2004

The Effect of Direct Access with Direct Reimbursement on Physical Therapy Practice

Heather LaFreniere  
University of North Dakota

Katie Sauvageau  
University of North Dakota

Follow this and additional works at: https://commons.und.edu/pt-grad

Part of the Physical Therapy Commons

Recommended Citation
https://commons.und.edu/pt-grad/276

This Scholarly Project is brought to you for free and open access by the Department of Physical Therapy at UND Scholarly Commons. It has been accepted for inclusion in Physical Therapy Scholarly Projects by an authorized administrator of UND Scholarly Commons. For more information, please contact zeineb.yousif@library.und.edu.
THE EFFECT OF DIRECT ACCESS WITH DIRECT REIMBURSEMENT
ON PHYSICAL THERAPY PRACTICE

by

Heather LaFreniere
Bachelor of Science in Physical Therapy
University of North Dakota, 2003

Katie Sauvageau
Bachelor of Science in Physical Therapy
University of North Dakota, 2003

A Scholarly Project
Submitted to the Graduate Faculty of the
Department of Physical Therapy
School of Medicine
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Master of Physical Therapy

Grand Forks, North Dakota
May
2004
This Scholarly Project, submitted by Heather LaFreniere and Katie Sauvageau in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Advisor and Chairperson of Physical Therapy under whom the work has been done and is hereby approved.

Renee A Maloney
(Graduate School Advisor)

Thomas Woud
(Chairperson, Physical Therapy)
PERMISSION

Title The Effect of Direct Access with Direct Reimbursement on Physical Therapy Practice

Department Physical Therapy

Degree Master of Physical Therapy

In presenting this Independent Study Report in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, we agree that the Department of Physical Therapy shall make it freely available for inspection. We further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised our work or, in her absence, by the Chairperson of the department. It is understood that any copying or publication or other use of this independent study or part thereof for financial gain shall not be allowed without our written permission. It is also understood that due recognition shall be given to us and the University of North Dakota in any scholarly use which may be made of any material in our Independent Study Report.

Signature [Signature]

Date ____________________________

iii
TABLE OF CONTENTS

LIST OF FIGURES ............................................. vi
LIST OF TABLES ............................................. vii
ACKNOWLEDGMENTS ........................................ viii
ABSTRACT .................................................. ix

CHAPTER

I INTRODUCTION AND LITERATURE REVIEW .......... 1

History .................................................. 1
Direct Access ........................................... 3
Advantages of Direct Access ............................ 4
Concerns Regarding Direct Access .................... 6
Physical Therapy Within North Dakota ............... 8
Purpose of This Study ................................... 9

II METHODS ................................................. 10

Survey Development .................................... 10
Subject Selection ....................................... 11
Survey Distribution .................................... 12
Data Collection, Analysis and Reporting .............. 13

III RESULTS AND DISCUSSION .......................... 14

Demographics ........................................... 15
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clientele Changes</td>
<td>15</td>
</tr>
<tr>
<td>Marketing Strategies</td>
<td>19</td>
</tr>
<tr>
<td>Physical Therapist/Physician Relationships</td>
<td>20</td>
</tr>
<tr>
<td>Insurance/Reimbursement Changes</td>
<td>21</td>
</tr>
<tr>
<td>Benefits of Direct Access with Direct Reimbursement</td>
<td>24</td>
</tr>
<tr>
<td>Personal Effects on the Physical Therapist</td>
<td>26</td>
</tr>
<tr>
<td>Limitations</td>
<td>28</td>
</tr>
<tr>
<td>IV CONCLUSION</td>
<td>30</td>
</tr>
<tr>
<td>APPENDIX A</td>
<td>31</td>
</tr>
<tr>
<td>APPENDIX B</td>
<td>34</td>
</tr>
<tr>
<td>APPENDIX C</td>
<td>36</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>40</td>
</tr>
</tbody>
</table>
**LIST OF FIGURES**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Percentages of patient load seen under direct access with direct reimbursement depending on whether the patient has received previous treatment for the respective diagnosis.</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Response of participants regarding the statement, &quot;I have noticed an increase in personal work related stress following the implementation of direct access with direct reimbursement.&quot;</td>
<td>27</td>
</tr>
<tr>
<td>3</td>
<td>Response of participants regarding the statement, &quot;I have noticed an increase in job satisfaction following the implementation of direct access with direct reimbursement.&quot;</td>
<td>28</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>6</td>
<td>26</td>
</tr>
</tbody>
</table>

1. Professional Characteristics ........................................... 16
2. Clientele Demands for Physical Therapy Services Following Implementation of Direct Access with Direct Reimbursement ................................... 17
3. Reimbursement Changes Following the Implementation of Direct Access with Direct Reimbursement ........................................... 22
4. Insurance Changes Following the Implementation of Direct Access with Direct Reimbursement ........................................... 23
5. The Leading Benefits of Direct Access with Direct Reimbursement ........................................... 24
ACKNOWLEDGMENTS

We would like to sincerely thank Dr. Renee Mabey, PT, for all her valuable time and effort in making our project a good learning experience and valuable study. Thank you for going the extra mile all the time.

Dr. Thomas Mohr, PT, supported our research by funding our scholarly project and supporting our efforts. Thank you.

Thank you Alyson White for taking the time to type and format our scholarly project, which you perfected. Thank you Debbie Larson and Sherri Johnson for your assistance on our scholarly project.

A special thanks goes to all the faculty and staff of the University of North Dakota Department of Physical Therapy. We have become professionals right before your eyes with your help every step of the way. Thank you for taking the time to help us along our journey.

We would like to take this opportunity to sincerely thank our family and friends. We are forever in your debt for your support, love, and understanding. Finally, we would like to thank God for giving us the endurance to finish this project and successfully complete our physical therapy education.
ABSTRACT

In 2002, North Dakota passed legislation that allowed physical therapists to be directly reimbursed by Blue Cross Blue Shield of North Dakota for physical therapy services. The purpose of the study is to determine the effects of direct access with direct reimbursement on physical therapy practice. The survey was sent to 400 licensed physical therapists within Arizona, Maryland, and Minnesota. These states were chosen for their experience in utilizing direct access with direct reimbursement and the geographic location.

The survey consisted of 7 categories addressing demographics, clientele changes, marketing strategies, physical therapist/physician relationship, insurance changes, direct effects on patient care and personal effects on physical therapists. The results were analyzed and frequencies for all respondents were determined. Handwritten comments were recorded within the results in order to obtain understanding of the respective responses.

There were 42 surveys returned for a response rate of 11%. Twenty-eight were completed and 8 of the completed surveys were used for data analysis. The results of the study indicate there is a consumer demand for direct access with direct reimbursement. Physical therapists stated the top benefits of direct access with direct reimbursement were improved relationships with patients and earlier intervention. Respondents noticed no change regarding their relationship
with physicians, insurance coverage, or reimbursement. Marketing strategies were not utilized at this time to promote or educate consumers regarding direct access with direct reimbursement.

Due to the less than expected return rate, the data are limited in demonstrating the effects of direct access with direct reimbursement on physical therapy practice. Handwritten comments indicated lack of knowledge and understanding by physical therapists, consumers, and other health care professionals. Further studies should be completed once direct access with direct reimbursement has become more utilized by the physical therapy profession.
CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

In 1918 following the end of World War I, soldiers returned from war with disabilities affecting their jobs and home lives. Health care workers called "reconstruction aides" helped individuals overcome or accommodate to their disabilities to help them function within society. Reconstruction aides were the physical therapists of the past. Today's physical therapists are experts in examining and treating impairments of the musculoskeletal and neuromuscular systems which in turn affect activities of daily living. The professional responsibilities and educational requirements have expanded and continue expanding attaining an autonomous role within the health care profession.

History

The "reconstruction aides" were required to fulfill 3 months of classes revolving around human anatomy and exercise to receive a certificate to practice physical therapy. Their practice was formulated less on academics and heavily on experience gained from working closely with orthopedic surgeons. The definition of a physical therapist was "an educated trained assistant to members of the established medical profession in the following areas: muscle training, therapeutic massage, electrotherapy, light therapy, mechanotherapy, and
hydrotherapy guided by policy to practice only under the prescription of the licensed physician.\textsuperscript{35}

Within the next 10 years, the American Physical Therapy Association (APTA) was established and began to standardize the profession by implementing educational requirements and a professional code of ethics. During this time, role responsibilities and education increased helping physical therapists practice independently from the physician.\textsuperscript{34,35} By the 1970s, the role of the physical therapist had evolved to taking a patient history, conducting systems reviews, performing tests and measures, and providing the appropriate interventions.\textsuperscript{33} The educational curriculum focused on giving the students skills in basic procedures and included the rationale for each procedure. The educational settings transitioned from hospitals and health care settings to colleges and universities. By the year 2002, all physical therapy graduates from an accredited institution earned a Master's degree.\textsuperscript{33}

Today's physical therapists are employed in a variety of settings and treat a vast array of conditions including orthopedic, neurological, cardiopulmonary, musculoskeletal, work place, and sports injuries.\textsuperscript{33} Educational institutions offer a doctorate in physical therapy focusing on differential diagnosis and clinical decision-making skills providing physical therapists with the knowledge and skills necessary to provide quality health care. The APTA continues to encourage the growth of the physical therapy profession by establishing two goals, thus moving physical therapists toward autonomous practice by 2020. The goals are to
achieve direct access to physical therapy in all states and to receive direct reimbursement for physical therapy services.  

Direct Access

Direct access is the ability to evaluate patients without a physician’s referral and make decisions about clinical management. Direct access has been achieved at the state level in 2 ways through provisions and omission. Provisions allow the public to have access to physical therapy services under certain guidelines. Several common guidelines consist of requiring the patients to see a physician after 60 days of physical therapy intervention, requiring physical therapists to be licensed for 2 years prior to practicing under direct access, and limiting the patient population to individuals with musculoskeletal pathologies. Omission means that within the state practice act there is no language limiting physical therapy practice through direct access. As of August 2003, 14 states were practicing under omission and 24 states identified provisions within their state practice acts. Twelve states still require a physician’s referral for evaluation and treatment by a physical therapist.

Success of direct access established within the 38 states has been overshadowed by limited direct reimbursement. The definition of direct reimbursement is payment from a third-party payer for physical therapy services performed without a physician’s referral. Arizona, Delaware, Minnesota, Maryland, and North Dakota are among the minority of states that have successfully achieved direct access with direct reimbursement for physical therapy services.
Advantages of Direct Access

Since 1957, physical therapy has gained autonomy through direct access with the support of the APTA.\textsuperscript{33} The APTA's argument against requiring a physician's referral for physical therapy services states "it (laws requiring physicians referral for physical therapy intervention) does not recognize the professional training and expertise of licensed physical therapists nor does it serve the needs of those patients who require physical therapy but find they must first be seen by a physician."\textsuperscript{25}

Direct access provides needed health care for all citizens by extending additional entry points into the health care system.\textsuperscript{25-27} There are several advantages found within research for utilizing direct access to physical therapy services including decreased costs, shorter visits, shorter durations of treatment, promoting prevention, and increasing job satisfaction of physical therapists.\textsuperscript{25,27}

As the national debt continues to grow, health care is a major area of concern in cutting costs while still maintaining quality care. By allowing physical therapists to be the entry point into the health care system, the cost of claims will decrease by eliminating the cost of the initial visit to the physician.\textsuperscript{25,27,28} Research has found physician referral generated 67% more claims and 60% more office visits than direct access episodes. The cost of the total paid claims is also 123% higher with a physician referral. The average direct access episode of care was $1,004, while the physician referral cost was $2,236.\textsuperscript{27}

The initial visit is not the only way direct access has helped to decrease the cost of care. Direct access allows individuals to be seen more easily and
quickly which helps to decrease long-term care.\textsuperscript{25} For example, a physical therapy patient seen through direct access will have decreased time between the onset of signs and symptoms and the initial treatment, requiring less treatment duration and improving the overall outcome of treatment.\textsuperscript{25,27} Research supports this theory finding patients with a physician’s referral to physical therapy are 65\% longer in treatment duration than direct access care.\textsuperscript{27} In 1975, James and Stuart conducted a study involving the United States Army evaluating the efficiency of physical therapists as the initial screener for patients with low back pain. Patients’ waiting time, treatment time, number of visits, and quality of care were assessed in this study. The patients reported more “expeditious” treatment having physical therapists as the initial screeners. Quality of care was reported to be satisfactory to the patient, physician, and physical therapist.\textsuperscript{23} In addition, the work and school settings have decreased loss wages, absenteeism, and injury by implementing early intervention and on-site treatment with direct access.\textsuperscript{4,28}

Within the older population, patients progress rapidly from an impairment to functional limitation leading eventually to a disability.\textsuperscript{21} By allowing physical therapists direct access, prevention and wellness can be incorporated into the treatment program to help with the current status and long-term effects of the condition.\textsuperscript{25,27} Preventing a disability arising from a musculoskeletal problem will help control long-term care and decrease the cost of care.\textsuperscript{21}

Physical therapists have increased their professional responsibilities and education to include the necessary skills to evaluate and safely treat an individual
with a musculoskeletal pathology. One study which examined the difference between physical therapists in Massachusetts, a direct access state, and Connecticut, a physician's referral state, found that the therapists from Massachusetts were more satisfied and challenged by their career when compared to those from Connecticut. Direct access allows physical therapists to reach their full potential as professional clinicians utilizing their knowledge and skills achieving greater job satisfaction.

Concerns Regarding Direct Access

A study in 1988 comparing private and hospital-based outpatient physical therapy facilities found that treating patients through direct access was the exception instead of the standard. This study showed that 33.3% of private practices reported they did not allow evaluations without a physician’s referral, 45.3% reported not allowing treatment, and 34.2% reported neither evaluation nor treatment occurred without a physician’s referral. Durchholz and Domholdt surveyed physical therapists in 3 states with direct access and found that 45% of physical therapists had seen patients through direct access, but only approximately 10% of their patient caseload was direct access clientele.

Research surrounding direct access has identified 3 main reasons for limited utilization of direct access to physical therapy services: employer policy, limited direct reimbursement, and personal preference. Domholdt and Durchholz confirmed this information by surveying physical therapists within direct access states finding that 49.1% were limited by employer policy, 43.6%
lack of reimbursement, and 23.6% personally preferred to practice with a physician’s referral.

Employers are fearful of the repercussions that would follow from allowing the physical therapist to work autonomously through direct access. Physical therapists have felt opposition from a variety of sources including hospital associations, insurance companies, medical associations, physicians, and chiropractors. These health care professionals have raised issues such as improper treatment, inappropriate care, and lack of access to diagnostic testing limit the quality of care physical therapists deliver through direct access.\textsuperscript{23,25,27} In the eyes of these professionals, direct access legislation would allow the physical therapists to diagnosis and treat beyond their competency level putting the patients at risk.\textsuperscript{25,27}

The other concern regarding low utilization of direct access is limited direct reimbursement. Medicare will not allow direct reimbursement until the physical therapist is labeled as a physician within the Medicare system. Optometrists, podiatrists, and chiropractors with similar education and professional responsibilities as a physical therapist are allowed direct access with direct reimbursement under Medicare.\textsuperscript{21} The APTA is planning to gain direct reimbursement from Medicare to help encourage other third-party payers to reimburse for physical therapy services rendered through direct access.

The third reason for low utilization of direct access is that professional physical therapists themselves fear the consequences of practicing without a physician’s referral. The 2 main fears expressed by these physical therapists are
fears of malpractice and alienating physicians. Legal responsibilities with direct access do increase, but malpractice is not an issue of concern among the majority of physical therapists practicing. Liability insurance costs and number of liability claims were exceedingly low before and after direct access. The limited research has indicated that there was no increased incidence of malpractice occurring following the initiation of direct access. Maginnis and Associates, providers of liability coverage for physical therapists, stated “direct access has had no material effect on the professional liability exposure.” Two other major liability insurers for licensed physical therapists reported that direct access had not increased claims or liability costs for physical therapy.

Physical Therapy Within North Dakota

North Dakota (ND) is one of the few states that has achieved the goals set by the APTA. North Dakota legislated direct access in 1989 and was granted direct reimbursement by North Dakota Blue Cross Blue Shield (BCBS) in 2002. Direct access was achieved under omission within the state practice stating “license revocation upon failure to refer a patient whose medical condition is out of the scope of physical therapy.” As of October 2002, internal policy was changed allowing North Dakota BCBS to reimburse for physical therapy services rendered through direct access. This is a major achievement for ND physical therapists because BCBS is the health insurance carrier for approximately 75% of the ND population. ND physical therapists are now the entry point into the health care system for patients with musculoskeletal impairments. The current
problem is many physical therapists are concerned how direct access with direct reimbursement will affect their practice and how they maintain quality care.

Purpose of This Study

The purpose of this study is to help ND physical therapists become aware of the effects direct access with direct reimbursement has on the physical therapy practice. A survey was sent to randomly chosen physical therapists in Arizona, Maryland, and Minnesota. The survey focused on 7 main areas: professional characteristics, clientele changes, marketing strategies, physical therapist/physician relationships, insurance changes, direct effects on patient care, and personal affects on physical therapists. The outcome of this survey will allow ND physical therapists to anticipate any changes utilizing direct access with direct reimbursement.
CHAPTER II

METHODS

Survey Development

The idea for this research developed at a North Dakota Physical Therapy Association (NDPTA) meeting attended by one of the student researchers. Physical therapists within North Dakota were raising questions regarding how direct access with direct reimbursement would affect their practice. The concerns raised were the various risks associated with utilizing direct access with direct reimbursement and how to educate the public about the upcoming changes. Contact with the American Physical Therapy Association (APTA) following that meeting helped in gaining basic information and identifying issues the APTA has faced during this growing period in other states. Susan Villageliu from the APTA was contacted through email and gave feedback regarding which states have had success utilizing direct access with direct reimbursement which included Arizona, Delaware, and Maryland.

Questions were formed by researching the effects direct access has had on physical therapy practice and also the struggles other professionals have faced within their profession by utilizing direct access with direct reimbursement. Non-physician providers, such as nurses, nurse practitioners, nurse midwives, family and marriage counselors, and chiropractors, have overcome issues such
as quality of care, cost effectiveness, and extended health care options to achieve direct access with direct reimbursement within their respective fields.\textsuperscript{9,10} The survey questions developed from the literature review and personal communication focused on physician/physical therapist relationships, clientele changes, effects on patient care, insurance changes, marketing, and personal effects on the physical therapist (see Appendix A). Sample surveys were completed by 30 physical therapists within the surrounding area to ensure research questions were readable, understandable, and appropriate. This study was approved by the University of North Dakota Institutional Review Board and was numbered IRB-200305-243 (see Appendix B).

Subject Selection

The methodology behind choosing the states was related to the geographic location and the longevity of direct access with direct reimbursement policies. Maryland has been very successful with receiving direct reimbursement from Blue Cross Blue Shield for services provided by direct access. Blue Cross Blue Shield is one of Maryland's major third-party payers, which is similar to North Dakota. Minnesota was chosen because of its similar geographic location and high percentage of rural clientele. Arizona and Delaware were chosen because they have had experience with utilizing direct access with direct reimbursement for a number of years. The executive officer of each state licensing board was contacted to access names and addresses of licensed physical therapists. Delaware was not able to participate in the study secondary to a state legislative act which did not allow the names and addresses of
practicing physical therapists to be released to the public. Arizona’s and Maryland’s executive directors were compliant with our requests and sent the names and addresses of the licensed physical therapists at no charge. Minnesota complied with our request, but required a fee for obtaining the information. The lists obtained from Arizona and Maryland contained the names and addresses of all the physical therapists licensed within the respective state, which were randomized by the student researcher. The list from Minnesota was randomized by the secretary of the state licensing board prior to being received by the student researchers.

The survey was sent to a total of 400 licensed physical therapists within Maryland, Minnesota, and Arizona. The names were randomly chosen from publicly available lists obtained from the state licensing boards. Arizona and Minnesota each have 2800 licensed physical therapists and Maryland has 3900 licensed physical therapists. In order to give fair weight to the number of physical therapists in each state, 120 subjects were selected from Minnesota and Arizona while 160 subjects were selected from Maryland.

Survey Distribution

The survey was mailed to randomly selected physical therapists in Maryland, Minnesota, and Arizona. The surveys were sent with a cover letter explaining the purpose of the survey. A self-addressed envelope was included with each survey. If practitioners did not treat by means of direct access with direct reimbursement, they were asked to disregard the survey and return it in the envelope provided. The surveys were coded with the state abbreviations,
which were capitalized in the bottom right-hand corner of the first page of the survey, to help identify which state was represented. The deadline for returning the completed survey was 6 weeks from the date of mailing. A reminder card was sent 2 weeks following the initial mailing.

Completing the survey constituted implied consent by the physical therapist. No identifying marks for specific individuals or significant risk was associated with this survey. Only the student researchers and advisor had access to the returned surveys and completed data entry. There were no monetary benefits for completing the survey. The benefits of this survey included improved awareness of physical therapy trends following legalization of direct access with direct reimbursement for North Dakota physical therapists.

Data Collection, Analysis and Reporting

The completed surveys were returned to the University of North Dakota Department of Physical Therapy. Data were entered into a Statistical Package for Social Sciences (SPSS) 11.0 spreadsheet and analyzed using descriptive and analytical statistics. Narrative data were entered into a WordPerfect document, coded, and analyzed by category. The results will be reported within the completed scholarly project in May 2004. The data will be reported to the University of North Dakota Department of Physical Therapy, North Dakota Physical Therapy Association, American Physical Therapy Association, and will be made available upon request to other interested parties.
CHAPTER III
RESULTS AND DISCUSSION

Four hundred surveys were initially mailed. Of these surveys, 42 were returned, generating a 11% return rate. Twenty-eight (7%) of the returned surveys were usable. Of the 28 that were usable, 8 (2%) surveys qualified as a valid survey containing appropriate results regarding the survey questions, meaning the respondent practiced under direct access with direct reimbursement. The researchers felt the main reason for the poor return rate was the limited knowledge and use of direct access with direct reimbursement among physical therapists, physicians, consumers, and facilities.

Participants were permitted to write additional comments for each question in order to fully explain their responses. The handwritten comments from the valid surveys are listed under their respective categories. Additional comments from the respondents who did not have experience practicing under direct access with direct reimbursement are located in Appendix I. This chapter is divided into 8 categories which include demographics, clientele changes, marketing strategies, physical therapist/physician relationship, insurance/reimbursement changes, benefits of direct access with direct reimbursement, and personal affects on physical therapists. The results for each
category will discuss previous research, findings from this study, and the researchers’ interpretations.

Demographics

Five of the surveys used for final analysis were from Maryland, 2 were from Minnesota, and 1 from Arizona. All of the respondents were female with a mean age of 40.6 years. Seven (88%) of the respondents had achieved a bachelor’s or master’s degree in physical therapy. Four (50%) of the therapists held a position as a staff physical therapist, 2 (25%) held the position of supervisor, and 2 (25%) held the position of owner. Seven (88%) of the respondents worked in an outpatient clinic and 1 (13%) worked from a home office. The mean number of years practicing as a physical therapist was 17.6 and the mean number of years practicing under direct access with direct reimbursement was 10.6. Five (63%) of the respondents were APTA members and 3 (38%) were non-members. See Table 1 for a complete listing of respondent demographics. Due to the small return rate, demographics are noted but no comparison to the population of practicing physical therapists is offered.

Clientele Changes

Five (63%) of the respondents agreed that direct access with direct reimbursement had increased their total patient load. Seven (88%) of the respondents agreed that there is a high demand for direct access when direct reimbursement is available (Table 2). Previous studies have not identified any demand for direct access with direct reimbursement. The researchers feel
Table 1. Professional Characteristics

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Age in Years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean = 40.6 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range = 32 to 48 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Entry Level PT Degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>BSPT</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>MSPT</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td><strong>Highest Earned Degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>BSPT</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>MSPT</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td><strong>APTA Membership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td>Non-member</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td><strong>Primary Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>4</td>
<td>50</td>
</tr>
</tbody>
</table>
Table 1. Professional Characteristics (cont.)

<table>
<thead>
<tr>
<th>Supervisor</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>2</td>
<td>25</td>
</tr>
</tbody>
</table>

Primary Practice Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>7</td>
<td>88</td>
</tr>
<tr>
<td>Home Office</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>

Years Practicing as PT

Mean = 17.06 years
Range = 7 to 26 years

Years Practicing as a PT with Direct Access and Direct Reimbursement

Mean = 10.6 years
Range = 0.5 to 19 years

Table 2. Clientele Demands for Physical Therapy Services Following Implementation of Direct Access with Direct Reimbursement

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct access with direct reimbursement has increased my patient load.</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>There is a high demand for direct access, when direct reimbursement is available.</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
clientele changes cannot be noted at this time due to lack of knowledge and experience working with direct access with direct reimbursement.

In this study, for patients seen under direct access with direct reimbursement, an average of 34% were new clients with a recurring diagnosis, 30% were previous patients with a recurring diagnosis, 15% were previous patients with a new diagnosis, and 10% were new patients with a new diagnosis (fig. 1). This study shows that only 10% of the patients seen by direct access with direct reimbursement were new patients with new diagnoses. The researchers feel that this low percentile indicates that the majority of patients seen under direct access with direct reimbursement are familiar with physical therapy services.

Previous studies have expressed the concerns of other health care professionals regarding the quality of care given by physical therapists through direct access with direct reimbursement. Their major concerns were improper treatment, inappropriate care, and lack of access to diagnostic testing. The physical therapy profession addressed these concerns and implemented a more in-depth focus on differential diagnosis and clinical decision-making skills in physical therapy programs. The physical therapist's education and role now include taking a patient history, conducting a systems review, performing tests and measures, and providing the appropriate intervention or referral in an effort to prevent misdiagnosis. No previous studies, including ours, support the concerns of inappropriate self-referrals.
Figure 1. Percentages of patient load seen under direct access with direct reimbursement depending on whether the patient has received previous treatment for the respective diagnosis.

Marketing Strategies

Respondents were asked a number of questions regarding changes of marketing strategies within their facility or state, upon implementation of direct access with direct reimbursement. One therapist responded that word-of-mouth was the only strategy used to market her facility. "I only use word-of-mouth; I don't advertise and I am swamped."

Strategies used for marketing direct access with direct reimbursement were not reported within previous studies or the results from this survey. In the
past, physical therapists played a passive role in the health care field and relied on referrals from physicians, but with the implementation of direct access with direct reimbursement, physical therapists will need to become more aggressive in marketing themselves to secure a full patient load. Lack of marketing impedes educating the consumers on available services which limits its utilization. In the future, physical therapy students would benefit if marketing classes were included in their curriculum.

Physical Therapist/Physician Relationships

Respondents were asked if they noticed any changes in the number of physical therapy referrals or changes in the relationship between physical therapists and the physicians following the implementation of direct access with direct reimbursement. None of the respondents reported a change in physician/physical therapist relationships and 6 (86%) of the respondents reported no change in the number of physician referrals following implementation of direct access with direct reimbursement.

The following comments suggest this is related to an ongoing requirement for referral at the facility or third-party payer level:

• “I worked in an outpatient orthopedic clinic and sports medicine center that was physician owned until I opened my own manual therapy practice two years ago. It still requires a physician referral for all patients. In my private manual therapy practice, 90% of my referrals are word-of-mouth and 98% are direct access. My Medicare patients are the only ones who use a physician referral at this time.”
• "Maryland has had direct access since 1979, so it has just become the norm; however, Medicare and managed care insurance continue to require MD referrals so the majority of our patients are still by physician referral."

The following comments explain the reason for no change in the relationship between physicians and physical therapists:

• "Medicare and managed care insurance continue to require physician referrals so the majority of our patients are still by physician referral."
• "5 months is too brief a time to analyze this info."
• "They (physicians) regard us as highly skilled clinicians who are able to diagnosis and treat."
• "I am respected for my knowledge and expertise in treating the difficult to treat patients."

There has been no data demonstrating a change in the relationship or in the number of referrals between the physician and physical therapist since the implementation of direct access with direct reimbursement.23,25,27 The results of this survey show that physicians value the physical therapist's role on the health care team. In order to preserve this good rapport with physicians, it is important to maintain an open relationship throughout this transitional period.

Insurance/Reimbursement Changes

The respondents were asked to identify changes in billing or insurance reimbursement following the implementation of direct access with direct reimbursement. Five (63%) of the respondents identified no change in the fee
schedule following the implementation of direct access with direct reimbursement. In response to the question “Was there an increase in denials from third-party payers following the implementation of direct access with direct reimbursement?” 3 (43%) stated an increased need for evidence-based practice, 3 (43%) stated no increased need for evidence-based practice. In regard to changes in the number of denials from insurance companies, 3 (43%) respondents reported no increase, 3 (43%) reported an increase, and 2 gave no response to the question (Table 3). In regard to personal insurance, 4 (50%) of the respondents stated no increase in liability insurance and 1 (14%) respondent stated an increase in annual premium of malpractice insurance following the implementation of direct access with direct reimbursement (Table 4).

Table 3. Reimbursement Changes Following the Implementation of Direct Access with Direct Reimbursement

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>The fee schedule was changed.</td>
<td>8</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>I noticed an increased need for evidence based practice.</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>I noticed an increased number of denials.</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 4. Insurance Changes Following the Implementation of Direct Access with Direct Reimbursement

<table>
<thead>
<tr>
<th></th>
<th>Total n</th>
<th>Yes n</th>
<th>Yes %</th>
<th>No n</th>
<th>No %</th>
<th>Unknown n</th>
<th>Unknown %</th>
</tr>
</thead>
<tbody>
<tr>
<td>The cost of liability insurance</td>
<td>8</td>
<td>1</td>
<td>13%</td>
<td>4</td>
<td>50%</td>
<td>3</td>
<td>38%</td>
</tr>
<tr>
<td>increased.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The annual premium of malpractice</td>
<td>7</td>
<td>1</td>
<td>14%</td>
<td>2</td>
<td>29%</td>
<td>4</td>
<td>57%</td>
</tr>
<tr>
<td>insurance increased.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is a concern that health care costs and liability insurance premiums will increase following the implementation of direct access with direct reimbursement. This concern has been disputed in a number of previous studies, along with the results of this study. Research demonstrates both liability insurance and the number of liability claims by physical therapy were exceeding low both before and after direct access with direct reimbursement. Our respondents reported no change in their fee schedule, personal liability insurance, or annual premium of malpractice insurance following direct access with direct reimbursement.

Physical therapists fear direct access with direct reimbursement could possibly increase denials or increase the need for evidence-based practice from third-party payers. In this study, only a single respondent reported an increased need for evidence-based practice and an increase in denials from third-party payers. No data were found within previous research, but the researchers feel it
is too early to assess the effects direct access with direct reimbursement may have on third-party payers' decisions regarding reimbursement.

Benefits of Direct Access with Direct Reimbursement

All of the respondents agreed with the statement "direct access with direct reimbursement has benefitted patient care" and 7 (88%) agreed that it was a benefit to their facility. Earlier intervention was ranked as a benefit by all of the respondents (ranked number 1 6 times). Improved relationships with their patients was ranked as a benefit by 7 of the respondents. Cost effectiveness was ranked as a benefit by 5 of the respondents (ranked number 1 2 times). See Table 5.

Table 5. The Leading Benefits of Direct Access with Direct Reimbursement

<table>
<thead>
<tr>
<th>Benefit</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased number of physical therapy treatments</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>Earlier intervention of physical therapy treatments*</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Improved cost effectiveness of physical therapy treatments</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td>Improved physical therapist and patient relationships</td>
<td>7</td>
<td>88</td>
</tr>
</tbody>
</table>

* Ranked #1 6 times.
Comments regarding the benefits of patient care include:

- "I am able to see patients sooner because they do not have to wait to get a physician appointment; most of the time the physicians aren't really sure what is wrong with my patients."
- "More effective treatment and decision making immediately."

Comments regarding cost effectiveness include:

- "We are able to get patients in quicker and do not have to wait for a re-referral."
- "It decreases the amount of unnecessary paperwork."
- "More timely payment of services."

Research has shown the benefits of direct access include decreased costs, visits, and duration of treatments; promoted prevention and wellness; and increased job satisfaction of physical therapists.\textsuperscript{25,27} James and Stuart\textsuperscript{23} conducted a study that used physical therapists as the initial entry point into the health care system. They observed a decreased waiting time, treatment time, and number of visits, and satisfactory quality of care.

The researchers feel direct access with direct reimbursement allows necessary admission to the health care system for earlier intervention avoiding the long-term effects of an impairment. By decreasing the long-term effects, health care costs can be controlled.
Personal Effects on the Physical Therapist

Physical therapists stated that continuing education, work experience, and entry level degree were most beneficial in preparation for working under direct access with direct reimbursement (Table 6).

Table 6. What Prepared You for Working Under Direct Access with Direct Reimbursement?

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing education</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Work experience</td>
<td>7</td>
<td>88</td>
</tr>
<tr>
<td>Entry level degree</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td>Certifications</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Post graduate work</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>

Seven (88%) of the respondents stated there was no increase in work-related stress following the implementation of direct access with direct reimbursement. One (13%) of the respondents noted an increase in stress due to an increase in workload. None of the respondents felt that job satisfaction decreased following the implementation of direct access with direct reimbursement. See figures 2 and 3 for detailed results.
Preparation of physical therapists for working under direct access with direct reimbursement is an important aspect of the transition into autonomous practice. The researchers feel that both entry-level degree and continuing education are important in preparing and preserving the knowledge needed to practice under direct access with direct reimbursement.

Direct access with direct reimbursement increases responsibility and, therefore, creates a possibility for increased work-related stress. Although an increase in stress is an important factor to consider, this study did not find a significant increase in work-related stress. Previous studies have identified fear
of malpractice and alienation from physicians as contributing factors to work-related stress.\textsuperscript{25,29} Along with the increased responsibility, however, the researchers suspect there will be an increase in job satisfaction. Possible reasons for the increase in job satisfaction are due to increased autonomy, increased respect as a health care team member, less paperwork, more effective and efficient treatments, and a better relationship between the patient and the physical therapist.\textsuperscript{25}

Limitations

Direct access with direct reimbursement is not common practice among physical therapy professionals at this time.\textsuperscript{25,27,29} Direct reimbursement is not
accessible in all states or reimbursed by all third-party payers. The limited amount of knowledge, experience, and the short duration of direct access with direct reimbursement created a less than expected return rate. Thirty-six of the returned surveys were not completely filled out due to limited knowledge or inadequate experience using direct access with direct reimbursement. This low return rate caused the results to be biased toward the 8 completed surveys.
In conclusion, this study had a less than expected return rate affecting the significance of the results. The handwritten comments stated by physical therapists were helpful in understanding why direct access with direct reimbursement was limited within physical therapy practice. Many of the physical therapists felt they have limited exposure to direct access with direct reimbursement, which is supported by previous research.\textsuperscript{25,27,29}

The survey indicated direct access with direct reimbursement has not been marketed to the consumers or professionals, limiting their knowledge of physical therapy services. This survey would be more valuable when sufficient experience is gained by physical therapists and active marketing strategies are in place to educate the public about their health care options. Only then will the effects of direct access with direct reimbursement be fully observed on physical therapy practice.
Section I: Professional Characteristics

Age: 
Gender: 
Entry-level physical therapy degree: 
Highest-level degree achieved: 
Number of years practicing as a physical therapist: 
Please list any specific certifications/licenses: 

Are you currently an APTA member? 
Yes No

Identify your primary work setting: (Please check one)
- Acute Care Hospital
- Rehabilitation Center
- Extended Care Facility
- Outpatient Clinic
- School/Preschool
- Home Health
- Academic Institution
- Other (please specify): 

Identify your primary position within that facility: (Please check one)
- Staff physical therapist
- Administrator
- Supervisor
- Owner

In your physical therapy career, how many years of experience do you have treating patients under direct access with direct reimbursement? years

---

Section II: Clientele Changes

*Within sections II, VI & VII, please refer to this key. 
SA = Strongly agree
A = Agree
N = Neutral
D = Disagree
SD = Strongly disagree

1) What percentage of your patient/client load is seen through direct access? 
What percentage of your patient load is seen through direct access with direct reimbursement? 

2) There is a high consumer demand for direct access to physical therapy services, when direct reimbursement is provided.

3) Direct access with direct reimbursement has increased my overall patient/client load.

4) For those patients/clients seen under direct access (DA) with direct reimbursement (DR), please estimate the percentage of patients seen in each category:

New patients with recurring diagnoses are 
% of the clientele I see under DA with DR.

New patients with new diagnoses are 
% of the clientele I see under DA with DR.

Previous patients with recurring diagnoses are 
% of the clientele I see under DA with DR.

Previous patients with new diagnoses are 
% of the clientele I see under DA with DR.

---

Section III: Marketing Strategies

1) Once direct access with direct reimbursement was approved, did your state physical therapy association implement any additional marketing strategies to educate the public about changes in physical therapy services? Please circle one:

Yes No

If additional strategies were implemented, please rank the top three strategies that were most effective in increasing the public’s use of direct access with direct reimbursement.

TV advertisements
Newspaper advertisements
Radio advertisements
Word of mouth
Public service announcements
Flyers
Other (please specify):

---

Section IV: Physical Therapist/Physician Relationships

1) There was (an) 
in physician referrals following direct access with direct reimbursement. Please circle one:

Increase Decrease No Change

Please explain your answer:

---

Section V: Insurance Changes

1) Did your fee schedule change following direct access with direct reimbursement? Please circle one:

Yes No Unknown

Please explain your answer:

---
Section VI: Direct Effects on Patient Care

1) Direct access with direct reimbursement has benefited patient care.
   Yes ☐ No ☐

If yes, please rank the top three which have been most beneficial:
   - Number of treatments required
   - Earlier intervention
   - Cost effectiveness
   - Better patient/therapist relationship
   Please describe:

2) Direct access with direct reimbursement is cost effective for my facility.
   SA = Strongly Agree    A = Agree
   N = Neutral    D = Disagree    SD = Strongly Disagree

   Please explain:

3) Which of the following prepared you for practice under direct access with direct reimbursement?
   Please rank the top three:
   - Entry-level degree
   - Continuing education
   - Certification
   - Work experience
   - Postgraduate course work
   - (i.e. Master or Doctorate)
   - Other (Please specify):

Section VII: Personal Affects on Physical Therapists

1) I noticed an increase in personal work related stress following direct access with direct reimbursement. Please circle one:
   Yes ☐ No ☐

If yes, please rank the top three:
   - Increased workload
   - Tension between yourself and physicians
   - Increased insurance problems
   - Adapting to new regulations/stipulations
   - Pressure for evidence-based research
   - Other (Please specify):

2) My job satisfaction increased following the implementation of direct reimbursement.
   SA = Strongly Agree    A = Agree
   N = Neutral    D = Disagree    SD = Strongly Disagree

3) I feel direct access with direct reimbursement has been of benefit to the physical therapy profession.
   SA = Strongly Agree    A = Agree
   N = Neutral    D = Disagree    SD = Strongly Disagree

Any additional comments regarding physical therapy practice with direct access covered by direct reimbursement are greatly appreciated:

Thank you for your time in completing this survey. Your input is extremely valuable to helping North Dakota physical therapists' transition towards autonomy.

Thank you.

How has Direct Access with Direct Reimbursement Affected Physical Therapy Practice?

The following is a survey regarding the effects of direct access with direct reimbursement on physical therapy practice. If you do not treat patients by means of direct access with direct reimbursement please disregard this survey and return it in the return envelope provided. Thank you.

Definitions:
- Direct Access: the ability to evaluate and treat patients without a physician's referral
- Direct Reimbursement: receiving payment from a third-party payer for physical therapy services performed without a physician referral.
APPENDIX B
REPORT OF ACTION: EXEMPT/EXPEDITED REVIEW
University of North Dakota Institutional Review Board

Date: 5/9/2003 Project Number: IRB-200305-243

Principal Investigator: Mabey, Renee; LaFreniere, Heather; Sauvageau, Katie

Department: Physical Therapy

Project Title: The Effects of Direct Access with Direct Reimbursement on Physical Therapy Practice

The above referenced project was reviewed by a designated member for the University's Institutional Review Board on May 9, 2003 and the following action was taken:

☐ Project approved. Expedited Review Category No. ______________________

☐ Next scheduled review must be before ______________________

☐ Copies of the attached consent form with the IRB approval stamp dated ____________________________________________ must be used in obtaining consent for this study.

☐ Project approved. Exempt Review Category No. ______________________

☐ This approval is valid until ______________________ as long as approved procedures are followed.

☐ No periodic review scheduled unless so stated in the Remarks Section.

☐ Copies of the attached consent form with the IRB approval stamp dated ____________________________________________ must be used in obtaining consent for this study.

☐ Minor modifications required. The required corrections/additions must be submitted to ORPD for review and approval. This study may NOT be started UNTIL final IRB approval has been received.

☐ Project approval deferred. This study may not be started until final IRB approval has been received.

REMARKS: Any adverse occurrences in the course of the research project must be reported immediately to the IRB Chairperson or ORPD.

Any changes in protocol or Consent Forms must receive IRB approval prior to being implemented. You must submit a memo with a copy of the Consent Form and a revised Human Subjects Review Form, with the appropriate signatures, to the Office of Research and Program Development for review and approval.

PLEASE NOTE: Requested revisions for student proposals MUST include adviser's signature. All revisions MUST be highlighted.

☒ Education Requirements Completed. (Project cannot be started until IRB education requirements are met.)

Waiver of a documental Consent is granted under 46.117(c)(2)

cc: Chair, Physical Therapy

Signature of Designated IRB Member
UND's Institutional Review Board

Date 5/9/03

If the proposed project (clinical medical) is to be part of a research activity funded by a Federal Agency, a special assurance statement or a completed 310 Form may be required. Contact ORPD to obtain the required documents.
APPENDIX C
Twenty of the returned surveys were filled out by physical therapists who did not practice under direct access with direct reimbursement. Although these surveys were unable to be used for data analysis, the additional hand-written comments provided by these respondents gave significant insight into the reasons why direct access and direct reimbursement is so sparingly used in physical therapy practice. The following questions pertain to physical therapy practice subsequent to implementation of direct access and direct reimbursement.

Were there changes in marketing strategies by your state association or facility?

- "(I) worked with Blue Cross Blue Shield to facilitate payment for direct access services."
- "Don’t know." (4 respondents)

Were there changes in the number of physician referrals?

- "All insurance reimbursement requires MD orders."
- "My facility always requires MD referral and now third-party payers won’t pay without an MD referral."
- "All insurance reimbursement requires MD orders."
- "Medicare requires MD orders."
- "In home care and sub-acute I don’t see patients by direct access; mostly Medicare, MHO, MA."
- "We had an increase in referrals following recent marketing activities but patients did see physicians to get referrals."
• “I work with disabled children in a multi-handicapped center.”
• “We don’t rely on physician referral in school setting.”

Were there changes in the relationship between physicians and physical therapists?

• “(Direct reimbursement is) not recognized by third-party payers.”
• “Third-party payers want MD referral so we just get one prior to seeing the patient.”
• “(I work) in a school setting.”
• “I don’t work in a direct access/direct reimbursement facility.”
• “(I) have not experienced (direct access with direct reimbursement).”
• “(I) don’t treat any (patients by direct access with direct reimbursement).”

Were there changes in fee schedules?

• “I’m not aware of fee schedule changes except for yearly increases.”
• “We only bill Medicaid for physical therapy with our students.”
• “Services are provided free to county residents.”

Is direct access with direct reimbursement cost effective for your facility or your patients?

• “Not allowed to use it.”
• “Does not apply to my facility.”
• “No experience with (direct access or direct reimbursement).”
• “We only bill Medicaid. Direct access hasn’t affected my facility.”

What prepared you for practicing under direct access and direct reimbursement?
• "Direct access was an integral part of my physical therapy education from the first."

• "Clinical during school."

• "Assistance/help from experienced co-workers."
REFERENCES


37. BCBS website