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Physical Therapy Association of Washington

Response to Washington State Chiropractic Association Paper: “On the Question of an Expansion of the Scope of Practice of Physical Therapists in Washington to Include Grade 5 Mobilizations and Manipulations of the Spine”

December 2009

EXECUTIVE SUMMARY

Last month, the Washington State Chiropractic Association (WSCA) put forward their paper entitled “*On the Question of an Expansion of the Scope of Practice of Physical Therapists in Washington to Include Grade 5 Mobilizations and Manipulations of the Spine*” to the Physical Therapy Association of Washington (PTWA). At the request of WSCA, we (PTWA) reviewed their paper. After defining and describing the listed concerns, WSCA offered their acceptable threshold recommendations in exchange for being neutral on PTWA’s current bill seeking to remove the prohibition language on spinal manipulation from the physical therapy practice act.

After carefully reviewing their purported concerns, we believe the WSCA paper lacks a valid foundation and projects a misinformed and biased viewpoint. Because the WSCA critique is based on the chiropractic analysis of physical therapist practice, this PTWA document wishes to clarify and validate the anecdotal inaccuracies and misconceptions about physical therapist practice expressed by WSCA.

In summary, this paper will refute the WSCA paper with the following statements from the physical therapy perspective:

- The three physical therapy schools in Washington (University of Washington, Eastern Washington University, and University of Puget Sound) safely and effectively teach spinal manipulation to their students. There is no arbitrary number of hours; instead, students must demonstrate safety, skill, and clinical decision making to assure competence.
- Physical therapists and chiropractors define “manipulation” differently and use the technique for different reasons within their respective treatment philosophies.
- Physical therapy law permitted the practice of spinal manipulation prior to 1983 and physical therapists currently practice manual therapy, including mobilization of the spine, within the confines of the current practice act.
- Since the 1960s, physical therapists have researched and developed a wide body of knowledge in spinal manipulation.
- Manipulation provided by physical therapists does not place the public at risk for injury.
- There is no evidence of any agreement between PTWA and WSCA to never seek legislation removing the spinal manipulation prohibition.

Based on the reasoning within their paper, we disagree with WSCA’s interpretation and threshold recommendations. There are many definition statements and practice philosophies projected by WSCA that are not applicable to or reflective of the practice of physical therapy. Also, overlapping scopes of practice are a reality and therefore it’s not reasonable to expect any profession to have a completely unique scope of practice, exclusive of all others. Healthcare education and the practices of physical therapists and chiropractors have developed in such a way that some skills or procedures are similar, but have very different applications in practice based on the training within their respective profession.

The physical therapy scope of practice in the State of Washington should reflect the evolution of competencies of the profession as well as the relationship of education, training, evidence regarding the public benefit and the capacity of the Board of Physical Therapy to effectively manage practice. Unlike WSCA, we feel with the evolution of physical therapist practice, there is strong evidence in the arenas of competency and benefits to the public that supports striking the prohibition language on spinal manipulation from the physical therapy practice act.

The following clarifications and relevant validations are provided, referenced and listed below. In addition, the Appendix at the end of this paper offers further information and corrections to WSCA regarding our discussion of physical therapy state practice acts. Please note: Section titles from the WSCA paper are in bold and referenced by page number.

PROLOGUE p. 1

WSCA paper:

“Grade 5 mobilization and manipulation is the terminology preferred in the physical therapy field to reflect the introduction of a high velocity, low amplitude thrust designed to take a given articulation beyond the passive range of motion into what is referred to as the “para-physiologic zone” usually resulting in joint cavitation (popping)...This is also the type of procedure that in chiropractic circles is referred to as an adjustment or manipulation. In addition there is a conceptual difference between physical therapy concepts and chiropractic concepts with respect to the degree and extent of neurologic implications to the procedure.”

PTWA response:

This is not the physical therapy definition of grade V mobilization and manipulation. This is a chiropractic definition. The physical therapy profession doesn't advocate or use the term “para-physiologic zone” nor perform chiropractic spinal adjustments to treat a vertebral subluxation or to influence neurophysiologic function. Physical therapists don't manipulate a joint beyond the normal physiologic range of motion.

The APTA Guide to Physical Therapist Practice defines manual therapy techniques as: skilled hand movements intended to improve tissue extensibility, increase range of motion, induce relaxation, mobilize or manipulate soft tissues and joints, modulate pain, and reduce soft tissue swelling, inflammation, or restriction.¹ This intervention is part of the patient/client overall plan of care. It is not a stand-alone treatment or philosophy of care.¹ Mobilization/Manipulation is defined as: a manual therapy technique comprising a continuum of skilled passive movements to the joints and/or related soft tissues that are applied at varying speeds and amplitudes, including a small amplitude/high velocity therapeutic movement.¹ The APTA Manipulation Education Manual defines Thrust Joint Manipulation as: a high velocity, low amplitude therapeutic movement within or at the end of range of motion.² In physical therapy, it is the speed of application of the force that distinguishes a thrust from a non-thrust manipulation technique and all mobilization/manipulation techniques are to be practiced on a continuum of skilled passive movements based on the ongoing assessment of the patient/client response dictating whether or not further progressions are indicated to accomplish the therapeutic goals of restoration of motion and reduction of pain as part of an overall rehabilitation plan of care.¹

Joint cavitation or audible popping is irrelevant to achieving therapeutic effects or desired outcomes.^{3,4} Also, this noise and experience happens normally in individuals during self-movement when stretching or exercising and therefore is not a valid parameter for defining regulatory practices.

The Federation of Chiropractic Licensing Boards (FCLB) published a paper describing the minimum criteria for performing high velocity low amplitude (HVLA) procedures.⁵ The authors state the purpose of manual methods (including HVLA procedures) is to resolve “functional disorders classically

described including the terms subluxation, subluxation complex, or nonallopathic lesion.”⁵ The law describing chiropractic in Washington state (RCW 18.25) doesn’t include the term or define Grade V mobilization or spinal manipulation, rather it defines chiropractic treatment as “the use of procedures involving spinal adjustments” for the “treatment of the vertebral subluxation complex and its effects.”⁶

Using the term ‘manipulation’ as a synonym for ‘adjustment’ in this document is misleading, because the two professions define the term manipulation differently and use the technique for different reasons and differing treatment philosophies. According to Minken, et al in their clinical practice guideline on manipulation terminology states: “...the clinicians and lay practitioners who historically have used, and now use, manipulations have continued to use a broad array of descriptive terminology, congruent with their wide variety of theoretical constructs and schema. This has rendered meaningful discussion on manipulative techniques nearly impossible.”⁷

HISTORICAL PERSPECTIVES: THE EVOLUTION OF MANIPULATIVE CARE p. 1-2

WSCA paper:

“For over twenty years there has been a détente in Washington between chiropractic profession and the physical therapy profession with respect to certain elements of practice that are provided by one group or another. The chiropractic profession provides the overwhelming majority of spinal adjusting or manipulation in Washington. Professionally the chiropractic community has not sought an expansion of scope of practice to include the use of physical modalities such as galvanic current, therapeutic ultrasound and similar procedures in return for the physical therapy profession not seeking a scope of practice expansion to include grade 5 mobilizations and manipulation. This historic agreement certainly did include elements of “turf” but there were also logical clinical reasons why both professions were served by the agreement. The present situation seeks to alter this agreement...”

PTWA response:

PTWA has no evidence that such an agreement was made between the two associations in 1983 when the physical therapy act was amended. The PT association agreed to add the prohibition on spinal manipulation at the request of the chiropractic association, because at the time the evidence was not overwhelmingly supportive for providing this technique and direct patient access (without referral) was the critical issue. It was always the intent of the PT association to strike the prohibition language from statute when clear supporting evidence was available. In fact, both associations met in 1999 to discuss this topic of removing the prohibition language on spinal manipulation.

Over the past twenty years, evidence has shown the benefit of providing this technique under specific clinical criteria. In addition, the criteria for entry-level physical therapy education have increased since then including updated education and training in spinal manipulation.⁸ Indeed, the three physical therapy schools in our state moved from offering a bachelor degree program to presently conferring the title Doctor of Physical Therapy (DPT) at all three schools as a reflection of the increased depth and breadth in professional education preparation. The Department of Health (DOH) Physical Therapy Sunrise Review in 1999 states: “For those physical therapists who were educated and licensed prior to 1983, manipulation was in the scope of practice...The legislature removed manipulation from the scope of practice at the same time it removed the requirement for a PT to have a referral before performing any services. Because many years have passed since this occurred, and to assure the public is adequately protected, an endorsement to the license would make sure that adequate training and competency is possessed by the PT before the PT does a spinal manipulation.”⁹ PTWA acknowledged this DOH recommendation by including new language in the proposed legislation: “A physical therapist may perform spinal manipulation only upon showing evidence of adequate education and training in spinal manipulation and shall submit to the secretary an affidavit that includes evidence of adequate education and training in spinal manipulation. A physical therapist who has graduated from an

approved school of physical therapy in 2009 or later is not subject to this requirement.”¹⁰

The statement that *‘the chiropractic community has not sought an expansion of scope of practice’* is false. The chiropractic association did expand the scope of practice in 1992 with the addition of “joint manipulation” into chiropractic law: RCW 18.25.006 Definitions. (10) "Extremity manipulation" means a corrective thrust or maneuver applied to a joint of the appendicular skeleton. Intent -- 1992 c 241: "This act is intended to expand the scope of practice of chiropractic only with regard to adjustment of extremities in connection with a spinal adjustment."⁶ The physical therapy act has always allowed for grade V mobilizations and manipulations of all joints. This included manipulation of the spine and its immediate articulations before the 1983 change in the law. In addition, in 2003 there was a DOH sunrise review to add modalities to the chiropractic scope of practice at the request of WSCA.⁹ PTWA testified in support of these additions as long as the terms protected under RCW18.74.090 (physical therapy, physiotherapy, physical therapist, physiotherapist,) were not used and the Chiropractic Commission endorsement requirement for modalities exempted the practice of physical therapy.⁹ While WSCA has not pursued legislation related to this sunrise review, it is clear that the goal was to expand chiropractic scope of practice.

It's true that the chiropractic community enjoys providing the *‘majority of spinal adjusting or manipulation in Washington,’* because law prohibits its practice in the physical therapy community. Each profession is responsible for its members knowing and following their respective practice acts.

It is an inaccurate assumption that physical therapists define the profession based on the use of modalities such as galvanic current and therapeutic ultrasound. Many health professionals use these modalities. Physical therapists don't own or wish to be defined by modalities. Physical therapy is a health care profession “with an established theoretical and scientific base and widespread clinical applications in the restoration, maintenance, and promotion of optimal physical function.”¹

CHIROPRACTIC'S CENTRAL ROLE IN DEVELOPING SPINAL MANIPULATION SPECIALIZATION

p. 2-3

WSCA paper:

“The practice of spinal manipulation is not a part of the scope of practice of physical therapists in Washington.”

PTWA response:

Physical therapy law permitted the practice of spinal manipulation prior to the amendment of the in 1983. Currently, physical therapists do practice manual therapy including mobilization of the spine within the confines of the current practice act. Spinal manipulation techniques are taught in all three physical therapy schools in this state. Competency in performing these techniques is mandated by the accreditation body overseeing physical therapy education in the United States (Commission on Accreditation of Physical Therapy Education or CAPTE).⁸

WSCA paper:

“In fact, the chiropractic profession has been a world-wide leader in the advancement of manipulative care, with ongoing research and protocol development in this area. In contrast, physical therapy has had minimal interest in this area save those views imported to the United States by manual practitioners from cultures where procedures of this nature were more widely appreciated and accepted.”

PTWA response:

It is true that physical therapists from Europe and other countries such as New Zealand and Australia have had a profound influence on the practice of physical therapy over the past century of our

history.¹¹ In fact, the first president of the APTA, Mary McMillan, cites the work of P. Henry Ling from Sweden as a major influence to her treatment philosophy that includes manipulation and therapeutic exercise techniques in her 1921 textbook.¹² Ling started the physical therapy education program in Sweden in 1813, over 80 years before chiropractic was founded. Ling advocated and developed the use of manipulation, massage, and therapeutic exercises to treat human ailments, which he referred to as Medical gymnastics.¹² The physical therapy profession embraces our international heritage in development and advancement of our profession in contrast to the chiropractic profession that began in the United States and only recently expanded its development internationally.

Since the 1960s, physical therapy has researched and developed a wide body of knowledge in spinal manipulation emphasizing pain relief and restoration of function based on best evidence.¹³ The APTA recognized the Orthopedic Section in 1974.¹⁴ In 1989, the American Board of Physical Therapy Specialties (ABPTS) awarded the first board certification (OCS) as a demonstration of advanced knowledge, skills, and abilities to the public by recognizing the unique body of knowledge and training in the area of orthopedic physical therapy (including manual therapy and spinal manipulation).¹⁵ Much of the recent evidence supporting spinal manipulation has been published by physical therapists.

DEVELOPING NECESSARY PROCEDURAL SKILL SETS p. 3-5

WSCA paper:

"One of the most common forms of spinal adjusting employs what are referred to as high-velocity, low-amplitude procedures. It is these procedures that the physical therapy community is attempting to rebrand and rename as "thrust joint manipulation". These procedures involve the delivery of a carefully measured force at considerable speed with a high level of control and expertise by the clinician. These procedures take an articulation or joint beyond the normal range of motion, into a less than injurious range of movement, to effect mechanical, vascular and neurological changes in the immediate area and beyond. Well performed these procedures may appear simple and straightforward. In reality they are complex and complicated psychomotor skills that require considerable training, repetition and clinical experience to deliver appropriately and effectively. Performed incorrectly they carry significant risk of harm. As with any skill, regular use in practice refines performance."

PTWA response:

The differences in definitions of spinal manipulation need to be recognized. Different professions define the technique in different ways (Table).

The APTA Manipulation Education Manual defines Thrust Joint Manipulation as: a high velocity, low amplitude therapeutic movement within or at the end of range of motion.² When performed by a physical therapist, this technique doesn't take the articulation or joint beyond the normal physiologic range of motion or anatomic range.

The American Osteopathic Association defines high velocity/low amplitude technique as: "an osteopathic technique employing a rapid, therapeutic force of brief duration that travels a short distance within the anatomic range of motion of a joint, and that engages the restrictive barrier in one or more planes of motion to elicit release of restriction and is also known as thrust technique."¹⁶

The Washington chiropractic practice act states: "Chiropractic adjustment means chiropractic care of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder. Such care includes manual or mechanical adjustment of any vertebral articulation and contiguous articulations beyond the normal passive physiological range of motion."⁶

Table. Terminology for HVLA

Profession	Physical Therapy	Chiropractic	Osteopathic
Technique	Grade V Mobilization, Manipulation, or Thrust	Spinal adjustment	Thrust
Purpose and goals	Reduce pain and restore motion as part of a comprehensive rehabilitation plan of care	Treat and resolve functional disorders known as the vertebral subluxation complex and its effects	Elicit release of the restrictive barrier in one or more planes of motion
Location of procedure	Within normal range of motion of one joint segment	Beyond the normal passive physiologic range of motion (paraphysiologic zone)	Within anatomic (normal) range of motion of a joint

WSCA paper:

“Performed incorrectly they carry significant risk of harm.”

PTWA response:

Manipulation provided by physical therapists doesn't place the public at increased risk for serious injury. The physical therapy profession agrees that manipulation is a skill that requires extensive training to assure patient safety, and this is why there is an emphasis throughout the curriculum in physical therapist professional education programs on clinical decision making to assure safe and appropriate patient selection for all physical therapy treatment procedures including spinal manipulation based on knowledge and training in the indications and contraindications for manual therapy and the patient/client response to the treatment.^{8, 17, 18, 19}

Evidence-based treatment guidelines for treatment of low back pain have continually advised to refrain from ordering imaging in the absence of red flags.^{20, 21, 22, 23} Red flags are signs and symptoms characteristic of a disease process that need to be addressed by a doctor of medicine. Physical therapists receive extensive training in identification of red flags and in making appropriate referrals.^{1, 8, 13, 17, 24} Excessive use of diagnostic imaging has been associated with escalation of health care costs and poor patient outcomes resulting in increased use of surgery for conditions such as non-specific low back pain.²⁵

Cervical spine manipulation techniques pose a risk of adverse effects that range from mild soreness to severe neurovascular injury and death.^{26, 27, 28} Adverse reactions to cervical spine manipulation may include a temporary increase in neck pain, radiating arm pain, headache, dizziness, impaired vision, or ringing in the ears.²⁹ Although minor temporary adverse reactions to cervical spine manipulation are fairly common, catastrophic complications from cervical manipulation are extremely rare.^{28, 29} Physical therapists were involved in 2 percent of the reported injuries and no deaths were attributed to physical therapists providing cervical spine manipulation.³⁰

Serious or severe complications including cauda equina syndrome from providing lumbar spinal manipulation are extremely rare.³¹ Cauda equina syndrome (presenting with urinary retention, fecal incontinence, and widespread neurological signs and symptoms in the lower extremities that may include gait abnormality, saddle area numbness, or a lax anal sphincter) is a medical emergency that should be surgically treated as soon as possible to relieve pressure on the nerves. The risk of cauda

equina syndrome from lumbar spinal manipulation has been estimated to be less than 1 in 100 million manipulations.^{32, 33} Haldeman reviewed the literature over a 77-year period and found only 10 reports of cauda equina syndrome following lumbar spinal manipulation none of which were from physical therapists performing the treatment.³⁴

Physical therapists have an extremely good medical/legal track record of patient safety and the use of spinal manipulation. According to Heath Providers Service Organization, the primary liability insurance carrier for physical therapists in the United States, there are no higher claims losses for physical therapists who utilize spinal manipulation than for those who use other types of physical therapy interventions.³⁵ This finding is a result of sound clinical decision-making principles and practicing within the medical model of screening for red flags, adhering to appropriate indications and contraindications including when and when not to perform spinal mobilization and manipulation, and referring to other medical practitioners those patients who present with conditions outside the physical therapist scope of practice.

WSCA paper:

"It is the experience of the chiropractic community that many persons in the broader circles of health care have a simplistic view of grade 5 mobilizations and manipulation. It is this simplistic view that is the basis for the perspective that these skills can be "picked up" at a seminar or "are just a little different than other things we already do."

PTWA response:

In 1964 an Australian physiotherapist, Geoffrey Maitland, was the first to describe, develop, and define Grade I-V mobilization techniques.³⁶ He defines Grade V technique as: "A manipulation is similar to a grade IV mobilization in amplitude and position in range; it differs only in its speed. A grade IV mobilization is an oscillatory movement that the patient can prevent if he chooses to do so, whereas the movement of the manipulation is so quick it cannot be prevented by the patient. Because there is a link between the two procedures, it is perhaps an advantage to consider manipulation as a grade V movement. Manipulation is rarely chosen at the beginning of treatment, and certainly never in the presence of a very painful joint or a joint whose movement is protected by muscle spasm. One of the cardinal rules of treatment of passive movement is that a movement must never be forcibly thrust through protective spasm. Manipulations are usually progressions from mobilizations that have increased in strength and shown clearly that further increase is necessary".³⁶

The knowledge, skills, and abilities to safely and effectively perform these techniques as well as the judgment it takes to decide the appropriateness their application are part of the entry-level physical therapy curriculum.⁸

As stated earlier, the physical therapy act has always allowed for Grade I-V mobilizations and manipulations of all joints, including manipulation of the spine and its immediate articulations before the 1983 law change. Currently, physical therapists in Washington mobilize the spine using Grade I-IV techniques by applying forces within a range, speed, and amplitude used in a continuum and based on the evaluation and intervention response. Performing Grade V mobilization or manipulation is a technique similar in amplitude and range, but different in speed to Grade IV mobilization. Grade V is actually equal in depth and pressure at the end of available range as a Grade IV+ mobilization; the main difference is that a Grade V includes a thrust at the end of available range. The choice of which Grade I-V technique to employ for intervention depends on the ongoing decision making that occurs during the evaluation process and reassessments.

WSCA paper:

“The literature speaks to the problems of “transferability” of other manual health care related skills to spinal manipulation.³⁷ Simply stated the skills are unique, specialized and don’t transfer well.”

PTWA response:

The above statement contradicts the study’s results. There were no statistically significant differences between the outcome mean values comparing the novice and experienced chiropractor groups ability to perform a recently instructed manipulation technique.³⁷ There is no evidence to support the statement: “...skills are unique, specialized and don’t transfer well.”

LIMITED DIAGNOSTIC ABILITY AND DIAGNOSTIC TEST TRAINING p. 5-6

WSCA paper:

“The ability to provide or order imaging and laboratory services are important deficiencies in the education, training, and experience of physical therapists in Washington with respect to grade 5 mobilization and manipulation. Of even greater importance, in terms of deficiencies, is the absence of education, training and experience in the interpretation of various imaging studies and laboratory findings that are associated with the capacity to determine the appropriateness of manipulative care...The physical therapist in Washington is ill-equipped as a result of inadequacies of education and training to provide proper evaluation, and order the appropriate studies and finally to interpret the results of the needed studies to appreciate when spinal manipulation should NOT be performed. Moving into the area of grade 5 mobilization and manipulation requires the clinician to interpret imaging available notwithstanding the report of another provider such as a radiologist, as would be expected with other types of interventions such as surgery...Virtually every chiropractor can relate an experience of receiving a “clean” radiology report only to discover a fracture on the images that had been missed.”

PTWA response:

The Federation of Chiropractic Licensing Boards paper entitled “High-velocity, low amplitude spinal adjusting/manipulation performance: Minimum criteria for safety and adequate competence” lists professional responsibilities, case complexity and diagnoses, relative risks, training and skills for Doctors of Chiropractic providing high-velocity low amplitude spinal adjustments/manipulations (HVLA).⁵ There is no discussion on ordering or interpreting imaging studies or laboratory services as a requirement prior to performing HVLA.⁵

As stated earlier, evidence-based treatment guidelines for treatment of low back pain have continually advised to refrain from ordering imaging in the absence of red flags.^{20, 21, 22, 23} Excessive use of diagnostic imaging has been associated with escalation of health care costs and poor patient outcomes resulting in increased use of surgery for conditions such as non-specific low back pain.²⁵ Ernst concluded that data suggests an overuse of spinal radiography in the chiropractic profession constituting a safety problem.³⁸ Radiation exposure from cervical and lumbar spine imaging needs to be considered in the context of risks and benefits.³⁹

Red flags are signs and symptoms characteristic of a disease process that needs to be addressed by a doctor of medicine. Physical therapists receive extensive training in identification of red flags and in making appropriate referrals.^{1, 8, 13, 17, 24} Physical therapists also have the training and expertise to recognize contraindications and know when not to perform manual therapy.^{1, 2, 8, 13, 24}

Clinical practice guidelines and clinical prediction rules for spinal manipulation have been developed and validated and many of these were authored by physical therapists.⁴⁰ These papers include discussions and recommendations on when and when not to perform spinal mobilization and manipulation and when it’s appropriate to refer to other medical practitioners for diagnostic imaging and laboratory services.

LIMITED TRAINING IN MANIPULATIVE CARE PROCEDURES p. 6-7

WSCA paper:

"The education, training and clinical experience of physical therapists in Washington does not include adequate preparation, instruction, and clinical experience in manipulation procedures to warrant the authority and scope expansion being requested...For those presently in physical therapy programs in the State of Washington the curricular models provided as evidence of appropriate course offerings in this area are deficient in content and experience."

PTWA response:

According to a letter written by the three Washington state physical therapy program directors and addressed to all state legislators and the Department of Health earlier this year: "There is no doubt that the proper and safe training of spinal manipulation is effectively and safely being taught and practiced in the three DPT programs at the University of Puget Sound, Eastern Washington University (EWU), and the University of Washington (UW)."⁴¹ A review of these physical therapy program curricula (provided to WSCA) lists the relevant courses pertaining to teaching and acquisition of skills for manual therapy including spinal manipulation based on the Normative Model.¹⁷ Physical therapists enter the profession proficient in manual therapy including Grade V mobilization and manipulation of the spine.

The WSCA asks to compare physical therapy curriculum with chiropractic curriculum. This is not possible due to the significant difference in curricular philosophy where the chiropractic education is based on clocking hours and tabulating number of procedures while the physical therapist professional education is outcome criteria based.^{8, 42} In other words, the physical therapy education focuses on providing whatever level of instruction method is necessary to assure that the student can demonstrate safe, effective application of treatment procedures before the student is allowed to practice the procedure on live patients. There is also emphasis in the physical therapy curriculum on clinical problem solving.⁸ The physical therapy profession intentionally chose this model of education to reflect best evidence-based practice and to ensure patient/client protection and safety.^{1, 8}

In contrast, the chiropractic profession places emphasis on number of procedures performed rather than on demonstration of competence and clinical decision making.⁴² Even members of the chiropractic profession have been critical of these training methods and have advocated to switch to a more outcome based curriculum model.⁴³ Arbitrary numbers of hours of training does not assure safety and competence; demonstration of safety, skill, and clinical decision making as tested on objective testing methods assures safety and competence.

WSCA paper:

"A review of the Manipulation Education Manual for physical therapist professional degree programs published by the APTA details faculty requirements related to manipulation training of physical therapists reveals remarkable lax, virtually non-existent faculty qualification criteria with respect to this clinical area...Faculty criteria that are "desirable" as opposed to required is alarming. The "pursuit of training in manipulation" is equally alarming as one would be expected to have the skill they are to instruct rather than be in pursuit of it themselves."

PTWA response:

The authors have mistaken the Manipulation Education Manual as a binding accreditation document. Rather, the purpose of this manual is to offer guidelines and recommendations to physical therapy educators (faculty members and clinical instructors) of manual therapy.²

The CAPTE Accreditation Handbook identifies the standards and requirements for physical therapy education programs.⁷ This document describes the expectations of faculty members, which includes contemporary expertise in assigned teaching areas, effective teaching and evaluation skills, ongoing scholarly agenda, and service accomplishments.⁷ Clinical instructors must have at least one year of experience and demonstrate clinical competence in the area of practice, be effective teachers, and be able to assess and document student performance including deficits and unsafe practices.⁷ Curriculum mandates providing physical therapy interventions to achieve patient/client goals and outcomes include manual therapy techniques (including mobilization/manipulation thrust and non-thrust techniques) for patient/client management.⁸

In contrast the CCE doesn't require faculty members to participate in ongoing scholarly work.⁴²

EXISTING MODELS FOR ESTABLISHING MINIMUM COMPETENCY STANDARDS p. 7-9

WSCA paper:

"Around the globe there is considerable interest in spinal manipulation...Concerns about the appropriateness of these attempts led the World Health Organization (WHO) to develop a guideline in this area entitled "WHO Guidelines on the basic training and safety in chiropractic"⁴⁴...Medical doctors and other health care professionals may complete the requirements for a full chiropractic education over a shorter period because of credits granted in view of their prior education...duration of training should not be less than 2,000 hours...The educational standards for programs and institutions accredited by CCE mandates a minimum education experience regardless of educational or professional qualifications prior to the chiropractic programs...the requirement in this area is also in the range of 2,000 hours of education, training, and clinical experience."

PTWA response:

The WHO document pertains to the pursuit of a chiropractic education.⁴⁴

Physical therapy is a unique health care profession with its own body of knowledge, educational programs, competencies, history of practice, and regulatory agencies that benefit the health and safety of the public.^{1, 8, 17, 45} The physical therapy community has the obligation, duty, and authority to self-regulate the profession.⁴⁴ Physical therapists when performing manual therapy including spinal manipulation do not hold themselves out as Doctors of Chiropractic unless licensed to do so.

In addition the FCLB White Paper on Spinal Adjustment states: "A recommended minimum criteria for the performance of high-velocity, low amplitude procedures is the demonstrated ability to perform differential diagnosis in the context of section IVa above, with a skill level considered safe and functionally adequate based on a minimum of 150 class (10 credit) hours training" are necessary to master the HVLA technique."⁵ This is far less than the requested 2,000 hours.

CONCERNS FOR PATIENT SAFETY p. 9-10

WSCA paper:

"The literature related to manipulation is very clear and repetitious in advocating that manipulation be reserved to those providers who will apply the procedure consistently and regularly"⁴⁶...data from the literature and professional liability reports indicate that those non-chiropractor providers who deliver 6% of spinal manipulation in the United States are responsible for a disproportionately high percentage of adverse outcomes in the is area.⁴⁷"

PTWA response:

The Manga paper cited above is entitled: A study to examine the effectiveness and cost-effectiveness of chiropractic management of low-back pain.⁴⁶ While PTWA agrees with the intent of the

quoted statement above, the term “chiropractic management” is not synonymous or equivalent with “manipulation.”

Livingston for a three-year period in his general medical practice examined 676 patients with back pain.⁴⁷ Of these, 172 (25%) had seen a chiropractor previously, and 12 (7%) had received some sort of injury, primarily to soft tissue.⁴⁷ Updated research and professional liability reports (after this article’s publication in 1971) are available on this topic that demonstrates the safety of physical therapist practice of manual therapy including spinal manipulation.^{13, 24, 30, 35, 40}

EXISTING PUBLIC ACCESS TO MANIPULATIVE CARE p. 10

WSCA paper:

“...one went to the question of the need of the public for this service the request for expansion of scope continues to be hard to appreciate as being in the public interest...the chiropractic profession is meeting the needs of the consumer public for this service and is doing so at a level of proficiency that no other profession is capable of matching at this time.”

PTWA response:

Spinal manipulation by a physical therapist is prohibited in the State of Washington.⁴⁸ The public is denied access to a beneficial (decreased pain, restoration of function) and cost effective (decreased number of visits) treatment technique in the physical therapist ‘tool bag’ repertoire.

Citizens of the State of Washington support the two state physical therapy programs (UW, EWU) with tax dollars. It is mandatory that these schools teach manual therapy including spinal manipulation. Some graduates of these programs are leaving this state because of the spinal manipulation prohibition and not being able to practice best evidence-based medicine. There is a current and projected shortage of physical therapists in our nation and this flight of graduates exacerbates the shortage to access of care in our state.⁴⁹

Competition in the market place keeps costs down. Consumers will benefit from this proposal by having a choice of qualified providers to choose from for their care as well as additional provider access for patients. Indeed, the WSCA applicant report for the DOH Sunrise Review states: “Continuity of care will be enhanced with the patient under care by the same provider for both chiropractic and physiotherapy services... In addition, the patient may incur less clinical visits overall by seeing one provider for the services.”⁴⁹ Let the public decide from whom to receive their spinal manipulation care.

PROFESSIONAL INTERESTS AT PLAY p. 10

WSCA paper:

“The physical therapy profession is seeking to provide the services that the chiropractic profession has developed, advocated, supported and refined for over a century because they are sound billable service not because they are appropriately trained to provide this service. In comparison the chiropractic profession is concerned about these services being provided in a substandard manner...The chiropractic profession has a right to expect that its “signature gesture”⁵⁰ is respected in the marketplace and in legislation.”

PTWA response:

In practice, physical therapists use the same code for all manual therapy techniques (soft tissue and joint mobilization/manipulation, manual lymphatic drainage, manual traction) for billing purposes. There is not a separate rehabilitation billing code for Grade V mobilization or manipulation. Physical therapists will not gain increased income for performing Grade V mobilizations or manipulations.

The physical therapy profession has a large body of knowledge in the area joint and spine mobilization/manipulation.^{1, 13, 14, 40}

The “signature gesture” is defined in the article as “adjusting with the hands” and “Chiropractors believe that the correction of spinal abnormality—the adjustment of vertebrae—is a critical healing act.”⁵⁰ Again, WSCA seeks to equate the term Grade V mobilization and manipulation with adjustment. Physical therapists don’t practice or provide chiropractic adjustments or chiropractic spinal manipulations.

THRESHOLD RECOMMENDATIONS p. 10-12

WSCA paper:

“...would include initial and intermediate coursework in imaging interpretation to minimally include x-ray hard tissue interpretation, x-ray soft tissue interpretation, magnetic resonance imaging, computed tomography and the range of neuromusculoskeletal diagnostic imaging employed for diagnosis, including differential diagnosis. Laboratory procedure ordering, interpretation, and a broadened perspective on differential diagnosis as well as a formalized expansion of differential diagnosis capabilities would also be required...”

PTWA response:

Physical therapists are part of a health care team. The elements of patient/client management that lead to optimal outcomes in physical therapy include examination, evaluation, diagnosis, prognosis, interventions and outcome results.^{1, 2, 8} Every physical therapy evaluation (including for spinal pain) includes determination of whether or not a consultation with or referral to another provider is warranted.^{1, 2, 8} This includes recommendations for consideration of ordering imaging or laboratory tests from the referring provider or primary care provider.

Clinical practice guidelines don’t recommend imaging in every case of neck or low back pain.^{51, 52, 53, 54} Physical therapists complete an evaluation in order to determine whether or not a patient/client is appropriate to receive manual therapy including spinal manipulation (or any other type of physical therapy services). This may include the recommendation that an imaging study be obtained.^{8, 55} The public is protected from potential harm, because physical therapists have the required knowledge, skills, and abilities to safely determine the appropriateness of and provide manual therapy including spinal manipulation.

The FCLB White Paper on Spinal Adjustments doesn’t mention performing imaging studies prior to performing HLVA techniques.⁵

WSCA paper:

“at present current faculty requirements of the APTA of persons teaching in this area do not require any special education or training in the procedures²...coursework would entail approximately 2,000-2,400 additional clock hours of education, training and clinical experience...consistent with the spirit and intent of the WHO guidelines...and consistent with other acceptable practices such as those developed and implemented in Minnesota.”

PTWA response:

This incorrect comment on faculty member requirements was earlier refuted. WSCA authors are confusing the Manipulation Education Manual guidelines and recommendations with CAPTE accreditation body mandates, which includes contemporary expertise in assigned teaching areas, effective teaching and evaluation skills, ongoing scholarly agenda, and service accomplishments.⁸

As earlier stated, the FCLB White Paper on Spinal Adjustment states: "A recommended minimum criteria for the performance of high-velocity, low amplitude procedures is the demonstrated ability to perform differential diagnosis in the context of section IVa above, with a skill level considered safe and functionally adequate based on a minimum of 150 class (10 credit) hours training" are necessary to master the HVLA technique.⁵ This recommendation is much lower than the requested 2,000-2,400 additional hours.

The Minnesota statute 146.23 doesn't pertain to the practice of physical therapy in Minnesota, so the specified hours requirement in the statute are irrelevant to physical therapy.⁵⁶

WSCA paper:

"This view is consistent with physical therapy literature that points to education and training beyond entry-level physical therapy education and the utility of clinical/residency/fellowship training, post-professional academic programs and manual therapy certification."⁵⁷

PTWA response:

The above statement is taken out of context from the APTA White Paper.³⁹ It refers to the offerings available for post-graduate physical therapist advancement and professional development. It doesn't imply that performing thrust joint manipulation techniques are beyond entry-level physical therapy education.

The purpose of the Byran, et al article was to describe the status of spinal mobilization instruction within professional physical therapy education programs and to assess quantitative changes in spinal manipulation curricula between 1986 and 1993.⁵⁷ The CAPTE education mandates, including manual therapy techniques (including mobilization/manipulation thrust and nonthrust techniques), were effective in January 2006.⁸

SUMMARY p. 12-13

WSCA paper:

"With respect to the expansion of scope of practice of physical therapists to pursue rights to perform Grade 5 mobilization and manipulation the chiropractic community is concerned about protection of the public and the protection of the reputation of the service itself."

PTWA response:

Grade V mobilization and manipulation techniques are not "owned" by a single profession. Indeed, the origins of these terms, Grades I-V mobilization and manipulation, came from the physical therapy community.^{11, 12, 36}

The Federation of State Boards of Physical Therapy (Federation) is committed to the development of a national framework that jurisdiction licensing authorities may use to assess continuing competence of physical therapy practitioners.⁴⁵ As part of that commitment, it is important to develop standards that articulate a measurable degree of required performance. The standards chosen will be used to determine the level of performance to which licensees will be held accountable for ongoing practice:

- Physical therapists are bound by a code of ethics
- Physical therapists are self-regulating
- Physical therapists maintain currency by participating in lifelong-learning. Lifelong-learning includes development of knowledge, skills and abilities in order to meet current standards of practice
- Physical therapists are committed to delivering quality patient care services
- Physical therapists are an integral part of the health care delivery team

- Physical therapists are responsible for all aspects of physical therapy services including those provided by assistive personnel under the direction of the physical therapist

In conclusion, PTWA has diligently and truthfully answered all of WSCA's questions and concerns with documented evidence. PTWA has met the burden of proof for removing the prohibition on spinal manipulation by providing irrefutable evidence.

Physical therapists have the appropriate entry-level education (taught by qualified and experienced instructors) and competencies including knowledge, skills, and abilities to safely and effectively perform Grade V mobilization and manipulation of the spine. Physical therapists are trained in examination, evaluation, and diagnosis to recognize when it's appropriate to refer a patient/client back to the referring provider or recommend an imaging study or laboratory service. There is a long history of the practice of manipulation by physical therapists, including in this state prior to 1983. Physical therapists are trained to evaluate for red flags and contraindications before performing any intervention including Grade V mobilization and manipulation. There is no evidence to suggest that the performance of Grade V mobilizations and manipulation of the spine by physical therapists is harmful to the public. Indeed, evidence suggests that the prohibition of performing spinal manipulation by physical therapists in Washington is harming its citizens because of publicly funded higher education new graduates are leaving the state, the shortage of physical therapists, and the excess cost of loss of decreased patient/client visits. Physical therapists will not gain increased profits by providing spinal manipulation. The physical therapy profession is self-regulated in the State of Washington and the public is protected.

PTWA agrees with WSCA that performing "grade 5 mobilizations and manipulation as a matter of competency as opposed to turf." PTWA respectfully asks for WSCA to adopt a neutral or supportive stance on the removal of spinal manipulation prohibition legislation pertaining to the practice of physical therapy.

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APPENDIX: Physical Therapy Practice Acts on Spinal Mobilization and Manipulation in the United States

This information provides supporting evidence pertaining to the practice of spinal manipulation by physical therapists.

- **APTA information:**

- Manual Therapy part of definition: AZ, ID, KS, NJ, ND, TN, WA, WY
- Manipulation part of definition: CT (referral), HI (rules), LA, ME (referral), NC, ND, WA, WY
- Mobilization part of definition: CO, DE, HI, IL, MA, MI, MT, NE, NV, NJ, ND, PA, SD, TX, WA, WV, WY
- Silent in definition, but mobilization and manipulation are practiced: AK, AL, DC, CA, GA, IN, KY, MD, MN, MO, MS, NH, NM, NY, OH, OK, OR, RI, SC, UT, VT, VA, WI
- Prohibits chiropractic manipulations or adjustments to correct a subluxation: FL, CT, IA, MN, WI
- Prohibits direct thrust to move a joint beyond its normal range: TN
- Prohibits spinal manipulation: AK, WA

- **Ambiguities in state practice acts explained:**

- AZ (Manual therapy defined):
 - Title 32, Chapter 19
32-2001 Definitions:
5. "Manual therapy techniques" means a broad group of passive interventions in which physical therapists use their hands to administer skilled movements designed to modulate pain, increase joint range of motion, reduce or eliminate soft tissue swelling, inflammation, or restriction, induce relaxation, improve contractile and noncontractile tissue extensibility, and improve pulmonary function. These interventions involve a variety of techniques, such as the application of graded forces.
- FL (silent):
 - Title XXXII Chapter 486.021 Definitions:
10) "Physical therapy assessment" means observational, verbal, or manual determinations of the function of the musculoskeletal or neuromuscular system relative to physical therapy, including, but not limited to, range of motion of a joint, motor power, postural attitudes, biomechanical function, locomotion, or functional abilities, for the purpose of making recommendations for treatment.
(11) "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage...For the performance of specific chiropractic spinal manipulation, a physical therapist shall refer the patient to a health care practitioner licensed under chapter 460.
 - 64B17-6.001 Minimum Standards of Physical Therapy Practice.
(1) Definitions (d) Assessment – Observational, verbal, or manual determinations of the function of the musculoskeletal or neuromuscular system relative to physical therapy, including, but not limited to, range of motion of a joint, motor power, postural attitudes, biomechanical function, locomotion, or functional abilities, for the purpose of making recommendations for treatment.

- MT (Mobilization and manual therapist defined)
 - Title 37-11-101 Definitions.

(7) "Physical therapy" means the evaluation, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction and pain, injury, and any bodily or mental conditions by the use of therapeutic exercise, prescribed topical medications, and rehabilitative procedures for the purpose of preventing, correcting, or alleviating a physical or mental disability.

(9) "Physical therapy practitioner", "physical therapy specialist", "physiotherapy practitioner", or "manual therapists" are equivalent terms, and any derivation of the phrases or any letters implying the phrases are equivalent terms
 - Title 37-11-104 Physical therapy evaluation and treatment.

(1) Physical therapy evaluation includes the administration, interpretation, and evaluation of tests and measurements of bodily functions and structures; the development of a plan of treatment; consultative, educational, and other advisory services; and instruction and supervision of supportive personnel. •

(2) Treatment employs, for therapeutic effects, physical measures, activities and devices, for preventive and therapeutic purposes, exercises, rehabilitative procedures, massage, mobilization, and physical agents including but not limited to mechanical devices, heat, cold, air, light, water, electricity, and sound.
- NV (Mobilization defined)
 - Chapter 640 NRS 640.024 "Practice of physical therapy" defined. "Practice of physical therapy" 1. Includes:
 - (a) The performing and interpreting of tests and measurements as an aid to evaluation or treatment;
 - (b) The planning of initial and subsequent programs of treatment on the basis of the results of tests; and
 - (c) The administering of treatment through the use of therapeutic exercise and massage, the mobilization of joints by the use of therapeutic exercise without chiropractic adjustment, mechanical devices, and therapeutic agents which employ the properties of air, water, electricity, sound and radiant energy.
- SC (Silent)
 - Title 40, Chapter 45. Section 40-45-20 Definitions.

(9) "The practice of physical therapy" means the evaluation and treatment of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction, and pain from injury, disease, and any other bodily or mental condition and includes the administration, interpretation, documentation, and evaluation of physical therapy tests and measurements of bodily functions and structures; the establishment, administration, evaluation, and modification of a physical therapy treatment plan which includes the use of physical, chemical, or mechanical agents, activities, instruction, and devices for prevention and therapeutic purposes; and the provision of consultation and educational and other advisory services for the purpose of preventing or reducing the incidence and severity of physical disability, bodily malfunction, and pain

- UT (Manual therapy defined):
 - 58-24b-102 Definitions. 14. "Therapeutic interventions" include:
 - (d) manual therapy, including:
 - (i) soft tissue mobilization;
 - (ii) therapeutic massage; or
 - (iii) joint mobilization, as defined by the division, by rule

- WV (Mobilization defined):
 - §Chapter 30-20-2. Definitions.
 - (f) "Physical therapy" means the therapeutic treatment of any person by the use of massage, mechanical stimulation, heat, cold, light, air, water, electricity, sound and exercise, including mobilization of the joints and training in functional activities, for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability, and the performance of neuro-muscular-skeletal tests and measurements as an aid in diagnosis, evaluation or determination of the existence of and the extent of any body malfunction.
 - The West Virginia Board has stated that PTs may perform grade V mobilization techniques so long as they have the education and training to do so.
 - WV Chiropractic law defines spinal manipulation:
§30-16-3.Definitions.
 - (5) "Spinal manipulation" and "spinal adjustment" are interchangeable terms that identify a method of skillful and beneficial treatment where a person uses direct thrust or leverage to move a joint of the patient's spine beyond its normal range of motion, but without exceeding the limits of anatomical integrity.