Informational Meeting Agenda

July 28, 2026
10 a.m.
Behrakis Grand Hall (Creese Student Center), Drexel University

10:00-10:10 a.m. **Call to Order and Member Introductions**

10:10-11:00 a.m. **PANEL ONE – Expansion of direct access to physical therapy services**

Stephen Carp, MSPT, Ph.D.; DeSales University
American Physical Therapy Association – Pennsylvania Chapter

Jay Grandeo, PT, DPT, DScPT
Department of Physical Therapy & Rehabilitation Sciences, Drexel University

William Kuprevich, DO
Pennsylvania Osteopathic Medical Association

Marc Belitsky, DC
Pennsylvania Chiropractic Association

11:00-11:50 a.m. **PANEL TWO – Permitting dry needling by physical therapists**

JJ Thomas, DPT, MPT, CMTPT; Primal Physical Therapy
American Physical Therapy Association – Pennsylvania Chapter

Jay Grandeo, PT, DPT, DScPT
Department of Physical Therapy and Rehabilitation Sciences, Drexel University

William Kuprevich, DO
Pennsylvania Osteopathic Medical Association

Marc Belitsky, DC
Pennsylvania Chiropractic Association

Suzanne Kaczor, D.Ac., Dipl. Ac. (NCBAHM), L.Ac.
President, Association of Professional Acupuncture in PA

Janelle Farkas, Dipl. Ac. (NCBAHM), L.Ac.
Legislative Chair, Association of Professional Acupuncture in PA

11:50-12:00 p.m. **Closing Remarks and adjournment**

A Story About Direct Access

https://widener.instructuremedia.com/embed/0ef58410-a697-4bc6-843b-59f603dc1ce0

MODERNIZING DIRECT ACCESS

Physical Therapy Practice Act Modernization in Pennsylvania

The Ask: Extending the treatment window from 30 to 60 days and eliminating the Certificate of Authorization requirement

Presented to the House Professional Licensure Committee by the
American Physical Therapy Association – Pennsylvania (APTA PA)
Tuesday, July 28, 2026

The History of Direct Access in Pennsylvania

From restricted referral-only care to a conditional, time-limited model

Pre-2000s

Referral-Only Practice

PTs in PA could not treat patients without a prior physician referral.

Direct Access Enacted

30-Day Window Created

PTs may treat without referral for up to 30 days — but only with a Certificate of Authorization.

Today

PA Lags the Nation

All states except PA and Virginia have eliminated the certificate requirement entirely.

Current requirement: To qualify for a Certificate of Authorization, a PT must meet additional direct patient care requirements beyond what is already required for licensure — a duplicative step most states no longer impose.

Where Pennsylvania Stands Today

Current law creates an outlier status among the states

48

of 50 states

either never required or have eliminated the certificate-of-authorization requirement for direct access physical therapy. Only Pennsylvania and Virginia still require it.

Current Law (30 Days)

- Treatment without referral capped at 30 days from first visit
- A separate Certificate of Authorization is required, on top of licensure
- PA is one of the only states with an added clinical-practice requirement before initial eligibility

Proposed Modernization

- Treatment window extended to 60 days, a timeframe better aligned with contemporary practice standards
- Certificate of Authorization requirement eliminated — licensure alone qualifies a PT
- Aligns Pennsylvania with nearly every other state in the country

The Proposal: Three Changes

A modernization endorsed by APTA and APTA Pennsylvania, reflected in House Bill 1583 - Direct Access

1

Extend the treatment window

Increase the referral-free treatment period from 30 to 60 days, consistent with contemporary standards of practice.

2

Eliminate the certificate requirement

Remove the anachronistic need for a Certificate of Authorization before treating patients by direct access.

3

Preserve referral responsibility

Physical therapists remain fully responsible for making appropriate referrals when a patient's needs exceed their scope.

Pennsylvania is one of the only states with an additional clinical-practice requirement before initial direct-access eligibility — this proposal removes it.

Why Expansion Benefits Patients and the System

~95%

of outpatient PT episodes conclude within 48 days

A 60-day window covers nearly all episodes of care without interruption for a referral.

Source: Alliance for Physical Therapy Quality and Innovation

- **Quicker Access and uninterrupted continuity of care**

  Patients avoid a break in treatment while waiting on a referring provider — protecting momentum in recovery.

- **Fewer unnecessary physician visits**

  Extending the window reduces the number of patients who must return to a primary care visit solely to renew a referral.

- **Better outcomes, lower cost**

  Peer-reviewed research (Ojha et al., 2014) links direct-access physical therapy to improved outcomes and reduced cost of care versus physician-referred episodes.

- **Aligned with doctoral-level training**

  PTs already hold clinical doctorates and pass national licensure exams — the added certificate step tests nothing licensure doesn't already confirm.

PT Qualifications, Safeguards, and Our Ask

Doctor of Physical Therapy Are Trained for This Responsibility

- Doctoral-level education since 2000
- Minimum 30 weeks (1,050+ hours) of full-time clinical training
- National licensure exam plus mandatory continuing education
- Trained to recognize when a patient needs referral to another provider
- Bound by a Code of Ethics for the Physical Therapy Profession (updated 2025) requiring referral when goals aren't met within the direct-access window

Health Providers Service Organization (HPSO), the leading carrier of professional liability insurance for physical therapists in the US, states,

> "Direct access is not a risk factor that we specifically screen for in the underwriting of our program nor do we charge a premium differential for physical therapists in direct access states. We currently have no specific underwriting concerns with respect to direct access for physical therapists."

Existing Safeguards Are Unaffected

DPTs keep full responsibility for obtaining, if required by specific insurers, appropriate referrals and preauthorizations for therapy. As an example, many Worker's Compensation carriers may still require a referral.

Our Ask of the Committee

Support legislation to extend direct access from 30 to 60 days and eliminate the Certificate of Authorization requirement — bringing Pennsylvania in line with 48 other states and improving patient access to rehabilitative care.

Peer-Reviewed Citations Which Provide Evidence Supporting Direct Access To Physical Therapy.

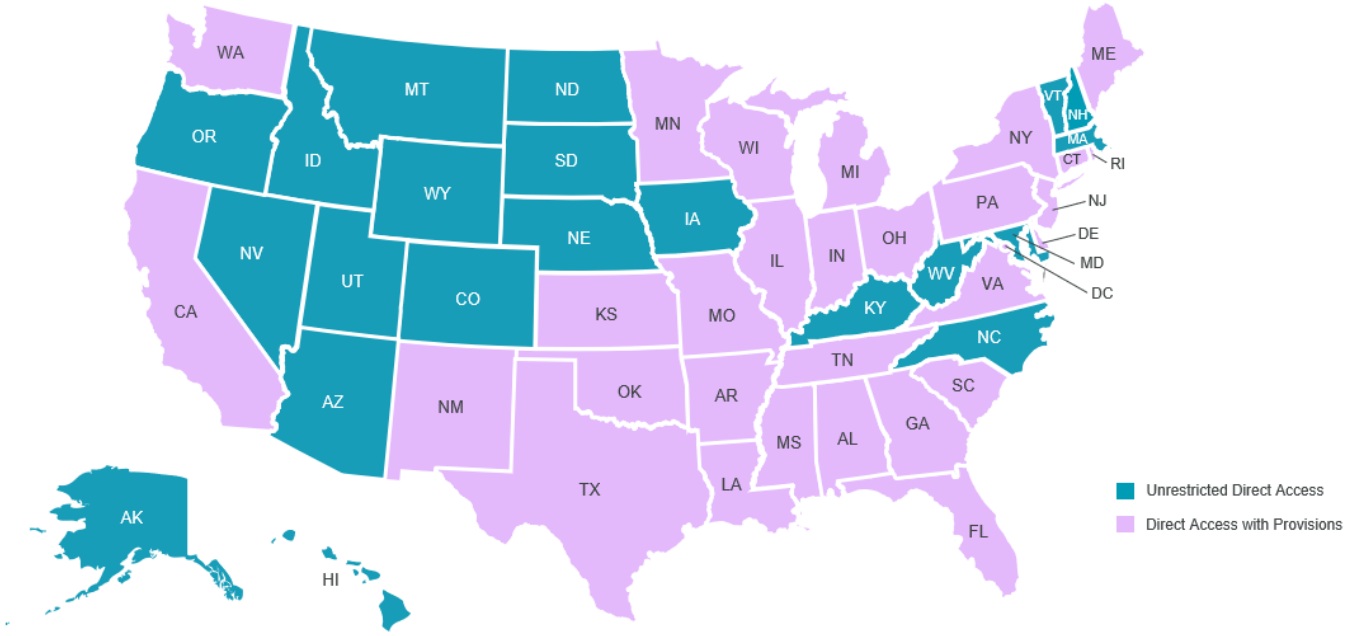
- Hon S, Ritter R, Allen DD. Cost-effectiveness and outcomes of direct access to physical therapy for musculoskeletal disorders compared to physician-first access in the United States: systematic review and meta-analysis. Phys Ther. 2021;101(1):pzaa201.
- Demont A, Bourmaud A, Kechichian A, Desmeules F. The impact of direct access physiotherapy compared to primary care physician-led usual care for patients with musculoskeletal disorders: a systematic review of the literature. Disabil Rehabil. 2021;43(12):1637-1648.
- Babatunde OO, Bishop A, Cottrell E, et al. A systematic review and evidence synthesis of non-medical triage, self-referral and direct access services for patients with musculoskeletal pain. PLoS One. 2020;15(7):e0235364.
- Piscitelli D, Furmanek MP, Meroni R, De Caro W, Pellicciari L. Direct access in physical therapy: a systematic review. Clin Ter. 2018;169(5):e249-e260.
- World Physiotherapy. Direct Access and Advanced Scope of Practice in Physical Therapy. London, UK: World Physiotherapy; 2023. Accessed July 15, 2026.

These five references are well suited to support arguments that direct access:

- Is **safe** for patients with musculoskeletal conditions,
- Produces **clinical outcomes comparable or superior** to physician-first care,
- Reduces unnecessary imaging, medication use, and healthcare visits,
- Improves patient satisfaction, and.
- Lowers overall healthcare costs.

Levels of Patient Access to Physical Therapist Services in the U.S.

Although all 50 states, D.C., and the U.S. Virgin Islands all enjoy a form of direct access to physical therapist services, provisions and limitations vary among jurisdictions. This map and the key below identify each jurisdiction's level of direct access. Starting on page 2 is a summary of the language (if any) in each state's practice act related to direct access. (Data current as of July 2025.)



Patient access with provisions (29 states, D.C., U.S. Virgin Islands)

Access to evaluation and treatment with some provisions such as a time or visit limit, or referral requirement for a specific treatment intervention such as needle EMG or spinal manipulation.

Alabama
Arkansas
California
Connecticut
Delaware
District of Columbia
Florida
Georgia
Indiana
Illinois
Kansas
Louisiana
Maine
Michigan
Minnesota
Mississippi
Missouri
New Jersey
New York
New Mexico
Ohio
Oklahoma
Pennsylvania
Rhode Island
South Carolina
Tennessee
Texas
U.S. Virgin Islands
Virginia
Washington
Wisconsin

Unrestricted patient access (21 states)

No restrictions or limitations whatsoever for treatment absent a referral.

Alaska	Iowa	Nebraska	Oregon	Wyoming
Arizona	Kentucky	Nevada	South Dakota	
Colorado	Maryland	New Hampshire	Utah	
Hawaii	Massachusetts	North Carolina	Vermont	
Idaho	Montana	North Dakota	West Virginia	

State and Direct Access Enactment Year — Level of Direct Access to Physical Therapy Services

AL, 2012 (Revised 2024) — Provisional

A physical therapist must meet the following requirements to qualify to perform physical therapy services without a prescription or referral:

- Possesses a doctorate in physical therapy or a master's degree from an accredited institution with 10 years of clinical practice experience.
- Annually completes an additional two hours of continuing education focusing on the professional standard of care.

A physical therapist meeting the above requirements may perform physical therapy on a patient without a referral for 30 calendar days, or 11 visits, whichever occurs first. If the patient does not have a beneficial response within that time frame the patient shall be referred to a health care provider as appropriate. These treatment limitations do not apply to any of the following:

- Children with a diagnosed developmental disability pursuant to the patient's plan of care.
- As part of a home health care agency pursuant to the patient’s plan of care.
- To a patient in a nursing home pursuant to the patient’s plan of care.
- A patient previously diagnosed with a chronic condition for which physical therapy services are appropriate after informing the physical therapy referrer rendering the diagnosis.
    - The diagnosis shall have been made within the immediately preceding 120 days. The physical therapist shall provide the physical therapy referrer with a plan of care for physical therapy services within the first 15 days of treatment.
- Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness.

AK, 1986 — Unrestricted

No Restrictions to Access

License revocation or suspension when failure to refer a patient to another qualified professional when the patient’s condition is beyond PT training.

AZ, 1983 — Unrestricted

No Restrictions to Access

A physical therapist shall refer a client to appropriate health care practitioners if the PT has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of practice and if PT is contraindicated.

AR, 1997 — Provisions

Requires physician referral for bronchopulmonary hygiene, debridement and wound care.

CA, 1968 (Revised 2013, 2018) — Provisions

- PT must refer the patient to their physician if, at any time, the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a physical therapist or the patient is not progressing toward documented treatment goals as demonstrated by objective, measurable, or functional improvement.
- PT shall disclose to the patient any financial interest he or she has in treating the patient and, if working in a physical therapy corporation, shall comply with Chapter1, Article 6, commencing with Section 650.
- With the patient's written authorization, the physical therapist shall notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient.
- The physical therapist shall not continue treating the patient beyond 45 calendar days or 12 visits, whichever occurs first, without receiving, a dated signature on the physical therapist's plan of care from the patient's physician, surgeon, or podiatrist indicating approval of the physical therapist's plan of care. Approval of the physical therapist's plan of care shall include an in-person patient examination and evaluation of the patient's condition and, if indicated, testing by the physician and surgeon or podiatrist, except when providing wellness physical therapy services, or providing physical therapy services pursuant to a family service plan or individualized education plan (IEP) and the individual does not have a medical diagnosis. (Effective 1/1/2019)
- Must provide notice to the patient, orally and in writing, in at least 14-point type and signed by the patient indicating they are receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

CO, 1988 — Unrestricted

No Restrictions to Access

- Disciplinary action when failure to refer a patient to another qualified professional when the patient's condition is beyond PT training.
- Prohibits diagnosis of disease.

CT, 2006 — Provisions

- Earned a bachelor's degree and has practiced physical therapy for at least four out of the most recent six years or earned a master's degree or higher,
- Must refer any person receiving such treatment to an appropriate licensed practitioner of the healing arts if, upon examination or reexamination, the same condition for which the person sought physical therapy does not demonstrate objective, measurable, functional improvement in a period of thirty consecutive days or at the end of six visits, whichever is earlier.

- Grade V spinal manipulation, such treatment shall only be performed upon the referral or by a licensed physical therapist who (i) earned a bachelor's degree prior to January 1, 1998, and has practiced physical therapy for at least four out of the most recent six years of his or her clinical practice, or earned a master's degree or higher in physical therapy from an accredited institution of higher education, and (ii) holds a specialist certification in orthopedic physical therapy from the American Physical Therapy Association, or proof of completion of forty hours of course work in manual therapy, including Grade V spinal manipulation.
- Prohibits diagnosis of disease.

DC, 2007 — Provisions

Must refer patient to primary care provider if no reasonable progress is made within 30 days.

DE, 1993 — Provisions

- Permits treatment with or without referral by a licensed medical or osteopathic physician.
- Must refer patient if symptoms are present for which treatment is outside scope of PT.
- May treat a patient for up to 30 days after which a physician must be “consulted.”
- Prohibits substantial modification of prescriptions accompanying a patient.

FL, 1992 (Revised 2016) — Provisions

- Must refer patient or consult with health care practitioner if the patient’s condition is outside scope of PT.
- If PT treatment is required beyond 30 days for a condition not previously assessed by a practitioner of record, the PT shall obtain a practitioner of record who will review and sign the plan.
- Requirement that practitioner of record review and sign plan of care does not apply when a patient has been physically examined by a physician licensed in another state, diagnosed by the physician as having a condition for which physical therapy is required, and the PT is treating that condition.
- Prohibits PTs from implementing plan of treatment for patients in acute care settings including hospitals, ambulatory surgical centers, and mobile surgical facilities.

GA, 2006 (Revised 2015) — Provisions

To practice via direct access, a PT must meet on the following requirements:

- Have a doctorate in physical therapy or equivalent degree from an accredited institution plus two years of clinical practice experience; OR
- Have a doctorate in physical therapy or equivalent and either a) Post graduate certification, (b) American Board of Physical Therapy Specialties Board Certification; or c) Residency or fellowship training; OR
- Five years of clinical practice experience;

After 21 days or eight visits from the initiation of a physical therapy plan of intervention, the PT must receive a referral from the patient's physician or dentist. The day and visit limitations contained in this subparagraph does not apply:

- In the case of services provided for health promotion, wellness, fitness, or maintenance purposes, in which case the physical therapist shall refer a client seen for health promotion, wellness, fitness, or maintenance purposes to an appropriate physician if the client exhibits or develop/s signs and symptoms beyond the scope of practice of the physical therapist;
- In the case of a patient diagnosed within the previous nine months with a neuromuscular or developmental condition when the evaluation, treatment, or services are being provided for problems or symptoms associated with that previously diagnosed condition; or

- In the case of a patient diagnosed within the previous 90 days with a chronic musculoskeletal condition and noted by a current relevant document from an appropriate licensed health care provider.

PTs must provide a written disclosure to direct access patients that a physical therapy diagnosis is not a medical diagnosis by a physician or based on radiological imaging and that such services might not be covered by the patient's health plan or insurer.

If dry needling treatment is going to be performed on a patient seen via direct access, the PT must first consult with the patient's physician (or physician assistant).

HI, 2010 — Unrestricted

No Restrictions to Access

Failing to immediately refer any patient to an appropriate healthcare provider if there is reasonable cause to believe that the patient's condition is beyond the physical therapist's scope of practice or is a condition for which physical therapy is contraindicated is an act professional misconduct.

ID, 1987 — Unrestricted

No Restrictions to Access

- Prohibits the use of radiology, surgery or medical diagnosis of disease.
- Must refer when patient condition is outside PT scope of practice.

IL, 1988 (Revised 2018) — Provisions

- A physical therapist providing services without a referral from a health care professional must notify the patient's treating health care professional within 5 business days after the patient's first visit that the patient is receiving physical therapy. This does not apply to physical therapy services related to fitness or wellness, unless the patient presents with an ailment or injury.
- A physical therapist shall refer a patient to the patient's treating health care professional of record or, in the case where there is no health care professional of record, to a health care professional of the patient's choice, if:
    - The patient does not demonstrate measurable or functional improvement after 10 visits or 15 business days, whichever occurs first, and continued improvement thereafter;
    - The patient returns for services for the same or similar condition after 30 calendar days of being discharged by the physical therapist; or
    - The patient's condition, at the time of evaluation or services, is determined to be beyond the scope of practice of the physical therapist.
- Wound debridement services may only be provided by a physical therapist with written authorization from a health care professional.
- A physical therapist shall promptly consult and collaborate with the appropriate health care professional anytime a patient's condition indicates that it may be related to temporomandibular disorder so that a diagnosis can be made by that health care professional for an appropriate treatment plan.

IN, 2013 (Revised 2019) — Provisions

- May evaluate and treat for no more than 42 calendar days beginning with the date of the initiation of treatment without a referral. If additional treatment is needed, the PT shall obtain a referral from the individual's provider (physician, podiatrist, psychologist, chiropractor, dentist, nurse practitioner, or physician assistant).

- Order or referral from a physician, osteopath, or chiropractor required for spinal manipulation. Referring physician, osteopath, or chiropractor must have examined the patient before issuing the order or referral. “Spinal manipulation” defined as “a method of skillful and beneficial treatment by which a physical therapist uses direct thrust to move a joint of the patient’s spine beyond its normal range of motion, but without exceeding the limits of anatomical integrity.”
- Order or referral from physician, osteopath, or podiatrist required for sharp debridement. “Sharp debridement” defined as “the removal of foreign material or dead tissue from or around a wound, without anesthesia and with generally no bleeding, through the use of: (A) a sterile scalpel; (B) scissors; (C) forceps; (D) tweezers; or (E) other sharp medical instruments; in order to expose health tissue, prevent infection, and promote healing.”

IA, 1988 — Unrestricted

No Restrictions to Access

- Permits evaluation and treatment with or without a referral from a physician, podiatric physician, dentist or chiropractor, except that a hospital may require that PT evaluation and treatment provided in the hospital be done only upon prior review by and authorization of a member of the hospital’s medical staff.
- Prohibits PTs from practicing operative surgery or osteopathic or chiropractic manipulation or administering or prescribing drugs or medicine.

KS, 2007 (Revised 2013) — Provisions

- May evaluate and initiate treatment on a patient without a referral. If providing treatment without a referral and patient is not progressing toward documented treatment goals as demonstrated by objective, measurable, or functional improvement, or any combination thereof, within 10 visits or 15 business days from the initial treatment visit following the initial evaluation visit, the PT shall obtain a referral from an appropriate licensed health care practitioner (physician, podiatrist, physician assistant, advanced practice registered nurse, chiropractor, dentist, or optometrist).
- When a patient self-refers to a PT, the PT shall provide written notice to the patient, prior to the commencement of treatment, that a physical therapy diagnosis is not a medical diagnosis by a physician.
- Wound debridement may only be performed after approval is obtained from a physician or other licensed health care practitioner.
- A hospital or ambulatory surgery center may require a physician order or referral for physical therapy services for a patient currently being treated in such facility.
- Physical therapists may provide, without a referral, services which do not constitute treatment for a specific condition, disease or injury to: (1) Employees solely for education and instruction related to workplace injury prevention; or (2) the public for the purpose of fitness, health promotion and education.
- Physical therapists may provide services without a referral to special education students who need physical therapy services to fulfill the provisions of their individualized education plan or individualized family service plan.

KY, 1987 — Unrestricted

No Restrictions to Access

- Must refer to a physician or dentist when patient condition is beyond scope of practice.

- When basis for treatment is referral, the PT may confer with the referring physician, podiatrist, dentist or chiropractor.

LA – 2003 (Revised 2016) — Provisions

May perform physical therapy services without a prescription or referral under the following circumstances:

- All PTs who have a DPT or 5 years of clinical practice experience are eligible to implement physical therapy treatment with or without a prescription or referral for 30 calendar days.
- After 30 days a referral is required by a physician, dentist, podiatrist, or chiropractor, unless there is measurable or functional improvement.

ME, 1991 (Revised 2023) — Provisions

When treating a patient without a referral from an advanced practice registered nurse, certified nurse midwife, physician assistant, naturopathic doctor or Doctor of Medicine, osteopathy, podiatry, dentistry or chiropractic, the PT:

- Cannot make a medical diagnosis.
- Must consult or refer the patient to a licensed advanced practice registered nurse, certified nurse midwife, physician assistant, naturopathic doctor, doctor of medicine, osteopathy, podiatry, dentistry or chiropractic if no improvement in the patient is documented within 30 days of initiation of treatment and the condition the physical therapist or physical therapist assistant is treating has not been medically diagnosed in the last 90 days.
- Must consult or refer the patient to a licensed advanced practice registered nurse, certified nurse midwife, physician assistant, naturopathic doctor, doctor of medicine, surgery, osteopathy, podiatry, dentistry or chiropractic if treatment is required beyond 120 days for a condition that has not been medically diagnosed.
- Exceptions to the requirements to refer a patient include:
    - Services provided for purposes of health promotion, injury prevention, wellness, fitness, athletic performance or maintenance therapy
    - Patients diagnosed within the previous 9 months with a chronic neuromuscular or developmental condition when the services are being provided for problems or symptoms associated with that previously diagnosed condition
    - Services provided pursuant to an individualized education plan or individual family service plan under federal law.

Without a referral PT may not administer drugs.

- Employers are not liable for charges under workers' compensation for services unless the employee has been referred to the PT.
- Must make referral when beyond the scope of PT practice.

MD, 1979 — Unrestricted

No restrictions to access

MA, 1982 — Unrestricted

No Restrictions to Access

- Regulation sets PT Code of Ethics as standard for referral relationships. PT will refer to a licensed practitioner of medicine, dentistry or podiatry if symptoms are present of which PT is contraindicated or which symptoms are indicative of conditions for which treatment is outside scope of PT practice.

PT will also provide ongoing communication with the licensed referring practitioner.

PT must disclose to patient any financial interest if the referring source derives income from the PT services.

MI, 2015 — Provisions

May provide treatment without a prescription from a licensed physician, etc. under the following conditions:

- For 21 days or 10 treatments, whichever occurs first. The physical therapist must determine the patient's condition requires physical therapy before delegating interventions to a physical therapist assistant.
- The patient is seeking physical therapy services for purposes of injury prevention or promoting fitness.
- Must refer the patient to an appropriate healthcare professional if there is reasonable cause to believe that symptoms or conditions are present that require services beyond the scope of practice of physical therapy.
- Must consult with an appropriate healthcare professional if the patient does not show reasonable response to treatment in a time period consistent with the standards of practice as determined by the Board of Physical Therapy.

MN, 1988 (Revised 2008) — Provisions

- Medical diagnosis prohibited.
- Patient may be treated by a physical therapist without an order or referral from a physician, chiropractor, dentist, podiatrist, or advanced practice nurse for up to 90 days.
- Allows a physical therapist, who has been licensed for less than one year, to provide physical therapy without referral when working in collaboration with a physical therapist who has more than one year of experience.
- Physical therapist must refer a patient to a licensed health care professional at any time during care if the patient's condition is beyond the scope of the physical therapist.
- Allows direct access without time limits for patients being treated for prevention, wellness, education, or exercise.

MS, 2006 (Revised 2024) — Provisional

A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for physical therapy.

To perform physical therapy services without a prescription or referral a physical therapist must meet one of the following requirements to qualify:

- Has obtained a doctorate degree in physical therapy from an accredited institution or five years of licensed clinical practice experience.

A physical therapist meeting the above requirement may perform physical therapy on a patient without a referral for 30 calendar days. However, if the patient does not make measurable or functional improvement within that time frame the physical therapist shall refer the patient to an appropriate health care provider. This treatment limitation does not apply to any of the following:

- To children with a diagnosed developmental disability pursuant to the patient's plan of care.
- As part of a home health care agency pursuant to the patient's plan of care.
- To a patient in a nursing home pursuant to the patient's plan of care.
- Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress or promotion of fitness.

- To an individual for a previously diagnosed condition or conditions for which physical therapy services are appropriate after informing the health care provider rendering the diagnosis. The diagnosis must have been made within the previous 180 days. The physical therapist shall provide the health care provider who rendered the diagnosis with a plan of care for physical therapy services within the first 15 days of physical therapy intervention.

MO, 1999 (Revised 2023) — Provisions

A physical therapist shall consult with an approved health care provider if, after every ten visits or thirty days, whichever occurs first, the patient has demonstrated measurable or functional improvement from the course of physical therapy services or treatment provided and the physical therapist believes that continuation of the course of physical therapy services or treatment is reasonable and necessary based on the physical therapist's evaluation of the patient. The physical therapist shall not provide further physical therapy services or treatment until the consultation has occurred.

- The consultation with the approved health care provider shall include information concerning:
    - The patient's condition for which physical therapy services or treatments were provided;
    - The basis for the course of services or treatment indicated, as determined from the physical therapy evaluation of the patient;
    - The physical therapy services or treatment provided before the date of the consultation;
    - The patient's demonstrated measurable or functional improvement from the services or treatment provided before the date of the consultation;
    - The continuing physical therapy services or treatment proposed to be provided following the consultation; and
    - The professional physical therapy basis for the continued physical therapy services or treatment to be provided.

Continued physical therapy services or treatment following the consultation with and approval by an approved health care provider shall proceed in accordance with any feedback, advice, opinion, or direction of the approved health care provider. The physical therapist shall notify the consulting approved health care provider of continuing physical therapy services or treatment and the patient's progress at least every ten visits or thirty days after the initial consultation unless the consulting approved health care provider directs otherwise.

MT, 1987 — Unrestricted

No Restrictions to Access

- PT evaluation and treatment procedures may be performed by a licensed PT without referral.
- License revocation if PT practices beyond the scope and limitation of training and education.

NE, 1957 — Unrestricted

No Restrictions to Access

- Performing procedures outside of the scope of PT practice constitutes unprofessional conduct.

NV, 1985 — Unrestricted

No Restrictions to Access

- Physical therapy does not include the diagnosis of physical disabilities, the occupation of a masseur who massages only the superficial soft tissues of the body, and chiropractic adjustment.

NH, 1988 (Revised 2023) — Unrestricted

A physical therapist shall refer a patient or client to appropriate health care practitioners when:

- The physical therapist has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of practice; or
- Physical therapy is contraindicated

NJ, 2003 — Provisions

A physical therapist shall refer a patient to a health care professional licensed to practice dentistry podiatry or medicine and surgery in this State or other appropriate licensed health care professional:

- When the physical therapist doing the examination evaluation or intervention has reason to believe that physical therapy is contraindicated, or symptoms or conditions are present that require services outside the scope of practice of the physical therapist; or
- When the patient has failed to demonstrate reasonable progress within 30 days of the date of the initial treatment.

Not more than 30 days from the date of initial treatment of functional limitation or pain, a physical therapist shall inform the patient's licensed health care professional of record regarding the patient's plan of care. In the event there is no identified licensed health care professional of record, the physical therapist shall recommend that the patient consult with a licensed health care professional of the patient's choice. In a school setting, the schedule of physical therapy services shall be reported to tile child study team by the physical therapist within 30 days of the date of initial treatment.

NM, 1989 (Revised 2015) — Provisions

A PT evaluate and treat absent a referral, however the PT must refer a patient to the patient’s licensed health care provider if, after 30 days of initiating physical therapist intervention, the patient has not made measurable or functional improvement with respect to the primary complaints. If the patient is making measurable progress and improving, the 30-day limit does not apply.

Additionally, the 30-day provison does not apply to:

- Treatment provided for a condition related to a chronic neuromuscular or developmental condition for a patient previously diagnosed as having a chronic neuromuscular or developmental condition.
- Services provided for health promotion, wellness, fitness; or
- Services provided to a patient who is participating in a program pursuant to an individual education plan or individual family service plan under federal law

NY, 2006 — Provisions

- Treatment can be rendered by a Licensed PT without a referral for 10 visits or 30 days, whichever comes first.
- Licensed PT must have practiced PT on a full-time basis for no less than three years; be of at least twenty-one years of age.
- PT must provide written notification that services without a referral might not be covered by the patient’s health plan or insurer; notification must state that said services might be covered by health plan or insurer with a referral. Must keep a copy of the written notification in the patient’s file.

NC, 1985 (Revised 2019) — Unrestricted

No Restrictions to Access

- Medical diagnosis of disease or treatment beyond the scope of physical therapy must be referred as specified in G.S. 90-270.35
- Failure to refer to a licensed medical doctor or dentist when patient's condition is beyond scope of PT practice is considered unlawful practice.

ND, 1989 — Unrestricted

No Restrictions to Access

- License revocation when failure to refer to a licensed health care professional any patient whose medical condition is beyond the scope of PT practice.

OH, 2004 — Provisions

- Must have a master's degree or two years' experience.
- If no progress in 30 days, must refer to appropriate health care provider.
- PT shall inform the patient's health care provider within 5 days of initial evaluation
- If orthotics are needed, PT is limited to certain applications of orthotic devices

OK, 2014 (Revised 2025) — Provisions

- A licensed physical therapist may treat a patient without a referral for 30 days including, but not limited to, operating under a direct-to employer contract.
    - The aforementioned does not include workers' compensation claims.
- Any treatment provided beyond a 30 day period shall be only under the referral of a physician, surgeon, physician assistant, dentist, chiropractor, podiatrist, or advanced practice nurse.

OR, 1993 (Revised 2005, 2007, 2013) — Unrestricted

No Restrictions to Access

A licensed physical therapist shall immediately refer a person being treated by the licensed physical therapist to a provider of care if the person exhibits symptoms:

- That require treatment or diagnosis by a provider of medical care;
- For which physical therapy is contraindicated;
- That the physical therapist does not know how to treat; or
- For which treatment is outside the scope of practice of physical therapy.

PA, 2002 — Provisions

- Licensees may apply to the board for a certificate of authorization to practice physical therapy under this act without the required referral.
- A certificate of authorization to practice physical therapy without a referral under subsection (a) shall not authorize a physical therapist either to treat a condition in any person which is a nonneurologic, nonmuscular or nonskeletal condition or to treat a person who has an acute cardiac or acute pulmonary condition unless the physical therapist has consulted with the person's licensed physician, dentist or podiatrist regarding the person's condition and the physical therapy treatment plan or has referred the person to a licensed physician, dentist or podiatrist for diagnosis and referral.
- The certificate of authorization shall be displayed by the certificate holder in a manner conspicuous to the public.

- The renewal of the certificate of authorization shall coincide with the renewal of the license of the licensee.
- A physical therapist with a certificate of authorization may treat a person for up to 30 days from the date of the first treatment. A physical therapist shall not treat a person beyond 30 days from the date of the first treatment unless he or she has obtained a referral from a licensed physician, dentist or podiatrist

RI, 1992 (Revised 2017) — Provisions

- Must disclose to the patient in writing the scope and limitations of the practice of physical therapy and shall obtain their consent in writing.
- Must refer the patient to a doctor of medicine, osteopathy dentistry, podiatry or chiropractic within 90 days after the treatment commenced (unless the treatment has concluded).

SC, 1998 — Provisions

- In the absence of a referral, must refer the patient to a licensed medical doctor or dentist if providing PT services beyond 30 days after the initial evaluation.
- Must refer patient to a licensed medical doctor or dentist if patient's condition is beyond scope of PT.

SD, 1986 — Unrestricted

No Restrictions to Access

TN, 1999 (Revised 2007, 2020, 2023) — Provisions

- In the absence of a referral by a doctor of medicine, chiropractic, dentistry, podiatry, osteopathy, nurse practitioner or physician assistant the physical therapist may conduct a initial evaluation and may provide physical assessments or instruction, including a recommendation of exercise to an asymptomatic person.
- In emergency situations, including minor emergencies, may provide assistance to a person to the best of their ability; immediately afterward referring the person to the appropriate health care practitioner.
- May treat a patient without referral when, within the scope of PT practice, the following are met:
  1. The patient's physician has been notified;
  2. If within 30 days the PT determines that the patient has made no progress, the PT discontinues services and refers the patient to a healthcare practitioner who qualifies as a referring practitioner;
  3. Services are not provided beyond 90 days without the PT consulting with the patient's appropriate healthcare practitioner;
  4. If the patient was previously diagnosed by a physician with chronic, neuromuscular, or developmental conditions, and the evaluation, treatment, or services are being provided for problems or symptoms associated with one or more of those previously diagnosed conditions, then 2 and 3 above do not apply; and
  5. If the PT has reasonable cause to believe the patient has symptoms or conditions that require services beyond the scope of PT practice, that reasonable therapeutic progress is not being achieved, or that treatment is contraindicated, the PT refers the patient to appropriate health care practitioners.

Texas, 1991 (Revised 2019, 2021, 2025) — Provisions

A physical therapist may evaluate and treat a patient without a referral for up to 30 consecutive days under the following conditions:

- The physical therapist has been licensed to practice for at least one year; and
- Is covered by professional liability insurance in the minimum amount required by the Board.
- Prohibits the diagnosis of disease.

A physical therapist who treats a patient without a referral shall obtain from the patient a signed disclosure on a form prescribed by the board in which the patient acknowledges that:

- Physical therapy is not a substitute for a medical diagnosis by a physician;
- Physical therapy is not based on radiological imaging;
- A physical therapist cannot diagnose an illness or disease; and
- The patient's health insurance may not include coverage for the physical therapist's services.

UT, 1985 — Unrestricted

No Restrictions to Access

- Prohibits diagnosis of disease, surgery, acupuncture or x-ray for diagnostic or therapeutic uses.

U.S.V.I — Provisions

- A licensed physical therapist may perform physical therapy services without a prescription or physician referral under the following conditions:
    - The physical therapist has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of practice, or if the patient is not progressing toward documented treatment goals as demonstrated by objective, measurable, or functional improvement.
    - The physical therapist may not continue treating the patient beyond 45 calendar days or 12 visits, whichever occurs first, without receiving, a dated signature on the physical therapist's plan of care from the patient's physician, surgeon, or podiatrist indicating approval of the physical therapist's plan of care. Approval of the physical therapist's plan of care must include an in-person patient examination and evaluation of the patient's condition and, if indicated, testing by the physician, podiatrist, chiropractor, nurse practitioner, physician assistant and dentists.
    - The physical therapist shall provide notice to the patient, orally and in writing, in at least 14-point type and signed by the patient indicating they are receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing the patient with physical therapy treatment services only after receiving, a date signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

A physical therapist's failure to refer a patient to another qualified professional when the patient's condition is beyond the physical therapist's training subjects the physical therapist to disciplinary.

VT, 1988 — Unrestricted

No Restrictions to Access

Va., 2001 (Revised 2007, 2015, 2021, 2023) — Provisions

A physical therapist who has completed a doctor of physical therapy program or who has obtained a certificate of authorization pursuant to Section 54.1-3482.1 may evaluate and treat a patient without a referral under the following conditions:

- The patient is not receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery; a licensed nurse practitioner acting in accordance with a practice agreement; or licensed physician assistant acting under supervision of a physician, for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services, or
- The patient is receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery; a licensed nurse practitioner acting in accordance with a practice agreement; or licensed physician assistant acting under supervision of a physician, at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services; and
    - The patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician from whom he is currently receiving care.
    - The patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner.
    - The physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist.
- A physical therapist who has not completed a doctor of physical therapy program or who has not obtained a certificate of authorization pursuant to Section 54.1- 3482.1 may conduct a one-time evaluation of a patient, but provide no treatment, without a referral. The PT must immediately refer the patient to an appropriate provider if needed.

Note: A PT may provide physical therapy services via direct access with no restrictions for student athletes in a school setting; workplace ergonomics; wellness, fitness, and health screenings; prevention of disabilities, impairments, and functional limitations; and service for infants and toddlers, from birth to age three, who require physical therapy services to fulfill the provisions of their individualized services plan under Part C of the Individuals with Disabilities Education Act, and students with disabilities who require physical therapy services to fulfill the provisions of their individualized education plan or physical therapy services.

Invasive procedures, with the exception of dry needling, within the scope of practice of physical therapy shall always be performed only under the referral or direction of a physician, osteopath, chiropractor, podiatrist, or dentist, nurse practitioner, or a physician assistant acting under the supervision of a licensed physician.

WA, 1988 — Provisions

- Wound care services may be performed only upon referral from or after consultation with an authorized health care practitioner.
- No restriction on the ability of any insurance entity or any state agency or program from limiting or controlling the utilization of physical therapy services using any type of gatekeeper function.
- Must refer patients when symptoms or conditions are beyond the scope of practice.

WV, 1984 — Unrestricted

No Restrictions to Access

Prohibits electromyography examination and electrodiagnostic studies other than the determination of chronaxia and strength duration curves except under the supervision of a physician electromyographer and electrodiagnostician.

WI, 1989 — Provisions

Written referral of a physician, chiropractor, dentist or podiatrist required except if a PT provides services:

- In schools to children with exceptional education needs.
- As part of a home health care agency.
- To a patient in a nursing home pursuant to the patient's plan of care.
- Related to athletic activities, conditioning or injury prevention.
- To an individual for a previously diagnosed medical condition after informing the individual's physician, chiropractor, dentist or podiatrist who made the diagnosis.

Physical Therapy Examining Board Regulations

Written referral is not required for the following services related to the work, home, leisure, recreational and educational environments:

- Conditioning.
- Injury prevention and application of biomechanics.
- Treatment of musculoskeletal injuries except for acute fractures or soft tissue avulsions.

Must refer a patient to a physician, chiropractor, dentist, podiatrist, or other appropriate health care practitioner if services needed are beyond the scope of physical therapy.

Physical therapists providing services pursuant to a referral shall communicate with the referring physician, chiropractor, dentist, or podiatrist as necessary to ensure continuity of care.

WY, 2003 (Revised 2019) — Unrestricted

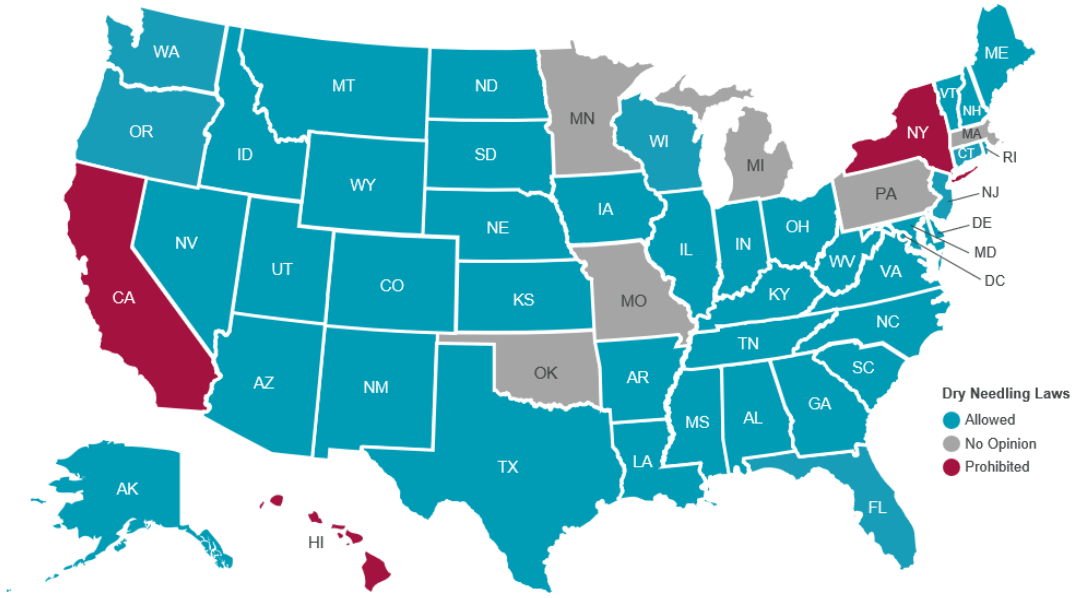
No Restrictions to access

- Must refer to physician if symptoms or conditions require services beyond the scope of physical therapy or if physical therapy is contraindicated.

Last updated: 07/30/24
Contact: advocacy@apta.org

State Laws and Regulations Governing Dry Needling Performed by Physical Therapists in the U.S.

Laws that govern physical therapists' ability to perform dry needling vary among the states. This map and the key below identify which state laws permit dry needling, which prohibit it, and which are silent on it.



Law permits PTs to perform dry needling (41 states and D.C.)

Alabama	District of Columbia	Georgia	Maryland	New Jersey	Rhode Island	Vermont
Alaska	Florida	Idaho	Mississippi	New Mexico	South Carolina	Virginia
Arizona	Kansas	Illinois	Montana	North Carolina	South Dakota	Washington
Arkansas	Kentucky	Indiana	Nebraska	North Dakota	Tennessee	West Virginia
Colorado	Louisiana	Iowa	Nevada	Ohio	Texas	Wisconsin
Connecticut		Maine	New Hampshire	Oregon	Utah	Wyoming
Delaware						

Law prohibits PTs from performing dry needling (Three states)

California	Hawaii	New York

Law is silent on PTs performing dry needling (Six states)

Massachusetts	Minnesota	Oklahoma
Michigan	Missouri	Pennsylvania

This map provides general information only "as is" with no guarantee of completeness, accuracy, or timeliness. It is not a substitute for determining your own regulatory, facility, or payer requirements for practice. You are responsible for fulfilling your legal and professional obligations by complying with applicable local, state, and federal laws and regulations.

Last updated: 07/18/25
Contact: tajahfranklin@apta.org

Written Statement for the Pennsylvania House Professional Licensure Committee
Regarding Proposed Changes to the Pennsylvania Physical Therapy Practice Act
Expansion of Direct Access and Authorization of Trigger Point Dry Needling

Submitted by:
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Expansion of Direct Access for Physical Therapy

Thank you for the opportunity to comment on two very important topics in the physical therapy profession: expansion of direct access to physical therapy services and whether physical therapists should be permitted to perform dry needling in Pennsylvania. I am a clinical professor in the Doctor of Physical Therapy (DPT) program at Drexel University. I have been a professor in entry-level DPT programs for the past 12 years and practiced as a physical therapist for 25 years. Prior to moving to Pennsylvania, I lived and worked in Virginia. I practiced as a clinician in that state for 25 years. While there, I had the opportunity to work in clinics that relied heavily on direct access, and I utilized trigger point dry needling as a complementary intervention initially in 2012.

I am in favor of expanding direct access for physical therapy in the state of Pennsylvania based upon the curriculum content of DPT programs. The Commission on Accreditation in Physical Therapy Education (CAPTE) requires all DPT programs include curricular content in the areas of medical screening and differential diagnosis, pharmacology, diagnostic Imaging, clinical reasoning and evidence-based practice, and clinical education.

DPT students are trained to perform a systems review, identify red flags, and determine whether a patient's presentation is appropriate for physical therapy or requires referral to another provider. This has been recognized as a non-optional component of physical therapy examination since the early 1990s. Physical therapists are trained to screen across body systems including gastrointestinal, cardiovascular, pulmonary, genitourinary, integumentary, neurological and to refer patients with "yes" responses on systems checklists to a physician.[1] Physical therapists are also educated to identify contraindications and precautions, including medication-related risks, medical comorbidities, and patient presentations that warrant referral or

alternative management. Safe practice requires not only determining when an intervention is appropriate but also recognizing when it is not.

DPT programs require pharmacology coursework, so graduates can understand medication effects, interactions, and rehabilitation implications. This knowledge is essential when evaluating patients who lack a physician's medication reconciliation. Additionally, DPT curricula include imaging interpretation. With this, graduates can review and contextualize imaging findings relevant to their patients' musculoskeletal conditions.

CAPTE requires a minimum of 30 weeks of full-time supervised clinical education across multiple settings, during which students must demonstrate competency in patient examination, evaluation, diagnosis, prognosis, intervention, and outcomes assessment. Most programs exceed this minimum.[2] These knowledge and clinical reasoning skills are reinforced through extensive supervised clinical education in a variety of practice settings, where students must demonstrate competency in patient examination, clinical decision-making, safety, and professional judgment before graduation.

Over 94% of DPT graduates report their curricula emphasized "problem solving/critical thinking" and "clinical reasoning."[2] One study at a DPT program found statistically significant increases in perceived competence with direct access from year one to year two ($p = .018$), year one to year three ($p = .005$), and year two to year three ($p = .016$), demonstrating that the curriculum progressively builds the skills and confidence needed for autonomous practice.[3]

Finally, entry-level clinicians must successfully pass the National Physical Therapy Examination to become eligible for licensure in the United States. The examination, administered by the Federation of State Boards of Physical Therapy (FSBPT) explicitly tests competencies essential for direct access practice, including medical screening, clinical decision-making, recognition of red flags, and determination of when referral to another provider is appropriate. The fact that the national licensure examination tests these competencies reflects the FSBPT's position that all licensed physical therapists should be prepared for autonomous practice, including direct access. All 50 states permit some form of direct access. Maintaining restrictive provisions places Pennsylvania behind the national consensus and limits Pennsylvanians' access to timely, cost-effective musculoskeletal care.

Trigger Point Dry Needling

Additionally, I favor the use of trigger point dry needling as a complementary intervention in the treatment of musculoskeletal conditions. Through extensive training in anatomy, musculoskeletal assessment, neuromuscular physiology, and clinical reasoning, all three major professional and regulatory bodies (APTA, CAPTE, and FSBPT) hold positions that support dry

needling as within the scope of physical therapy practice with important nuances regarding additional training requirements.

Dry needling requires precise knowledge of muscle anatomy, neurovascular structures, and spatial relationships to avoid high-risk structures. DPT education provides this through cadaver dissection and vertical integration of anatomy throughout the DPT curriculum. Cadaver dissection is used in 90.5% of all 261 accredited US DPT programs, with 71.4% also using didactic lectures and 60.7% using computer-assisted technology. DPT anatomy curricula cover six regional components including upper limb, lower limb, thorax/abdomen, pelvis, spine, and head with subsections on joints, osteology, muscles, nervous system, vasculature, and spatial orientations. Physical therapists who learned anatomy through dissection demonstrated statistically significantly greater anatomical knowledge in the thorax and abdominal region ($P = 0.02$)[4,5]

DPT curricula devote substantial time to musculoskeletal examination, including palpation of muscles, tendons, ligaments, and bony landmarks; the same skill set required to identify trigger points for dry needling. Physical therapists are educated in infection prevention, universal precautions, safe handling of sharps, management of adverse events, and emergency response. Dry needling education builds upon these foundational competencies while emphasizing patient selection, contraindications, high-risk anatomical regions, and techniques designed to minimize the risk of complications. Trigger points are defined as hyperirritable spots in palpable taut bands of skeletal muscle fibers, and their identification requires the precise palpation skills that are a core DPT competency.[6]

The APTA's position is the DPT degree provides the foundational knowledge base including anatomy, physiology, musculoskeletal assessment, and clinical reasoning upon which dry needling-specific post-professional training is built. The APTA supports additional post-professional education in dry needling technique, safety, and clinical application, but argues that this training builds on, rather than replaces, the extensive foundational education already provided by the DPT curriculum.[7]

The FSBPT's position is dry needling is a skilled intervention that requires additional training beyond entry-level DPT education, but that the DPT degree provides the necessary foundational knowledge in anatomy, physiology, and musculoskeletal assessment to support safe post-professional training in the technique. As with all physical therapy interventions, dry needling is performed within established standards of professional practice that include informed consent, appropriate documentation, ongoing assessment of patient response, and adherence to evidence-based clinical decision-making.

CAPTE's standards are designed to produce graduates who can independently examine, evaluate, diagnose, and intervene across the full scope of physical therapy practice. The accreditation framework is intentionally broad enough to accommodate the evolution of practice, including the adoption of new evidence-based interventions like dry needling, without requiring that every specific technique be taught at the entry level.

Thank you again for allowing our profession to speak on these very important topics. Providing the best pathway for clinical care and allowing physical therapists to perform interventions that support the health and wellbeing of our patients and community members is a goal we all share. I encourage the General Assembly to support these updates to the Physical Therapy Practice Act. Allowing appropriately trained physical therapists to perform dry needling and expanding direct access will improve timely access to high-quality, evidence-informed care for Pennsylvanians while maintaining the profession's rigorous standards for education, patient safety, and professional accountability.

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Testimony of
William J. Kuprevich Jr., D.O., FAOASM
On Behalf of the Pennsylvania Osteopathic Medical Association (POMA)

Before the House Professional Licensure Committee

Chairman, Minority Chairman, and members of the House Professional Licensure Committee:

Thank you for the opportunity to present testimony on behalf of the Pennsylvania Osteopathic Medical Association (POMA). We appreciate the Committee's willingness to hear from stakeholders on these important issues. Changes to healthcare policy deserve careful consideration because they have direct implications for patient safety, quality of care, and access to appropriate treatment. As physicians, we believe it is our responsibility to share our perspective based on decades of clinical experience.

Allow me to briefly introduce myself.

I recently retired after 47 years of practicing as a board-certified osteopathic family physician in Bloomsburg, Pennsylvania. I am also board certified in Sports Medicine and have served as a physician for high school, collegiate, and Olympic athletes throughout my career. My experience culminated in serving as Chief Medical Officer for Team USA at the 2007 Pan American Games in Rio de Janeiro and the 2008 Summer Olympics in Beijing. Following those events, I continued to provide medical coverage for USA Women's Basketball through World Cup competitions until 2021.

Throughout its history, POMA has consistently advocated for policies that prioritize patient safety while supporting thoughtful, evidence-based improvements to healthcare delivery. It is in that spirit that we offer the following comments.

Expansion of Direct Access

POMA has concerns regarding the proposal to expand direct access to physical therapy from 30 days to 90 days without physician involvement.

Thirty days provides a reasonable period to determine whether a patient is making measurable progress toward the treatment goals established during the initial evaluation. If meaningful improvement has not occurred within that timeframe, it is appropriate to reassess the diagnosis and overall treatment plan.

A reevaluation by the patient's primary care physician may confirm that the current course of treatment remains appropriate, or it may identify the need for an entirely different approach.

Additional medical evaluation can uncover conditions that fall outside the scope of musculoskeletal care and may require prompt intervention.

For example, while back pain is commonly caused by muscle strain or other musculoskeletal conditions, it may also be the presenting symptom of a serious underlying disease such as a lung tumor or other systemic illness. These diagnoses may not be readily apparent during physical therapy evaluation alone. Waiting a full 90 days before additional medical assessment could unnecessarily delay diagnosis and treatment, with potentially significant consequences for the patient.

If a revised treatment plan is needed, initiating that plan after 30 days may improve patient comfort, reduce unnecessary delays, and lead to better clinical outcomes rather than continuing ineffective therapy for an additional two months.

POMA believes that collaboration between physical therapists and physicians results in the highest quality patient care. We therefore do not support extending direct access from 30 to 90 days without greater physician involvement after the initial 30-day period. Closer monitoring promotes better outcomes and enhances patient safety.

Dry Needling

The second issue before the Committee is the proposal to authorize physical therapists to perform dry needling.

Understanding the nature of this procedure is essential to understanding our concerns.

Dry needling involves inserting a needle into muscle tissue to treat painful musculoskeletal conditions that limit movement and function. Before the procedure is performed, an accurate diagnosis must first be established, followed by a determination that dry needling is the most appropriate treatment among several available therapeutic options.

Unlike many medical procedures, dry needling is performed without direct visualization of the structures beneath the skin. As a result, significant complications can occur.

For example, inserting a needle into muscles of the upper back or chest carries the risk of puncturing a lung and causing a pneumothorax (collapsed lung). There is also the possibility of injuring blood vessels or other vital structures, creating a true medical emergency.

Within the sports medicine community, dry needling is sometimes performed by orthopedic surgeons, sports medicine physicians, and, in some countries, physical therapists working with elite athletic teams. Importantly, these individuals typically receive extensive education and specialized training beyond their entry-level professional education.

Even among highly trained practitioners, the risks of dry needling are well recognized. Many limit the procedure to specific anatomical regions because of the increased risk associated with

the torso and other sensitive areas. Furthermore, the medical literature continues to evolve, and additional research is still needed regarding patient selection and long-term effectiveness.

Several important questions remain unanswered regarding this proposal.

- What level of education and clinical training will be required before a physical therapist may perform dry needling independently?
- Who will establish the educational standards and competency requirements?
- What qualifications must instructors possess to ensure consistent, high-quality training?
- Will there be standardized certification requirements across Pennsylvania?
- Will practitioners be required to complete continuing education or periodic recertification to maintain competency?
- What physician collaboration will be available when symptoms suggest an underlying diagnosis beyond a musculoskeletal condition?
- What emergency protocols will be required should complications such as pneumothorax, vascular injury, or other adverse events occur, particularly in rural communities where immediate hospital access may be limited?

These questions are not merely academic; they directly affect patient safety.

POMA's position is that authorizing physical therapists to perform dry needling, without first answering these questions and establishing appropriate safeguards, presents an unnecessary risk to Pennsylvania patients.

We remain concerned about three primary areas:

- The adequacy and consistency of training.
- The diagnostic expertise necessary to determine when dry needling is appropriate and when another diagnosis should be considered.
- The ability to recognize and manage potentially serious complications.

Once a new scope of practice is granted, it becomes significantly more difficult to impose additional safeguards or restrictions after the fact. For that reason, it is essential that these issues be resolved before authorization is granted—not afterward.

Accordingly, POMA cannot support expanding the scope of practice to include dry needling at this time.

Should additional evidence, standardized training requirements, physician collaboration, and appropriate patient safety protections be developed, we would be willing to reevaluate our position. At present, however, too many critical questions remain unanswered.

Conclusion

POMA's mission is to advocate for policies that place patient safety first. Patients trust healthcare professionals—and policymakers—to carefully evaluate any proposal that expands the scope of practice of a licensed healthcare profession.

We respectfully urge the Committee to proceed cautiously regarding both the proposed expansion of direct access and authorization of dry needling by physical therapists until sufficient evidence and safeguards are in place to ensure these changes can be implemented without compromising patient safety.

Thank you for the opportunity to present our testimony. I would be happy to answer any questions the Committee may have.

Pennsylvania Chiropractic Association

Legislative Brief to the House Professional Licensure Committee

Proposed Expansion of Physical Therapy Practice Authority

Direct Access and Dry Needling

Prepared by the Pennsylvania Chiropractic Association

July 2026

Core Principle

Expanded clinical authority should not attach automatically to a professional title or general license.

It should be supported by education and demonstrated competency proportionate to the responsibility being granted, consistent with the profession's statutory role, subject to professional accountability, and accompanied by meaningful patient protections.

Executive Position

The Pennsylvania Chiropractic Association supports responsible modernization of Pennsylvania's healthcare practice acts.

Physical therapists are important members of the healthcare community. PCA does not oppose improved access to physical therapy or the performance of dry needling by appropriately trained physical therapists.

The concepts under consideration, however, are not technical or symbolic changes. They would amend the statutory and regulatory framework governing physical therapy and materially expand the legal authority granted to the profession.

The direct-access proposal would double the period during which a qualifying physical therapist may treat a patient without referral from 30 to 60 days. It would also remove portions of the existing qualification structure associated with direct-access authority, including the separate certificate framework, the two-year clinical-experience requirement, and direct-access-specific continuing-education provisions.[1][2][3][4]

The dry-needling proposal would add a skin-penetrating procedure to the physical therapy scope. It would require completion of a certification program approved by the State Board of Physical Therapy but would not establish a minimum amount of education, a hands-on training requirement, an individual competency examination, or an individual Board-issued certification.[5]

PCA respectfully submits that the Committee should defer favorable consideration of these proposed expansions until the proponents demonstrate that the authority requested is supported by evidence, education, demonstrated competency, and patient protections proportionate to the responsibilities being granted.

PCA is not prescribing amendment language. The proponents should be given the opportunity, and bear the responsibility, to offer language that meaningfully resolves the concerns identified in this brief.

Legislative Framework for Evaluating Scope-of-Practice Expansion

Professional practice acts do considerably more than authorize individual procedures. They define a profession's legal role within Pennsylvania's healthcare system, establish the educational and licensing foundation required for practice, determine the degree of independent clinical responsibility assigned to licensees, and establish the safeguards that protect patients when professional authority is expanded.

Accordingly, the relevant legislative question is not simply whether an individual practitioner can be trained to perform a particular procedure. The broader question is whether the profession's statutory, educational, and regulatory framework supports extending that authority across the licensed profession while maintaining appropriate public protections.

The same framework should be applied consistently to every profession, including chiropractic:

1. What patient or healthcare-access problem is the proposed expansion intended to address?
2. What evidence demonstrates that the proposed change is necessary and likely to improve patient access or outcomes?
3. What education and demonstrated competency support the additional authority?

4. Is the requested authority consistent with the profession's existing statutory role and clinical responsibilities?
5. What safeguards protect patients from delayed referral, delayed diagnostic evaluation, or care outside the profession's authorized scope?

This framework does not prevent modernization. It ensures that modernization remains evidence-informed, professionally accountable, and protective of patients.

Proposed Expansion of Physical Therapy Direct-Access Authority

Pennsylvania Already Permits Direct Access

Pennsylvania currently permits qualifying physical therapists to evaluate and treat patients without referral for up to 30 calendar days.[1][2]

That authority is not unrestricted.

Current regulations require referral when physical therapy is contraindicated, when treatment is outside the physical therapy scope, or when treatment exceeds the practitioner's education, expertise, or experience. They also restrict treatment without consultation or referral for nonneurologic, nonmuscular, nonskeletal, acute cardiac, and acute pulmonary conditions.[2]

The current 30-day period is therefore not a prohibition against direct access.

It is the defined boundary of a limited exception within a statutory and regulatory model that otherwise recognizes referral, condition, and scope limitations.

Thirty days permits a qualifying physical therapist to initiate care, monitor the patient's response, determine whether measurable improvement is occurring, and identify when consultation or referral is necessary.

The law then creates a defined clinical checkpoint before treatment continues without referral.

This Is a Practice Act Change

The direct-access proposal would move that mandatory referral point from 30 to 60 days.[4]

It would also remove the separate direct-access certificate structure and the two-year clinical-practice requirement. The proposal would delete the existing direct-access-specific continuing-education requirement, which currently requires at least 10 hours in evaluative procedures for treating patients without referral.[3][4]

The proposal should therefore be evaluated according to its cumulative effect.

It does not merely extend treatment time. It combines broader independent authority with the removal of existing experience and continuing-competency safeguards.

Policy consideration	Current framework	Proposed framework
Treatment without referral	30 days	60 days
Nature of authority	Limited direct-access exception	Extended independent patient management
Clinical checkpoint	Required after one month	Delayed until after two months
Two years of clinical experience	Required	Deleted
Direct-access-specific continuing education	At least 10 evaluative hours	Statutory subsection deleted
Additional preparation for the added month	Not applicable	None identified
Additional patient safeguard for the added month	Current 30-day boundary	None identified

A change in time can become a change in role.

Thirty days facilitates timely initial access.

Sixty days permits two full months of independent patient management. That materially extends professional autonomy and narrows the practical distinction between limited direct access and broader point-of-entry care.

Potential for Delayed Appropriate Care

PCA is not asserting that physical therapists routinely miss serious conditions or fail to refer appropriately.

The concern is structural.

Extending direct-access treatment from 30 to 60 days lengthens the period during which a patient may remain in a physical therapy plan before another authorized provider must become involved.

That concern is greatest when a patient:

- Fails to make measurable progress;
- Develops new or worsening symptoms;
- Presents with an uncertain or evolving clinical picture;
- Requires imaging, testing, or broader diagnostic evaluation;

- Has a condition outside the physical therapy scope; or
- Would benefit from earlier referral or coordinated care.

Most patients may proceed through physical therapy without difficulty.

Practice acts must also protect the patient whose condition does not follow the expected course.

The current 30-day boundary creates a defined opportunity for another clinical perspective. The proposed expansion would remove that mandatory checkpoint for an additional month without identifying an accompanying increase in education, competency, reassessment, or referral safeguards.[4]

Questions the Proponents Should Answer

1. What evidence demonstrates that Pennsylvania's current 30-day period is inadequate?
2. What patient-access or outcome problem will be solved by extending it to 60 days?
3. What additional education, demonstrated competency, clinical checkpoint, or patient safeguard accompanies the additional month of independent management?
4. What process protects against delayed referral or delayed diagnostic evaluation when the patient is not improving or the clinical presentation changes?

If proponents believe those concerns can be resolved through amendment, they should propose the language.

If the added authority cannot be supported by evidence and proportionate safeguards, the existing 30-day boundary should remain.

Why the 30-Day Boundary Matters

Physical therapists evaluate patients and exercise clinical judgment within the physical therapy scope. The issue is not whether they possess examination, screening, or referral skills.

The relevant distinction is the breadth of responsibility assigned to the profession under Pennsylvania law.

Physical therapy practice includes evaluating and testing individuals with mechanical, physiological, developmental, functional, health-related, and movement-related conditions to determine a diagnosis, prognosis, and treatment plan within the physical therapy scope.[1]

Broader point-of-entry responsibility includes independently considering alternative explanations for a patient's symptoms, determining whether imaging or broader diagnostic evaluation may be necessary, deciding whether the proposed care is appropriate, and referring or co-managing the patient when it is not.

These responsibilities may overlap. They are not interchangeable.

Chiropractic Reflects a Point-of-Entry Model

Pennsylvania's Chiropractic Practice Act includes diagnosis when necessary to determine the nature and appropriateness of chiropractic treatment, recognizes X-ray as an instrument of analysis, and permits discipline when a chiropractor fails to refer a patient whose diagnosis indicates that consultation or treatment by another licensed practitioner is appropriate.[6]

National chiropractic education is structured around that responsibility.

Council on Chiropractic Education standards require a minimum 4,200-hour Doctor of Chiropractic program. The required clinical-sciences curriculum includes physical, clinical, and laboratory diagnosis; diagnostic imaging; orthopedics; neurology; patient management; emergency procedures; and clinical decision-making.[7]

CCE standards prepare graduates to provide direct-access, portal-of-entry care, independently establish diagnoses, manage patient care, and determine when referral or co-management is appropriate.[7]

National chiropractic examinations reinforce that preparation. NBCE Part III assesses case history, physical and neuromusculoskeletal examination, diagnosis or clinical impression, diagnostic imaging, laboratory and special studies, and case management. Part IV assesses applied and hands-on competency.[8]

This comparison is not offered to diminish physical therapy.

It demonstrates why changes to a practice act must remain aligned with the profession's underlying statutory and educational model.

The current 30-day framework gives physical therapists meaningful initial access within the physical therapy scope. Extending that period to 60 days materially narrows the practical distinction between limited direct access and broader point-of-entry management.

That change should require a deliberate legislative finding that the profession's education, examination, referral responsibilities, and patient protections are commensurate with the expanded role.

Proposed Addition of Dry Needling to the Physical Therapy Scope

The dry-needling proposal would amend the Physical Therapy Practice Act to include dry needling.

The proposal defines dry needling as the use of a filiform needle to stimulate trigger points and diagnose and treat neuromuscular pain and functional movement deficits. It would permit a licensed physical therapist to perform the procedure after completing a certification program

approved by the State Board of Physical Therapy and would prohibit physical therapist assistants from performing it.[5]

Those provisions offer some protection.

They do not establish a complete qualification standard.

The proposal does not state:

- A minimum amount of education;
- A minimum in-person or hands-on training requirement;
- Required anatomical or safety content;
- An individual competency-testing requirement; or
- An individual Board-issued certification requirement.

Program Approval Is Not Individual Competency

Dry needling is a skin-penetrating procedure performed near nerves, blood vessels, organs, and pulmonary structures.

Prospective studies report minor adverse events such as bleeding, bruising, soreness, and treatment-related pain. Major adverse events were reported less frequently.[9][10]

Those findings do not support prohibiting dry needling.

They support meaningful preparation in anatomy, needle depth and direction, contraindications, infection control, patient selection, complication recognition, emergency response, referral, and hands-on procedural competency.

Approval of an educational program does not necessarily establish that every individual completing it can safely perform the procedure.

The Committee should require proponents to explain:

1. How much education will be required?
2. How much must be conducted in person and hands-on?
3. How will each practitioner demonstrate anatomical knowledge and practical competency?
4. Will the Board approve programs only, or will it also certify the individual practitioners performing the procedure?

PCA does not prescribe the answer. The qualification process should be clear, enforceable, and proportionate to the procedure being authorized.

PCA Applies the Same Standard to Chiropractic

PCA is pursuing its own proposal to add dry needling to the chiropractic scope.

PCA has not requested automatic authority based solely on possession of a chiropractic license.

PCA's proposed model requires individual certification by the State Board of Chiropractic. A chiropractor must either pass an approved examination or complete at least 24 hours of Board-approved education, including at least 20 hours in an in-person, hands-on classroom setting.[11]

Qualification issue	Physical therapy proposal	Standard PCA accepts for chiropractic
Minimum education	Not stated	At least 24 hours
In-person, hands-on education	Not stated	At least 20 hours
Individual Board certification	Not expressly required	Required
Examination pathway	Not stated	Expressly authorized

This comparison is included for a limited purpose.

It demonstrates the standard PCA is willing to apply to its own profession:

Underlying professional education may provide the foundation for expanded authority, but procedure-specific authority should be supported by procedure-specific preparation and individual qualification.

The physical therapy profession may propose a different model. It should be expected to demonstrate that its model provides a reasonably comparable level of competency and patient protection.

Requested Committee Action

PCA respectfully recommends that the Committee defer favorable consideration of proposals expanding physical therapy direct-access or dry-needling authority until the Committee is satisfied that the requested expansions are supported by:

- Objective evidence demonstrating the need for the proposed changes;
- Educational preparation and demonstrated competency proportionate to the authority requested;
- Clearly defined statutory or regulatory safeguards;
- Appropriate mechanisms for referral and patient protection; and

- Transparent Board oversight and public accountability.

PCA welcomes continued dialogue with the sponsors, the physical therapy profession, the State Board of Physical Therapy, and all interested stakeholders regarding amendments that meaningfully address these issues while preserving access to high-quality conservative healthcare throughout the Commonwealth.

Conclusion

The concepts before the Committee present important questions regarding professional autonomy, patient access, education, competency, and public protection. PCA respectfully submits that these issues should be evaluated through a consistent legislative framework applicable to every healthcare profession seeking expanded statutory authority.

Modernization of Pennsylvania's healthcare practice acts should remain evidence-informed, proportionate to the responsibilities being granted, and accompanied by safeguards that maintain public confidence in the Commonwealth's professional licensing system.

PCA appreciates the Committee's careful consideration of these issues and welcomes the opportunity to provide any additional information that may assist the Committee in its deliberations.

Authorities and Supporting Materials

Bracketed numbers in the brief correspond to the authorities and materials below.

1. Commonwealth of Pennsylvania, Physical Therapy Practice Act, Act 110 of 1975, as amended.
2. 49 Pa. Code § 40.61, Certificate of authorization to practice physical therapy without a referral. The regulation addresses qualification, referral obligations, condition restrictions, scope limitations, and the 30-day treatment period.
3. 49 Pa. Code § 40.63, Continuing education for direct-access certificateholders. The regulation requires 30 biennial contact hours, including at least 10 hours in evaluative procedures for treating patients without referral.
4. Informational-hearing materials and proposed statutory language describing an expansion of physical therapy treatment without referral from 30 to 60 days and the removal of existing certificate, experience, and continuing-education provisions.
5. Informational-hearing materials and proposed statutory language describing the addition of dry needling to the physical therapy scope following completion of a State Board-approved certification program.
6. Commonwealth of Pennsylvania, Chiropractic Practice Act, Act 188 of 1986, as amended.

7. Council on Chiropractic Education, *Accreditation Standards: Principles, Processes & Requirements for Accreditation*, January 2026.
8. National Board of Chiropractic Examiners, examination descriptions and Part IV examination materials addressing case history, examination, diagnosis, diagnostic imaging, clinical studies, case management, clinical decision-making, and applied competency.
9. Boyce, D., Wempe, H., Campbell, C., et al. “Adverse Events Associated With Therapeutic Dry Needling.” *International Journal of Sports Physical Therapy*. 2020;15(1):103–113.
10. Brady, S., McEvoy, J., Dommerholt, J., and Doody, C. “Adverse Events Following Trigger Point Dry Needling: A Prospective Survey.” *Journal of Manual & Manipulative Therapy*. 2014;22(3):134–140.
11. PCA scope-modernization materials describing an individual State Board certification model requiring either an approved examination pathway or at least 24 hours of education, including at least 20 hours of in-person, hands-on instruction.

Pennsylvania Medical Society

ADVOCATE. EDUCATE. NAVIGATE.

Written Comments of the Pennsylvania Medical Society Regarding Dry Needling and Expanding Direct Access

Submitted to the Pennsylvania House Professional Licensure Committee

Chairman Burns, Chairman Emrick, and members of the House Professional Licensure Committee:

On behalf of the Pennsylvania Medical Society (PAMED) and the physicians we represent, thank you for the opportunity to submit comments regarding physical therapists doing dry needling and expanding direct access.

Physical therapists are essential members of the health care team. Their expertise complements physicians' training and expertise, and patients benefit most when these professionals work together through coordinated care.

PAMED supports some clarification around dry needling and opposes expanding direct access for physical therapists.

PAMED supports some clarification around dry needling, which would recognize dry needling as part of physical therapy practice, require physical therapists performing it to complete a certification program approved by the State Board of Physical Therapy, and prohibit physical therapist assistants from performing the procedure.

The Centers for Disease Control and Prevention reports that 24.3% of U.S. adults experienced chronic pain in 2023, including 8.5% whose pain frequently limited their life or work activities. Research indicates that dry needling can provide short-term relief for certain forms of musculoskeletal pain.

PAMED opposes expanding direct access for physical therapists in its entirety. Some of the conversations have included things that would:

- Extend physical therapy without a referral from 30 to 60 days;
- Eliminate the separate certificate of authorization;
- Remove the two-year clinical experience requirement; and
- Eliminate the requirement that 10 continuing education hours address direct access evaluation.

Together, these provisions would expand direct access authority while removing safeguards specifically intended to support it. A newly licensed physical therapist could potentially treat a patient without a referral for up to 60 days without completing continuing education focused on evaluating direct-access patients.

PAMED supports timely access to physical therapy. However, symptoms that appear musculoskeletal can arise from neurologic, vascular, infectious, inflammatory, malignant, or other underlying conditions. Extending direct access could delay a broader medical evaluation for patients whose symptoms require additional investigation. Timely coordination among health care professionals provides an important opportunity to reassess the patient, refine the diagnosis, and adjust the treatment plan when symptoms do not improve as expected.

One PAMED physician evaluated a patient whose hip pain and gait instability had been treated as hip osteoarthritis through direct-access physical therapy. A comprehensive medical evaluation ultimately revealed severe cervical spinal stenosis and spinal cord compression as the primary cause of the patient's instability. The correct diagnosis allowed the physician and physical therapist to coordinate an appropriate treatment plan, but the delay prolonged the patient's risk of falls, disability, and neurologic injury.

The current 30-day framework allows patients to begin physical therapy promptly while establishing a reasonable point for addition clinical evaluation. PAMED does not support doubling that period while simultaneously eliminating experience and education requirements intended to protect direct-access patients.

Thank you for considering the perspective of the Pennsylvania Medical Society.

Respectfully submitted,

Lorraine Rosamilia, MD, FAAD
Chair, Board

Ashley E. Wilkerson, MD, FACOG
Vice Chair, Board

APA Penn Statement on Patient Safety and Training Standards in Dry Needling

The Association for Professional Acupuncture in Pennsylvania (APA Penn) offers the following statement to clarify the nature of dry needling, current training standards, and our position on patient safety.

What is dry needling?
Dry needling is a modern term commonly used to describe a procedure that has been documented in medical literature for more than 2,000 years. The procedure involves the insertion of acupuncture needles into muscular trigger points and a lifting/ thrusting, also known as “pistoning,” technique to relieve pain and muscle tension. The term “dry” refers only to the absence of injectable substances. Acupuncture needles are classified as a Class II medical device by the FDA, regulated under 21 CFR 880.5580, and legally only sold to licensed, qualified professionals. Under Pennsylvania law (63 P.S. § 1802), acupuncture is defined as the insertion of needles to stimulate the body for therapeutic purposes, including pain relief. By both legal definition and clinical practice, dry needling falls within this scope.

This is not the first time an East Asian therapy has been separated and rebranded for United States consumers. The Graston Technique™ and generic Instrument-Assisted Soft Tissue Mobilization (IASTM) are gua sha that uses modernized tools to perform scraping strokes for therapeutic benefit, with varying levels of pressure employed. While there’s no mention of gua sha on The Graston Technique’s™ website, a web search for “Graston and gua sha” brings up a variety of results, with several asserting that The Graston Technique™ focuses on targeting deeper muscles and tendons, while gua sha focuses on the surface level of the body. Yet scientific studies and randomized controlled trials have supported gua sha’s impact on biological processes such as reducing inflammation and neural damage (Ge et al., 2025), physical performance (Wang et al., 2019), blood pressure (Zhu et al., 2024), and even gene expression (Qi et al., 2023). The Graston Technique™ represents a monetization of a misinterpretation of an East Asian technique; “dry needling” is the newest misinterpretation.

Who may perform dry needling, and what training is required?
There are no established federal standards to govern the practice of dry needling, and guidelines vary widely by state.

In Pennsylvania, licensed acupuncturists and physicians (MD/DO) who have completed formal physician acupuncture training programs are authorized to perform acupuncture and related needling techniques. Licensed acupuncturists complete a multi-year graduate program, including more than 660 hours of supervised clinical practice, pass multiple national board examinations, and obtain Clean Needle Technique certification before treating patients independently. Physicians pursuing acupuncture certification complete 200 hours of formal postgraduate training. Both groups of licensees are required to complete continuing education credits to maintain their licenses.

By contrast, some physical therapists, occupational therapists, chiropractors, and other healthcare providers in Pennsylvania perform dry needling after completing short continuing education

courses – many that are significantly less than the 200 hours of additional training required for licensed physicians. These courses vary widely in length and quality, often include minimal supervised clinical training, and are not subject to standardized curriculum or educator requirements, competency examinations, or uniform needle safety certification. Dry needling is not part of the required core education for licensure in these professions.

At present, Pennsylvania legislation does not include standardized training hours, educator experience/vetting, supervised clinical experience, Clean Needle Technique certification, adverse-event reporting, or continuing education requirements for non-acupuncturists performing dry needling.

Risks and patient-safety concerns

All needle-based therapies are inherently invasive and carry risk, particularly when performed in high-risk anatomical regions such as the cervical, thoracic, and parascapular areas. In these regions, vital structures, including the lungs, lie close to the surface of the body. For this reason, patients receiving acupuncture in Pennsylvania must provide informed consent acknowledging pneumothorax (collapsed lung) as a potential, though rare, complication.

When training standards are unclear or inconsistent, patients have no reliable way to assess whether the individual performing an invasive needle procedure is adequately prepared to do so safely. The absence of standardized reporting requirements further limits the ability to accurately track and compare adverse events across professions. Based on the limited data that is available from two studies evaluating major adverse events, serious complications from acupuncture performed by licensed acupuncturists are uncommon - the incidence of pneumothorax with acupuncture performed by acupuncturists was 2 per 250,000 treatments (0.0008%), while major adverse events were 20 in 20,494 treatments for physical therapists (0.098%), though the definition of “major adverse events” is not uniform across studies (Smith et al., 2024; Boyce et al., 2020; Ernst et al., 2001;). The incidence rate for physical therapists is 120 times larger than the rate for acupuncturists.

Several national medical organizations, including the American Medical Association, have raised concerns regarding the minimal training requirements associated with some dry needling education programs.

No matter what language is used to describe or differentiate this therapeutic procedure, a person’s body and nervous system reaction to acupuncture or dry needling is the same. Acupuncture fMRI (functional magnetic resonance imaging) research has demonstrated that the “brain response to acupuncture stimuli encompasses a broad network of regions consistent with not just somatosensory, but also affective and cognitive processing” (Huang et al., 2012). Put simply, fMRI data from 46 publications showed that brain activation/ deactivation patterns differed considerably between points (Huang et al., 2012). Practitioners other than acupuncturists/ physician acupuncturists have insufficient context - eastern or western - to assess the appropriateness of needle insertion or post-treatment effects that occur as a result of this systemic response.

This lack of context presents an even higher risk when treating pregnant patients. Traditionally, there are certain acupuncture points and areas of the body that are avoided during pregnancy until late in the final trimester when the body is preparing for birth. While study results are mixed, a systematic review and meta-analysis of seventeen studies identified a “statistically significant increase in the spontaneous onset of labor rate favoring acupuncture vs no acupuncture” (Zamora-Brito et al., 2024). Local pelvic points, distal points, and electroacupuncture were all represented in the publication.

Why is electroacupuncture relevant to a discussion on dry needling? Many non-acupuncturists have built their argument on the foundation that dry needling is not acupuncture because there is no needle retention. Yet there are non-acupuncturist training advertisements that explicitly state that electrical stimulation, and thus needle retention, is included in the course. While consistently expanding knowledge is something every practitioner should strive for, the increasing prevalence of such training in Pennsylvania is a clear demonstration that non-acupuncturists have little intention of sticking to their own definition of dry needling, further increasing the associated risks to patients (*see “Upcoming Dry Needling Courses in Pennsylvania” on page 4*).

Recent reported cases

Recent publicly reported cases, including one involving a Philadelphia resident treated in a physical therapy setting and another involving a professional athlete, have brought renewed attention to these concerns. In both instances, dry needling was associated with pneumothorax (collapsed lung), resulting in pain and trauma, medical intervention, and loss of work and normal activity. While individual cases cannot establish overall incidence rates, they underscore the importance of rigorous training, clear standards, and transparency for patients considering needle-based care.

APA Penn’s position

Patients deserve clear, accurate information about who is performing invasive needle procedures and what training and credentials those practitioners hold. When therapies carry inherent risk, robust education, transparent communication, and consistent oversight are essential to ensure safety.

APA Penn exists to advocate for the highest standards of patient safety, transparency, and high professional standards in needle-based care. We support policies that protect the public by ensuring that invasive procedures are performed only by practitioners with appropriate education, supervised clinical training, demonstrated competency, and accountability.

Examples of Upcoming Dry Needling Courses in Pennsylvania

Intricate Art Spine & Body Solutions, Glen Mills, PA - 8/21 - 8/23
https://intricateartseminars.com/intricate-art-dry-needling-2/

> Throughout the course we demonstrate and discuss our unique autonomic nervous system-centered approach focused on depressing sympathetic activity, elevating parasympathetic activity, and inducing autonomic nervous system homeostasis, the key to health. You will walk away with a deep understanding of our needling methodology and how to help any impairment with dry needling, including why electric auricular vagus nerve needling is a key to success.
>
> The gut-brain axis and the hypothalamic-pituitary-adrenal axis, key players of the autonomic nervous system, are strongly and positively affected by thoughtful needling. You will learn why. Electrical needling is discussed and you will learn why it increases efficacy, pain relief, and comfort of treatment. Advanced neurophysiology is discussed at length in regard to utilizing thoughtful dry needling to positively affect our autonomic nervous system and regulate it toward homeostasis. The key to health.

Evidence in Motion, Southampton, PA 10/10 - 10/11
https://evidenceinmotion.com/course/functional-dry-needling-level-1/

> Functional Dry Needling (FDN) Level 1 teaches technical proficiency in foundational dry needling techniques. This course gives clinicians the tools to elevate their practice and fosters confidence and competence to integrate dry needling into practice the very next day. Musculature taught includes the lumbar spine, posterior hip, thigh and lower extremity, cervical spine, shoulder, and upper extremity.
>
> Anatomy, safety, precautions, and psychomotor aspects of needling are reinforced alongside instruction in history, supportive evidence, clinical application and reasoning, and the use of electrical stimulation with needling. FDN Level 1 is a hybrid learning experience that integrates online learning prior to the lab-based weekend intensive.

Professional Pelvic Health Consultants, Newton, PA - 10/24 - 10/25
https://www.pphc.co/product-page/dry-needling-pelvic-health-pregnancy-postpartum-considerations-pa-8-15-26

> Dry Needling + Pelvic Health: Pregnancy + Postpartum Considerations is a lab intensive, hybrid course designed with the pelvic health and orthopedic practitioner in mind who treat a perinatal population. This course is an innovative approach to treating the neuromusculoskeletal conditions commonly associated with the pregnancy and postpartum periods. This dry needling course will address physiologic changes that occur during pregnancy, dysfunctions such as pregnancy and postpartum pain syndromes, pelvic floor dysfunctions, pregnancy-related carpal tunnel syndrome, pregnancy-related plantar fasciitis, labor induced peripheral neuropathy, postural dysfunction, headaches and much more! We will instruct participants in the application of dry needling to the extremities, cervical spine, thoracic spine, lumbosacral spine and pelvic floor musculature. This course will provide a comprehensive review of anatomy, a strong emphasis on safety and precautions, ample lab time to optimize dry needling techniques, as well as dialogue surrounding clinical integration and relevant evidence.

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Written Comments

Informational Meeting

Extended Direct Access to Physical Therapy Services and Dry Needling

House Professional Licensure Committee

July 28, 2026

Introduction

Independence Blue Cross (IBX) appreciates the opportunity to submit written comments to the House Professional Licensure Committee for this informational meeting on potential changes to the scope of practice for physical therapists.

IBX recognizes the important role physical therapists play in the delivery of healthcare and in supporting positive patient outcomes. As part of our commitment to ensuring access to high-quality care, IBX provides coverage for physical therapy services through a wide range of health benefit plans and products.

We respectfully submit the following comments to highlight considerations related to patient care, care coordination, and health insurance coverage.

Direct Access to Physical Therapy (PT) Services

The Committee's first area of focus is expanding direct access to PT services without a referral from a licensed physician or other qualified healthcare professional.

It's important to highlight the vital role a member's primary care provider serves in promoting care coordination. Primary care providers are uniquely positioned to oversee a patient's overall treatment plan, ensure that care provided by multiple practitioners is appropriately integrated, maintain comprehensive medical records, and identify potential underlying conditions that may require further evaluation and treatment. These safeguards help reduce the risk of fragmented care and delayed diagnosis.

In addition, certain plan designs, including Health Maintenance Organization (HMO) and Point-of-Service (POS) products, utilize referral requirements as a core component of their care management framework. Under these plans, referrals are generally required for members to access specialty care services, including physical therapy. Changes to direct access requirements may therefore have implications for existing benefit designs and care coordination models.

Further, while physical therapists provide valuable care, PT services have been the subject of documented fraud and improper billing cases involving Medicare, Medicaid and commercial insurers. Most recently in Pennsylvania was the federal prosecution of the owners of Hertel & Brown Physical and Aquatic Therapy who were convicted of improper billing and the use of unlicensed personnel to provide services billed as though they were rendered by licensed practitioners. Examples like this underscore the importance of oversight.

The involvement of primary care providers or prescribing healthcare professionals serves as an important safeguard that supports accurate diagnosis, coordinated treatment, and appropriate utilization of healthcare services.

Dry Needling

The second topic before the Committee is authorizing physical therapists to perform dry needling. IBX similarly urges caution with respect to this proposal.

Coverage determinations are ultimately governed by the terms and conditions of an individual member's health benefit plan. Currently, trigger point injections involving the administration of anesthetics are generally covered by IBX for the treatment of myofascial pain syndrome when established medical necessity criteria are met.

By contrast, trigger point procedures that do not involve the injection of medication, commonly referred to as dry needling, are currently considered investigational and experimental. This coverage determination is based on current analysis of available peer-reviewed literature and evidence regarding safety, efficacy, and long-term clinical benefits of the procedure.

As with all emerging treatments and procedures, IBX continuously monitors this evolving body of scientific and clinical evidence and evaluates coverage policies accordingly.

Conclusion

Again, we appreciate the opportunity to provide comments on these proposals. Physical therapists are valued members of the healthcare delivery system and provide important services that contribute to patient recovery and overall well-being. We offer these comments to assist the Committee in understanding the potential implications these proposals may have for patient care, care coordination, health insurance coverage, and existing healthcare delivery frameworks.

Thank you for your consideration. We look forward to continuing to serve as a resource to the Committee on these and other healthcare-related issues.