



Last Updated: 05/30/2013
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MEDICATION MANAGEMENT AND PHYSICAL THERAPISTS

Overview – Medication Management

“Medications are involved in 80 percent of all treatments and impact every aspect of a patient’s life.”¹ Medicare beneficiaries with multiple chronic illnesses see an average of 13 different physicians, have 50 different prescriptions filled per year, account for 76 percent of all hospital admissions, and are 100 times more likely to have a preventable hospitalization than those with no chronic conditions.”² Managing medications for optimal patient outcomes has been the subject of extensive research for decades. Emerging integrated models of care, such as the medical home, are involving more care team members in the medication management process.

Medication therapy management (MTM) is defined as a distinct service or group of services that optimizes drug therapy with the intent of improved therapeutic outcomes for individual patients. In 2004, this definition was adopted by 11 national pharmacy organizations. “Medication therapy management includes a broad range of professional activities, including but not limited to performing patient assessment and/or a comprehensive medication review, formulating a medication treatment plan, monitoring efficacy and safety of medication therapy, enhancing medication adherence through patient empowerment and education, and documenting and communicating MTM services to prescribers in order to maintain comprehensive patient care.”³

Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model Version 2.0 is a model designed to improve collaboration among pharmacists, physicians, and other healthcare professionals; enhance communication between patients and their healthcare team; and optimize medication use for improved patient outcomes. The medication therapy management services described in this model empowers patients to take an active role in managing their medications. The services are dependent upon pharmacists working

¹ <http://www.pcpcc.net/sites/default/files/media/medmanagement.pdf> accessed 4-1-13

² Anderson GF. Testimony before the Senate Special Committee on Aging. The Future of Medicare: Recognizing the Need for Chronic Care Coordination. Serial No. 110-7, pp 19-20 (May 9, 2007).

³ <https://www.accp.com/docs/positions/misc/CoreElements.pdf> accessed 4-15-13

collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence based guidelines.^{4 5}

Medication therapy management includes five core components: a medication therapy review (MTR), personal medication record (PMR), medication-related action plan (MAP), intervention and/or referral, and documentation and follow-up. MTM is performed between a patient and pharmacist.⁶

“Comprehensive medication management is defined as the standard of care that ensures each patient’s medications (whether they are prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended.

Comprehensive medication management includes an individualized care plan that achieves the intended goals of therapy with appropriate follow-up to determine actual patient outcomes. This all occurs because the patient understands, agrees with, and actively participates in the treatment regimen, thus optimizing each patient’s medication experience and clinical outcomes.^{7 8 9}

PCPCC This approach has evolved through the emergence of the care team approach in the medical home. The PCPCC states that “[t]he work of pharmacists and medication therapy practitioners needs to be coordinated with other team members in the PCMH.”¹⁰

The need for comprehensive medication management by the care team includes, but is not limited to, (1) the central role of medication use in the treatment of chronic conditions, (2) the likelihood of multiple prescribers involved in the patient’s care, and (3) the need for patients to occasionally transition from one care setting to another, even when their care is being coordinated by a medical home.¹¹

Physical Therapist’s Limited Role in Medication Management

⁴ Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1(1):2-4.

⁵ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: Institute of Medicine; 2001.

⁶ Medication therapy Management in Pharmacy Practice. Core Elements of an MTM Service Model. Version 2.0. American Pharmacists Association and National Association of Chain Drug Stores Foundation. March 2008; . <https://www.accp.com/docs/positions/misc/CoreElements.pdf> accessed 4-9-13.

⁷ American Medical Association. *Current Procedural Terminology*. Chicago, IL, 2007.

⁸ CMS. Prescription Drug Coverage 2010 Call Letter. Available at: <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/2010CallLetter.pdf>.

⁹ Minnesota Statute 256B.0625 Subd. 13h, 2005. Available at: <https://www.revisor.mn.gov/statutes/?id=256B.0625>

¹⁰ <http://www.pcpcc.net/sites/default/files/media/medmanagement.pdf> accessed 4-1-13.

¹¹ Ibid.

Under the Guide to Physical Therapist Practice (“Guide”), notation of medications taken for a current condition, medications previously taken, as well as medications taken for other conditions physical therapists should be documented during the history portion of patient management. The Guide further instructs that obtaining a full patient history includes gathering data “through consultation with other members of the team; and through review of the patient client record.”¹²

Physical Therapist State Practice Acts (SPAs) typically do not contain medication management provisions. The most express directive relating to physical therapists and medication management and their allowance to “monitor” medications comes from the Centers for Medicare and Medicaid Services in OASIS C requirements. The majority of states require licensed personnel to administer medications. States that permit unlicensed staff to administer medications generally require that they do so under nurse delegation provisions, though a few require only consultation with a physician or pharmacist or specific training. Examples include the following:

Nebraska defines medication administration as providing medications for another person according to the “five rights” (the right drug to the right recipient in the right dosage by the right route at the right time); medication provision means giving or applying a dose of medication to an individual and includes helping an individual in giving or applying the medication to himself or herself. Adult day service providers must ensure that medication aides and other unlicensed persons who provide medications are trained and have demonstrated the minimum competency standards specified in the relevant rules.

Vermont requires an adult day center to have the capacity to administer medications to its participants and requires a medication management policy that describes a center’s medication management practices with due regard for state requirements, including the Vermont State Nurse Practice Act. An adult day center must provide medication management under the supervision of a registered nurse or a licensed practical nurse under the direction of a registered nurse.

Wisconsin specifies that if staff administer participants’ medications, non-licensed staff must consult with the prescribing practitioner or pharmacist about each medication to be administered, and other conditions related to storage and documentation must be met.

Maine allows unlicensed employees to administer medications only if they have completed, at a minimum, an approved medication course within the previous 12 months or were employed in a health care setting during the previous 12 months where medication administration was part of their responsibilities.

Most states require providers to have written policies for medication management and administration and policies may differ based on health care setting. For example, Georgia requires adult day care programs to have a written policy for medication management

¹² *Guide to Physical Therapist Practice* (2003).

designating specific staff to be authorized and trained to assist with the administration of medications and designating the program's role in the supervision of self-administered medications and/or staff-administered medications.¹³

APTA Official Statement

In 2010, The American Physical Therapy Association (APTA) issued an official statement on the Role of Physical Therapists in Medication Management:

The Role of Physical Therapists in Medication Management

As States continue to formulate their policies on the role of physical therapists in medication management as related to homecare, APTA would like to clarify our position, as well as, provide reference to the federal Medicare home health policy.

APTA believes and it has been acknowledged in federal guidance that it is within the scope of the physical therapist to perform a patient screen in which medication issues are assessed even if the physical therapist does not perform the specific care needed to address the medication issue. The physical therapist is competent and qualified to serve as case manager and facilitate coordination of care with physicians and nurses.

APTA has a position statement adopted by its House of Delegates which states:

“Physical therapist patient/client management integrates an understanding of a patient's/client's prescription and nonprescription medication regimen with consideration of its impact upon health, impairments, functional limitations, and disabilities. The administration and storage of medications used for physical therapy interventions is also a component of patient/client management and thus within the scope of physical therapist practice.

Physical therapy interventions that may require the concomitant use of medications include, but are not limited to, agents that:

*Reduce pain and/or inflammation
Promote integumentary repair and/or protection
Facilitate airway clearance and/or ventilation and respiration
Facilitate adequate circulation and/or metabolism
Facilitate functional movement”.*

In addition, within the Normative Model of Physical Therapist Professional Education:

Version 2004, Pharmacology is a primary content area and includes:

Pharmacokinetic principles
Dose-response relationships
Administration routes
Enhancement of transdermal drug absorption

¹³ Many states also specify requirements related to self-administration of medications. For example, Texas requires individuals who self-administer their medications to be counseled at least once a month by licensed nursing staff to ascertain if they continue to be capable of self-administering their medications.

Absorption and distribution
Biotransformation and excretion
Factors affecting pharmacokinetics
Potential drug interactions
Pharmacodynamics

Also, within the Guide to Physical Therapist Practice (included in the Patient/Client Management Model), medications are gathered from the patient/client history. This includes: medications for current condition; medications previously taken for current condition; and medications for other conditions.

The position of APTA has been formally recognized and adopted into the Medicare Home Health Outcomes Assessment Instrument, known as OASIS-C. In March 2009 OASIS-C training materials and conferences, the Center for Medicare and Medicaid Services (CMS) specifically addressed the question of whether the physical therapist could complete OASIS item M2000 regarding medications. In its response, CMS consistently referred to APTA's position as laid out in the above paragraphs. In fact, a link to APTA's position is readily accessible in the Medicare OASIS tools and resources provided on the CMS website: (http://www.cms.gov/HomeHealthQualityInits/06_OASISC.asp#TopOfPage).

Therefore, APTA strongly urges State entities to duly note and recognize the role of the physical therapists in medication management (i.e. screening, evaluation, collection of information, identification of adverse events/reactions, and education) in the home. APTA is more than willing to work with any State entity to ensure that all home health policies reflect the appropriate role of physical therapists in medication management.

Physical therapists, Medication and State Law

Below are additional examples of state statutes and other directives that are either permissive or restrictive in relation to medication and physical therapists, some specific to OASIS:

California

Physical Therapy Board of California

In August of 2012 a decision was rendered by Board Staff and the acting Board President that the ability to review and identify the implications of a patient's current medications is not within the scope of practice for the Physical Therapist.

In February 2014, the Board held a meeting on whether to withdraw this position.

http://www.ptbc.ca.gov/about_us/meetings/materials/20130213.pdf

Colorado

Colorado Physical Therapists Practice Act

Effective July 1, 2011¹⁴

12-41-103. Definitions.

...

(D) The administration of topical and aerosol medications consistent with the scope of physical therapy practice subject to the requirements of section 12-41-113;

12-41-113. Special practice authorities and requirements-rules.

...

(2) **Administration of medications.** Physical therapists or physical therapist assistants under the direct supervision of a physical therapist may administer topical and aerosol medications when they are consistent with the scope of physical therapy practice and when any such medication is prescribed by a licensed health care practitioner who is authorized to prescribe such medication. A prescription or order shall be required for each such administration.

Connecticut

Restrictive:

Connecticut General Statutes

Chapter 376

Physical Therapists

Sec. 20-66. Definitions. As used in this chapter, unless the context otherwise requires:

- (1) "Physical therapist" means a person licensed to practice physical therapy in this state;
- (2) "Physical therapy" means the evaluation and treatment of any person by the employment of the effective properties of physical measures, the performance of tests and measurements as an aid to evaluation of function and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability. "Physical therapy" includes the establishment and modification of physical therapy programs, treatment planning, instruction, wellness care, peer review, [and] consultative services and the use of low-level light laser therapy for the purpose of accelerating tissue repair, decreasing edema or minimizing or eliminating pain, but does not include surgery, the prescribing of drugs, the development of a medical diagnosis of disease, injury or illness, the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes. As used in this section, "low-level light laser therapy" means low-level light therapy having wave lengths that range from six hundred to one thousand nanometers.

Idaho

¹⁴ <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=ContentType&blobheadervalue1=inline%3B+filename%3D%22Colorado+Physical+Therapists+Practice+Act%2C+Effective+July+1%2C+2011.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251832458565&ssbinary=true> accessed 4-1-13.

“As the agency authorized by the Kentucky General Assembly to regulate the practice of physical therapy in this Commonwealth, the Board is empowered to interpret its statutes and regulations. In summary, while a physical therapist may complete a drug regimen review as required on the OASIS, any questions from the patient should be referred to another health care professional as mandated by 201 KAR 222:053 Section 3.” (from ID OASIS Guidebook)

Kentucky

“As the agency authorized by the Kentucky General Assembly to regulate the practice of physical therapy in this Commonwealth, the Board is empowered to interpret its statutes and regulations. In summary, while a physical therapist may complete a drug regimen review as required on the OASIS, any questions from the patient should be referred to another health care professional as mandated by 201 KAR 222:053 Section 3.” (Kentucky General Assembly statement, March 18, 2010)

Missouri

APRIL 1, 2010

The Most Frequently Asked Questions of the Bureau M2000 Drug Regimen Review

1) Q: Is it correct that Physical Therapists now have it in their scope of practice to do the Drug Regimen Review?

A: NO. A Physical Therapist cannot do the complete drug regimen review as outlined in the Conditions of Participation CFR 484.55(c). The Bureau has recently contacted the State Board for Physical Therapists and received confirmation that drug regimen review is NOT part of the physical therapist scope of practice. Therefore, the complete drug regimen review, in a therapy-only case, must still be performed by the registered nurse.

I think some of the confusion has been the result of misinterpretation of the information on the OASIS-C; specifically in regards to whether it is still expected that a therapist should be able to do the OASIS-C with all the new data items that have been added. CMS has made it clear that the Conditions of Participation have not changed. In a therapy-only case, the therapist can do the OASIS-C assessment; however, there has to be documentation in the medical record that the drug regimen review was performed by the registered nurse. The physical therapist will then answer M2000 and the M0090 date would be the date that the therapist and the registered nurse collaborated.

Further confusion stemmed from CMS's trainings on OASIS-C in which a slide that is titled "What about PTs?" In this slide they shared the comments from the American Physical Therapy Association regarding whether PTs can respond to the new items in OASIS-C. It states, "It is within the scope of the PTs to perform a patient screen in which medication issues are assessed, even if the PT does not perform the specific care needed to address the medication issue." This does not say that it is within the scope of practice of the therapist to conduct a complete drug regimen review.

Questions #32 and #32.1, Category 2-Comprehensive Assessment, from the CMS Q&As somewhat address this issue.

New Jersey

NEW JERSEY STATE BOARD OF PHYSICAL THERAPY EXAMINERS

PUBLIC SESSION MINUTES

March 25, 2008

A regular meeting of the New Jersey State Board of Physical Therapy Examiners was held at 124 Halsey Street, Newark, New Jersey, in the Somerset Conference Room, 6th Floor, on Tuesday March 25, 2008. The meeting was convened in accordance with the provisions of the Open Public Meetings Act. Nancy Kirsch, Chairperson of the Board, called the meeting to order at 9:35 A.M. and a roll call was taken.

C. Letter from Princeton HomeCare Services

RE: Medication Reconciliation


Princeton HomeCare Services asked whether a physical therapist can complete medication reconciliation. Medication reconciliation consists of listing prescription medications that are in the home of a home care patient in the patient's chart.

The Board will advise Princeton HomeCare Services that a physical therapist can complete medication reconciliation.

New York

Medication Review:

Medication Reviews by PTs

The State Board for Physical Therapy has recently received many questions about the role of the physical therapist in completing all the assessments, including the drug regimen reviews, for certified home health agencies (CHHA) and long term home health care programs (LTHHCP), specifically the OASIS-C form. The Board has worked diligently to come to an agreement as to the methods, policies and procedures that have to be followed that will allow the physical therapists to complete the review. Please see the guidance letter ( 183K) from the Department of Health.

<http://www.op.nysed.gov/prof/pt/ptfaq.htm>

North Carolina

**Position Statement – North Carolina Board of Physical Therapy Examiners
Physical Therapist's Role in Managing and Recording Medications**

Adopted – June 28, 1999

Revised – September 23, 2010

Gathering information on the medication a patient is taking and the patient's ability to take the proper dosage would be considered within the scope of practice for a physical therapist. It would also be appropriate for a physical therapist to provide basic information on medications that may have an impact on the PT plan of care; however, to provide an educational intervention, especially on medications unrelated to the PT plan of care, would **not** be considered within the scope of practice for a physical therapist.

It is also appropriate for a PTA to document medication changes if all the PTA is doing is simply recording changes in medication orders from the physician, PA, or nurse practitioner, but it is not appropriate for the PTA to make any interpretations or recommendations regarding medications. However, if a PTA believes that a medication change could result in harm or injury to the patient, the PTA should immediately notify the PT, who will then contact the referring practitioner.

If a PT identifies a discrepancy between the discharge medication order and the prescription on the bottle or the amount that the patient says he/she is taking, it is the physical therapist's responsibility to contact the appropriate health care practitioner to let him / her know of the discrepancy. As always, the PT should document the conversation or correspondence. If there is to be a change in the medication, this information should be forwarded to the home health nurse. If the health care practitioner asks the PT to confirm the patient the medications that the patient taking and there are no changes in the dosages, etc., the physical therapist may do so.

Regarding **PRN Standing Orders** that have been approved by the Medical Director: It would **not** be a violation of the **North Carolina Physical Therapy Practice Act** or Board's rules for a PT to advise a patient as to what PRN standing orders involving the medications exist.

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Ohio

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board Physical Therapy Section, March 8, 2012, 9:30 a.m.

JB2. Lyndi Schwab, PT: Ms. Schwab asked the Occupational and Physical Therapy Sections whether it is acceptable for occupational and physical therapists to sign the medication sheets in a client's chart.

Reply: There is nothing in the Ohio Occupational Therapy Practice Act that prohibits an occupational therapist from completing medication reconciliation provided that the occupational therapist has received training, demonstrated and documented competence in this activity. There is nothing in the Physical Therapy Practice Act that prohibits a physical therapist from performing a medication reconciliation that includes interviewing a patient about current medications, comparing those to the list of prescribed medications, and implementing a computerized program or referring the lists to other practitioners to identify suspected drug interactions. Even though not part of the physical therapy plan of care, the reconciliation may be performed as an administrative task of any health care professional. Other such administrative tasks that are not part of a physical therapy plan of care but that may be performed by physical therapy personnel include removal of staples, coaguchecks, listening for bowel sounds, and other patient assessments. However, no procedure should be performed by a physical therapist or physical therapist assistant unless the practitioner demonstrates competence in that procedure. You may also wish to view the APTA's Home Health Section FAQ regarding medication reviews.

Pennsylvania

Permissive:

§ 40.51a. Transdermal administration of drugs.

A physical therapist may perform transdermal administration of drugs through the use of modalities such as ultrasound and electrical stimulation. If a prescriptive medication is used, the medication must be prescribed by the referring physician and dispensed in the name of the patient by the referring physician or pharmacist. Between treatment sessions, drugs must be properly stored in a manner consistent with pharmaceutical practice. After the patient is discharged, the remaining drugs must be disposed of by the physical therapist or returned to the patient.

Restrictive:

§ 40.2. Practice of medicine prohibited.

The license issued to those practicing physical therapy does not authorize the right to use the title "Doctor of Medicine," or the right to use drugs administered internally. Except as authorized in section 9 of the act (63 P. S. § 1309), a person licensed under the act as a physical therapist may not treat human ailments by physical therapy or otherwise except upon the referral of a physician or other person authorized by law to order the same.

Disclosure:

(b) *Use of patient disclosure forms.*

(1) It is the physical therapist's responsibility to disclose to the patient a financial or ownership interest when making a referral covered by the act of May 26, 1988 (P. L. 403, No. 66) (35 P. S. § § 449.21—449.23). The Board believes that meaningful disclosure shall be given to each patient at the time a referral is made. The disclosure may be made orally or in writing. In either event, it is recommended that the disclosure be memorialized, dated and signed at the time of referral by the physical therapist and the patient, and that the physical therapist maintain written evidence of the disclosure. If the physical therapist delegates the disclosure to another person in the therapist's office, the disclosure shall be memorialized, dated and signed by the person making the disclosure and the patient.

(2) The memorialization of the disclosure shall be substantially in the following form:

I ACKNOWLEDGE THAT I HAVE BEEN ADVISED BY MY PHYSICAL THERAPIST THAT HE HAS A FINANCIAL OR OWNERSHIP INTEREST IN THE FACILITY OR ENTITY TO WHICH HE HAS REFERRED ME, AND THAT HE HAS ADVISED ME THAT I AM FREE TO CHOOSE ANOTHER FACILITY OR ENTITY TO PROVIDE THE SERVICE, DRUG, DEVICE OR EQUIPMENT.

(3) Written evidence shall constitute presumptive evidence that the physical therapist made the required disclosure in an enforcement proceeding before the Board. The disclosure to the patient is not the act of the patient signing the form, but is the act of the physical therapist disclosing to the patient the therapist's financial or ownership interest and advising the patient of the patient's freedom of choice.

...

(c) *Guidelines for disclosure.* If the patient is a minor, unconscious, of unsound mind, or otherwise incompetent to understand freedom of choice in the selection of a facility or entity, disclosure shall be made to the guardian, spouse or closest adult next of kin. A physical therapist may not disclose his interest unless the patient is competent to understand his freedom of choice. A physical therapist will not be disciplined for failure to disclose if an emergency prevents consulting the patient or the patient's next of kin.

(d) *Posting notice of disclosure requirement.* It is recommended that compliance with the disclosure requirement include the prominent posting of a printed notice, at least 8 1/2" x 11" in the physical therapist's waiting room in all office locations, substantially in the following form:

TREATMENT IN THIS OFFICE MAY INCLUDE A RECOMMENDATION FOR FURTHER DIAGNOSTIC TESTING, FOR VARIOUS FORMS OF THERAPY OR TREATMENT, OR FOR DRUGS OR DEVICES. PENNSYLVANIA LAW REQUIRES YOUR PHYSICAL THERAPIST TO DISCLOSE TO YOU ANY FINANCIAL INTEREST HE HAS IN TREATMENT FACILITIES, TESTING LABORATORIES, MEDICAL EQUIPMENT SUPPLIES, PHARMACEUTICAL COMPANIES AND PHARMACIES TO WHICH HE REFERS YOU. HE MUST

ALSO ADVISE YOU THAT YOU ARE FREE TO CHOOSE ANOTHER FACILITY OR ENTITY TO PROVIDE THE SERVICE, DRUG, DEVICE OR EQUIPMENT.
(ACT 66-1988)

Utah

Utah Physical Therapy Practice Act

58-24b-403. Administration of a prescription drug.

(1) A licensed physical therapist may purchase, store, and administer topical and aerosol medications that require a prescription only as provided in this section.

(2) A licensed physical therapist may purchase, store, and administer:

(a) topically applied medicinal agents, including steroids and analgesics, for wound care and for musculoskeletal treatment, using iontophoresis or phonophoresis; and

(b) aerosols for pulmonary hygiene in an institutional setting, if a licensed respiratory therapist is not available in, or within a ten mile radius of, the institution.

(3) A licensed physical therapist may only purchase, store, or administer a medication described in this section pursuant to a written prescription issued by a practitioner who is licensed to prescribe that medication.

(4) This section does not authorize a licensed physical therapist to dispense a prescription drug.

<http://www.dopl.utah.gov/laws/58-24b.pdf>

General Medication Management Laws

California

California Code of Regulations

ARTICLE 12. TOPICAL MEDICATIONS

1399.75. Compliance with Regulations.

A physical therapist may apply or administer topical medications to a patient as set forth in this article.

Note: Authority cited: Sections 2615 and 2620.3, Business and Professions Code. Reference: Section 2620.3, Business and Professions Code.

History:

(1.) New Article 12 (Sections 1399.75-1399.79) filed 2-11-81; Register 81, No. 7.

1399.76. Topical Medications Defined.

As used in this article "topical medications" means medications applied locally to the skin or underlying tissue where there is a break in or absence of the skin where such medications require a prescription or order under federal or state law.

Note: Authority cited: Sections 2615 and 2620.3, Business and Professions Code. Reference: Section 2620.3, Business and Professions Code.

1399.77. Administration of Medications.

Topical medications may be administered by a physical therapist by:

- (a) Direct application;
- (b) Iontophoresis; or
- (c) Phonophoresis.

Note: Authority cited: Sections 2615 and 2620.3, Business and Professions Code. Reference: Section 2620.3, Business and Professions Code.

1399.78. Authorization and Protocols Required.

Topical medications shall be applied or administered by a physical therapist in accordance with this section.

(a) Any topical medication applied or administered shall be ordered on a specific or standing basis by a practitioner legally authorized to order or prescribe such medication.

(b) Written protocols shall be prepared for the administration or application of each of the groups of medications listed in Section 1399.79 for which a prescription is required under Federal or State law, which shall include a description of the medication, its actions, its indications and contraindications, and the proper procedure and technique for the application or administration of medication.

Note: Authority cited: Sections 2615 and 2620.3, Business and Professions Code. Reference: Section 2620.3, Business and Professions Code.

History:

- (1.) Amendment of Note filed 3-8-2000; Register 2000, No. 10.

1399.79. Authorized Topical Medications.

A physical therapist may apply or administer those topical medications listed in this section in accordance with the provisions of this article:

- (a) Bacteriocidal agents;
- (b) Debriding agents;
- (c) Topical anesthetic agents;
- (d) Anti-inflammatory agents;
- (e) Antispasmodic agents; and
- (f) Adrenocortico-steroids.

Note: Authority cited: Sections 2615 and 2620.3, Business and Professions Code. Reference: Section 2620.3, Business and Professions Code.

History:

- (1.) Amendment of subsection (f) and Note filed 3-8-2000; Register 2000, No. 10.
<http://www.ptbc.ca.gov/laws/regulations.shtml>

Illinois

Medication therapy management services

(aa) "Medication therapy management services" means a distinct service or group of services offered by licensed pharmacists, physicians licensed to practice medicine in all its branches, advanced practice nurses authorized in a

written agreement with a physician licensed to practice medicine in all its branches, or physician assistants authorized in guidelines by a supervising physician that optimize therapeutic outcomes for individual patients through improved medication use. In a retail or other non-hospital pharmacy, medication therapy management services shall consist of the evaluation of prescription drug orders and patient medication records to resolve conflicts with the following:

- (1) known allergies;
- (2) drug or potential therapy contraindications;
- (3) reasonable dose, duration of use, and route of administration, taking into consideration factors such as age, gender, and contraindications;
- (4) reasonable directions for use;
- (5) potential or actual adverse drug reactions;
- (6) drug-drug interactions;
- (7) drug-food interactions;
- (8) drug-disease contraindications;
- (9) identification of therapeutic duplication;
- (10) patient laboratory values when authorized and available;
- (11) proper utilization (including over or under utilization) and optimum therapeutic outcomes; and
- (12) drug abuse and misuse.

"Medication therapy management services" includes the following:

- (1) documenting the services delivered and communicating the information provided to patients' prescribers within an appropriate time frame, not to exceed 48 hours;
- (2) providing patient counseling designed to enhance a patient's understanding and the appropriate use of his or her medications; and
- (3) providing information, support services, and resources designed to enhance a patient's adherence with his or her prescribed therapeutic regimens.

"Medication therapy management services" may also include patient care functions authorized by a physician licensed to practice medicine in all its branches for his or her identified patient or groups of patients under specified conditions or limitations in a standing order from the physician.

"Medication therapy management services" in a licensed hospital may also include the following:

- (1) reviewing assessments of the patient's health status; and
- (2) following protocols of a hospital pharmacy and therapeutics committee with respect to the fulfillment of medication orders.

Other Medication References in Guide to Physical Therapist Practice (2003):

Interventions:

Electrotherapeutic Modalities

Electrotherapeutic modalities are a broad group of agents that use electricity and are intended to assist functional training; assist muscle force generation and contraction; decrease unwanted muscular activity; increase the rate of healing of open wounds and soft tissue; maintain strength after injury or surgery; modulate or decrease pain; or reduce or eliminate soft tissue swelling, inflammation, or restriction. Modalities may include biofeedback, electrical stimulation (muscle and nerve), and electrotherapeutic delivery of **medication**.

Physical therapists select, prescribe, and implement these modalities when the examination findings, diagnosis, and prognosis indicate the use of electrotherapeutic modalities to decrease edema and swelling; enhance activity and task performance; enhance health, wellness, or fitness; enhance or maintain physical performance; enhance wound healing; increase joint mobility, muscle performance, and neuromuscular performance; increase tissue perfusion; prevent or remediate impairments, functional limitations, or disabilities to improve physical function; or reduce risk factors and complications.

The use of electrotherapeutic modalities in the absence of other interventions should not be considered physical therapy unless there is documentation that justifies the necessity of their exclusive use.

...

Interventions

Electrotherapeutic modalities may include:

- Biofeedback
- Electrotherapeutic delivery of **medications**
 - iontophoresis
- Electrical stimulation
 - electrical muscle stimulation (EMS)
 - electrical stimulation for tissue repair (ESTR)
 - functional electrical stimulation (FES)
 - high voltage pulsed current (HVPC)
 - neuromuscular electrical stimulation (NMES)
 - transcutaneous electrical nerve stimulation (TENS)