Van H. Wanggaard
Wisconsin State Senator

TESTIMONY ON SENATE BILL 453

Thank you, Madam Chair and committee members, for this hearing on Senate Bill 453. This is a bi-partisan bill that would save patients time and money by allowing physical therapists who are licensed in Wisconsin to order X-rays. The legislation is being brought forward by request from the Wisconsin Physical Therapy Association.

Physical therapists are entry level providers and in many cases, patients seek a physical therapist first after suffering an injury or impairment. In Wisconsin, patients have been able to see physical therapists without a referral from a physician or other provider (also known as direct access) since 1987.

Today, ordering X-rays is taught and tested in all six accredited physical therapy programs in Wisconsin and in all doctorate programs across the US. However, current Wisconsin law does not include physical therapists in the list of medical providers from whom a radiologic technologist may accept an order for an X-ray. This results in a legal conflict with physical therapists sending patients directly for X-rays.

Senate Bill 453 will provide clarity in two ways. First, by adding physical therapists to the list of providers whom a radiologist technician can receive an order from. Second, the bill explicitly allows physical therapists with specific training and education to order X-rays.

There are a number of limitations and safeguards in the bill to ensure quality care. The bill specifies that physical therapists can order X-rays, but not administer or interpret them. Images will still be reviewed by radiologists. Also, insurance billing would remain unchanged, and would still be done by radiologist technicians. The bill provides that the physical therapist must, when ordering X-rays, communicate with the patient's primary care physician or an appropriate health care provider to ensure coordination of care. Lastly, it is important to note that this is not a mandate. Hospitals would still be allowed to determine by their own boards whether to adopt this model.

Senate Bill 453 will save patients time and money, ensure prompt treatment and avoid needless referral to another medical provider. Again, thank you for hearing this important bill; I urge quick passage.

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February 3, 2016

Testimony on SB 453

Good afternoon Chair Vukmir and committee members. Thank you for allowing me the opportunity to testify today on SB 453 which gives physical therapists the ability to order x-rays.

Under this bill, a physical therapist may only order x-rays if they undergo extensive training outlined in the bill, This training includes obtaining a clinical doctorate degree in physical therapy, completing a nationally recognized specialty certification program, completing a nationally recognized residency or fellowship certified by an organization recognized by the examining board and completing a formal X−ray ordering training program with demonstrated physician involvement.

That is the key distinction in this bill – physical therapists will be added to the list of medical professionals who can ***order*** x-rays. Physical therapists will not be ***reading or interpreting*** the x-rays.

Patient safety is of the utmost importance and at the forefront of every caregiver's mind. This bill requires a physical therapist to communicate with the patient's primary care physician for appropriate coordination of care with limited exceptions that are outlined in the bill.

This is a sensible bill that will make it more convenient for physical therapy patients who may need an x-ray and may help reduce their health care costs. Instead of being referred back to another health care provider just to order an x-ray, a physical therapist would be able to order an x-ray under this bill, eliminating the extra time and money it would take to be referred back to another health care professional.

Again, thank you for holding a public hearing on Senate Bill 453. I would be happy to answer any questions you have on the bill.

http://docs.legis.wisconsin.gov/2015/proposals/ab549

WRS
Wisconsin Radiological Society

Wisconsin Medical Society

TO: Senate Committee on Health and Human Services
Senator Leah Vukmir, Chair

FROM: Tyler Prout, Wisconsin Radiological Society and Wisconsin Medical Society

DATE: February 3, 2016

RE: Opposition to Senate Bill 453

Good afternoon Senator Vukmir and committee members.

Thank you for the opportunity to testify on Senate Bill 453. My name is Tyler Prout. I am a board certified practicing radiologist who lives in Madison. I am an officer of the Wisconsin Radiological Society (WRS) and a member of the Wisconsin Medical Society. I am representing both of these societies today. I am also a member of the American College of Radiology. Together our Societies represent more than 12,000 physicians, residents and medical students and 774 physician radiologists in the state. In 2014, I also served as a member of the state's ad hoc advisory group of technical experts for the most recent revision of the Wisconsin administrative code, ch. DHS 157, on radiation protection.

Radiologists are physicians who supervise and interpret medical imaging studies such as x-rays, CT scans, MRI and ultrasound. As a valued consultant to physicians and other clinicians, we radiologists make diagnoses based on imaging findings to assistant in patients' management and treatment. As such, under SB 453, radiologists would be responsible for interpreting the medical images that physical therapists would be allowed to order.

As experts in imaging acquisition and interpretation, radiologists understand both the clinical and legal implications of this proposed legislation. Our concerns regarding SB 453 are not about competition nor are they about money. In fact, the bill could potentially have a positive financial impact on radiologists if physical therapists order a lot of x-rays. Instead, our concerns are based solely on patient care and systemic issues.

That said, radiologists and other physicians recognize and appreciate that physical therapists are well trained and perform a crucial role in helping patients recover from surgery, injury and common ailments. Physicians, radiologists included, highly value the skills and services provided by physical therapists. They are highly valued members of the health care delivery team – critical for the delivery of high quality patient care.

Currently, when a physical therapist wants to order an x-ray, the patient must first go to their physician for a comprehensive medical exam or receive an order from an allowed provider (MD, PA or NP).

The initial patient visit with a physician is important, because it allows the physician to gather the necessary information about the patient's health history, consider other diagnoses, and determine the best course of treatment. This approach allows for a consideration of a myriad of diagnostic possibilities in the context of the full medical review, while minimizing patient risk.

SB 453 would allow a patient to completely bypass their primary care doctor, since as it is drafted, the bill does not require strict supervision and collaboration with a physician. This is concerning because significant medical conditions detected by x-rays may lie outside of the education and scope of practice of physical therapists. As a result, a patient may not be appropriately referred to another health care provider or important findings could fail to be followed up in a timely manner or at all in the absence of physician supervision.

When patients are seen by similar mid-level providers such as PAs or nurse practitioners, the State Legislature has built in safeguards for patients in obligating either supervisory or collaborative relationships with physicians. Such relationships are not required for physical therapists. So, episodes of care that bypass that first comprehensive patient evaluation will be done without the guidance of a primary care physician. WRS and WMS is concerned that significant medical conditions detectable via x-rays that lie outside of the education and scope of practice of physical therapists may not be appropriately referred or managed by physical therapists in the absence of physician supervision. While some physical therapists practicing in an academic environment may have appropriate policies and relationships with physicians to allow referral of the patient to appropriate care, many physical therapists are not affiliated with such institutions or policy, and the management of such findings is outside the scope of their training. Failure of the physical therapist to act on a finding described in a report by a radiologist could lead to unnecessarily delayed treatment and adverse patient outcomes, as well as liability to the radiologist.

Here are some examples.

You go to the physical therapist for back pain. PT orders lumbar spine x-rays. The result: There is some disk degeneration and arthritis, as is commonly seen, that may or may not matter. Much to all of our chagrin, probably each of you on this committee and myself included will show some degenerative disk disease or arthritis on that x-ray. But most of those findings are not symptomatic. The key is weeding out what findings are significant. But in this example, your pain is actually coming from a kidney stone trying to pass. This is a very common occurrence. Entertaining that possibility is not typically in a PT's training, so many important differential diagnostic possibilities will not be entertained. A physician, though, is more likely to have thought of this possibility and ordered a urinalysis looking for blood in the urine, and ordered the more appropriate scan to confirm the diagnosis. In the meantime, my report to the PT describes your disk disease, which will probably be the main focus of the physical therapist.

Similarly not all back or neck pain may be musculoskeletal in etiology. There may be more sinister or life threatening causes including multiple myeloma (a cancer of white blood cells) or infection. Some of us may have learned of a tragic case recently publicized in the WSJ about an active, healthy farmer and runner who developed a fatal staph infection with subsequent sepsis that presented initially as back pain. In this instance, according to the article, there may have been a delay in diagnosis which may be a difficult early diagnosis to make even for a physician who has all necessary tests and labs at his/her disposal not to mention clinical acumen. His illness from presentation to death was ten days. The point here is that to think that the probability for a physical therapist, who cannot order the appropriate lab tests, is equal to that of a physician to arrive at this diagnosis in a timely fashion is highly unlikely.

Furthermore, most would agree that detecting early signs and symptoms of sepsis is generally beyond the scope of a PT's training,

An additional concern is that x-rays may reveal incidental, but significant disease totally unrelated to the pathology that the PT is focused. The PT may be unfamiliar with the pathology and its appropriate management. Consequently, such problems may go unaddressed or be lost due to communication problems, particularly when the patient does not have a primary care physician and accesses care without establishing a relationship with a physician or physician-supervised provider. Examples include a pulmonary nodule, unexpected bone tumor, an aortic aneurysm seen on a spine x-ray, or a manifestation of a broader systemic illness such as kidney failure manifest as its effect on the bone.

Let's use the scenario of a lung nodule. A nodule – possible lung cancer – is seen on your shoulder x-ray. The radiologist reports this and the need for further evaluation such as a CT scan. While in most situations, particularly in the centers of excellence such as at the University of Wisconsin Hospital where there is comprehensive structure and vertically integrated pathways, the PT will appropriately, and is obligated to, refer to another health care team member.

However, the model at UW is not necessarily the model throughout the state. Smaller or unaffiliated PT practices may not have the proper mechanisms to communicate a referral to an unknown physician, particularly since the bill does not mandate supervision or at the very least collaboration. Furthermore, the PT's do not have a malpractice insurance requirement, which then shifts the focus of any lawsuits to the interpreting radiologist who rendered an accurate report. This is significant because case law has made it clear that radiologists are obligated to communicate to patients even though there may not be a direct known relationship. So even though the radiologist rendered an accurate report, they can be and have been successfully sued for failure to communicate.

There is another potentially significant concern. A large proportion of patients treated by physical therapists are Medicare patients. I have been advised that CMS currently does not pay for x-rays ordered by the vast majority of physical therapists. Only a small subset of ECS qualified therapists that don't usually practice in the situations described by the WPT are eligible for reimbursement by CMS. What does this mean? Patients will assume their x-ray study is paid for by Medicare like most other scenarios. As a result, patients will be caught off guard when they are on the hook for that expense. Notably, the charge for the x-rays the senior will receive will likely be higher than the discounted Medicare rate, because the general practice for uncovered services is to charge the facility "rack rate". Our seniors will not appreciate that obligation for what is usually a significantly higher charge.

While one solution would be to require patients be informed of this scenario, this puts the patients in an undesirable, awkward position to refuse a PT's recommended test that otherwise would have been paid for if they saw their physician first. One potential solution would be the use of an advanced beneficiary notice, an example of which is provided. To get the x-rays and have them rightfully paid for, the patient would have to reestablish an appointment with a physician after the fact, causing delay and patient inconvenience.

The patient care concerns that result from the lack of a supervision or collaborative requirement, along with the Medicare non-payment issues create practical barriers to implementing this bill as proposed. Without a strict requirement that PTs coordinate with physicians, SB 453 poses significant patient safety and liability concerns. Any poor outcomes and/or missed and delayed diagnosis would be a disservice to patients and negate any savings anticipated by skipping visits to physician's offices.

The Wisconsin Medical Society and Wisconsin Radiological Society encourage the Committee to consider statutory requirements for physician supervision if a PT desires to order an x-ray. If the Legislature decides to elevate the physical therapist's practice status, it may wish to require that PTs carry malpractice coverage. If the State Legislature wishes to advance this bill, additional scrutiny of the training required for ordering x-rays would also need to be reviewed. In addition, to address the CMS issue raised you may want to include an informed consent provision which would clearly disclose to Medicare patients that they would be obligated to pay the cost of x-rays that are ordered independently by a physical therapist. However, this would not obviate the inconvenience of having the patient pay out of pocket or have to make a return visit to the doctor in order to have the x-ray paid for.

Thank you for this opportunity to share our concerns.

Good Morning Mr. /Madam Chairman and honorable senate members;

Thank you for the opportunity to present on behalf of my profession in support of the legislation allowing the physical therapists to request/order radiology services, specifically x-rays, for our patients.

I have been a practicing physical therapist since 1973 and have served on active duty in Uniform in the US Navy and the US Public Health Service since 1987 as a credentialed and privileged physical therapist provider. I have a Bachelor's in Physical Therapy, a couple of master's degrees not related to PT; one in administration and management and the other in national security and strategic studies which afforded me the additional naval credentialing of health care administration as well. Also I have a Doctorate in Physical Therapy.

In the Navy the PT's with demonstrated competency in radiology for physical therapists have been privileged to order appropriate studies that are reviewed and interpreted by the Radiologists.

In the military, the physical therapists are considered the musculoskeletal specialists and with the direct access to care, we are able to provide timely evidenced based care to our patients. After a thorough clinical examination for their complaints and the full review of systems, if clinically indicated we order the x-rays and also if indicated we request specialty consultations like orthopaedics, neurology, neurosurgery etc. so the patient receives appropriate specialty care in a timely manner without having to go through various barriers or a shuffle back and forth to the primary care providers who are already over worked and overbooked. Such a practice has helped relieve the Primary Care providers to take care of patient's health and wellness, urgent systemic or medical conditions and other sicknesses in a timely manner.

In the military we manage musculoskeletal injuries straight from training, sports, and work places. I personally have been able to provide immediate evidence based definitive care for sprains and strains etc. with excellent outcomes to get our service members back to their training or work (yes that can be the battlefield) in an expedited manner. That said, we are able to refer to specialty care without delay if the diagnostic studies were noted positive for fracture etc. Once for a patient with neck pain upon requesting the x-rays we found a Thyroid tumor so the patient was referred to Endocrinology expeditiously with a positive outcome. Also in another case, a young midshipman injured his neck during rugby practice and after a thorough history and examination I ordered X-rays, consulted with neurosurgery and referred him to neurosurgery for an acute disc herniation. He underwent surgery within a week thus preventing any long term impairments and that Midshipman graduated this year (2015) and was commissioned as an Ensign in the Navy. I can cite numerous examples of other patients that I have encountered over the years.

Thank you again for the opportunity to present my experience on behalf of my profession. I am open to any questions you might have at this time.

Good Afternoon, my name is Julie Sherry. I have been a licensed physical therapist in the State of Wisconsin and employed as such within the UW hospital and clinics orthopedic spine clinic for the past 20 years. Within those 20 years, I have the treated patients both in and outside of the confines of being able to order x-rays. I took time away from a busy clinic schedule today because I think it is so important to share with you my "in the trenches" perspective about how x-ray privileges are used by physical therapists. I hope my REAL patient care examples provide you a reason to pass Assembly Bill 549.

In my part-time practice, I see approximately 300 new patients each year. These patients span in age from 6 to 96 years old, with complaints ranging from acute whiplash (that was the 6 year old; his parents brought him up from IL to seek care at the UW hospital) to degenerative osteoporotic mid back pain to acute low back pain in a local high school soccer player. During each patient initial evaluation, I use medically-substantiated radiology prediction rules to guide my clinical decision making. I use those radiology practice guideline and determine that a large majority of these patients do not need x-rays ordered by me. In fact, over the 5 years when the UW hospital board was allowing PTs to order x-rays; I did so less than ten times. That is 10 patients out of 1500. That is 0.6% of the time.

In some cases, however, my ability to order x-rays on the spot assists me in helping the patient get the best, most cost effective and efficient care possible. With that said, I'd like to share 2 patient care examples. The first one happened in 2009- the story of a patient that I evaluated while x-rays ordering was within my domain; the second – well it that just happened between Christmas and New Years 2015.

My first example is of a 16 year old boy that came to me through direct access to PT services in the late Spring 2009. Let's call him Noah. I knew Noah and his family from two years prior. When Noah was a freshman, he was diagnosed with a bilateral stress fracture of the lowest vertebrae in his spine. This type of injury is quite common in athletic boys just finishing a growth spurt. Over half of the time, these fractures do no heal. I treated Noah for a few sessions back in 2007, giving him exercises and moral support that even though the stress fractures were deemed "non-union", ...there was a gap between to front and the back of his vertebrae.

Because his back pain was improved, the Sports MD gave him clearance to return to his Freshman season. Noah played competitive soccer for more than two years. Unfortunately, at his high school team's Regional final game his junior year, Noah got slide- tackled and had a return of his intense sharp lower back pain. His muscles spasmed. He, and his parents, were told to rest and hope that the symptoms would subside by the following week so that he could participate in the sectional game. They decided to come and see me.

I saw Noah 3 days after his injury. His history and clinical exam pointed to the possibility that his pre-existing injury may have worsened and that the impact from the slide-tackle had now caused that that lower bone to shift forward, a sometime

serious and surgically indicated condition called spondylolisthesis. This condition that would waylay his ability to get back on the field. More importantly, as the person "in the trenches" trying to get Noah back on the field, I needed to know about the extent of this forward slippage to determine what treatments I could safely provide. I wanted to be as aggressive as possible in my treatment techniques but knew I needed to screen, with x-ray, for this condition. So, I did.

You want to know what happened? The x-ray looked normal; and since I had that added piece of information, I proceeded with appropriately aggressive joint and soft tissue mobilization. Noah missed playing in that first sectional game, but his team made it to the State tournament, and so did he. Pretty straight forward; if I hadn't been able to order that x-ray right there on the spot, his care would have been delayed, his family likely would have had to pay extra office surcharges to see urgent care or his pediatrician. That, I think, is a good example of how a PTs utilize x-ray privileges in the State of Wisconsin. That, I hope, is how health care in the 21st century should work.

On the other hand, in my present day clinical practice, I cannot order x-rays. I'd like to share a second example of when things don't work out so well. I met Jane (let's call her Jane about 6 weeks ago. Jane is a woman in her late 60's that got tripped up in a dog leash and fell on Thanksgiving while walking with her daughter. Jane first went to urgent care and was told to put ice on it and was given pain medication. Her very low low back (tailbone, really) pain got worse as the weekend went by. On Monday she called her primary doctor and was seen a few days later. AP and lateral x-rays of her pelvis were done and read as normal. She was advised to rest and continue to use pain medication as necessary. Two weeks later, she called her doctor's office to report the pain was no better. They placed an order for physical therapy.

When I met Jane, she was about 1 month out from her injury. She was walking with a decided limp. Her clinical exam revealed bony tenderness to the left side of the sacrum bone, and distinct buttock pain with movements that loaded the sacroiliac joint on that side. Within the hospital system, I had the ability to review the x-rays that were done a few weeks previously and noticed that the views that were done might not have been the best x-ray angulation view to view the sacroiliac joint. I was concerned that perhaps given the timing of the first x-rays, or the angulation of them, that there was a bony insult. I had a duty to refer. I called the referring MD office. I actually placed 2 different phone calls and was not able to get immediate response from the MD office. Later in the day, I got pulled away from treatment of another patient to field a conversation with the doctor's nurse, in order to request the exact x-ray view I thought needed to be done. I had to SPELL the name of the x-ray angulation view, as the nurse from the primary care office (her primary care MD is a gynecologist) was unfamiliar with it. This took 18 hours to get everything in place. Jane had to go home with my advice to either go back to urgent care and specifically request a Ferguson view x-ray, or use crutches and wait for me to get an answer from the MD office. She chose the latter- and because of the delay in getting

the x-ray, had to sleep another night without really knowing what was going on. She was frustrated, because of the delayed response that is inherent to the system of health care that we live in.

You want to know what happened to Jane? A small fracture was found, at the very bottom of her left sacrum bone. But, thankfully- her pain is improving with the correct treatment- rest and limited weight bearing for the time being.

In summary, I hope that my statement provides you with a better understanding of how Physical Therapists use x-rays strictly within the confines of our practice act which specifically states that PTs have the duty to refer if there is suspicion of soft tissue avulsion or fracture. It assists our ability to safely and appropriately provide on-the-spot care.

Thank you