Position on Physician-Owned Physical Therapy Services (POPTS)

January 2005

An American Physical Therapy Association White Paper

Position on Physician-Owned Physical Therapy Services (POPTS)

January 2005

Introduction

Physical therapy referral for profit describes a financial relationship in which a physician, podiatrist, or dentist refers a patient for physical therapy treatment and gains financially from the referral. A physician can achieve financial gains from referral by (a) having total or partial ownership of a physical therapy practice, (b) directly employing physical therapists, or (c) contracting with physical therapists. The most common form of referral for profit relationship in physical therapy is the physician-owned physical therapy service, known by the acronym "POPTS." The problem of physician ownership of physical therapy services was first identified by the physical therapy profession in the journal *Physical Therapy* in 1976.[1] While POPTS relationships were still limited in number in 1982, Charles Magistro, former APTA President, characterized POPTS as, "a cancer eating away at the ethical, moral and financial fiber of our profession."[2]

For many years, the American Physical Therapy Association (APTA) has opposed referral for profit and physician ownership of physical therapy services, taking the position that such arrangements pose an inherent conflict of interest impeding both the autonomous practice of the physical therapist and the fiduciary relationship between the therapist and patient. What became known as "the POPTS issue" was addressed by APTA's House of Delegates in 1983, 1985, and 1999, with APTA specifically opposing referral for profit arrangements between physicians and physical therapists.[3,4,5] The 2003 APTA House of Delegates once more resolved to develop state and federal legislative initiatives to achieve legal prohibition of POPTS.[6] However, in recent years, facing pressures of decreasing revenues and increased costs of malpractice insurance premiums, and aided by weakening of federal antitrust legislation, physicians have accelerated the addition of POPTS to their practice. APTA's push to achieve autonomous practice and direct access are in conflict with the medical profession's renewed push to subsume physical therapy as an ancillary service for financial gain.

At the center of the clash between these two opposing forces are two questions: First, should one profession be able to claim financial control over another? Second, what are the real and potential consequences of referral-for-profit relationships and, more specifically, POPTS? Physical therapists must be unified in their vision of physical therapy as a profession, accepting the rights and responsibilities that come with such a designation. Only when members of the profession view themselves as autonomous professionals will they present themselves to consumers and the medical community as such and curtail their own participation in referral-for-profit relationships, including POPTS. Within physical therapy practice and the broader medical community, there must be renewed examination of the ethical and legal consequences of referral-for-profit relationships, and a push to strengthen legislative and regulatory prohibitions of such relationships.

Evolution of Physical Therapy as an Autonomous Profession

A profession commonly is defined as an occupation, the practice of which influences human well being and requires mastery of a complex body of knowledge and specialized skills, requiring both formal education and practical experience.[7] Other elements of a profession include responsibility for keeping and advancing a body of knowledge; setting credible, useful standards; and self-governance.

In less than 80 years, the physical therapy profession evolved from a small group of women providing physical therapy to World War I soldiers and veterans to more than 110,000 men and women licensed as physical therapists and assistants, more than 66,000 of whom are represented by its professional organization, APTA. Physical therapists formed their first professional association in 1921. By the end of the 1940s, the APTA established its policy-making body, the House of Delegates.

As the Association further formalized its professional identity, the House of Delegates approved the Association's Code of Ethics in 1935, articulating principles for the ethical practice of physical therapy. The APTA Judicial Committee (now the Ethics and Judicial Committee) in 1981 adopted the Guide for Professional Conduct, which interprets the Code of Ethics. APTA further described the profession with the publication of *Guide to Physical Therapist Practice*,[8] representing a "framework for describing and implementing practice."[9]

In 1977, the Association assumed independent control for establishing educational standards through the Committee on Accreditation in Education (CAE), the forerunner of the Commission on Accreditation in Physical Therapy Education (CAPTE). As the profession expanded the scope of its services and the clients it served, physical therapy education programs also evolved, growing in depth and length from certificate programs to bachelor's and master's degrees. By 2007, 80 percent of all entry-level physical therapist education programs will be at the doctoral level, reflecting APTA's Vision 2020 Statement, "By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy."[10]

Simultaneous with the profession's development of rigorous educational standards, a successful movement for licensure as autonomous practitioners was mounted. State licensure eventually replaced a "registry" that had been controlled by a physician board, culminating in physical therapist licensure in all 50 states.

For 25 years, the profession has demonstrated its commitment to establishing a unique and complex body of knowledge through the work of the Foundation for Physical Therapy. The Foundation has funded research that supports the development of evidence-based physical therapist practice, awarding more than $10 million in grants and scholarships to hundreds of researchers.

Physical Therapist: Professional Practice Owner or Employee?

Clearly, physical therapy meets the definitions of profession. As such, physical therapists should enjoy the legal protections accorded other professionals. In many states, professionals may not practice as agents of corporations except those formed as professional corporations,

in which all owners must be licensed to practice one profession. By adopting such laws states have prevented the inherent conflict that exists when one profession refers to another within the corporation for financial gain.

Historically, physical therapists were employed most frequently by hospitals, or other health care institutions. Ideally, as health care delivery evolves into other business models, physical therapists will seek business arrangements allowing control of the practice to be held by physical therapists, operating as independent or autonomous professionals. However, because physicians still largely control referrals for physical therapy, many physical therapists elect to become employees of physician professional corporations. A 2004 APTA survey on POPTS reported that more than 80 percent of the responding therapists encountered situations in which physicians retained patients within their own practices, rather than referring patients to other physical therapy providers.[11]

Real and Potential Effects of POPTS on Consumers

Conflict of Interest. Once a physical therapist is employed by a physician or physician group, a conflict of interest exists, in which the best interests of the patient or client may be compromised for financial gain by the physician owner. Having a financial interest in other services to which a physician refers a client may cloud the physician's judgment as to the need for the referral, as well as the length of treatment required. Similarly, the physical therapist employed by a physician may face pressure to evaluate and treat all patients referred by the physician, without regard to the patient's needs. The consumer is likely unaware of any conflict of interest, assuming no conflict of interest exists when the service is provided within the physician's office. Physician associations have argued that self-referral to a physician-employed physical therapist is not a conflict of interest by labeling physical therapy as an "ancillary service,", one provided "incident to" physician practice. However, the suggestion that physical therapy is not a separate profession is clearly wrong.

Loss of Consumer Choice. In addition to inherent conflicts of interest that exist within POPTS, physician referral to services within his/her office, or to those with whom he/she may have a financial interest, limits the consumer's right to choose his/her physical therapist. The consumer may not recognize this loss of choice, as no other option is offered. Observation of the fiduciary responsibility between physician and patient is vital to preserving both consumer choice and the autonomous practice of the physical therapist.

Economic and Financial Harm. The harm done by POPTS is not merely a matter of principle or abstract ethics. Health policy researchers have provided data demonstrating specific harms from conflict of interest in physical therapy referrals. Studies have demonstrated that POPTS arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists. In a study examining costs and rates of use in the California Workers' Compensation system, Swedlow et al reported that physical therapy was initiated 2.3 times more often by the physicians in self-referral relationships than by those referring to independent practices.[12] In a subsequent symposium address by two of the study's authors, Johnson and Swedlow noted that physical therapy accounted for an estimated $575 million per year in California workers' compensation costs. Furthermore, they concluded that the

"phenomenon" of self-referral or POPTS "generates approximately $233 million per year in services delivered for economic rather than clinical reasons."[13]

In a study appearing in the *Journal of the American Medical Association*, Mitchell and Scott documented higher utilization rates and higher costs associated with services provided in POPTS (referred to as joint venture clinics) in the state of Florida.[14] The study revealed greater utilization of physical therapy services by the joint venture clinics, rendering on average about 50 percent more visits per year than their counterparts. It also concluded that visits per physical therapy patient were 39 percent higher in joint venture clinics.[14(p2057)] Joint venture clinics also generated almost 32 percent more net revenue per patient than their counterparts.

Rationale for Opposition to POPTS

Ethical Prohibitions. APTA and the American Medical Association actually agree on the fundamental principle of conflict of interest. The APTA Code of Ethics[15] and Guide for Professional Conduct [16] require that a physical therapist shall seek only such remuneration as is deserved and reasonable for physical therapy services (Principle 7). The Guide contains specific prohibitions against placing one's own financial interest above the welfare of individuals under his/her care (7.1.B), as well as overutilization of services (7.1.D). The Guide also requires physical therapists to disclose to patients/clients if the referring physician derives compensation from the provision of physical therapy (7.3). The AMA, like APTA, rejects the conflict of interest inherent in referral for profit. The AMA Council on Ethics and Judicial Affairs (CEJA) has said that, "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients,"[17] and that, "physicians should not refer patients to a health care facility which is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility."[18] The latter statement could be interpreted to prohibit referral to physical therapy practices in which a physician has an investment interest when he/she does not directly provide care or services to the referred patient.

Legal and Regulatory Prohibitions. Real and potential conflicts of interest among physicians with financial interests in entities to which they refer were recognized by members of Congress in the 1980s. The correlation between financial ties and increased utilization was the impetus for Congress to enact the "Stark I" law in 1989,[19] preventing Medicare from paying for clinical laboratory services if the referring physician had a financial interest in the facility. In 1993, Congress enacted the "Stark II" law, which expanded the list of services to which the laws applies to include physical therapy services[20] Specifically, the law states that if a physician or a member of a physician's immediate family has a financial relationship with a health care entity, the physician may not make referrals to that entity for the furnishing of designated health services (including physical therapy services) under the Medicare program, unless an exception applies. After the law was enacted, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) issued final regulations implementing the law on January 4, 2001.[21] Unfortunately, bowing to physician interests, the agency wrote rules that enable physicians to structure their practices in order to furnish physical therapy in their offices (so-called "incident to" services discussed previously) without violating the law.

Conclusion

Recognizing the incongruity of POPTS and APTA's Vision 2020 that embraces the autonomous practice of doctorally prepared professionals, the inherent conflicts of interest existing within POPTS, the loss of the patient/client's right to choice of provider, and the increased cost to society identified resulting from POPTS, the American Physical Therapy Association reaffirms its decades-long position of opposition to physician-owned physical therapy services. APTA supports legislative and regulatory measures at the state and federal levels to ban physician ownership of physical therapy services. These efforts include sponsoring efforts to strengthen state practice acts to prohibit POPTS—and gaining direct access to Medicare patients.

---

[1] Hiltz DL. Hiring of physical therapists. [Letter to the editor]. *Phys Ther.*1976;56(9):1061.
[2] Magistro CM. Physician-Physical Therapist Financial Arrangements. Read at Combined Sections Meeting of the American Physical Therapy Association, San Diego, Calif. February 14-17, 1982.
[3] Report of the House of Delegates session. *Phys Ther*. 1983;63(11):1810.
[4] '99 House issues strong statements. *PT—Magazine of Physical Therapy*. 1999;7(9):82.
[5] *Progress Report*. 1985;14(7):5.
[6] Opposition to physician ownership of physical therapy services reaffirmed. *PT—Magazine of Physical Therapy*. 2003;11(9):64.
[7] The Online Ethics Center for Engineering and Science at Case Western Reserve University. Available at http://onlineethics.org/glossary.html. Accessed July 23, 2004.
[8] Guide to Physical Therapist Practice. Phys Ther. 1997;77:1163-1650.
[9] Rothstein J. On the second edition of the guide, *Phys Ther.* 2001;81(1):6-8.
[10] APTA House of Delegates. APTA Vision Sentence for Physical Therapy 2020 and APTA Vision Statement for Physical Therapy 2020 (HOD 06-00-24-35). American Physical Therapy Association. 2000. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/GOALS_AND_MISSION/HOD_06002435. Accessed January 7, 2005.
[11] Unpublished results of APTA member survey on the impact of physician ownership of physical therapy services. September 2004.
[12] Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California workers' compensation system as a result of self-referral by physicians. *NEJM.*1992;327:1502-1506.
[13] Johnson G, Swedlow A. Medical referral-for-profit in California workers' compensation. Unpublished addendum to the authors' 1992 article, based on course notes from their presentation of findings at a physical therapy symposium. January 1992.
[14] Mitchell JM, Scott E. Physician ownership of physical therapy services. *JAMA*. 1992;268:2055-2059.
[15] APTA House of Delegates. Code of Ethics (HOD 06-00-12-23). American Physical Therapy Association. 2000. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/ETHICS/HOD_06001223. Accessed January 7, 2005.
[16] APTA Ethics and Judicial Committee. Guide for Professional Conduct. American Physical Therapy Association. 2001. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_4/GUIDEFORPROCONDUCT. Accessed January 7, 2005.
[17] AMA Council on Ethics and Judicial Affairs. Current Opinions. American Medical Association. Available at http://www.ama_assn.org/ama/pub/category/2498.html. Accessed November 23, 2003.
[18] American Medical Association Council on Ethics and Judicial Affairs. Current Opinions E-8.03 Conflicts of Interest: Guidelines and E08.02 Conflicts of Interest: Health Facility Ownership by a physician. Available at http://www.ama-assn.org/ama/pub/category/2498.html. Accessed November 23, 2003.
[19] Omnibus Budget Reconciliation Act of 1989, Pub L No. 101-329, Section 6204.
[20] Omnibus Budget Reconciliation Act of 1993, Pub L No. 103-66, Section 13562.
[21] 66 *FR* 855 (Jan 4, 2001) (codified at 42 CFR Parts 411 and 424).

American Physical Therapy Association
The Science of Healing. The Art of Caring.℠
www.apta.org