middle of the road about this. But I'm having a hard time seeing why one profession, aside from being concerned that people be tested for competency, would feel that they had the right to move all the way into regulating what another professional board could do. In essence, excluding them from doing that. I think there's an overlapping level of competency here.

Tupa: I think we'd agree with you but in terms as being a substantial equivalent with education and training, that is a major concern. For instance, if you're an advance practice nurse and you have prescriptive authority, sure you're regulated by the board of nursing for that authority, but you're inheritantly tied to the Board of Medical Examiners because you have to have that collaborative agreement with a physician in order to be able to prescribe. If the competencies, in terms of education and training were substantially equivalent, we would have no problem and would have no objection to their definition of manual therapy. But that hasn't been demonstrated to us and I, quite frankly, don't know what constitutes competency for the performance of those high level manipulations--whether it's a weekend course or a six month course or a two week course, I'm not sure, I don't know.

Chairman Lee: I'm still back to my original question, which is, why do you think it's *your* job to decide if physical therapists are competent; do you not trust that the board who is running that profession is going to make sure that the people who are in that profession are going to do an adequate job? I would say the same thing if doctors were coming challenging chiropractors. Do you think you have the right to say what that field does or do you not trust the people who are in

that profession whose goal it is to make sure that everybody practicing that profession is doing the very best work they can.

Tupa: No, I think all boards are capable of regulating their own professionals. However, if, and I represent the association of chiropractors, not the board. If the board or if the association were to decide that it wanted to allow chiropractors to perform surgery, I would expect that the board of medical examiners would probably stand up and say they're not competent to perform invasive surgery because they don't have the education and training.

Chairman Lee: But I'd really be surprised if the board of chiropractors would allow that.

Sen. Lyson: Right now we really don't have a board for these people. We're establishing it aren't we?

Chairman Lee: Yes we do. Physical therapists are licensed already.

Sen. Lyson: It appears to me we're establishing one.

Chairman Lee: Mr. McDonald, would you like to respond to that?

McDonald: There is a state board of physical therapists. The law that I attached to my original testimony of 2/7, the current statute which is chapter 43-26 of the century code. What we're doing is, as I indicated earlier, since there were so many changes, we simply thought we were going to repeal the old law and enact a new law so you could follow along. In this case, there is a board of physical therapy examiners that has existed since 1959.

Sen. Dever: But isn't that new language at the bottom of page 3?

McDonald: Everything in the bill is new language, we're repealing chapter 43-26 and creating a new chapter called 43-26.1 of the NDCC. To respond from earlier testimony, we've been performing these types of manipulations, up to level five, for 50 years. There has never been a

single complaint raised. You heard from a physiatrist, a physician who treats the muscular skeletal portions of the body, that's her specialty, she said that she felt that physical therapists could do this; the orthopedic surgeons submitted testimony saying the same thing; Medicare, Medicaid, Blue Cross Blue Shield, and all major health insurances pay for this-for spinal manipulations. Every hospital in North Dakota makes it a part of their practice. They have large physical therapy departments; MeritCare employs almost 50 physical therapists; St. Alexius employs almost 30, the perform these manipulations based on the order from orthopedic surgeons and other physicians on staff. They believe the training is sufficient to handle it . Dr. Jodi Roller, from the University of Mary testified that her students are trained in this and that they do have courses in this. The University of North Dakota would say the same. We realize that we don't spell this out, so we said in our amendments that we hope to do this now. We're going to try to spell out these specific areas of training so that it is set. People will have to reach these certain levels to do these certain practices. That's what we'd like to be able to do by this amendment. This seems to set out those levels of training needed, but the chiropractors are saying that no level of training would satisfy them and that's where we come at odds and can't reach an agreement because we're saying we're going to set out the levels, spell them our for you, and I guess if they don't like them then they can challenge them.

Sen. Dever: Since it has not been addressed at all in the past and now it is being addressed, now with this controversy, do you see the practice of that manipulation increasing?

McDonald: That's hard for me to say. I suspect that if we set out certain levels of achievement I suppose you could say yes that people would want to achieve them. I don't think you'll see a lot of increase however, because it's based upon 95% of the practice of physical therapy in North

Dakota is in clinics or hospitals, so that is geared to specific orders and references by physicians. But I do think that if you had to achieve these levels that more people would try to achieve them. It's not easy to predict.

Sen. Brown: How many physical therapists, state wide, are practicing at the level five?

McDonald: We don't track those now, so there's not a specific number. It's probably a small number that regularly practice at the level five. There are others that may, on occasion that have used it, but not as a regular part of their practice. I think you heard from two of those people in testimony earlier Jeff Schmidt and Mary Jo Wager from MeritCare Hospital who both indicated they practice at that level and had additional experience.

Sen. Dever: Does the board currently include members that have had that training?

McDonald: I'm not sure. We have two physicians on the board who were physical therapists at one time, one lay person, but I'm not sure.

Sen. Lyson: I have information that the colleges right now have four hours of manual therapy which would be manipulations.

Chairman Lee: What are you reading from?

McDonald: The curriculum is a seven year program at the University of Mary and the University of North Dakota has a great many courses in mobilization and manipulation and diagnostics. There is certainly more than four hours worth; whether the terminology is different, I'm not sure where that phrase is coming from that you have, but I know that is not correct.

Sen. Brown: I've read that University of Mary is graduating its first class of doctorate candidates. Is there anyone out there able to perform this level?

McDonald: The training they had prior to the doctorate program enable them to start out at this level with some additional training. They had some of this training in mobilization and manipulation prior to their doctorate program. The doctorate program is the one that's coming in right now. Prior to that it was a six year training.

Sen. Lyson: I don't have a problem with this if they have a doctorate.

Chairman Lee: I'm not sure they need a doctorate to do manipulations.

Sen. Lyson: We're not talking about *just* manipulations, we're talking about level five, this is their terms, not the AMAs terms, not the chiropractors terms, this is the physical therapists terms.

Chairman Lee: But that's one thing in a whole area of practice.

Sen. Lyson: If that's the case, if that's what we're talking about here, then maybe they need a doctor's degree to do that.

McDonald: I have to respectfully disagree. Level five was not our term at all.

Sen. Lyson: Show me where it says it anywhere else. It's not in the AMA, it's not in the chiropractic, anyplace, that's were it's at, in the physical therapists.

Sen. Warner: I understood that to be a chiropractic term.

Chairman Lee: It is.

McDonald: It's in the chiropractic amendment, not in our bill at all.

Sen. Lyson: It's not in the chiropractic portion, this is a phrase coined by the physical therapists.

Chairman Lee: I'm not sure that's true. The phrase was brought to us in the chiropractic testimony and both parties know what it is, but I don't think it was brought to our attention.

McDonald: Part of the problem is that there are different terms used for the same thing, but the so called level or grade five, that is not a physical therapy definition commonly used by the

chiropractors. They are not the type that are billed or identified as such by the physical therapists. Physical therapists bill for mobilization and manipulation. The amendment that the chiropractors presented to you identified the level at which they wanted to prohibit us from doing.

The committee took some time to go over the past testimony, and look at the amendments offered. Chairman Lee spoke specifically of the portion of the bill that dealt with disciplinary action if a physical therapist practiced beyond their level of expertise. It was mentioned that the board needs to accommodate those already practicing. Chairman Lee mentioned that she has been in the legislature long enough to see the many groups that always fight with one another. Sometimes they work things out and sometimes not. But she still trusts the competency of professional boards to regulate their own people.

Senator Warner moved DO PASS on the amendment offered by Mr. McDonald, seconded by Sen. Lyson

Vote: 4 yeas, 1 nay, 0 absent

Senator Warner moved DO PASS the amended bill, seconded by Senator Dever.

Vote: 3 yeas, 2 nays, 0 absent Carrier: Senator Judy Lee

Adopted by the Human Services Committee
February 14, 2005

PROPOSED AMENDMENTS TO SENATE BILL NO. 2366

Page 2, remove lines 1 through 4

Page 2, line 5, replace "3." with "2."

Page 2, line 7, replace "4." with "3." and replace ""Jurisdiction of the United States" means any state, the District of Columbia, the" with ""Manual therapy" means the use of techniques such as mobilization or manipulation, manual lymphatic drainage, and manual traction on one or more regions of the body."

Page 2, remove line 8

Page 2, line 9, replace "5." with "4." and remove "continuously"

Page 2, line 14, replace "6." with "5."

Page 2, line 17, replace "7." with "6."

Page 2, line 20, replace "8." with "7."

Page 2, line 22, replace "9." with "8."

Page 2, line 25, replace "10." with "9."

Page 2, line 27, after "limitations" insert "in movement and mobility"

Page 3, line 1, after "limitations" insert "in movement and mobility"

Page 3, line 4, after "training" insert "related to positioning, movement, and mobility"

Page 3, line 7, after "equipment" insert "related to positioning, movement, and mobility"

Page 3, line 11, replace "Reducing" with "Engaging as a physical therapist in reducing"

Page 3, line 14, after "Engaging" insert "as a physical therapist"

Page 3, line 15, replace "11." with "10."

Page 3, line 19, replace "12." with "11."

Page 4, line 4, remove "**and duties**" and replace "shall" with "may"

Page 4, line 23, remove "and residential" and after the second underscored comma insert "business"

Page 4, line 24, replace "numbers" with "number"

Page 4, remove line 30

Page 5, remove lines 1 through 3

Page 6, remove lines 12 and 13

Page 6, line 14, replace "3." with "2."

Page 6, line 16, replace "4." with "3."

Page 6, line 21, replace "5." with "4."

Page 6, line 25, replace "6." with "5."

Page 7, line 1, replace "7." with "6."

Page 7, line 6, replace "valid unrestricted license from another" with "license in good standing from another jurisdiction that imposes requirements for obtaining and maintaining a license which are at least as stringent as the requirements imposed in this state."

Page 7, remove lines 7 and 8

Page 7, line 29, replace "consultation by means of telecommunications to a" with "services in accordance with section 43-51-03."

Page 7, remove line 30

Page 8, line 11, after "license" insert "annually"

Page 8, line 13, after "state" insert ", and may be subject to a late renewal fee"

Page 8, line 17, replace "a lapsed" with "an expired"

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Page 9, line 25, remove "continuously"

Page 10, line 8, remove "A list of final disciplinary actions taken by the board."

Page 10, line 9, remove "d."

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Page 11, line 25, remove "recognized"

Page 11, line 26, after "profession" insert "adopted by rule by the board"

Page 12, line 14, replace "documented consent" with "the written authorization"

Page 12, line 15, replace "required" with "permitted"

Page 12, line 16, replace "by means of telecommunications" with "under section 43-51-03"

Page 12, line 26, after the underscored period insert "The board shall require each licensee to provide the board with evidence of competence regarding the various elements of manual therapy the licensee practices so that the board may determine satisfactory competency levels and requirements as provided under section 43-26.1-03."

Page 12, line 27, remove "recognized"

Page 12, line 28, remove "and" and remove "further"

Page 13, line 6, replace "A" with "Except as otherwise provided by law, a"

Page 13, line 26, remove ", persons,"

Renumber accordingly

Date: 2-14-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2366

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass amendment (offered 2-14 by Jack McDonald)

Motion Made By Sen Warner Seconded By Sen Lyson

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓	✓			
Sen. Stanley Lyson	✓				

Total (Yes) 4 No 1

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-14-05
Roll Call Vote #: 2

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2366

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass as amended

Motion Made By Sen Warner Seconded By Sen Brown

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown		✓			
Sen. Stanley Lyson		✓			

Total (Yes) 3 No 2

Absent Ø

Floor Assignment Sen. J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2366: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (3 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2366 was placed on the Sixth order on the calendar.

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2005 HOUSE HUMAN SERVICES

SB 2366

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2366

House Human Services Committee

❑ Conference Committee

Hearing Date 3/8/05

Tape Number	Side A	Side B	Meter #
1	x		0--end
		x	0--end
Committee Clerk Signature			

Minutes:

Chairman Price: Opened the hearing on SB 2366. All committee members were present.

Senator Gary Lee, District 22: I am here to introduce SB 2366 on behalf of the 406 physical therapist and physical therapist assistants in the state. This bill updates the practice originally enacted in 1959, and last updated to any substance of degree in 1979. Rather that considerable cutting and pasting into the old law, this bill creates a new chapter of the century code. The proposed legislation incorporates a great deal of the old practice act along with the current administrative rules and regulations for physical therapists. The language includes much of the national practice act for physical therapists. The bill spells out more clearly and in more detail what the current practice is in North Dakota. Physical therapist work closely with more than a dozen allied health professions in developing the legislation. The Attorney General's office also reviewed the bill. Many of the comments from these groups were incorporated into the language of the bill. There certainly continues to be basic difference of opinion between physical

therapists and chiropractors in performing certain techniques. I expect for the bill to have a good hearing and hear both sides of that issue today. I believe each profession needs to be able to set the standard of practice for their own profession and then regulate its practice. This is the basic reason for the existence of professional licensing boards. I would encourage a do pass recommendation on the bill and I would attempt to answer any questions that you have, but the presenters to follow certainly have more information and knowledge in their profession than I do.

Jack McDonald, North Dakota Board of Physical Therapy Examiners and North Dakota Physical Therapy Association: (2.3) We are going to have a number of speakers and I will introduce them right now. (Proceeded to introduce everyone). I will let them speak first and then I will clean up at the very end. Most of the written testimony for the speakers have been passed out. I also passed out a copy of the current physical therapy law and the current rules and regulations.

Dr. Shelly Killen, Board Certified Phsyatrist practicing at St. Alexius Medical Center/Teacher at University of Mary Physical and Occupational Medical Schools: (3.4)

(See Attached Testimony)

Representative Kaldor: (5.8) I know one the questions that I have as we are getting communication from Chiropractors about the subject of joint cavatation. Can you tell me if that is different from CPT 97140?

Dr. Killen: I think it is. In looking at what one of the things that the Chiropractors have mentioned is the low aptitude to high velocity thrust type maneuvers. To be honest, I haven't seen physical therapists do those. If it is, it is very few and the very limit of their ability. That is a motion that I normally seen done by chiropractics. They are not the only ones that can do it.

Certainly any physician of osteopathic medicine has adequate training. As a physician I can go to courses that provide me the training to do that. That is not done very frequently. I am sure that they are going to define that more clearly than I will.

Representative Kaldor: As you understand it, that would not be part of that CPT 97140?

Dr. Killen: It is not. It actually has its own code. Which they have put forth. It is actually under the Chiropractic Treatment Codes. However, the way the definition is put forth in the book does not say that someone else cannot use those codes. The code that the physical therapists are using is a general code. If I do a massage in my office, I need to use the same code. If one of one of my occupational therapists does a lymphatic drainage massage, they need to use the same code. Etc. There are multiple entities that will use that same code. It was interesting that when I was reading the osteopathic manipulative treatment codes, those are position specific.

Kevin Axtman, Practicing Physical Therapist in North Dakota for 23 years and on the State Examining Committee for Physical Therapists: (8.2) (See Attached Testimony)

Brought letter from Phil Johnson who was unable to be there.

Mark Romanick, Assistant Professor at UND,Physical Therapist/PHD/LATC: (12.1) (See Attached Testimony)

Representative Weisz: (14.9) What is level 5 manipulation?

Mark Romanick: Grade 5 is defined as high velocity/low amptitude therapeutic movement.

Representative Weisz: Is that taught in your program?

Mark Romanick: Yes it is.

Chairman Price: That is taught do you feel, to competency levels; do see the physical therapists using it on a regular basis? I am trying to coordinate what Dr. Killem said verses what you are saying.

Mark Romanick: Yes it is used; some more than others. Some physical therapists have a practice that would take them into conditions that don't require it as much. For example, pediatrics and geriatrics would use it less. The orthopedic area of medicine would be more apt to use the mobilization and manipulation techniques on a more frequent basis. Yes I am comfortable with the competency of them to perform.

Mary Jo Wagar,President of the North Dakota Physical Therapy Association, Practicing PT, OCS, FAAOMPT: (16.2) I am here today to ask for your endorsement of SB 2366. I hope to be able to clarify the intention of this bill, and dispel some of the myths that have been circulating. The purpose of this bill is to modernize the language of our current practice act to better reflect the practice of physical therapy as it is today. The language in our practice act is much in need of updating because our rules and regulations have been stretched to their limit. Even though the premise of physical therapy as a profession has remained unchanged, the depth and breathe of our training has progressed. Some treatment approached currently use certainly were not in existence when the current laws were written. Currently over half of all accredited schools of physical therapy graduate students with doctorate degrees and the remainder are masters degrees. This is certainly a progression from bachelors program that I graduated from 1977, and by at least the year 2020 all physical therapist programs will offer doctorate degrees and this is a mandate from our national organization. In addition, physical therapists have several opportunities within our profession for continuing education in all areas by taking and

passing specialty exams. In North Dakota physical therapist are required by law to provide evidence of continuing education. Many therapists obtain specialty certification other ways. Usually requiring additional course work and practical exams. We are especially proud of the fact that in our profession we have made great strides in the area of research which assures our clients and patients are receiving the best treatment our national organization provides funding for research through the Foundation for Physical Therapy and locally our state organizations have established a research fund aims at existing clinicians and students interested in pursuing clinical research. Joint manipulation has always been part of the practice of physical therapists despite that as you have heard. There has been a significant campaign on the part of the Chiropractic Association to eliminate this particular technique from our scope of practice. Reasons sited have included lack of sufficient training, patient ????, and claims of non-coverage of insurance carriers. I won't belabor the education because you have already heard from instructors at UND, but I want to all that physical therapy programs are very rigorous programs and the average GPA of those students accepted into the programs in the state is a 3.5. So we are dealing with highly motivated and very capable individuals here. The most important aspect of being able to safely apply physical therapy techniques including, but not limited to, manipulation is a strong education base. One needs to be able to evaluate the patient as a whole, be able to identify movement experiments in education, as well as counter any type of treatment given. In the case of manipulation, the actual act of performing a manipulation is probably one of the easiest parts of that technique. It is the knowledge and the skill of knowing when, when not, and where to apply that type of technique that is the most difficult part. If you need proof, or want to know, what a grade 5 of manipulation is really - what it sounds like, just observe teenagers for a while.

Many perform self manipulation on the neck, back, extremities, in a very habitual manor. That is a capitation that you are hearing when they do that. Is it skilled manipulation, no, but non the less it is an example. There is no evidence that patient safety is a concern. There have not been any reports in the recorded history. In addition we are bound by our code of ethics, that cause us to refer patients to appropriate practitioner when we identify conditions outside of our scope of knowledge, experience, or expertise. Currently the use of manipulation is covered by all insurance payers including Medicare under the CPT code 97140. We are not seeking to use the chiropractic code for spinal adjustments or the correction of ????? stations. And ????? stations in the context of a condition a physical therapist would use manipulation to correct is not part of our vocabulary. One argument heard previously was that a CPT 97140 code is a 15 minute code, and manipulation actually take a matter of seconds. This is true, but manipulation alone during a course of physical therapy would be very unusual. In most cases the manipulation would be proceeded by a combination of joint mobilization, education, and exercise. This the hallmark of physical therapy. Should this still be modified in any way that would not allow physical therapist to be able to continue to use manipulation as part of their practice, patients would have limited access to the type of treatment that they may need. In addition, we have two physical therapy schools in the state; it would become one of the few states who do not allow physical therapists to use manipulation. It would seem that we may have difficulty recruiting and keeping these young people that are cream of the crop within our state. They are going to school expecting to be able to practice what they are taught without unreasonable imposed limits. In looking at the need for more health care providers in our state as the baby boomers are beginning to age, and we will certainly need all the caregivers we can get. In summary, the modernization of the language

in our practice act better describes how the current 400+ physical therapists and assistants in the state can practice proficiently in the state of North Dakota. It will assure the citizens in our state have access to and are receiving physical therapy that is provided by the professionals who have graduated from accredited programs, are licensed by the state, and uphold the high standards of safety, ethics, and best practice.

Representative Weisz: (24.1) Is there a difference in the level of training between the masters and the doctorate, as far as manual manipulation?

Mary Jo Wagar: I think I will defer that question to Steve Beigler from University of Mary. He would be able to better describe that.

Chairman Price: How many therapists have a doctorate level of education, and what type of setting they are operating in? And could you get in writing the training for physical therapists and physical therapists assistants, etc.?

Mary Jo Wagar: I do not have those numbers off the top of my head, but I could get them.

Representative Nelson: (25.2) How many states from a regional and national standpoint have or allow PT's to do manipulation?

Mary Jo Wagar: The three that do not allow it are Washington, Arkansas, and Tennessee.

Jeff Schmidt, Physical Therapist for Americare: (25.9) I would like to address the safety issue. Safety is a non-issue for physical therapists. There have been no complaints regarding this. The chiropractors have sited as an issue. I would encourage you to ask the chiropractic association if they bring up the safety issue. See what kind of issue it is for them. The way I see it, I do grade 5 manipulation every day. I do them in my practice, shoulders, back, etc. They are a vital part of my practice, and to have part of my practice taken away from me - I would be

working with one hand behind my back. I am going to draw an analogy. Imagine those Senators from the building said you cannot use 3 ring binders anymore, and you had to try and work without them, to me that limits your ability. And working without a grade 5 manipulation is limiting my ability to practice and limiting the people who come to me to be able to help them. If I have restraints on my practice, something I have been doing for the last 14 years, I can't fathom that! To have another organization try and limit our practice and keep us from something we have been managing ourselves as an association for years, it really gets me railed up. If you have any questions?

Representative Potter: **(29.4)** I can understand the pop of a finger being one thing, but I would think that the pop of my back would be a different matter - Is it just as easy with the back to pop as it is with your finger?

Jeff Schmidt: It is all joint mechanics. If you understand joint mechanics. The pop only occurs when a joint is made to go beyond where they are resting comfortably. They say that cavatation is associated with a grade 5 manipulation. It is all the same thing that is happening - it is just different joints. Now, can that be harmful? If done incorrectly to a back or a neck, sure. Ask the chiropractic association about that. They would know. It is just a matter of a joint being stretched, and that is something that we have been doing. No change at all.

Representative Kaldor: **(31.1)** Do you see the line blurring between what chiropractors have been doing for a long time and what physical therapists are doing now?

Jeff Schmidt: I do. I have only been at this for 14 years. I can only relate to what I have experienced lately, but I do practice grade 5 manipulation. I think that some chiropractors are getting into more exercise prescription aside from only grade 5 manipulation. We do more so

toward exercise. Many people ask me what makes me different than a chiropractor, and as I go in years now, it is less and less. When I went through school it was a bachelors degree, and now they are all masters degrees, and half of them are doctorate degrees. The students coming out now are sharp, very impressive.

Steve Ziegler, Physical Therapy Faculty Member at University of Mary: (32.7) (See Attached Testimony)

Chairman Price: (40.4) You have gone from the bachelors to the masters, and now you are going for your doctorate; what do see in the differences in the level of training in this area between the programs?

Steve Ziegler: Obviously an increase in length, and changes in autonomous practice meaning physical therapy and treating patients without a referral has changed drastically over the last 5 to 10 years.

Chairman Price: My question partly is should the bachelors level be allowed the same?

Steve Ziegler: All of those that have had a bachelors have had to maintain a competency level of continuing education.

Representative Porter: (41.7) What are the existing continuing education hours to maintain your license in the state of North Dakota?

Steve Ziegler: 25 hours minimum every 2 years. As a practitioner, I know I far exceed that on an annual basis.

Representative Porter: In that 25 hours, is it all didactic or is there some clinical proficiency?

Steve Ziegler: I believe the requirement is that 15 of the 25 have to be clinically related.

Representative Sandvig: (42.9) I realize that you have lots of education, but I am wondering how much hands on experience you have with the grade 5 cavatation manipulation therapy?

Steve Ziegler: You mean how much I currently am practicing or education?

Representative Sandvig: Education

Steve Ziegler: There are at least within our program directly addressing that issue three courses. Ten credit hours that address that, but there are also a lot of foundational courses before that that lead up to these courses.

Representative Sandvig: Exactly how many hours or months of schooling would that involve?

Steve Ziegler: Our program is 3 full years of education plus summers. That is our whole educational process. That is post-professional. We also have pre-professional requirement which is basically three years of education in foundational sciences. A minimum of 19 credits.

Representative Sandvig: How much of that three years is actual hands on experience with cavacation level 5?

Steve Zigler: Ten credit hours. That is a minimum. There is some additional course work in some other classes that I teach. Which would be an additional credit to that.

Representative Sandvig: If you put that into months, how many months of training.

Steve Ziegler: That first course begins in that first year, and it goes to the last credit hours. So there would be about 2 years total. I would say it would be at least 20 to 30 hours per credit. That is difficult to do in giving exact hours.

Chairman Price: (48.0) Are there any limited number of patients that you are practicing on within those hours, or students? How many people have you done this to before you get out of school?

Steve Ziegler: Those students have practiced it on themselves and during their practicals. I cannot say exactly how many.

Cliff LaFreniere, Orthopedic Manual Therapist: (49.4-end Side A) (See Attached Testimony)

(Tape 1, Side B)

Joseph Carlson ND - Written Testimony Only

Jack McDonald: (See Attached Testimony)

Chairman Price: (6.2) At this time we will take the opposition.

Ken Tupa, North Dakota Chiropractic Association: (6.9) (See Attached Testimony)

Jeff Askew, President of North Dakota Chiropractic Association: (11.9) (See Attached Testimony)

Representative Porter: (36.2) In the CPT discussion, in looking at the definition of that 97140 it just says mobilization/manipulation, it does not list any levels 1-5. Where do you think it is restrictive in the 1-5 part looking at that billing code?

Jeff Askew: I spoke with our guru with the AMA coding committee. He absolutely said that the 97140 code is very specifically not intended to be a high velocity code. It is for low velocity maneuvers and other types of manual therapy. That is why there is another code to cover the high velocity maneuvers. Even though both of us can do the 97140 code, when we do a high velocity maneuver, it is a different code we use.

Representative Porter: In the training for a doctorate in osteopathic medicine, how much training do they receive in Level 5 manipulations? And also for the physicians, since you quoted them as being a high number of problems in your statistics?

Jeff Askew: I have to speak a little bit vaguely about that, but I know where I can get the information. It is from the same federal chart that I quoted. Generally speaking, osteopaths have been manipulators through history, they do a lot less than they practice. My understanding from the ones that I know is most of them have to take extra training for that.

Representative Porter: **(39.3)** If that is the case, then you have physicians and osteopaths also trained at the level of the high velocity manipulations, why aren't they here giving us the same cases you are giving us? And why aren't they expressing an interest in the patient safety areas that you are?

Jeff Askew: That is a good question. I know of one medical doctor that does any manipulation. It is done very infrequently. I know personally one, and I believe there are two, osteopaths in town, the one I know personally does absolutely zero manipulations. Most osteopaths aren't practicing it.

Representative Kaldor: **(40.9)** You have given us a lot of material, and I appreciate some of your concerns. I want to get to your amendment because it is confusing for us. The definition of terms seems to be critical. What you do in your practice; the same word can be used and we are getting two different definitions. You mentioned the frozen shoulder as an example, and you have no problems with the therapist doing whatever that is. Would that be defined, what they do, would you consider what they do to a frozen shoulder as being a cavatation of the joint?

Jeff Askew: No we would not. Sometimes there is a pop, but often times there is a tearing of the adhesion. The joint is not what usually pops. It is just not that kind of maneuver.

Representative Kaldor: **(42.3)** Maybe you can clarify for me exactly what a cavatation of a joint is?

Jeff Askew: A joint normally has liquid between two closely approximated cartilage surfaces and when you suddenly increase that space, a vacuum is formed, and gasses are released from the surrounding liquids and the sudden vacuum forming releases the pop. That distance created in the joint; that air cushion ride for a short time is what produces the benefits of joints realigning etc. It is the thrust that takes it there in a risk situation. A cavatation with a thrust is where the risks come in. That is why our amendment uses the term thrust.

Representative Kaldor: (45.1) I am interested in you testimony regarding diagnosis. The impression given is that this particular high velocity/low amplitude thrust is the core of chiropractic care and yet when you talk about diagnosis, it would be hard to assume from reading this that one might go to a chiropractor and not expect to get a high velocity/low amplitude thrust without going through a thorough process of determining whether that is going to do any good. Could you elaborate a little more on that? It seem as though it is a mono focus therapy and I am curious about the diagnosis part of that that would lead you in a different direction.

Jeff Askew: That is an excellent question. When a patient comes into our clinic we do a thorough oral history on them and get a history on the current injury or illness, how it happened, when it happened, I doubt that it is any different than what the physical therapists do. We do an orthopedic/chiropractic/neurological evaluation of the patient looking for a nerve related problem or something more central, or muscle strength problem that would not be coming from a spinal nerve problem, x-ray findings, etc. The value of diagnosis can't be under stressed.

Chairman Price: Further questions?

Alisa Mitskog, Chiropractor in Wahepton: (49.8) May I address Rep. Porters question about the osteopathic issue. I interned in a osteopathic hospital. I was surprised to see only one

practitioner in the hospital use manipulation and I asked him why. It takes a lot of practice and skill and I am certainly training at doing a good job at providing that service. **(See Attached Testimony)**

(Tape 2, Side A)

Charles Whitney, DC (just testimony)

Chairman Price: In your case, was it that you did not have a correct diagnosis, or that it was just too much stress?

Alisa Mitskog: It was an ill performed procedure. The student, in hindsight, was in student clinic and did not have the experience and the clinical was not there. That situation was too much force. There are provisions in place. Before you are a graduate in chiropractic school, you have to have performed x amount of adjustments. That is in place to guarantee that you have enough experience before you graduate. After graduation there is a national boards that you have to take and there are 4 parts and the 4th part there is a practicum that you have to perform manipulation.

Chairman Price: Any other questions? Any one else to testify in opposition? We will close the hearing on SB 2366.

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2366

House Human Services Committee

❑ Conference Committee

Hearing Date March 22, 2005

Tape Number	Side A	Side B	Meter #
Committee Clerk Signature			

Minutes:

Chairman Price opened the discussion on SB 2366.

This last time we met on this, there was an amendment proposed.

Rep. Uglem: Motion for a Do Pass.

Rep. Damschen: Second

Chairman Price: Mr. McDonald, regarding the "Evidence of Confidentiality", how are you coming on this?

J. McDonald: As soon as the amended bill is out of the Senate. But we have been gathering information all along. We hope to have everything we need by August 1, 2005. This will include a level of education, covering all therapists.

Chairman Price: Does this specify they cannot do "Level 5"?

J. McDonald: Yes it does.

Vote: Do Pass as amended. 10-0-2. Carrier: Rep. Nelson

Date: 3/22/05 Roll Call Vote #: 1

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2364

House **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amended

Motion Made By Rep Uglem Seconded By Rep Damschen

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S.**Price**	x		Rep.L. **Kaldor**	x	
V Chrm.G. **Kreidt**	x		Rep.L. **Potter**	x	
Rep. V. **Pietsch**	x		Rep.S. **Sandvig**	AB	
Rep.J.O. **Nelson**	x				
Rep.W.R. **Devlin**	x				
Rep.T. **Porter**	x				
Rep.G. **Uglem**	x				
Rep C. **Damschen**	x				
Rep.R. **Weisz**	AB				

Total ( ) 10 **No** 6

Absent 2

Floor Assignment Rep Nelson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2366: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). SB 2366 was placed on the Sixth order on the calendar.

Page 2, remove lines 1 through 4

Page 2, line 5, replace "3." with "2."

Page 2, line 7, replace "4." with "3." and replace ""Jurisdiction of the United States" means any state, the District of Columbia, the" with ""Manual therapy" means the use of techniques such as mobilization or manipulation, manual lymphatic drainage, and manual traction on one or more regions of the body."

Page 2, remove line 8

Page 2, line 9, replace "5." with "4." and remove "continuously"

Page 2, line 14, replace "6." with "5."

Page 2, line 17, replace "7." with "6."

Page 2, line 20, replace "8." with "7."

Page 2, line 22, replace "9." with "8."

Page 2, line 25, replace "10." with "9."

Page 2, line 27, after "limitations" insert "in movement and mobility"

Page 3, line 1, after "limitations" insert "in movement and mobility"

Page 3, line 4, after "training" insert "related to positioning, movement, and mobility"

Page 3, line 7, after "equipment" insert "related to positioning, movement, and mobility"

Page 3, line 11, replace "Reducing" with "Engaging as a physical therapist in reducing"

Page 3, line 14, after "Engaging" insert "as a physical therapist"

Page 3, line 15, replace "11." with "10."

Page 3, line 19, replace "12." with "11."

Page 4, line 4, remove "and duties" and replace "shall" with "may"

Page 4, line 23, remove "and residential" and after the second underscored comma insert "business"

Page 4, line 24, replace "numbers" with "number"

Page 4, remove line 30

Page 5, remove lines 1 through 3

Page 6, remove lines 12 and 13

Page 6, line 14, replace "3." with "2."

Page 6, line 16, replace "4." with "3."

Page 6, line 21, replace "5." with "4."

Page 6, line 25, replace "6." with "5."

Page 7, line 1, replace "7." with "6."

Page 7, line 6, replace "valid unrestricted license from another" with "license in good standing from another jurisdiction that imposes requirements for obtaining and maintaining a license which are at least as stringent as the requirements imposed in this state."

Page 7, remove lines 7 and 8

Page 7, line 29, replace "consultation by means of telecommunications to a" with "services in accordance with section 43-51-03."

Page 7, remove line 30

Page 8, line 11, after "license" insert "annually"

Page 8, line 13, after "state" insert ", and may be subject to a late renewal fee"

Page 8, line 17, replace "a lapsed" with "an expired"

Page 8, line 19, replace "lapsed" with "expired"

Page 8, line 25, replace "lapsed" with "expired"

Page 9, line 25, remove "continuously"

Page 10, line 8, remove "A list of final disciplinary actions taken by the board."

Page 10, line 9, remove "d."

Page 10, line 12, replace "shall" with "may"

Page 10, line 13, replace "consent" with "authorization" and replace "required" with "permitted"

Page 10, line 23, replace "finds" with "findings"

Page 11, line 19, after "exists" insert ", except with a spouse"

Page 11, line 25, remove "recognized"

Page 11, line 26, after "profession" insert "adopted by rule by the board"

Page 12, line 14, replace "documented consent" with "the written authorization"

Page 12, line 15, replace "required" with "permitted"

Page 12, line 16, replace "by means of telecommunications" with "under section 43-51-03"

Page 12, line 26, after the underscored period insert "The board shall require each licensee to provide the board with evidence of competence regarding the various elements of manual therapy the licensee practices so that the board may determine satisfactory competency levels and requirements as provided under section 43-26.1-03."

Page 12, line 27, remove "recognized"

Page 12, line 28, remove "and" and remove "further"

Page 13, line 6, replace "A" with "Except as otherwise provided by law, a"

Page 13, line 26, remove ", persons,"

Renumber accordingly

2005 TESTIMONY

SB 2366

Attachment 1

2/7/2005

SB 2366 - PT Practice Act

Madame Chair & Members of the Senate Human Services Committee, for the record I am Gary A. Lee, Senator from District 22. District 22 includes the greater part of Cass County, in Eastern ND.

I'm here this morning simply to introduce SB 2366 on behalf of the State's 467 Physical Therapists and Physical Therapy Assistants. This bill updates their Practice Act originally enacted in 1959 and last updated to any substantive degree in 1979.

Rather than considerable cutting and pasting into the old law, this bill creates a new chapter to the NDCC. The proposed legislation incorporates a great deal of the old practice act along with the current administrative rules and regulations for Physical Therapists. The language includes much of the National Practice act for Physical Therapists.

The Bill spells out more clearly and in more detail what the current scope of practice is in ND.

The Physical Therapists worked closely with more than a dozen allied health professions in developing the legislation. The Attorney General's Office also reviewed the bill. Many of the comments from these groups were either incorporated into the language of the bill or will be offered in amendments this morning.

There continues to be a basic difference of opinion between the Physical Therapists and Chiropractors in performing certain techniques. I expect you will hear from both sides on that issue today. I believe each profession needs to be able to set the standards of practice for their own profession and then regulate its practice. That is the basic reason for the existence of professional licensing boards.

I am confident you will give the bill a good hearing.

I urge you to adopt the amendments offered by the Physical Therapists and then give the bill a DO Pass.

I would attempt to answer any questions, but the presenters to follow really have much more information and knowledge about the detail of the bill than I can provide.

Attachment 2

Feb. 7, 2005 - SB 2366

SENATOR LEE AND COMMITTEE MEMBERS:

I am Dr. Shelley Killen. I am a board certified physician practicing physical medicine and rehabilitation at St Alexius in Bismarck ND. I also have the pleasure of teaching at the University of Mary with their Physical Therapy and Occupational Therapy students and before that I taught at the Medical College of Ohio and interacted with their O.T. and P.T. schools also. After having read though the proposed changes to the ND Practice Act, I would like to voice my support of this act. It updates the current language to today standards and follows practice as it is done today. I have also had a chance to discuss the amendments the physical therapists will offer today, especially the definition of manual therapy. I agree with those. The definition is the one commonly used in the medical community.

The definitions as I see them written are well covered within their training and are well within their scope of practice. I am very pleased and comfortable to refer my patients to the care of Physical Therapists across the state and in my current practice I do in fact refer across the state. I have found all the therapists I have worked with truly do see the treatment of clients as a team effort and will always call me with questions and treatment options in the best interest of the client.

Attachment 3

To: Senators of the Senate Human Services Committee

Re: SB 2366

My name is Kevin Axtman, and I have been a practicing physical therapist in the state of North Dakota for almost 23 years since graduating from UND in 1982. I am currently serving my second term on the North Dakota State Examining Committee for Physical Therapists. Our committee consists of 3 physical therapists, a consumer member not in the health professions and 2 physician members. Our current physician members (Dr. Brenda Miller of Bismarck and Dr. Phil Johnson of Fargo) were physical therapists prior to medical school. The committee's primary duties are to look out for the public's safety and welfare (making sure physical therapists practice within their scope of practice) and that well qualified physical therapists practice in North Dakota (being of good moral character, graduating from an approved school and passing a national test). There are currently 477 physical therapists and 253 physical therapy assistants licensed to practice in North Dakota.

SB 2366 has been a 3-year project, which began with updating our Administrative Rules. Our Rules were completed and put into practice 7/2004. Our current Practice Act has language from 1959. SB 2366 was put together to update definitions of our current practice. It does not add or change what physical therapists are currently practicing in the state of North Dakota. We have also expanded the section on Grounds for disciplinary action. By including the statements in that section; "practicing or offering to practice beyond the scope of the practice of physical therapy", and "failing to refer a patient or client to an appropriate practitioner if the diagnostic process reveals finds that are outside

the scope of a physical therapist's knowledge, experience, or expertise", it makes it very clear to all therapists that practicing beyond one's expertise is subject to disciplinary action.

We have contacted 15 health groups around the state to make comments on our Practice Act. We have made changes based on comments from the Pharmacy Board, Occupational Therapists and Chiropractors. Our only controversial issue is from the Chiropractors who want to restrict manual therapy. Manual therapy is within the physical therapist's scope of practice, has been and is currently practiced by physical therapists and is reimbursed by insurance companies.

As part of the ND State Examining Committee for Physical Therapists since 1999, I know of no complaints or injury to patients in which physical therapists have performed manual therapy. Our executive officer, Lynn Kubousek, who has been with the committee since 1979, also has no records of complaints or injury.

We would ask for your support of SB2366 with the physical therapy amendments, and let physical therapists practice as they are currently practicing without restrictions from other professions.

Attachment 4

ORTHOPAEDIC ASSOCIATES FARGO

February 3, 2005

Mark A. Lundeen, MD
R. Mark Askew, MD
Philip Q. Johnson, MD
Jeffrey P Stavenger, MD
David L. Wiest, MD
Howard T. Berglund, MD
Matthew J. Nelsen, MD
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Jack McDonald
Fax: 701-223-5366

Dear Committee Members:

Thank you very much for allowing us to discuss the new proposed rules and regulation changes for the North Dakota physical therapists. Unfortunately I will be unable to attend the hearing personally but I felt that it was important enough of a bill that it requires input from myself so excuse me for the letter but it's the best that I could do on this short notice.

Once again, the purpose of this letter is for me to express my unconditional support for the proposed changes on the rules and regulations for the North Dakota Physical Therapy Act. The board has spent a great deal of time and going back and forth with the North Dakota physical therapists and the North Dakota PT Association trying to come to a consensus about these final revised changes so that everyone has a strong consensus. The one issue that seems to have arisen from outside interests deals with manual therapy techniques. As a trained physical therapist as well as an orthopedic surgeon there is no question in my mind in my daily practice I encounter physical therapists who are experts in performing manual therapy techniques for various soft tissue as well as hard tissue diseases and injuries. It is my opinion both from an educational standpoint having gone through the curriculum and continuing education courses that physical therapists indeed do have the expertise as well as the training to perform manual therapy techniques in treating musculoskeletal problems. In addition, they do have the necessary diagnostic skills to identify these injuries and quite frankly I think they do sometimes better jobs than some physicians because of their expertise in both the anatomy, the physiology and the kinesiology of the musculoskeletal system.

I therefore hope that you will give strong consideration to passage of the current rules and regulations as they have been revised by us on the State Board of Examining Physical Therapists. If you would need any further information from me, I am readily available by phone or by any type of either telecommunication or print. Once again, thank you very much for your time and your evaluation of this very important bill.

Sincerely Yours,

Philip Q. Johnson, M.D., P.C.

PQJ/crb Dict. 2-03-05

Attachment A 5

FEBRUARY 7, 2005
AMENDMENTS PROPOSED BY
ND PHYSICAL THERAPY EXAMINING COMMITTEE
ND PHYSICAL THERAPY ASSOCIATION

PROPOSED AMENDMENTS TO SB 2366

On page 2, line 1, after the word "means" insert "consultation pursuant to section 43-51-03." and remove the remainder of the line

On page 2, remove lines 2 through 4

On page 2, line 7, after "4." insert "Manual therapy" means the use of manual therapy techniques such as mobilization/manipulation, manual lymphatic drainage and manual traction on one or more regions. and remove the remainder of the line

On page 2, line 9, remove "continuously"

On page 2, line 27, after "limitations" insert "in movement and mobility"

On page 3, line 1, after "limitations" insert "in movement and mobility"

On page 3, line 4, after "training" insert "related to positioning, movement and mobility"

On page 3, line 7, after "equipment" insert "related to positioning, movement and mobility"

On page 3, line 11, remove "Reducing" and insert "Engage as a physical therapist in reducing"

On page 3, line 14, after "Engaging" insert "as a physical therapist "

On page 4, line 4, remove "shall" and insert "may"

On page 4, line 23, remove "and residential" and after "address," insert "business"

On page 4, remove line 30

On page 5, line 1 through 3

On page 6, remove lines 12 and 13

On page 6, line 14, replace "3." with "2."

On page 6, line 16, replace "4." with "3."

On page 6, line 21, replace "5." with "4."

On page 6, line 25, replace "6." with "5."

On page 7, line 1, replace "7. with "6."

On page 7, line 6, after the word "a" insert "license in good standing from another jurisdiction that imposes requirements for obtaining and maintaining a license which are at least as stringent as the requirements imposed in this state." and remove the remainder of the line

On page 7, remove lines 7 and 8

On page 7, line 29, after "providing" insert "services in accordance with section 43-51-03." and remove the remainder of the line

On page 7, remove line 30

On page 8, line 11, after "license" insert "annually"

On page 8, line 13, after "state" insert "and may be subject to a late renewal fee"

On page 8, line 17, replace "lapsed" with "expired"

On page 8, line 19, replace "lapsed" with "expired"

On page 8, line 25, replace "lapsed" with "expired"

On page 9, line 25, remove "continuously"

On page 10, line 8, after "c." remove the remainder of the line

On page 10, line 9, remove "d."

On page 10, line 12, replace "shall" with "may"

On page 10, line 13, replace "consent" with "authorization" and replace "required" with "permitted"

On page 10, line 23, replace "finds" with "findings"

On page 11, line 19, after "exists" insert "except with a spouse"

On page 11, line 25, remove "recognized"

On page 11, line 26, after "profession" insert "adopted by rule by the board"

On page 12, line 14, replace "documented consent" with "the written authorization"

On page 12, line 15, replace "required" with "permitted"

On page 12, line 27, remove "recognized"

On page 12, line 28, remove "and" and remove "further"

On page 13, line 6, replace "A" with "Except as otherwise provided by law, a"

Renumber accordingly

Attachment 6

CURRENT LAW & RULES

CHAPTER 43-26
PHYSICAL THERAPISTS

43-26-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Physical therapist" means a physical therapist registered under this chapter.

2. "Physical therapist assistant" means a physical therapist assistant registered under this chapter who assists, under direction of a registered physical therapist, in the practice of physical therapy and who performs such delegated procedures commensurate with the assistant's education and training.

3. "Physical therapy" means the art and science of a health speciality concerned with the prevention of disability and the physical rehabilitation for congenital or acquired disabilities resulting from, or secondary to, injury or disease. The practice of physical therapy means the practice of the health specialty, and encompasses physical therapy evaluation, treatment planning, instruction, and consultative services, including:

   a. Performing and interpreting tests and measurements as an aid to physical therapy treatment.

   b. Planning initial and subsequent treatment programs, on the basis of test findings.

   c. Administering treatment by therapeutic exercise, neurodevelopmental procedures, therapeutic massage, mechanical devices, and therapeutic agents which employ the physical, chemical, and other properties of air, water, heat, cold, electricity, sound, and radiant energy for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability.

4. "Supportive personnel" means persons other than registered physical therapists who function in a physical therapy setting and assist with physical therapy care.

43-26-02. Duties of state board of medical examiners. Repealed by S.L. 1979, ch. 470, § 12.

43-26-03. Examining committee. Repealed by S.L. 1979, ch. 470, § 12.

43-26-04. State examining committee - Members - Terms - Appointments - Vacancies. The state examining committee for physical therapists, hereinafter the "committee", shall administer this chapter. The committee shall consist of three registered physical therapists, two licensed physicians, and a citizen who is not a health care professional. The governor shall appoint the committee members for a term of five years, staggered so the terms of no more than two members expire each year. No person may serve more than two full consecutive terms. Terms begin on July first. Appointments to the committee to fill a vacancy occurring for other than the expiration of a term may only be made for the remainder of the unexpired term. Each physical therapist appointed must have had at least three years of physical therapy experience in North Dakota immediately prior to appointment, and must practice in North Dakota during the term. Each physician appointed must have practiced medicine at least three years in North Dakota immediately prior to appointment and must practice in North Dakota during the term. Each member of the state examining committee, before entering upon the discharge of official duties, shall take and file with the secretary of state the oath of office prescribed for state officials.

43-26-05. Officers - Duties - Compensation. A president and a vice president must be elected annually by the committee from its members to serve for one year or until their

successors are elected and qualified. The committee shall designate a secretary who does not have to be a committee member. The committee has authority to prescribe reasonable rules and regulations relative to the qualification and examination of physical therapist and physical therapist assistant applicants. As to any matters coming under its jurisdiction, the committee may take such testimony as it may deem necessary in the exercise of its powers and the performance of its duties under this chapter. Any committee member has the power to administer oaths in taking such testimony.

A simple majority of the committee constitutes a quorum for the transaction of business. The secretary shall keep a record of all committee proceedings. The committee shall meet at such time and at such place as the president shall direct. The committee shall conduct examinations for the registration of physical therapists and physical therapist assistants at least once each year. The committee shall hire and set the compensation for any employees it needs to administer this chapter. Committee members shall receive expenses from committee funds for each day or a portion thereof spent in committee work as provided for other state officers in chapter 44-08. All funds collected or received by the committee must be deposited and disbursed in accordance with section 54-44-12.

43-26-06. Applicants - Qualifications - Examinations. It is the duty of the committee to pass upon the qualifications of all applicants for physical therapy and physical therapist assistant examination and registration, provide for and conduct all examinations, determine the applicants who successfully pass the examination, and duly register such persons. To be registered as a physical therapist or a physical therapist assistant, a person must:

1. Be at least eighteen years of age.
2. Be of good moral character.
3. Have been graduated by a school of physical therapy or a program of physical therapist assistant training approved by the committee.

Examinations must embrace subjects to test an applicant's knowledge of the basic and clinical sciences as they relate to physical therapy, and physical therapy theory and procedures, and such other subjects as the committee may determine to be necessary. When applying to take the registration examination, the applicant shall pay the committee a fee fixed by committee regulation and not exceeding two hundred dollars which may not be returned if the application is denied. The committee may determine the fee without complying with chapter 28-32.

43-26-07. Registration. The committee shall register all applicants as physical therapists or physical therapist assistants who successfully pass the examinations provided for in this chapter and who are otherwise qualified as required herein, and shall furnish a certificate of registration to each successful applicant.

43-26-08. When examination not required - Fee. The committee may issue a registration certificate without examination to an applicant who presents satisfactory evidence of having passed the examination in physical therapy of the American registry of physical therapists, or an examination before a similar, lawfully authorized examining board in physical therapy or for physical therapist assistants of another state, the District of Columbia, a United States territory, or a foreign country. However, this reciprocity can be granted only if the standards for registration in physical therapy or physical therapist assistants in such other jurisdiction are determined by the committee to be as high as North Dakota's. The committee shall establish a registration fee under this section within the limits of section 43-26-06.

43-26-09. Renewals - Continued currency - Fees. In January of each year every physical therapist or physical therapist assistant shall apply to the committee for an extension of the person's registration, and pay a fee determined by the committee which may not exceed one hundred dollars. The committee may determine the fee without complying with chapter 28-32. Registration that is not annually renewed on or before January thirty-first lapses on that date. The committee, in its discretion, may reinstate a lapsed registration upon payment of the full

renewal fee as provided in this section and may, in its discretion, require a late renewal fee of fifty dollars.

The committee may adopt rules to require some evidence of continued currency for registration or reregistration as a physical therapist or a physical therapist assistant.

43-26-10. Rules and regulations. The committee shall adopt whatever rules and regulations, pursuant to the provisions of chapter 28-32, are necessary to carry out the provisions of this chapter. The committee secretary shall keep a record of all proceedings under this chapter and a list of all persons registered under it. The register shall show the name, address, date, and number of the original registration and the renewal thereof. The secretary annually shall, on or before February fifteenth, compile a list of all registered physical therapists and physical therapist assistants and mail a copy to the state department of health. A copy of this list may be obtained from the secretary for a fee fixed by the committee. The committee shall use the funds it receives under this chapter to defray its expenses in administering this chapter. The secretary shall sign all orders for payment of money and other accounts and other orders of the committee.

43-26-11. Refusal, suspension, or revocation of certificate. The committee may refuse to register any physical therapist or physical therapist assistant, or may suspend or revoke the registration of any physical therapist or physical therapist assistant, for any of the following grounds:

1. Use of controlled substances, drugs, or liquor to an extent that affects professional competency.

2. A determination by the committee that a conviction of the holder of an offense has a direct bearing on the holder's ability to serve the public as a physical therapist or physical therapist assistant or that, following conviction of any offense, the holder is not sufficiently rehabilitated under section 12.1-33-02.1.

3. Procuring, aiding, or abetting an illegal abortion.

4. Obtaining or attempting to obtain registration by fraud or deception.

5. A finding by a court of competent jurisdiction that the registrant is a mentally ill person and has not thereafter been restored to legal capacity.

6. Conduct unbecoming a person registered as a physical therapist or physical therapist assistant, or detrimental to the best interests of the public.

7. Treating or attempting to treat or diagnose ailments or other health conditions of human beings other than by physical therapy and as authorized by this chapter.

8. Failing to refer to a licensed health care professional any patient whose medical condition at the time of evaluation is determined by the physical therapist to be beyond the scope of practice of physical therapy as defined in section 43-26-01.

9. Failure of a physical therapist to report to the committee any physical therapist the holder knows to be in violation of this section.

10. In the case of a physical therapist assistant, practicing or offering to practice other than under direction of a physical therapist.

11. Failure to comply with continuing education requirements adopted by the committee.

12. Failure to provide adequate supervision of supportive personnel as required by this chapter or by rule.

43-26-12. Use of certain words and initials prohibited. It is unlawful for any persons, corporations, limited liability companies, or associations to, in any manner, represent themselves as physical therapists or physical therapist assistants, as providing physical therapy services, or to use in connection with their names the words or letters physical therapist, physiotherapist, physical therapy technician, registered physical therapist, physical therapist assistant, P.T.A., P.T., Ph. T., P.T.T., or R.P.T., or any other letters, words, abbreviations or insignia, indicating or implying they are physical therapists or physical therapist assistants, or provide physical therapy services, without a valid existing certificate or registration as physical therapists or physical therapist assistants issued to them pursuant to this chapter. Nothing in this chapter shall prohibit any persons licensed or registered in this state, under chapter 43-17 or another law, from carrying out the therapy or practice for which they are duly licensed or registered. Nor shall it prevent schools and YMCAs from furnishing therapy service to their players and members. This chapter does not prohibit massage therapists from engaging in their practice provided they do not represent themselves as physical therapists or physical therapist assistants.

43-26-13. Physical therapist or physical therapist assistant must be registered - Representations and billings without registration prohibited - Enforcement - Injunctions. No person, persons, corporations, limited liability companies, or associations shall practice physical therapy or hold themselves out, represent themselves, or send out billings as providing physical therapy services, without personal registration or the use of registered employees as provided in this chapter. It shall be unlawful to employ an unregistered physical therapist or physical therapist assistant to provide physical therapy services. The secretary, under the direction of the committee, shall aid the state's attorneys of the various counties in the enforcement of the provisions of this chapter and the prosecution of any violations thereof. In addition to the criminal penalties provided by this chapter, the civil remedy of injunction shall be available to restrain and enjoin violations of any provisions of this chapter without proof of actual damages sustained by any person.

43-26-14. Penalty. Any person violating any of the provisions of this chapter is guilty of a class B misdemeanor.

ARTICLE 61.5-01

GENERAL ADMINISTRATION

CHAPTER 61.5-01-01
ORGANIZATION OF THE COMMITTEE

61.5-01-01-01. Organization of the state examining committee for physical therapists.

1. **History**. The state examining committee for physical therapists was created in 1959 to assist the state board of medical examiners in the examination and registration of physical therapists in North Dakota. While it operated as a separate committee, it was by law an advisory committee to the state board of medical examiners. The forty-sixth legislative assembly in 1979 revamped most of North Dakota Century Code chapter 43-26 on physical therapists, and in the process made the committee a separate entity with complete jurisdiction over the examination and registration of physical therapists.

2. **Committee membership**. The committee consists of six persons appointed by the governor. Three committee members must be registered physical therapists, two members must be licensed physicians, and one member must be a nonhealth care professional. Committee terms are to be staggered and are for five years. Possible nominations to the committee will be solicited by the committee's secretary, who may be the executive officer, from all registered physical therapists in the state at the time notices for registration renewal are sent out.

3. **Meetings**. The committee shall hold at least one annual meeting, and such other meetings as may be called by the president. Any committee member who fails to attend two consecutive annual meetings shall have been deemed to have resigned unless the member has reasons satisfactory to the committee for being unable to attend.

4. **Compensation**. Committee members shall receive expenses from committee funds for each day or a portion thereof spent in committee work as provided for other state officers in North Dakota Century Code chapter 44-08.

5. **Executive officer.** The committee shall designate an executive officer, who does not have to be a committee member, but who must be a North Dakota licensed physical therapist, and shall compensate any person it hires to administer the committee's duties.

   The committee's executive officer is:

   Ms. Lynn G. Kubousek
   P.O. Box 69
   Grafton, ND 58237
   (701) 352-0125

History: Effective December 1, 1980; amended effective August 1, 1983; April 1, 1988; April 1, 1992; February 1, 1993; July 1, 2004.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 28-32-02.1, 43-26-05

CHAPTER 61.5-01-02
DEFINITIONS

Section
61.5-01-02-01 Definitions

61.5-01-02-01. Definitions. Unless specifically stated otherwise, the following definitions are applicable throughout this title:

1. "A school of physical therapy or a program of physical therapist assistant training" is a nationally accredited program approved by the committee.

2. "Committee" means the North Dakota state examining committee for physical therapists.

3. "Consultation by means of telecommunications" means that a physical therapist renders professional or expert opinion or advice to another physical therapist or health care provider via telecommunications or computer technology from a distant location. It includes the transfer of data or exchange of educational or related information by means of audio, video, or data communications. The physical therapist may use telehealth technology as a vehicle for providing only services that are legally or professionally authorized. The patient's written or verbal consent will be obtained and documented prior to such consultation. All records used or resulting from a consultation by means of telecommunications are part of a patient's record and are subject to applicable confidentiality requirements.

4. "Direct supervision" means the physical therapist is physically present on the premises and immediately available for direction and supervision. The physical therapist will have direct contact with the patient during each visit. Telecommunications does not meet the requirement for direct supervision.

5. "National examination" or "examination" means the examination adopted by the federation of state boards of physical therapy.

6. "Onsite supervision" means the supervising physical therapist is continuously onsite and present in the department or facility where services are provided, is immediately available to the person being supervised, and maintains continued involvement in appropriate aspects of each treatment session in which supportive personnel are involved in components of care.

7. "Physical therapist" means a person who applies physical therapy.

8. "Physical therapist assistant" means a health care worker who assists the physical therapist in the provision of physical therapy. The physical therapist assistant must be a graduate of a physical therapist assistant

associate degree program accredited by an agency recognized by the secretary of the United States department of education or the council on postsecondary accreditation. The physical therapist assistant must be licensed to practice in North Dakota.

9. "Physical therapy" means the art and science of a health specialty concerned with the prevention of disability and the physical rehabilitation for congenital or acquired disabilities resulting from, or secondary to, injury or disease. The practice of physical therapy means the practice of the health specialty, and encompasses physical therapy evaluation, treatment planning, instruction, and consultative services, including:

   a. Performing and interpreting tests and measurements as an aid to physical therapy treatment.

   b. Planning initial and subsequent treatment programs on the basis of test findings.

   c. Administering treatment by therapeutic exercise, neurodevelopmental procedures, therapeutic massage, mechanical devices, and therapeutic agents which employ the physical, chemical, and other properties of air, water, heat, cold, electricity, sound, and radiant energy for the purpose of correcting or alleviating any physical or mental condition, or preventing the development of any physical or mental disability.

10. "Physical therapy aide" means a person trained under the direction of a physical therapist who performs designated and supervised routine tasks related to physical therapy.

11. "Student" is an individual who is currently engaged in the fulfillment of a physical therapy or physical therapist assistant educational program approved by the committee.

12. "Supportive personnel" are persons other than registered physical therapists who function in a physical therapy setting and assist with physical therapy care.

History: Effective December 1, 1980; amended effective April 1, 1992; December 1, 1994; July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-01, 43-26-04, 43-26-06, 43-26-07, 43-26-10, 43-26-11(12)

ARTICLE 61.5-02

EXAMINATION, REGISTRATION, AND FEES

CHAPTER 61.5-02-01
EXAMINATIONS

61.5-02-01-01. Frequency of examinations. Computer-based examinations are available by appointment at designated sites in North Dakota.

History: Effective December 1, 1980; amended effective July 1, 2004.
General Authority: NDCC 43-26-05, 43-26-10
Law Implemented: NDCC 43-26-05

61.5-02-01-02. Location of examinations. The committee shall designate testing site locations within North Dakota. Other testing sites are available in the United States, United States territories, and Canada.

History: Effective December 1, 1980; amended effective July 1, 2004.
General Authority: NDCC 43-26-05, 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-06

61.5-02-01-03. Repeating examinations. An applicant who fails an examination may repeat the examination, but must pay another examination fee each time the examination is repeated. An applicant may write the examination a maximum of four times within one calendar year. After the fourth time, an applicant must wait one calendar year and show evidence of remediation approved by the committee before again taking the examination.

History: Effective December 1, 1980; amended effective April 1, 1992; July 1, 2004.
General Authority: NDCC 43-26-05, 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-06

61.5-02-01-04. Eligibility to take examination. An applicant must have graduated from an approved program prior to writing the examination.

History: Effective April 1, 1992; amended effective July 1, 2004.
General Authority: NDCC 43-26-05, 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-06

CHAPTER 61.5-02-02
REGISTRATION

61.5-02-02-01. General registration requirements for graduates of approved curricula. The following requirements apply to all applicants for registration who are graduates of physical therapy or physical therapist assistant curricula approved by the committee:

1. A completed application form.
2. Payment of the appropriate fees as set by the committee.
3. An official transcript giving evidence of graduation from a curricula approved by the committee.
4. Passing scores on the national examination.
5. Completion of the juris prudence examination.
6. At the committee's discretion, an interview with the committee or designees thereof.

History: Effective December 1, 1980; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-06

61.5-02-02-02. Types of registration.

1. Official registration.
   a. By examination, general registration requirements must be met.
   b. By endorsement, United States jurisdiction.
      (1) General registration requirements must be met.
      (2) Verification of registration in good standing from the jurisdictions in which the applicant has been registered.

(3) Copy of scores on the national examination transmitted by a score transfer service approved by the committee.

(4) If the applicant has not practiced physical therapy for three or more years, the applicant must take or retake the national examination.

2. Foreign-educated applicant.

a. By examination.

(1) A completed application form.

(2) Payment of the appropriate fees as set by the committee.

(3) Verification of documents by an agency recognized by the committee.

(a) Satisfactory evidence that the applicant's education is substantially equivalent to the requirements of physical therapists educated in a physical therapy education program approved by the committee.

(b) Graduated from a physical therapist education program that prepares the applicant to engage without restrictions in the practice of physical therapy.

(c) Proof that the applicant's school of physical therapy education is recognized by its own ministry of education.

(d) Pass the board-approved English proficiency examination if the applicant's native language is not English.

(4) Passing scores on the national examination.

(5) Completion of juris prudence examination.

(6) At the committee's discretion, an interview with the committee or designees thereof.

(7) Completion of a six-month preceptorship under the direct supervision of a physical therapist, registered and actively practicing in North Dakota.

b. By endorsement from another United States jurisdiction.

(1) A completed application form.

(2) Payment of the appropriate fees as set by the committee.

(3) Verification of documents by an agency recognized by the committee.

(a) Satisfactory evidence that the applicant's education is substantially equivalent to the requirements of physical therapists educated in a physical therapy education program approved by the committee.

(b) Graduated from a physical therapist education program that prepares the applicant to engage without restrictions in the practice of physical therapy.

(c) Proof that the applicant's school of physical therapy education is recognized by its own ministry of education.

(d) Pass the board-approved English proficiency examination if the applicant's native language is not English.

(4) Copy of passing scores on the national examination received by a score transfer service approved by the committee.

(5) Completion of juris prudence examination.

(6) Verification of registration in good standing from the jurisdictions in which the applicant has been registered.

(7) At the committee's discretion, an interview with the committee or designees thereof.

(8) Completion of a six-month preceptorship under the direct supervision of a physical therapist, registered and actively practicing in North Dakota.

(9) If the applicant has not practiced physical therapy for three or more years, the applicant must take or retake the national examination.

History: Effective December 1, 1980; amended effective April 1, 1992; December 1, 1994; July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-01, 43-26-04, 43-26-06, 43-26-07, 43-26-10, 43-26-11(12)

61.5-02-02-03. Registration requirements for graduates of foreign curricula. Repealed effective July 1, 2004.

61.5-02-02-04. Types of registration. Repealed effective July 1, 2004.

61.5-02-02-05. Renewal of registration.

1. Registrations shall be renewed annually by January thirty-first.

2. If a registrant fails to receive the renewal notice, it is the responsibility of the registrant to contact the committee before the January thirty-first deadline.

3. Any registrant who fails to make application for renewal of registration by January thirty-first will, at the committee's discretion, pay a late renewal fee as prescribed in section 61.5-02-03-01.

4. A registration expires if not renewed by January thirty-first.

5. If a registration has expired for more than a year, the registrant is not eligible for renewal, but must apply for registration. However, registrants whose registrations have lapsed and who have been unregistered for more than one year but less than three years from the last renewal may not be required to take the national examination, provided the continuing education requirements have been met.

6. All licensed physical therapists may be required to file with the committee a notarized statement indicating they have read these administrative rules.

History: Effective December 1, 1980; amended effective April 1, 1992; December 1, 1994; July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-01, 43-26-09, 43-26-11(12)

61.5-02-02-06. Exceptions to registration.

1. The following persons are exempt from North Dakota physical therapy registration requirements when engaged in the following activities:

   a. A person in a professional education program approved by the board who is pursuing a course of study leading to a degree as a physical therapist and who is satisfying supervised clinical education requirements related to the person's physical therapy education while under onsite supervision of a licensed physical therapist.

   b. A physical therapist who is practicing in the United States armed services, United States public health service, or veterans administration pursuant to federal regulation for state licensure of health care providers.

c. A physical therapist who is licensed in another jurisdiction of the United States or a foreign-educated physical therapist credentialed in another country if that person is performing physical therapy in connection with teaching or participating in an educational seminar of no more than sixty days in a calendar year.

d. A physical therapist who is licensed in another jurisdiction of the United States if that person is providing consultation by means of telecommunication to a physical therapist licensed under North Dakota Century Code chapter 43-26.

2. If aides or students provide physical therapy services other than under direct supervision of a registered physical therapist, they are in violation of North Dakota Century Code chapter 43-26.

3. Upon application to the committee, a physical therapist currently registered in good standing in another state or jurisdiction, and who is not subject to any pending disciplinary proceeding, may practice physical therapy in North Dakota without obtaining registration from the committee provided the practice is limited to no more than thirty full or partial days per year. The one-year period starts on the date the written application is approved by the committee. Prior to any such limited practice, the physical therapist must apply to the committee, using forms provided by the committee, and pay an application fee of twenty-five dollars. The application must include:

a. Verified documentation from the appropriate registration authority identifying the requirements for registration in that jurisdiction, confirming that the physical therapist is registered and in good standing in that jurisdiction, and confirming that the physical therapist is not subject to any pending disciplinary proceedings.

b. The dates, locations, and scope of practice the physical therapist intends to perform in North Dakota.

c. The purpose of the physical therapist's limited North Dakota practice and the physical therapist's employer.

d. Other information required by the committee.

History: Effective December 1, 1980; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-08, 43-51-05, 43-51-06

61.5-02-02-07. Registration refused, revoked, suspended, or restricted.

1. The committee may refuse, suspend, restrict, or revoke a registration on the grounds stated in North Dakota Century Code section 43-26-11.

2. The committee may refuse to grant registration to any applicant who begins practice as a physical therapist or as a physical therapist assistant prior to being registered to practice in North Dakota.

History: Effective December 1, 1980; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-11

CHAPTER 61.5-02-03
FEES

61.5-02-03-01. Fees.

1. Application fee - not refundable - $150.00.

2. Annual renewal fee - $60.00 for physical therapist and $40.00 for physical therapist assistant.

3. Late renewal fee - $50.00.

History: Effective December 1, 1980; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-06, 43-26-08, 43-26-09, 43-26-10

ARTICLE 61.5-03

CONTINUING EDUCATION

CHAPTER 61.5-03-01
CONTINUING EDUCATION REQUIREMENT

61.5-03-01-01. Continuing education requirement. The committee shall establish, and revise as it deems necessary, rules and regulations to require some form or system of continuing education as a requirement for registration or reregistration as a physical therapist or a physical therapist assistant.

History: Effective December 1, 1980; amended effective April 1, 1992.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-09

61.5-03-01-02. Hours, effective date, and requirements. Effective January 31, 1992, all physical therapists and physical therapist assistants must obtain twenty-five contact hours of continuing education every two years to be eligible for registration or reregistration. One contact hour equals sixty minutes of instruction. There may be no carryover of credit hours to the next reporting period. The committee shall determine reporting groups, methods, and deadlines.

History: Effective April 1, 1992.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-09

CHAPTER 61.5-03-02
COURSES AND CREDIT STANDARDS

61.5-03-02-01. Course content. Twenty-five contact hours are required every two years. At least fifteen of the required hours must be clinically related, five of which may be cardiopulmonary resuscitation. Nonclinical courses must relate to a therapist's job responsibilities. All continuing education courses related to physical therapy sponsored by the American physical therapy association, state physical therapy associations, medical institutions, or educational institutions are automatically approved. Any continuing education courses planned, sponsored, or cosponsored by the arthritis foundation, the American heart association, or other similar national or state health organizations, which meet the credit standards of section 61.5-03-02-02, are automatically approved. Any postsecondary coursework taken at an accredited educational institution will be automatically approved, provided the coursework meets the credit standards.

History: Effective April 1, 1992.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-09

61.5-03-02-02. Credit standards. The following credit standards apply to any continuing education course that is intended to meet the continuing education requirements for physical therapists or physical therapist assistants:

1. The educational activities must have significant intellectual or practical content dealing primarily with matters directly related to the practice of physical therapy or to the professional responsibility or ethical obligations of the participants.

2. Each person making a presentation at a continuing education course must be qualified by practical or academic experience to teach the subject the person covers.

3. Participants shall attend educational activities in a classroom or other setting suitable for the activity. Video, motion picture, or sound presentations may be used.

4. Credit may not be given for entertainment or recreational activities or programs, employment orientation sessions, holding an office or serving as an organizational delegate, meeting for the purpose of making policy, or noneducational association meetings.

5. Credit may not be given for meals, keynote speeches, introductory or preliminary sessions, postsession activities, and similar events associated with continuing education programs.

6. A person teaching an approved continuing education course must be awarded additional credit for preparation time not to exceed a ratio of five to one between preparation time and presentation time respectively. Presentation time counts as contact hours for continuing education purposes. This credit may be taken for only one course annually.

7. Coursework may be acquired through self-study, provided that the coursework is accompanied by appropriate written materials.

History: Effective April 1, 1992; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-09

CHAPTER 61.5-03-03
VERIFICATION OF COMPLIANCE

61.5-03-03-01. Verification of compliance.

1. At the January license renewal deadline immediately following their two-year continuing education cycle, registrants shall provide a signed and notarized statement provided by the committee listing the continuing education courses taken and indicating compliance with the required twenty-five hours of continuing education. The committee, in its discretion, may require additional evidence necessary from a registrant to verify compliance.

2. The committee shall periodically select a sample of the registered physical therapists and may request evidence of the continuing education to which they have attested. Documentation may come directly from the registrant or from state or national organizations that maintain those types of records.

3. A person who claims extenuating circumstances in not being able to meet the continuing education requirements shall petition the committee for consideration of those special conditions.

4. As of January 31, 1992, registrants registering in North Dakota for the first time from other states or countries who do not have twenty-five hours of continuing education credits within the last two years will be required to complete thirteen hours of continuing education within a year of their initial registration in North Dakota, and will thereafter be on the two-year continuing education cycle provided in these rules.

History: Effective April 1, 1992; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-05, 43-26-09

ARTICLE 61.5-04

VIOLATIONS

CHAPTER 61.5-04-01
VIOLATIONS

61.5-04-01-01. Violations. Complaints and problems about alleged violations of North Dakota Century Code chapter 43-26 shall be forwarded to the committee for its consideration. The committee shall review and, if necessary, investigate all complaints and allegations that come before it concerning North Dakota Century Code chapter 43-26 violations. The committee may seek the advice and assistance of legal counsel in this review and investigation process. The committee may direct its executive officer, or other personnel, to act either directly, on its behalf, or to assist others, in filing complaints of North Dakota Century Code chapter 43-26 violations with state's attorneys, and to provide assistance and information as required by state's attorneys. The committee may seek the advice of legal counsel concerning the use of injunctions as a means of preventing or stopping North Dakota Century Code chapter 43-26 violations, and may direct legal counsel, on its behalf, to use such remedies.

History: Effective December 1, 1980; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-13

ARTICLE 61.5-05

SUPERVISION OF SUPPORTIVE PERSONNEL

CHAPTER 61.5-05-01
SUPERVISION OF SUPPORTIVE PERSONNEL

61.5-05-01-01. Delegation of responsibility. When a physical therapist delegates patient care responsibilities to physical therapist assistants or other supportive personnel, the physical therapist holds responsibility for supervision of the physical therapy program. Physical therapists shall not delegate to a less qualified person any activity that requires the unique skills, knowledge, and judgment of the physical therapist. The primary responsibility for physical therapy care rendered by supportive personnel rests with the supervising physical therapist. Adequate supervision requires, at a minimum, that the supervising physical therapist perform the following activities:

1. Designate or establish channels of written and oral communication.
2. Interpret available information concerning the individual under care.
3. Provide initial evaluation.
4. Develop plan of care, including short-term and long-term goals.
5. Select and delegate appropriate tasks for plan of care.
6. Assess competence of supportive personnel to perform assigned tasks.
7. Direct and supervise supportive personnel in delegated tasks.
8. Identify and document precautions, goals, anticipated progress, and plans for reevaluation.

9. Reevaluate, adjust plan of care when necessary, perform final evaluation, and establish followup plan of care.

History: Effective December 1, 1994.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-09, 43-26-11

61.5-05-01-02. Physical therapist assistants. The physical therapist assistant shall perform specific physical therapy duties under the supervision of a physical therapist who is properly credentialed in the jurisdiction in which the physical therapist assistant practices.

1. Performance of service in general.

   a. The physical therapist assistant may initiate or alter a treatment program only with prior evaluation by, and approval of, the supervising physical therapist.

   b. The physical therapist assistant, with prior approval by the supervising physical therapist, may adjust the specific treatment procedure in accordance with changes in the patient's status.

   c. The physical therapist assistant may interpret data only within the scope of the physical therapist assistant's education.

   d. The physical therapist assistant may respond to inquiries regarding a patient's status to appropriate parties within the protocol established by the supervising physical therapist.

   e. The physical therapist assistant shall refer inquiries regarding patient prognosis to a supervising physical therapist.

   f. Documentation other than the initial note and the discharge summary can be written by a physical therapist assistant.

2. Service in home health, long-term care, and school settings.

   a. A qualified physical therapist must be accessible by communication to the physical therapist assistant at all times while the physical therapist assistant is treating the patient.

   b. An initial visit must be made by a qualified physical therapist for evaluation of the patient and establishment of a plan of care.

   c. A joint visit by the physical therapist and physical therapist assistant or a conference between the physical therapist and physical therapist assistant must be made prior to or on the first

physical therapist assistant visit to the patient. The physical therapist must complete the initial evaluation.

d. At least once every sixth physical therapist assistant visit or at least once every thirty calendar days, whichever occurs first, the physical therapist must visit the patient. Following each onsite visit by a physical therapist, the medical/education record must reflect a documented conference with the physical therapist assistant outlining treatment goals and program modification. The physical therapist must make the final visit to terminate the plan of care.

e. A supervisory onsite visit must include:

(1) An onsite functional assessment.

(2) Review of activities with appropriate revisions or termination of plan of care.

(3) Assessment of utilization of outside resources.

3. Service in hospitals or other clinical settings require constant onsite supervision.

a. All duties must conform with section 61.5-05-01-01.

b. A joint treatment with the physical therapist and physical therapist assistant or after a direct treatment by the physical therapist with a conference between the physical therapist and physical therapist assistant must occur at least once per week.

History: Effective December 1, 1994; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-09, 43-26-11

61.5-05-01-03. Athletic trainers. Repealed effective July 1, 2004.

61.5-05-01-04. Physical therapy aides. The physical therapy aide may assist the physical therapist in the following activities:

1. Carry out established procedures for the care of equipment and supplies.

2. Prepare, maintain, and clean up treatment areas and maintain a supportive area.

3. Transport patients, records, equipment, and supplies in accordance with established policies and procedures.

4. Assemble and disassemble equipment and accessories.

5. Under the direct supervision of a physical therapist, assist in preparation for and perform routine tasks as assigned.

History: Effective December 1, 1994; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-09, 43-26-11

61.5-05-01-05. Supervision ratios. A physical therapist, at any one time, may supervise a maximum of three supportive personnel if no more than two are physical therapist assistants.

History: Effective December 1, 1994; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-09, 43-26-11

61.5-05-01-06. Supportive personnel identification. All supportive personnel shall wear an identification badge identifying them as a physical therapist assistant or physical therapy aide, or as appropriate. Supportive personnel shall not use any term that implies they are licensed physical therapists.

History: Effective December 1, 1994; amended effective July 1, 2004.
General Authority: NDCC 43-26-10
Law Implemented: NDCC 43-26-09, 43-26-11

Attachment 7

TESTIMONY ON SENATE BILL 2366

Jeff Askew, D.C.
President, North Dakota Chiropractic Association
February 7, 2005

Madame Chair Lee and Members of the Human Services Committee:

My name is Jeff Askew, I am here this morning as President of the North Dakota Chiropractic Association to address SB 2366. While our association does not oppose the overall intent of the bill, we would like to address two primary issues of concern with the language of the bill.

Page 3, line 5 includes "manual therapy" as within the scope of practice of physical therapy. While PTs certainly do perform manual therapy, the concern we have is not with the use of the term, but rather with its potential for an extremely broad and overreaching interpretation.

We would like to offer an amendment for your consideration that clearly defines manipulation/mobilization within the term "manual therapy."

In our discussions with the PTs, they have correctly and appropriately conveyed their definition of Manual Therapy directly from the AMA CPT coding manual. It is the same definition used by the AMA, Medicare, North Dakota Blue Cross, and WSI, and we agree with its use. The Coding manual defines Manual Therapy as:

> *"Mobilization/manipulation, manual lymphatic drainage, manual traction; one or more regions." (The code number is 97140 and refers to each 15 minutes of therapy.)*

While we agree with the use of the definition, we have significant concerns about its potential for too broad of interpretation, allowing PTs to perform a high level of manipulation that goes beyond the scope of this code. These higher levels of manipulation involve training and skill requirements outside the realm of current PT education.

In the spectrum of manual therapy or physical medicine terminology, there are three reasonable categories for the use of the terms mobilization and manipulation.

1) Massage therapists refer to mobilizing joints and manipulating soft tissues.
2) Physical therapists refer to mobilization and manipulation of joints and soft tissues. They often refer to four levels of mobilization that don't involve a thrust, and have recently begun to be interested in what they refer to as a "Level 5 Mobilization" which does involve a thrust.
3) Doctors of Chiropractic use either the traditional term "adjustment" or, in more recent years, the more generic terms, "Chiropractic Manipulative Therapy (CMT)", or simply "Manipulation."

For the sake of our discussion, it might be better to use the generic, profession-neutral, non-jargon term "High Velocity, Low Amplitude Thrust." This term describes the high but very controlled velocity, the shallowness of the maneuver, and the suddenness required of the impulse. This maneuver takes a joint outside the boundaries of normal

physiologic range of motion but stays within the boundaries of anatomic joint integrity (in order to avoid injury).

VISUAL EXAMPLE HERE (Finger extension to active range of motion, passive range of motion, and beyond.)

This High Velocity, Low Amplitude thrust produces some very unique and special therapeutic benefits. It also presents special risks and requires significant skill.

The PT's intention is to have their new practice law convey onto them the ability to perform HVLA thrust manipulations. They have argued that the reference to "mobilization/manipulation" in their CPT code definition would encompass any level of manipulation. We feel this is an inaccurate stretch.

The curricula from massage therapy schools describe mobilization, manipulation, and myofascial release, all terms within the CPT code for manual therapy, but their licenses clearly do not allow them to perform the advanced manual therapies.

Similarly, the presence of the term manipulation/mobilization in the definition of the manual therapy code set does not inherently place High Velocity, Low Amplitude thrust manipulation into the realm of the PT just as Chiropractors can't manipulate a heart catheter just because the word manipulation is in our code set.

The same CPT manual quoted for the definition of Manual Therapy recognizes the difference between these different types of manipulation and has a separate and distinct code set for describing the chiropractic-type thrusting manipulative therapy. This code series, 98940-98943, is different because the service is different from routine "Manual Therapy" type manipulation/mobilization, regardless of who provides it. It is defined as:

"*Chiropractic manipulative treatment (CMT).*"

There is further evidence of the CPT manual differentiating between the two types of manipulation. The 97140 PT series of codes are time based codes, billed per 15-minute increment. In contrast, the 98940 series of codes are not time based, recognizing the momentary nature of the procedure.

Medicare supports our position on this. The Federal Department of Health and Human Services has determined that spinal manipulation, in the context of this type of manipulation performed by a chiropractor and the type that PTs call Level Five Mobilization, is a physician level service. Physical therapists, as non-physicians, cannot provide the physician service of manual manipulation of the spine for Medicare beneficiaries. It is to be used only by Doctors of Chiropractic, Osteopaths, and Medical Doctors. The Medicare Operational Policy Letter to this effect is included as an attachment to my testimony.

What is the problem with providers with little or no training performing these procedures? These intense manual techniques carry undeniable risks to patients we serve. Few professionals are adequately trained. Use of these techniques requires the ability to diagnosis extremity joint and spinal segmental pathology, including interpretation of diagnostic imaging, such as plain film radiographs, MRI scans, or CT scans. In addition to mastering tension presets, lines of drive, torques, depth of thrust and speed of thrust, the practitioner must have the diagnostic skills to determine if spinal manipulation is the

appropriate course of treatment, what type of manipulation to perform to maximize the benefit to risk ratio, whether or not to discontinue or alter the course of manipulative treatment, and when to conduct further diagnostics tests or make a referral to another type of provider. At the onset, it is necessary to determine whether the patient's complaint is due to a mechanical joint problem or another pathology. Without training in differential diagnosis, this would not be possible.

Only doctors of medicine, osteopathy and chiropractic are licensed in North Dakota as physicians. As physicians, these three are able to perform evaluation and management services per the CPT manual and have the diagnostic training to make appropriate decisions regarding spinal manipulation.

Without clearly defining the type of manipulation within the term "manual therapy," the interpretation could be broad enough to include even the highest level of chiropractic manipulation, subject to significantly different and reduced educational and training standards.

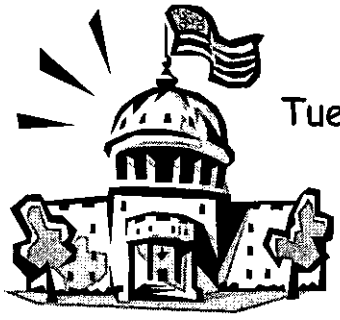
Our second concern with SB 2366 lies in the language limiting the administration of physiotherapy modalities to licensed physical therapists. In our discussions with them, the PTs have made it clear that they do not intend for this language to limit our ability to hire employees to apply physiotherapy services to our patients under our license. This practice is allowed under our law. To clarify that intent, we would just add the language of "unless otherwise provided by law" as you see in the written amendment.

Madame Chair and members of the Committee, I thank you for the opportunity to testify before you this morning and would be happy to answer any questions you may have.

Attachments:

1) Proposed amendments
2) Department of Health and human Services operational Policy Letter #23

Attachment 1



Tuesday, February 08, 2005

MEMO

TO: SEN. JUDY LEE
FROM: JACK McDONALD
RE: SB 2366, Physical Therapy Practice Act

Enclosed is a revision of the proposed amendments that (on page 3, shaded) requires each physical therapy licensee to provide the board with evidence of competence in manual therapy, with the level of competence to be determined by the physical therapy board. This, combined with §43-26.1-03 (7) that already requires the board to "establish mechanisms for assessing the continuing professional competence of physical therapists to engage in the practice of physical therapy" is a significant change that I think meets the concerns of the chiropractors.

The chiropractors have not presented any evidence that physical therapists are not sufficiently trained to perform the various manipulations being discussed. They only state they don't think they have enough training. There has not been a single complaint about manipulation performed by a physical therapist in the nearly 50 years since they have been independently licensed in North Dakota. During this time, physical therapists have successfully performed all of these manipulations under the orders of physicians and orthopedic surgeons in hospitals and clinics throughout North Dakota. These services have been accepted not only by Blue Cross/Blue Shield, but also by Medicare and Medicaid. They have met the performance standards of all ND hospitals and clinics.

Physical therapists are now uniformly graduating with doctorates evidencing six or seven, years of intensive study and training. They are required to get 25 hours of continuing education every 2 years.

Jack McDonald
223-5300 (cell 220-1996)
jackmcdonald@wheelerwolf.com

FEBRUARY 8, 2005
ADDITIONAL AMENDMENTS (SHADED) PROPOSED BY
ND PHYSICAL THERAPY EXAMINING COMMITTEE
ND PHYSICAL THERAPY ASSOCIATION

PROPOSED AMENDMENTS TO SB 2366

On page 2, line 1, after the word "means" insert "consultation pursuant to section 43-51-03." and remove the remainder of the line

On page 2, remove lines 2 through 4

On page 2, line 7, after "4." insert "Manual therapy" means the use of manual therapy techniques such as mobilization/manipulation, manual lymphatic drainage and manual traction on one or more regions. and remove the remainder of the line

On page 2, line 9, remove "continuously"

On page 2, line 27, after "limitations" insert "in movement and mobility"

On page 3, line 1, after "limitations" insert "in movement and mobility"

On page 3, line 4, after "training" insert "related to positioning, movement and mobility"

On page 3, line 7, after "equipment" insert "related to positioning, movement and mobility"

On page 3, line 11, remove "Reducing" and insert "Engage as a physical therapist in reducing"

On page 3, line 14, after "Engaging" insert "as a physical therapist "

On page 4, line 4, remove "shall" and insert "may"

On page 4, line 23, remove "and residential" and after "address," insert "business"

On page 4, remove line 30

On page 5, line 1 through 3

On page 6, remove lines 12 and 13

On page 6, line 14, replace "3." with "2."

On page 6, line 16, replace "4." with "3."

On page 6, line 21, replace "5." with "4."

On page 6, line 25, replace "6." with "5."

On page 7, line 1, replace "7. with "6."

On page 7, line 6, after the word "a" insert "license in good standing from another jurisdiction that imposes requirements for obtaining and maintaining a license which are at least as stringent as the requirements imposed in this state." and remove the remainder of the line

On page 7, remove lines 7 and 8

On page 7, line 29, after "providing" insert "services in accordance with section 43-51-03." and remove the remainder of the line

On page 7, remove line 30

On page 8, line 11, after "license" insert "annually"

On page 8, line 13, after "state" insert "and may be subject to a late renewal fee"

On page 8, line 17, replace "lapsed" with "expired"

On page 8, line 19, replace "lapsed" with "expired"

On page 8, line 25, replace "lapsed" with "expired"

On page 9, line 25, remove "continuously"

On page 10, line 8, after "c." remove the remainder of the line

On page 10, line 9, remove "d."

On page 10, line 12, replace "shall" with "may"

On page 10, line 13, replace "consent" with "authorization" and replace "required" with "permitted"

On page 10, line 23, replace "finds" with "findings"

On page 11, line 19, after "exists" insert "except with a spouse"

On page 11, line 25, remove "recognized"

On page 11, line 26, after "profession" insert "adopted by rule by the board"

On page 12, line 14, replace "documented consent" with "the written authorization"

On page 12, line 15, replace "required" with "permitted"

On page 12, line 26, after "herein." Insert "The board shall require that each licensee provide the board with evidence of competence in the various elements of manual therapy pursuant to section 43-26.1-03 (7)."

On page 12, line 27, remove "recognized"

On page 12, line 28, remove "and" and remove "further"

On page 13, line 6, replace "A" with "Except as otherwise provided by law, a"

Renumber accordingly

Lee, Judy E.

From: Tony Schotzko [tschotz@hotmail.com]
Sent: Monday, February 14, 2005 12:28 AM
To: Lee, Judy E.; Dever, Dick D.; Warner, John M.; Brown, Richard L.; Lyson, Stanley
Subject: SB 2366

Dear Senators,

My name is Tony Schotzko and I am currently a physical therapy student at the University of Mary. I am in the first class that will graduate with a doctorate in physical therapy degree. As we are updating our practice act to current terminology that would reflect the way that therapists are practicing today, I would like to voice my concerns.

I had the opportunity to attend the committee meeting where manipulations were the main topic of discussion. I was disappointed to hear the education level of our profession attacked by professionals in the chiropractic field, as well as attacks aimed toward our ability to perform a skill that has always been within the realm of physical therapy practice. I will be tested for competence in performing manipulations this semester. Patients should not be limited in their choice of healthcare providers who can perform this skill. A patient should be able to go to their professional of choice to receive treatment and feel safe in that provider's hands.

The state examining board regulates our profession, and as a future professional, I will be accountable to each of my clients for practicing safely. I will assume resoponsibility for the safety and well-being of all my patients. If I am unable to use all the skills I am acquiring during my professional training, I would consider finding a state where I could use all of the talents and skills that I have acquired thus far. Thank you for your ears and please support SB 2366 with only physical therapy amendments.

Sincerely,
Tony Schotzko

Attachment 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
OPERATIONAL POLICY LETTER #23

Date Issued: Revised – January 15, 2002 (Revision of December 14, 1994)

Operational Policy Letter #: OPL 2002.023

To: **Current M+C Organizations**

Subject: **Manual Manipulation of the Spine to Correct Subluxation – Medicare Coverage**

Effective Date: **January 15, 2002**

Implementation Date: **January 15, 2002**

Operational Policy Question:

Which practitioners are authorized by law to perform manual manipulation of the spine to correct a subluxation as a Medicare–covered service?

Answer:

Section 1861 (r) of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation. (As a standard Medicare Part B benefit, manual manipulation of the spine to correct a subluxation must be made available to enrollees in all Medicare + Choice plans). The statute specifically references manual manipulation of the spine to correct a subluxation as a physician service. Thus, Medicare+Choice organizations must use physicians, which include chiropractors, to perform this service. They may not use non-physician physical therapists for manual manipulation of the spine to correct a subluxation. Medicare+Choice organizations may continue to use physical therapists to treat enrollees for conditions not requiring physician services as defined in section 1861 (r) of the Social Security Act.

Contact: **CMS Regional Office Managed Care Staff**

This OPL was prepared by the Center for Beneficiary Choices.

Attachment 1A

Wednesday, February 09, 2005

MEMO

TO: SEN. JUDY LEE
FROM: JACK McDONALD
RE: SB 2366, Physical Therapy Practice Act

Enclosed is another revision of the proposed amendments that (on page 3, shaded) requires each physical therapy licensee to provide the board with evidence of competence in manual therapy, with specific language requiring the board to determine levels of competency.

However, it is essential that the Physical Therapy Board be allowed to determine these levels, and not some other profession. With this language, if a physical therapist is practicing beyond the level of competence stated by the board, he or she would then be subject to discipline, including loss of license.

This, combined with §43-26.1-03 (7) that already requires the board to "establish mechanisms for assessing the continuing professional competence of physical therapists to engage in the practice of physical therapy" I think more than provides the level protection and assurance to the public that committee members are seeking.

Jack McDonald
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jackmcdonald@wheelerwolf.com

FEBRUARY 9, 2005
ADDITIONAL AMENDMENTS (SHADED) PROPOSED BY
ND PHYSICAL THERAPY EXAMINING COMMITTEE
ND PHYSICAL THERAPY ASSOCIATION

PROPOSED AMENDMENTS TO SB 2366

On page 2, line 1, after the word "means" insert "consultation pursuant to section 43-51-03." and remove the remainder of the line

On page 2, remove lines 2 through 4

On page 2, line 7, after "4." insert "Manual therapy" means the use of manual therapy techniques such as mobilization/manipulation, manual lymphatic drainage and manual traction on one or more regions. and remove the remainder of the line

On page 2, line 9, remove "continuously"

On page 2, line 27, after "limitations" insert "in movement and mobility"

On page 3, line 1, after "limitations" insert "in movement and mobility"

On page 3, line 4, after "training" insert "related to positioning, movement and mobility"

On page 3, line 7, after "equipment" insert "related to positioning, movement and mobility"

On page 3, line 11, remove "Reducing" and insert "Engage as a physical therapist in reducing"

On page 3, line 14, after "Engaging" insert "as a physical therapist "

On page 4, line 4, remove "shall" and insert "may"

On page 4, line 23, remove "and residential" and after "address," insert "business"

On page 4, remove line 30

On page 5, line 1 through 3

On page 6, remove lines 12 and 13

On page 6, line 14, replace "3." with "2."

Attachment 1 (2/14/0

FEBRUARY 14, 2005
AMENDMENTS PROPOSED BY
ND PHYSICAL THERAPY EXAMINING COMMITTEE
ND PHYSICAL THERAPY ASSOCIATION

PROPOSED AMENDMENTS TO SB 2366

On page 2, line 1, after the word "means" insert "consultation pursuant to section 43-51-03." and remove the remainder of the line

On page 2, remove lines 2 through 4

On page 2, line 7, after "4." insert "Manual therapy" means the use of manual therapy techniques such as mobilization/manipulation, manual lymphatic drainage and manual traction on one or more regions. and remove the remainder of the line

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On page 6, line 14, replace "3." with "2."

Jack McDonald

On page 6, line 16, replace "4." with "3."

On page 6, line 21, replace "5." with "4."

On page 6, line 25, replace "6." with "5."

On page 7, line 1, replace "7. with "6."

On page 7, line 6, after the word "a" insert "license in good standing from another jurisdiction that imposes requirements for obtaining and maintaining a license which are at least as stringent as the requirements imposed in this state." and remove the remainder of the line

On page 7, remove lines 7 and 8

On page 7, line 29, after "providing" insert "services in accordance with section 43-51-03." and remove the remainder of the line

On page 7, remove line 30

On page 8, line 11, after "license" insert "annually"

On page 8, line 13, after "state" insert "and may be subject to a late renewal fee"

On page 8, line 17, replace "lapsed" with "expired"

On page 8, line 19, replace "lapsed" with "expired"

On page 8, line 25, replace "lapsed" with "expired"

On page 9, line 25, remove "continuously"

On page 10, line 8, after "c." remove the remainder of the line

On page 10, line 9, remove "d."

On page 10, line 12, replace "shall" with "may"

On page 10, line 13, replace "consent" with "authorization" and replace "required" with "permitted"

On page 10, line 23, replace "finds" with "findings"

On page 11, line 19, after "exists" insert "except with a spouse"

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On page 11, line 26, after "profession" insert "adopted by rule by the board"

On page 12, line 14, replace "documented consent" with "the written authorization"

On page 12, line 15, replace "required" with "permitted"

On page 12, line 26, after "herein." Insert "The board shall require that each licensee provide the board with evidence of competence in the various elements of manual therapy they currently practice so the board can determine satisfactory competency levels and requirements pursuant to section 43-26.1-03 (7)."

On page 12, line 27, remove "recognized"

On page 12, line 28, remove "and" and remove "further"

On page 13, line 6, replace "A" with "Except as otherwise provided by law, a"

Renumber accordingly

Attachment 2
2/14/05

Suggested Amendments for SB 2366

ND Chiropractic Association

Page 2, insert,

"Manual Therapy" means a group of techniques comprising a continuum of skilled passive movements to the joints or related soft tissues throughout the normal range of physiological motion without engaging in a high velocity thrust or impulse or any other technique that is intended to or could result in cavitation of the joint."

Page 13, line 6, insert after 2. , "Unless otherwise provided by law," and replace "A" with "a"

Ken Tupa

SB 2366 - PT Practice Act

Madame Chair & Members of the Human Services Committee, for the record I am Gary A. Lee, Senator from District 22. District 22 includes the greater part of Cass County, in Eastern ND.

I'm here this morning simply to introduce SB 2366 on behalf of the State's 467 Physical Therapists and Physical Therapy Assistants. This bill updates their Practice Act, originally enacted in 1959 and last updated to any substantive degree in 1979.

Rather than considerable cutting and pasting into the old law, this bill creates a new chapter to the NDCC. The proposed legislation incorporates a great deal of the old practice act along with the current administrative rules and regulations for Physical Therapists. The language includes much of the National Practice act for Physical Therapists.

The Bill spells out more clearly and in more detail what the current scope of practice is in ND.

The Physical Therapists worked closely with more than a dozen allied health professions in developing the legislation. The Attorney General's Office also reviewed the bill. Many of the comments from these groups were incorporated into the language of the bill.

There continues to be a basic difference of opinion between the Physical Therapists and Chiropractors in performing certain techniques. I expect you will hear from both sides on that issue today. I believe, each profession needs to be able to set the standards of practice for their own profession and then regulate its practice. That is the basic reason for the existence of professional licensing boards.

I am confident you will give the bill a good hearing. I again would encourage a DO PASS recommendation.

I would attempt to answer any questions, but the presenters to follow really have much more information and knowledge about the detail of the bill than I can provide.

(2)

March 8, 2005 SB 2366

Representative Price and Committee Members

I am Dr. Shelley Killen. I am a board certified physical practicing physical medicine and rehabilitation at St Alexius in Bismarck ND. I also have the pleasure of teaching at the Univ of Mary with their P.T. and O.T. students and before that I taught at the Medical College of Ohio and interacting with their O.T. and P.T. schools also. After having read though the proposed changes to the ND Practice Act I would like to voice my support of this act. It updates the current language to today standards and follows practice as it is done today.

I have also had a chance to discuss the amendments the physical therapists will offer today, especially the definition of manual therapy. I agree with their definition as it reflects not only the definition as used in the medical community but also reflect the definition as laid out in the CPT codes. CPT 97140 Manual therapy techniques(e.g. Mobilization/manipulation, manual lymphatic drainage, manual traction). I do not see this as physical therapists trying to extend their scope of practice but as updating their definition into current terms. And in terms of training physical therapists today are coming into practice with a minimum of a masters level and majority with a doctorate.

The definitions as I see them written are well covered with in their training and are well within their scope of practice. I am very pleased and comfortable to

refer my patients to the care of Physical Therapists across the state and in my current practice I do in fact refer across the state. I have found all the therapists I have worked with truly do see the treatment of clients as a team effort and will always call me with questions and treatment options in the best interest of the client

#3

To: Representatives of the House Human Services Committee

Re: SB 2366

My name is Kevin Axtman, and I have been a practicing physical therapist in the state of North Dakota for almost 23 years since graduating from UND in 1982. I am currently serving my second term on the North Dakota State Examining Committee for Physical Therapists. Our committee consists of 3 physical therapists, a consumer member not in the health professions and 2 physician members. Our current physician members (Dr. Brenda Miller of Bismarck and Dr. Phil Johnson of Fargo) were physical therapists prior to medical school. The committee's primary duties are to look out for the public's safety and welfare (making sure physical therapists practice within their scope of practice) and that well qualified physical therapists practice in North Dakota (being of good moral character, graduating from an approved school and passing a national test). There are currently 477 physical therapists and 253 physical therapy assistants licensed to practice in North Dakota.

SB 2366 has been a 3-year project, which began with updating our Administrative Rules. Our Rules were completed and put into practice 7/2004. Our current Practice Act has language from 1959. SB 2366 was put together to update definitions of our current practice based on the Model Practice Act for Physical Therapy. It does not add or change what physical therapists are currently practicing in the state of North Dakota. It will not restrict another licensed profession's practice. We have also expanded the section on Grounds for disciplinary action. By including the statements in that section; "practicing or offering to practice beyond the scope of the practice of physical therapy", and "failing

to refer a patient or client to an appropriate practitioner if the diagnostic process reveals finds that are outside the scope of a physical therapist's knowledge, experience, or expertise", it makes it very clear to all therapists that practicing beyond one's expertise is subject to disciplinary action.

We have contacted 15 health groups around the state to make comments on our Practice Act. We have made changes based on comments from the Pharmacy Board, Occupational Therapists and Chiropractors. Our only controversial issue is from the Chiropractors who want to restrict manual therapy. Manual therapy is within the physical therapist's scope of practice, has been and is currently practiced by physical therapists and is reimbursed by insurance companies.

As part of the ND State Examining Committee for Physical Therapists, I know of no complaints or injury to patients in which physical therapists have performed manual therapy in the Committee's 50 years of existence.

I must add that as a practicing physical therapist and athletic trainer, I am concerned with the restrictions that the chiropractors' language contains and how it will limit my future treatment of patients. I use many forms of manual therapy in my daily practice to help patients with joint problems. Manual therapy is not a new procedure to physical therapists.

We would ask for your support of SB2366 with the physical therapy amendments, and let physical therapists practice as they are currently practicing without restrictions from other professions.

#3A

ORTHOPAEDIC ASSOCIATES FARGO

February 3, 2005

Mark A. Lundeen, MD
R. Mark Askew, MD
Philip Q. Johnson, MD
Jeffrey P. Stavenger, MD
David L. Wiest, MD
Howard T. Berglund, MD
Matthew J. Nelsen, MD
Andrew J. Hvidsten, MD
Timothy L. Haugen, CPA
Administrator

Physician Consultants for The Red River Valley Sports Medicine Institute and The Frappier Acceleration Program

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House Human Services Committee

RE: SB 2366

Dear Committee Members:

Thank you very much for allowing us to discuss the new proposed rules and regulation changes for the North Dakota physical therapists. Unfortunately I will be unable to attend the hearing personally but I felt that it was important enough of a bill that it requires input from myself so excuse me for the letter but it's the best that I could do on this short notice.

Once again, the purpose of this letter is for me to express my unconditional support for the proposed changes on the rules and regulations for the North Dakota Physical Therapy Act. The board has spent a great deal of time and going back and forth with the North Dakota physical therapists and the North Dakota PT Association trying to come to a consensus about these final revised changes so that everyone has a strong consensus. The one issue that seems to have arisen from outside interests deals with manual therapy techniques. As a trained physical therapist as well as an orthopedic surgeon there is no question in my mind in my daily practice I encounter physical therapists who are experts in performing manual therapy techniques for various soft tissue as well as hard tissue diseases and injuries. It is my opinion both from an educational standpoint having gone through the curriculum and continuing education courses that physical therapists indeed do have the expertise as well as the training to perform manual therapy techniques in treating musculoskeletal problems. In addition, they do have the necessary diagnostic skills to identify these injuries and quite frankly I think they do sometimes better jobs than some physicians because of their expertise in both the anatomy, the physiology and the kinesiology of the musculoskeletal system.

I therefore hope that you will give strong consideration to passage of the current rules and regulations as they have been revised by us on the State Board of Examining Physical Therapists. If you would need any further information from me, I am readily available by phone or by any type of either telecommunication or print. Once again, thank you very much for your time and your evaluation of this very important bill.

Sincerely Yours,

Philip Q. Johnson, M.D., P.C.

PQJ/crb Dict. 2-03-05

the joint up to the first tissue stop (at the beginning of range); used to reduce pain.

b. Grade 2: The bone is moved parallel to the joint surface until the slack is taken up and the tissues surrounding the joint are tightened; used to decrease pain.

c. Grade 3: The bone is moved parallel to the joint surface with an amplitude large enough to place a stretch on the joint capsule and on surrounding periarticular structures.

Traction is always the first procedure. Gliding mobilization is then performed in the direction in which the mobility test has shown that the gliding is actually restricted (direct technique). For restricted joints, apply a minimum of a 6-second stretch force, followed by partial release (to grade 1 or 2), then repeat at 3- to 4-second intervals. When applying stretching techniques, move the bony partner through the available range of motion first (until resistance is felt), and then apply the stretch force against the resistance.

2. Graded oscillation techniques (see Fig. 3-10).[139] Glides are graded along a scale of 1 to 5 as follows:

a. Grade 1: Slow, small-amplitude oscillation parallel to the joint surface at the beginning of range; used to reduce pain.

b. Grade 2: Slow, large-amplitude oscillation parallel to the joint surface within the free range; used to reduce pain (does not move into resistance or limit of range).

c. Grade 3: Slow, large-amplitude oscillation parallel to the joint surface from middle to end of range; used to increase mobility (reaches the limit of range or takes the joint through the first tissue stop).

d. Grade 4: Slow, small-amplitude oscillation parallel to the joint surface at the limit (end) of range; used to increase mobility.

e. Grade 5: Fast, small-amplitude, high-velocity, non-oscillatory movement parallel to the joint surface beyond the pathologic limitation of range (through the first tissue stop), also called a thrust manipulation. Grade V is used when resistance limits movement, in the absence of pain.

Some indications for a thrust manipulation (Grade V) of the peripheral joints may include:[34]

1. Replacement of a joint dislocation, for example, a subluxed cuboid, a dislocated shoulder, or in a child with a pulled elbow
2. Reduction of an internal derangement of a joint in which a torn meniscus (knee) or loose body (elbow) produces blocking of movements
3. Stretching or breaking down adhesions. In chronic adhesive capsulitis of the shoulder, thrust manipulation may be used to break down periarticular adhesions and increase joint mobility.

The oscillatory treatment movements (grades I–III) may be smooth and regular or performed with an irregular rhythm in an attempt to trick muscles when large-amplitude treatment movements are hindered by tension.[34] The oscillatory movements are usually used in one or two methods, either (1) as small- or large-amplitude movements, at a rate of two or three per second, applied anywhere within the range, or (2) combined with sustained stretch as small-amplitude oscillations applied at the limit of the joint range. One may vary the speed of oscillations for different effects such as low-amplitude, high-speed to inhibit pain, or slow speed to relax muscle guarding.[138] If gliding in the restricted direction is too painful, gliding mobilization can be started in the painless direction.

The only consistency between the dosages of the two gliding methods is with grade 1, in which no tension is placed on the joint capsule or surrounding tissue.[115] The choice of using oscillatory or sustained techniques depends on the patient response. When dealing with pain management or high tone, oscillatory techniques are recommended. When dealing with loss of joint play and decreased functional range, sustained techniques are recommended. Traction, grade 1, is used with all gliding tests and gliding mobilizations.

TECHNIQUES FOR THE RELIEF OF PAIN AND MUSCLE GUARDING

Relief of pain and muscle guarding is desirable in relatively acute conditions, as a treatment in and of itself, and in chronic conditions to prepare for more vigorous stretching. The techniques in acute conditions are performed to increase proprioceptive input to the spinal cord so as to inhibit ongoing nociceptive input to anterior horn cells and central receiving areas (see Chapter 4, Pain). They are what Maitland refers to as grades I and II techniques.[138] Movement is performed at the beginning or midpoint of the available joint-play amplitude, avoiding tension to joint capsules and ligaments. A rhythmic oscillation of the joint is produced at a rate of perhaps two to three cycles per second.

In the case of acute joint conditions, these may constitute the only passive mobilization techniques used until the acute manifestations subside. In more chronic cases, these techniques should be used at the initiation of a treatment session, between stretching techniques, and at the end of a session in order to promote relaxation of muscles controlling the joint.

#4

Testimony by
Mark Romanick, PT, PhD, LATC
Assistant Professor of Physical Therapy
University of North Dakota
In favor of SB 2366

Manual Therapy Education in Physical Therapy at the University of North Dakota and in Accreditation Standards

Madam Chairman and members of the Committee:

Manual therapy education is an integral component of the education a physical therapist receives at accredited institutions in the United States, and therefore at the University of North Dakota. Courses in the physical therapy curriculum that address this component include: anatomy, biomechanics and kinesiology, neuroscience, pathology, clinical evaluation, differential diagnosis, and intervention (e.g., physical agents, mobilization, and exercise) as students progress toward a doctoral degree of physical therapy. These courses build on one another, progressing from foundation to evaluation to intervention content. In addition to academic coursework (consisting of classroom and laboratory settings), students complete 36 weeks of clinical education, directed by credentialed clinical instructors. Total classroom and clinical time in the professional program is 3360 clock hours, preceded by 90 university credit hours obtained prior to admission into the physical therapy program. In addition to courses that contribute to manual therapy practice, 2 courses are designated specifically for that area of physical therapy. These courses are Manual Therapy I and Manual Therapy II, both of which focus on physical therapy evaluation and intervention for conditions of the extremity and spine joints and soft tissue. The 2 courses total 4 credit hours with substantial laboratory time (>50%) for demonstration, practice, and competency development of clinical techniques.

Physical therapy standards of practice include manual therapy:

1) The Guide to Physical Therapy Practice (American Physical Therapy Association document developed as a standard for terminology and preferred practice patterns in physical therapy) defines the term manipulation as:

   "A manual therapy technique comprised of a continuum of skilled passive movements to joints and/or related soft tissues that are applied at varying speeds and amplitudes, including a small amplitude/high velocity therapeutic movement."

2) The Normative Model for Physical Therapist Professional Education requires that:

   "Manipulation is an intervention that should be taught in entry-level physical therapist education."

3) The Commission on Accreditation of Physical Therapy Education (CAPTE) requires that manual therapy, including manipulation be taught as part of the entry level curriculum.

Comprehensive education in the area of manual therapy is provided to physical therapy students in compliance with the Normative Model of Physical Therapist Professional Education, CAPTE education requirements, and clinical expectations denoted in the Guide to Physical Therapy Practice.

#5

Testimony
By
Mary Jo Wagar PT, OCS, FAAOMPT
North Dakota Physical Therapy Association
In favor of HB 2366

My name is Mary Jo Wagar. I am the president of the North Dakota Physical Therapy Association. I work as a physical therapist for MeritCare Health System in Fargo and have been a practicing physical therapist in North Dakota for 28 years. I graduated from the University of North Dakota with a BS in physical therapy in 1977 and The Kaiser Permanente Residency Program in Orthopedic Physical Therapy in 1982. I am a certified orthopedic specialist through the American Physical Therapy Association and currently enrolled in the transitional doctorate program in physical therapy at UND.

We are here today to ask for your endorsement of SB 2366. I hope to be able to clarify the intension of this bill and dispel some of the myths that have been circulated. The purpose of this bill is to modernize the language of our Practice Act to better reflect the practice of physical therapy today. Language within our current Practice Act dates back to the 50s. Our current rules and regulations, which serve as the interpretation of our Practice Act, have been stretched to their limit.

Even though the basic premise of physical therapy as a profession has remained unchanged, the depth and breadth of our training has progressed and some of the treatment approaches currently used were not in existence at the inception of our current Practice Act, for example, the use of iontophoresis, computerized strength testing and balance assessment to name a few.

Currently over one half of all accredited schools of physical therapy graduate therapists with a doctorate degree and the remainder are master's level programs. This is certainly a progression from the bachelor's programs offered in 1977. By at least the year 2020 all physical therapy schools will offer doctorate degrees as mandated by our national association. In addition, physical therapists have the opportunity to obtain recognized

specialty certification in the areas of geriatrics, orthopedics, sports medicine, electrophysiology, neurology and pediatrics by successfully qualifying for and passing specialty examinations established by the American Physical Therapy Association.

Continuing education and professional development have always been an emphasis in our profession, and in North Dakota, physical therapists are required by law to provide evidence of continuing education activity. Many therapists obtain specialty certifications in areas of interest by completing additional course work and practical exams.

We are especially proud of the fact that our profession has made great strides in the area of research which assures that our patients and clients are receiving the best evidence based practice. Our national organization provides founding for research through the Foundation for Physical Therapy and locally, our state organization has established a research fund aimed at assisting clinicians and students interested in pursuing clinical research.

Joint manipulation has always been a part of the practice of physical therapists. Despite that, there has been a significant campaign on the part of the Chiropractic Association to attempt to eliminate this particular technique from our scope of practice. Reasons cited have included; lack of sufficient training, patient safety and claims of non-coverage by Medicare.

As I have mentioned, physical therapists must graduate from accredited schools of physical therapy many of which, including the two physical therapy schools within the state, are doctorate programs. These rigorous programs include comprehensive education in all of the sciences with an emphasis on anatomy, physiology, kinesiology, disease processes and medical screening, not to mention the application of clinical skills including manipulation. We are dealing with very capable and highly motivated students. The average GPA of those accepted into physical therapy programs in the state is 3.5.

The most important aspect of being able to safely apply physical therapy techniques, including but not limited to manipulation is a strong education base. One needs to be able to evaluate the patient as a whole, be able to identify movement impairments and indications and potential contraindications for any type of treatment given. In the case of manipulation, the actual act of performing a manipulation is probably the easiest part; it is the knowledge and skill of knowing when, when not and where that type of technique should be applied. If you need proof of that, observe teenagers. Many perform self-manipulation of their necks, backs, and extremities in a very habitual manner. Is this a skill manipulation? No, but non-the-less it is an example of a manipulation.

There is no evidence that patient safety is a concern. There have not been any complaints brought before our licensure board regarding safety or injury related to manipulation in recorded history. Physical therapists work closely with other medical professionals including medical doctors and typically have access to their reports as well as radiology and laboratory findings. In addition, we are bound by our code of ethics and this Practice Act to refer patients to an appropriate practitioner when we identify conditions that are "outside of the scope of our knowledge, experience or expertise."

Currently the use of manipulation by physical therapists is covered by all insurance payers, including Medicare under The American Medical Association (AMA) Common Procedural Terminology (CPT). The code we use is 97140, which includes "manual therapy techniques; mobilization/manipulation, lymphatic drainage, and manual traction". We are not seeking to use the chiropractic code for spinal adjustment for the "correction of subluxation". This is a chiropractic code and "subluxation" in the contest of a condition a physical therapist would use manipulation to correct is not in our vocabulary. One argument heard previously was that the CPT code 97 140 is a 15 minute code and a manipulation takes a matter of seconds. This is true but the use of manipulation alone during the course of a physical therapy visit would be very unusual. In most cases, a manipulation would be preceded by a combination of joint and soft tissue mobilization as well as exercise and patient education. This is the hallmark of physical therapy.

Should this bill be modified in a way that would not allow physical therapists to be able to continue to use manipulation as a part of their practice, patients would have limited access to the type of treatment they need. In addition, we have two physical therapy schools within the state. If we become one of a few states who do not allow physical therapists to utilize manipulation, it would seem that we may have difficulty recruiting and keeping these young people in our medical work force. They expect to be able to practice what they are taught without unreasonably imposed limits.

In summary, the modernization of the language of our Practice Act will better describe how the approximately 400 physical therapists and physical therapist assistants currently practice our profession in the state of North Dakota. It will assure that the citizens of our state have access to and are receiving physical therapy services provided by professionals who are graduates of accredited programs of physical therapy, licensed in the state of North Dakota and who uphold high standards of ethics, safety, and best practice. Thank-you for your time and support of this bill.

#6

Testimony

By

Steven Ziegler PT, MMgt. Cert. MDT

In favor of HB 2366

My name is Steven Ziegler. I am a physical therapy faculty member at the University of Mary. My primary content areas of teaching include kinesiology and biomechanics, orthopedics primarily of the spine and manual therapy including thrust and non-thrust techniques. I have held this position for the past seven years and have been a practicing physical therapist in the North Dakota for 14 years. I graduated from the University of North Dakota with a BS in physical therapy in 1991. I received a Masters in Management degree from the University of Mary in 1999 and I am currently enrolled in a Doctorate of Science degree program in Orthopedics and Sports Medicine at Rocky Mountain University of Health Professions in Provo, UT. I am also certified in Mechanical Diagnosis and Therapy by the McKenzie Institute of the USA.

I would like to start by saying SB 2366 is a bill to update the language of the physical therapy practice act to the current practice of physical therapy. One area of contention is the use of manual therapy including mobilization and manipulation by physical therapists. The physical therapy profession dates back to 1899 in Europe. Most of the early teaching of physical therapy was done by physician James Mennell and Edgar Cyriax. Some of the earliest writing of these two physicians referred to the teaching of manual therapy including manipulation to these early therapists. James Mennell encouraged his colleagues to send their patients to the therapists they trained. Physical Therapy was formally organized as a profession in the United States in 1921 following World War I. Physical therapy has always had a strong background in manual medicine and strong ties to traditional medicine. In the 1960's the American Medical Association (AMA) started a Commission on Quackery to address false claims of treating systemic disease with manipulative medicine. Not wanting to be associated with such practices the physical therapy profession started using different terminology such as mobilization to describe current manual therapy. However, the teaching of manual therapy has always been a part of entry level physical therapy education.

To be a licensed physical therapist in North Dakota a graduate has to pass a national licensing exam. In order to take this exam the students has to graduate from a physical therapy education program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). For a physical therapy education program to be accredited by CAPTE each program has to meet the criteria established by CAPTE. The most recent evaluative criteria includes "Manual Therapy Techniques (including Mobilization / Manipulation Thrust and Non-thrust Techniques)". Each student has to be taught these techniques and pass written exam and laboratory practical exams to meet this criterion. Therefore, the issue of education and competency is established in the education and licensing process.

Scientific research has shown physical therapist, osteopathic physicians, and chiropractors to be effective in performing spinal manipulation. Research has also shown physical therapy student to be as effective in performing spinal manipulation as licensed physical therapists. Scientific research has also address the issue of risk of adverse effects form spinal manipulation. Comparative risk analysis has shown the risk of an adverse effect primarily a grastro-intestinal bleed or ulcer from taking Non-steroidal Anti-Inflammatory Drugs (NSAIDs such as ibuprofen, motrin, advil, or aleve) is 1000 times greater than the risk of an adverse effect from manipulation of the lower back and 300-400 greater than manipulation of the neck. Therefore the risks, although real, are quite small. In the physical therapy program at the University of Mary safety including risks, indications, contraindications, and precautions are strongly emphasized and followed throughout the educational process. There is also the risk of the patient not improving or increasing disability if the intervention of spinal manipulation is not allowed to be offered to physical therapy patients.

The Institute for Alternative Futures published The Future of Chiropractic Revisited: 2005 - 2015 in January 2005. In this publication the chiropractic profession sates "Probably the most serious competitive threat on the horizon is from physical therapists". The publication goes not to state it is the training received by physical therapist that creates this competitive threat. Based on the testimony stated previously the risks in spinal manipulation are small and the

educational competency is established in the professional education process. The arguments against physical therapist practicing spinal and extremity manipulation may be more about competition than competency or safety.

In conclusion, physical therapists have been trained in manual therapy including mobilization and manipulation since the beginning of the profession. Current accreditation of educational programs requires the teaching of mobilization/manipulation including thrust and non-thrust techniques. Spinal manipulation is a safe and effective treatment by physical therapist. I would like to encourage a do pass on SB 2366 without further amendments and thank-you for your time and support of this bill.

#7

CLIFFORD LAFRENIERE
CURRICULUM VITAE OF PROFESSIONAL EDUCATION/EXPERIENCE

EDUCATION

BS Degree in Physical Therapy from the University of North Dakota, 1976

POST-GRADUATE CONTINUING EDUCATION:

Basic course in Extremity and Spinal mobilization, Stanley Paris, 72 hours, February 1978

Transcutaneous Electrical Nerve Stimulation, Gerald Lampe, 14 hours, April 1978

Human Performance and Cardiovascular Health, 40 hours, February 1979

Basic Sports Medicine Seminar, Ron Peyton, Atlanta, 40 hours, June 1979

The Complete Shoulder, Sandy Burkhardt, 17 hours, November 1979

Pain Management Seminar (Acupuncture and TENS), Ron Brickey, 13 hours, March 1980

Soft Tissue Assessment and Treatment, Cyriax Course I, 24 hours, October, 1980

Physical Therapy and Dentistry I, Mariano Rocobado, 40 hours, June 1981

La Crosse Health and Sports Science Symposium, 45 hours, December 1982

Cybex Testing, Basic, George Davies, 16 hours, February 1983

Cybex Testing, Advanced, George Davies, 20 hours, June 1984

Work Capacity Evaluation/Industrial Consultation, Keith Blankership, 2 CEU's April 1985

The Knee Before and After Injury, Lenox Hill Conference, 24 hours, May 1985

Athlete's Knee and Shoulder, Cincinnati Institute of Sports Medicine, 1985

Anatomy Review, Arnie Keck, 8 hours, January 1986

When the Foot Hits the Ground, APRN, 24 hours, May 1986

Isokinetic Evaluation of the Back, Doug Ross, 36 hours, June 1986

1987 Advances of the Knee and Shoulder, Cincinnati Institute of Sports Medicine, 25 hours, June 1987

National Strength Training and Conditioning Conference, 32 hours, June 1987

Challenge of the Lumbar Spine, 20 hours, October 1987

Club Cybex, 40 hours, October 1987

Industrial Musculoskeletal Health: Sports Medicine for Working People, 19 hours, September 1988

The Knee: Bob Mangine, 16 hours, November 1988

American Back Society Fall Symposium on Back Pain, 19 hours, December 1988

Muscle Imbalance: Shirley Sahrmann, 10 hours, April 1989

Industrial M-S Health, Tom Mayer, Dallas TX, September 28-30, 1989, 1.7 CEU's

Industrial Rehab II, Cincinnati, Keith Blankership, October 5-7, 1989, 1.9 CEU's

Physical Therapy Role in Industrial Medicine, Susan Iserhagen, Grand Forks, October 13-15, 1989, 15 hours

The Knee, Ed Forina, November 18, 1989, 8 hours

Surgical and Non-Surgical Stabilization Lumbar Spine, Liz Schorn, PTOSI, Minneapolis, January 26-27, 1990, 1.2 CEU's

The Spine, Mechanical Diagnosis and Therapy (Part A-Lumbar, Part B Cervical/Thoracic), Riki Yamada, PT, Duluth, Minnesota, April 26 - May 1, 1990, Part A-3.2 CEU's, Part B-1.6 CEU's

The Spine, Mechanical Diagnosis and Therapy, Part C., Wayne Rath, PT, New Orleans, LA, December 1990. 20 hours

McConnell Patellofemoral Course - Basic, Charles Felder, PT, Chicago, IL, May 7-8, 1990, 16 hours

McConnell Patellofemoral Course - Advanced, Jenny McConnell, PT, Minneapolis, MN, April 19-20, 1991, 13 hours

McKenzie Institute International Conference Faculty, 1.4 CEU's, August 1991

ADA and How It Affects Practice, APTA Private Practice Section, .7 CEU's, November 1991

Quality Enhancement, Deming Seminar, W.E. Deming, 40 hours, December 1991

Micro Current Electrical Neuromuscular Stimulation Seminar. Valerie Sinkus 6.5 Hours (.65 CEU's) February 1, 1992.

Current Concept In The Evaluation and Treatment of the Knee and Shoulder. Bob Mangine and Kevin Wilk, 2.3 CEU's, July 1992

The Spine, Mechanical Diagnosis and Therapy, Part D, Wayne Rath, 3.2 CEU's

Improving Scapular Stability - Effective Applications & Techniques. Steven Guffey. 6.5 Hours 6.5 CEU's. April 3, 1993.

Cybex International Seminar - CEU's (Clinical 15.5, Fitness - 10) Cybex. October 20-24, 1993.

1993 Advances on the Knee and Shoulder, Cincinatti Sportsmedicine Institute, 24 hours, May 1993

NDATA Fall Meeting, Athletic Injuries to the Shoulder and Elbow, Dr. Ron Kvitne, 5 hours, October 1994

Surface EMG for Movement Dysfunction - .8 CEU's, Barb Headley, May 1995

McConnell Approach to the Shoulder - CEU's (14 hours), Jenny McConnell, June 1995

McKenzie Inst. Annual Meeting, Minneapolis, Minnesota, July 1995, 16 hours.

Documentation and Functional Assessment, Carole Lewis, Minneapolis, Minnesota, August 25 - 27, 1995, 20 hours.

PPS Annual Meeting, (Business Application of Physical Therapy), St. Louis, November 1995, 11 hours.

Current Concepts In ACL Rehabilitation, Satellite Broadcast RTN Kevin Wilke, January 21,1998, 1.5 contact hours.

Healthsouth Internal Continuing Education, Spine Clinical Specialization Level I, George Aaron, January 24-25, 1998, 15 contract hours.

Healthsouth Internal Continuing Education, Knee Clinical Specialization Level I, Mike HS Faculty, June 13-14, 1998, 14 contract hours.

Healthsouth Internal Continuing Education, Shoulder Clinical Specialization I, Tim Heck, August 15-16, 1998, 14 contract hours.

Healthsouth Internal Continuing Education, Shoulder Clinical Specialization II, Ed Mulligan, September 12-13, 1998, 14 contract hours.

Healthsouth Internal Continuing Education, Shoulder Clinical Specialization Level III, HS Faculty, October 31-1, 1998, 13 contract hours.

Recognition and Treatment of Shoulder Injuries in the Overhead Athlete, Kevin Wilke, RTN, May 17,1998, 5.0 contact hours

Mulligan Concept - Mobilization With Movement, Brian Mulligan, McLean Va, 9/29/99, 13 hours. Lecture Lab course

Mulligan Concept - Mobilization With Movement Advanced, Brian Mulligan, Marco Island, 10/03/99, 13 hours. Lecture Lab course

NDAPTA Peer Review Training, Stephanie Lunning, January 15-16, 1999, 11.0 contact hours UND,

Healthsouth Continuing Education, Advanced Knee Concepts, Fargo, ND, 4/17-18, 1999, 8 contact hours

Healthsouth Continuing Education, Foot and Ankle Update, Ed Mulligan, Grand Forks, ND, 4/15-4/16-2000, 16 contact hours.

Healthsouth Continuing Education, Industrial Medicine Services 101, Faculty, Minneapolis, MN, 1/18-1/19, 2001, 12 contact hours.

Healthsouth Continuing Education, Industrial Medicine Services 102, Pam Padgett, Fargo, ND, 3/2001, 8 contact hours.

APTA Reimbursement Chairperson Summit, Rhea Cohn, Baltimore, MD, Oct 2001, 16 contact hours

Healthsouth Continuing Education, Innovators Summit, Brad Cooper, Denver, CO, 11/2001, 16 contact hours.

Healthsouth Continuing Education, Spine Lab Course, Craig Taft, Grand Forks, ND Mar 2002, 15 contact hours.

APTA Reimbursement Chairperson Forum, Rhea Cohn, Baltimore, MD, Nov 2002, 11 contact hours

APTA Reimbursement Chairperson Forum, Rhea Cohn, Baltimore, MD, Nov 2003, 15 contact hours

Intro to Core Stabilization and Soft Tissue, Barb Headley, March 11-13, 2004 16 contact hours.

Primal Reflex Release Techniques – Basic Course; John Iams, Aug 2004, 24 contact hours

APTA Reimbursement Chairperson Summit, Rhea Cohn, Baltimore, MD, Dec 2004, 16 contact hours

Primal Reflex Release Techniques – Intermediate Course, John Iams, Jan 2004, 24 contact hours.

EXPERIENCE

June 1976 thru April 1977: Medical Center Rehabilitation Hospital, Department Head for Cavalier County Memorial Hospital.

April 1977 thru April 1978, Professional Physical Therapy Services, Chief Therapist for St. Mary's Hospital; Scottsbluff, Nebraska

April 1978 thru June 1980: Chief Physical Therapist, Gibson General Hospital; Trenton, Tennessee

June 1980 thru October 1982: Sports Medicine Clinic, Staff Therapist, Grand Forks, North Dakota

October 1982 to November 1996: Private Practice, Great Plains Physical Therapy Clinic and Fitness Center, P.C.

November 1996 to August 2003, Administrator/Regional Clinical Coordinator for Healthsouth Sports Medicine Rehabilitation Clinic, Grand Forks.

August 2003 to present, Owner/operator, Select Therapy , Grand Forks, ND.

Reimbursement Chair for NDPTA 2001 to current
Trainer, Grand Forks Public Schools - 1982 to 1996
Licensed Athletic Trainer, July 1984
Head Trainer, North Dakota State High School Track Meet, 1989 to 1993.
Head Trainer, North Dakota State Hockey Tournament, 1986 to 1992

HONORS

1993 Small Business Person of the Year, Grand Forks Chamber of Commerce, Grand Forks, North Dakota
1993 Lecturer for Cybex International. 16 day lecture and inservice on the role of isokinetics in rehabilitation and athletic performance. Countries served were Thailand, Phillipines, and Malaysia.

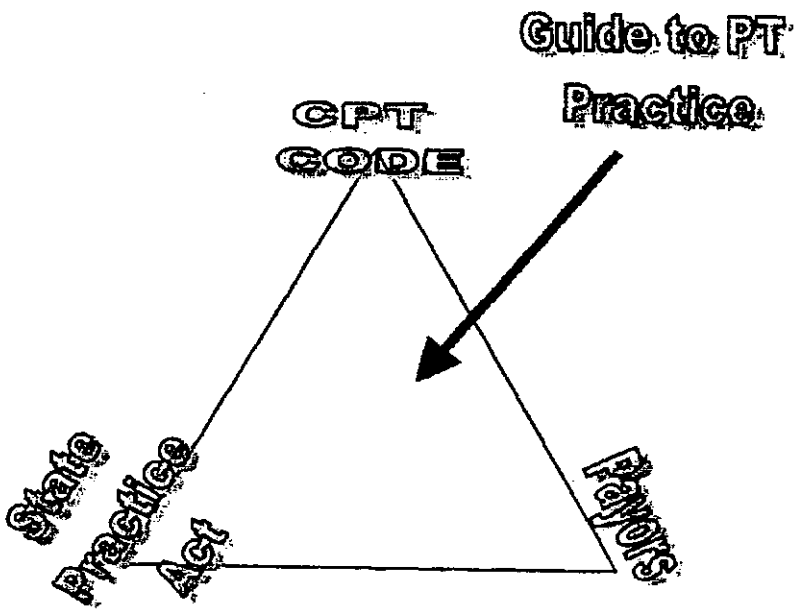
MEMBERSHIP

American Physical Therapy Association
Associate Professor University of North Dakota, School of Medicine, Physical Therapy Department.
Economic Development Advisory Board Member

The Reimbursement Triangle:

In physical therapy, there are many practice settings where physical therapists are completely disconnected from the reimbursement of their services. We have no idea what is being paid for our services and we may not have any idea what denials are coming back. This is a tragedy. Regardless of your work setting, physical therapists need to know how charges are filed and what reimbursement issues there are. How can we advocate for our services if we have no idea how our services are being covered?

This weekend at the Reimbursement Chairs Meeting in Baltimore, the following concept was novel in its method of capturing the way we function from day to day in the reimbursement arena. Their concept was the "Reimbursement Triangle".



State Practice Act:

There are many things we do from day to day that govern the way we practice and how we delegate services provided under our supervision and practice. The state practice act gives us a framework from a state level. What is permissible under our state statute may not be allowed or aligned with the CPT Code or third-party payors. A prime example would be the Medicare ruling not allowing care by non-PT/PTA care givers to be considered a skilled care.

CPT Code:

The CPT code is a framework imposed over our practice that sets in place a value for our services that is standardized and precise in its definition of delivering a skilled care.

Payors:

As for payors, there are many differing policies that may define how we practice because what is allowed by state practice act may not be in compliance with a payor's policies.

If you consider this concept, there are any number of combinations of interactions with these three components that affect the way we see and handle physical therapy services. One component that may have been overlooked and certainly has an impact on our practice is the APTA *Guide to Physical Therapist Practice.* This is a standard of practice that can be used in medico-legal defense of our scope of practice.

Outpatient Therapy Services

270. CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES

Outpatient physical therapy (PT), occupational therapy (OT), or speech pathology (SP) services furnished to a beneficiary by a participating provider are covered only when furnished in accordance with the following conditions.

270.1 Physician Certification and Recertification.--

A. Content of Physician Certification.--No payment may be made for outpatient PT, OT, or SP services unless a physician certifies that:

o A plan for furnishing such services is or was established by the physician, physical therapist, occupational therapist, or speech pathologist and periodically reviewed by the physician (see §270.3);

o The services are or were furnished while the patient was under the care of a physician (see §270.2); and

o The services are or were reasonable and necessary to the treatment of the patient's condition.

Since the certification is closely associated with the plan of treatment, the same physician who establishes or reviews the plan must certify the necessity for the services. Obtain the certification at the time the plan of treatment is established or as soon thereafter as possible. A physician is a doctor of medicine, osteopathy, or podiatric medicine if the services are consistent with the function he/she is legally authorized to perform in the State in which he/she performs the function. The services performed by physicians within this definition are subject to any limitations imposed by the State on the scope of practice.

B. Recertification.--When services are continued under the same plan of treatment, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and must estimate how long services are needed. Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. Recertifications are signed by the physician who reviews the plan of treatment. You may choose the form and manner of obtaining timely recertification.

C. Method and Disposition of Certifications.--There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way, as long as the contractor can determine, when necessary, that the certification and recertification requirements are met. Retain certification by the physician and certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file when the request for payment is forwarded.

D. Delayed Certification.--Obtain certifications and recertifications as promptly as possible. Payment is not made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications are to include an explanation for the delay and any other evidence necessary in the case. You may choose the form and manner of obtaining delayed certifications and recertifications.

270.2 Outpatient Must Be Under Care of Physician.--Outpatient PT, OT, or SP services are furnished only to an individual who is under the care of a physician. There must be evidence in the patient's clinical record that he/she has been seen by a physician at least every 30 days. If the patient has not been seen by the physician within a 30 day period, you are responsible for contacting the physician. This physician may be the patient's private physician, a physician on your staff, a physician associated with an institution which is the patient's residence, or a physician associated with a medical facility in which the patient is an inpatient. The attending physician establishes or reviews the plan of treatment and makes the necessary certifications.

270.3 Outpatient PT, OT, or SP Services Furnished Under a Plan.--To be covered, Outpatient PT, OT, or SP services must be provided under a written plan of treatment established by:

- o A physician (after any necessary consultation with the physical therapist, occupational therapist, or speech pathologist);
- o The physical therapist who provides the physical therapy services;
- o The occupational therapist who provides the OT services; or
- o The speech pathologist who provides the SP services.

Make sure the plan is established, i.e., it is reduced to writing either by the person who established the plan or by you when you make a written record of that person's oral orders, before treatment begins. The plan must be promptly signed by the ordering physician, therapist, or speech pathologist and incorporated into the patient's clinical record.

Make sure the plan details the type, amount, frequency, and duration of the physical therapy, OT, or SP services to be furnished. The plan must also indicate the diagnosis and anticipated goals. Any changes to this plan must be made in writing and must be signed by the physician, therapist, or pathologist. Changes to the plan may also be made pursuant to oral orders given by the attending physician to a qualified physical therapist, a qualified occupational therapist, a qualified speech pathologist, a registered professional nurse, or a physician on your staff.

Changes to such plans also may be made pursuant to oral orders given by the speech pathologist to another qualified speech pathologist, by the occupational therapist to another qualified occupational therapist, by the physical therapist to another qualified physical therapist, or by the therapist or pathologist to a registered professional nurse on your staff. Such changes must be immediately recorded in the patient's record and must be signed by the individual receiving the orders. While the physician may change a plan of treatment established by the pathologist or therapist providing such services, the therapist or pathologist may not alter a plan of treatment established by a physician.

The patient's plan normally need not be forwarded with the claim but is retained in the provider's file. The provider must certify on the billing form that the plan is on file.

270.4 Outpatient Requirement--PT, OT, and SP services are covered when furnished by a provider to its outpatients, i.e., to patients in their homes, to patients who come to the facility's outpatient department, or to inpatients of other health facilities. In addition, coverage includes OT, OT, and SP services furnished by participating hospitals and SNFs to inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of outpatient PT, OT, and SP services that have inpatient facilities (other than participating hospitals and SNFs) may not furnish covered outpatient services to their own inpatients. However, an inpatient of one institution may be considered an outpatient of another institution. Thus, all providers of outpatient PT, OT, and SP services may furnish such services to inpatients of another health facility.

Outpatient PT, OT, and SP services are covered when furnished in the home. However, the expense of making a trip to the home is not always reasonable and necessary. If the patient is not confined to the home, such added expense is not considered reasonable and necessary for the treatment of an illness or injury since the home visit is more costly than a medically appropriate and realistically feasible alternative pattern of care, e.g., in the facility's outpatient department. Consequently, these additional expenses incurred by providers due to travel to a person who is not homebound are not covered.

271. PHYSICAL THERAPY SERVICES

271.1 Conditions of Coverage.--

A. General.--To be covered, physical therapy services must:

- o Relate directly and specifically to the plan of treatment described in §270.3, and
- o Be reasonable and necessary to the treatment of the individual's illness or injury.

Services related to activities for the general well-being and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute physical therapy services for Medicare purposes.

B. Evaluation.--The physical therapy evaluation is an integral component of physical therapy services. It establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's condition must form the basis for the physical therapy treatment goals. A physical therapy initial evaluation (excluding routine screening) is covered when it is reasonable and necessary for the qualified physical therapist to determine if there is an expectation that either restorative or maintenance services are appropriate for the patient's condition. When a patient exhibits a demonstrable change in physical functional ability, reevaluations are covered to reestablish appropriate treatment goals. Reevaluations are also covered for ongoing assessment of the patients's rehabilitation needs. Initial evaluations or reevaluations that are determined reasonable and necessary are covered even though the expectations are not realized or when the evaluation determines that skilled rehabilitation is not needed.

C. Reasonable and Necessary.-- The following conditions must be met for services to be considered reasonable and necessary:

- o The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

- o The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical therapist. Services which do not require the performance or supervision of a physical therapist are not considered reasonable or necessary physical therapy services even if they are performed or supervised by a physical therapist.

NOTE: When the intermediary determines the services furnished were of a type that could have been safely or effectively performed only by or under the supervision of a qualified physical therapist, it presumes that such services were properly supervised. However, this assumption may be rebutted. If, in the course of processing claims, the intermediary finds that physical therapy services are not being furnished under proper supervision, the intermediary denies the claim and brings this matter to the attention of the Division of Health Standards and Quality of the HCFA RO.

o There must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist. Alternatively, the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease state.

o The amount, frequency, and duration of the services must be reasonable.

NOTE: Claims for physical therapy services denied because the services are not considered reasonable and necessary are excluded from coverage and are thus subject to consideration under the waiver of liability provision in §1879 of the Act.

D. Types of Therapy.--

1. Restorative Therapy.-- To constitute physical therapy, a service must be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential is insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, the services are not considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness it is determined that the expectations will not materialize, the services are no longer considered reasonable and necessary and are excluded from coverage.

2. Maintenance Program.-- The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures and do not require the judgment and skill of a qualified physical therapist for safety and effectiveness. However, in certain instances, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson's disease patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine the most effective type of exercise to maintain the patient's present functional level.

In such situations, the following services constitute physical therapy:

o The initial evaluation of the patient's needs;

o The design by the qualified physical therapist of a maintenance program appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician;

o The instruction of the patient or supportive personnel, e.g., aides, nursing personnel or family members, if furnished on an outpatient basis, in carrying out the program; and

o Reevaluations as required.

If a patient has been under a restorative physical therapy program, the physical therapist regularly reevaluates the condition and adjusts the exercise program. The physical therapist should have already designed the required maintenance program and instructed the patient, supportive personnel, or family members, if the services have been furnished on an outpatient basis, in implementing the program before it is determined that no further restoration is possible. Therefore, when the therapist does not establish a maintenance program until after the restorative physical therapy program has been completed, no further physical therapy services are reasonable and necessary. Therefore, establishing such a program is not reasonable and necessary to the treatment of the patient's condition and is not covered.

271.2 Application of Guidelines.-- The following discussion illustrates the application of the above guidelines to the more common modalities in which the reasonableness and necessity of physical therapy services is a significant issue.

A. Hot Pack, Hydrocollator, Infra-Red Treatments, Paraffin Baths, and Whirlpool Baths.-- Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case, the skills, knowledge, and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they are part of the physical therapy service.

B. Gait Training.--Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a qualified physical therapist. However, if gait evaluation and training cannot reasonably be expected to significantly improve the patient's ability to walk, such services are not considered reasonable and necessary. Repetitious exercises to improve gait or maintain strength and endurance and assisted walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a qualified physical therapist.

C. Ultrasound, Shortwave, and Microwave Diathermy Treatments.--These modalities must always be performed by or under the supervision of a qualified physical therapist. Therefore, such treatments constitute physical therapy.

D. Range of Motion Tests.--Only the qualified physical therapist may perform range of motion tests, and such tests constitute physical therapy.

E. Therapeutic Exercises.--Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist because of either the type of exercise employed or the condition of the patient constitute physical therapy.

Range of motion exercises require the skills of a qualified physical therapist only if:

o They are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored) and;

o Such exercises, either because of their nature or the condition of the patient, may only be performed safely and effectively by or under the supervision of a qualified physical therapist.

Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function (see §271.1D2) do not require the skills of a qualified physical therapist.

(conditions must be met.)

o The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.

o The services must be of such a level of complexity and sophistication, or the patient's condition must be such, that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist.

Update on Provider Protections Under Medicare+Choice

The Chair next welcomed Thomas Gustafson, Director of Plans and Provider Purchasing in the Center for Health Plans and Providers. Following his presentation at the June Council meeting, which paid special attention to the chiropractor issue, Mr. Gustafson sent Council Members a clarifying letter. At this meeting Mr. Gustafson attempted to re-state his clarification, which went like this (verbatim from the transcript):

- A manual manipulation of the spine to correct a subluxation is specifically referenced in the Social Security Act in connection with the definition of a physician, in particular the chiropractor as a physician for this purpose.
- Since Medicare+Choice plans and other managed care organizations are required to make available all Medicare Part A and Part B benefits, they, by extension, must make this particular service available. Since it is identified as a physician service, they must make available physicians in order to deliver it.
- These physicians may include any providers that are defined as physicians under the Social Security Act included but not limited to chiropractors, and this is the subject of a lawsuit with the American Chiropractic Association.
- A Medicare+Choice plan must make available physicians capable of performing manual manipulation of the spine to correct a subluxation.
- A corollary implication is that plans cannot rely exclusively on non-physician practitioners, such as physical therapists, in order to fulfill this responsibility.
- However, plans may continue to use physical therapists. Physical therapy is also a benefit under Medicare. Physical therapists employed by or under contract with plans may continue to perform and be paid for manipulative treatments, including manipulation of the spine. I'm saying that very carefully.
- The anti-discrimination provision indicates that a plan should not discriminate on the basis of licensure. The section goes on to say that this paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.
- Finally, the Inspector General is carrying out a study to help update HCFA's understanding of the actual situation at the point of care. The results are expected momentarily.

Mr. Gustafson noted that HCFA published a final rule on that matter on February 17th, laying out different paths of appeal for providers who were signed onto a plan and providers who were not. That rule permitted plans to withhold administrative detail from complainant providers under the rubric of Aproprietary information. However, the plans cannot use the Aproprietary information shield to prevent their providers from learning relevant administrative information.

(Practicing Physicians Advisory Board to CMS, Minutes from September 1999 Meeting, Letter 30)

Update

APTA Update on CMS Operational Policy Letter

Last week we notified you of a recent ruling from the Centers for Medicare and Medicaid Services (CMS) concerning manual manipulation of the spine to correct a subluxation.

Manual manipulation, including manipulation of the spine, is a long-standing part of physical therapist practice, for which physical therapists have billed and been paid by Medicare for years. The manual therapy services provided by physical therapists are included under CPT codes in the 97000 series, which do not refer to "subluxation."

The CMS Operational Policy Letter addressed the question of "which practitioners are authorized by law to perform manual manipulation of the spine to correct a subluxation as a Medicare-covered service." The CMS letter concludes that Medicare+Choice organizations "may not use non-physician physical therapists for manual manipulation of the spine to correct a subluxation." The CMS letter reasons that, because the Medicare law refers to manual manipulation of the spine to correct a subluxation only in a section that defines a "physician" for purposes of the statute, manual manipulation of the spine to correct a subluxation is "a physician service," and thus Medicare+Choice organizations may use only "physicians", including chiropractors, and not physical therapists, to provide the service. (Chiropractors are considered "physicians" under the Medicare statute for the limited purpose of providing manual manipulation of the spine to correct a subluxation).

APTA notes that the CMS Operational Policy Letter applies only to Medicare+Choice, and not to traditional fee-for-service Medicare. More importantly, the CMS Operational Policy Letter expressly applies only to manual manipulation of the spine to correct a subluxation. Consequently, APTA believes that physical therapists may continue to furnish manual manipulation of the spine for any other purpose to Medicare+Choice beneficiaries, so long as physical therapists practice within the scope of their state licensure. Moreover, since the CPT codes for manual manipulation currently used by physical therapists do not reference "subluxations," the CMS Operational Policy Letter does not restrict in any fashion the ability of physical therapists to furnish the services they have historically furnished to Medicare+Choice beneficiaries, or the ability of physical therapists to bill for those services as before. In short, APTA views the CMS Operational Policy Letter as a clarification of pre-existing policy, rather than a change in policy that would affect in any way the scope of physical therapist practice under Medicare+Choice.

Based on preliminary discussions, it is APTA's understanding that CMS and HHS officials do not disagree with APTA's position on this issue. CMS officials have indicated that the OPL is limited in scope and only applies to manual manipulation of the spine to correct a subluxation. Further, CMS/HHS continues to oppose the lawsuit brought by the American Chiropractic Association (ACA), in which the ACA seeks (a) to declare chiropractors the exclusive providers of manual manipulation services to correct a subluxation; and (b) to prohibit physical therapists from providing any manual manipulation of the spine services to Medicare+Choice beneficiaries. APTA has sought to intervene in the lawsuit, and has filed briefs opposing the ACA's substantive arguments. The case is pending.

Manipulation: A Covered Physical Therapist Service

With the filing of a "Stipulation of Dismissal," Medicare's recognition of physical therapists as providers of manipulation services is no longer under challenge. The Federal Government and the American Chiropractic Association (ACA) have agreed to the dismissal of Count II of the ACA's suit (*American Chiropractic Association, Inc v Tommy G Thompson, Secretary of Health and Human Services*), which sought a ruling from the Court that physical therapists could not perform manual manipulation of the spine as a Medicare covered service.

With dismissal of Count II, the government's long-standing policy of treating manipulation of the spine provided by a physical therapist as a Medicare covered service remains in effect. This policy frequently was affirmed in the Government's pleadings to the Court. In one instance, the Government wrote that "a physical therapist may provide, and be reimbursed by Medicare for, the services of manipulative treatment of the spine as long as that service is appropriate and within the scope of the physical therapist's license." And in another, while affirming that manipulation of the spine *to correct a subluxation* is a physician service, the government went on to say that "this reading of the statute does not, however, preclude physical therapists from providing whatever services they are authorized to perform under the scope of their licenses."

The ACA based its decision to file the stipulation of dismissal on the publication of a revised version of the Centers for Medicare and Medicaid Services' (CMS) Operational Policy Letter #23. This Letter states that "the statute specifically references manual manipulation of the spine *to correct a subluxation* as a physician service" (emphasis added) and that Medicare+Choice organizations "may not use non-physician physical therapists for manual manipulation of the spine *to correct a subluxation*" (emphasis added). The letter concludes with the statement: "Medicare+Choice organizations may continue to use physical therapists to treat enrollees for conditions not requiring physician services." On several occasions CMS representatives have confirmed that these physical therapist treatments include manipulation of the spine services, precisely as was stated in the Government's submissions to the Court.

In light of the dismissal of Count II, APTA withdrew its motion to intervene in the lawsuit because ACA is no longer seeking relief that would adversely affect physical therapists. APTA has reserved its right to ask the Court for permission to file an amicus brief on the remaining issues before the court if future developments warrant that action.

With this somewhat surprising turn of events, another challenge to the right of physical therapists to manipulate the spine falls quietly by the wayside.

#8

3/7/05

Dear House Human Services Committee:

I am writing in support of the physical therapists for SB 2366. I am a board certified orthopedic surgeon with the Bone and Joint Center since 1995 in Bismarck, North Dakota. I work with physical therapists on a daily basis that treat my patients after injuries or surgeries. Physical therapists must work with these patients who can or have developed joint range of motion problems. I am comfortable with the manual therapy techniques that physical therapists use to assist my patients toward a full recovery. I fully support the language they are putting forth defining manual therapy as performed by the physical therapist in SB 2366.

Sincerely,

Joseph Carlson, M.D.

(9)

Tuesday, March 08, 2005

HOUSE HUMAN SERVICES COMMITTEE
SB 2366

REP. PRICE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing here today on behalf of the North Dakota Board of Physical Therapy Examiners and the North Dakota Physical Therapy Association. I appreciate the opportunity to make a few brief comments about SB 2366 and give you some additional material.

First, there may be some confusion about amendments. We are not offering any amendments and we respectfully ask that you resist any amendments offered by others today. We are asking that you consider this bill as is without amendments.

Secondly, there may also be some confusion about the results of a recent federal court case wherein the American Chiropractic Association's effort to limit the use of manipulation was dismissed. Attached as **Exhibit A** is an explanation of that case and copies of two policy letters from the Centers for Medicare and Medicaid Services (CMS) regarding coverage of manipulation of the spine by physical therapists. The letters and the dismissal of the court case affirm the government's policy of treating spinal manipulation by physical therapists as a covered service.

There may be some question about where our definition of manual therapy (Page 2, line 3) came from and that somehow this is a "new" definition that allows therapists to provide a "new" procedure. Attached as **Exhibit B** is a definition of the CPT codes and how they are used by every medical facility and insurer in the country. Code 97140 is the code that physical therapists have been using for years to bill their manual therapy procedures. You will note it is exactly the same definition used in SB 2366. Nothing new or startling here.

Chiropractors don't own spinal manipulation and are not the final arbitrators on who can practice it. As noted in the May 5, 2000, policy letter from the Veterans Administration (**Exhibit C**), manual therapy is performed by several professions and there is no evidence that it is more risky or effective when performed by any profession.

Attached as **Exhibit D** is a thorough report of the very issue we're discussing today ordered by the Virginia Legislature in 1999 and conducted by the Virginia Board of Medicine. It concludes it is not necessary to restrict physical therapy practice for patient safety as claimed by the chiropractors.

Attached as **Exhibit E** is a list of the courses taken by physical therapists at the University of North Dakota's Department of Physical Therapy. The University of Mary's course offerings are similar. You can see the emphasis on manual therapy techniques throughout.

And, finally, as **Exhibit F,** is a clipping from last Sunday's *Bismarck Tribune that* indicates the type of advanced training physical therapists obtain.

I'd like to re-emphasize a few points from our earlier testimony.

- North Dakota physical therapists have been performing the types of manipulations the chiropractors want to prevent us from using for the last 50 years, and **there has not been a single complaint. Not one!!**
- You heard testimony from a physiatrist – a physician who specializes in muscular-skeletal disorders – who said that from her personal observation and experience ND physical therapists are trained to perform these manipulations. An orthopedic surgeon submitted written testimony saying the same thing.
- Every hospital in the state permits physical therapists to perform these manipulations as ordered by orthopedic surgeons and other doctors across the state.
- Medicare, Medicaid, Blue Cross/Blue Shield and every other major insurance carrier has paid for the performance of these manipulations for years.
- You've heard from instructors in the state's fine two doctoral programs that they teach and cover these manipulation techniques throughout the entire program.
- You will not hear anyone from the medical community, or from a hospital or clinic in the state, that physical therapists should not be performing these manipulations. You will not hear from any patients or consumers that physical therapists should not be performing these techniques. You will not hear about a single case or incident...ever...in North Dakota where a patient has been put at risk or been injured by a physical therapist.

Legislators have asked why we can't reach some agreement on this issue. The physical therapists have made every change possible short of allowing the chiropractors to set the standards for the physical therapists.

We have added language to the Act on page 4, line 13, whereby our board will establish methods to assess the continuing competence of physical therapists. On page 12, at line 17, the board is mandated to establish criteria for judging the competence of physical therapists regarding manual therapy. But, the chiropractors, despite their statements about adequate training, don't really want any standards for physical therapists in this regard. Their proposed amendment prohibits physical therapists from performing these manipulations ever....no matter what standards or training the PTs receive.

North Dakota now has two schools of physical therapy that offer doctoral programs accredited by all of the major medical and educational accrediting agencies in the country. This accreditation takes into account the curriculums that include training in mobilization and manipulation. The graduates of these programs want to practice the profession they've been trained for. Many would like to practice in North Dakota. But they won't be able to if the chiropractors are successful in taking away a key element of the practice.

Therefore, we respectfully request you adopt the proposed amendments and then give this bill a DO PASS. Thank you for your time and consideration.

American Physical Therapy Association

Advocacy

Manipulation: A Covered Physical Therapist Service

With the filing of a "Stipulation of Dismissal," Medicare's recognition of physical therapists as providers of manipulation services is no longer under challenge. The Federal Government and the American Chiropractic Association (ACA) have agreed to the dismissal of Count II of the ACA's suit (*American Chiropractic Association, Inc v Tommy G Thompson, Secretary of Health and Human Services*), which sought a ruling from the Court that physical therapists could not perform manual manipulation of the spine as a Medicare covered service.

With dismissal of Count II, the government's long-standing policy of treating manipulation of the spine provided by a physical therapist as a Medicare covered service remains in effect. This policy frequently was affirmed in the Government's pleadings to the Court. In one instance, the Government wrote that "a physical therapist may provide, and be reimbursed by Medicare for, the services of manipulative treatment of the spine as long as that service is appropriate and within the scope of the physical therapist's license." And in another, while affirming that manipulation of the spine *to correct a subluxation* is a physician service, the government went on to say that "this reading of the statute does not, however, preclude physical therapists from providing whatever services they are authorized to perform under the scope of their licenses."

The ACA based its decision to file the stipulation of dismissal on the publication of a revised version of the Centers for Medicare and Medicaid Services' (CMS) Operational Policy Letter #23. This Letter states that "the statute specifically references manual manipulation of the spine *to correct a subluxation* as a physician service" (emphasis added) and that Medicare+Choice organizations "may not use non-physician physical therapists for manual manipulation of the spine *to correct a subluxation*" (emphasis added). The letter concludes with the statement: "Medicare+Choice organizations may continue to use physical therapists to treat enrollees for conditions not requiring physician services." On several occasions CMS representatives have confirmed that these physical therapist treatments include manipulation of the spine services, precisely as was stated in the Government's submissions to the Court.

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issues before the court if future developments warrant that action.

With this somewhat surprising turn of events, another challenge to the right of physical therapists to manipulate the spine falls quietly by the wayside.

respect to any legislative and regulatory changes that the Secretary determines are necessary to ensure access to such services." *Id.* The Secretary did not issue the report by the January 1, 1993 deadline. Am. Compl. ¶ 33, Answer ¶ 33.

On December 14, 1994, the Secretary and the Health Care Financing Administration ("HCFA"), now called the Centers for Medicare and Medicaid Services ("CMS"),[2] issued Operational Policy Letter #23 ("OPL #23"), which discusses §1395x(r)(5)). OPL #23 originally read as follows:

MANUAL MANIPULATION OF THE SPINE - MEDICARE COVERAGE

Operational Policy Question:

Which practitioners are authorized by law to perform manual manipulation of the spine as a Medicare-covered service?

Answer:

Section 1861(r) [codified as 42 U.S.C. §1395x(r)] of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation demonstrated by x-ray. The statute specifically references manual manipulation of the spine to correct a subluxation demonstrated by x-ray as a physician service. Thus, managed care plans may use physicians to perform this service.

Managed care plans contracting with Medicare are not required, however, to offer services of chiropractors, but may use other physicians to perform this service. In addition, managed care plans may offer manual manipulation of the spine as performed by non-physician practitioners, such as physical therapists, if allowed under applicable state law.

Please also note that section 2153.1 of the Medicare HMO/CMP manual states that marketing materials of the managed care plans must clearly state which physician specialties are authorized by the plan to provide manual manipulation of the spine.

[2] The name was changed by announcement of the Secretary effective June 14, 2001.

See Am. Compl at Ex. S; Pl.'s Mem. Supp. Summ. J. Ex. 11 at 1.[3]

On April 12, 1999, the Secretary submitted the report required by § 4204(f) of OBRA, over five years after it became due. *See* Pl.'s Statement Of Material Facts ¶ 25; Def.'s Response To Pl.'s Statement Of Material Facts ¶ 25; Pub. L. No. 101-508, § 4204(f), 104 Stat. 1388, 112 (1990), *as amended by* Pub. L. No. 103-432, § 157, 108 Stat. 4398, 4442 (1994). The report to Congress entitled "Chiropractic Services In Medicare Managed Care" (the "'99 Report"), appears to have been submitted in response to the filing of this suit. *See Am. Chiropractic Ass'n*, 108 F. Supp. 2d at 4 (opinion of Judge Harris).

The '99 Report seeks to determine "the extent to which HMOs make chiropractic services

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[3] OPL #23 was updated January 15, 2002, apparently as part of an agreement between the parties that resulted in the dismissal of Count II of the Amended Complaint. *See* Stipulation of Dismissal filed March 1, 2002. OPL #23 now reads as follows:

> **Operational Policy Question:**
> Which practitioners are authorized by law to perform manual manipulation of the spine to correct a subluxation as a Medicare-covered service?
>
> **Answer:**
> Section 1861(r) [codified as 42 U.S.C. §1395x(r)] of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation. (As a standard Medicare Part B benefit, manual manipulation of the spine to correct a subluxation must be made available to enrollees in all Medicare + Choice plans). The statute specifically references manual manipulation of the spine to correct a subluxation demonstrated by x-ray as a physician service. Thus, Medicare + Choice organizations must use physicians, which include chiropractors, to perform this service. They may not use non-physician physical therapists for manual manipulation of the spine to correct a subluxation. Medicare+Choice organizations may continue to use physical therapists to treat enrollees for conditions not requiring physician services as defined in section 861(r) of the Social Security Act.

Department of Health and Human Services Operational Policy Letter *available at* http://www.cms.hhs.gov/healthplans/opl/default.asp?

American Medical Association

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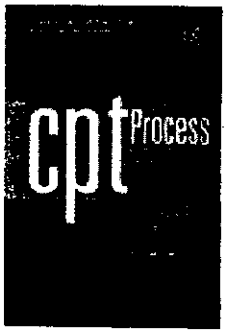
CPT Process – How a Code Becomes a Code



What is CPT?

Current Procedural Terminology (CPT®), Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients, and third parties.

How is CPT used?

CPT descriptive terms and identifying codes currently serve a wide variety of important functions. This system of terminology is the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. CPT is also used for administrative management purposes such as claims processing and developing guidelines for medical care review.

The uniform language is likewise applicable to medical education and research by providing a useful basis for local, regional, and national utilization comparisons.

How was CPT developed?

The American Medical Association (AMA) first developed and published CPT in 1966. The first edition helped encourage the use of standard terms and descriptors to document procedures in the medical record; helped communicate accurate information on procedures and services to agencies concerned with insurance claims; provided the basis for a computer oriented system to evaluate operative procedures; and contributed basic information for actuarial and statistical purposes.

The first edition of CPT contained primarily surgical procedures, with limited sections on medicine, radiology, and laboratory procedures. The second edition was published in 1970, and presented an expanded system of terms and codes to designate diagnostic and therapeutic procedures in surgery, medicine, and the specialities. At that time, a five-digit coding system was introduced, replacing the former four-digit classification. Another significant change was a listing of procedures relating to internal medicine.

In the mid to late 1970s, the third and fourth editions of CPT were introduced. The fourth edition, published in 1977, represented significant updates in medical technology and a system of periodic updating was introduced to keep pace with the rapidly changing medical environment. In 1983, CPT was adopted as part of the Centers for Medicare and Medicaid Services (CMS), formerly Health Care Financing Administration's (HCFA), Healthcare Common Procedure Coding System (HCPCS). With this adoption, CMS mandated the use of HCPCS to report services for Part B of the Medicare Program. In October 1986, CMS also required state Medicaid agencies to use HCPCS in the Medicaid Management Information System. In July 1987, as part of the Omnibus Budget Reconciliation Act, CMS mandated the use of CPT for reporting outpa surgical procedures.

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Today, in addition to use in federal programs (Medicare and Medicaid), CPT is used extensively throughout the United States as the preferred system of coding and describing health care services.

HIPAA and CPT

The Administrative Simplification Section of the Health Insurance Portability and Accountability Act (HIPAA)of 1996 requires the Department of Health and Human Services to name national standards for electronic transaction of health care information. This includes; transactions and code sets, national provider identifier, national employer identifier, security, and privacy. The FinalRule for transactions and code sets was issued on August 17, 2000. The rule names CPT (including codes and modifiers) and HCPCS as the procedure code set for:

- Physician services.
- Physical and occupational therapy services.
- Radiological procedures.
- Clinical laboratory tests.
- Other medical diagnostic procedures.
- Hearing and vision services.
- Transportation services including ambulance.

The Final Rule also named ICD-9-CM volume 1 and 2 as the code set for diagnosis codes, ICD-9-CM volume 3 for inpatient hospital services, CDT for dental services, and NDC codes for drugs.

All health care plans and providers who transmit information electronically are required to use established national standards by the end of the implementation period, October 16, 2003. In addition, all local codes have been eliminated and national standard code sets must be used after October 16, 2003.

Who maintains CPT?

The CPT Editorial Panel is responsible for maintaining the CPT nomenclature. This panel is authorized to revise, update, or modify the CPT codes. The Panel is comprised of 17 members. Of these, 11 are physicians nominated by the AMA; one physician each nominated from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the American Hospital Association, and the Centers for Medicare and Medicaid Services (CMS), and the co-chair and a representative of the Health Care Professionals Advisory Committee. The AMA's board of trustees appoints the Panel members. Of the eleven AMA seats on the panel, 7 are regular seats, having a maximum tenure of two 4-year terms, or a total of 8 years for any one individual. One of these seats is designated for a physician who can represent the managed care viewpoint. The 4 remaining seats, called rotating seats, have one four-year term. These rotating seats allow for diverse specialty input.

Five members of the Editorial Panel serve as the panel's Executive Committee. The Executive Committee includes the Editorial Panel chairman and co-chairman, and three panel members-at-large, as elected by the entire panel. One of the three members-at-large of the executive committee must be a third-party payer representative.

Supporting the CPT Editorial Panel in its work is a larger body of CPT advisors, the CPT Advisory Committee. The members of this committee are primarily physicians nominated by the national medical specialty societies represented in the AMA House of Delegates. Currently, the Advisory Committee is limited to national medical specialty societies seated in the AMA House of Delegates and to the AMA Health Care Professionals Advisory Committee (HCPAC), organizations representing limited-license practitioners and other allied health

to demonstrate significant improvement within a reasonable and fairly predictable amount of time. Covered services for beneficiaries with vision impairment include:

- Mobility
- Activities of daily living
- Other rehabilitation goals that are medically necessary

Applicable procedure codes include:

97110 Therapeutic exercises

97116 Gait training

97532 Development of cognitive skills

97533 Sensory integrative techniques

97535 Self-care/home management training

97537 Community/work reintegration

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

The provider and/or patient perform therapeutic exercises to one or more body areas to develop strength, range of motion, endurance, and flexibility. This code requires direct contact and may be billed in 15-minute units.

MED: MCM 2050.3, 2210, 4161

97112 Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

The provider and/or patient perform activities to one or more body areas that facilitate reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception. This code requires direct contact and may be billed in 15-minute units.

MED: MCM 2050.3, 2210, 4161

97113 Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

The provider directs and/or performs therapeutic exercises with the patient/client in the aquatic environment. The code requires skilled intervention by the provider and documentation must support medical necessity of the aquatic environment. This code may be billed in 15-minute units.

MED: MCM 2210

Coding Tip

When performing aquatic therapy, the physical therapist must be present, providing one-to-one contact with the patient, but does not have to physically be in the pool.

97116 Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)

The provider trains the patient in specific activities that will facilitate ambulation and stair climbing with or without an assistive device. Proper sequencing and safety instructions are included when appropriate. This code requires direct contact and may be billed in 15-minute units.

MED: MCM 2050.3, 2210, 4161

97124 Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

The provider uses massage to provide muscle relaxation, increase localized circulation, soften scar tissue, or mobilize mucous secretions in the lung via tapotement and/or percussion. This code requires direct contact and may be billed in 15-minute units.

MED: MCM 2050.3, 2210, 4161

Coding Tip

The use of code 97124, massage, by definition includes effleurage, petrissage and/or tapotement; however, PTs often perform services that are more focused or complex than would fall under this definition. PTs should consider the use of 97140, Manual therapy, in these situations.

97139 Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)

This code may be used if the provider performs a therapeutic procedure to one or more body areas that is not listed under the current codes. A narrative descriptor should be noted on the claim. This code may be billed in 15-minute units.

MED: MCM 2050.3, 2210, 4161

97140 Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

The provider performs manual therapy techniques including soft tissue and joint mobilization, manipulation, manual traction and/or manual lymphatic drainage to one or more areas. This code

Appendix C

Appendix D

Appendix E

Appendix F

Department of Veterans Affairs
Veterans Health Administration
Washington, D.C., 20420

VHA DIRECTIVE 2000-014

May 5, 2000

CHIROPRACTIC CARE AND SERVICES

1. PURPOSE: This Veterans Health Administration (VHA) directive establishes policy and guidance related to VHA chiropractic care and services.

2. BACKGROUND

a. On November 30, 1999, Public Law (Pub. L.) 106-117, the Veterans' Millennium Health Care and Benefits Act (the Millennium Act) was signed into law. Section 303 of the Millennium Act requires the Under Secretary for Health, within 120 days from the date of enactment, and after consultation with chiropractors, to establish a VHA-wide policy regarding the use of chiropractic treatment in the care of veterans. The statutory language establishes no parameters with respect to such policy, except for the consultation requirement. Subsection (b) of section 303 limits the definition of the term "chiropractic treatment" to the manual manipulation of the spine for the treatment of "such musculoskeletal conditions as the Secretary considers appropriate." The law defines "chiropractor" as an individual "who is licensed to practice chiropractic in the State in which the individual performs chiropractic services; and holds the degree of doctor of chiropractic from a chiropractic college accredited by the Council on Chiropractic Education." A group of VHA officials met with representatives of the leading chiropractic organizations on February 24, 2000, for purposes of consultation as specified in Pub. L. 106-117.

b. When considering the scientific evidence concerning chiropractors, it is important to keep in mind two related, but distinct, concepts. Spinal manipulation is a form of manual therapy that is used by chiropractors, physical therapists, osteopaths, and some medical doctors. Chiropractic treatment frequently involves spinal manipulation, but may also include other non-thrust manual therapies, such as mobilization and massage, as well as advice about exercises, nutrition, and proper diet. Prior studies estimate that 70 to 90 percent of patients presenting to chiropractors will be treated with spinal manipulation.

c. There is sufficient evidence in the form of randomized clinical trials to conclude that spinal manipulation is a modestly efficacious form of therapy for some patients with uncomplicated low-back pain. These data include clinical trials where the manipulations were provided by physical therapists, osteopaths, and chiropractors. There are no clinical trial data to support a position that spinal manipulation delivered by chiropractors is more effective or less risky than spinal manipulation delivered by any other type of practitioner.

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d. What is not established is the effectiveness of either spinal manipulation or chiropractic care relative to other forms of care for patients with low-back pain. For example, a recent high-quality randomized clinical trial published in the New England Journal of Medicine (November 1999, Vol. 341) compared chiropractic care to physical therapy care or self-care. Both the chiropractic group and the physical therapy group had small benefits compared to the patients receiving self-care, but there were no differences between the chiropractic group and the physical therapy group. Furthermore, both chiropractic care and physical therapy care cost more per patient than self-care.

THIS VHA DIRECTIVE EXPIRES MAY 5, 2005

e. The cost-effectiveness of chiropractic care is uncertain. Observational studies based on claims data or workmen's compensation data tend to suggest that chiropractic care is of lower cost, while scientific and rigorous randomized clinical trial data report chiropractic care is more expensive.

f. Health Care Financing Administration (HCFA) regulations regarding reimbursement of chiropractic care are clearly delineated in Section 2251 of the HCFA Carriers Manual. Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation. Chiropractic care is, therefore, limited to the treatment of spinal subluxation that is documented by either physical examination or by x-ray. ***NOTE:*** *Full details related to chiropractic care coverage and limitations as defined by HCFA can be found in the HCFA Carriers Manual Section 2251.*

3. POLICY

a. It is VHA policy that VHA medical centers and clinics may offer chiropractic spinal manipulative therapy for musculoskeletal problems of the spine. Following a referral from a Department of Veterans Affairs (VA) clinician, chiropractic services may be authorized consistent with Title 38 United States Code (U.S.C.) 1703(a)(2)(B). ***NOTE:*** *Title 38U.S.C. authorizes VA to contract for non-VA medical services for veterans receiving VA care and who require additional care to complete their treatment. It is recommended that when such services are authorized under this authority, payment for non-VA outpatient chiropractic care should be set up as an individual authorization and paid through the Fee-basis payment process in the Veterans Health Integrated Systems and Technology Architecture (VistA). Facilities may procure local contracts for chiropractic services when it is determined that the need for such services is sufficient to support the contract action.*

b. VHA will collect information on the utilization of chiropractic consultation and services by VA staff. VHA has not developed a body of experience on the type and amount of chiropractic services VA facilities will require or utilize, and there are neither current established authorization for appointment nor credentialing requirements for chiropractors in Title 38.

4. ACTION

a. The determination of the level of necessary chiropractic services is best made at the facility or the Veterans Integrated Services Network (VISN) level. ***NOTE:*** *The need for chiropractic services is likely to be affected by many local or regional factors, such as the burden of illness, availability and access to alternative services, (e.g., physical therapy), urban versus rural environments, patient preferences, etc. Delineating a nationally uniform requirement for the frequency, intensity and duration of chiropractic services, without regard to local exigencies,*

would be inefficient and inappropriate.

b. VISNs and/or medical centers will develop a local policy for chiropractic care and services within 120 days of the publication of this policy. The VISN or local policy must address the following:

(1) The provision of provider and patient information and education related to chiropractic services.

(2) The identification and collection of data related to the provision of chiropractic services that can be collected and analyzed nationally. At a minimum, VISNs and/or facilities must ensure that the following will be captured in existing Fee Payment Package (VistA) files and/or the medical record; the:

(a) Reason for referral,

(b) Applicable International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) code,

(c) Current Procedural Terminology (CPT)-4 code,

(d) Number of treatments provided,

(e) Cost per visit, and

(f) Results of treatment.

(3) The mechanism(s) and process (es) that will be utilized to authorize, provide, and evaluate the appropriateness and effectiveness of chiropractic services.

(4) Delineate how chiropractic care will be incorporated into the existing local quality reviews, local utilization management policies, and local credentialing and privileging policies (in accordance with VHA Handbook 1100.19) in a manner that assures an appropriate level of oversight.

c. Medical centers and VISNs must ensure that chiropractic services are provided only by individuals who are licensed to practice chiropractic in the State in which the individual performs chiropractic services; and who hold the degree of Doctor of Chiropractic from a chiropractic college accredited by the Council on Chiropractic Education."

5. REFERENCES

a. Public Law 106-117, Section 303 of the Veterans' Millennium Health Care and Benefits Act.

b. Title 38 United States Code 7402(b)(10).

c. VHA Handbook 1100.19, Credentialing and Privileging.

6. FOLLOW-UP RESPONSIBILITY: The Chief Patient Care Services Officer (11) is responsible for the contents of this Directive. ***NOTE:*** *Questions may be directed to the Office of Primary and Ambulatory Care at (202) 273-8558.*

7. **RESCISSION:** This VHA Directive expires May 5, 2005.

S/ Frances Murphy, M.D. for
Thomas L. Garthwaite, M.D.
Deputy Under Secretary for Health

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VIRGINIA BOARD OF MEDICINE
DEPARTMENT OF HEALTH PROFESSIONS

Study of Spinal Manipulation
Pursuant to Request from the Chair of the Senate Committee on Education and Health

Background and Authority:

During the 1999 Session of the General Assembly, the Senate Committee on Education and Health considered Senate Bill 1141, relating to manual spinal care or spinal manipulation. The Committee failed to report the bill but, at the request of the patron, Senator Edward Schrock, asked the Virginia Board of Medicine to examine the issues relating to spinal manipulation. A letter conveying that request was sent by the Chair of the Committee, Senator Jane Woods, and received by the Board on April 27, 1999 (A copy of the letter from Senator Woods is attached to this report.)

Senate Bill 1141 defined "manual spinal care" as a skill procedure whereby a person uses a directed thrust, contact or leverage to the articular joints with the intent of affecting the structure and/or function of a person's spine. According to the legislation, the procedure includes, but is not limited to, uniquely distinct procedures, such as osteopathic manipulative treatments, spinal manipulations, and chiropractic adjusting techniques and should "only be performed by persons who are (i) doctors of osteopathy, chiropractic or medicine, licensed in Virginia and (ii) practitioners of the specific form of care rendered." Opposition to the bill arose because of its restrictions on the current scope of practice for physical therapists, who are allowed to perform manipulation or mobilization on a patient under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry or dental surgery. The Board of Medicine did not take a position on this or any other piece of legislation during the 1999 Session.

A similar bill was introduced in the 1998 General Assembly, carried over to the 1999 Session, and not reported by the Senate Committee on Education and Health. Senate Bill 600 defined "spinal manipulation" as the skillful treatment of the joints of the spine through the use of directed thrust or leverage to move or mobilize a joint in the patient's spine which is performed by a licensed practitioner of chiropractic or osteopathic medicine; it does not include orthopedic or medical reduction of fractures or dislocations. The legislation further provided that 200 hours of training in a course or institution approved by the Board is required for a licensed physician, osteopath, or chiropractor to be able to perform spinal manipulation. At its meeting on February 5, 1998, the Board voted to oppose any prohibition preventing an individual or group of individuals from doing manipulation.

Study Task Force of the Virginia Board of Medicine

For the purpose of reviewing information on spinal manipulation and data on the risk of harm to the public, receiving public comment, and bringing recommendations to the Board, the President of the Board of Medicine appointed a Study Task Force. With James F. Allen, a medical doctor specializing in neurosurgery and member of the Board serving as Chairman, the Task Force consisted of Paul M. Spector, an osteopathic member of the Board, Jerry R. Willis, a chiropractic member of the Board, and Winston R. Pearson, Jr., Chairman of the Advisory Board on Physical Therapy,

The Executive Director of the Board of Medicine, Warren K. Koontz, M.D. and the Regulatory Boards Administrator for the Department of Health Professions, Elaine J. Yeatts, provided staff assistance for the Committee. In addition, Kirsten A. Barrett, a policy research analyst with the Department conducted much of the basic research and prepared a draft report on the practice and risk of manipulation.

Definitions and Description of Spinal Manipulation or Manual Spinal Care

At its initial meeting, the study task force was asked to define spinal manipulation or manual spinal care, terminology referenced in Senator Woods' letter. Dorland's Medical Dictionary defines manipulation as "skillful or dexterous treatment, as by hand. In physical therapy, the forceful passive movement of a joint beyond its active limit of motion." There is no definition of "spinal manipulation" in the dictionary nor was there agreement among chiropra

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practitioners about the definition and description of manual spinal care and related terms. Seeking clarification, the Executive Director of the Board of Medicine requested information and definitions from state boards and associations relating to the professions of medicine, osteopathy, podiatry, chiropractic and physical therapy.

Definitions provided by the Virginia Chiropractic Association are as follows:

> **Spinal Manipulation:** Passive movement of short amplitude and high-velocity which moves the joint into the paraphysiologic range. This is accompanied by cavitation or gapping of the joint that results in an intrasynovial vacuum phenomenon thought to involve gas separating from fluid.
>
> **Spinal Mobilization:** Passive movements within physiological joint range of motion without cavitation or the popping sound inherent to manipulation.

Definitions provided by the Virginia Physical Therapy Association and the American Physical Therapy Association are as follows:

> **Manual Therapy:** A broad group of skilled hand movements, including but not limited to mobilization and manipulation, used by the physical therapist to mobilize or manipulate soft tissues and joints for the purpose of modulating pain; increasing range of motion; reducing or eliminating soft tissue swelling, inflammation or restriction; inducing relaxation; improving contractile or non-contractile tissue extensibility; and improving pulmonary function. Manual therapy techniques include connective tissue massage, joint mobilization and manipulation, manual lymphatic drainage, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage
>
> **Spinal Care:** A generic term that describes no specific intervention, philosophy or methodology. In contrast, the Guide to Physical Therapist Practice describes the "disablement model" and defines "impairment," "functional limitation," and "disability." These are terms that can be applied to any human condition including those that involve the spine.
>
> **Mobilization:** A skilled passive hand movement that can be performed with variable amplitudes at variable speeds.
>
> **Manipulation**: A skilled passive hand movement that usually is performed with a small amplitude at a high velocity.

When applied to treatment of spine dysfunction, manual therapy techniques are often termed manual spinal care or manual spinal therapy. The term's spinal mobilization or spinal manipulation may be used depending on the intervention performed.

Utilization of Manual Therapy Techniques in Physical Therapy:

Historically, physical therapists have utilized manipulation in their practices; the literature supporting its use by physical therapists dates back to 1928. Manual therapy techniques, including mobilization and manipulation, are identified as direct physical therapy interventions in the Guide to Physical Therapist Practice, Revised 4/99. In the Guide, intervention is defined as "the purposeful and skilled interaction of the physical therapist with the patient/client – and, when appropriate, with other individuals involved in care – using various methods and techniques to produce change in the condition that are consistent with evaluation, diagnosis and prognosis. Decisions are contingent on the timely monitoring of response to intervention and the progress made toward anticipated goals and expected outcomes."

Manual therapy techniques may be an appropriate intervention for patients with musculoskeletal, neuromuscular, cardiopulmonary and/or integumentary dysfunction. Candidates for manual therapy include patients / clients with: limited range of motion (ROM), muscle spasm, pain, scar tissue or contracted tissue and/or soft tissue swelling, inflammation or restriction. The anticipated goals to be achieved after the application of manual therapy techniques may include any or all of the following:

1. Increased ability to perform movement tasks
2. Decreased edema, lymphedema or effusion
3. Improved integumentary integrity
4. Improved joint integrity and mobility
5. Improved motor function
6. Reduction in muscle spasm
7. Reduction in pain
8. Improvement in quality and quantity of movement between and across body segments
9. Reduction in risk of secondary impairment
10. Reduction in soft tissue swelling, inflammation or restriction
11. Increased tolerance to positions and activities
12. Decreased utilization and cost of health care services
13. Improved ventilation, respiration and circulation

Utilization of Manipulation in Osteopathic Medicine:

According to the American Association of Colleges of Osteopathic Medicine, Osteopathic Manipulative Treatment (OMT) is a system of manual manipulation treatment developed by Dr. Andrew Taylor Still in the late 1800's, based on his recognition of the role that the musculoskeletal system plays in the body's continuous effort to resist and overcome illness and disease. OMT is composed of a spectrum of manual techniques that physicians may use to alleviate pain, restore freedom of motion, and enhance the body's own healing power. Often these techniques are used in conjunction with more conventional forms of medical care, such as prescribing medication or performing surgery. The most commonly used manipulative techniques in osteopathy are: articulatory techniques, counterstrain, cranial treatment, myrfascial release treatment, lympathic techniques, soft tissue techniques, and thrust techniques.

Education and Training

Physical Therapy Education

There are presently 189 accredited and 25 developing physical therapy programs in the United States (APTA, 1999). Of the accredited programs, 24 are at the bachelor's level, 158 at the master's level and 7 at the doctoral level. In Virginia, there are four accredited physical therapy programs and one developing physical therapy program. By 2002, all physical therapy education programs will be at the Master's level or higher.

Program accreditation is granted through the Commission on Accreditation of Physical Therapy Education (CAPTE). CAPTE is the only recognized agency in the United States for the accreditation of physical therapy and physical therapist assistant programs. Although accreditation is a voluntary process, graduation from an accredited physical therapy education program is one of the necessary requirements for licensure. Since licensure is necessary in all fifty states at this time, institutions necessarily seek accreditation through CAPTE. In addition, many states, including Virginia, require the applicant to successfully pass the national physical therapy examination which has been jointly developed, and is jointly administered and scored, by the Federation of State Boards of Physical Therapy and the Professional Examination Service (PES).

In the accreditation process, CAPTE uses the Evaluative Criteria for the Accreditation of Education Programs for the Preparation of Physical Therapists. The Evaluation Criteria outlines four areas of compliance for institutions. These are organization, resources and services, curriculum development and content and program assessment.

Entry-level skills and knowledge necessary for safe physical therapy practice are outlined in the section of the Evaluative Criteria addressing curriculum development and content. Topic areas include, but are not limited to, communication, critical inquiry and decision-making, professional development, examination, plan of care, intervention, prevention and wellness and social responsibility. Manual therapy techniques can be found in the intervention section (3.8.3.28f). The framework provided in the curriculum development and content section of the Evaluative Criteria is expanded on in the Normative Model of Physical Therapist Education.

The Normative Model of Physical Therapists Professional Education includes manipulation as course content and skill acquisition components. The Normative Model is used by educational programs to determine necessary course content for the physical therapy curriculum and details the educational outcomes for the graduate to achieve in many areas, including intervention. Included in the section on intervention are educational outcomes related to safe practice and skill acquisition. The following is a listing of the educational outcomes related to safe practice:

13.1 Practice in a safe setting and manner to minimize risk to the patient, client, therapist, and others.

The graduate:

- is aware of high-risk aspects of practice.
- is aware of measures to prevent risk.
- corrects unsafe conditions.
- applies standard safety procedures.
- seeks assistance when necessary.
- instructs others in safety procedures
- documents critical incidents
- is aware of impaired-provider issues.
- implements risk-management procedures after a critical incident.

In regards to skill acquisition in performing various physical therapy interventions, the following educational outcomes are identified in the Normative Model:

13.2.1 Provide direct physical therapy interventions to achieve goals that facilitate expected patient or client outcomes based on the examination and on the impairment, functional limitations, and disability.

The graduate:

- administers physical therapy intervention to achieve the desired patient or client response
- delivers treatment procedures accurately based on applicable practice guidelines.
- performs treatment procedures with consideration for safety, timeliness, energy conservation, and organization, including preparation, sequencing, progression, and setting priorities.
- modified intervention based on the attainment of outcomes based on impairment, functional limitations, and disability.
- confers with patient concerning outcomes.

Manual therapy is listed as an intervention in the Evaluative Model and its components are described in the Normative Model. Manual therapy may include connective tissue massage, joint mobilization and manipulation, manual lymphatic drainage, manual traction, passive range of motion, soft-tissue mobilization and manipulation and therapeutic massage.

Additionally, in the area of examination, the Normative Model details the nature of joint integrity and mobility testing. This is germane to the issue of manual therapy. Joint integrity and mobility tests may include:

- Analysis of the nature and quality of movement of the joint or body part during the performance of specific movement tasks
- Assessment of joint hypermobility and hypomobility
- Assessment of pain and soreness
- Assessment of response to manual provocation of the joint
- Assessment of sprain
- Measurement of soft tissue restriction

Utilization of the Evaluative Criteria and Normative Model at the Institutional Level

Samples of actual course syllabi from Shenandoah University School of Health Professions, Program in Physical Therapy and from Hampton University demonstrate how the course objectives, the curriculum development and content criteria relate to manual therapy techniques, as set forth in the Evaluative Criteria and Normative Model.

The Department of Physical Therapy at Virginia Commonwealth University provided a list of course work in which the content relates to manipulation, with the number of contact (lecture and lab) hours of training that each student receives.

Content Related to Manipulation	Course Name	Contact Hours
Gross Anatomy	PHT 501	72 hours lecture, 72 hours lab
Histology/Microscopic Anatomy	PHT 505	56 hours lecture, 20 hours lab
Kinesiology	PHT 502	30 hours lecture, 30 hours lab
Biomechanics	PHT 507	30 hours lecture, 30 hours lab
Examination of the patient with Musculoskeletal (including manipulation of the spine)	PHT 508	90 hours lecture, 45 hours lab (appox. half spent on the spine)
Pathology of the musculoskeletal system (manipulation of spine included)	PHT 540	15 hours lecture
Pathology of the musculoskeletal system	PHT 548	15 hours lecture
Treatment of patients with musculoskeletal problems	PHT 548	60 hours lecture, 30 hours lab (approx. half spent on spine)
Traction and massage of the spine	PHT 533	5 hours lecture, 10 lab

In addition to course work, there are a number of methods by which physical therapists acquire clinical competence in manipulation. They include:

- Clinical programs in entry level education - Marymount University in Northern Virginia has specialized clinical opportunities available for students wishing to become proficient in manipulation which range from 3 to 6 months in length and provide direct instruction and supervision.
- Post-professional degree programs - Several exists in universities in the United States both at the masters and doctoral level that offer extensive didactic and clinical training in manipulation.
- Post-professional continuing education - There is an array of post-professional continuing education, such as the North American Institute of Orthopedic Manual Therapy (courses range from 42 to 84 hours) offered around the country which are devoted entirely or partially to manipulation. Included in these are MAPS seminars (Maitland Australian Physiotherapy Seminars) at which accurate assessment and clinical decision-making are emphasized and the methodology includes live patient demonstrations and a hands-on laboratory format.
- Post-professional clinical residency programs - A number of programs exist across the country which offer extensive clinical and didactic training in the area of manipulation.
- Orthopedic Certified Specialist Certification - The American Board of Physical Therapy certifies specialists in a number of specialty areas of physical therapy, including one related to manipulation. The minimum eligibility requirements include at least 6,000 hours of direct patient care in orthopaedics or evidence of completion of an accredited clinical residency and passage of a written examination of advance knowledge and clinical skills.
- Clinical mentorships - The American Physical Therapy Association offers a program designed to assist clinicians interested in developing advanced clinical competencies by providing them with mentors who have expertise in the area of manipulation.

Chiropractic Education Programs

There are presently 16 chiropractic colleges accredited by the Commission on the Accreditation of the Council of Chiropractic Education (CCE). The CCE is recognized by the United States Department of Education. As with physical therapy, in order to obtain a license to practice chiropractic in any of the fifty states, graduation from an accredited chiropractic institution or educational program is one of the necessary requirements. In addition, many states, including Virginia, require the applicant for licensure to successfully complete the four-part National Board of Chiropractic Examiners examination (NCBE). This examination covers basic sciences, clinical sciences, clinical competency and practical skills.

The CCE has described the minimal acceptable clinical criteria necessary for the competent practice of chiropractic. These are found in the Standards for Chiropractic Programs and Institutions, Section 3. The Criteria for Accreditation V.

Mission Elements – Clinical Competencies. Included are clinical competencies in the areas of history taking, physical examination, psychosocial assessment, diagnosis and clinical impression and adjusting competencies. Attitudes, knowledge and skills are described for each area of clinical competence.

The following is an example of the attitudes, knowledge and skills associated with the adjusting competencies.

Adjusting Competencies:

The adjustment is a precise procedure that uses controlled force, leverage, direction, amplitude, and velocity directed at specific articulations. Doctors of chiropractic employ adjustive procedures to influence joint and neurophysiologic function. Other manual procedures may be used in the care of patients such as manipulation, which are not as precise or specific.

Attitudes:

1. Appreciate the need to explain what will be done when administering the adjustment, discuss risks, and recognize the potential for patient apprehension and concern.
2. Demonstrate awareness of the need to accommodate patient privacy and modesty in the course of administering chiropractic adjustments.
3. Demonstrate awareness of the need to reassess and modify adjustive methods appropriate to the needs of the patient.

Knowledge:

1. Demonstrate an appreciation of the normal and abnormal structural and functional articular relationships.
2. Demonstrate awareness of the pathophysiology and methods of evaluating articular biomechanics.
3. Understand the principles and methods of various adjustive and manipulative procedures common to the practice of chiropractic.
4. Recognize the clinical indications and rationale for selecting a particular adjustive or manipulative procedure.
5. Be able to select and appropriately use equipment and instruments necessary to administer adjustive or manipulative procedures.
6. Recognize the indications and contraindications for, and potential complications of adjustive and manipulative procedures.

Skills:

1. Demonstrate an ability to palpate specific anatomical landmarks associated with spinal segments and other articulations.
2. Select and effectively utilize palpatory and other appropriate methods to identify subluxations of the spine and other articulations.
3. Effectively use equipment and instruments that support adjustive or manipulative procedures.
4. Demonstrate an ability to effectively deliver the correct adjustive or manipulative procedures which utilize appropriate positioning, alignment, contact and execution.
5. Demonstrate the ability to effective administer a variety of adjustive or manipulative procedures in order to accommodate differences in patient body type and clinical status.
6. Accurately record the method of determining location, specific procedure followed and outcome of adjustment.
7. Select and employ palpation and other methods for identifying the effects following adjustive or manipulative procedures.
8. Communicate the health benefits of adjustments to patients.
9. Demonstrate an ability to perform adjustive procedures in a confident and decisive manner.
10. Discuss potential immediate or delayed reactions or responses to the adjustment.

[From: Standards for Chiropractic Programs and Institutions, January 1999; www.cce-usa.org]

All professionals licensed by the Board of Medicine have an obligation to practice with skill and safety. A physician licensed to practice medicine or osteopathic medicine is authorized to practice "the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method." (§ 54.1-2900 of the *Code of Virginia)* Nothing in law or regulation stipulates that additional training beyond that required for basic licensure must be acquired to perform complex brain surgery or other such specialized practices. The professional is

expected to practice within his or her scope of education, training and ability. The same may be said about other licensees of the Board who are all subject to disciplinary provisions in § 54.1-2914 of the *Code of Virginia.*

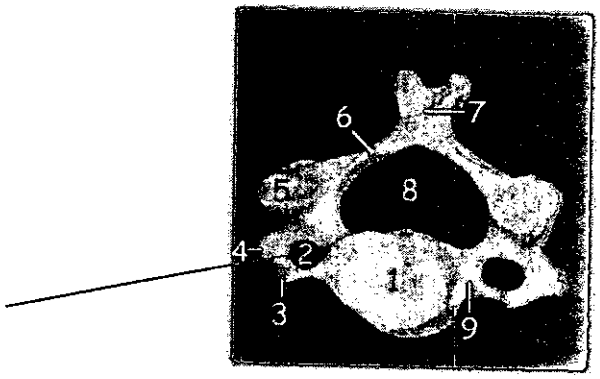
In the section on unprofessional conduct (§ 54.1-2914), the *Code* provides that any practitioner of the healing arts regulated by the Board shall be guilty of unprofessional conduct if he: 1) conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts; 2) conducts his practice in such a manner as to be a danger to the health and welfare of his patients or to the public; or 3) performs any act likely to deceive, defraud or harm the public. For example, the Guide of Professional Conduct for the American Physical Therapy Association provides that if the examination of a patient reveals findings that are outside the scope of the physical therapist's knowledge, experience or expertise, the physical therapist shall so inform the patient and refer to an appropriate practitioner. If, therefore, a practitioner licensed by the Board, whether it be a physician, an osteopath, a chiropractor or a physical therapist engages in the practice of manipulation without the necessary skills and ability to treat a patient safely and competently, that practitioner could face disciplinary action by the Board. Practitioners understand, both ethically and professionally, that there must be a limitation on practice based on their field of knowledge, particular expertise, and range of ability and training.

Spinal Manipulation: Risk of Harm

Spinal manipulation is a technique used by healthcare professionals to, among other things, aid in the reduction of pain, increase motion and enhance one's mobility. Whenever there is a technique that is perceived as carrying "risk", one needs to assess the actual risk of harm that the technique presents. In the area of spinal manipulation, there is a perceived risk of neurovascular disruption, with subsequent deficits, that can occur during or after the manipulative procedure. In the absence of rigorous, well-controlled studies, one must rely on case reports that are in the literature to determine if a trend exists in regards to the harm that has been associated with manipulative procedures performed by various healthcare professionals.

Anatomical Basis for Potential Harm: Cervical Region

Regarding risk of harm, the primary anatomical structures of concern are the vertebral arteries (VA). The vertebral arteries course through the vertebral foramen. The location of the foramena that houses the vertebral arteries in the cervical region is illustrated below.

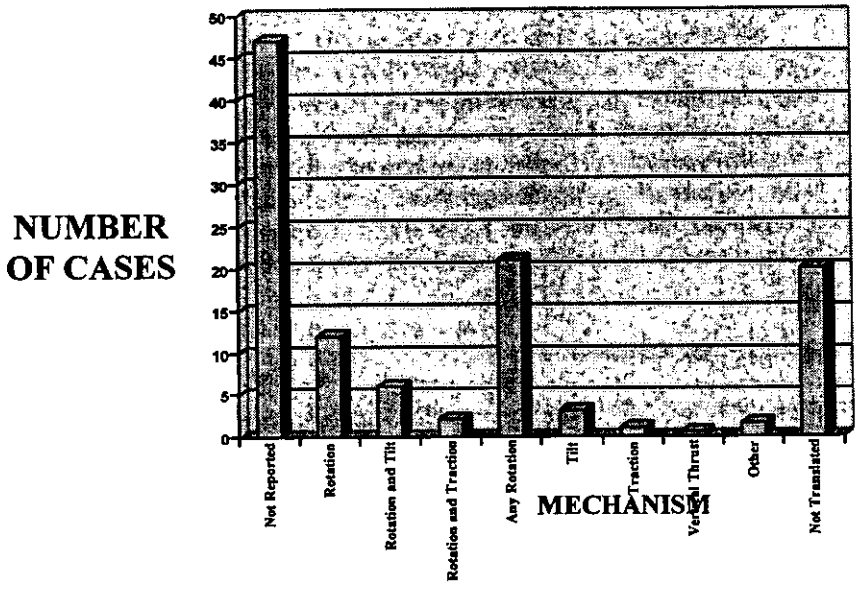


From: http://numedsun.ncl.ac.uk/~nds4/tutorials/column/text/1c.html

The vertebral arteries, at their termination, join together to form the singular basilar artery. Prior to this, the right and left posterior inferior cerebellar arteries (PICA) branch off the left and right VA's respectively. The basilar artery and its subsequent branches are important in supplying blood to the posterior portion of the brain and the brainstem itself. Disruption in this circulatory structure can result in symptoms that include, but are not limited, to the following: dizziness, visual deficits, dysarthria, dysphagia, ataxia, impaired sensation, impaired motor function and nystagmus.[1] In extreme cases, death can result from disruption of the vertebrobasilar system.

Vertebrobasilar accidents that result in ischemic episodes are often associated with one of the following mechanisms: compression and/or stretching of the VA wall, intimal tear with clot formation, intimal tear with embolic formation, vessel wall disruption with subintimal hematoma, vessel wall dissection with pseudoaneurysm formation or perivascular bleeding.

The majority of incidences of injury resulting from spinal manipulation have been reported in case study format. Consequently, specific information about the exact mechanism of injury to the vertebrobasilar system as a result of spinal manipulation is limited. The following is a graph depicting the type of cervical spine manipulation that resulted in injury: (In 24% of the reported cases, the type of manipulation was not identified because the original article was not published in English and the description of the manipulation was missing from the secondary source interpretation or the English-language abstract.)



Adapted from: DeFabio, R.P., *Manipulation of the cervical spine: Risks and benefits.* Physical Therapy, 1999; 79(1):50-62.

Injury resulting from spinal manipulation was reported as early as 1934.[1] There are case reports in the literature describing the occurrence of vascular compromise of the vertebrobasilar subsequent to cervical spine manipulative procedures. In 1977, Easton and Sherman reported two cases of cerebrovascular accident as a result of chiropractic manipulation.[3] In 1991, Frisona and Anzola reported three cases whereby patients suffered vertebrobasilar strokes as a result of chiropractic manipulation.[4] In 1993, Sinel and Smith provided a case report of a 32 year old female who suffered a thalamic infarct as a result of spinal manipulation that involved high velocity head turning.[5] Terret and DiFabio have done extensive literature reviews in the area of injury resulting from spinal manipulation.[1,2]

In his article entitled, "Manipulation of the Cervical Spine: Risks and Benefits," Richard Di Fabio studied 177 published cases of injury reported in 116 articles between 1925 and 1997. The most frequently reported injuries involved arterial dissection or spasm and lesions of the brain stem. Physical therapists were involved in less than 2% of the cases, and no deaths were attributed to manipulation of the cervical spine by physical therapists.

Limitations in Present Research:

The research that has been done to date, as indicated previously, primarily involves case reporting. In the majority of cases valuable information is lacking in regards to the following:

1. Type of clinician
2. Experience of clinician
3. Patient's past and present medical history
4. Type of manipulative procedure

The following is a chart of "clinician type" derived from the 180 cases (sometimes the same case was reported multiple times, though an attempt was made to eliminate the redundant cases) reported by Terret[1]:

Chiropractor / Chiropractic	Medical Practitioner	Osteopath	Physio-therapist	Other	Unknown
103	27	13	6	13	21

*Other category includes: self, wife, kung fu practitioner, barber, lay practitioner, naturopath and kinesiotherapist

Terrett has also "corrected" the identity of the practitioner if it was reported to be a chiropractor, but from his research, the report contained inaccurate descriptions of the practitioner. In some cases, therefore, the practitioner originally identified as a chiropractor was changed to another type of practitioner. In 50 of the 78 cases that resulted in significant disability and/or death, he has identified the treating clinician as a chiropractor. Three out of seventy-eight were attributed to intervention performed by physical therapists, and two of those occurred in South Africa and New Zealand.

Injury Occurrences Independent of Spinal Manipulation:

There have also been occurrences of vertebrobasilar strokes independent of spinal manipulation procedures. In 1973, Nagler reported three cases whereby vertebral artery obstruction occurred as a result of neck hyperextension during activities which included gymnastics, calisthenics and yoga.[6] Additionally, in 1977, Easton and Sherman reported a stroke that occurred while head turning during driving.[3] Terrett reports additional occurrences of stroke related to head/neck rotation and/or extension, independent of spinal manipulation. In the cases reported, head movement occurred during activities such as neck extension for a nosebleed, archery, star gazing, rap dancing and sleeping.[1]

Malpractice Reports:

Maginnis and Associates, the group that provides Professional Liability Insurance for physical therapists through the American Physical Therapy Association (APTA), has reported that no specific losses can be attributed to "manipulation or high velocity thrust". A memorandum written in May of 1996 from Judith Cipriano, the Director of Property and Casualty Product Development stated that they were "not able to find a single claim with this allegation."

In a memorandum written in March of 1999, the Underwriting Manager for CNA Health Pro reported to the APTA that they had conducted a review of their national claim file (approximately 600 claims) and found only three claims that mentioned manipulation. Two claims occurred in 1993; one was closed with no payment. One claim was filed in 1997; they did not report whether a payment was made. All three involved manipulation of the neck, and none of these claims occurred in Virginia.

In a commentary written in the Journal of Manipulative and Physiological Therapeutics in 1997, Jagbandhansingh indicates that between 1991 and 1995, the National Chiropractic Mutual Insurance Company paid over 73 million dollars for 1,403 losses at an average of $52,000 per case (ref).[7] The most common malpractice claims reported between 1991 and 1995 are identified in the table below:

MALPRACTICE CLAIM	PERCENT OF CASES
Disc Problems	26.7 %
Fractures	13.8%
Failure to Diagnose	13.1%
Aggravation of Prior Condition	7.1%
Cerebrovascular Accident	5.4%
Burn	3.4%
Therapy	3.0%

From: Jagbandhansingh, MP. Most common causes of chiropractic malpractice lawsuits. *Journal of Manipulative and Physiological Therapeutics.* 1997;20(1):60-63.

Ruling by the Health Care Financing Administration

It had been reported that the Health Care Financing Administration (HCFA) would no longer cover manipulation of the spine if the services were provided by a physical therapist. In a letter from Dr. Thomas Gustafson, Director of Plan and Provider Purchasing Policy Group dated July 21, 1999, he has stated that that is not the case and a clarification of HCFA's position was provided. Section 1852 (a) of the Social Security Act requires Medicare managed care plans to provide all Medicare services, including physician services, to their Medicare enrollees. Accordingly, plans must make available to patients physicians, which includes chiropractors, to deliver manual manipulation of the spine to correct a subluxation. Managed care plans may also use physical therapists to provide services, including manipulative treatment of the spine and other areas, as long as physicians are included and they do not rely only on non-physician practitioners to provide services under the plan.

It was further noted that the HCFA policy is applicable to managed care plans only and has no implications for fee-for-service Medicare. Dr. Gustafson reported that there is no intention on the part of HCFA to introduce additional restrictions on which professionals can bill for manipulative treatments.

Studies and Actions from Other States

As a result of legislation introduced in the New York, the State Education Department's Office of the Professions, which is authorized to regulate 38 professions, including chiropractic, medicine, and physical therapy, conducted a lengthy process of research, analysis and debate on the issue of spinal manipulation. Information about spinal manipulation was obtained from health literature, criteria of national accrediting bodies, national examination blueprints, and statutes of other states. All the data was sent to the Department's counsel with a request for a legal opinion. Findings of the report were as follows:

- Course content on manipulation must be included in the curricula of every physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education.
- The National Physical Therapy Examination, used as the licensure examination for physical therapy, identifies spinal manipulation as an area to be tested.
- Literature supports physical therapists' historic experiences with manipulation, while numerours letters from physicians indicate that physical therapists are performing spinal manipulation with skill and expertise and have been for many years.
- Agreement was reached among the representative chiropractic and physical therapy members of a joint practice committee meeting that what physical therapy refers to as "Stage V Mobilization" is synonymous to what chiropractic describes as "manipulation," that is, movement of joint beyond the elastic barrier without destroying the integrity of the joint structure.
- Definitive evidence was not found to support the position that physical therapists' use of manipulative procedures poses a greater risk to the public's health and welfare than from chiropractors performing this procedure.

The subsequent opinion of the Office of Counsel stated that the law clearly authorizes physical therapists to perform spinal manipulation and/or spinal mobilization and has done so for at least nineteen years. Manipulation was determined to be an activity that can be performed under the heading of physical and mechanical means.

With regard to individual competence to perform spinal manipulation, it is unprofessional conduct in New York for a licensee to perform professional responsibilities which the licensee knows she or he is not competent to perform. Whether a practitioner is a physical therapist, a physician, or a chiropractor, licensees could be charged with unprofessional conduct if they undertake to perform tasks for which they are not competent by education, training or experience, even if those tasks are within their legal scope of practice.

The chiropractic profession has been actively engaged in seeking restrictive legislation on the practice of spinal manipulation. While bills have been introduced in a number of states to restrict the practice of manipulation, most have died in committee; others have been defeated by the legislature or are still under consideration. In several cases, efforts to restrict manipulation have resulted in changes to state practice acts. In North Carolina, physical therapists are precluded from performing manipulation of the spine, unless prescribed by a physician (in Virginia, all physical therapy is performed under the direction and referral from a physician). In West Virginia, the chiropractic practice act limits spinal manipulation to licensees that have received a minimum of 400 hours of classroom instruction and a minimum of 800 hours of supervised clinical training at a facility where spinal manipulation is a primary method of treatment. The state of Florida has adopted a statute stating that physical therapy practitioners are not authorized to practice chiropractic medicine, including specific spinal manipulation. Arkansas, Iowa, Minnesota, Nevada, Utah, and Washington also have some restriction on the practice specified in law.

Under-girded by a policy statement on spinal manipulation urging the profession to "protect the art as uniquely chiropractic", which was adopted by the American Chiropractic Association (ACA) at its annual meeting in August, 1999, legislative efforts are likely to continue.

REVIEW OF DISCIPLINARY CASES IN VIRGINIA

In making a determination on regulation of any profession, the primary issue is always the protection of public and safety. Before any consideration is given to restricting the current scope of practice for any licensed profession, there should be evidence that the public is not being adequately protected. To make that determination on harm to the public, a report was prepared on Complaints, Violations, Sanctions for Chiropractors, Physical Therapists, Physical Therapist Assistants (1991 - 1998) - See attachment.

In addition, the Department conducted a review of all complaints for Chiropractors and Physical Therapists (including those which did not result in a disciplinary case):

Total number:	649 complaints filed
	537 complaints against chiropractors
	112 complaints against physical therapists

Of the 112 physical therapy complaints, 68 involved either unprofessional conduct or standards of care. All of those case files were reviewed by a researcher for any complaints involving spinal manipulation. The finding was that: **No case has ever been documented in Virginia against a physical therapist performing spinal manipulation (or mobilization).** (All cases in which there was any mention of the words "manipulation" or "spine" were specifically copied and also reviewed by Dr. Warren Koontz, Executive Director of the Board of Medicine.)

SUMMARY OF PUBLIC COMMENT ON STUDY

Comments received in writing on the study included the following:

The position of the Virginia Physical Therapy Association is that there is no evidence that manipulation by a Virginia licensed physical therapist has resulted in patient complications and that any legislation to restrict their practice is unnecessary.

A physical therapist wrote that the "force, amplitude, direction, duration, and frequency of manipulative treatment or spinal manual care are discretionary decisions made by the physical therapist on the basis of education and clinical experience and on the individual patient's profile and are within the scope of practice of what physical therapists are qualified to do."

A recent graduate of Shenandoah University's masters level program in physical therapy wrote to say that she has been comprehensively educated to specialize in manual therapy for all joints of the body. Without the ability to treat the spine, physical therapists would be neglecting a huge component of musculoskeletal injuries.

A medical doctor, a rehabilitation specialist, board-certified in physical medicine wrote to say that the physical therapists to whom he refers patients are well-versed in spinal manipulation and should have full privileges to treat patients with biomechanical dysfunctions. These therapists have taken extensive course-work in high-velocity, low-amplitude techniques, muscle energy techniques, strain/counterstrain and soft tissue mobilizations.

A physical therapist wrote to express concern over the possibility of limiting the current scope of practice. He points out that joint manipulation is often necessary to ensure that a stiff joint can move through its full range of motion.

A chiropractor who is a delegate to the American Chiropractic Association wrote to explain that a ACA committee has been formed to develop data on Spinal Manipulative Therapy (SMT) and that in its opinion, SMT is a chiropractic science and art that should be a physician-applied service provided only by trained and qualified specialists.

The Virginia Society of Chiropractic noted that medical doctors receive no training in spinal adjustive procedures and recommended that "only Doctors of Chiropractic and Osteopathy, when a) properly trained as part of their core curriculum, including faculty observed clinical training and b) licensed in the Commonwealth, are qualified to perform their profession-specific spine procedures."

The position of the Virginia Osteopathic Medical Association is that Doctors of Osteopathy should not be included in any language that defines the type of manipulation that is being performed or provides any hourly requirement or restriction.

RECOMMENDATION OF THE BOARD OF MEDICINE:

In § 54.1-100, it is stated that every person has a right to engage in any lawful profession and that the Commonwealth cannot abridge such right except as a reasonable exercise of its police powers when it is clearly found that such abridgment is necessary for the preservation of the health, safety and welfare of the public. No regulation is to be imposed on a profession except for situations in which the unregulated practice of the profession can harm or endanger the public and the potential for harm is recognizable and "not remote or dependent upon tenuous argument."

The Board of Medicine considered the content of the report on spinal manipulation as developed by the Task Force and voted 11-5 to accept the report with the following recommendation:

In the opinion of a majority of the Board of Medicine, no evidence has been presented to suggest that additional statutes or regulations are necessary to protect preserve the health, safety and welfare of the public. In fact, there is evidence that the public has not been harmed or endangered by physical therapists who practice spinal manipulation and that the potential for harm is remote. Therefore, the report of the Board to the Chair of the Senate Committee on Education and Health is that legislation such as proposed by Senate Bill 600 in 1998 and Senate Bill 1141 in 1999 is both unnecessary and unwarranted and that there should be no limitations placed on the professions that currently utilize manual spinal care or spinal manipulation within their scope of practice.

References

1. Terrett, A.G. *Vertebrobasilar stroke following manipulation.* National Chiropractic Mutual Insurance Company; 1996, 13.

2. DiFabio RP. Manipulation of the cervical spine: Risks and benefits. *Physical Therapy.* 1999;79(1):50- 62.

3. Easton JD, Sherman DG. Cervical manipulation and stroke. *Stroke.* 1977;8(5):594-597.

4. Frisoni GB, Anzola GP. Vertebrobasilar ischemia after neck motion. *Stroke.* 1991;22:1452-1460.

5. Sinel M, Smith D. Thalamic infarct secondary to cervical manipulation. *Arch Phys Med Rehab.* 1993;74:543-546.

6. Nagler W. Vertebral artery obstruction by hyperextension of the neck: report of three cases. *Arch Phys Med Rehab.* 1973;54:237-240.

7. Jagbandhansingh, MP. Most common causes of chiropractic malpractice lawsuits. *Journal of Manipulative and Physiological Therapeutics.* 1997;20(1):60-63.

March 7, 2005

COURSE DESCRIPTIONS – UND SCHOOL OF PHYSICAL THERAPY
HIGHLIGHTED AREA SHOW DIRECT INVOLVEMENT WITH MANUAL THERAPY

101. Orientation to Physical Therapy. 1 credit. Overview of the field of rehabilitation. Survey of the occupational therapist and physical therapist. Films, lectures, and observation in clinical settings.

401. Intervention Techinques I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Beginning skills for patient management including skills and safety in positioning, draping, therapeutic massage, surface anatomy and an introduction to communication techniques. Laboratory.

402. Professional Communication and Behavior. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lecture and practice in interprofessional and interpersonal communication including professional behavior, ethics, patient education, scientific writing, and written documentation.

409. Clinical Pathology I. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Disease groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, pediatrics, geriatrics, and sensory disabilities. In this course students learn general pathology and begin to prepare to differentially diagnose problems.

410. Clinical Pathology II. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Disease groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, pediatrics, geriatrics, and sensory disabilities. In this course learn orthopedic and neurological pathology in preparation for differential diagnosis.

412. Biomechanics and Kinesiology. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Biomechanics and kinesiology of musculature acting on the extremities and trunk. Theory and techniques of muscle testing and goniometry. Laboratory. In this course students lean applied anatomy, biomechanics, joint structure and function. This course is integral to learning manual therapy.

413. Exercise in Health and Disease. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lecture and laboratory work to examine and (maintain)/increase mobility, strength, and endurance for healthy individuals and those with disease, with completion of an exercise prescription to address impairments and functional limitations. Functions of the musculoskeletal, pulmonary, and cardiovascular systems will be addressed individually and within their relationships. Laboratory. This course deals with exercise physiology, musculoskeletal function, cardiopulmonary function and is integral to exercise prescription and diagnosis.

415. Motor Control. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lecture and laboratory work in therapeutic exercise to establish and maintain muscular control and coordination, including muscle re-education, facilitation, and relaxation. Laboratory.

417. Clinical Examination and Evaluation I. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Emphasizes patient/client management elements of examination and evaluation. Emphasis is given to the musculoskeletal and neurological systems. Laboratory. This course is an orthopedic and neurologic evaluation course. Students learn examination and evaluation skills essential for diagnosis. This course is integral to manual therapy.

422. Anatomy for Physical Therapy. 5 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Detailed lectures and demonstrations on musculoskeletal anatomy and neuroanatomy. Laboratory. This is an advanced anatomy course dealing with musculoskeletal and neuroanatomy. It is the basis for all other examination, evaluation and intervention courses in the curriculum. This course is integral to manual therapy.

EXHIBIT
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423. Neuroscience for Physical Therapy. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Structure and function of the human nervous system including clinical application relevant to physical therapy practice. This is an advanced neuroscience course which covers neuroanatomy and neurophysiology. Many of the principles taught in this course are applicable to manual therapy as it relates to the spine.

426. Manual Therapy I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Introduction to joint mobilization with emphasis on peripheral joints. Basic evaluation treatment techniques and exercises for the lumbar and cervical spine. Laboratory. This is the student's first course in manual therapy techniques and covers the extremities and spine. Emphasis on mobilization with some introduction to manipulation.

490. Special Topics. 1-4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Introduction and investigation of advanced clinical procedures and topics. Topics discussed will be dictated by student and faculty interests.

491. Independent Study in Physical Therapy. 1-4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Research and independent study in a specialized area of Physical Therapy.

511. Applied Movement Science and Rehabilitation Procedures. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Integration of clinical evaluation, functional goals, and treatment planning for individuals with neurological and multiple musculoskeletal dysfunction. The primary focus is on rehabilitation skills including assessment, exercise, handling techniques, functional activities, equipment prescription, patient education, ADLs, as well as community mobility and governmental services. Laboratory. This course covers a number of topics, but includes material relative to the diagnosis and intervention for patients with neurological and musculoskeletal dysfunction.

512. Therapeutic Agents. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Theory and application of various hydrotherapy, phototherapy, and thermotherapy modalities in Physical Therapy, including heat, light, sound, and water. Laboratory.

513. Intervention Techniques II. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Theory and practical application of introductory patient care techniques in physical therapy including gait, range of motion, transferring, bandaging, wound care, vital signs, and aseptic and isolation techniques. Laboratory.

514. Case Management I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Case management, with integration of examination, evaluation, diagnostic, plan of care, and intervention strategies. Verbal and written communication of results will be emphasized. In this course students work on case studies which include the entire case management of a patient, including examination, evaluation, diagnosis, prognosis and intervention.

519. Electrotherapy and Electrodiagnosis. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Theory and application of therapeutic electrical currents, biofeedback, electromyography, and nerve conduction velocity in physical therapy. Laboratory

520. Clinical Internship I. 18 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Full time clinical experience in selected physical therapy provider centers throughout the United States. This is a course which is 18 weeks long (two nine-week experiences at two different facilities) and includes full time clinical experience working with patients under the supervision of an experienced clinical faculty member.

521. Critical Inquiry I. 1 credit. Prerequisite: Registered in Professional Physical Therapy Curriculum. Introduction to the collection of clinical data leading to a case study report. Students write up two case studies regarding patients they have worked with. This includes examination, evaluation, diagnosis, prognosis and intervention and outcome.

522. Administration in Physical Therapy. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lectures/discussion and seminar formats used to explore concepts of administration procedures as applied to Physical Therapy and the health care delivery system.

523. Lifespan I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Course focus is on rehabilitation issues related to pediatrics including the characteristics of disabling conditions, developmental evaluation and intervention, the use of adaptive equipment, legal issues and strategies to promote collaborative service provision to children and families. Laboratory. Students learn the fundamentals of pediatric physical therapy which includes examination, evaluation, diagnosis and intervention.

524. Psychological Aspects of Disability. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Readings and discussion course. Study of psychological coping mechanisms, reactions and motivational factors pertinent to the disabled. Review of adjustment problems unique to specific disabilities and/or disease processes, including the terminally ill.

525. Clinical Examination and Evaluation II. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Emphasizes patient/client management elements of examination and evaluation. Emphasis is given to systems review and differential diagnosis, clinical decision making resulting in referral and/or modified physical therapy interventions, and the communication of findings. Laboratory. This is a differential diagnosis course. Students learn learn clinical decision making skills, advanced examination/evaluation skills for all body systems. This is course is integral to manual therapy.

526. Manual Therapy II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Fundamentals of spinal mobilization techniques along with theory and application of specific approaches to spinal manual therapy. Laboratory. This course covers spinal mobilization and manipulation techniques.

527. Critical Inquiry II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Clinical research design, clinical decision making, and preparation of a case study and a paper on a clinical topic.

535. Lifespan II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Examine the factors and forces that affect life quality in later years. The physiological, psychological, and sociological aspects of aging will be considered, including those influences in the cultural context that enhance and impede continued growth of the person. Laboratory. This course covers aspects of the geriatric population and would have some elements useful for diagnosis.

537. Strategies for Early Intervention. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. This course is designed to review current practices in early intervention. Course materials will focus on characteristics of disabling conditions that influence growth and development of motor skills, cognition and educational development. Emphasis will be on collaborative service provision with an interdisciplinary approach. Topics also covered include: current issues, assessment of the child/family unit and legislative guidelines for service provision. Elective course.

538. Advanced Pediatrics Assessment and Treatment Techniques. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. This course is designed to provide physical therapy students with opportunities to explore and implement standardized and criterion-referenced evaluation instruments to identify need areas for treatment. In addition, students will design treatment programs for children with disabilities by integrating current therapeutic techniques with efficacy studies. Elective course

539. Prevention and Wellness. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. The theory and practice of prevention of injury, maintenance and improvement of wellness, and sports and work related injury management with emphasis upon preparticipation screening, emergency/trauma evaluation, the role of support devices, and rehabilitation techniques appropriate for the athlete and employed. This course covers examination, evaluation and diagnosis of conditions with particular emphasis on sports medicine, work injury and health and wellness promotion.

549. Advanced Applied Anatomy/Clinical Kinesiology. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Study of applied anatomy and its importance to research and clinical application, particularly as related to Physical Therapy. Elective course.

552. Clinical Internship II. 18 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Full time clinical experience in selected physical therapy provider centers throughout the United States. This is another 18 week (two nine-week) full time clinical experience at two different clinical sites around the United States.

561. Seminar: Physical Therapy. 1-4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. This course serves to focus student attention toward graduate study in Physical Therapy. Explore and discuss areas of interest for student and faculty. May repeat to 4 credits maximum.

562. Readings: Physical Therapy. 1 to 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Review of current literature pertinent to Physical Therapy; critical examination of design, content, and validity of conclusions.

572. Teaching Experience in Physical Therapy. 1-3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Supervised experience in University teaching in Physical Therapy. Projects in curriculum development, formulation of teaching/learning objectives, teaching materials, evaluation tools, and experience in competency based learning environment.

583. Critical Inquiry III. 1 credit. Registered in Professional Physical Therapy Curriculum. Introduction to research instruments including surveys, electrical and mechanical instrumentation critical to research methods. Includes discussion of validation, calibration and reliability of instruments used in physical therapy research. Students develop a proposal for their scholarly projects and complete IRB use of human subject forms.

590. Directed Studies/Clinical Concepts. 1-12 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Individualized study of a particular area of interest for the student approved by his/her major advisor and supervised by preceptors with specialty and/or recognized expertise in the area of interest. Study may include library research, clinical research, discussion/seminars, projects and directed clinical experience.

591. Critical Inquiry IV. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Students begin data collection and analysis for the scholarly project requirement.

592. Case Management II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Case management, with emphasis on the teaching/learning process and techniques targeted to promote and optimize physical therapy services. Strategies appropriate for instruction of patients/clients, health care providers, agencies, and the public will be addressed. This is advanced case management course which includes discussion patient care from the examination/evaluation stages to diagnosis/prognosis, intervention and outcome assessment.

990. Continuing Education Workshops in Physical Therapy. 1 to 8 Credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Credit in Physical Therapy may be granted for workshops, conferences, institutes, or other types of short-term activities, provided they have been approved for credit by the Chairperson of Physical Therapy and the Dean of the Graduate School. Written report of the activity is required. A one-week workshop shall carry no more than 1 semester hour of credit.

995. Scholarly Project. 1 credit. Prerequisite: Registered in Professional Physical Therapy Curriculum. Students provide a final written and oral report to the faculty on the results of their collaborative Scholarly Project.

996. Continuing Enrollment/Physical Therapy. Credit arranged.

3/7/05 UND DPT Curriculum – Total Contact Hours = 3360 (minimum)

	Contact Hours
Professional Year 01 – Fall Semester (17 cr.)	
PT 401 ..... Intervention Techniques I	68
PT 402 ..... Professional Communication and Behavior	34
PT 409 ..... Clinical Pathology I	85
PT 422 ..... Anatomy for Physical Therapy	204
PT 423 ..... Neuroscience for Physical Therapy	68
Total Contact Hours	**459**
Professional Year 01 - Spring Semester (19 cr.)	
PT 410 ..... Clinical Pathology II	68
PT 412 ..... Biomechanics and Kinesiology	102
PT 413..... Exercise in Health and Disease	68
PT 415 ..... Motor Control	68
PT 417 ..... Clinical Examination and Evaluation I	136
PT 426 ..... Manual Therapy I	68
Total Contact Hours	**510**
Professional Year 01 - Summer Session (10 cr.) – Graduate School	
PT 512 ..... Therapeutic Agents	54
PT 513 ..... Intervention Techniques II	54
PT 514..... Case Management I	36
PT 519 ..... Electrotherapy and Electrodiagnosis	36
Total Contact Hours	**180**
Professional Year 02 - Fall Semester (19 cr.) – Graduate School	
PT 520 ..... Clinic I: Clinical Practice	720
PT 521 ..... Critical Inquiry I	18
Total Contact Hours	**738**
Professional Year 02 - Spring Semester (17-18 cr.) – Graduate School	
PT 522 ..... Administration in Physical Therapy	51
PT 523..... Lifespan I	51
PT 524..... Psychological Aspects of Disability	34
PT 526 ..... Manual Therapy II	51
PT 527 ..... Critical Inquiry II	34
PT 583..... Critical Inquiry III	17
EFR 515 .... Statistics I	51
Electives	34 (minimum)
Total Contact Hours	**323**
Professional Year 02 - Summer Session (9-10 cr.) – Graduate School	
PT 591..... Critical Inquiry IV	9
PT 592..... Case Management II	36
PT 562..... Readings: Physical Therapy	9
Electives.....	18 (minimum)
Total Contact Hours	**72**
Professional Year 03 - Fall Semester (16-17 cr.) – Graduate School	
PT 511 ..... Applied Movement Science/Rehabilitation Procedures	102
PT 525 ..... Clinical Examination and Evaluation II	85
PT 539..... Prevention and Wellness	68
PT 535..... Lifespan II	34
PT 561 ..... Seminar: Physical Therapy	17
Electives	34 (minimum)
Total Contact Hours	**340**
Professional Year 03 - Spring Semester (19 cr.) – Graduate School	
PT 552 ..... Clinic II: Clinical Practice	720
PT 995 ..... Scholarly Project	18
Total Contact Hours	**738**

Therapists attend

Medcenter One Health Systems recently sponsored a course titled "Using Manual Therapy in Your Physical Therapy Practice." The course was directed by Todd Watson, a licensed physical therapist from North Carolina with 12 years of experience in orthopedic physical therapy.

Fifteen Medcenter One associates attended the course. They were: **Melanie Carvell, Bryan Guthmiller, Phyllis Heyne, Carol Hineman, Amanda Holzworth, Mike Ibach, Jeff Lange, Todd Leingang, Jim Morgan, Jackie Mrachek, Mike Neff, Becky Sorenson, Michelle Vetter, Loren Wershau** and **Rick Winden.**

EXHIBIT
tabbies
F

(10) #1 opp

Testimony on SB 2366
House Human Services Committee
March 8, 2005

Madam Chair Price and members of the House Human Services Committee:

My name is Ken Tupa. I am a registered lobbyist with the North Dakota Chiropractors Association.

As you know, SB 2366 repeals the existing practice act for physical therapists and replaces it with a model act. We understand an update to their act is overdue and while we recognize this legislation intends to bring the statute up to speed with the current practice environment for physical therapists our concern is that this bill speeds ahead of their actual training in one particular area of that practice.

Our association was contacted near the end of 2004 by their association to review a draft of the legislation and address any concerns we may have. At that time we identified a few minor issues upon which we have been able to reach agreement, however since that time there has been one issue of concern to us where we continue to have different views.

The concern we have with SB 2366 is specific to the definition of "manual therapy." While we do not disagree with the definition beginning on page 2, line 3, as it is an accurate coding definition, we support adding an amendment to this current definition that addresses where lower level manipulations end and the highest level begins.

Manual therapy, including the manipulation and mobilization of joints and the spine carry an undeniable risk to the patient. Chiropractors have 4800 hours of professional school focused on manipulating joints and the spine,

including how to perform it effectively, how to limit the risks of the procedure, and the diagnostic training to know when and when not to use it. Performing these procedures safely requires adequate training.

At the same time, we do not claim to own manipulation. We recognize there are inherent areas of overlap between professions and value the work of physical therapists mobilizing joints, but there are also recognized boundaries between professions. These boundaries exist for the safety of the patient and can most often be defined with differing levels of education and training. In this case, those differing levels of education and training are specific to the highest level of manipulation, or what we would call a Chiropractic Adjustment.

This Chiropractic Adjustment is at the core of the chiropractic profession – it is why chiropractors become chiropractors. We are not seeking to restrict this high level manipulation to our profession, but as recognized professionals of this service, we feel it is essential that education and training are met to provide this safely and effectively to citizens of ND.

In our discussions with the PT Association, we were told that 2 or 3 physical therapists in ND may be providing this highest level manipulation and that their training for this highest level was post-graduate. Chiropractors provide almost all of high level manipulations as their education and training prepares them specifically for this procedure (other providers include MDs and DOs). Additionally, to remain competent it is necessary to perform spinal manipulation frequently due to the skill of the procedure.
In order to perform these manipulations safely, one must have more than a seminar or several weeks of training and perform the procedure frequently. Such a spinal manipulation also requires a demonstration of the diagnostic competencies for effective diagnosis and thus safe and appropriate delivery

of these manipulations and should be addressed prior to seeking the authority within a scope of practice to provide the service.

We are not suggesting the chiropractic profession have control over the profession of physical therapy and acknowledge PTs are skilled health care providers and that in the future PTs may have the training to provide all levels of mobilization and manipulation. Understanding that regulatory boards merely practice to the fullest extent of their scope as dictated by the Legislature, our intent is to appropriately provide you with information about our concerns as this legislation is considered. If any provider is allowed to perform these services without adequate training there are certain undeniable risks to the citizens who will receive these highest levels of mobilization and manipulation services.

We agree that professions should govern themselves as empowered by the Legislature, however when a health care profession is seeking to provide within its scope, services currently provided with a demonstrated standard for safe and effective delivery, we feel it is appropriate to express our concerns and urge you to support our amendment.

Madam Chair and members of the Committee: Thank you for the opportunity to testify before you this morning. The NDCA appreciates your consideration of our amendment.

Amendment:

Page 2, line 5, after "body" insert "<u>throughout the normal range of physiological motion without engaging in a high velocity thrust or impulse or any other technique that is intended to or could result in cavitation of the joint</u>"

#11
#2-opp

TESTIMONY ON SENATE BILL 2366

Jeff Askew, D.C.
President, North Dakota Chiropractic Association
March 8, 2005

Madame Chair Price and Members of the House Human Services Committee:

My name is Jeff Askew. I am a licensed Doctor of Chiropractic, practicing in Bismarck for 25 years. I am here this morning as President of the North Dakota Chiropractic Association to address SB 2366. As Mr. Tupa has stated, our concerns lies in the broad language regarding manual therapy and the Physical Therapists' intended use of that language.

Before I get into the main substance of my presentation, I'd like to clean up the playing field a bit.

First, I have tremendous respect and admiration for the work the PTs do and their role in the health care continuum. I have had good relationships, both personal and professional, with the PTs in this town, and I don't think that is an unusual situation. I have referred patients to PTs, PTs have referred patients to me. I've been a patient in a physical therapist's office and I've treated 5 or 6 PTs as patients in my clinic. PTs are thoroughly educated, wonderfully skilled practitioners who perform a great service. References I will make here to PT education and training are in the context of their preparation to perform one very specific procedure.

Second, we agree that PTs have taken their training and skills to a level that far surpasses their current practice code and that they should be able to put into practice everything they are adequately trained to do. The NDCA does not feel it is appropriate for them to be allowed to do that which they are not adequately trained to do, regardless of any claims that they are already performing these procedures outside their current scope of practice. Our amendment would allow them to do everything they are currently trained to do but would delay the inclusion of the highest level of manipulation until they are adequately trained.

There are three primary issues at hand here:

- Turf protection/Scopes of Practice
- Patient safety
- Quality Control

I stand before you today with a truly daunting task at hand. The proponents of this bill will tell you that our amendment is an attempt to restrict their practice. I am here to tell you that it is about patient safety or quality control. As Mr. Tupa indicated, we do not claim to own the chiropractic adjustment, even though we invented it and it has carried our name for 108 years. The NDCA board has had some very frank talks about this. While suddenly doubling the number of providers who can perform this service will have an interesting and frightening impact, we don't' feel we have a moral or ethical right to prevent other professionals from employing this tool. We may not be able to convince you of that, but it is important to state, nonetheless.

We feel that until PTs have addressed their training in this specific area, including attaining the diagnostic skills to know when and when not to perform this procedure, and have the testing and credentialing processes in place, patient safety is an issue. I am confident that before our time is up, we will have demonstrated this to you.

The third area is quality control. It is simply logical that if a patient or a third party insurer is paying for a procedure, they would want to be purchasing a quality procedure delivered by an expert. The skill to deliver this procedure safely goes hand in hand with the skill to delver it with maximum therapeutic benefit, giving the payers their money's worth.

The other very difficult part of my task is trying to help you make sense out of some of the very conflicting information you've been getting in e-mails and personal discussions. This has become quite an emotionalized case. In a few minutes, I intend to go through some of the various arguments and comments that have been posed one by one and, hopefully, bring some clarity to this.

Before we discuss this any further, we need to define this procedure we're talking about. I'm going to have to get a bit technical for a moment. Mobilization and manipulation are broad and vague terms. Mobilization and manipulation describe a continuum of actions. At one end, we have procedures that are safely performed by a layperson. When spouses hug at the end of a workday and one rubs the other's neck for a moment or gives the other a backrub, that is amateur manual therapy.

At the other end of the spectrum is the procedure we are discussing. It is a procedure that Medicare has labeled a physician-only service for all 50 states without exception. It involves a very quick, shallow thrust into a joint to create a shifting or gapping in the joint sometimes resulting in a cavitation or "pop." (**VISUAL EXAMPLE**: finger extension). In between these two extremes lies a plethora of manual therapies available to both PTs and Chiropractic Doctors.

PTs call it Level Five Mobilization or spinal manipulation. Doctors of Chiropractic call it a chiropractic adjustment or spinal manipulation or spinal manipulative therapy. Lay people call it "popping my back" or "cracking my neck." Whatever it's called, it is the same thing, and changing the label doesn't change what it is.

The generic description for this procedure would be, "high velocity (quick), low amplitude (shallow), thrust (or impulse)." I'll use this non-jargon, non-profession-specific term primarily for this discussion, with the initials HVLAT. This HVLAT produces some very unique and special therapeutic benefits. It also presents some special risks and requires significant specialized skill to perform safely and effectively.

This leads us to the issue of safety. This is not about building fences. This is a safety issue. HVLAT Spinal manipulation kills people. Not often, but it does kill people. Not as often when done by chiropractors as when others perform this procedure, but it does kill people.

- There are about 40-50 manipulation-caused strokes in the US every year[1]
- There are about a dozen manipulation-caused deaths every year.[2]
- Only 6% of the HVLAT manipulation is performed by non-chiropractors, yet non-chiropractors produce over half of the cerebrovascular accidents.[3]
- In one study of 35 cases that resulted in death after manipulation, the practitioners included chiropractors, medical doctors, osteopaths, naturopaths, and two lay people.
- According to the independent research group, the Rand Corporation, PT's don't even show up on the radar screen (DC's do 94% of HVLAT, MD's do 4%, and DOs do 2%, leaving not a lot for PTs).[4] Still, at least 6 cases in this study of HVLAT performed by PTs resulted in neurovascular accidents.[5]
- The exact ratio of neurovascular injuries caused by non-chiropractors compared to chiropractors is difficult to ascertain and might be much higher than this. The reason for this is that it is well documented that authors of some of these studies have used the term "chiropractic" when no chiropractor was involved.[6]

As with most medical treatments, the most severe side effects are also the rarest. More common minor side effects occur in about one quarter of treatments.[7]

Before we get carried away, let's realize how rare the serious accidents are. I'd like to compare receiving an HVLAT manipulation to riding in an airplane:

- Getting a chiropractic adjustment is thirteen times safer than flying in a plane.[8]
- Both are much safer than their competing solutions. (Manipulation is 100-400 times safer than NSAIDs[9] and incomparably safer than surgery. Air travel is 16 time safer than car travel.[10]) So both flying and receiving HVLAT manipulation are reasonable options in their respective fields.

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[1] http://chiro.org/LINKS/FULL/What_are_the_Risk_of_Chiropractic.html
[2] http://chiro.org/LINKS/FULL/What_are_the_Risk_of_Chiropractic.html
[3] Terrett, Allen. Current Concepts In Vertebrobasilar Complications following Spinal Manipulation. P.89-104.
[4] Paul G. Shekelle, A.H. Adams, M.R. Chassin, et al., The Appropriateness of Spinal Manipulation for Low-Back Pain: Project Overview and Literature Review (Santa Monica: RAND Corporation, 1991).
[5] Terrett, Allen. Current Concepts In Vertebrobasilar Complications following Spinal Manipulation. P.89-104.
[6] Terrett, Allen. Current Concepts In Vertebrobasilar Complications following Spinal Manipulation. P.105-115.
[7] Stevinson, Clare, MSc. Ernts, Edzard, MD, PhD. Risks Associated with Spinal Manipulation. American Journal of Medicine 2002; 112:566-570.
[8] http://www.nsc.org/lrs/statinfo/odds.htm
[9] The American Journal of Medicine, May 2002
[10] http://www.nsc.org/lrs/statinfo/odds.htm

- In spite of their safety records, both can, on rare occasions cause death.

- Both involve complete submission to a professional.
    - When driving a car, the individual as some control over the safety of his own actions. When riding on an airplane, the individual totally submits all control to the skills of the pilot.
    - With lower level mobilization, a patient can tell the provider to stop any time the treatment is getting uncomfortable. With HVLAT manipulation, once the action is initiated there is no turning back. The patient is totally reliant upon the provider's skills.

- With both spinal manipulation and flying, the rarity of severe accidents does not negate the importance of constant attention to maintaining and improving safety standards.

- Each would become even more dangerous in the hands of lesser-trained personnel.

More advanced types of health care require more advanced training, more advanced testing, more advanced certification, and more advanced licensure. Not all manipulation is alike.

We can't have a discussion about safety without a discussion of training, both in terms of skills in HVLAT manipulation and in diagnoses. Chiropractors go to eight years of college and study an average of 550 hours in manipulation,[11] all of it specifically HVLAT manipulation. We have a year of outpatient clinical experience under supervision. After our discussions with PTs, I am still unclear as to their level of training specific to Level Five Mobilization. I think that is worth knowing.

Additionally, chiropractors perform this procedure dozens of times every day and not only maintain, but also improve their physical skills in this area. The HVLAT is a distinct art. Without frequent and voluminous repetition, the skill cannot be adequately maintained. Picture the difference in the skill development and retention in a golfer who only hits 6 balls a month compared to someone who hits 3000 balls per month.

A key component of the ability to perform this procedure safely is the ability to use differential diagnosis. The practitioner must have the diagnostic skills to determine if HVLAT manipulation is the appropriate course of treatment, what type of manipulation to perform to maximize the benefit to risk ratio, whether or not to discontinue or alter the course of manipulative treatment, and when to conduct further diagnostics tests or make a referral to another type of provider. At the onset, it is necessary to determine whether the patient's complaint is due to a mechanical joint problem or another pathology. Without training in differential diagnosis, this would not be possible.

The average chiropractor has over 800 hours of diagnostic training in chiropractic school.[12] This includes heavy training in both taking and reading x-rays. While certainly

[11] Federal AHCPR study, available at http://www.chiroweb.com/archives/ahcpr/chapter3.htm
[12] Federal AHCPR study, available at http://www.chiroweb.com/archives/ahcpr/chapter3.htm

not every patient needs x-ray, without this ability, it is not possible to adequately filter out high-risk patients.

Arguments and Rebuttals

Now I'd like to address some of the specific comments that have been made by the proponents of this bill.

- PT argument: "If chiropractors get their amendment, we will not be able to practice as we have been."

  In our discussions with the PTs before the legislative session began, they told us that only two or three PTs, are performing the procedures and only very infrequently. By their own accounting to us, this restriction would not change anything at all for almost all PTs. We would argue that any who are actually performing HVLAT manipulation are undertrained.

- PT argument: PTs have been performing manual therapy for years and billing under a standard CPT code for manual therapy (usually 97140 or 97139).

  While this might be true, it is misleading in that they have not been performing "Level 5 Mobilizations" in any significant numbers (again, two or three PTs, by their own account, and these performing the procedure only very infrequently). Not all manual therapy is the same. If they have been performing Levels 1 through 4 for years, and correctly billing it under the named codes, that would be no reflection on whether they have been performing Level 5 mobilizations.

- PT argument: They have been reimbursed for this manipulation (suggesting that reimbursement is an endorsement if their performance).

  While it may be true that they have been reimbursed for some manipulations, that fact does not constitute an endorsement of their performance of the procedure. The only way a payer knows what procedure was performed is through the code submitted. If a PT set a fracture or performed open heart surgery and billed it as a 97140 procedure code, they would get reimbursed for a 97140, because the insurance company would think a physical therapy procedure was performed, not a heart surgery. Since the 97140 code is appropriate to be performed by a PT, no red flags go up.

- PT argument: They have been reimbursed for this manipulation by Medicare (suggesting that reimbursement is an endorsement if their performance).

Medicare has determined that HVLAT manipulation of the spine is a physician level service.[13] Only doctors of medicine, osteopathy and chiropractic are licensed in North Dakota as physicians. Federal regulations specifically state that physical therapists, as non-physicians, are not to provide this service for Medicare Beneficiaries. No local or regional carriers can supercede these regulations with their own regulations. Medicare does provide physical therapy codes to be used for non-physician physical therapy procedures. If Medicare has reimbursed a PT for HVLAT, I submit to you unequivocally that they did not do so knowingly. The Coding guidelines indicate that a provider is supposed to use the most accurate code possible to reflect the service performed. The 97140 Code is for low velocity work.

- PT argument: Chiropractors are trying to govern the PTs' profession.

  We have never suggested that our profession should have any control over theirs. Understanding that the regulatory boards merely uphold the scope of practice laws dictated by the legislature, our intent is to appropriately provide the legislature with information about our concerns while laws are being considered. If we were to try to expand our scope of practice to include surgery or prescriptions before have our training system in place to a level that met the concerns of existing experts in the fields of surgery and prescriptions, we would expect to meet with quite a bit of resistance and discussion from other professions.

- PT argument: ""They [Chiropractors] do not use mobilization to stretch structures closest to the joint to regain normal function, they tend to focus on the spine, not the shoulders, knees, elbows, wrists, ankles, feet or jaw."[14]

  I don't have any specific data on how frequently DCs perform HVLAT on extremities, and while a small number of Chiropractors do not treat extremities, most do. Our practices involve manipulation of all joints, not just the spine.

- PT argument: "If chiropractors have their way, I could not [use mobilization to stretch those structures closest to the joint so you can regain normal function]."

  Untrue. Our amendment would not restrict this PT form performing this lower level mobilization at all.

- PT argument: "Please support the passing of SB 2366, in full so that both Physical Therapists and Chiropractors can provide the best care they feel is appropriate.

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[13] Section 1861 (r) of the Social Security Act

We would ask you to support our amendment so the PTs can pass their practice act and each of us can do what we're trained to do. As a Chiropractor I do not prescribe medications because I am not trained, nor do I seek a weekend course to learn how. Scope of training, not scope of desire, should determine scope of practice.

This high velocity, low amplitude thrusting manipulation - this small area of expertise - this tiny sliver on the continuum of mobilization and manipulation, is the area where chiropractors live and breathe every working hour of every day. It was our invention and it is our area of absolute expertise. It is what we aspire to do when we first dream of becoming a chiropractor. It is our singular focus while we labor through 8 years of college, including a year of clinical supervision. Its safe delivery in the presence of undeniable risks is why we labor through 800 hours of diagnosis in order to learn when and when not to perform it. Its amazing benefits are why we struggle through 550 hours of technique classes to polish our skills so can delver it safely. Its difficulty is why, after 25 years, I continue to learn to do it more effectively and more safely. It is the very essence of being a chiropractor. We are flattered that after over a century, others are recognizing the value of this procedure and wanting to perform it, but please, please understand that it cannot be learned in a weekend, or 10 weekends, or even 20.

Please do not pass this bill without first passing our amendment to ensure that high velocity, low amplitude manipulation is performed only by those with sufficient and specific training. This is not about protecting our profession; it is about protecting people.

Madame Chair and Human Services Committee, thank you for allowing me to speak to you today. I would be happy to answer any questions you might have.

(12)
#3 opp

Madam Chair and Members of the House Human Services Committee

My name is Alisa Mitskog and I'm a licensed chiropractor from Wahpeton and I am here testifying on my own behalf.

I want to share with you an experience that happened to me.
While in chiropractic school, I was adjusted by a fellow student.
He was a student in his 8th trimester and had studied manipulation for three trimesters. He adjusted my neck with such tremendous force that he caused a contusion to my spinal cord, resulting in a Brown-Sequard Syndrome. This condition left me with hemiparalysis and paresis. on the right side of my body. I was unable to walk with my right leg or use my right arm for one week. I was hospitalized during that time.
The neurologists were shocked that spinal manipulation could cause this type of damage to someone's cervical spine and spinal cord.
Fortunately, I regained the use of my arm and leg.
However, I do suffer from the residual effects of my injury.
I have a syrinx in my spinal cord and also have three cervical disc herniations.

The purpose of sharing my story with you is to stress the importance of manipulation being performed by trained professionals.
A large part of a chiropractor's education is manipulation (over 500 hours), but another important aspect of chiropractic education is diagnosis (over 800 hours). Physical and clinical diagnosis provides chiropractors the vital knowledge of when to adjust a patient and but more importantly when not to adjust a patient.

Manipulation by untrained professionals is risky.
My story demonstrates this. My classmate had some training in manipulation, but his education was not complete and he did not have enough experience to safely perform this maneuver.
This experience has also influenced the manner in which I treat patients.
I fully understand the potential injury that manipulation can cause when performed incorrectly.

Thank you for allowing me to share this information with you today.

Alisa Mitskog, DC

(13) #4 - MP.

TRI-STATE CHIROPRACTIC CENTER
CHARLES F. WHITNEY, D.C.
101 Fourth Street N.W.
Bowman, North Dakota 58623
Telephone: (701) 523-3239

Monday March 7, 2005

RE: SB 2366

Ms. Chair Clara Sue Price, Representative Members of Human Services:

You have heard Testimony that this issue of Manipulation is something that the Physical Therapists already do, That they are already being paid for, and that this law is merely a recognition of what already is.

1) The level 5 manipulation IS NOT TAUGHT in their schools

2) The level 5 manipulation IS RECOGNIZED AS A PHYSICIAN ONLY service. WHAT IS THE ISSUE HERE IF THEY HAVE PHYSICIAN LEVEL TRAINING? There is none! They REFUSE to establish even minimal education requirements before they would allow this . WHY?

3) WHY WOULD THE PHYSICAL THERAPISTS WANT TO PERFORM A SERVICE THAT IS CURRENTLY A DOCTORAL LEVEL TRAINING SERVICE WITHOUT A SIMILAR LEVEL OF TRAINING? Our issue is not with the letters after a provider's name, but it is very much the number of hours of schooling, clinical experience, and diagnostic capabilities of that provider.

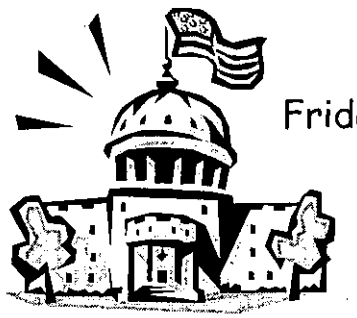
4) When polled at the start of this session in our attempts to address this issue with them, by their own admission, very few (much less than 10 providers statewide) were doing level 5 manipulation. Why is there a need for a law change for something they admit they are not trained to do and virtually none of them are doing?

5) This IS NOT A CHEAPER/BETTER ALTERNATIVE; any one familiar with their track record will tell you that allowing this change WILL increase costs to the patient ("after all Blue Cross will allow a payment of.... when performed by a physical therapist.) Each of us has had patients come to us for physiotherapy because Chiropractors have always been much more cost effective.

6) Allowing this bill to become law would create a broad ill defined scope of practice for the physical therapists. This is the epitome of bad law.

THANKYOU FOR YOUR CONSIDERATION

Charles F Whitney DC



Friday, March 11, 2005

MEMO

TO: REP. CLARA SUE PRICE
FROM: JACK McDONALD
RE: Physical Therapy bill, SB 2366

Attached is the information you requested concerning physical therapists. I hope you will be able to support the bill as is, without the proposed chiropractic amendments.

If you have any questions, please let me know.

Jack McDonald
223-5300/ cell 220-1996
jackmcdonald@wheelerwolf.com

Friday, March 11, 2005

2005 North Dakota Physical Therapy Licensure Statistics

of licensed PTs in North Dakota – 484

working in North Dakota – 394

living in North Dakota – 404

living and working in North Dakota – 375

of licensed PTAs in North Dakota – 273

working in North Dakota – 74

living in North Dakota – 79

living and working in North Dakota - 69

North Dakota graduates – UND – 255 licensed and living in ND
252 working in ND

- U of Mary – 53 licensed and living in ND
50 working in ND

- UND Williston – 45 licensed and living in ND
(PTA) - 45 working in ND

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EDUCATION

University of North Dakota – DPT – doctor of physical therapy
[3 years pre-physical therapy coursework + 3 ½ years professional education]

University of Mary – DPT – doctor of physical therapy
[3 years pre-physical therapy coursework + 8 semesters (3 years + 2 summer sessions) professional education]

Williston State College – AA (2-year degree) – physical therapist assistant
(considered supportive personnel, but can work without direct supervision in extended care facilities, schools and home health when having direct access by phone to a therapist and having periodic review of programs, at least every 6th visit or every month, whichever comes first)

2005 Worksite Statistics - North Dakota Physical Therapists

394 Physical Therapists working in North Dakota

- 296 – Hospitals
- 27 – Private Practice
- 3 – Chiropractic Clinics
- 10 – Nursing Homes
- 13 – Physician-supervised Clinics
- 16 – School Systems
- 20 – University Programs

****

Clinical Contacts: Hospitals: Mary Jo Wagar – MeritCare Medical Ctr., Fargo
234-8700
mary.jp.wagar@meritcare.com

Michael Rexin – Trinity Health, Minot
857-5286
mrexin@ndak.net

Independent Clinics: Cliff Lafreniere – Select Therapy, Grand Forks
746-8374
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Reed Argent – First Choice Physical Therapy, Inc., Minot
839-4102
argent@ndak.net

Chiropractic Clinics: Steven McNichols – St. Alexius Medical Center, Bismarck
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mcnicholssteven@hotmail.com

Jay Steckler – Chuppe Clinic
258-0029
steckler-99@hotmail.com

Melissa Mees – Bismarck Chiropractic Clinic
223-6613
cowgirlupnd@excite.com

Additional information regarding UND

UND – Bachelor of Science in Physical Therapy, 1970-1992
Master of Science in Physical Therapy, 1993-2004
* 61 licensed therapists went back to UND to get MPT
Doctor of Physical Therapy, 2004 – 1st class of 43 complete doctoral curriculum
* 41 new graduates remained at UND to receive DPT
(15 in December 2003 + 26 in December 2004)
* 50 licensed therapists have gone back to UND to get DPT
(anticipated graduation August 2005)

Physical therapists believe the chiropractors' testimony totally disregards the coursework and training physical therapists receive regarding differential diagnosis which has always been a mainstay of physical therapy education, especially when it comes to diagnosing musculoskeletal problems. Secondly, physical therapists work in concert with medical doctors who also are involved in determining the patient's diagnosis, ordering laboratory tests and imaging. Physical therapists are trained to take a history, perform examination and evaluation procedures, determine a diagnosis and most importantly determine which patients would benefit from physical therapy services and which ones would not.

Physical therapists are also trained to know when to refer back to the physician when they feel they are outside of their scope of practice. In fact, not doing this would violate Section 43-26.1-13 of the proposed Practice Act (SB 2366) and could result in loss of licensure.

Chiropractors go to eight years of college and study an average of 550 hours In manipulation, all of it specifically HVLAT manipulation. They are required to perform approximately 200 manipulations.

Physical therapy students have at least 6 and ½ years of college and a number of them have 7 and ½ years if they enter the professional physical therapy program with a degree. At a minimum they have over 3000 hours of professional physical therapy training including differential diagnosis, anatomy, physiology, biomechanics, exercise physiology, examination and evaluation of all system but with extensive emphasis on the musculoskeletal and nervous systems. They are taught to screen patients and decide on the proper intervention based on the diagnosis and criteria that will help predict which patients will benefit most from certain interventions. For those patients who have signs and symptoms that are thought not to benefit from physical therapy or who have "red flags" indicating a condition beyond the scope of physical therapy practice they are taught to refer out to the proper physician for further evaluation. Physical therapists have a close relationship to medical doctors and rely on them for medical and diagnostic screening and to rule out the presence of signs and symptoms that would not benefit from physical therapy or would be contraindicated.

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ADMITTED TO VA AND DC BARS

March 14, 2005

Jeff Askew, D.C., President
North Dakota Chiropractic Association
301 E. Front Ave., Suite 107
Bismark, ND 58504

Dear Dr. Askew:

This is a follow up to our recent telephone conversation. As we discussed, the Department of Health and Human Services (HHS) has determined that physical therapists, as non-physicians under the Medicare program, are not qualified under Medicare to be paid for the physician service of manual manipulation of the spine to correct a subluxation. While the question arose under the Medicare+Choice program, there is no question that the determination is applicable to the entire Medicare program.

Title Section 1395x of Title 42 of the United States Code establishes the definitions for the entire Medicare program. Specifically, Section 1395x(r) identified five provider types which are included under the definition of "physician" for the purposes "of this subchapter" [subchapter XVIII-Health Insurance for Aged and Disabled (Medicare)]. The identified "physician" providers are doctors of medicine or osteopathy, doctors of dental surgery or of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Again, these definitions apply across the board to the entire Medicare program and are not limited to the Medicare+Choice program. Physical therapists are not included in the definition of physician. They are therefore not qualified to be paid under Medicare for physician services.

We also have explicit statements from HHS on this point. On June 17, 1999, Dr. Thomas Gustafson, Director, HCFA Plan and Provider Purchasing Group, appeared before the Practicing Physician Advisory Council (PPAC) and in response to questioning from Dr. Jerilynn Kaible, PPAC Chiropractic Representative, as to whether a physical therapists could be paid for the physician service of manual manipulation of the spine to correct a subluxation, stated:

> "Because there has been some confusion about the ability of physical therapists to be paid for delivering this service under Medicare, and I believe at one time we – our interpretation was yes, that was okay, we have come to a more mature understanding of what the statute in fact provides, and physical therapists are not permitted to bill Medicare or to be billed for Medicare for this service. (Emphasis added)

Also, In a November 26, 1999 pleading before the U.S. District Court for the District of Columbia, attorneys for HHS again restated the policy which is applicable across the board in Medicare:

> "As explained in footnote 8 of the Secretary's Motion to Dismiss, a physical therapist is not qualified to provide a "physicians' service" because such a practitioner does not meet the definition of "physician " in Section 1395x(r) and, therefore, cannot be paid by Medicare for providing the service defined in 1395x(r)(5) as manual manipulation of the spine to correct a subluxation. (Emphasis added)

Therefore, we believe it is a well settled point that physical therapists, as non physicians, are not qualified under Medicare to be paid for the physician service of manual manipulation of the spine to correct a subluxation, and that this policy is not limited to only the Medicare+Choice program but rather is applicable to the entire Medicare program.

In connection with your question pertaining to the 97140 code, one first needs to keep in mind that this is a non-physician level code. It does not involve elements of physician level evaluation and management or diagnosis of a patient's condition but rather describes various procedures, one of which includes manipulation. In addition, these codes are merely descriptors of authorized services performed by the particular provider. It is therefore an administrative device which does not in itself convey any authority to the provider to perform the identified service. It is a prime example of placing "the cart before the horse" by suggesting that somehow the use of an identifying descriptor of a service in some measure provides the underlying authority for the provision of such service. The CPT codes 98940 to 98943, however, are based on the statutory authorization of a chiropractor as a physician under Medicare to utilize this physician level code and reflects the chiropractors state authorized authority to perform the manipulation service, to properly diagnose the patient, and to perform physician level evaluation and management services. All such authority derives from the chiropractor's scope of practice as recognized by federal and state law and not merely from the use of the 98940 to 98943 CPT codes themselves.

While 97140 is a reimbursable procedure for physical therapists under Medicare, that does not specifically grant them authority to perform manipulation. 97140 is code under which several procedures are assigned, one of which is manipulation another of which is mobilization. A physical therapist can be permitted by his/her state scope of practice to perform mobilization and can therefore bill for 97140, but that does not any way authorize them to perform every service under the 97140 code, e.g. manipulation. State law and scope of practice is the only means by which they can legally perform a given procedure.

While discussions of this nature can sometimes become bogged down by discussions of the application of CPT codes or definitions thereunder, the more important inquiry from any legislative standpoint is the question of what is in fact in the best interest of the patient population of the particular state. Doctors of Chiropractic are extensively trained to not only perform manipulative techniques but just as importantly to perform a comprehensive diagnosis of a patient's condition. Both functions are essential to assure protection of the patient population, since the patients underlying condition may require a referral for specialized medical treatment. Chiropractors are extensively trained in diagnostic procedures, this physician level responsibility combined with their unparalleled education, training and expertise in manipulative techniques provide protection to potential individuals seeking care. To permit access to manipulative services to individuals with lesser training in manipulative techniques and little or no training in diagnostic services presents, in our view, a serious risk of harm to the patient population of any state.

Sincerely,

Thomas R. Daly/mah

Thomas R. Daly
Legal Counsel to the
American Chiropractic Association

TRD/mah

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3/16/05

TO: Madam Chair Price and Members of the North Dakota House Human Services Committee

RE: Physical Therapy Century Code * SB 2366

The North Dakota Chiropractic Association has asked me to provide an objective opinion on changes the NDPTA is proposing in their 2005 century code as relating to extremity and spinal joint manipulation or level 5 mobilization.

I have had the unique opportunity to have completed degrees in physical therapy (University of Minnesota 1987) and in chiropractic(Northwestern Health Sciences University 1998). I have held licensure as a physical therapist in the state of North Dakota, in good standing, from 1987-1995 and again from 1998-1999. I have held licensure as a doctor of chiropractic in the state of North Dakota from 1999 until the present, currently practicing with Meritcare Health Systems in Fargo, ND.

As I understand, proposed changes in the physical therapy century code include language that allows all physical therapists to perform extremity and spinal level 5 joint mobilization or high velocity manipulation of extremity or spinal joints. I believe inclusion of language such as this in the century code goes beyond the educational preparedness of all physical therapists and manual expertise of the majority of physical therapists practicing in the state of North Dakota to perform these techniques safely. Therefore, allowing all physical therapists the legal right to perform this specific, highly technical procedure on the citizens and guests of North Dakota places patients at undo risk of injury.

Spinal and extremity level 5 mobilization or manipulation is define as a dynamic thrust of high controlled velocity, amplitude, and direction delivered within the boundaries of joint anatomic integrity, but outside the boundaries of normal physiologic range of joint motion (Bergmann, 1993). Manual techniques performed at this intensity carry undeniable risks to the patients we serve. Few professionals are adequately trained.

In my clinical experience practicing as a doctor of chiropractic, patients have directly accessed or have been medically referred to me with conditions where spinal mobilization/manipulation is completely contraindicated. These conditions have included; cervical fracture/dislocation, multiple spinal compression fracture, aortic aneurysm, and pleural effusion with mass, spinal metastatic disease, carotid artery disease with occlusion, and severe spinal stenosis. Limiting risk to the patients we serve requires the ability to examine and diagnose extremity joint and spinal segmental pathology, interpretation of diagnostic imaging (plain film radiographs, MRI scan, or CT scan) and at times clinical laboratory medical tests.

Doctors of Chiropractic train hundreds of hours in developing the academic and practical proficiency in joint mobilization/manipulation techniques by the time they complete training. This, in addition the

thousands of hours in preparation for development of diagnostic skills to include; history and physical examination, interpretation of diagnostic imaging and clinical lab testing. Chiropractors complete a 4-part national board exam to test their diagnostic, interpretive, and manual skills. Chiropractors have all the legal rights and educational skills necessary to maximize patient safety as it relate to joint manipulation/level 5-mobilization technique. A 1990's Spine journal article, discussing the benefits of cervical manipulation, has indicated that chiropractors perform 90% of all spinal manipulation as determined by archival research of procedure coding. It is because of this education, training and proficiency that chiropractors feel patient safety may be compromised when physical therapists have different training, not including diagnostics, interpretation of radiographic or clinical laboratory tests, or national board exams in this area of expertise.

Physical Therapists are very resourceful, highly educated professionals. They have a history of delivering rehabilitative care with great skill and integrity. This includes manual therapy involving joint mobilization. Upon graduation from physical therapy school new graduates have a generalized comprehensive education which prepares them to begin practice an area of preferred specialization. Students receive an introduction to manual therapy techniques in their academic and clinical training. In most instances, proficiency in manual therapy techniques takes years of postgraduate 2-5 day seminars. In my personal experience, practical application and proficiency is obtained by direct patient contact post seminar, rather than repetitive development of skills in a supervised clinical or classroom setting.

Physical Therapists lack the accredited education in manipulation procedures, diagnostic imaging, and clinical laboratory medicine to perform these more vigorous techniques in an unsupervised manner.

I respectfully submit this testimony in written form.

Sincerely,

Thomas P. Solien, DC, BS PT

ND Chiropractic Association
SB 2366

Revised Amendment – Ken Tupa, Lobbyist, NDCA

3. "Manual therapy" means the use of techniques such as mobilization or manipulation, manual lymphatic drainage, and manual traction on one or more regions of the body.

Amendment to clarify the HVLA thrust to the vertebral column:

Page 2, line 5, after "body" insert "throughout the normal range of physiological motion without engaging in a high velocity thrust or impulse that is intended to or would be likely to result in cavitation of an articulation of the spine or pelvis."

In testimony before the House Human Services Committee the question arose whether or not our initial amendment would prevent Physical Therapists from, for instance, treating a "frozen shoulder" to regain movement or other lower level manipulations that might result in a cavitation or "popping" of the joint.

I want to give you some information clarifying the issue of "cavitation" of the joint vis-à-vis the intent of our amendment which is not to prevent PTs from performing a mobilization or manipulation resulting in a "cavitation" but to address the seriousness of the high velocity, low amplitude thrust (HVLA) which is a chiropractic adjustment. This new amendment applies to the vertebral column only and does not restrict physical therapists from manipulating extremities.

Our intent was confirmed by Dr. Killen (a physical therapist and instructor at the PT program at U of Mary) who testified in committee that she witnessed none of this type of manipulation (all level 5) by PTs in her practice throughout the state.

Cavitation of a joint is not what makes a high velocity low amplitude thrust into a joint assume risk. Taking the joint into the paraphysiological range(beyond passive range of motion (ROM) and beyond control of the patient to stop the procedure) is what makes the procedure require highly skilled practitioners in its application.

In this paraphysiological area there is the obvious risk to the surrounding soft tissues (cartilage, ligaments, tendons, etc), but **the proximity to neurologic tissues in the spine is what adds to the required level of skill necessary to perform the procedure safely and effectively.**

Our amendment is only concerned with the willful intent of thrusting into the spinal region taking it outside the passive range and just short of anatomical damage which is almost always accompanied by an audible release/cavitation. The simple "cracking of knuckles" does not involve a HVLA thrust.

If a chiropractor, upon setting up on a patient to do a cervical adjustment, causes a small cavitation to occur prior to reaching the passive endpoint, an adjustment has NOT been performed. In fact, the chiropractor will continue to perform a HVLA thrust into the joint taking it into the paraphysiologic range(where the restorative/healing benefit is obtained). This procedure, the majority of the time but not always,
MOVES BONES/ RESTORES PROPER STRUCTURAL ALIGNMENT. And, while almost always accompanied with a cavitation/pop, it is not the cavitation alone that defines this procedure.

Not only do chiropractors have nearly 600 hours of education and training specific to this HVLA, they are required (as part of their education) to demonstrate this procedure after having performed it many, many times over and over again on individuals. Additionally, chiropractors have over 1000 of education and training specific to the diagnosis to know when and when not to perform this procedure.

Again, the intent of our amendment is not to prohibit PTs from performing those mobilizations/manipulations they are currently trained to perform and which may result in a cavitation of the joint, rather our amendment addresses the HVLA thrust into a joint (the vertebral column) where appropriate training is necessary to first diagnosis the need and secondly perform the procedure safely.