DIRECT ACCESS TO THE PHYSICAL THERAPIST
A Practice Act Revision (**H.F. 2689/S.F. 3049**)

BREAKING DOWN BARRIERS TO PHYSICAL THERAPY IN MINNESOTA

For 45 years, Minnesotans have had the ability to see a physical therapist (PT). Yet patients still hit unnecessary roadblocks: a 90-day limit on care without a doctor referral, extra physician visits, and confusing rules for new PTs. These obstacles don't make care safer. They cost money, delay recovery, and sometimes lead to more expensive treatments.

What this bill does:

- **Keeps patients in care:** Eliminates the 90-day pause and the need for physician referrals, so patient care continues smoothly without interruptions that could impede or slow patient progress.
- **Reflects modern practice:** Updates the law to match the education, training, and licensing of Doctors of Physical Therapy.
- **Clarifies teamwork:** Modernizes the rules for how PTs and physical therapist assistants (PTAs) work together.
- **Protects patients and the profession:** Strengthens title and term protections and allows the Minnesota Board of Physical Therapy to enforce the rules with fines when needed.

What this bill does not do:

- It does **not** give PTs new abilities or expand their scope of practice.

Why this matters:

- **Saves money:** Patients avoid unnecessary doctor visits, delayed care, and costly interventions. Insurance plans already recognize that referrals are often an unnecessary expense.
- **Safe and proven:** States with unrestricted PT access don't see higher risk or insurance claims. In 45 years, the Minnesota Board of Physical Therapy has never disciplined a PT for patient harm from self-referral.
- **Smart policy:** The U.S. military uses the same principle to keep people healthy and ready while avoiding delays and extra costs.
- Twenty-one states, including North and South Dakota, Iowa, and Nebraska, already allow for unrestricted direct access to PT services.

H.F. 2689/ S.F. 3049 will ensure that Minnesotans get faster, safer, and more efficient care without paying more.

If you have questions about this bill, contact info@mnapta.org

APTA Minnesota
A Chapter of the American Physical Therapy Association

Physical Therapy Direct Access: MYTHS and TRUTH

HF 2689 (Reyer)/SF 3049 (Boldon)

MYTH: Removing the 90-Day Referral puts patients at risk

TRUTH: There is no evidence showing increased patient harm from direct access to physical therapy. The Minnesota Board of Physical Therapy has reported no disciplinary actions related to patient harm from access without referral, and malpractice insurers do not charge higher premiums in states that allow full direct access. Current law also requires PTs to refer patients whose conditions fall outside the scope of physical therapy, with disciplinary consequences for failing to do so.

MYTH: Physical therapists lack the education to provide unsupervised care.

TRUTH: PTs are trained at the doctoral level in a first line of entry model. Acceptance to PT programs is highly competitive and after the rigorous didactic portion students must complete and pass full time internships prior to sitting for the national licensure exam. PTs are licensed under the MN Board of Physical Therapy. Licensed PTs have never required supervision and for 40 years have been providing physical therapy services without referral. This bill removes the 2 remaining barriers to accessing the services of a PT.

MYTH: Physical therapists can't treat without referral currently.

TRUTH: To correct this misinterpretation of current statute:

1. No referral is required for prevention and wellness services (and there is no 90-day limit)
2. No referral is required for patients who have been previously diagnosed (and there is no 90-day limit)
3. No referral is required for patients who have not been previously diagnosed, but for those who require services beyond 90 days, the patient does have to secure a referral to continue. Our bill addresses this arbitrary access barrier
4. Newly licensed PTs (under 1 year) must either practice under collaboration or must require a referral. Our bill also addresses this language that was put in place in 1985 when PT education was at the bachelor's degree level.

MYTH: Physical therapists aren't trained or licensed to provide a medical diagnosis.

TRUTH: That is true. The statutory scope of practice includes evaluation which excludes a "medical" diagnosis. However, the PT evaluation includes a diagnostic process that differentiates patterns of symptoms and impairments that are consistent with conditions appropriate for physical therapy, and those that are not and should be referred. This type of diagnosing drives the interventions and has been required under statute, with or without referral, for 40 years in MN.

MYTH: This bill will expand the scope of practice of the physical therapist.

TRUTH: The scope of practice for PTs was written in 1952 and is not being altered or expanded. What is being changed are the barriers to access to the PT.

APTA Minnesota
A Chapter of the American Physical Therapy Association

Minnesota Board of Physical Therapy
Report to the Legislature

Disciplinary Actions taken against Physical Therapists whose conduct resulted in physical harm to a patient during August 1, 2008-January 12, 2010

Pursuant to MS 3.197 the cost of preparing this report was approximately $30.

Statutory Authority: Minnesota Session Law 2008c199s4

REPORT:
There are no Board of Physical Therapy disciplinary actions against physical therapists whose conduct resulted in physical harm to a patient, as the result of statutory changes made in the 2008 legislative session to MS 148.75 and 148.76, subdivision 2.

Reference: 2008 Session Laws, Chapter 199
Sec. 4. **BOARD OF PHYSICAL THERAPY REPORT.**
By January 15, 2010, the Board of Physical Therapy must report to the legislature any disciplinary actions taken against physical therapists whose conduct resulted in physical harm to a patient, only if that conduct was a result of the statutory changes made in the 2008 legislative session to Minnesota Statutes, sections 148.75 and 148.76, subdivision 2.

Date: January 12, 2010
Author: Stephanie Lunning, Executive Director
Published by Minnesota Board of Physical Therapy, 2829 University Ave SE, Suite 420, Minneapolis, MN 55414, 612-627-5406, physical.therapy@state.mn.us, www.physicaltherapy.state.mn.us

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March 6, 2026

Health Finance and Policy Committee
Chairs Bierman and Backer
H.F. 2689

Senate Health and Human Services Committee
Chair Wiklund
S.F. 3049

Dear Senators and Representatives:

I am writing in support of H.F. 2698, S.F. 3049, the Access to Physical Therapy Bill, which removes the current limitations and barriers to direct access for physical therapists. I write from dual capacities, a scientist at the University of Minnesota, and the Program Director for the University of Minnesota Doctorate in Physical Therapy (DPT) program. I do not officially speak on behalf of the University, but as a licensed physical therapist in the State of Minnesota, and educator, and patient myself.

Importantly, direct access to physical therapy services has been the law in Minnesota since the 1980s, with some limitations that this updated bill seeks to address. Thus, the bill does not change the scope of practice, but some barriers to access change (removal of 90-day limit and 1-year supervised employment restrictions). The primary concern raised in opposition to the proposed Physical Therapy Bill language is the potential for patient harm. This is a critical consideration, however, there is simply no evidence for direct access to physical therapy resulting in patient harm, nationally or in the state of Minnesota. **No adverse events related to direct access are reported from tracking that has occurred in Minnesota (no reports of harm) or in the scientific literature.** As a scientist, a thorough search of the scientific literature reveals **no publications identifying any increase in patient safety incidents in physical therapy unrestricted direct access settings.** Instead, there is evidence to support *reduced cost, reduced use of imaging, higher patient satisfaction, less medication usage, and impressively, lesser utilization of physical therapy*, as care was initiated sooner. Notably, **the military model has incorporated direct access physical therapy for many years,** improving access to care, readiness, and saving millions of dollars annually. Further supporting this safety premise, physical therapy malpractice insurance does not "risk adjust" for unrestricted direct access states versus limited direct access states.

An additional, vitally important reason to support this legislation is cost savings. In today's healthcare environment, unnecessary "gatekeeper" appointments add unnecessary cost as well as inconvenience and treatment delay to patients. Physician time is also lost to paperwork rather than ability to see new patients in practice. When patients have to wait for care due to physician shortages, outcomes go down and costs go up. In addition, many clinics are unable to hire new graduate physical therapists because of the restriction of one year of supervised practice prior to being able to see patients through direct access. This creates unnecessary barriers to care for

patients when there is a shortage of physical therapy practitioners, particularly in central and rural Minnesota.

When direct access to physical therapy was first initiated in Minnesota, physical therapists were being trained at the Bachelor's degree level. Our physical therapists are now trained with a professional doctorate or DPT (as are all new physical therapists across the nation). This is a 3-year post-graduate degree. At the University of Minnesota, the degree includes 136 graduate credits and a year of supervised full time clinical experiences. All graduates must pass a national licensure examination, and satisfy the licensure regulations of the respective state(s) where they practice. *The commission on physical therapy education accreditation no longer accredits programs that are not training physical therapists at the doctoral level. The accrediting body requires that educational programs assess student safety for clinical practice prior to beginning full-time clinical rotations.* Our DPT faculty also contribute to the education of nurse practitioners and medical resiidents in preparation for musculoskeletal practice. *Doctorate in Physical Therapy students have extensive education in screening, assessing for red-flags, and differential diagnosis, allowing them to refer to physician practitioners when needed for care outside their scope.*

Physical therapists are experts in movement assessment and non-surgical, non-pharmacologic interventions, ideally suited toward front line conservative care for musculoskeletal health concerns. In the current era attempting to reform the healthcare system toward value-based payments incorporating both quality and efficiency, this bill is an important positive step for patient access and affordability.

Sincerely,

Paula M. Ludewig, PT, PhD, FAPTA
Professor and Director
Division of Physical Therapy and Rehabilitation Science
Department of Family Medicine and Community Health

Written Testimony in Support of H.F. 2689 / S.F. 3049

Submitted to:
Minnesota House Health Finance & Policy Committee
Minnesota Senate Health & Human Services Committee

March 2026

Dr. Dylan Ziehme
Doctor of Physical Therapy
Board-Certified Clinical Specialist in Orthopedic Physical Therapy
St. Paul, Minnesota — House District 66A
Licensed Physical Therapist: Minnesota & Wisconsin
Practicing Physical Therapist, Hudson, Wisconsin

Chair and Members of the Committee,

My name is Dylan Ziehme. I am a Doctor of Physical Therapy, a Board-Certified Specialist in Orthopedic Physical Therapy, and am licensed to practice physical therapy in both Minnesota and Wisconsin. I am a constituent in District 66A living in St. Paul and practice as a physical therapist in Hudson, WI. I am writing in support of H.F. 2689 / S.F. 3049, the companion bills modifying Minnesota's physical therapy practice statute.

From my perspective as a clinician practicing just across the Minnesota–Wisconsin border, I see the access issues addressed by this bill every week. Patients travel from across the Twin Cities into western Wisconsin because they cannot access timely specialty physical therapy care in the metro. Some come from as far as Golden Valley, which can mean a 45–60-minute drive across the metro for care. These delays are particularly pronounced for specialty services, where wait times are often substantially longer than for general outpatient visits. I see this most clearly in pelvic health, where pregnant and postpartum patients travel from the city because they cannot wait months for care during pregnancy or after delivery. I also see the same pattern in musculoskeletal care and in obesity-related care. My obesity caseload alone grew approximately 40% last year, reflecting the growing demand for conservative care addressing obesity and metabolic conditions. When patients cannot access rehabilitation services promptly, recovery is delayed, symptoms persist longer, and opportunities for early intervention are missed. These experiences make the access issues addressed by this bill very real for my patients and reflect a broader capacity challenge in our health system: when rehabilitation care

is delayed, patients remain in primary care, urgent care, emergency departments, and specialty clinics longer than necessary.

These bills remove two statutory barriers that interrupt efficient care: the current 90-day treatment limitation without referral and the first-year collaboration restriction for newly licensed physical therapists. The legislation also updates PTA collaboration requirements to reflect a contemporary team-based model, including real-time collaborative treatment sessions and regular documentation of plan-of-care appropriateness.[1-3]

From a patient access standpoint, those provisions matter. Under current law, patients may have to pause effective treatment after 90 days to obtain an additional referral before continuing care, and newly licensed PTs face a first-year restriction that can create another unnecessary barrier to timely access. These requirements delay recovery, create unnecessary appointments, and add avoidable administrative work. Removing them improves the patient experience, supports timely access to rehabilitation, and helps decompress primary care, urgent care, emergency departments, and orthopedic clinics by allowing patients to access physical therapy as an additional point of entry. This also reduces waste by eliminating unnecessary or duplicative visits and reducing premature imaging and prescribing that do not improve patient outcomes.[1,4-7]

Questionnaire B explains that typical DPT programs require three years of post-baccalaureate education, an average of 123 post-baccalaureate credits, and an average of 40 weeks of full-time clinical rotations totalling approximately 1,600 hours of supervised clinical training before licensure. Accreditation standards require training in examination, evaluation, differential diagnosis, and clinical decision making within the physical therapy scope of practice, and these competencies are tested on the National Physical Therapy Examination (NPTE) prior to licensure.[3]

Questionnaire B further states that more than 50% of the National Physical Therapy Examination (NPTE) assesses knowledge and skills necessary to assure competency in diagnosis across the lifespan, including determining whether a patient’s condition is appropriate for physical therapy management or requires referral to another clinician.[3] In physical therapy practice, diagnosis refers to identifying a patient condition when the appropriate management falls within the physical therapy scope of practice, while recognizing when findings require referral to another clinician. In my practice, we collaborate closely with physicians and routinely refer patients back to primary care, obstetrics, orthopedics, and other specialists when findings fall outside the physical therapy scope of practice.

The bill clarifies statutory language to reflect this established clinical process and aligns Minnesota statute with current education, licensure testing, and routine physical therapy practice.

Published research supports the safety and value of allowing patients to access physical therapy earlier in an episode of care. Across 472,013 military PT visits, investigators reported no adverse events attributable to PT diagnosis or management, and university health research

found no unidentified serious pathology or adverse events among 12,976 patients who accessed PT without referral. Comparative studies have also reported similar safety profiles between advanced-practice PT clinics and primary care settings. Malpractice actuarial data are consistent with that literature: CNA/HPSO reports similar loss experience across states and does not use direct access status as an underwriting risk factor or basis for premium differentials. Research on low back pain also associates earlier PT access with lower physician utilization, less imaging, lower odds of early and long-term opioid use, and substantially lower downstream costs, including approximately 60% lower total low-back-pain-related costs in one Military Health System analysis.[4-11]

Collectively, the literature associates earlier PT access with reduced physician visits, imaging, opioid exposure, and downstream utilization for common musculoskeletal conditions while maintaining appropriate referral to physicians when needed.[4-13]

For these reasons, I support H.F. 2689 / S.F. 3049. From my position in Hudson, I see the practical effects of delayed access in the metro every week when patients cross the river for care they could and should have been able to receive sooner closer to home. They are traveling out of state because the wait for specialty PT closer to home is months long. That is not a minor inconvenience; it is a real access problem for patients dealing with pain, disability, and disease. Removing these statutory barriers would improve patient access and patient experience, reduce avoidable delays and waste, and help more patients get the right care sooner.

Thank you for your consideration.

Dylan Ziehme, DPT, OCS

References

1. Minnesota House File 2689 / Senate File 3049 bill text.
2. Minnesota bill text: current 90-day treatment limitation and first-year collaboration restriction in the amended prohibitions section.
3. Questionnaire B for H.F. 2689 / S.F. 3049: doctoral education, average 123 post-baccalaureate credits, and average 40 weeks of full-time clinical rotations.
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6. Mabry LM, Notestine JP, Moore JH, Bleakley CM, Taylor JB. Safety Events and Privilege Utilization Rates in Advanced Practice Physical Therapy Compared to Traditional Primary Care: An Observational Study. Mil Med. 2020;185(1-2):e290-e297.
7. CNA/HPSO. Levels of Patient Direct Access. January 2025.

8. Garrity BM, McDonough CM, Ameli O, et al. Unrestricted Direct Access to Physical Therapist Services Is Associated With Lower Health Care Utilization and Costs in Patients With New-Onset Low Back Pain. Phys Ther. 2020;100(1):107-115.
9. 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.
10. Kazis LE, Ameli O, Rothendler J, et al. Observational retrospective study of the association of initial healthcare provider for new-onset low back pain with early and long-term opioid use. BMJ Open. 2019;9(9):e028633.
11. Childs JD, Fritz JM, Wu SS, et al. Implications of early and guideline adherent physical therapy for low back pain on utilization and costs. BMC Health Serv Res. 2015;15:150.
12. Boissonnault WG, Ross MD. Physical therapists referring patients to physicians: a review of case reports and series. J Orthop Sports Phys Ther. 2012;42(5):446-454.
13. VA/DoD Clinical Practice Guideline for the Diagnosis and Treatment of Low Back Pain. 2022.

Chair Backer, Chair Bierman and Members of the House Health Committee,

As physicians who regularly collaborate with physical therapists in caring for our patients, we support HF 2689/SF 3049 and the removal of Minnesota's current 90-day limitation on direct access to physical therapy.

In clinical practice, physical therapists are trusted partners in patient care. They are highly trained in evaluating movement, identifying musculoskeletal conditions, and guiding patients through recovery from injury, surgery, and chronic conditions. Physicians partner with physical therapists every day to help patients.

The current 90-day restriction does not improve patient safety. Instead, it creates an administrative barrier that can interrupt care for patients who are progressing well under the supervision of a licensed physical therapist. Requiring patients to pause treatment solely to obtain a referral often delays recovery and adds unnecessary strain to already busy medical practices.

Importantly, physical therapists are trained to recognize when a patient's condition requires medical evaluation. When symptoms fall outside their scope of practice or raise medical concerns, physical therapists appropriately refer patients to physicians or other healthcare providers. This collaborative approach is standard practice in modern healthcare.

Removing the 90-day barrier does not diminish the role of physicians. Rather, it allows each member of the healthcare team to practice to the full extent of their training while ensuring patients receive timely, appropriate care.

Maintaining unnecessary restrictions on physical therapy access does not protect patients, it delays care and costs patients money. Eliminating this barrier will improve continuity of treatment, reduce administrative burden, and allow patients to recover more efficiently.

For these reasons, we respectfully urge your support for HF 2689/SF 3049.

Sincerely,

Shanda R. Dorff, MD, FAAFP
Parisa Salehi, MD
Christina Gonzaga, DO
Katherine Rogers, MD
Nathalie Lechault, MD
Ifeanyi Opoku, MD
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January 2026

Justin Elliott
Vice President, Government Affairs
American Physical Therapy Association
3030 Potomac Ave., Suite 100
Alexandria, VA 22305-3085

RE: Levels of Patient Direct Access

Dear Mr. Elliott:

CNA has been the underwriting company for the APTA-endorsed physical therapy professional liability insurance plan, offered by Healthcare Providers Service Organization, since 1992, and is responsible for managing reported claims.

CNA insures physical therapists who are employed and practice in various locations and specialties. As part of our underwriting due diligence, CNA regularly monitors professional liability claim trends to help ensure that we are adequately accounting for new and emerging risks.

We are aware that as of January 1, 2026 all 50 states, the District of Columbia, and the U.S. Virgin Islands allow patients direct access to physical therapist services for both evaluation and some level of treatment without a physician referral. The level of access to treatment without a referral can be categorized as limited, provisional, and unrestricted. We regularly monitor trends to be sure that we are adequately accounting for all risks. The current actuarial summary of the CNA/HPSO Program indicates that the average loss experience from physical therapy services in all states to be similar and not influenced by the level of patient direct access.

Based on the above, our underwriting practices have not changed. Level of patient 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 states with unrestricted patient direct access. We currently have no specific underwriting concerns with respect to direct access for physical therapists or the level of patient access.

Sincerely,

David Griffiths
President-Healthcare

Copy: Crystal Miller, CNA Healthcare

Tseganesh Selameab, MD, FACP
Governor, ACP Minnesota Chapter

Michelle Herbers
Executive Director, ACP Minnesota Chapter
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March 11, 2026

Members of the Health Finance and Policy Committee,

On behalf of the Minnesota Chapter of the American College of Physicians (MN-ACP), representing nearly 2,500 internal medicine physicians and subspecialists across our state, I write to oppose HF 2689.

Physical Therapists (PTs) are valuable members of health care teams. However, there is a significant difference in the depth and breadth of training between PTs and physicians. Physicians complete four years of medical school before entering 3-5 years of residency, sometimes followed by 1-3 years of fellowship. In comparison, PTs typically complete 2-3 years of training in total.

If this bill were to become law, PTs would be able to diagnose and treat patients indefinitely without physician referral. This will lead to situations where PTs with significantly less training and experience than physicians would be entirely responsible for the development and implementation of treatment plans of potentially complex patients. This would allow any PT to practice without physician oversight. In contrast, physicians in their first year of residency, following 4 years of medical school compared to 2-3 years of PT school, cannot even practice without physician oversight. This is an extreme expansion of the PT scope of practice that will lead to missed diagnosis and worse outcomes for patients.

Physicians are trained to recognize complex and subtle symptoms that may indicate serious underlying conditions – such as cancer, neurological disorders, or systemic disease – that may initially present as musculoskeletal complaints. Research demonstrates that direct access to PTs without physician involvement increases the risk of missed or delayed diagnoses [Childs et al., 2005, "A description of physical therapists' knowledge in managing musculoskeletal conditions," BMC Musculoskeletal Disorders].

On behalf of MN-ACP, I respectfully urge you to oppose HF 2689.

Sincerely,

Tseganesh Selameab, MD
Tseganesh Selameab, MD, FACP
Governor, American College of Physicians Minnesota Chapter

Sally Berryman, MD
Sally Berryman, MD, FACP
Chair, Health and Public Policy Committee, American College of Physicians Minnesota Chapter

Minnesota Chapter

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American Academy of Pediatrics
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March 11, 2026

Dear Members of the Health Finance and Policy Committee,

On behalf of the more than 1,000 pediatricians and pediatric subspecialists represented by the Minnesota Chapter of the American Academy of Pediatrics (MNAAP), we write in strong opposition to HF 2689.

Pediatricians are committed to ensuring that children and adolescents receive care from the right professional, at the right time, and in the right setting. Physical therapists are valued members of the pediatric care team, and pediatricians frequently partner with them to support children with musculoskeletal conditions, developmental delays, injuries, and rehabilitation needs. Maintaining clear roles within the care team is essential to ensuring coordinated, safe, and high-quality care for Minnesota's children.

MNAAP is concerned that HF 2689 removes important patient safety safeguards by eliminating the current 90-day cap on direct patient access to physical therapy without physician involvement. In pediatric practice, persistent musculoskeletal symptoms can signal serious underlying conditions. These conditions may initially appear similar to common musculoskeletal complaints but require timely medical evaluation to ensure appropriate diagnosis and treatment. The current 90-day referral requirement helps ensure that children with unresolved symptoms receive appropriate medical assessment.

The bill also expands the statutory definition of physical therapy to include "diagnosis other than medical diagnosis." While this language states that it does not constitute the practice of medicine, the use of the term "diagnosis" without clear definition of risks creates confusion about professional roles in patient care. The American Academy of Pediatrics has consistently emphasized that scope-of-practice expansions should not blur professional responsibilities or allow non-physician clinicians to assume roles that require the depth and breadth of physician training.

Minnesota's current framework appropriately balances timely access to physical therapy with necessary medical oversight. Maintaining the 90-day referral requirement protects patients while preserving the collaborative team-based model of care that benefits children and families across our state.

For these reasons, the Minnesota Chapter of the American Academy of Pediatrics respectfully urges the committee to oppose HF 2689.

Sincerely,

Katie Smentek, MD
President, Minnesota Chapter American Academy of Pediatrics

March 10, 2026

Representative Jeff Backer, Co-Chair
House Health Finance and Policy Committee
Centennial Office Building
Saint Paul, Minnesota 55155

Representative Robert Bierman, Co-Chair
House Health Finance and Policy Committee
Centennial Office Building
Saint Paul, Minnesota 55155

Re: MPMA Opposition to House File 2689

Dear Co-Chair Backer, Co-Chair Bierman, and Committee Members:

I am writing in my capacity as President of the Minnesota Podiatric Medical Association (MPMA), which represents more than 200 podiatric physicians and surgeons across Minnesota.

MPMA strongly opposes House File 2689, the physical therapy direct access bill introduced by the Minnesota Chapter of the American Physical Therapy Association (APTA-MN). While framed as an access bill, the legislation would significantly expand the scope of practice for physical therapists while simultaneously eliminating important patient safety protections currently embedded in Minnesota law.

This bill expands the physical therapy scope of practice by introducing diagnostic language into the practice act while removing existing medical oversight provisions that help ensure patients receive appropriate medical evaluation and care. Expanding autonomy while eliminating safeguards that require involvement of physicians, podiatrists, and other diagnostically trained providers creates a clear risk for delayed diagnoses, inappropriate treatment, and avoidable complications—particularly for patients with complex or serious conditions.

Under current Minnesota law, patients already have significant access to physical therapy services. Patients may see a physical therapist for prevention, wellness, exercise, and education once their condition has been diagnosed by a medical doctor, podiatric physician, chiropractors, dentist, or certain advanced practice nurses. In other words, patients can access physical therapy without an initial referral so long as a qualified provider has established the medical diagnosis. For these patients, treatment may continue for up to 90 days before a follow-up evaluation by a diagnostically trained provider is required.

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House File 2689 removes these critical patient protections. Specifically, the bill:

- Eliminates the requirement that a medical diagnosis be established before treatment begins
- Removes the 90-day limitation requiring follow-up medical evaluation
- Eliminates the requirement that newly licensed physical therapists practice under collaboration or physician orders during their first year of licensure
- Adds "diagnosis" language to the physical therapy practice act

Taken together, these provisions represent a substantial expansion of autonomy while removing the very safeguards designed to protect patients.

Although the bill adds the word "diagnosis" to the practice act, it explicitly limits this authority to a "physical therapy diagnosis" and expressly states that it does not constitute a medical diagnosis. This distinction exists for an important reason: physical therapists are not trained or licensed to make medical diagnoses.

A functional evaluation performed by a physical therapist is fundamentally different from a medical diagnosis and treatment plan developed by a physician, podiatric physician, dentist, chiropractor, or advanced practice nurse. Physical therapy education is primarily focused on rehabilitation and therapeutic modalities intended to address functional deficits after a diagnosis has already been established. It does not include the extensive medical diagnostic training required to evaluate underlying pathological conditions, order and interpret diagnostic tests, or manage complex medical issues.

The difference in education and clinical training between physical therapists and physicians or podiatric physicians is substantial. A Doctor of Podiatric Medicine (DPM) completes four years of podiatric medical school followed by a three-year residency program, with many completing additional fellowship training. During their education and residency, podiatric physicians rotate through numerous medical and surgical specialties—including internal medicine, family medicine, radiology, pathology, infectious disease, emergency medicine, anesthesiology, dermatology, orthopedics, vascular surgery, and general surgery—and are held to the same standards as their MD and DO colleagues. This comprehensive training provides the diagnostic foundation necessary to identify and treat complex medical conditions affecting the foot and ankle and the broader systemic conditions that often manifest there.

Podiatric physicians, like medical doctors and certain other licensed providers, are authorized to diagnose medical conditions, order and interpret diagnostic imaging such as MRI and CT scans, and prescribe medications. Physical therapists cannot order diagnostic imaging or prescribe medications, which significantly limits their ability to evaluate underlying pathology and underscores why they are not licensed to make medical diagnoses.

MPMA's concerns are not theoretical. Our members have firsthand clinical experience with situations in which physical therapists have exceeded the boundaries of their scope of practice and training. Examples reported by our members include physical therapists independently managing postoperative wounds, altering surgical care plans without consulting the operating surgeon, disregarding postoperative instructions, and performing debridement procedures without physician orders. These situations create real patient safety risks and demonstrate the importance of maintaining appropriate medical oversight.

APTA-MN has argued in its Scope of Practice Questionnaire that a 2008 legislatively mandated report from the Board of Physical Therapy found no evidence of harm associated with direct access and that opponents have failed to produce credible evidence of patient safety concerns. This argument is misleading.

Complaints filed with the Board of Physical Therapy are not publicly available unless they result in formal disciplinary action such as a public reprimand. Most complaints are resolved confidentially and therefore never appear in public records. The absence of publicly reported disciplinary cases should not be interpreted as the absence of patient harm.

More importantly, dismissing the concerns raised by podiatric physicians, medical doctors, and other diagnostically trained providers ignores the real-world clinical experience of professionals who regularly diagnose and treat complications resulting from delayed or missed diagnoses.

Unlimited direct access to physical therapy, as authorized by this legislation, increases the likelihood that serious medical conditions may go undiagnosed or be mismanaged. The following examples illustrate the risks that arise when patients do not first receive a proper medical diagnosis:

1. A patient presenting with foot pain or a small lump may appear to have a sprain or benign soft tissue condition. However, diagnostic imaging ordered by a podiatric physician may reveal a benign or malignant tumor. Without proper medical evaluation, such a diagnosis could be missed.
2. A patient may be suffering from complex regional pain syndrome (CRPS), a difficult condition that requires early recognition and specialized treatment. Delayed diagnosis can result in severe chronic pain and long-term disability.
3. A patient with a partial tendon rupture could be mistakenly treated for a sprain. Proper diagnosis requires imaging studies that physical therapists cannot order. Without accurate diagnosis, continued therapy could lead to a complete rupture requiring surgical intervention.
4. A patient may have a fracture or dislocation of the foot or ankle that cannot be confirmed without radiologic imaging. Treating such injuries without proper diagnosis can significantly worsen the condition and prolong recovery.

These examples underscore why a medical diagnosis by a qualified diagnostically trained provider must occur before therapeutic treatment begins.

Physical therapists play an important and valuable role in patient rehabilitation, and MPMA respects their contributions to the healthcare system. However, rehabilitation professionals should not be placed in the position of serving as the initial point of diagnosis for conditions that may involve complex medical pathology.

For these reasons, the Minnesota Podiatric Medical Association respectfully urges the committee to oppose House File 2689.

Sincerely,

Stephanie Kvas, DPM
President
Minnesota Podiatric Medical Association

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MINNESOTA
ORTHOPAEDIC
SOCIETY

March 11, 2026

Co-Chair Backer, Co-Chair Bierman, and Members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Orthopaedic Society (MOS), representing over 150 members from a variety of practice and academic settings, I write to express our strong opposition to HF 2689.

Physical therapists are a critical part of the health care team, providing first-line treatment for musculoskeletal conditions and helping patients recover after surgeries, fractures, and injuries. Orthopaedic surgeons work closely with physical therapists to ensure coordinated, high-quality care.

MOS views the current 90-day cap on direct patient access as an important safeguard for patient safety. Most musculoskeletal conditions improve with regular therapy within 90 days. When symptoms persist, they may indicate serious underlying conditions including infection, neurologic disorders, or systemic illness. All of which require medical evaluation. Removing the referral requirement after 90 days risks delaying diagnosis and treatment for these patients.

The bill also expands the statutory definition of physical therapy to include “diagnosis other than medical diagnosis.” While this does not constitute practicing medicine, the term “diagnosis” is not clearly defined, creating potential confusion about roles and responsibilities in patient care.

Physical therapists are highly trained, earning doctoral degrees, but their education differs significantly from physicians, who complete over 12,000 hours of supervised training after medical school. This training allows physicians to identify complex or potentially dangerous conditions—something the 90-day referral helps ensure.

Minnesota’s current framework balances direct access to therapy with necessary medical oversight. The 90-day referral is a modest, essential protection for patients. For these reasons, the Minnesota Orthopaedic Society respectfully urges the committee to oppose HF 2689.

Sincerely,

Brett Freedman, MD
President, Minnesota Orthopaedic Society