Virginia Department of Health Professions

June 29, 2017
Board Room 4
2:00 p.m.

Agenda
Virginia Board of Physical Therapy Regulatory Advisory Panel

Call to Order – Melissa Wolff-Burke, PT, Ed.D., Panel Chair
- Welcome and Introductions
- Emergency Egress Procedures

Approval of Agenda

Public Comment

The Board will receive public comment related to agenda items at this time. The Board will not receive comment on any pending regulation process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

Charge of Regulatory Advisory Panel – Melissa Wolff-Burke, Panel Chair

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Discussion
- Review of Public Comment Received Regarding Proposed Regulations on the Practice of Dry Needling
- Review of Additional/Updated Materials on the Regulation of Dry Needling
- Review of Current Proposed Language

Next Steps

Meeting Adjournment

Packet Materials:
1. Proposed Regulation
2. Agency Background Document
3. Guidance Document 112-9 - Guidance on Dry Needling in the Practice of Physical Therapy (Revised August 26, 2010)
4. FSBPT Resource Paper Regarding Dry Needling - 6th Edition (December 2016)
5. Analysis of Competencies for Dry Needling by Physical Therapists, Final Report (Human Resources Research Organization (HumRRO) - July 2015)
6. Code of Virginia, Chapter 34.1 of Title 54.1 - Physical Therapy
7. Regulations Governing the Practice of Physical Therapy - 18 VAC 112-20-10 et seq. (May 5, 2017)
8. Other States' Selected Regulations and Code Sections Regarding Dry Needling (Maryland, Utah, Tennessee, Colorado, Delaware, Mississippi, Kansas (Proposed))
9. Summary of Public Comment on Proposed Regulations - Dry Needling

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the public body at the meeting and will be available to the public pursuant to Virginia Code Section 2.2-3708(D).

Board of Physical Therapy

Regulatory Advisory Panel Meeting

June 29, 2017

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1. Proposed Regulation

Proposed Text

Action: Practice of dry needling

Stage: Proposed 12/14/16 11:20 AM [latest]

18VAC112-20-121

18VAC112-20-121. Practice of dry needling.

A. Dry needling is an invasive procedure that requires referral and direction in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing; if the initial referral is received orally, it shall be followed up with a written referral.

B. Dry needling is not an entry level skill but an advanced procedure that requires additional training. The training shall be specific to dry needling and shall include emergency preparedness and response, contraindications and precautions, secondary effects or complications, palpation and needle techniques, and physiological responses.

C. Prior to the performance of dry needling, the physical therapist shall obtain informed consent from the patient or his representative. The informed consent shall include the risks and benefits of the technique and shall clearly state that the patient is not receiving an acupuncture treatment. The informed consent form shall be maintained in the patient record.

2. Agency Background Document

Form: TH-02
10/15

townhall.virginia.gov

Proposed Regulation
Agency Background Document

Agency name	Board of Physical Therapy
Virginia Administrative Code (VAC) citation(s)	18VAC112-20
Regulation title(s)	Regulations Governing the Practice of Physical Therapy
Action title	Practice of dry needling
Date this document prepared	5/23/16

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

The proposed regulatory action will replace Guidance Document 112-9 on dry needling. It includes reference to the statutory requirement for referral and direction from a medical practitioner, requirements for additional training and the content of such training, a requirement informed consent, and the disclosure to patients on the difference between acupuncture and dry needling.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

FSBPT = Federation of State Boards of Physical Therapy
FDA = Food and Drug Administration

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including: 1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable; and 2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.

18VAC112-20-10 et seq. Regulations Governing the Practice of Physical Therapy are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400 (6) provides the Board of Physical Therapy the authority to promulgate regulations to administer the regulatory system:

> ***§ 54.1-2400 -General powers and duties of health regulatory boards***
> *The general powers and duties of health regulatory boards shall be:*
> ...
> *6. To promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title. ...*

In the statutory definition of physical therapy, the practice of dry needling is not addressed, but treatment may be interpreted to include such practice:

§ 54.1-3473. Definitions.
As used in this chapter, unless the context requires a different meaning:...
"Practice of physical therapy" means that branch of the healing arts that is concerned with, upon medical referral and direction, the evaluation, testing, treatment, reeducation and rehabilitation by physical, mechanical or electronic measures and procedures of individuals who, because of trauma, disease or birth defect, present physical and emotional disorders. The practice of physical therapy also includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures within the scope of practice of the physical therapist. However, the practice of physical therapy does not include the medical diagnosis of disease or injury, the use of Roentgen rays and radium for diagnostic or therapeutic purposes or the use of electricity for shock therapy and surgical purposes including cauterization.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The purpose of the action is to specify the qualifications for and limitations of the practice of dry needling as performed by physical therapists. For physical therapists, dry needling is not an entry level skill for which competency has been assured through an accredited educational program and national examination. It is an advanced procedure that requires additional training, referral and direction and informed consent. Without a regulatory standard, the Board cannot hold a physical therapist accountable for requirements specific to dry needling. Therefore, the Board has determined that regulations are necessary to protect the health and safety of patients who may receive dry needling in the course of a physical therapy treatment.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

New section 121 on the performance of dry needling includes reference to the statutory requirement for referral and direction from a medical practitioner, requirements for additional training and the content of such training, a requirement informed consent, and the disclosure to patients on the difference between acupuncture and dry needling.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

1) The Board believes the proposed regulation offers protection for patients who receive a dry needling procedure during the course of physical therapy treatment. Regulatory requirements for referral, training, and informed consent provide greater assurance of competency and accountability than the guidance document that currently exists. The Board does not believe there are disadvantages to the public as the procedure is limited in scope and relatively safe to perform.
2) There are no advantages or disadvantages to the agency or the Commonwealth.
3) The Director of the Department of Health Professions has reviewed the proposal and performed a competitive impact analysis. The Board is authorized under 54.1-2400 to "*promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system.*" There is no restraint on competition as a result of promulgating this regulation. To the contrary, this regulation addresses the practice of a procedure that one profession contends is solely within its scope of practice but which has been safely performed by physical therapists in Virginia with appropriate training and referral for more than a decade.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no applicable federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

There are no localities particularly affected.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the Board of Physical Therapy is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments may do so via the Regulatory Townhall website, www.townhall.virginia.gov, or by mail to Elaine Yeatts at Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233 or elaine.yeatts@dhp.virginia.gov or by fax to (804) 527-4434. Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of this stage and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (**http://www.townhall.virginia.gov**) and on the Commonwealth Calendar website (https://www.virginia.gov/connect/commonwealth-calendar). Both oral and written comments may be submitted at that time.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including: **a) fund source / fund detail; and** **b) a delineation of one-time versus on-going expenditures**	a) As a special fund agency, the Board must generate sufficient revenue to cover its expenditures from non-general funds, specifically the renewal and application fees it charges to practitioners for necessary functions of regulation; b) The agency will incur no additional costs for mailings to the Public Participation Guidelines mailing lists, conducting a public hearing, and sending notice of final regulations to regulated entities. Since most mailings to the PPG list are handled electronically, there is very little cost involved. Every effort will be made to incorporate those into anticipated mailings and Board meetings already scheduled. There are no on-going expenditures.
Projected cost of the new regulations or changes to existing regulations on localities.	There is no cost to localities.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	Licensed physical therapists
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	There is no estimate of the number affected since the Board does not require a separate credential to practice dry needling. There are 7786 physical therapists currently licensed in Virginia. There is no estimate of small businesses; some PT's have their own practice and others practice within large health care systems.
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: **a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and** **b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.**	If a physical therapist chooses to obtain additional education and training to add dry needling as a modality for his/her patients' benefit, there are a variety of courses offered. Most involve multi-day seminars with hands-on training and cost approximately $1,000.
Beneficial impact the regulation is designed to produce.	Greater assurance of advanced skill in dry needling and accountability for its safe performance.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

The issue of whether dry needling is within the scope of the practice of physical therapy has been debated for a number of years. In 2007-2008, a Task Force of physical therapists, licensed acupuncturists and a physician reviewed the issue in Virginia and recommended that the Board adopt guidance on the qualifications necessary to perform the technique and the disclosure to patient to distinguish dry needling from acupuncture.

Recently, the American Academy of Medical Acupuncture raised the issue again in a letter to Governor McAuliffe in opposition to the practice by physical therapists. The Board reviewed the letter and reiterated its position and that of the Federation of State Boards of Physical Therapy that "acupuncture is an entire discipline and profession where as dry needling is merely one technique which should be available to any professional with the appropriate background and training."

Recent legal opinions and decisions appear to reinforce the authority of the Board of Physical Therapy to determine whether dry needling is within the scope of practice for physical therapy. A lawsuit filed by the NC Board of Acupuncture against the NC Board of Physical Therapy Examiners was dismissed without prejudice by the Court on April 26, 2016. On May 9, 2016, the Attorney General of Texas wrote that a Court would likely rule that the "Board of Physical Therapy Examiners has authority to determine that trigger point dry needling is within the scope of practice of physical therapy."

Since it is acknowledged that dry needling in physical therapy is an advanced skill, the Board does find it necessary to set out the requirements for referral, training, and informed consent to safely perform it on patients. Currently, a Guidance Document has such specifications, but it is not enforceable and is more appropriately regulatory in nature. Counsel for the Board has advised that the language in Guidance Document 112-9 is prescriptive and therefore should be included in 18VAC112-20-10 et seq.

Regulatory flexibility analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

As noted above, the practice of dry needling must be included in regulation in order to assure the health and safety of patients and have accountability for competent practice by physical therapists. There are no alternative regulatory methods.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

There was a comment period on the NOIRA from November 30, 2015 to December 30, 2015. On the Virginia Regulatory Townhall, there were 1496 comments.

Commenter	Comment	Agency response
1266 commenters	Opposed dry needling regulation for physical therapy because 1) it is the practice of acupuncture; 2) PT's do not have adequate training; 3) it is outside the scope of practice for physical therapy. Two incidents of adverse reaction were noted by commenters.	The Board believes that 1) dry needling is not the practice of acupuncture but a modality to address hyperirritable loci or trigger points in the muscle to elicit a physiological response. It differs in the treatment goal and method; 2) PT's have doctoral degrees with extensive education in anatomy, pathophysiology and manual skills, so the additional training specific to dry needling is sufficient; and 3) the Federation of State Boards of Physical Therapy has commissioned an analysis of competencies and has determined that dry needling is within a PT's scope of practice. At least 30 states permit the practice. Several court decisions have affirmed that it is the prerogative of the board governing physical therapy to determine whether it is within their scope of practice. Since there is no public action against a licensee for dry needling, the agency cannot respond to the adverse action reports.
230 commenters	Supported dry needling as practiced by physical therapists – many of the commenters were patients who attested to the benefits of dry needling in their healing and pain control.	The Board concurs with the commenters who cite the education and training of PT's to perform dry needling, the safety and effectiveness of the procedure, and the evidence that it is within their scope of practice.
Acupuncture Society of Virginia	Opposed the proposal to authorize dry needling because it is outside the scope of practice of physical therapy and would exceed the Board's authority to adopt regulations; cited the statutory definition of the practice of physical therapy; dry needling constitutes the illegal practice of medicine. Dry needling can cause harm and should not be performed by	Board counsel can determine whether regulations relating to dry needling exceed its statutory authority. In regard to the 1996 rule of the FDA, it was a reclassification of acupuncture needles from Class III to Class II and that acupuncture needles are only for use by qualified practitioners of acupuncture as determined by the states. A legal analysis by a firm that does significant work on FDA regulatory issues has advised FSBPT that the ruling indicates that the FDA would not involve

	minimally educated practitioners. Dry needling is the practice of acupuncture. Acupuncture needles are a Class II medical device and sales are limited to qualified practitioners of acupuncture (1996 statement of the FDA).	itself in determining who was a "qualified practitioner," leaving that up to the states. Indeed, this board is not aware of any challenge by the FDA to use of needles by physical therapists in the 30 states in which it is allowed. The needles used by PT's are called solid filaform needles. The response to the other comments is the same as above.
Council of Colleges of Acupuncture and Oriental Medicine	The Council offered the same points in opposition as the Acupuncture Society. In addition, the Council noted that there is no national standard for education and training of physical therapists in dry needling. Noted social media sites in other states offer dry needling for unapproved purposes.	The comment about a lack of a national standard for education and training outside of an accredited physical therapy program is correct. Such training is becoming incorporated into PT doctoral programs which must be accredited by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association. Any complaints of unethical or incompetent practice will be investigated by the Department of Health Professions on a case-by-case basis.
American Academy of Medical Acupuncture	Acupuncture cannot be mastered in a weekend course; dry needling is an invasive procedure that can cause harm in the hands of minimally educated practitioners. Dry needling represents a departure from the traditional scope of practice for PT.	The Board agrees with the comment but does not agree that dry needling is outside of the scope of practice for PT who have extensive education in anatomy and physiology
American Academy of Physical Medicine and Rehabilitation	Dry needling is an invasive procedure and should only be performed by practitioners with training in the routine use if needles. Poses a threat to the public.	The Board appreciates the comment and believes that PT's have the basic knowledge and training in anatomy, etc., to safely perform invasive procedures for which they are then specifically and sufficiently trained.
Diane Slivinski, L.Ac.	Opposed to allowing PT's to do dry needling as it is the practice of acupuncture, and 54 hours of training is insufficient.	Same response as above.

Family impact

Please assess the impact of this regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

There is no impact on the family.

Detail of changes

Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below.

For changes to existing regulation(s), please use the following chart:

Proposed new section number, if applicable	Proposed change, intent, rationale, and likely impact of proposed requirements
121	A. Dry needling is an invasive procedure which requires referral and direction in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing; if the initial referral is received orally, it shall be followed up with a written referral. *Subsection D of § 54.1-3482 specifies that: "Invasive procedures within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of 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."* *In order to ensure that the requirement was met for performance of dry needling, the Board requires that there be a written referral in the patient record.* B. Dry needling is not an entry level skill but an advanced procedure that requires additional training. The training shall be specific to dry needling and shall include emergency preparedness and response, contraindications and precautions, secondary effects or complications, palpation and needle techniques, and physiological responses. *To determine the competencies necessary to safely perform dry needling, the Federation of State Boards of Physical Therapy contracted with a research firm to conduct an analysis. In July of 2015, the report was issued setting out the job tasks and specialized knowledge necessary for performance of dry needling. The Board used the Analysis and course content from reputable providers to set out the subject areas that must be included in training for dry needling. Although the current guidance document specifies that 54 hours of coursework in dry needling is necessary, the Board did not specific the number of hours in regulation for three reasons: 1) the hours necessary to achieve minimal competency may vary; physical therapists who have had little experience in practice may need more hours to develop the competencies for*

	dry needling, while those who have had more experience and other advanced education may not need basic level training; 2) there are no hours specified in the regulations of most other states; and 2) there are no hours of training specified for other highly specialized or invasive practices, such as the performance of electromyography (EMG). Results from the Analysis of Competencies for Dry Needling by Physical Therapists indicate that 86% of the knowledge requirements related to competency in dry needling is acquired during the course of PT clinical education, and on 14% of the knowledge requirements must be acquired through post-graduate education or specialized training in dry needling. All physical therapy education programs are now at the doctoral level, and some have already introduced dry needling into the curriculum. C. Prior to the performance of dry needling, the physical therapist shall obtain informed consent form from the patient or his representative. The informed consent shall include the risks and benefits of the technique and shall clearly state that the patient is not receiving an acupuncture treatment. The informed consent form shall be maintained in the patient record. *Requirements for informed consent for an invasive procedure are similar to those for medicine. Patients should understand the potential risks and benefits of the procedure and should be told that they are not receiving an acupuncture treatment which focuses on energy flow and meridians from a holistic approach to practice.*

3. Guidance Document 112-9 – Guidance on Dry Needling in the Practice of Physical Therapy

(Revised August 26, 2010)

Board of Physical Therapy

Guidance on Dry Needling in the Practice of Physical Therapy

Upon recommendation from the Task Force on Dry Needling, the Board voted that dry needling is within the scope of practice of physical therapy but should only be practiced under the following conditions:

- Dry needling is not an entry level skill but an advanced procedure that requires additional training.
- A physical therapist using dry needling must complete at least 54 hours of post professional training including providing evidence of meeting expected competencies that include demonstration of cognitive and psychomotor knowledge and skills.
- The licensed physical therapist bears the burden of proof of sufficient education and training to ensure competence with the treatment or intervention.
- Dry needling is an invasive procedure and requires referral and direction, in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing and specific for dry needling; if the initial referral is received orally, it must be followed up with a written referral.
- If dry needling is performed, a separate procedure note for each treatment is required, and notes must indicate how the patient tolerated the technique as well as the outcome after the procedure.
- A patient consent form should be utilized and should clearly state that the patient is not receiving acupuncture. The consent form should include the risks and benefits of the technique, and the patient should receive a copy of the consent form. The consent form should contain the following explanation:

  Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.

4. FSBPT Resource Paper Regarding Dry Needling – 6th Edition (December 2016)

FSBPT Resource Paper Regarding Dry Needling
6th edition

Federation of State Boards of Physical Therapy

December 2016
Original publication: March 8, 2010

The FSBPT would encourage review of the information in this resource paper in order to determine whether dry needling is within the scope of practice for a physical therapist for the jurisdiction in question. The information presented in this paper will provide some background and evidence on which the state licensing authority may wish to base the decision regarding scope of practice.

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FSBPT Resource Paper Regarding Dry Needling

Preface

The volume of activity in the states from 2010-2014 regarding Dry Needling or Intramuscular Manual Therapy (terms used synonymously) necessitated annual updates of the Federation of State Boards of Physical Therapy (FSBPT) original resource paper published in March 2010. This 6th edition contains changes from 2015-2016. Many boards have been approached to give an opinion as to the ability for physical therapists (PT) in that jurisdiction to legally perform dry needling. As each state is independent to determine its own laws and rules, board opinions and actions have varied widely creating inconsistent requirements for physical therapy practice from state to state.

Introduction

It is not unusual for a state licensing board to be asked for an opinion as to whether or not an evaluative technique, treatment, or procedure is within the scope of practice for that given profession. It is as important to base regulation on evidence, when possible, as it is to base practice on evidence. The FSBPT would encourage review of the information in this resource paper in order to determine whether dry needling is within the scope of practice for the physical therapist for the jurisdiction in question. The information presented in this paper will provide some background and evidence on which the state licensing authority may wish to base the decision regarding scope of practice.

The practice act in the state is the final authority on what is included in the scope of practice of a profession. Physical Therapy practice acts are by design non-specific and ambiguous; the details of the law are fleshed out with the applicable regulations. The practice act is rarely written with a laundry list of procedures, tests, or measures that a Physical Therapist is allowed to perform, thus making it very susceptible to different interpretations. The respective state board writes rules and regulations based on that statutory authority to give practical meaning to the law. As many specifics are not found in law, many state boards of PT have been approached for a judgment as to whether or not a certain intervention or procedure is within the scope of PT practice in that jurisdiction. New and evolving procedures are rarely, if ever, specifically addressed in the practice act.

State boards are often faced with opposition when another professional group claims the activity in question as their own. However, it is very clear that no single profession owns any procedure or intervention. Overlap among professions is expected and necessary for access to high quality care.

> *One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession's skill set does not mean another profession cannot and should not include it in its own scope of practice.*[1]

The FSBPT (FSBPT) collaborated with five other healthcare regulatory organizations to publish ***Changes in Healthcare Professions Scope of Practice: Legislative Considerations***. These organizations present the argument that if a profession can provide supportive evidence in the four foundational areas: Historical Basis, Education and

[1] ***Changes in Healthcare Professions Scope of Practice: Legislative Considerations.*** Revised 10/2009, page 9.

Training, Evidence, and Regulatory Environment, then the proposed changes are likely to be in the public's best interest. A more developed investigation of the four foundational areas is found below.[2]

1. ***Is there a historical basis for adding the activity in question to the scope of practice?***
    a. Has there been an evolution of the profession towards the addition of the new skill or service?
    b. What is the evidence of this evolution?
    c. How does the new skill or service fit within or enhance a current area of expertise?
2. ***Is there evidence of education and training which supports the addition of the activity in question to the scope of practice?***
    a. Does current entry-level education prepare practitioners to perform this skill as their experience increases?
    b. If the change in scope is an advanced skill that would not be tested on the entry-level licensure examination, how is competence in the new technique assured?
    c. What competence measures are available and what is the validity of these measures?
    d. Are there training programs within the profession for obtaining the new skill or technique?
    e. Are standards and criteria established for these programs? Who develops these standards? How and by whom are these programs evaluated against these standards?
3. ***What is the evidence which supports the addition of the activity in question to the scope of practice?***
    a. Is there evidence within the profession related to the particular procedures and skills involved in the changes in scope?
    b. Is there evidence that the procedure or skill is beneficial to public health?
4. ***What is the regulatory environment in the jurisdiction?***
    a. Is the regulatory board authorized to develop rules related to a changed or expanded scope?
    b. Is the board able to determine the assessment mechanisms for determining if an individual professional is competent to perform the task?
    c. Is the board able to determine the standards that training programs should be based on?
    d. Does the board have sufficient authority to discipline any practitioner who performs the task or skill incorrectly or might likely harm a patient?
    e. Have standards of practice been developed for the new task or skill?
    f. How has the education, training and assessment within the profession expanded to include the knowledge base, skill set and judgments required to perform the tasks and skills?
    g. What measures will be in place to assure competence?

Dry Needling: Terms & Definitions

Dry needling use as an intervention in physical therapy has grown dramatically in the last few years, but overall, is still a relatively small part of physical therapy practice. With the increased interest in dry needling and more continuing education providers offering courses in dry needling, the acupuncture community has taken notice. Many comparisons of dry needling provided by physical therapists to the intervention and treatment provided by acupuncturists have been made.

[2] Ibid, page 12-13.

Dry needling has also known as intramuscular manual therapy, trigger point dry needling, or intramuscular needling. Beginning in 2009, the American Physical Therapy Association had recommended the use of the term "intramuscular manual therapy" to describe the intervention provided by physical therapists, however since late 2011, the organization advocates using dry needling as the term of choice. FSBPT uses dry needling as the preferred term.

The term dry needling may be confusing and have different meanings depending upon the audience. In the past, "dry needling" was more of an adjective, referring to the fact that nothing was injected with the needle; the term has evolved into meaning an intervention which has certain physiological effects from the insertion and placement of the needles. However, many groups still debate the proper term and exact definition to describe this intervention.

Dry Needling (FSBPT) is defined in the **Analysis of Competencies for Dry Needling by Physical Therapists** paper prepared for the FSBPT by Human Resources Research Organization (HumRRO) as ***"a skilled technique performed by a physical therapist using filiform needles to penetrate the skin and/or underlying tissues to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability."***[3] HumRRO is a non-profit, social and behavioral science research and consulting firm dedicated to the measurement and improvement of human and organizational performance.

- Physical therapy is defined in the FSBPT **Model Practice Act for Physical Therapy** as "the care and services provided by or under the direction and supervision of a physical therapist who is licensed pursuant to this [act]. The term "physiotherapy" shall be synonymous with "physical therapy" pursuant to this [act]."[4]

- Dry needling (APTA) is a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. Dry needling (DN) is a technique used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, and, diminish persistent peripheral nociceptive input, and reduce or restore impairments of body structure and function leading to improved activity and participation.[5]

Acupuncture definitions vary widely. Acupuncture is defined in the Delaware and Florida statutes as follows:

> "Acupuncture" refers to a form of health care, based on a theory of energetic physiology that describes and explains the interrelationship of the body organs or functions with an associated acupuncture point or combination of points located on "channels" or "meridians." Acupuncture points shall include the classical points defined in authoritative acupuncture texts and special groupings of acupuncture points elicited using generally accepted diagnostic techniques of oriental medicine and selected for stimulation in accord with its principles and practices. Acupuncture points are stimulated in order to restore the normal function of the aforementioned organs or sets of functions. Acupuncture shall also include the ancillary techniques of oriental medicine including moxibustion, acupressure or other forms of manual meridian therapy and recommendations that include oriental dietary

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[3] Analysis of Competencies for Dry Needling by Physical Therapists. Human Resources Research Organization. July 2015.p. ii.

[4] The Model Practice Act for Physical Therapy: A Tool for Public Protection and Legislative Change. p. 1.

[5] Description of Dry Needling in Clinical Practice: An Educational Resource Paper. American Physical Therapy Association. February 2013. p. 2.

therapy, supplements and lifestyle modifications according to the principles of oriental medicine.[6]

"Acupuncture" means a form of primary health care, based on traditional Chinese medical concepts and modern oriental medical techniques that employs acupuncture diagnosis and treatment, as well as adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease. Acupuncture shall include, but not be limited to, the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body and the use of electroacupuncture, Qi Gong, oriental massage, herbal therapy, dietary guidelines, and other adjunctive therapies, as defined by board rule.[7]

The Oregon statutory definition of the practice of acupuncture includes many treatment interventions such as therapeutic exercise, manual therapy techniques including massage, electrotherapeutic modalities, physical agents and mechanical modalities that are also found in the FSBPT's Model Practice Act and the American Physical Therapy Association's Guide to Physical Therapist Practice.[8]

"Acupuncture" includes the treatment method of moxibustion, as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.
(b) The practice of acupuncture also includes the following modalities as authorized by the Oregon Medical Board:
(A) Traditional and modern techniques of diagnosis and evaluation;
(B) Oriental massage, exercise and related therapeutic methods;[9]

"Practice of physical therapy" means:
1. Examining, evaluating and testing individuals with mechanical, physiological and developmental impairments, functional limitations, and disabilities or other health and movement-related conditions in order to determine a diagnosis, prognosis and plan of treatment intervention, and to assess the ongoing effects of intervention.
2. Alleviating impairments, functional limitations and disabilities by designing, implementing and modifying treatment interventions that may include, but are not limited to: therapeutic exercise, functional training in self-care and in home, community or work integration or reintegration, manual therapy including soft tissue and joint mobilization/manipulation, therapeutic massage, prescription, application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment, airway clearance techniques, integumentary protection and repair techniques, debridement and wound care, physical agents or

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[6] Delaware State Code. TITLE 24 Professions and Occupations. CHAPTER 17 MEDICAL PRACTICE ACT. Subchapter X. Acupuncture Practitioners
[7] Florida State Code. Title XXXII Regulation of Professions and Occupations. Chapter 457 Acupuncture. 457.102
[8] Guide to Physical Therapist Practice. 2nd ed. Phys Ther. 2001, 81:9-744.
[9] Oregon Revised Statutes. Chapter 677 – Regulation of Medicine, Podiatry and Acupuncture. 677.757 Definitions. 2009.

modalities, mechanical and electrotherapeutic modalities, and patient-related instruction.[10]

Although the FSBPT Model Practice Act does not specifically mention dry needling, there is nothing to specifically exclude the technique. The following section from the Model Practice Act would be relevant in the discussion regarding dry needling:

> ***Other procedures that might be addressed in rules are whether physical therapists can use certain machines and perform procedures such as electroneuromyography, needle EMG, dry needling, etc. that are not specifically addressed in the statutory language.***[11]

Competencies Required of Physical Therapists to Perform Dry Needling

To provide its members with objective, professionally-developed guidance, FSBPT sponsored a practice analysis of the competencies required of physical therapists to perform dry needling. Competencies are measurable or observable knowledge, skills, and/or abilities an individual must possess to perform a job competently. FSBPT contracted with HumRRO to conduct the study in accordance with current best-practices in practice analysis procedures. As an independent contractor, HumRRO was instrumental in carrying out an objective, unbiased analysis.

The study concluded that more than four-fifths of what PTs need to know to be competent in dry needling is acquired during the course of their entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities. Advanced or specialized training, almost solely related to the needling technique and the psychomotor skills, is required to make up the deficit. The full study may be found here.

Legislative and Regulatory Decisions

Dry Needling in the USA (As Of 12/2016)

Allowed	35
Prohibited	9
Silent	6
Caution	1

States that allow dry needling are not permitting the intervention to be delegated to support personnel.

State Legislation

[10] The Model Practice Act for Physical Therapy. A Tool for Public Protection and Legislative Change. 4th edition. FSBPT. 2006.
[11] Model Practice Act for Physical Therapy, p. 59.

In May 2012, Georgia became the first state to introduce and pass a bill that added dry needling to the practice act of physical therapists. The Georgia State Board of Physical Therapy had ruled previous to the statute change that dry needling was in the scope of physical therapy practice. However, language in the acupuncture practice act was inserted that specifically states dry needling is a technique of the practice of acupuncture. As the practice of acupuncture is regulated in Georgia by the Georgia Medical Composite Board, and the Physical Therapy Board found that dry needling is appropriate in physical therapy, the Board of Physical Therapy and Medical Board met to discuss dry needling. The boards seemed to have found common ground as the Georgia Physical Therapy Association and the Physical Therapy Board introduced the bill and the Medical Board did not oppose. On April 19, 2011, the Georgia bill passed and was sent to the governor for signature. The governor signed the legislation into law; at that time no other state physical therapy practice acts specifically mentioned dry needling or intramuscular manual therapy. The Georgia practice act was updated in 2015 and the language regarding dry needling was revised requiring consultation with a physician prior to initiating dry needling treatments.

In 2014, 3 additional states passed legislation that specifically adds dry needling to the Practice Act of physical therapists. Utah added dry needling specifically into its practice act on 4/1/2014. The law requires PTs to meet additional education and training requirements and be licensed two years or more before they can do dry needling. In Arizona, SB 1154 was signed by the governor on 4/24/14 updating the PT practice act with a definition of dry needling and grounds for disciplinary action. . Delaware was the final state of the 2014 legislative session to include dry needling in the physical therapy practice act by passing HB 359 and securing the Governor's signature.

In the 2015 and 2016 legislative sessions, Tennessee and Kansas respectively added dry needling to the physical therapy practice act. In both of these states, the decision had been made previously that dry needling was not in the scope of practice of physical therapists. March 23, 2015 the Tennessee state legislature sent the bill including dry needling to Governor Haslam. The bill was signed to become Public Chapter No. 124 on April 9, 2015. Kansas has dry needling in its practice act as of May 13, 2016 when Governor Brownback signed the bill.

There is one state that specifically cannot allow dry needling based on its statute. Hawaii's practice act specifically prohibits physical therapists from puncturing the skin for any purpose. The Florida physical therapy practice act contains language (see bold below) which is confusing and ambiguous on the topic of dry needling. The law specifically excludes penetrating the skin in the performance of acupuncture, however since dry needling may be one tool utilized by acupuncturists, the law could be interpreted to mean PTs cannot perform dry needling. The Florida Physical Therapy Board has not yet taken up the issue of whether or not dry needling is allowed by PTs under the statute.

> "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage; **the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs;**[12]

Regulations

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[12] Florida Statute. Chapter 468. Physical Therapy Practice.

Multiple jurisdictions have finalized regulations permitting physical therapists to perform dry needling. See Appendix A

Board Policy/Interpretation

Maine

In February 2016, the Board of Examiners responded to a physical therapist in Maine asking if dry needling is within the scope of practice for PT's in Maine. The Board responded that physical therapists could perform dry needling noting however that specific training requirements would not be developed. The PT is "individually responsible for obtaining and maintaining the necessary knowledge, skill, and competency to safely practice any area of their physical therapy practice."[13] The Board also noted that dry needling is distinct from acupuncture and the proper term to be used by PTs is dry needling.

Multiple jurisdictions have issued Board policy or an interpretation which permit physical therapists to perform dry needling. See Appendix A.

Declaratory Opinions

Iowa

In August 2015, the Iowa Acupuncture and Oriental Association (IAOMA) formally wrote to the Iowa Board of Physical and Occupational Therapy asking them to "legally define the practice of dry needling and restrict its use to those professions who are legally licensed to practice acupuncture and handle acupuncture needles."[14] IAOMA submitted 8 questions to the Board and very strongly asserted that physical therapists should not be performing dry needling.

The Board refused to answer questions 1-7 based on the fact that they were not "questions that are appropriately resolved by petitioning for a declaratory order." [15] The Board chose to answer question number 8 which was specific to whether or not dry needling is within the scope of physical therapy as defined by the Iowa Code. The Board determined by declaratory order that yes, dry needling is in the scope of practice of physical therapists.

Attorney General Opinions

Maryland

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[13] Board of Examiners in Physical Therapy. Advisory Ruling No. 2016-01. June 17, 2016.

[14] Accessed 12/13/2016. Iowa Acupuncture and Oriental Association to the Iowa Board of Physical and Occupational Therapy. http://www.iowaapta.org/documents/filelibrary/dry_needling/agenda_for_dry_needling_meeting_on__B0BB1FD4A6499.pdf

[15] Iowa Board of Physical and Occupational Therapy, January 14, 2016. Accessed 12/13/2016. https://idph.iowa.gov/Portals/1/userfiles/26/PTOT/Ruling%20on%20Petition%20for%20Declaratory%20Order%20on%20Dry%20Needling.pdf

In 1989, Maryland became the first jurisdiction to allow dry needling. However, after 20+ years of physical therapists performing dry needling in Maryland, in August 2010 the state acupuncture board requested an Attorney General (AG) opinion on two subjects:

1. whether or not dry needling falls within the definition of the practice of physical therapy; and

2. the appropriateness of the Board of Physical Therapy Examiners to include it in the scope of practice of PTs without legislation.

This opinion was requested in the absence of any specific complaint of harm being filed against any PTs with the licensing board. The Maryland AG reframed the critical question to being "whether dry needling falls within the scope of practice of physical therapy, regardless of whether it would also fall within the scope of practice of acupuncture."[16] The AG's opinion was that dry needling could fall within the scope of physical therapy as use of a mechanical device, however, the "Maryland Physical Therapy Board's informal statement that dry needling is consistent with the practice of physical therapy does not carry the force of law, as it is not a regulation adopted pursuant to the State Administrative Procedure Act."[17] In January 2011, the board of physical therapy began the rule making process for dry needling specifics in the state of Maryland. After significant public input and negotiations the rules were finalized in the third quarter of 2014.

Mississippi

In 2012, the AG in Mississippi issued an opinion that stated the "Physical Therapy Board does have the authority to include IMT and dry needling in its scope by rule or regulation and that legislative approval or enactment is not required."[18] Additionally, physical therapists performing dry needling in accordance with any regulation or interpretation by the Board of Physical Therapy would not be practicing acupuncture without a license.

Kentucky

In September 2013, the Kentucky Board of Physical Therapy received the results of an opinion requested of the AG by Kentucky Board of Medical Licensure. The AG found that dry needling is within the scope of practice of physical therapy with proper training. These results supported the Board's policy decision that dry needling is within the scope of practice for physical therapists.

Louisiana

In the first quarter of 2014, the Louisiana State Board of Medical Examiners requested an AG opinion as to whether or not dry needling was within the scope of physical therapists. The PT Board, who had, through policy, previously allowed dry needling for physical therapists, formally opposed this request in May 2014 writing to the Louisiana AG that:

- Use of mechanical devices in PT treatment is lawful.
- The PT practice act encompasses invasive treatments.

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[16] Attorney General Opinion. State of Maryland, Office of the Attorney General. August 17, 2010.
[17] Ibid.
[18] Attorney General Opinion. State of Mississippi, Office of the Attorney General. September 10, 2012.

- Dry needling done by PT is not an unlawful practice of medicine.
- Healthcare professions share tools and treatment.
- The dry needling rule was promulgated within the confines of the PT practice act in a transparent process.[19]

There has been no opinion returned from the AG as of the writing of this paper.

Tennessee

Another outside group requested an AG opinion in Tennessee the first half of 2014. The AG returned on 6/9/2014 with the opinion that dry needling is not in physical therapy's scope of practice. The opinion stated that "nothing in subdivision...clearly indicates legislative intent to include within the practice of physical therapy the invasive use of needles for therapeutic purposes." [20] Further, "dry needling's obvious similarity to acupuncture cannot be ignored, and physical therapists may not perform acupuncture, which is a branch of medicine."[21]

Tennessee successfully added dry needling to the physical therapist practice act in 2015 despite the AG opinion.

Texas

The Chairman of the Texas State Board of Acupuncture Examiners requested an opinion of the Attorney General of Texas after no resolution could be reached with the Executive Council Board of PT & OT Examiners as to whether dry needling is, or is not, within the scope of practice of a physical therapist.

The summary conclusion by the Attorney General was that "a court would likely conclude that the Board of Physical Therapy Examiners has authority to determine that trigger point dry needling is within the scope of practice of physical therapy." The AG Opinion was request in early November 2015. The final opinion was published May 9, 2016.

Washington

In April 2016, Representative Cody received an answer to her request for an AG opinion questioning whether the practice of dry needling falls within the scope of practice of a licensed physical therapist. The AG determined that the "statute that defines the practice of physical therapy allows a variety of interventions, but...the statute excludes dry needling from the practice of physical therapy."[22] Our conclusion is based solely on the law as currently written; it is not our role to weigh the policy benefits and drawbacks of authorizing physical therapists to engage in dry needling. The legislature, of course, could also expand the scope of physical therapy by amending the relevant statutes.

Nebraska

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[19] Letter from Louisiana Physical Therapy Board (Charlotte F. Martin, Executive Director) to Honorable James D "Buddy" Caldwell, Attorney General State of Louisiana. May 15, 2014.

[20] Attorney General Opinion. State of Tennessee, Office of the Attorney General. June 19, 2014.

[21] Ibid

[22] Attorney General Opinion. State of Washington, Office of the Attorney General. April 15, 2016. AGO 2016 No. 3

An AG opinion in July 2016 concluded that when evaluated in the context of the APTA or state Board definition of dry needling, a reasonable argument can be made that dry needing is a "mechanical modality" or a "physical agent or modality" thus falling in the statutory definition of physical therapy.[23]

Other State Attorney Opinions

Illinois

In August 2010 a verbal opinion from the legal counsel in the Department of Professional Regulation stated that dry needling was not prohibited by the Illinois physical therapy practice act. In April 2014, an attorney in the same department issued a contrary informal opinion stating dry needling was NOT in the physical therapy scope of practice. In the opinion, the attorney expressed some concern that there were no specific standards of practice in place in the Illinois statute or regulations for PTs to perform dry needling. An additional rationale given for the opinion was noting that all current procedures listed in the physical therapy practice act are non-invasive and would then follow that invasive procedures would not be included. And, unlike the physical therapy practice act, the acupuncture practice act clearly defines the standards of practice to perform needle procedures.

The attorney did conclude however that the AG is the only office that may render official opinions regarding statutory interpretation. There is an ongoing debate on this topic and whether or not physical therapists are permitted to perform dry needling in Illinois at this time.

Court Cases

North Carolina

In September 2015, the NC Acupuncture Licensing Board filed a lawsuit against the NC Board of Physical Therapy Examiners, arguing that dry needling by PTs is the unlawful practice of acupuncture. In early October, *Henry v North Carolina Acupuncture Licensing Board*, was filed as an antitrust case. The suit argued that the North Carolina Acupuncture Licensing Board (NCALB) was restraining trade by trying to restrict physical therapists from practicing dry needling.

Superior Court in NC dismissed the original case of the NC Acupuncture vs the PT Board in April 2016. The anti-trust case is ongoing.

Iowa

In August 2015, the IAOMA, filed for judicial review against the Iowa Physical and Occupational Therapy Board's declaratory order related to dry needling. A point made by the Court was "deference to the agency's findings is particularly important when, as here, the matters to be decided call for the exercise of judgment on a matter within the agency's expertise and knowledge.[24]" The Iowa district court affirmed the decision by the Iowa PT Board and denied and dismissed the petition for judicial review. Read the entire opinion here.

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[23] Attorney General Opinion. State of Nebraska, Office of the Attorney General. July 8, 2016.

[24] Iowa District Court, CASE NO. CVCV051242 Accessed 12/13/16
https://idph.iowa.gov/Portals/1/userfiles/26/PTOT/Judge%20Decision%20Dry%20Needling.pdf

Washington

The Superior Court for King County issued a ruling on October 10, 2014 in which they determined PTs were not legally allowed to perform dry needling in the State of Washington. The PT Board has no declared position on PTs and dry needling.

As background, Kinetacore was holding a continuing education course regarding dry needling at a clinic in Washington. South Sound Acupuncture Association filed a lawsuit against the instructor from Kinetacore, the clinic where the class was held, and the PTs who attended the course alleging that those named in the suit were illegally practicing acupuncture in Washington and that participants who are not licensed to practice acupuncture or medicine pose a significant threat to public health.

Wisconsin

A Wisconsin District Court Ruling in February 2014 upheld physical therapists' ability to publish the rule allowing dry needling. In 2013, the Acupuncture Center, Inc. (Midwest College of Oriental Medicine) vs WI Physical Therapy Examining Board lawsuit demanded that the PT board publish a rule to prohibit dry needling by PTs. The case was found to have no validity and was dismissed. Although they threatened to do so, the representatives in this matter do not have the authority to request an AG opinion in Wisconsin.

Other

Oregon

Oregon's position continues to be under scrutiny, and may best be described as cautiously neutral at this time. Although ruling in July 2009 that dry needling is likely within the scope of PT practice with the appropriate training, difficulties and unsuccessful attempts at communication with the Oregon Medical Board and Acupuncture Committee have led to the following position since November 2009:

> *Upon further discussions the Physical Therapist Licensing Board believes that the dry needling of trigger points is likely within the physical therapist scope of practice (excluding PTAs). The board acknowledges that the dry needling of trigger points is an advanced intervention requiring post physical therapy graduate training and education. Further, the board recommends that the acupuncture committee, physical therapist and medical boards work in partnership with their professional associations to define a minimum competency by which a physical therapist can safely practice the intervention of dry needling of trigger points. In the interest of public safety, until training and education can be determined, the board strongly advises its licensees to not perform dry needling of trigger points.*[25]

The Oregon Physical Therapy Board continues to reach out to the Medical Board and Acupuncture Committee to help in the development of the list of competencies required for PTs to perform dry needling, but have received no positive response from either entity.

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[25] http://www.oregon.gov/PTBrd/docs/Current.Topics/Board.Statement.Relevant.to.Dry.Needling.pdf

The Commonwealth of Massachusetts is also embroiled in heated discussions over dry needling by physical therapists. The Board of Registration in Medicine, who is over the acupuncturists, disagree with the initial ruling by the Board of Allied Health (includes PT) that dry needling is within the scope of practice of PTs. After much public outcry from the acupuncture community, the decision was suspended by upper levels of the executive branch until more discussions could take place between the interested parties and other stakeholders. At this time, the decision stands at an impasse as both groups maintain their positions on the issue.

Washington

In March of 2016, Senator Randi Becker, Chair of the Senate Health Care Committee requested the Department of Health (department) conduct a sunrise review of a proposal to add dry needling to the physical therapist scope of practice. In December 2016, the final Physical Therapy Dry Needling Sunrise Review was submitted to the legislature. The report stated that the sunrise criteria for increasing a profession's scope of practice was not met in the application *as submitted* (italics added). However, the report further found that:

- With adequate training that includes a clinical component, dry needling may fit within the physical therapist's scope of practice in treating neuromusculoskeletal pain and movement impairments.
- Evidence provided in this review demonstrates a low rate of serious adverse events from physical therapists performing dry needling in other states, the United States military, and Canada.[26]

The final conclusion was that the Washington legislature may consider legislation adding dry needling to the scope of practice of PTs with additional safety requirements as recommended in the report.

Dry Needling Internationally

Dry needling is also accepted as being within the scope of physical therapy practice in many countries, including Australia, Belgium, Canada, Chile, Denmark, Ireland, the Netherlands, New Zealand, Norway, South Africa, Spain, and the United Kingdom, among others.

The Question of Acupuncture

Currently, some overlap exists between the physical therapy and acupuncture professions which can be demonstrated both in law and in practice. Physical therapists and acupuncturists both have a long history of treating myofascial pain and trigger points. Dry needling may be an intervention utilized by both professions to address these same problems. Dry needling is not the sole intervention, merely a tool used by both, as is acupressure.

Acupressure is another example of a shared intervention. Acupressure is a complementary medicine technique derived from acupuncture. In acupressure, physical pressure is applied to acupuncture points by the practitioner's hand, elbow, or with various devices. Clinically, physical therapists often utilize sustained, direct pressure for the relief of trigger points and pain.

The World Health Organization (WHO) has published a number of reports on acupuncture. Specifically, the report discussing traditional medicine refers to dry needling in acupuncture, but in context, the reference is comparing

[26]Washington State Department of Health **Physical Therapy Dry Needling Sunrise Review**. Pub No. 631-063. December 2016.

needling alone with needling in conjunction with complements such as laser, TENS, and electro-acupuncture.[27] The WHO report is not describing dry needling in the same context as it is used as an intervention in a physical therapy treatment plan. Many of the World Health Organization's reports regarding acupuncture including "Acupuncture: Review and Analysis of Reports on Controlled Clinical Trials," do not contain the term dry needling at all.[28] [29] [30]

In December 2010, the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) authored a position paper on dry needling and distributed it to the state boards of physical therapy and acupuncture throughout the United States. The CCAOM has taken the position to affirm the history of dry needling as an acupuncture technique. The CCAOM asserts that dry needling, beyond the sole needling of trigger points, is the practice of acupuncture regardless of whether it is called dry needling or intramuscular manual therapy. State boards may want to explore this CCAOM paper further in order to familiarize themselves with counter-arguments to including dry needling in the scope of PT practice.

Another group, the National Center for Acupuncture Safety and Integrity (NCASI) sent letters questioning the use of acupuncture needles by non-acupuncturists to FSBPT, APTA, and the Food and Drug Administration (FDA), online retailers of acupuncture equipment and boards of PT, Chiropractic, and Naturopathy (11/13/13). The group specifically questioned the legality of non-acupuncturists using of acupuncture needles and challenged board rulings allowing non-acupuncturists to use needles for dry needling. NCASI argued that specific requirements exist in statute under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §301 et seq. and the related regulations under the FDA. According to the group when a state board allows physical therapists (or others) to use these needles for dry needling, the use of the acupuncture needle is inconsistent with this statute and regulations. However, a legal analysis performed by FSBPT found that the allegation in the NCASI letter was without merit. The attorneys determined that in the FDA's regulations the state, not the FDA, determine who is a qualified practitioner to use acupuncture needles.

PTs using dry needling:

- do not and cannot claim to practice acupuncture,
- do not use acupuncture traditional Chinese medicine theories, meridian acupoints and terminology,
- do not use acupuncture diagnosis like tongue and pulse
- do not use of energy flow or meridians
- do not use dry needling to address things such as fertility, smoking cessation, allergies, depression or other non-neuro-musculoskeletal conditions which are commonly treated with acupuncture

As demonstrated in the definition of the practice of acupuncture from the statutes earlier in the paper, needle techniques are only a piece of the acupuncturist's full scope of practice. It is not the specific individual procedures, but the totality of a scope which defines a profession. Acupuncturists and physical therapists continue to have unique scopes of practice even with the overlap of some of the treatment techniques. It is completely reasonable for the acupuncture profession to want to protect the title and term *acupuncturist* or *acupuncture as* much as

[27] **Report Second Consultation Meeting On Traditional And Modern Medicine: Harmonizing The Two Approaches.** World Health Organization. April 2004. P. 7.
[28] **Acupuncture: Review And Analysis Of Reports On Controlled Clinical Trials.** World Health Organization.
[29] **International Standard Terminologies on Traditional Medicine in the Western Pacific Region.** World Health Organization
[30] **Guidelines on Basic Training and Safety in Acupuncture.** World Health Organization. 1996.

physical therapy profession protects *physical therapist* and *physical therapy*. Qualified, competent physical therapists that perform dry needling should not hold themselves out as providing acupuncture services. Qualified, competent acupuncturists instructing a client in traditional, oriental exercise should not hold themselves out as a physical therapist. Protection of titles and terms are important from a public protection stand point in that people need to be clear as to the qualifications of their practitioner of choice as well as his/her profession.

Overall, an important distinction is that acupuncture is an entire discipline and profession where as dry needling is merely one technique which should be available to any professional with the appropriate background and training. When performed by physical therapists, dry needling is physical therapy. When performed by chiropractors, dry needling is chiropractics. When performed by acupuncturists, dry needling is acupuncture. The philosophy and goal of the treatment will vary based upon your entire professional discipline, training, and scope of practice. There are multiple examples of shared interventions in health care. The accepted premise must be that overlap occurs among professions. The question for the state board should only be whether or not dry needling is within the scope of practice of physical therapy, not determining whether it is part of the scope of practice of acupuncturists.

Professional Associations

American Academy of Orthopedic Manual Physical Therapists: October 2009 position statement supporting intramuscular/dry needling as being within the scope of PT practice

- ***Position:***
  It is the Position of the AAOMPT that dry needling is within the scope of physical therapist practice.

- ***Support Statement:***
  Dry needling is a neurophysiological evidence-based treatment technique that requires effective manual assessment of the neuromuscular system. Physical therapists are well trained to utilize dry needling in conjunction with manual physical therapy interventions. Research supports that dry needling improves pain control, reduces muscle tension, normalizes biochemical and electrical dysfunction of motor endplates, and facilitates an accelerated return to active rehabilitation[31]

American Physical Therapy Association: In January 2012, APTA published an educational resource paper titled **Physical Therapists & the Performance of Dry Needling.** According to the paper, the document was meant to provide background information for state chapters, regulatory entities, and providers who are dealing with the issue of dry needling. In February 2013, APTA published a second paper regarding dry needling titled **Description of Dry Needling in Clinical Practice: an Educational Resource Paper**. Dry needling is included in the **Guide to Physical Therapist Practice 3.0**, manual therapy techniques for mobilization/manipulation, published August 1, 2014. Currently, there is no HOD or BOD policy on dry needling, however this is not unusual; there are no HOD or BOD policies at APTA on the ability of a physical therapist to perform any specific intervention.

American Medical Association: At the 2016 AMA Annual Meeting, delegates adopted this policy on dry needling:

> *RESOLVED, That our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with*

[31] http://aaompt.org/members/statements.cfm

standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists. (New HOD Policy).

Recommended Training Requirements for PTs to Perform Dry Needling

FSBPT contracted with the Human Resources Research Organization (HumRRO) in early 2015 to conduct a practice analysis of the competencies required of physical therapists to perform dry needling. Competencies are measurable or observable knowledge, skills, and/or abilities an individual must possess to perform a job competently. FSBPT sponsored the study and requested that it be undertaken in accordance with current best-practices in practice analysis procedures in order to provide its members with objective, professionally-developed guidance. The practice analysis drew from multiple sources of information (i.e., extant literature on dry needling; licensed physical therapists; dry needling experts) to provide an authentic and accurate assessment of the knowledge, skills, and abilities needed to perform dry needling safely and effectively. As a non-profit, social and behavioral science research and consulting firm dedicated to the measurement and improvement of human and organizational performance and independent contractor, HumRRO was instrumental in carrying out an objective, unbiased analysis.

Practice analysis relies on the input and judgment of subject matter experts to provide an accurate assessment of the job tasks and competencies. The expertise regarding dry needling was drawn from seven individuals selected to participate based on their depth and breadth of experience and education in dry needling. Their years of professional experience performing dry needling ranged from five to fourteen. All participants were licensed PTs with a minimum of fourteen total years of experience in physical therapy and a maximum of 31. Five participants possessed Doctorate level degrees (i.e., DPT); one had a Master's level degree (i.e., MPT/MSPT), and one had a Bachelor's degree. All were actively practicing dry needling, and five were currently in an educational or training role (e.g., faculty, instructor) providing dry needling instruction in addition to their clinical employment as therapists. One was a full-time faculty member.

Because this report focused on the competencies required of the PT to perform dry needling, it is not appropriate to assume the same competencies would quality a PTA to perform the treatment. Task differences between PTs and PTAs are partly related to the scope of educational curricula provided by accredited physical therapist assistant degree programs. Whereas assistants receive instruction in many of the same domains as PTs (e.g., anatomy and physiology, biomechanics, kinesiology, neuroscience, clinical pathology, behavioral sciences, communication, ethics/values), the depth and breadth of education and training is not equivalent. PTAs would need additional training beyond the supplemental education components identified that a PT requires to be competent in performing dry needling.

The conclusion of the analysis was that more than four-fifths of what PTs need to know to be competent in dry needling is acquired during the course of their entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities. Advanced or specialized training, almost solely related to the needling technique and the psychomotor skills, is required to make up the deficit. That report is available to the public at https://www.fsbpt.org/FreeResources/RegulatoryResources/DryNeedlingCompetencies.aspx

Currently, there are currently no consistent profession-wide standards/competencies defined for the performance of dry needling. Each state has defined what the requirements will be in that state. See Appendix B for state-by-state guidelines.

Historical Basis and Education

Although for a different purpose, physical therapists have a historical basis for needle insertion with the practice of EMG and NCV testing. At this time, laws in 46 states would allow PTs to perform needle electromyography and nerve conduction velocity testing.[32] Although the language and requirements vary, California, Florida, Kentucky, Missouri, New Hampshire, Oklahoma, Pennsylvania, Washington, and West Virginia have specific protection in statute for physical therapists to perform EMGs. North Carolina and Texas utilize administrative rule to authorize PTs to perform EMGs. An opinion from the Kentucky board specifically addresses EMG by fine wire insertion and affirms that these tests are within the scope of a physical therapist.[33] South Carolina also has a statement regarding performance of needle EMG. [34] The law in Oklahoma specifically defines the practice of physical therapy to include invasive and noninvasive techniques.

> *"Physical therapy" means the use of selected knowledge and skills in planning, organizing and directing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury, encompassing preventive measures, screening, tests in aid of diagnosis by a licensed doctor of medicine, osteopathy, chiropractic, dentistry or podiatry, or a physician assistant, and evaluation and invasive or noninvasive procedures with emphasis on the skeletal system, neuromuscular and cardiopulmonary function, as it relates to physical therapy.*[35]

At this time, dry needling is not being taught in most entry-level physical therapy programs but more and more programs are adding introductory information to the curriculum. At minimum, Georgia State University, Mercer University, University of Delaware, University of St. Augustine for Health Sciences, and the Army physical therapy program at Baylor all teach at least an introduction to dry needling. Other universities including the Ola Grimsby Institute are considering adding dry needling to the curriculum of both the advanced and entry level educational programs. Dry needling is also included in the Mercer University physical therapy residency program. Internationally, dry needling is being taught at many universities. In most educational programs for physical therapists, the needling technique is learned in conjunction with evaluation of the myofascial trigger points and used as a part of the patient's overall treatment plan.

The Commission on Accreditation in Physical Therapy Education (CAPTE) criteria requires the physical therapist professional curriculum to include content and learning experiences in the behavioral, biological and physical, and clinical sciences necessary for initial practice of the profession.[36] The entry-level curriculum must demonstrate inclusion of many topics which should provide a strong foundation to the understanding and performance of intramuscular manual therapy such as anatomy/cellular biology, physiology, neuroscience, pathology, pharmacology; study of systems including cardiovascular, pulmonary, integumentary, musculoskeletal, and neuromuscular; communication, ethics and values, teaching and learning, clinical reasoning, and evidence-based practice.

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[32] American Physical Therapy Association. State Affairs memorandum on review of EMG in the States.

[33] http://www.pt.ky.gov/NR/rdonlyres/4D460291-23A1-43E3-AFF3-DEE7506DF149/0/Electromyography.pdf

[34] http://www.llr.state.sc.us/POL/PhysicalTherapy/index.asp?file=PT%20Positions/electro.htm

[35] State Of Oklahoma Physical Therapy Practice Act. Title 59 O.S., Sections 887.2

[36] Commission on Accreditation in Physical Therapy Education. Accreditation Handbook. Effective January 1, 2006; revised 5/07, 10/07, 4/09 p. B28-B29.

Dry needling education purposefully does not include the basic tenets of acupuncture training such as Chinese medicine philosophy, meridians, qi, or diagnosis via tongue inspection, as the technique and its rational have no basis in oriental medicine. Dry needling is based primarily on the work of Dr. Janet Travell, a pioneer in trigger point research and treatment. According to the World Health Organization's **Guidelines on Basic Training and Safety in Acupuncture,** the basic study of acupuncture should include: [37]

- Philosophy of traditional Chinese medicine, including but not limited to concepts of *yin-yang* and the five phases.
- Functions of *qi*, blood, mind, essence and body fluids, as well as their relationship to one another.
- Physiological and pathological manifestations of *zang-fu* (visceral organs) and their relationship to one another.
- Meridians and collaterals, their distribution and functions.
- Causes and mechanisms of illness.

Overwhelmingly, physical therapists are getting instruction in dry needling through continuing education.

Dry Needling Evidence-based Practice

There are numerous scientific studies to support the use of dry needling for a variety of conditions.[38] Supporting textbooks include:

- Dommerholt J, Huijbregts PA, Myofascial trigger points: pathophysiology and evidence-informed diagnosis and management Boston: Jones & Bartlett 2011

- *The Gunn approach to the treatment of chronic pain.* Gunn, C.C., Second ed. 1997, New York: Churchill Livingstone.

- *Travell and Simons' myofascial pain and dysfunction; the trigger point manual.* Simons, D.G., J.G. Travell, and L.S. Simons, 2 ed. Vol. 1. 1999, Baltimore: Williams & Wilkins.

A literature search regarding intramuscular manual therapy or dry needling yields extensive results. Numerous research studies have been performed and published in a variety of sources. In addition to the references contained in this paper, the following is just a small sample:

- Dry Needling: a Literature Review with Implications for Clinical Practice Guidelines (Dunning et al, 2014) *Physical Therapy Reviews*, 19(4):252-265
- Dommerholt, J., O. Mayoral, and C. Gröbli, *Trigger point dry needling.* J Manual Manipulative Ther, 2006. **14**(4): p. E70-E87.

- Lewit, K., *The needle effect in the relief of myofascial pain.* Pain, 1979. **6**: p. 83-90.

[37] **Guidelines on Basic Training and Safety in Acupuncture.** World Health Organization. 1996. Pages 7-8.

[38] Dommerholt, J., O. Mayoral, and C. Gröbli, *Trigger point dry needling.* J Manual Manipulative Ther, 2006. **14**(4): p. E70-E87.

- Intramuscular Stimulation (IMS) - The Technique By: C. Chan Gunn, MD (http://www.istop.org/papers/imspaper.pdf)

- Dommerholt, J., *Dry needling in orthopedic physical therapy practice.* Orthop Phys Ther Practice, 2004. **16**(3): p. 15-20.

- Baldry, P.E., *Acupuncture, Trigger Points and Musculoskeletal Pain.* 2005, Edinburgh: Churchill Livingstone.

- Dommerholt, J. and R. Gerwin, D., *Neurophysiological effects of trigger point needling therapies*, in *Diagnosis and management of tension type and cervicogenic headache*, C. Fernández de las Peñas, L. Arendt-Nielsen, and R.D. Gerwin, Editors. 2010, Jones & Bartlett: Boston. p. 247-259.

- Simons, D.G. and J. Dommerholt, *Myofascial pain syndrome - trigger points.* J Musculoskeletal Pain, 2007. **15**(1): p. 63-79.

- Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B, Acupuncture and Dry-Needling for Low Back Pain: An Updated Systematic Review Within the Framework of the Cochrane Collaboration. Spine 30(8): p. 944-963, 2005.

- White A, Foster NE, Cummings M, Barlas P, Acupuncture treatment for chronic knee pain: a systematic review. Rheumatology (Oxford) 46(3): p. 384-90, 2007.

- Chu, J., et al., *Electrical twitch obtaining intramuscular stimulation (ETOIMS) for myofascial pain syndrome in a football player.* Br J Sports Med, 2004. **38**(5): p. E25.

Typically the literature refers to dry needling or acupuncture, and in some cases specifically looks at the effectiveness of acupuncture and dry needling, suggesting indeed that a difference exists.[39] Overall, the literature suggests and supports dry needling/intramuscular manual therapy as a safe, effective, viable treatment option for patients.

Dry needling has been practiced by physical therapists for over 20 years with minimal numbers of adverse effects reported. The most common side effects include post-needling soreness and minor hematomas. The FSBPT's Examination, Licensure and Disciplinary Database (ELDD) has no entries in any jurisdiction of discipline for harm caused by dry needling performed by physical therapists.

Many American providers of dry needling, with multiple course providers in Europe, have established a physical therapy-only, voluntary, web-based registry in Switzerland for reporting adverse effects. This registry currently includes two reports of pneumothoraces, a severe autonomic response of one patient, but no other "severe" side effects.[40] The administrators of this registry admit that it is underutilized. Additionally, the literature does not report serious injury or harm from intramuscular needling performed by a physical therapist.

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[39] Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B, Acupuncture and Dry-Needling for Low Back Pain: An Updated Systematic Review Within the Framework of the Cochrane Collaboration. Spine 30(8): p. 944-963, 2005.
[40] Dummerholt, J., Unpublished data. January 2010.

Conclusion

Returning to the four tenets from ***Changes in Healthcare Professions Scope of Practice: Legislative Considerations*** on which to base scope of practice decisions and summarizing the information above, it appears that there is a historical basis, available education and training as well as an educational foundation in the CAPTE criteria, and supportive scientific evidence for including dry needling in the scope of practice of physical therapists. The education, training and assessment within the profession of physical therapy include the knowledge base and skill set required to perform the tasks and skills with sound judgment. It is also clear; however, that dry needling is not an entry-level skill and should require additional training. [41] [42]

When considering the scope of practice decision, the regulatory environment in each jurisdiction will vary dramatically. However, recognizing that intramuscular manual therapy is not an entry-level skill, the jurisdictional boards that are authorized to develop rules related to determining if an intervention is within scope of practice must determine the mechanisms for determining that a physical therapist is competent to perform the task. To ensure public protection the board should also have sufficient authority to discipline any practitioner who performs the task or skill without proper training, incorrectly, or in a manner that might likely harm a patient.

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[41] **ACTIVITIES PERFORMED BY ENTRY-LEVEL PHYSICAL THERAPISTS IDENTIFIED DURING THE 2006 ANALYSIS OF PRACTICE.** FSBPT. 2006-2007.
[42] Knapp, D, Russell, L, Byrum, C. and Waters, S. **Entry-Level Practice Analysis Update for Physical Therapist Licensure Examinations Offered by the FSBPT.** Human Resources Research Organization. February 14, 2007.

Appendix A: States and Specific Dry Needling Statutes, Rules, or Policies

State	Y: Allows N: Does not allow	Other Information
AK	Y	April 24, 2012 letter to Alex Kay, PT regarding performance of dry needling. *Paraphrase:* The board will not address specific treatment approaches by licensure; however, expect the professionalism of the clinician to determine if they are qualified to provide the type of treatment in question or whether referral is more appropriate. The PT will be held accountable for demonstrating this competence if there is ever a complaint. March 2014 Agenda Item 8 - Trigger Point Dry Needling The board discussed they have already stated their view on this topic and they will not respond to the mass mailing letter which was sent to all jurisdictions. The board is aware both the Federation of State Boards of Physical Therapy and the American Physical Therapy Association have responded to the letter The board stands, in regard to performance of dry needling, the board will not address specific treatment approaches by licensure; however, they expect the professionalism of the clinician to determine if they are qualified to provide the type of treatment in question or whether referral is more appropriate. The physical therapist will be held accountable for demonstrating this competence if there is ever a complaint
AL	Y	Board minutes October 23, 2007: Dry Needling does fall within the scope of practice for physical therapy.

State	Y: Allows N: Does not allow	Other Information
AR	Y	Board minutes May 28, 2009: Michael DuPriest, PT emailed asking if dry needling is within the scope of practice. This issue was discussed at the February meeting and the Board determined further information was needed. Additional information was received from Michael DuPriest but his question in the second email was regarding needle EMG. The Board determined previously that EMGs are within the scope of practice. Clarification was received from Michael DuPriest and the Board determined dry needling is within the scope of practice. Board minutes January 31, 2013: Dry Needling Resource Paper: The Board reviewed the 3rd edition dry needling resource paper from FSBPT and discussed the procedure. The Board determined this paper would be used for future inquires regarding dry needling. From Board Exec Director email to Maribeth Decker at FSBPT (Nancy Worthen) dated 10/16/2-13The Board considers dry needling to be within the scope of practice for physical therapists but as with any other treatment they must have the appropriate skills and knowledge.
AZ	Y	2014 Dry needling added to PT practice act
CA	N	
CO	Y	In rules
DC	Y	In rules
DE	Y	2014 Dry needling added to PT practice act (10)a. "Practice of physical therapy" means: 1. Examining, evaluating, and testing patients/clients who have impairments of body structure or function, activity limitations or participation restrictions in physical movement and mobility, or other health and movement related conditions in order to determine a physical therapy diagnosis, prognosis, and plan of treatment intervention, and to assess the

State	Y: Allows N: Does not allow	Other Information
		ongoing effects of intervention; and 2. Alleviating impairments of body structure or function, activity limitations or participation restrictions in physical movement and mobility by designing, implementing, and modifying treatment interventions that may include: therapeutic exercise, functional training related to physical movement and mobility in self-care and in home, community, or work integration or reintegration; gait and balance training; neurological re-education; vestibular training; manual, mechanical, and manipulative therapy, including soft tissue, musculoskeletal manipulation, and joint mobilization/manipulation; dry needling; therapeutic massage; the prescription, application, and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic protective and supportive devices and equipment; airway clearance techniques; integumentary protection and repair techniques; nonsurgical debridement and wound care; evaluative and therapeutic physical agents or modalities; mechanical and electrotherapeutic modalities; and patient related instruction; and 3. Reducing the risk of impairments of body structure or function, activity limitations or participation restrictions in physical movement and mobility, including the promotion and maintenance of fitness, health, and wellness in populations of all ages; and 4. Engaging in administration, consultation, education, telehealth, and research. b. Nothing in this chapter shall be construed to limit the practice of physical therapy by physical

State	Y: Allows N: Does not allow	Other Information
		therapists as is currently being practiced or determined by the Board so long as such practice does not include surgery and the medical diagnosis of disease. Advanced services may require advanced training, as determined by the Board's rules and regulations, to assure the licensee meets the accepted standard of careandard of care.
FL	N	Florida physical therapy practice act contains language which specifically excludes penetrating the skin in the performance of acupuncture: "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs;[43] The board has not yet taken up the issue of whether or not dry needling is acupuncture. For now, this statute prohibits dry needling in Florida.
GA	Y	2011 Dry needling added to GA PT practice act; first state to have in statute The practice of physical therapy means: (A) Examining, evaluating, and testing patients and clients with mechanical, physiological, and developmental impairments, activity limitations, participation restrictions, and disabilities or other movement related conditions in order to determine a physical therapy diagnosis, prognosis, and plan of intervention and to assess the ongoing effects of intervention; (B) Alleviating impairments of body structure or function by designing, implementing, and modifying interventions to improve activity limitations or participation restrictions for the purpose of preventing or reducing the incidence and severity of physical disability, bodily malfunction, and pain;

[43] Florida Statute. Chapter 468. Physical Therapy Practice.

State	Y: Allows N: Does not allow	Other Information
		(C) Reducing the risk of injury, impairment, activity limitations, participation restrictions, and disability, including the promotion and maintenance of health, fitness, and wellness in populations of all ages; (D) Planning, administering, evaluating, and modifying intervention and instruction, including the use of physical measures, activities, and devices, including but not limited to dry needling for preventative and therapeutic purposes; and (E) Engaging in administration, consultation, education, teaching, research, telehealth, and the provision of instructional, consultative, educational, and other advisory services.
HI	N	Physical therapists, by statute, are not allowed to puncture the skin of a patient for any purpose
IA	Y	From 9/2010 Board of PT meeting minutes: In answer to a licensee's question regarding whether PTs may perform dry needling. Board determines that it does not appear to be prohibited.
ID	N	
IL	Y	Aug 2010 verbal opinion from the Il Dept. of professional regulation legal counsel that dry needling was not prohibited by the IL physical therapy practice act 2014 informal opinion that contradicts the above opinion. No clear resolution/decision at this time
IN	S	Claimed by some resources to have approved dry needling for PTs, minutes from Board meeting August 2012 state that "Indiana does not take a position on needling...The current statute is open and does not specifically state whether or not it is appropriate." Not prohibited, but not endorsed either.
KS	Y	Kansas Board of Healing Arts Board Minutes Dry needling regulations were proposed by the Kansas Physical Therapy Advisory Council on 8/12/16. The regulations will go through a multistep process (Dept. of Administration, AG, public hearing, judicial and legislative review etc) with the goal of being enacted on Jan 1, 2017.

State	Y: Allows N: Does not allow	Other Information
KY	Y	March 18, 2010 Opinion and Declaratory ruling regarding state law governing dry needling therapy by the Kentucky Board of Physical Therapy. The board is of the opinion dry needling is within the scope of the practice of "physical therapy" as defined in Kentucky law by the General Assembly at KRS 327.010(1). Dry needling is a treatment used to improve neuromuscular function. As such it falls within the definition of physical therapy as defined under KRS 327:010 (1) "Physical therapy" means the use of selected knowledge and skills ...invasive or noninvasive procedures with emphasis on the skeletal system, neuromuscular, and cardiopulmonary function, as it relates to physical therapy. There is nothing in KRS Chapter 327 to prohibit a licensed physical therapist from performing dry needling so long as the physical therapist is competent in performing this intervention. While dry needling is within the scope of practice of physical therapy, a physical therapist must practice only those procedures that the physical therapist is competent to perform. The board can discipline a physical therapist for "engaging or permitting the performance of substandard patient care by himself or by persons working under their supervision due to a deliberate or negligent act or failure to act, regardless of whether actual injury to the patient is established." KRS 327.070(2).
LA	Y	Within the Scope of Practice of PT; board regulations 2014 AG opinion requested by outside agency. As of Oct 31, 2014 no published opinion
MD	Y	January 2011- Oct 2014 Rule making process for dry needling specifics in the state of Maryland. Regulations are now final Aug 27, 2010 MD Attorney General's opinion was that dry needling could fall within the scope of physical therapy as use of a mechanical device, however, the "Maryland Physical Therapy Board's informal statement that dry needling is consistent with the practice of physical therapy does not carry the force of law, as it is not a regulation adopted pursuant to the State Administrative Procedure Act."
ME	Y	
MI	N	Informal advice was shared by the Attorney General's Office regarding the practice of "Dry Needling." Although the advice will need to be slightly revised, the outcome remains unchanged. Dry Needling is not within the scope of practice for physical therapists. Filler agreed to ask the Attorney General's Office to research the

State	Y: Allows N: Does not allow	Other Information
		issue and report back to the Board.
MS	Y	Board Minutes 2/2012: The Mississippi State Board of Physical Therapy considers that intramuscular manual therapy techniques are within the physical therapist scope of practice and is in the process of developing more specific competence requirements. The Attorney General has affirmed that the MS Board of PT was acting within its power to determine that dry needling was within scope of practice of PT.
MT	Y	The Montana Board of Physical Therapy has determined that trigger point dry needling is within the scope of practice for physical therapists. The board has formed a committee to begin the process of setting rules for trigger point dry needling which met for the first time June 30, 2011 and the rules were finalized September 23, 2016 (1) Dry needling is a skilled manual therapy technique performed by a physical therapist using a mechanical device, filiform needles, to penetrate the skin and/or underlying tissues to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability. (2) Dry needling requires a physical therapy examination and diagnosis. (3) Licensed physical therapists who perform dry needling must be able to demonstrate they have completed training in dry needling that must meet the American Physical Therapy Association (APTA) GUIDELINES: STANDARDS OF QUALITY FOR CONTINUING EDUCATION OFFERINGS BOD G11-03-22-69 and/or the Federation of State Boards of Physical Therapists (FSBPT) STANDARDS FOR CONTINUING COMPETENCE ACTIVITIES. (a) Dry needling courses must include, but not be limited to, training in indications, contraindications, potential risks, proper hygiene, proper use and disposal of needles, and appropriate selection of clients. (b) Initial training in dry needling must include hands-on training, written, and practical examination as required by this rule. (4) A licensed physical therapist must perform dry needling in a manner consistent with generally accepted standards of practice, including relevant standards of the Center for Disease Control and Prevention, and Occupational Safety and Health Administration blood borne pathogen standards as per 29 CFR 1910.1030 et seq. (5) Dry needling shall only be performed by a licensed physical therapist and may not be delegated. (6) The physical therapist performing dry needling must be able to provide written documentation, upon request by the board, which substantiates appropriate training as required by this rule. Failure to provide written documentation may result in disciplinary action.

State	Y: Allows N: Does not allow	Other Information
NH	Y	PT Board MINUTES of October 19, 2011: PTs can do dry needling if they have been trained to do so.
NJ	Y	Sept 2009, Board of PT determined dry needling is within the scope of practice of PTs. Currently being looked at by the Division of Consumer Affairs which may alter the opinion. No written documentation
NM	Y	March 2000, In a letter dated March 21, 2000, the PT board determined that the PT Act does not prohibit dry needling and that Section 61-12D-3, Paragraph I, Number 2 describing the practice of physical therapy supports that decision.
NC	Y	In 2010, NC PT Board voted to reverse previous policy which did not allow dry needling by PTs. Dec 9, 2010 Board Position Statement. Position: Based on currently available resource information, it is the position of the North Carolina Board of Physical Therapy Examiners that intramuscular manual therapy is within the scope of practice of physical therapists.
ND	Y	Board meeting May 13, 2013: The board voted to state that "Dry Needling" is within the scope of practice for PT in North Dakota.
NE	Y	Within the Scope of Practice of PT June 2011 board meeting minutes
NV	Y	Dry needling is within the SOP of PTs as ruled by NV Board of PT on March 20, 2012. As of April 19, 2012, the PT board legal counsel is writing up the new board Policy on dry needling and once signed by Chairman, Kathy Sidener, dry needling will be permissible by PTs in NV.
NY	N	Early 1990s (1992?) and affirmed in 2007 NY State Board issued an opinion at the time that it was not an entry level skill and therefore could not be done.
OH	Y	In a letter dated January 5, 2007, the OH OT, PT, and ATC Board affirms the position of the PT Section of the board that nothing in the OH PT practice act prohibits a PT from performing dry needling. The letter goes on to read that the PT must demonstrate competency in the modality.
OR	Y	November 2009: Upon further discussions the Physical Therapist Licensing Board believes that the dry needling of trigger points is likely within the physical therapist scope of practice (excluding PTAs). The board acknowledges that the dry needling of trigger points is an advanced intervention requiring post

State	Y: Allows N: Does not allow	Other Information
		physical therapy graduate training and education. Further, the board recommends that the acupuncture committee, physical therapist and medical boards work in partnership with their professional associations to define a minimum competency by which a physical therapist can safely practice the intervention of dry needling of trigger points. In the interest of public safety, until training and education can be determined, the board strongly advises its licensees to not perform dry needling of trigger points.
PA	N	PA PT board was advised by legal counsel that dry needling is not within the scope of practice of a PT
RI	Y	Feb 14, 2012 PT board minutes: Board members revisited the matter of dry needling for intramuscular therapy. A board member questioned if it pertained to other professions, including Acupuncturist. The board administrator related guidance from Atty. Tom Corrigan stating the use of a needle by one profession does not preclude a different profession from having a different use for a needle. Board members commented dry needling is within their scope of practice provided the licensed professional is comfortable trained and has appropriate background knowledge. For licensed physical therapists that are not qualified there are educational seminars they may sign up for and gain the required background and training.
SC	Y	In an email written in October 2004 in response to a licensee's question regarding scope of practice and dry needling, the Chairperson affirmed that dry needling appears to fall within the SOP of a licensed PT in SC if they are fully trained in its use and comply with all legal and ethical requirements for professional practice in physical therapy.
SD	N	The South Dakota Board of Medical and Osteopathic Examiners considers procedures involving the breaking or altering of human tissue for diagnostic, palliative or therapeutic medical purposes to be the practice of medicine. The board determines that dry needling is significantly different from "electromyography (EMG)", which the board previously opined was an activity within the scope of practice for a physical therapist. Decision: The South Dakota Board of Medical and Osteopathic Examiners determined that the procedure known as "dry needling" does not fall within the physical therapist scope of practice as defined in SDCL ch. 36-10. This opinion issued by the Board of Medical and Osteopathic Examiners is advisory in nature. It does not constitute an administrative rule or regulation and is intended solely to serve as a guideline for persons registered, licensed, or otherwise regulated by the Board of Medical and Osteopathic Examiners.
TN	Y	August 12, 2011- PT Board determined that DN was in scope for PTs overturning a previous policy that it

State	Y: Allows N: Does not allow	Other Information
		was not within scope AG Opinion June 19, 2014 "physical therapists may not perform acupuncture, which is a branch of medicine." Determined DN was in essence acupuncture thus nullifying Board's opinion Legislation passed 2015 to add dry needling to practice act TN: SECTION 1. Tennessee Code Annotated, Section 63-13-103(15)(B), is amended by inserting the language "dry needling," between the language "agents or modalities," and "mechanical and". **(B) Alleviating impairments and functional limitations by designing, implemen modifying therapeutic interventions that include, but are not limited to, therapeut functional training, manual therapy, therapeutic massage, assistive and adaptive prosthetic, protective and supportive equipment, airway clearance techniques, de wound care, physical agents or modalities, mechanical and electrotherapeutic mo patient-related instruction:** Regulation June 2016: 1150-01-.22 Dry Needling (1) In order to perform dry needling, a physical therapist must obtain all of the educational instruction described in paragraphs (2)(a) and (2)(b) herein. All such educational instruction must be obtained in person and may not be obtained online or through video conferencing. (2) Mandatory Training - Before performing dry needling, a practitioner must complete educational requirements in each of the following areas: SS-7039 (November 2014) 2 RDA 1693 (a) Fifty (50) hours of instruction, to include instruction in each of the four (4) areas listed herein, which are generally satisfied during the normal course of study in physical therapy school: 1. Musculoskeletal and Neuromuscular systems; 2. Anatomical basis of pain mechanisms, chronic pain, and referred pain; 3. Trigger Points; 4. Universal Precautions; and (b) Twenty-four (24) hours of dry needling specific instruction. 1. The twenty-four (24) hours must include instruction in each of the following six (6) areas: (i) Dry needling technique; (ii) Dry needling indications and contraindications; (iii) Documentation of dry needling; (iv) Management of adverse effects; (v) Practical psychomotor competency; and (vi) Occupational Safety and Health Administration's Bloodborne Pathogens Protocol.

State	Y: Allows N: Does not allow	Other Information
		2. Each instructional course shall specify what anatomical regions are included in the instruction and describe whether the course offers introductory or advanced instruction in dry needling. 3. Each course must be pre-approved or approved by the Board or its consultant, or the Board may delegate the approval process to recognized health-related organizations or accredited physical therapy educational institutions. (3) A newly-licensed physical therapist shall not practice dry needling for at least one (1) year from the date of initial licensure, unless the practitioner can demonstrate compliance with paragraph (2) through his or her pre-licensure educational coursework. (4) Any physical therapist who obtained the requisite twenty-four (24) hours of instruction as described in paragraph (2)(b) in another state or country must provide the same documentation to the Board, as described in paragraph (2)(b), that is required of a course provider. The Board or its consultant must approve the practitioner's dry needling coursework before the therapist can practice dry needling in this state. (5) Dry needling may only be performed by a licensed physical therapist and may not be delegated to a physical therapist assistant or support personnel. (6) A physical therapist practicing dry needling must supply written documentation, upon request by the Board, that substantiates appropriate training as required by this rule. (7) All physical therapy patients receiving dry needling shall be provided with information from the patient's physical therapist that includes a definition and description of the practice of dry needling and a description of the risks, benefits, and potential side effects of dry needling. Authority: T.C.A. §§ 63-13-304 and 63-13-305.
TX	Y	Texas Board of Physical Therapy Examiners letter dated 8/8/2014: "It is the opinion of the PT Board that the practice of trigger point dry needling is within the scope of practice of a Physical Therapist in the State of Texas."
UT	Y	2014 Dry needling added to PT practice act : (15) "Therapeutic intervention" includes: (a) therapeutic exercise, with or without the use of a device; (b) functional training in self-care, as it relates to physical movement and mobility; (c) community or work integration, as it relates to physical movement and mobility; (d) manual therapy, including: (i) soft tissue mobilization;

State	Y: Allows N: Does not allow	Other Information
		(ii) therapeutic massage; or (iii) joint mobilization, as defined by the division, by rule; (e) prescribing, applying, or fabricating an assistive, adaptive, orthotic, prosthetic, protective, or supportive device; (f) airway clearance techniques, including postural drainage; (g) integumentary protection and repair techniques; (h) wound debridement, cleansing, and dressing; (i) the application of a physical agent, including: (i) light; (ii) heat; (iii) cold; (iv) water; (v) air; (vi) sound; (vii) compression; (viii) electricity; and (ix) electromagnetic radiation; (j) mechanical or electrotherapeutic modalities; (k) positioning; (l) instructing or training a patient in locomotion or other functional activities,

State	Y: Allows N: Does not allow	Other Information
		with or without an assistive device; (m) manual or mechanical traction; (n) correction of posture, body mechanics, or gait; and (o) trigger point dry needling, under the conditions described in Section 58-24b-505.
VA	Y	Updated Board Policy Guidance Document on Aug 26, 2010. In process of formalizing board policy into Board regulations.
VT	-	Reported by one resource that in February 2012, the Vermont Office of Professional Regulation issued a statement that dry needling is within the scope of physical therapy in that state. Unable to substantiate this claim.
WA	N	October 10, 2014- Superior Court for King County issued a ruling stating dry needling was not in the scope of PT practice. 2016 AG opinion dry needling not in scope of practice. 2016 Sunset Review completed. Found additional safety requirements may justify putting dry needling in legislation adding to PT scope of practice.
WI	Y	BOARD MINUTES JULY 2009: BOARD DISCUSSION OF DRY NEEDLING Statute 448.50 (6) allows for "therapeutic intervention" within the scope of physical therapy. Larry Nosse discussed the use of dry needling as a therapeutic technique. This process uses sterile techniques, the surface skin is cleaned, it does not draw blood, and the physical therapists are trained in blood-body precautions. Mark Shropshire noted that the American Academy of Orthopedic and Manual Physical Therapists has made a position statement that dry needling is within the scope of practice of physical therapy. California, Nevada, Tennessee, and Florida do not allow this technique within the scope of practice within physical therapy because these states have language noting that PTs cannot puncture the skin. MOTION: Otto Cordero moved, seconded by Jane Stroede, that the board considers trigger point dry

State	Y: Allows N: Does not allow	Other Information
		needling as within the scope of practice of physical therapy provided that the licensed physical therapist is properly educated and trained. Motion carried unanimously. May 29, 2014: favorable district court ruling re: dry needling, followed by a non-appeal
WV	Y	July 18, 2012: Opinion of the West Virginia Board of Physical Therapy Regarding Dry Needling Therapy: "In summary, the Board is of the opinion that dry needling is within the scope of the practice of "physical therapy" as defined by West Virginia Code 30-20-9."
WY	Y	In a letter dated Aug 18, 2009 the Wyoming Board of Physical Therapy affirmed that nothing in the current practice act would preclude PTs performing dry needling with proper credentials. Regulations effective January 25, 2016: Chapter 1, Section 4. Definitions. Unless specifically stated otherwise, the following definitions are applicable throughout this title: (f) "Dry needling" is a manual therapy technique that uses a filiform needle as mechanical device to treat conditions within the scope of physical therapy practice. It is based upon Western medical concepts, requires a physical therapy examination and physical therapy diagnosis, and treats specific anatomic entities. Dry needling does not include the stimulation of auricular or acupuncture meridians. Chapter 7, Section 3. Evidence of competence; dry needing. (a) Dry needling may not be performed by a PTA or physical therapy aide. (b) Licensed physical therapists shall demonstrate that they have received training in dry needling in a course approved by state boards of physical therapy, the American Physical Therapy Association or individual chapters of the American Physical Therapy Association, the Federation of State Boards of Physical Therapy, or the International Association for Continuing Education Training. (i) The course shall include but not be limited to training in indications, contraindications, potential risks, proper hygiene, proper use and disposal of needles, and appropriate selection of clients. (ii) The course shall include a minimum of twenty-seven (27) hours of live face-to-face instruction. Online courses are not appropriate training in dry needling. (c) The physical therapist shall supply written documentation, upon request by the Board, that substantiates appropriate training as required by this rule. Failure to provide written documentation may result in disciplinary action taken by the Board.

Appendix B: Training Guidelines

STATE	TRAINING REQUIREMENTS
AZ	Rules currently being drafted
CO	**COLORADO PHYSICAL THERAPY LICENSURE RULES AND REGULATIONS** **4 CCR 732-1 RULE 11 - REQUIREMENTS FOR PHYSICAL THERAPISTS TO PERFORM DRY NEEDLING** A. Dry needling is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Dry needling does not include the stimulation of auricular or distal points. B. Dry needling as defined pursuant to this rule is within the scope of practice of physical therapy. C. A physical therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the physical therapist's scope of practice. D. To be deemed competent to perform dry needling a physical therapist must meet the following requirements: 1. Documented successful completion of a dry needling course of study. The course must meet the following requirements: a. A minimum of 46 hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training. b. Two years of practice as a licensed physical therapist prior to using the dry needling technique. E. A provider of a dry needling course of study must meet the educational and clinical prerequisites as defined in this rule, D(1) (a) &(b) and demonstrate a minimum of two years of dry needling practice techniques. The provider is not required to be a physical therapist. F. A physical therapist performing dry needling in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information: 1. Risks and benefits of dry needling 2. Physical therapist's level of education and training in dry needling 3. The physical therapist will not stimulate any distal or auricular points during dry needling. H. When dry needling is performed this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure.

STATE	TRAINING REQUIREMENTS
	I. Dry needling shall not be delegated and must be directly performed by a qualified, licensed physical therapist. J. Dry needling must be performed in a manner consistent with generally accepted standards of practice, including clean needle techniques, and standards of the center for communicable diseases. K. The physical therapist must be able to supply written documentation, upon request by the Director, which substantiates appropriate training as required by this rule. Failure to provide written documentation is a violation of this rule, and is prima facie evidence that the physical therapist is not competent and not permitted to perform dry needling. L. This rule is intended to regulate and clarify the scope of practice for physical therapists.
DC	**District of Columbia Municipal Regulations Title 17, Chapter 67, Physical Therapy** **6715 SCOPE OF PRACTICE** A physical therapist may also perform intramuscular manual therapy, which is also known as dry needling, if performed in conformance with the requirements of section 6716. **6716 REQUIREMENTS FOR PHYSICAL THERAPISTS TO PERFORM INTRAMUSCULAR MANUAL THERAPY** 6716.1 Intramuscular manual therapy may be performed by a licensed physical therapist who meets the requirements of this section. 6716.2 Intramuscular manual therapy shall be performed directly by the licensed physical therapist and shall not be delegated. 6716.3 Intramuscular manual therapy shall be performed in a manner that is consistent with generally accepted standards of practice, including clean needle techniques, and other applicable standards of the Centers for Disease Control and Prevention. 07-01-11 16 Title 17 District of Columbia Municipal Regulations 6716.4 Intramuscular manual therapy is an advanced procedure that requires specialized training. A physical therapist shall not perform intramuscular manual therapy in the District of Columbia unless he or she has documented proof of completing: (a) A board-approved professional training program on intramuscular manual therapy. The training program shall require each trainee to demonstrate cognitive and psychomotor knowledge and skills. The training program shall be attended in person by the physical therapist, shall not be attended online or through any other means of distance learning, and shall not be a self-study program (b) A professional training program on intramuscular manual therapy accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). The training program shall require each trainee to demonstrate cognitive and psychomotor knowledge and skills. The training program shall be attended in person by the physical therapist, shall not be attended online or through any other means of distance

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	learning, and shall not be a self-study program; or (c) Graduate or higher-level coursework in a CAPTE-approved educational program that included intramuscular manual therapy in the curriculum. 6716.5 A physical therapist shall only perform intramuscular manual therapy following an examination and diagnosis, and for the purpose of treating specific anatomic entities selected according to physical signs. 6716.6 A physical therapist who performs intramuscular manual therapy shall obtain written informed consent from each patient who will receive intramuscular manual therapy before the physical therapist performs intramuscular manual therapy on the patient. 6716.7 The informed consent form shall include, at a minimum, the following: (a) The patient's signature; (b) The risks and benefits of intramuscular manual therapy; (c) The physical therapist's level of education and training in intramuscular manual therapy; and (d) A clearly and conspicuously written statement that the patient is not receiving acupuncture. 6716.8 A physical therapist who performs intramuscular manual therapy shall maintain a separate procedure note in the patient's chart for each intramuscular manual therapy. The note shall indicate how the patient tolerated the intervention as well as the outcome after the intramuscular manual therapy. 6716.9 A physical therapist who performs intramuscular manual therapy shall be required to produce documentation of meeting the requirements of this section immediately upon request by the board or an agent of the board. 6716.10 Failure by a physical therapist to provide written documentation of meeting the training requirements of this section shall be deemed prima facie evidence that the physical therapist is not competent and not permitted to perform intramuscular manual therapy.
DE	15.4.2.6 Dry needling is an advanced procedure that requires specialized training. A Physical Therapist shall not perform dry needling in Delaware unless he or she has and maintains documented proof of completing a Board-approved training program on dry needling. 15.4.2.6.1 The program shall be a minimum of 54 hours, which shall be completed within no more than two years; 15.4.2.6.2 The Physical Therapist shall successfully complete the minimum passing criteria for the dry

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	needling program; and 15.4.2.6.3 The Physical Therapist shall only utilize the specific techniques for which he or she has demonstrated competency. 15.4.3 Physical Therapists who are performing dry needling at the time of enactment of this regulation, and who have completed 25 hours of dry needling education, may continue to practice dry needling, upon submission of proof of experience and education to the Board. Such Physical Therapists shall complete the required 54 hours of education within two years after enactment of this regulation. 15.4.4 Board approved dry needling training program: A dry needling training program shall include the following to be eligible for Board approval: 15.4.4.1 A dry needling training program shall require each trainee to demonstrate successful psychomotor and cognitive performance through practical and written examination. 15.4.4.2 A dry needling program shall be attended in person by the Physical Therapist, shall not be attended online or through any other means of distance learning and shall not be a self-study program. 15.4.4.3 The program curriculum shall include the following: 15.4.4.3.1 History and current literature review of dry needling and evidence based practice; 15.4.4.3.2 Pertinent anatomy and physiology; 15.4.4.3.3 Choice and operation of supplies and equipment; 15.4.4.3.4 Knowledge of technique including indications/contraindications and precautions for use; 15.4.4.3.5 Proper technique of tissue penetration; 15.4.4.3.6 Knowledge of hazards and complications; 15.4.4.3.7 Safe practice guidelines and generally accepted standards of practice including clean needle techniques and OSHA's bloodborne pathogen standards; 15.4.4.3.8 Post intervention care, including an adverse response or emergency; 15.4.4.3.9 Documentation of successful completion of psychomotor and cognitive performance through practical and written examination; and 15.4.4.3.10 Supervised training. 15.4.4.3.11 The dry needling program, including the required supervised training, shall be taught by a Physical Therapist who meets the qualifications of Regulation 15.4.

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	15.4.5 Scope of Practice 15.4.5.1 A Physical Therapist may not perform dry needling on a patient until completion of at least 25 hours of education in a Board approved dry needling program. 15.4.5.2 A Physical Therapist may not perform dry needling on high risk areas until completion of at least 54 hours of education in a Board approved dry needling program. As used in this regulation, high risk areas are the anterior cervical region, abdominal region, and the region directly over the ribs, unless the pincher technique is performed.
GA	Rules being promulgated.
KS	**Proposed Regulation:** **K.A.R. 100-29-18. Requirements for physical therapists to perform dry needling.** (a) Dry needling shall only be performed by a licensed physical therapist that is specifically trained and competent by virtue of education and training to perform dry needling as set forth below. Online study and self-study for dry needling instruction are not considered appropriate training. (b) Dry needling shall be performed solely for conditions and impairments that fall under the physical therapy scope of practice in Kansas, and may not be performed for the purposes of detoxification, smoking cessation, stress relief, fertility, or any condition outside the scope of physical therapy. (c) A licensed physical therapist shall perform dry needling in a manner consistent with generally acceptable standards of practice. Dry needling shall not be delegated and must be directly performed by a qualified, licensed physical therapist. (d) Physical therapists who did not obtain dry needling training as part of their graduate or post- graduate education shall meet the following requirements in order to perform dry needling: (1) Attendance and successful completion of a dry needling course approved by one or more of the following entities prior to the physical therapist taking such course: (A) Commission on Accreditation in Physical Therapy Education; (B) American Physical Therapy Association; (C) State Chapters of the American Physical Therapy Association; (D) Specialty groups of the American Physical Therapy Association; (E) Federation of State Boards of Physical Therapy; or (F) Any board approved course which contains a practical and written examination. (2) The course content shall include the following components of education and training: (A) Anatomical review for safety and effectiveness, (B) Indications and Contraindications for dry needling (C) Such course shall include evidence based instruction on the theory of dry needling practice, (D) Sterile needle procedures which shall include one of the following standards:

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	(i) The US Centers for Disease Control and Prevention; or (ii) The US Occupational Safety and Health Administration, (E) Blood-borne pathogens, (F) Post intervention care, including an adverse response or emergency, (G) Such training shall include an assessment of the physical therapist's dry needling technique and psycho-motor skills, and (H) Such course shall be taught by a licensed healthcare provider whose scope of practice incudes dry needling, who meets the regulatory minimum educational standard in their respective state or jurisdiction. Such instructor shall not have been disciplined by any state or jurisdictional licensing agency for any acts that would be violations of the Physical Therapy Practice Act or the Healing Arts Act. Such instructor shall also have performed dry needing for a minimum of two (2) years. (3) Upon completion of such training and education each physical therapist shall be able to demonstrate: (A) competent dry needling techniques. (B) appropriate management of dry needling equipment and supplies. (C) accurate and appropriate point selection. (D) appropriate positioning of the patient and the education of the patient regarding appropriate amount of movement while needles are inserted. (E) proper supervision and monitoring of patient during treatment. (F) appropriate communication with the patient to include informed consent. (G) appropriate patient selection to include but not be limited to: the expected outcome. (i) consideration of the patients' contraindications for dry needling. (ii) consideration of the patient's ability to understand the treatment and (iii) consideration of the patient's ability to comply with treatment requirements. (4) The scope of practice of each physical therapist performing dry needling shall be determined by and limited to the anatomical region of training obtained by the physical therapist. (5) After completion of a dry needling course, each physical therapist shall be required to log 200 dry needling sessions before taking each successive course in dry needling. (Authorized by 2016 HB 2615, effective January 1, 2017.) **K. A. R. 100–29–19. Informed consent.** (a) A physical therapist who performs dry needling shall obtain written informed consent from the patient before the physical therapist performs dry needling therapy

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	on the patient. (b) The informed consent shall include, at a minimum, the following: (1) the patient signature; (2) the risks and benefits of dry needling; (3) a diagnosis for which the physical therapist is performing dry needling; (4) the physical therapist shall notify the patient of such physical therapists anatomical region(s) of training obtained by the physical therapist; (5) such informed consent shall be required for each separate anatomical region treated; (6) such informed consent shall be maintained in the patient's treatment record; and (7) a statement that the procedure being performed is dry needling as defined by the physical therapy practice act. **K.A.R. 100-29-20. Record Keeping.** A physical therapist who performs dry needling therapy shall maintain a distinct procedure note in the patient's chart for each drying needling therapy session. The note shall indicate how the patient tolerated the intervention in the specified anatomical region as well as the outcome after a dry needling session. **K.A.R. 100-29-21. Request for documentation.** A physical therapist that performs dry needling shall be required to immediately produce documentation demonstrating that he or she has met the educational requirements of K.A.R. 100-28-18 upon request by the Board or an agent or employee of the Board. Failure of a physical therapist to provide such written documentation shall be deemed prima facie evidence that the physical therapist is not competent to perform dry needling and shall not be permitted to perform dry needling therapy.
LA	**Subchapter B. General Provisions** **§123. Definitions** A. As used in this Title, the following terms and phrases, defined in the practice act, La. R.S.37:2401–2424, shall have the meanings specified here. Dry Needling—a physical intervention which utilizes filiform needles to stimulate trigger points in a patient's body for the treatment of neuromuscular pain and functional movement deficits. Dry Needling is based upon Western medical concepts and does not rely upon the meridians utilized in acupuncture and other Eastern practices. A physical therapy evaluation will indicate the location, intensity and persistence of neuromuscular pain or functional deficiencies in a physical therapy patient and the propriety for utilization of dry needling as a treatment intervention. Dry needling does not include the stimulation of auricular points. **§311. Treatment with Dry Needling** A. The purpose of this rule is to establish standards of practice, as authorized by La. R.S. 37:2405 A.(8), for the utilization of dry needling techniques, as defined in §123, in treating patients. B. Dry needling is a physical therapy treatment which requires specialized physical therapy education and training for the utilization of such techniques. Before undertaking dry needling education and

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	training, a PT shall have no less than two years experience working as a licensed PT. Prior to utilizing dry needling techniques in patient treatment, a PT shall provide documentation to the executive director that he has successfully completed a board–approved course of study consisting of no fewer than 50 hours of face–to–face instruction in intramuscular dry needling treatment and safety. Online and other distance learning courses will not satisfy this requirement. Practicing dry needling without compliance with this requirement constitutes unprofessional conduct and subjects a licensee to appropriate discipline by the board. C. In order to obtain board approval for courses of instruction in dry needling, sponsors must document that instructors utilized have had no less than two years experience utilizing such techniques. Instructors need not be physical therapists, but should be licensed or certified as a healthcare provider in the state of their residence. D. A written informed consent form shall be presented to a patient for whom dry needling is being considered, telling the patient of the potential risks and benefits of dry needling. A copy of a completed form shall be preserved in the patient treatment record and another copy given to the patient. E. Dry needling treatment shall be performed in a manner consistent with generally accepted standards of practice, including sterile needle procedures and the standards of the U.S. Centers for Disease Control and Prevention. Treatment notes shall document how the patient tolerated the technique and the outcome of treatments.
MD	Regulations have not been finalized; out for public comment end of 2016
MS	D. To be deemed competent to perform intramuscular manual therapy a physical therapist must meet the following requirements: 1. Documented successful completion of a intramuscular manual therapy course of study; online study is not considered appropriate training. a. A minimum of 50 hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training. b. Three years of practice as a licensed physical therapist prior to using the intramuscular manual therapy technique. 2. The physical therapist must have board approved credentials for providing intramuscular manipulation which are on file with the board office prior to using the treatment technique. E. The provider of the required educational course does not need to be a physical therapist. A intramuscular manual therapy course of study must meet the educational and clinical prerequisites as defined in this rule, D(1)(a)&(b) and demonstrate a minimum of two years of intramuscular manual therapy practice techniques.

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	F. A physical therapist performing intramuscular manual therapy in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information: 1. Risks and benefits of intramuscular manual therapy. 2. Physical therapist's level of education and training in intramuscular manual therapy. 3. The physical therapist will not stimulate any distal or auricular points during intramuscular manual therapy. G. When intramuscular manual therapy is performed, this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure. H. Intramuscular manual therapy shall not be delegated and must be directly performed by a qualified, licensed physical therapist. I. Intramuscular manual therapy must be performed in a manner consistent with generally accepted standards of practice, including but not limited to, aseptic techniques and standards of the center for communicable diseases.
MT	Regulation finalized in 2016. (3) Licensed physical therapists who perform dry needling must be able to demonstrate they have completed training in dry needling that must meet the American Physical Therapy Association (APTA) GUIDELINES: STANDARDS OF QUALITY FOR CONTINUING EDUCATION OFFERINGS BOD G11-03-22-69 and/or the Federation of State Boards of Physical Therapists (FSBPT) STANDARDS FOR CONTINUING COMPETENCE ACTIVITIES. (a) Dry needling courses must include, but not be limited to, training in indications, contraindications, potential risks, proper hygiene, proper use and disposal of needles, and appropriate selection of clients. (b) Initial training in dry needling must include hands-on training, written, and practical examination as required by this rule.
NC	As of June 2012: **Position:** Based on currently available resource information, it is the position of the North Carolina Board of Physical Therapy Examiners that Intramuscular Manual Therapy (Dry Needling) is within the scope of practice of physical therapists. Intramuscular Manual Therapy is an advanced skill that requires additional training beyond entry-level education and should only be performed by physical therapists who have demonstrated knowledge, skill, ability, and competence as follows: Completion of an Intramuscular Manual Therapy course of study at a program approved by the Board with a minimum of 54 hours of classroom education, which must also include instruction in the clinical application of IMT

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	(Dry Needling). Since Intramuscular Manual Therapy requires ongoing re-evaluation and reassessment, it is not in the scope of work for physical therapist assistants or physical therapy aides.
NE	A physical therapist who wished to perform tissue penetration for the purpose of dry needling must meet the following requirements: 1. Complete pre-service or in-service training. The pre-service or in-service training must include: a. Pertinent anatomy and physiology; b. Choice and operation of supplies and equipment; c. Knowledge of technique including indications and contraindications; d. Proper technique of tissue penetration; e. Sterile methods, including understanding of hazards and complications; and f. Post intervention care; and g. Documentation of application of technique in an educational environment. 2. The training program shall require training to demonstrate cognitive and psychomotor skills. Also, the training program must be attended in person by the physical therapist. 3. Maintain documentation of successful completion of training.
OH	11/2011 Currently working to identify general guidelines for determining competence.
TN	Found in Regulation: Mandatory Training - Before performing dry needling, a practitioner must complete educational requirements in each of the following areas: SS-7039 (November 2014) 2 RDA 1693 (a) Fifty (50) hours of instruction, to include instruction in each of the four (4) areas listed herein, which are generally satisfied during the normal course of study in physical therapy school: 1. Musculoskeletal and Neuromuscular systems; 2. Anatomical basis of pain mechanisms, chronic pain, and referred pain; 3. Trigger Points; 4. Universal Precautions; and (b) Twenty-four (24) hours of dry needling specific instruction. 1. The twenty-four (24) hours must include instruction in each of the following six (6) areas: (i) Dry needling technique; (ii) Dry needling indications and contraindications; (iii) Documentation of dry needling; (iv) Management of adverse effects; (v) Practical psychomotor competency; and (vi) Occupational Safety and Health Administration's Bloodborne Pathogens Protocol. 2. Each instructional course shall specify what anatomical regions are included in the instruction and describe whether the course offers introductory or advanced instruction in dry needling. 3. Each course must be pre-approved or approved by the Board or its consultant, or the Board may delegate the approval process to recognized health-related organizations or accredited physical therapy educational institutions.

STATE	TRAINING REQUIREMENTS
UT	Rules currently being drafted
VA	Guidance Document 112-9 **Board of Physical Therapy Guidance on Dry Needling in the Practice of Physical Therapy** Upon recommendation from the Task Force on Dry Needling, the board voted that dry needling is within the scope of practice of physical therapy but should only be practiced under the following conditions: • Dry needling is not an entry level skill but an advanced procedure that requires additional training. • A physical therapist using dry needling must complete at least 54 hours of post professional training including providing evidence of meeting expected competencies that include demonstration of cognitive and psychomotor knowledge and skills. • The licensed physical therapist bears the burden of proof of sufficient education and training to ensure competence with the treatment or intervention. • Dry needling is an invasive procedure and requires referral and direction, in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing and specific for dry needling; if the initial referral is received orally, it must be followed up with a written referral. • If dry needling is performed, a separate procedure note for each treatment is required, and notes must indicate how the patient tolerated the technique as well as the outcome after the procedure. • A patient consent form should be utilized and should clearly state that the patient is not receiving acupuncture. The consent form should include the risks and benefits of the technique, and the patient should receive a copy of the consent form. The consent form should contain the following explanation: Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.
WY	Regulations effective January 25, 2016: Chapter 7, Section 3. Evidence of competence; dry needing. (b) Licensed physical therapists shall demonstrate that they have received training in dry needling in a course approved by state boards of physical therapy, the American Physical Therapy Association or individual chapters of the American Physical Therapy Association, the Federation of State Boards of Physical Therapy, or the International Association for Continuing Education Training. (i) The course shall include but not be limited to training in indications, contraindications, potential risks, proper hygiene, proper use and disposal of needles, and appropriate selection of clients. (ii) The course shall include a minimum of twenty-seven (27) hours of live face-to-face instruction. Online courses are not appropriate training in dry needling. (c) The physical

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	therapist shall supply written documentation, upon request by the Board, that substantiates appropriate training as required by this rule. Failure to provide written documentation may result in disciplinary action taken by the Board.

Appendix C: Examples of Courses in Dry Needling (not a complete list)

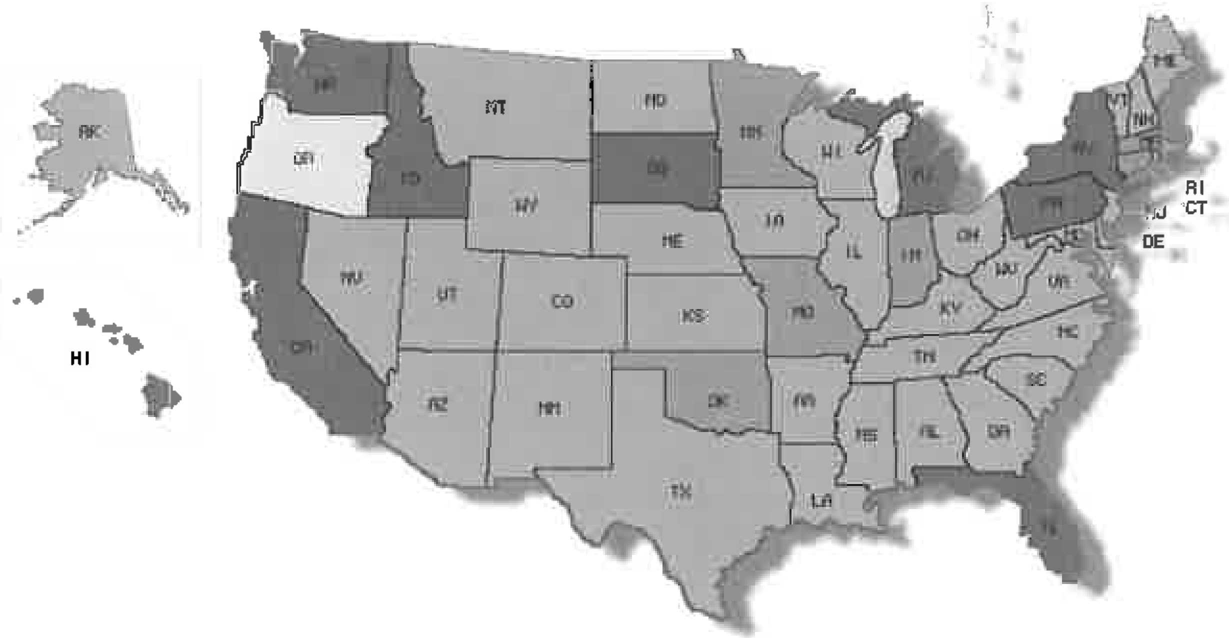
Course Title	Education Sponsor	Website
Trigger Point Dry Needling Level 1	Therapy Concepts	http://www.therapyconceptsinc.com/events.php#2
Trigger Point Dry Needling Level 2	Therapy Concepts	http://www.therapyconceptsinc.com/events.php#2
Systemic Integrative Dry Needling Course Pain Management, Sports and Trauma Rehabilitation		http://www.dryneedlingcourse.com/dry_needling_course.htm
Trigger Point Dry Needling Level I Training	GEMt – Global Education for Manual therapists	http://www.gemtinfo.com/physical-therapy/Trigger-Point-Dry-Needling-Level-I-Training/page17.html
Dry Needling Level 2 Training	Global Education for Manual therapists	http://www.gemtinfo.com/physical-therapy/Trigger-Point-Dry-Needling-Level-I-Training/page17.html
Dry Needling	Myopain Seminars	www.myopainseminars.com
DN-1: Dry Needling for Craniofacial, Cervicothoracic & Upper Extremity Conditions: an Evidence-Based Approach (Part 1 of the Certification in Dry Needling)	Spinal Manipulation Institute	http://www.dryneedlingseminars.com/?utm_source=National+PT+List&utm_campaign=42a600cd6b-Spinal_Manipulation_Institute_2010&utm_medium=email&utm_term=0_b80b4ebfeb-42a600cd6b-85739005
DN-2: Dry Needling for Lumbopelvic & Lower Extremity Conditions: an Evidence-Based Approach (Part 2 of the Certification in Dry Needling)	Spinal Manipulation Institute	http://www.dryneedlingseminars.com/?utm_source=National+PT+List&utm_campaign=42a600cd6b-Spinal_Manipulation_Institute_2010&utm_medium=email&utm_term=0_b80b4ebfeb-42a600cd6b-85739005

DN Course 1	Doublee PT Education	http://www.doubleepteducation.com
DN Course 2	Doublee PT Education	http://www.doubleepteducation.com
Functional Dry Needling Part A: Introduction, History, Legislative Issues, and Basic Technique	Medbridge	https://www.medbridgeeducation.com/courses/details/functional-dry-needling-part-a
Integrated Trigger Point Dry Needling for the Lower Quarter	Evidence in Motion	http://www.evidenceinmotion.com/educational-offerings/course_cat/continuing-courses/
Integrated Trigger Point Dry Needling for the Upper Quarter	Evidence in Motion	http://www.evidenceinmotion.com/educational-offerings/course_cat/continuing-courses/
Dr. Ma's Certification in Dry Needling course for Pain Management and Sports Medicine	Dr. Ma's American Dry Needling Institute	http://dryneedlingcourse.com/schedule-and-registration
Certified Training Course	Dry Needling Institute	http://fishkincenter.com/dryneedlinginstitute/

Appendix D: Dry Needling in the USA (map)

Dry Needling in the United States 12/2016

- Allowed
- Prohibited
- Silent
- Caution



Source: diymaps.net (c)

*District of Columbia specifically allowed

5. Analysis of Competencies for Dry Needling by Physical Therapists, Final Report (Human Resources Research Organization (HumRRO) – July 2015)

2015 No. 033

HumRRO
HUMAN RESOURCES RESEARCH ORGANIZATION

Analysis of Competencies for Dry Needling by Physical Therapists

Final Report

Prepared for: Federation of State Boards of Physical Therapy
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From HumRRO, we wish to thank Drs. Deirdre Knapp and Teresa Russell for their recommendations and guidance on numerous aspects of the planning and conduct of the competency development and in the preparation of this report.

Executive Summary

Dry needling is a skilled technique performed by a physical therapist using filiform needles to penetrate the skin and/or underlying tissues to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability.

Since 2010, jurisdictions have sought information from the Federation of State Boards of Physical Therapy (FSBPT) regarding the ability of physical therapists (PTs) to perform dry needling; however, no publically available studies have explicitly examined what PTs must know and be able to do to perform dry needling safely and effectively. To provide its members with objective, professionally-developed guidance, FSBPT sponsored a practice analysis of the competencies required of physical therapists to perform dry needling. Competencies are measurable or observable knowledge, skills, and/or abilities an individual must possess to perform a job competently.

The practice analysis drew from multiple sources of information (i.e., extant literature on dry needling; licensed physical therapists; dry needling experts) to provide an authentic and accurate assessment of the knowledge, skills, and abilities needed to perform dry needling safely and effectively. The process for developing the dry needling competencies included three main steps.

1. **Background Review** –Information gleaned from a review of the literature on dry needling was used to develop a preliminary set of dry needling "tasks" that describe job-related actions and a separate set of dry needling knowledge requirements that describe factual or procedural information directly involved in the performance the intervention.
2. **Practitioner Survey** – A survey of more than 350 licensed PTs, including individuals working in hospitals, private practice, clinics, academia, and the military, was administered to identify entry-level knowledge, skills, and abilities that are important for competency in dry needling.
3. **Task Force Meeting** – Seven dry needling experts, supported by observers from the American Physical Therapy Association (APTA) and FSBPT's Board of Directors, met to consolidate the information collected in the previous two steps and construct a final set of competencies.

Steps 1 and 2 were conducted concurrently between February and May, 2015. The Task Force meeting was held at FSBPT's headquarters on May 29-31, 2015.

The Task Force's primary objective was to identify knowledge, skills, and abilities that are specifically needed for competency dry needling. To accomplish this objective, they performed five activities.

1. **Define Dry Needling** – constructed a definition of dry needling that clearly communicates the purpose and defining features of the intervention
2. **Define the Standard for Competence (Safe and Effective Practice)** – clarified the standard of competence for dry needling representing the minimum level of proficiency needed to perform the technique competently
3. **Review and Refine Dry Needling Tasks** – identified job tasks that PTs perform when applying dry needling as part of a physical therapy treatment plan

4. **Review and Refine Dry Needling Knowledge Requirements** – identified the knowledge required to carry out the tasks identified in the previous activity
5. **Identify Dry Needling Skills and Abilities** – determined which skills and abilities are needed for safe and effective dry needling

The task force members were also charged with evaluating to what extent entry-level knowledge (i.e., knowledge required for licensure in physical therapy) is needed for safely and effectively using dry needling. To that end, the results of the 2011 Analysis of Practice for the Physical Therapy Profession (Bradley, Waters, Caramagno, & Koch, 2011) were incorporated into the analysis as a starting point. First, the Task Force identified which entry-level physical therapy job tasks and knowledge are relevant to competency in dry needling. Then, they identified additional tasks and knowledge that are needed specifically for performing the dry needling technique.

Major results from the dry needling practice analysis are presented below.

- Of the 214 entry-level and 27 dry needling-specific job tasks analyzed, 123 were identified as directly relevant to the competent performance of dry needling.
- Of the 116 entry-level and 22 dry needling-specific knowledge requirements, 117 were identified as important for competency in dry needling.
- 86% of the knowledge requirements needed to be competent in dry needling is acquired during the course of PT entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities.
- 16 (14%) of the knowledge requirements related to competency in dry needling must be acquired through post-graduate education or specialized training in dry needling.
- In terms of skill and ability requirements, psychomotor skills needed to handle needles and palpate tissues require specialized training. This skill was the only skill or ability noted as not being required to be an entry-level physical therapist.

The job tasks specifically involved in the use of dry needling are presented on the following pages along with the 16 knowledge requirements that are acquired through advanced or specialized training are displayed.

Table i. Dry Needling-specific Tasks

ID#	Tasks
	PATIENT/CLIENT ASSESSMENT
	Information Gathering & Synthesis
	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...
1.	...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
2.	...identify contraindications and precautions related to dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
3.	Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications.
	INTERVENTIONS
	Manual Therapy Techniques
	Position the patient/client to...
4.	...expose the area(s) to be needled
5.	...reduce the risk of harm to the patient/client and/or therapist
6.	Educate the patient/client on the impact of movement during treatment
7.	Perform palpation techniques to identify the area(s) to be needled
8.	Apply needle handling techniques that ensure compliance with relevant and current professional standards (e.g., wash hands, wear gloves, minimize needle contamination)
9.	Apply draping materials (e.g., linens, towels) to minimize unnecessary exposure and respect patient privacy
10.	Perform dry needling techniques consistent with treatment plan (e.g., place, manipulate, and remove needles)
11.	Manage needle removal complications (e.g., stuck needle, bent needle)
12.	Monitor patient/client's emotional and physiological response to dry needling
13.	Facilitate hemostasis as necessary
14.	Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
15.	Discuss post-treatment expectations with the patient/client or family/caregiver

ID#	Tasks
	Education
16.	Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action. benefits, tools and equipment)
17.	Educate patient/client or family/caregiver about potential adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
18.	Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age. allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
	Patient/client & Staff Safety
	Emergency Procedures
19.	Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles)
20.	Implement emergency response procedures to treat practitioner injuries sustained during dry needling (e.g., needle stick)

Table i. (Continued)

ID#	Tasks
Environmental Safety	
21.	Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
22.	Stock dry needling supplies and equipment in safe proximity during treatment
Infection Control	
23.	Implement infection control procedures to mitigate the effects of needle stick injuries
24.	Clean and disinfect blood and bodily fluids spills in accordance with regulatory standards and local jurisdictional policies and procedures
25.	Replace surfaces that cannot be cleaned
Professional Responsibilities	
26.	Determine own ability to perform dry needling safely and effectively

Table ii. Specialized Knowledge Required for Competency in Dry Needling

Anatomy and Physiology	
1.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
Emergency Preparedness and Response	
2.	Emergency preparedness and/or response procedures related to secondary physiological effects or complications associated with dry needling (e.g., shock, vasovagal)
3.	Emergency preparedness and/or response procedures related to secondary emotional effects or complications associated with dry needling (e.g., claustrophobia, anxiety, agitation)
4.	Standards for needle handling (e.g., hand hygiene, application of single-use needles)
Safety and Protection	
5.	Factors influencing safety and injury prevention
6.	Personal protection procedures and techniques as related to dry needling (e.g., positioning self to access treatment area, use of personal protective equipment)
7.	Theoretical basis for dry needling (e.g., applications for rehabilitation, health promotion, fitness and wellness, performance)
8.	Theoretical basis for combining dry needling with other interventions
9.	Secondary effects or complications associated with dry needling on other systems (e.g., gastrointestinal, cardiovascular/pulmonary, musculoskeletal)
10.	Theoretical basis of pain sciences, including anatomy, physiology, pathophysiology, and relation to body structures and function
11.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions)
12.	Palpation techniques as related to dry needling
13.	Needle insertion techniques
14.	Needle manipulation techniques
15.	Physiological responses to dry needling
16.	Solid filament needles (e.g., physical characteristics)

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Analysis of Competencies for Dry Needling by Physical Therapists

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Analysis of Competencies for Dry Needling by Physical Therapists

Introduction and Overview

Dry Needling in the Physical Therapy Scope of Practice

Dry needling is a procedural intervention used by physical therapists (PT) to treat pain, functional impairments, and disabilities. The technique involves the insertion of solid filament needles into the skin and underlying tissue to disrupt pain sensory pathways and relax contracted fibers (Dommerholt, & Fernández-de-las-Peñas, 2013). Clinical research suggests that dry needling helps reduce local and peripheral pain and sensitization, thereby hastening the restoration of muscle function and range of motion (Lewit, 1979; Dommerholt, 2011; Clewley, Flynn, & Koppenhaver, 2014). Dry needling (alone or with other physical therapy interventions) has been shown to be an effective treatment for neuromusculoskeletal diseases or conditions, including arthritis, tendonitis, carpal tunnel, and chronic pain (Dommerholt, 2004; Kalichman, & Vulfsons, 2010).

The theoretical genesis of dry needling is attributed to the pioneering work of Janet Travell, M.D. and David Simons, M.D. (Simons, Travell, & Simons, 1999) who used .22-gauge hypodermic needles to treat myofascial pain with trigger point therapy (i.e., needling of taut bands of muscle fibers). Over the past several decades, practitioners have adopted variations on the original approach including superficial and deep needling techniques (Gunn, 1997; Baldry, 2002; Ma, 2011). Modern dry needling has largely abandoned hypodermic needles in favor of round tip, solid filament needles ranging from .22 to .30 millimeters in diameter as the beveled tip of hypodermic needles causes greater tissue damage. In addition, modern dry needling is used to treat a variety of conditions and dysfunction of neuromusculoskeletal structures (Ma, 2011; Dommerholt & Fernández-de-las-Peñas, 2013; Dunning, et al, 2014).

The use of needles to treat health conditions is not unique to physical therapy. Needles of similar design are used by practitioners of Acupuncture and Oriental Medicine. However, the use of needles, per se, does not imply that one needling approach is equivalent to another or that one medical profession is infringing on the scope of practice of another. It is not the specific individual procedures or tools that define a profession, but the totality of the scope of practice (National Council of State Boards of Nursing, 2012).

Dry needling in the context of physical therapy is based on a distinct philosophical and theoretical framework supported by modern scientific study of the musculoskeletal and nervous systems (American Physical Therapy Association, 2012; Cummings, 2013; Dunning, et al, 2014). At every stage of the physical therapy visit, from patient selection to the actual needling of the affected areas, the PT is guided by his/her education, clinical training and experience, professional responsibilities and competence, and legally defined scope of practice, as well as the patient's reaction to needling. For example, the type and number of needles used, as well as their location, depth, and manipulation, are heavily influenced by the PT's knowledge of anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, and pathology, as well as the overall plan of care.

In the United States, physical therapy practice is governed by occupational and regulatory standards for ensuring public protection and professional integrity. Statutes (i.e., practice acts) define the scope of practice for a particular jurisdiction and licensure laws ensure practitioners meet and maintain prescribed standards for the competent performance of their jobs. However, practice acts are often ambiguous regarding the procedures and techniques PTs are allowed to perform because methodologies and evidence-based treatments continually evolve with

advances in education, research, and technology. As a result, interpretation of the law falls to state boards/agencies which develop rules and regulations to define, in practical terms, whether or not a specific procedure, technique, or modality is within the scope of practice. Because each state creates its own licensure laws, the scopes of practice vary—an allowed technique in one state may be restricted in another. Currently, dry needling is specifically allowed in 33 states and strictly prohibited in eight; the remaining states are either undeclared or have conflicting rulings.

Scope and Purpose of the Project

Since 2010, many jurisdictions have sought information from the Federation of State Boards of Physical Therapy (FSBPT) regarding the ability of PTs to perform dry needling. Much of the empirical research on dry needling has focused on the clinical aspects of the technique, such as methods of action and treatment effects (Dommerholt & Fernández-de-las-Peñas, 2013; Dommerholt, 2011; Dunning, et al, 2014). However, no publically available studies have explicitly examined what PTs must know and be able to do to perform dry needling safely and effectively, or what factors (personal capacities or environmental conditions) contribute to competent performance. To provide its members with objective, professionally-developed guidance, FSBPT sponsored a study of the competencies required for safe and effective dry needling.[1]

The primary objectives of this research were to:

1. **Define Dry Needling Competencies for Physical Therapists**
   a. What must physical therapists know and be able to do to perform dry needling safely and effectively?
   b. When, where, and how do physical therapists acquire the knowledge, skills, and abilities needed to perform dry needling?
2. **Evaluate Factors that Impact Safe and Effective Practice**
   a. What characteristics of the individual contribute to safe and effective dry needling?
   b. What institutional and environmental factors influence the safe and effective practice dry needling?

Research Design

The systematic process for developing competencies in a licensure context is often referred to as "practice analysis". The process begins with an analysis of the work itself to identify the tasks individuals perform on the job. This is followed by an investigation of the knowledge, skills, and abilities needed to perform those tasks. Finally, additional information is collected to determine the requirements for evaluating the quality of performance on a task (e.g., effective versus not effective). The result of this process is a list of the knowledge, skills, and ability requirements for competent performance.

[1] Competencies are defined as measurable or observable knowledge, skills, or abilities an individual must possess to perform a job effectively. They possess both descriptive and evaluative information (i.e., what characteristics an individual must possess and to what extent or level of quality). Because they describe behavioral characteristics of the individual in terms of the job being performed, competencies can provide a strong foundation for a variety of professional and regulatory functions, including the establishment of education and training requirements, performance assessment and management, professional guidelines, and practice regulations. They are also useful for communicating with and educating the public on the dry needling technique and how it fits with the physical therapy scope of practice.

Practice analysis relies on the input and judgment of subject matter experts (SMEs) to provide an authentic and accurate assessment of the job tasks and competencies. Their primary role is to bring their education, training, and on-the-job experience to bear in identifying knowledge, skills, and abilities that are relevant and important for competent practice. In this way, SME participation adds credibility and validity to the outcomes of the research.

FSBPT contracted with the Human Resources Research Organization (HumRRO) to conduct the study in accordance with current best-practices in practice analysis procedures. HumRRO is a non-profit, social and behavioral science research and consulting firm dedicated to the measurement and improvement of human and organizational performance. As an independent contractor, HumRRO was instrumental in carrying out an objective, unbiased analysis. In addition, HumRRO provided an external perspective of the nature of physical therapy work, particularly the human and environmental factors related to competent job performance.

Competency Development Process

The process for developing the dry needling competencies included three main steps. First, HumRRO staff conducted a background review of the literature on dry needling and constructed draft versions of the competencies. Concurrently with the background review, FSBPT surveyed a broad sample of licensed PTs to identify knowledge, skills, and abilities that are important for dry needling. Finally, HumRRO and FSBPT convened a task force meeting with experts in dry needling to consolidate the information collected in the previous two steps and construct a final list of competencies. Each step is described in more detail in the following sections.

Background Information Review

The purpose of the background review was to obtain current theoretical, procedural, and descriptive information on dry needling and translate it into a preliminary set of competencies. The review began with an internet search to identify source material containing information related to: dry needling knowledge and skills, tasks and/or duties, contraindications, adverse effects, safety, needle techniques, patient education and communication, and emergency preparedness and response. This search returned 30 sources encompassing websites, resource papers, text publications, peer-reviewed research journals, instructional curricula, and testing materials. FSBPT identified an additional seven electronic documents covering FSBPT periodicals and testing materials related to the National Physical Therapy Licensure Exam (NPTE). The complete list of source materials is provided in Appendix A.

During the review, text fragments (e.g., sentences, phrases, paragraphs) that provided potentially useful information were extracted and stored in an electronic database. A total of 937 fragments were collected ranging in size from 19 to 2,329 characters (including spaces). The average size of an extracted fragment was 229 characters. Examples include:

- "…inquiries specifically about reactions to needles…"
- "Sustained contractures of taut bands cause local ischemia and hypoxia in the core of trigger points."
- "The muscle and treatment area needled should be compressed immediately following needle with-drawal for hemostasis for up to 30 seconds or until any bleeding has stopped. A cotton swab may be used and should be discarded as appropriate."
- "The clinician should be cognizant of anatomical structures within the treatment area that are vulnerable to [dry needling], e.g. neurovascular structures and the lung, and ensure

that the needling technique avoids penetration of vulnerable anatomical structures. Also, voluntary and involuntary patient movement may compromise safe [dry needling], which is why the needling hand should always rest on the patient's body."

The extracted information was analyzed, sorted, and coded into groupings reflecting common (or recurrent) topics or themes. For example, the following sentences provided information related to knowledge of body systems affected by dry needling.

- "Dry needling is a neurophysiological evidence-based treatment technique that requires effective manual assessment of the neuromuscular system"
- "Anatomical knowledge of the vascular system is important as there is a potential to puncture blood vessels during needling"
- "Identify specific bony landmarks of the pelvis and differentiate individual pelvic muscles for needling"
- "Anatomical knowledge of internal organs is important as there is potential for internal organ penetration such as the kidney with needling of [trigger points] in the psoas major and quadratus lumborum muscles or organs within the peritoneal cavity with needling of TrPs in the abdominal muscles"

In some instances, a single fragment provided information across multiple topics and was coded accordingly. After sorting and grouping the information, common topics with each grouping were identified and used to construct draft lists of dry needling tasks and knowledge requirements.

Tasks are defined as discrete job-related actions taken to achieve some goal or purpose, and the tools, conditions, and reasons for doing so. Twenty-seven tasks were derived from the background review materials. Below is an example of a task statement.

Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements).

Knowledge requirements describe organized bodies of factual or procedural information that are directly involved in the performance of a job or job task. Twenty-seven knowledge requirements were derived from the background review. An example of a knowledge requirement statement is presented below.

Knowledge of contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications).

The draft lists of tasks and knowledge requirements were reviewed with FSBPT to (a) identify content gaps, (b) make adjustments to the phrasing or content, and (c) organize the information in a meaningful way for review by the Task Force. The complete list of draft statements is presented in Appendix B.

Practitioner Survey

The purpose of the practitioner survey was to identify entry-level physical therapy tasks and knowledge (required at the time of licensure) that are also required for dry needling. A large sample

of licensed PTs (n=353) was recruited to complete the survey. This sample included individuals working in hospitals, private practice, clinics, academia, and the military. Respondents were presented with two lists: 214 entry-level tasks (a.k.a., work activities) and 116 entry-level knowledge statements. Both lists were drawn verbatim from the results of the 2011 Analysis of Practice for the Physical Therapy Profession (Bradley, Waters, Caramagno, & Koch, 2011).[2] The practitioner survey was conducted concurrently with the review of background materials. Therefore, draft competencies from the review were not included in the practitioner survey. Respondents were instructed to rate whether each task (or knowledge) was relevant or not relevant to competency in performing dry needling. Tables indicating the percent of respondents selecting each task or knowledge as relevant were prepared for presentation to the Task Force.

Respondents were also asked to identify qualities or capabilities that PTs need to be effective in the practice of dry needling that were not already covered by the lists of tasks and knowledge statements. HumRRO content analyzed their responses and identified commonly cited characteristics. Broadly, the responses could be categorized into three areas of dry needling-specific information: skills and abilities, tasks, and knowledge. For example, some of the respondents suggested adding tasks related to needle selection and placement, identification of contraindications, and palpation. A small portion of respondents observed that PTs need knowledge of surface and cross-sectional anatomy, adverse effects related to needling, and clean needle techniques. The information identified by the survey respondents was incorporated into the draft list of tasks and competencies developed during the background review.

Task Force Meeting

The purpose of the Task Force meeting was to review the draft competencies and survey results and consolidate the information into a final set of dry needling competencies. FSBPT extended invitations to a group of dry needling experts who were employed in a variety of sectors (e.g., private, academia) and were geographically dispersed. Because more individuals were interested than there were positions to fill, FSBPT requested from each individual a short summary of his/her training and professional experience with dry needling as well as his/her availability to attend the Task Force meeting on the selected dates (see below). Based on the narratives, FSBPT looked for individuals who possessed regulatory experience with FSBPT or FSBPT's licensing boards and/or have been involved in the legislative process with regard to dry needling.

Seven individuals were selected to participate on the Task Force based on their depth and breadth of experience and education in dry needling. Their years of professional experience performing dry needling ranged from five to fourteen. All participants were licensed PTs with a minimum of fourteen total years of experience in physical therapy and a maximum of 31. Five participants possessed Doctorate level degrees (i.e., DPT); one had a Master's level degree (i.e., MPT/MSPT), and one had a Bachelor's degree. All were certified to practice dry needling, and five were currently in an educational or training role (e.g., faculty, instructor) providing dry needling instruction in addition to their clinical employment as therapists. One was a full-time faculty member.[3]

The Task Force meeting was held at FSBPT's headquarters on May 29-31, 2015. HumRRO staff facilitated the meeting with technical support from FSBPT as well as observers from the American Physical Therapy Association (APTA) and FSBPT's Board of Directors. The agenda covered the following activities:

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[2] Available at: https://www.fsbpt.org/download/pa2011_ptfinalreport20111109.pdf

[3] At this time there are no required certifications, or certifications that are acknowledged by a regulatory board. All Task Force members have extensive training in dry needling and practice it regularly.

1. Define Dry Needling
2. Define the Standard for Competence (Safe and Effective Practice)
3. Review and Refine Dry Needling Tasks
4. Review and Refine Dry Needling Knowledge Requirements
5. Identify Dry Needling Skills and Abilities

Define Dry Needling

The first activity was aimed at constructing a definition of dry needling that clearly communicates the purpose and defining features of the intervention without inadvertently narrowing the scope. A draft definition was presented to the Task Force for review and is presented below.[4]

> Draft definition: *Dry needling is a skilled intervention using a thin, filiform needle, without injectate, to penetrate the skin in order to stimulate and effect change in underlying tissues.*[5]

The Task Force noted several issues with the draft definition they believed would confuse certain audiences and narrow its applicability across individual practitioners and practice settings. These included the following.

- Dry needling is not limited to physical stimulation of acutely affected tissue.
- There is a neural component that includes the peripheral and central nervous system.
- Dry needling can be used to stimulate as well as inhibit the neuromusculoskeletal system.
- Dry needling is a method for evaluating, treating, and managing functional impairment and pain.
- Dysfunction and disability are also treated with dry needling.
- The term filiform should be kept; however, some needles are thicker than others so "thin" might be misleading.
- Needles may penetrate more than just the dermal layer (i.e., skin).

The definition adopted by Arizona Physical Therapy Board which was developed to address many of the same issues was presented. The Task Force elected to use this definition as a starting point and made a few additional revisions, such as adding "disability" to the list of things dry needling can be used to treat. The final definition is presented below.

> *Dry needling is a skilled technique performed by a physical therapist using filiform needles to penetrate the skin and/or underlying tissues to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability.*

Define the Standard for Competence (Safe and Effective Practice)

[4] This version was developed by FSBPT staff with contributions from two practicing physical therapists that have expertise in dry needling. The draft version was primarily developed as a starting point to facilitate discussion.
[5] Draft definition; do not cite.

The second activity was conducted to clarify the standard of competence for dry needling. This standard represents the minimum level of proficiency needed to perform the technique competently. Although there are many ways to define competence (e.g., efficiency, cost, speed, quality, satisfaction), the criteria "safe and effective" were selected because (a) they are meaningful to the practice of dry needling (and physical therapy in general), and (b) this approach is consistent with the 2011 practice analysis (Bradley, Waters, Caramagno, & Koch, 2011).

To begin, the Task Force participated in a brainstorming task to identify (at a broad level) what PTs do when applying dry needling, what they must know to do so safely and effectively, and what psychological or physical characteristics they must possess (e.g., skills, abilities). Examples of their responses include:

- DO: assess and evaluate; determine need for intervention, educate patients, establish goals, handle needles safely, manage waste disposal
- KNOW: anatomy; palpation techniques; dosing; informed consent; adverse effects; reimbursement
- POSSESS: psychomotor skills; social skills; ability to communicate; ethics; self-awareness; empathy/compassion; cultural competence

This activity helped orient the Task Force to the practice analysis approach and establish a common frame of reference regarding the meaning of safe and effective practice.

The Task Force noted that safety and effectiveness are related but distinct concepts so both criteria are warranted. They unanimously agreed that the concept of safety applies to both patient and practitioner and includes prevention as well as emergency response. Prevention covers direct actions such as safe needle handling and infection control, as well as more indirect actions like attending to and correctly interpreting patient data. In relation to the minimum standard for competence, they defined safe practice as the prevention and mitigation of harm to the patient or therapist, directly or indirectly, through careful patient selection, evaluation, and treatment.

The concept of effectiveness was more difficult to define because dry needling can be used to achieve a variety of therapeutic responses and outcomes (e.g., reduced pain and/or sensitization, increased mobility). Each patient's needs are dependent on his/her symptoms or conditions and whether dry needling is appropriate. Measuring the effectiveness of the treatment requires careful pre- and post-treatment assessment to establish a baseline health status, select the patient for dry needling, and detect change. Accordingly, the Task Force opted to define the standard for effectiveness in relation to the entire physical therapy session (or visit). In other words, dry needling is effective when the PT continually assesses and evaluates the patient and adjusts the treatment according to the patient's specific needs or presentation.

Review and Refine Dry Needling Tasks

The objective of the third activity was to identify job tasks that PTs perform when applying dry needling as part of a physical therapy treatment plan. Job tasks are not included as part of the competencies but the identification of tasks is essential for linking the competencies to the actions that PTs perform on the job. In other words, in order to identify the competencies required for a job, one must first understand the job itself. The job task analysis served this purpose.

The analysis was carried out in two parts. First, the Task Force reviewed a list of entry-level physical therapy tasks. These tasks were identified during the 2011 practice analysis (Bradley, Waters,

Caramagno, & Koch, 2011) and, as such, reflect the actions expected of all licensed, entry-level PTs. Because the same list was used in the practitioner survey, the Task Force reviewed the survey results (i.e., percent of respondents endorsing each task as relevant). Through discussion and consensus-building, the Task Force made a final determination of the relevance of each task. For this activity, relevance was based on the standard for competence defined in the previous section (i.e., a task is relevant if it is necessary for safe and effective practice).

Next, the Task Force reviewed the list of draft task statements developed during the background review. These tasks describe the procedural actions involved in performing the dry needling intervention and are at a somewhat finer grain of analysis than the entry-level tasks. As a result, the Task Force spent more time editing these tasks to improve their clarity and accuracy.

During the review, the Task Force noted that dry needling is always performed as part of a comprehensive treatment plan and almost never the only physical therapy intervention included in the plan. As a result, the Task Force initially identified all of the entry-level interventions as relevant to dry needling. However, this decision created redundancy with the list of entry-level physical therapy tasks and obscured the purpose and usefulness of the dry needling task list.[6] Because dry needling is frequently combined with other interventions, the Task Force observed that an important part of a PT's role is determining the proper sequence of events to reduce or eliminate the risk of relative contraindications. Therefore, instead of including every physical therapy intervention/treatment on the task list, the Task Force created a new statement that specifically addressed the action of sequencing dry needling with other interventions.

> *Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications.*

The statements describing the other interventions were excluded from the final dry needling task list.

Review and Refine Dry Needling Knowledge Requirements

The objective of the fourth activity was to identify the knowledge required to carry out the tasks identified in the previous activity. The Task Force began by reviewing the 116 entry-level knowledge requirements identified in the 2011 practice analysis as well as the practitioner survey results. They identified 13 statements as clearly unrelated to the safe and effective practice of dry needling and excluded them from further consideration. These statements covered knowledge of biofeedback, electromagnetic radiation, data collection techniques, and measurement science, to name a few. Next, the Task Force reviewed the 27 dry needling-specific knowledge requirements developed during the background review. This list was heavily refined to ensure the knowledge requirements were clear and accurate. During the review, the Task Force eliminated eight and created two new knowledge requirements.

Once the Task Force was comfortable with the content of the lists, they performed a rating task to evaluate the importance of the knowledge requirements. The importance rating reflects the extent to which the knowledge described by a particular statement is needed for safe and

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[6] From a methodological standpoint, task lists should include only actions/activities necessary to perform the work. The inclusion of other interventions on the dry needling task list suggests they are essential to the proper implementation of technique.

effective dry needling. If lack of the knowledge would lead to very serious negative consequences, the importance rating should be higher. If none or few consequences would result from a lack of the knowledge, the importance rating should be lower. The importance rating scale is shown below.

How important is the knowledge for the safe and effective performance of dry needling by a licensed physical therapist?

1. Minimally important
2. Somewhat important
3. Important
4. Very important
5. Extremely important

The Task Force members' rated each of the remaining 103 knowledge requirements. HumRRO compiled and analyzed the ratings to identify knowledge requirements for which there were large discrepancies in judgment (e.g., split-decisions, no clear majority) were marked for review. All of these discrepancies were resolved through a process of discussion to reinforce the purpose and goals of the activity and reach agreement regarding the knowledge that is required for competent dry needling.

Identify Dry Needling Skills and Abilities

The process for determining which skills and abilities are needed for safe and effective dry needling differed from that used for the tasks and knowledge requirements. To date, no publicly available description of skills and abilities needed for dry needling exists. However, the U.S. Department of Labor developed a comprehensive database called the Occupational Information Network (O*NET) which contains information on skills and abilities that are related to job performance in different industries, including physical therapy (Tsacoumis & Van Iddekinge, 2006). The data analysis conducted by the Department identified 21 skills and 22 abilities that apply to the physical therapy occupation. Accordingly, to identify attributes specifically related to dry needling, HumRRO integrated the O*NET information with expert judgments made by the Task Force.

First, the Task Force brainstormed a set of attributes needed for performing dry needling safely and effectively and identified five general activities.

1. Communicating with patients
2. Adapting behavior or treatment to accommodate patient's needs/preferences
3. Handling and controlling needles and palpating tissues
4. Reflecting on and evaluating own competence to perform dry needling (e.g., only treating areas for which the PT has specific training)
5. Abiding by professional and ethical standards (e.g., adhering to OSHA regulations)

They noted that PTs acquire the skills and abilities to perform these activities competently during their general physical therapy education, residency, and/or clinical internships, with one exception; the psychomotor skills needed to physically perform dry needling (e.g., needle insertion) are not learned in physical therapy school and must be developed as part of specialized training on the technique.

Next, HumRRO mapped the activities identified by the Task Force to the skills and abilities listed in the O*NET database. Two HumRRO analysts reviewed the definition of each O*NET

skill or ability as well as any behavioral examples provided and used this information to "link" the two sets of information. For instance, writing skill is defined in the O*NET database as "Communicating effectively in writing as appropriate for the needs of the audience" (e.g., taking a phone message, writing a memo to staff outlining new directives) and corresponds with the Task Force-identified activity focused on patient communication.

Outcomes

Dry Needling Job Tasks

Of the 214 job tasks required of entry-level, licensed PTs, 97 were judged to be relevant to dry needling. These tasks describe activities related to information gathering and systems review (n = 17), testing and measurement (n = 33), evaluation and diagnosis (n = 11), prognosis and plan of care (n = 5), non-procedural interventions (n = 16), and patient/client and staff safety (n = 15). Of the 27 tasks derived from the background review, 26 were identified as specifically relevant to dry needling (see Table 1). Nearly half (n = 12) of these tasks describe procedural actions such as positioning the patient, palpating the area(s) to be needled, needle handling, monitoring the patient, and disposing of medical waste. The remaining 14 tasks describe activities related to information gathering, prognosis and plan of care, non-procedural interventions, and patient/client and staff safety. The final list of 123 dry needling tasks is displayed in Appendix D. Tasks that were deemed not relevant to dry needling are presented in Appendix E.

Table 1. Dry Needling-Specific Tasks

ID#	Tasks
PATIENT/CLIENT ASSESSMENT	
Information Gathering & Synthesis	
	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...
1.	...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
2.	...identify contraindications and precautions related to dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
3.	Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications
INTERVENTIONS	
Manual Therapy Techniques	
	Position the patient/client to...
4.	...expose the area(s) to be needled
5.	...reduce the risk of harm to the patient/client and/or therapist
6.	Educate the patient/client on the impact of movement during treatment
7.	Perform palpation techniques to identify the area(s) to be needled
8.	Apply needle handling techniques that ensure compliance with relevant and current professional standards (e.g., wash hands, wear gloves, minimize needle contamination)
9.	Apply draping materials (e.g., linens, towels) to minimize unnecessary exposure and respect patient privacy
10.	Perform dry needling techniques consistent with treatment plan (e.g., place, manipulate, and remove needles)
11.	Manage needle removal complications (e.g., stuck needle, bent needle)
12.	Monitor patient/client's emotional and physiological response to dry needling

Table 1 (Continued)

ID#	Tasks
13.	Facilitate hemostasis as necessary
14.	Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
15.	Discuss post-treatment expectations with the patient/client or family/caregiver
Education	
16.	Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action, benefits, tools and equipment)
17.	Educate patient/client or family/caregiver about potential adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
18.	Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
Patient/client & Staff Safety	
Emergency Procedures	
19.	Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles)
20.	Implement emergency response procedures to treat practitioner injuries sustained during dry needling (e.g., needle stick)
Environmental Safety	
21.	Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
22.	Stock dry needling supplies and equipment in safe proximity during treatment
Infection Control	
23.	Implement infection control procedures to mitigate the effects of needle stick injuries
24.	Clean and disinfect blood and bodily fluids spills in accordance with regulatory standards and local jurisdictional policies and procedures
25.	Replace surfaces that cannot be cleaned
Professional Responsibilities	
26.	Determine own ability to perform dry needling safely and effectively

Dry Needling Competencies

Physical Therapy Knowledge Needed for Dry Needling

Determination of the knowledge needed for competency in dry needling was based on the average of Task Force members' importance ratings for each knowledge requirements. Mean importance ratings ranged from 1.57 to 4.71. Requirements with a mean rating of less than 2.00 ("Somewhat Important") were marked for potential elimination and discussed with the Task Force (n = 9). Of these, one statement (i.e., *knowledge of pneumatic compression modalities*) was retained as important because PTs must understand potential interactions between the interventions. Knowledge requirements falling near the threshold were discussed and reassessed. Of the 116 entry-level knowledge requirements, 95 were identified as important for dry needling. All 22 of the dry needling-specific knowledge requirements were identified as important for dry needling. The final list of 117 dry needling knowledge requirements is presented in Appendix F.

Knowledge requirements rated less than 2.00 were deemed not important to dry needling (n = 8). These included knowledge of other equipment and devices (e.g., prosthetics), other therapeutic modalities (e.g., mechanical), ultrasound imaging, and gastrointestinal interventions. Knowledge not related to competency in dry needling is presented in Appendix G.

Although much of the knowledge needed for dry needling is acquired during the course of a PT's entry-level education (e.g., coursework; clinical internships), dry needling is not an entry-level technique. Therefore, some knowledge must be developed through specialized training.[7] Sixteen knowledge requirements were identified as requiring advanced/specialized training for dry needling (see Table 2). All but one (i.e., *Factors influencing safety and injury prevention*) cover dry needling-specific knowledge such as surface anatomy, emergency preparedness and response procedures and standards (as related to dry needling), theoretical basis for dry needling, aspects of the technique itself, and secondary effects or contraindications related to the use of needles.

Table 2. Specialized Knowledge Required for Competency in Dry Needling

DRY NEEDLING-SPECIFIC KNOWLEDGE	
Anatomy and Physiology	
1.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
Emergency Preparedness and Response	
2.	Emergency preparedness and/or response procedures related to secondary physiological effects or complications associated with dry needling (e.g., shock, vasovagal)
3.	Emergency preparedness and/or response procedures related to secondary emotional effects or complications associated with dry needling (e.g., claustrophobia, anxiety, agitation)
4.	Standards for needle handling (e.g., hand hygiene, application of single-use needles)
Safety and Protection	
5.	Factors influencing safety and injury prevention
6.	Personal protection procedures and techniques as related to dry needling (e.g., positioning self to access treatment area, use of personal protective equipment)
7.	Theoretical basis for dry needling (e.g., applications for rehabilitation, health promotion, fitness and wellness, performance)
8.	Theoretical basis for combining dry needling with other interventions
9.	Secondary effects or complications associated with dry needling on other systems (e.g., gastrointestinal, cardiovascular/pulmonary, musculoskeletal)
10.	Theoretical basis of pain sciences, including anatomy, physiology, pathophysiology, and relation to body structures and function
11.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions)
12.	Palpation techniques as related to dry needling
13.	Needle insertion techniques
14.	Needle manipulation techniques
15.	Physiological responses to dry needling
16.	Solid filament needles (e.g., physical characteristics)

Physical Therapy Skills and Abilities Needed for Dry Needling

[7] The Task Force defined specialized training as a full course on a particular topic or set of topics—short (e.g., half-day) workshops do not fulfill this requirement—and recommended that opportunities to practice actual needling should be incorporated into and provided immediately after the training to reinforce learning.

As mentioned, the determination of skills and abilities needed for competent dry needling was made by coupling Task Force members' judgment with information from the O*NET database. HumRRO linked the five Task Force-identified activities to 16 O*NET skills and abilities. The list covers attributes that are needed to perform dry needling safely and effectively, including communication (e.g., reading, writing, speaking), active listening and clinical thinking, social skills, psychomotor abilities, and judgment and decision-making. The Task Force observed that the majority of these skills and abilities are acquired through entry-level training and education. However, because dry needling is not included in most entry-level physical therapy programs (Adrian, 2013), the psychomotor skills needed to handle needles and palpate tissues require specialized training.[8] The final list of skills and abilities is presented in Appendix H.

Role of the Physical Therapist Assistant in Dry Needling

Physical therapist assistants (PTAs) are health care workers who are directed and supervised by PTs. In this role, they are involved in direct patient care, including (but not limited to) observation and records management, therapeutic exercise, gait and balance training, massage, and patient education. However, PTAs do not evaluate, diagnose, assess/reassess, or prepare treatment plans for patients. They also do not make recommendations for various types of treatments modalities and equipment.

Task differences between PTs and PTAs are partly related to the scope of educational curricula provided by accredited physical therapist assistant degree programs. Whereas assistants receive instruction in many of the same domains as PTs (e.g., anatomy and physiology, biomechanics, kinesiology, neuroscience, clinical pathology, behavioral sciences, communication, ethics/values), the depth and breadth of education and training is not equivalent. PTAs spend roughly 16 weeks in clinical education, whereas PTs spend more than 27. In addition, PTAs receive no didactic or clinical training in evaluation and differential diagnosis. Because this report focused on the competencies required of the PT to perform dry needling, which are based on a strong foundation in evaluation and differential diagnosis, it is not appropriate to assume the same competencies would qualify a PTA to perform the treatment.

Conclusions

The practice analysis of dry needling revealed several important characteristics about PTs' capabilities for performing the intervention as part of their scope of practice. First, of the 116 entry-level and 22 dry needling-specific knowledge requirements, 117 were identified as important for competency in dry needling. More than four-fifths (86%) of what PTs need to know to be competent in dry needling is acquired during the course of their entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities. Advanced or specialized training (e.g., dry needling course, residency program) is required for 16 of the knowledge areas

[8] Although additional training is needed for the development of psychomotor skills (as well as the 16 knowledge requirements noted previously), there does not appear to be widespread agreement regarding the minimum number of practice hours necessary (Kalichman & Vulfsons, 2010). Indeed, the acquisition of knowledge and skills is dependent on more than just the number of hours of deliberate practice (Hambrick, Oswald, Altman, Meinz, Gobet, & Campitelli, 2014). The Task Force argued that variation across individuals in terms of their aptitude, education, experience, and clinical specialization results in different rates of development. Additionally, any practice hour metric should be theoretically or practically linked to the professional standard for safe and effective practice (AERA, APA, NCME, 2014).

needed for dry needling and these are almost solely related to the needling technique (e.g., selection, placement, and manipulation of needles; identification of contraindications). In addition, the psychomotor skills needed to handle needles and palpation of tissues specifically in regard to dry needling appropriately require specialized training Because this report focused on the competencies required of the PT to perform dry needling, which are based on a strong foundation in evaluation and differential diagnosis, it is not appropriate to assume the same competencies would qualify a PTA to perform the treatment.

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Appendix A
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Appendix B
Draft Dry Needling-Specific Tasks and Knowledge Requirements

Table B1. Draft List of Dry Needling Tasks

PATIENT/CLIENT ASSESSMENT

Information Gathering & Synthesis

Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...

1. ...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
2. ...identify contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)

INTERVENTIONS

Manual Therapy Techniques

Position the patient/client using supportive devices and equipment (e.g., pillows, rolls, cushions) to...

3. ...ensure the patient/client is comfortable and relaxed
4. ...enable ease of access to the tissue(s) being needled
5. ...reduce the risk of harm to the patient/client and/or therapist
6. Instruct the patient/client to limit movement during treatment
7. Perform palpation techniques to identify the area(s) to be needled
8. Apply sterile needle handling techniques (e.g., wash hands, wear gloves, avoid contact with needle shaft, use sterile plunger, minimize needle contact with skin)
9. Disinfect needle site using detergent, water, alcohol, or iodine solution
10. Perform dry needling techniques on muscles, tendons, ligaments, and other connective tissue to reduce pain and improve functional ability
11. Monitor patient/client's psychological and physiological response to dry needling
12. Apply pressure to the needle area to facilitate hemostasis
13. Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
14. Discuss post-treatment care with the patient/client or family/caregiver

NON-PROCEDURAL INTERVENTIONS

Education

15. Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action, tools and equipment)
16. Educate patient/client or family/caregiver about adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
17. Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)

Emergency Procedures

18. Implement emergency response procedures to treat injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding)
19. Remove broken, bent, or stuck needles using clean, sanitized equipment (e.g., tweezers, pliers)

Environmental Safety

20. Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
21. Clean and disinfect surfaces and textiles using detergent, water, and bleach
22. Stock dry needling tools and equipment in close proximity to treatment area
23. Stock infection control tools and equipment in close proximity to treatment area

Infection Control

24. Implement infection control procedures to mitigate the effects of needle stick injuries
25. Clean and disinfect blood and bodily fluids spills using detergent, water, and chlorine-generating

disinfectant

26. Replace surfaces that cannot be cleaned

Professional Responsibilities

27. Determine own ability to perform dry needling safely and effectively

Table B2. Draft List of Dry Needling Knowledge Requirements

Anatomy and Physiology

1. Anatomical features of the external body, including form, proportion, and projection of surface landmarks and their correspondence with underlying tissues, organs, and other structures

Emergency Preparedness and Response

Emergency preparedness and response procedures related to secondary effects or complications from:

2. ...perforation of underlying organs (e.g., pneumothorax)
3. ...perforation of blood vessels and arteries (e.g., bleeding, bruising)
4. ...trauma to the skin (e.g., cellulitis)
5. ...trauma to nerves (e.g., neuropraxia, axonotmesis, neurotmesis)
6. ...skeletal punctures (e.g., broken/bent needle)
7. Emergency preparedness and response procedures related to secondary psychological effects or complications (e.g., shock, claustrophobia, depression, drowsiness)

Safety and Protection

8. Clean needle techniques (e.g., needle site disinfection, hand hygiene, application of single-use needles, needle reinsertion guidelines, grasping and positioning needles, needle re-sheathing)
9. Draping techniques
10. Equipment sterilization procedures
11. Environment sterilization procedures
12. Personal protection procedures and techniques (e.g., positioning to access treatment area, use of personal protective equipment)
13. Patient positioning techniques (e.g., side-lying, prone, supine) and their effect on anatomy and physiology
14. Local laws and regulations regarding the disposal of needles and medical waste
15. Federal laws and regulations regarding infection prevention (e.g., Occupational Safety and Health Administration Standards)

Theory and Technique

16. Theoretical basis for dry needling interventions, including applications for rehabilitation, health promotion, and performance according to current best evidence
17. Theoretical basis for combining dry needling with other manual techniques and modalities
18. Theoretical basis for pain, including pathways, physiology, pathophysiology, and relation to movement impairment
19. Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)
20. Tissue palpation techniques, including pressure, duration, and hand placement
21. Needle insertion techniques, including depth, direction, velocity, manipulation, and duration
22. Targeted physiological responses to dry needling
23. Targeted psychological responses to dry needling

Equipment and Devices

24. Solid filament needles, including type, dimensions, and applications
25. Hollow filament, beveled needles. including type, dimensions, and applications
26. Diagnostic equipment and devices (e.g., magnetic resonance imaging devices, ultrasound elastographic devices, and intramuscular electromyographic devices)
27. Supportive devices and equipment (e.g., pillows, cushions, wedges)

Appendix C
Task Force Members

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Appendix D
Physical Therapy Tasks Required for the Competent Performance of Dry Needling

ID#	Tasks
	PATIENT/CLIENT ASSESSMENT
	Information Gathering & Synthesis
	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...
1.	...establish prior and current level of function
2.	...establish general health status (e.g., fatigue, fever, malaise, unexplained weight change)
3.	...identify risk factors and needs for preventative measures
4.	...identify patient/client's, family/caregiver's goals
5.	...determine if patient/client is appropriate for PT
6.	...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
7.	...identify contraindications and precautions related to dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
8.	Review medical records (e.g., lab values, diagnostic tests, specialty reports, narrative, consults)
9.	Gather information/discuss client/patient's current health status with interprofessional/interdisciplinary team members (e.g., teacher, physician, rehabilitation member)
	Systems Review
	Perform screen of the...
10.	...patient/client's current affect, cognition, communication, and learning style (e.g., ability to make needs known, consciousness, orientation, expected emotional/behavioral responses, learning preferences)
11.	...patient/client's quality of speech, hearing, vision (e.g., dysarthria, pitch/tone, use corrective lenses, use of hearing aids)
12.	...vestibular system (e.g., dizziness, vertigo)
13.	...gastrointestinal system (e.g., difficulty swallowing, heartburn, indigestion, change in appetite/diet)
14.	...genitourinary system (e.g., frequency, volume, urgency, incontinent episodes)
15.	...genital reproductive system (e.g., sexual and/or menstrual dysfunction)
16.	...cardiovascular/pulmonary system (e.g., blood pressure, heart rate)
17.	...integumentary system (e.g., presence of scar formation, skin integrity, edema)
18.	...musculoskeletal system (e.g., gross symmetry, strength, weight, height, range of motion)
19.	...neuromuscular system (e.g., gross coordinated movements, motor function, locomotion)
	Tests & Measures
	Cardiovascular and Pulmonary
	Select and perform tests and measures of...
20.	...cardiovascular function (e.g., blood pressure, heart rate, heart sounds)
21.	...pulmonary function (e.g., respiratory rate, oxygen saturation, breathing patterns, breath sounds, chest excursion)
22.	...peripheral circulation (e.g., peripheral pulses, capillary refill, blood pressure in upper versus lower extremities)
23.	...physiological responses to position change (e.g., orthostatic hypotension, skin color, blood pressure, heart rate)
	Anthropomorphic
24.	Quantify edema (e.g., palpation, volume test, circumference)
	Arousal, Attention, & Cognition
	Select and perform tests and measures of...

ID#	Tasks
25.	...attention and cognition (e.g., ability to process commands)
26.	...patient's/client's ability to communicate (e.g., expressive and receptive skills, following instructions)
27.	...arousal and orientation to time, person, place, and situation
28.	...recall (including memory and retention)
Nerve Integrity	
	Select and perform tests and measures of...
29.	...neural provocation (e.g., tapping, tension/stretch)
30.	...cranial nerve integrity (e.g., facial asymmetry, occulomotor function, hearing)
31.	...peripheral nerve integrity (e.g. sensation, strength)
32.	...spinal nerve integrity (e.g., dermatome, myotome)
Ergonomics and Body Mechanics	
	Select and perform tests and measures of...
33.	...postural alignment and position (static and dynamic)
Functional Mobility, Balance, & Vestibular	
	Select and perform tests and measures of...
34.	...balance (dynamic and static) with or without the use of specialized equipment
35.	...gait and locomotion (e.g., ambulation, wheelchair mobility) with or without the use of specialized equipment
36.	...mobility during functional activities and transitional movements (e.g., transfers, bed mobility)
Integumentary Integrity	
37.	Assess skin characteristics (e.g., blistering, continuity of skin color. dermatitis, hair growth, mobility, nail growth, sensation, temperature, texture, and turgor)
38.	Assess scar tissue characteristics (e.g., banding, pliability, sensation, and texture)
Joint Integrity & Range of Motion	
	Select and perform tests and measures of...
39.	...spinal and peripheral joint stability (e.g., ligamentous integrity, joint structure)
40.	...spinal and peripheral joint mobility (e.g., glide, end feel)
41.	...range of motion (e.g., functional and physiological)
42.	...active and passive joint range of motion (e.g., goniometry)
43.	...flexibility (e.g., muscle length, soft tissue extensibility)
Muscle Performance & Motor Function	
	Select and perform tests and measures of...
44.	...muscle strength, power, and endurance (e.g., manual muscle test, isokinetic testing, dynamic testing)
45.	..muscle tone (e.g., hypertonicity, hypotonicity, dystonia)
46.	...patient's need for assistance (e.g. during transfers, in the application of devices)
Reflex Integrity	
	Select and perform tests and measures of...
47.	...deep tendon/muscle stretch reflexes (e.g.. quadriceps, biceps)
48.	...superficial reflexes and reactions (e.g., cremasteric reflex, abdominal reflexes)
49.	...upper motor neuron integrity (e.g., Babinski reflex, Hoffman sign)
Pain & Sensory Integrity	
	Select and perform tests and measures of...
50.	...pain (e.g., location, intensity, characteristics, frequency)
51.	...deep sensation (e.g., proprioception, kinesthesia, pressure)
52.	...superficial sensation (e.g.,touch, temperature discrimination)
Evaluation & Diagnosis	

ID#	Tasks
	Interpret each of the following types of data to determine the need for intervention or the response to intervention:
53.	Cardiovascular/pulmonary system
54.	Lymphatic system
55.	Neuromuscular system
56.	Vestibular system
57.	Musculoskeletal system
58.	Integumentary system
59.	Anthropomorphic
60.	Genitourinary
61.	Pain
62.	Imaging, lab values, medications
63.	Develop physical therapy diagnosis by integrating system and non-system data
Development of Prognosis, Plan of Care, & Goals	
64.	Establish PT prognosis based on information gathered during the examination process
65.	Develop plan of care based on data gathered during the examination process, incorporating information from the patient/client, caregiver, payers, family members, and other professionals
66.	Revise treatment intervention plan based on treatment outcomes, change in patient/client's health status, and ongoing evaluation
67.	Develop goals based on information gathered during the examination process, incorporating information from the patient/client, caregiver, payers, family members, and other professionals
68.	Select interventions based on information gathered during the examination process, incorporating information from the patient/client, caregiver, payers, family members, and other professionals
69.	Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications.
INTERVENTIONS	
Manual Therapy Techniques	
	Position the patient/client to...
70.	...expose the area(s) to be needled
71.	...reduce the risk of harm to the patient/client and/or therapist
72.	Educate the patient/client on the impact of movement during treatment
73.	Perform palpation techniques to identify the area(s) to be needled
74.	Apply needle handling techniques that ensure compliance with relevant and current professional standards (e.g., wash hands, wear gloves, minimize needle contamination)
75.	Apply draping materials (e.g., linens, towels) to minimize unnecessary exposure and respect patient privacy
76.	Perform dry needling techniques consistent with treatment plan (e.g., place, manipulate, and remove needles)
77.	Manage needle removal complications (e.g., stuck needle, bent needle)
78.	Monitor patient/client's emotional and physiological response to dry needling
79.	Facilitate hemostasis as necessary
80.	Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
81.	Discuss post-treatment expectations with the patient/client or family/caregiver
Non-procedural Interventions	
Communication	
82.	Discuss physical therapy evaluation, interventions, goals, prognosis, discharge planning, and plan of care with interprofessional/interdisciplinary team members (e.g., teacher, physician, rehabilitation member)

ID#	Tasks
83.	Discuss physical therapy evaluation, interventions, goals, prognosis, discharge planning, and plan of care with patient/client and caregivers
84.	Provide written and oral information to the patient/client and/or caregiver
Documentation	
85.	Document examination results
86.	Document evaluation to include diagnosis, goals, and prognosis
87.	Document intervention(s) and patient/client response(s) to intervention
88.	Document patient/client and caregiver education
89.	Document outcomes (e.g., discharge summary, reassessments)
90.	Document communication related to the patient/client's care (e.g. with the doctor, teacher, case manager)
91.	Assign billing codes for physical therapy diagnosis and treatment provided
92.	Document disclosure and consent (e.g., disclosure of medical information, consent for treatment)
93.	Document letter of medical necessity (e.g., wheelchair, assistive equipment, continued therapy)
Education	
94.	Educate patient/client about current condition and health status (e.g., treatment outcomes, plan of care, risk and benefit factors)
95.	Educate caregivers about patient/client's current condition and health status (e.g., treatment outcomes, plan of care, risk and benefit factors)
96.	Educate healthcare team about role of the physical therapist in patient/client management
97.	Educate patient/client and caregiver on lifestyle and behavioral changes to promote wellness (e.g., nutrition interventions, physical activity, tobacco cessation)
98.	Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action, benefits, tools and equipment)
99.	Educate patient/client or family/caregiver about potential adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
100.	Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
Patient/client & Staff Safety	
Emergency Procedures	
101.	Implement emergency life support procedures
102.	Perform first aid
103.	Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles)
104.	Implement emergency response procedures to treat practitioner injuries sustained during dry needling (e.g., needle stick)
Environmental Safety	
105.	Perform regular equipment inspections (e.g., modalities, assistive devices)
106.	Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
107.	Perform regular equipment inspections (e.g., modalities, needle expiration, sharps containers)
108.	Stock dry needling supplies and equipment in safe proximity during treatment
Infection Control	
109.	Perform activities using appropriate infection control practices (e.g., universal precautions, hand hygiene, isolation, airborne precautions)
110.	Create and maintain an aseptic environment for patient/client interaction
111.	Implement infection control procedures to mitigate the effects of needle stick injuries
112.	Clean and disinfect blood and bodily fluids spills in accordance with regulatory standards and local jurisdictional policies and procedures
113.	Replace surfaces that cannot be cleaned

ID#	Tasks
Research & Evidence-Based Practice	
114.	Integrate current best evidence, clinical experience, and patient values in clinical practice (e.g., clinical prediction rules, patient preference)
Professional Responsibilities	
115.	Discuss ongoing patient care with the interprofessional/interdisciplinary team members
116.	Refer patient/client to specialists or other healthcare providers when necessary
117.	Disclose financial interest in recommended products or services to patient/client
118.	Provide notice and information about alternative care when the physical therapist terminates provider relationship with the patient/client
119.	Document transfer of patient/client care to another physical therapist (therapist of record)
120.	Determine own need for professional development (i.e., continued competence)
121.	Participate in learning and/or development activities to maintain the currency of knowledge, skills, and abilities
122.	Practice within the jurisdiction regulations and professional standards.
123.	Determine own ability to perform dry needling safely and effectively

Appendix E
Tasks NOT Related to Competency in Dry Needling

ID#	Tasks
	PATIENT/CLIENT ASSESSMENT
	Tests & Measures
	Cardiovascular and Pulmonary
	Select and perform tests and measures of...
1.	...perfusion and gas exchange (e.g., airway protection, pulse oximetry)
2.	...critical limb ischemia (e.g., skin perfusion pressure, pulse volume recordings)
3.	...aerobic capacity under maximal and submaximal conditions (e.g., gait speed, treadmill testing, cadence, numbers of stairs climbed, metabolic equivalents)
	Anthropomorphic
	Select and perform tests and measures of...
4.	...body composition (e.g., percent body fat, lean muscle mass, BMI, hip-to-waist ratio)
5.	...body dimensions (e.g., height, weight, girth, limb length, head circumference/shape)
	Muscle Performance
	Select and perform tests and measures of...
6.	...electrophysiological function using surface electrodes (e.g., surface EMG)
7.	...electrophysiological function using needle insertion (e.g., nerve conduction)
8.	...muscle integrity (e.g., ultrasound imaging)
	Environmental & Community Integration/Reintegration (Home, Work, Job, School, Play, & Leisure)
9.	Assess activities of daily living (ADL) (e.g., bed mobility, transfers, household mobility, dressing, self-care)
10.	Assess instrumental activities of daily living (IADL) (e.g., household chores, hobbies, money management)
11.	Assess ability to perform skills needed for integration or reintegration into the community, work, or school
12.	Assess barriers (e.g., social, economic, physical, environmental, work conditions and activities) to community, work, or school integration/reintegration
13.	Assess ability to participate in activities with or without the use of devices or equipment
	Ergonomics and Body Mechanics
14.	Select and perform tests of safety in work environments
	Select and perform tests and measures of...
15.	...specific work conditions or activities
16.	...tools, devices, equipment, and workstations related to work actions, tasks, or activities
17.	...ergonomics and body mechanics during self-care, home, management, work, community, or leisure actions, tasks, or activities (e.g., how patient moves, whether patient aggravates the injury)
	Functional Mobility, Balance, & Vestibular
	Select and perform tests and measures of...
18.	...vestibular function (e.g., peripheral dysfunction, central dysfunction)
	Integumentary Integrity
19.	Assess activities, positioning, and postures that may produce or relieve trauma to the skin
20.	Assess devices and equipment that may produce or relieve trauma to the skin

ID#	Tasks
21.	Assess wound characteristics (e.g., tissue involvement, depth, tunneling, burn degree)
Muscle Performance & Motor Function	
22.	Select and perform tests and measures of...
23.	...dexterity, coordination, and agility (e.g., rapid alternating movement, finger to nose)
24.	...ability to initiate, modify and control movement patterns and postures (e.g., catching a ball, gait)
25.	...ability to change movement performance with practice (e.g., motor learning)
Neuromotor Development & Sensory Integration	
26.	Select and perform tests and measures of...
27.	...acquisition and evolution of motor skills
28.	...sensorimotor integration
29.	...developmental reflexes and reactions (e.g., asymmetrical tonic neck reflex, righting reactions)
Evaluation & Diagnosis	
	Interpret each of the following types of data to determine the need for intervention or the response to intervention:
30.	assistive and adaptive device
31.	environmental, home, and work/job/school/play barriers
32.	ergonomics and body mechanics
33.	gait, locomotion, and balance
34.	orthotic, protective, and supportive device
35.	prosthetic requirements
36.	ADLs and home management
37.	Evaluate patient/client's ability to assume or resume work/job/school/play, community, and leisure activities
Development of Prognosis, Plan of Care, & Goals	
INTERVENTIONS	
Procedural Interventions	
Therapeutic Exercise/Therapeutic Activities	
38.	Train in aerobic capacity/endurance conditioning
39.	Train in strength, power, and endurance exercises
40.	Train in balance, coordination, and agility activities
41.	Train in body mechanics and postural stabilization techniques
42.	Perform flexibility techniques
43.	Train in flexibility techniques
44.	Train in neuromotor techniques (e.g., movement pattern training, neuromuscular education or reeducation)
45.	Perform desensitization techniques (e.g., brushing, tapping, uses of textures)
46.	Train in desensitization techniques (e.g., brushing, tapping, uses of textures)
47.	Perform mechanical repositioning for vestibular dysfunction
48.	Train in habituation/adaptation exercises for vestibular dysfunction (e.g., vestibuloccular reflex, position changes)
49.	Train in relaxation techniques
50.	Train in genitourinary management (e.g., pelvic floor exercises, bladder strategies)
51.	Train in gastrointestinal management (e.g., bowel strategies, positioning to avoid reflux)

ID#	Tasks
Pulmonary Interventions	
52.	Administer prescribed oxygen during interventions
53.	Perform manual/mechanical airway clearance techniques (e.g., assistive cough, percussion, vibration, shaking)
54.	Train in manual/mechanical airway clearance techniques (e.g., assistive devices, assistive cough, incentive spirometer, flutter valve, percussion/postural drainage)
55.	Perform techniques to maximize ventilation and perfusion (e.g., assistive cough, positioning)
56.	Train in breathing strategies (e.g., active cycle breathing, autogenic drainage, paced breathing, pursed lip breathing) and techniques to maximize ventilation and perfusion (e.g., assistive cough, positioning, pursed-lip breathing)
Functional Training	
57.	Recommend barrier accommodations or modifications (e.g., ramps, grab bars, raised toilet, environmental control units)
58.	Train in the use of barrier accommodations or modifications (e.g., ramps, grab bars, raised toilet, environmental control units)
59.	Train in Activities of Daily Living (ADL) (e.g., bed mobility, transfers, household mobility, dressing, self-care)
60.	Instruct in community and leisure integration or reintegration (e.g., work/school/play)
61.	Train in Instrumental Activities of Daily Living (IADL) (e.g., household chores, hobbies, money management)
62.	Train in mobility techniques (e.g., crawling, walking, running)
63.	Train in fall prevention and fall recovery strategies
64.	Train in behavior modification and cognitive strategies
Manual Therapy Techniques	
65.	Perform manual lymphatic drainage
66.	Perform spinal and peripheral manual traction
67.	Perform soft tissue mobilization (e.g., connective tissue massage, therapeutic massage)
68.	Perform peripheral mobilization /manipulation (thrust/non-thrust)
69.	Perform spinal mobilization (non-thrust)
70.	Perform cervical spinal manipulation (thrust)
71.	Perform thoracic and lumbar spinal manipulation (thrust)
Devices & Equipment	
	Apply, adjust, and/or fabricate...
72.	...adaptive devices (e.g., utensils, seating and positioning devices, steering wheel devices)
73.	...protective devices (e.g., braces, cushions, helmets, protective taping)
74.	...supportive devices (e.g., compression garments, corsets, elastic wraps, neck collars, serial casts)
75.	...orthotic devices (e.g., braces, casts, shoe inserts, splints)
	Apply and/or adjust...
76.	...assistive devices (e.g., canes, crutches, walkers, wheelchairs, tilt tables, standing frames)
77.	...prosthetic devices (e.g., lower extremity and upper-extremity)
78.	...mechanical neuromuscular reeducation devices (e.g., weighted vests, therapeutic suits, body weight supported treadmill, proprioceptive taping)
	Train in use of...
79.	...adaptive devices (e.g., utensils, seating and positioning devices, steering wheel devices)
80.	...assistive devices (e.g., canes, crutches, walkers, wheelchairs, tilt tables, standing frames)
81.	...orthotic devices (e.g., braces, casts, shoe inserts, splints)

ID#	Tasks
82.	...prosthetic devices (e.g., lower extremity and upper-extremity)
83.	...protective devices (e.g., braces, cushions, helmets. protective taping)
84.	...supportive devices (e.g., compression garments, corsets, elastic wraps, neck collars, serial casts)
85.	...mechanical neuromuscular re-education devices (e.g., weighted vests, therapeutic suits, body weight supported treadmill, proprioceptive taping)
Integumentary Repair	
86.	Perform debridement (e.g., nonselective, enzymatic or autolyic, or sharp)
87.	Apply topical agents (e.g., cleansers, creams, moisturizers, ointments, sealants) and dressings (e.g., hydrogels, negative pressure wound therapy, wound coverings)
88.	Recommend topical agents (e.g., pharmacological to physician, over-the-counter to patient) and dressings (e.g., hydrogels, negative pressure wound therapy, wound coverings)
Therapeutic Modalities	
89.	Perform biofeedback therapy (e.g., relaxation techniques, muscle reeducation, EMG)
90.	Perform iontophoresis
91.	Perform phonophoresis
92.	Perform electrical stimulation therapy (e.g., electrical muscle stimulation (EMS), TENS, functional electrical stimulation (FES))
93.	Perform cryotherapy procedures (e.g., cold pack, ice massage, vapocoolant spray)
94.	Train in cryotherapy procedures
95.	Perform hydrotherapy procedures using contrast baths/pools
96.	Train in hydrotherapy procedures using contrast baths/pools
97.	Perform ultrasound procedures
98.	Perform hot pack thermotherapy procedures
99.	Train in hot pack thermotherapy procedures
100.	Perform paraffin bath thermotherapy procedures
Mechanical Modalities	
101.	Apply intermittent pneumatic compression
102.	Apply continuous passive motion (CPM) devices
103.	Train in continuous passive motion (CPM) devices
104.	Apply mechanical spinal traction
105.	Train in mechanical spinal traction
Documentation	
106.	Document intervention/plan of care for specialized services and settings (e.g., individual education plan, individual family service plan, vocational transition plan)
Education	
107.	Educate community groups on lifestyle and behavioral changes to promote wellness (e.g., nutrition interventions, physical activity, tobacco cessation)
108.	Participate in the development of curriculum for the clinical education of students
Patient/client & Staff Safety	
Emergency Procedures	
109.	Implement disaster response procedures
Environmental Safety	
110.	Perform risk assessment of the physical environment (e.g., barrier-free environment, outlets, windows, floors, lighting)

ID#	Tasks
Infection Control	
Research & Evidence-Based Practice	
111.	Search the literature for current best evidence
112.	Evaluate the quality of published data
113.	Participate in research activities
114.	Compare intervention outcomes with published data
Professional Responsibilities	
115.	Supervise physical therapist assistant(s) and support personnel (licensed/unlicensed)
116.	Assign tasks to other personnel (licensed/unlicensed) to assist with patient/client care
117.	Report health care providers that are suspected to not perform their professional responsibilities with reasonable skill and safety to the appropriate authorities
118.	Report suspected cases of abuse involving children or vulnerable adults to the appropriate authority
119.	Report suspected illegal or unethical acts performed by health care professionals to the relevant authority
120.	Advocate for public access to physical therapy and other healthcare services
121.	Read and evaluate the quality of professional journals, magazines, and publications to maintain currency of knowledge
122.	Participate in professional organizations
123.	Perform community based screenings (e.g., posture, musculoskeletal, flexibility, sports-specific)

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HUMAN RESOURCES RESEARCH ORGANIZATION

Appendix F
Knowledge Requirements Related to Competency in Dry Needling

ID#	Knowledge
CARDIOVASCULAR/PULMONARY & LYMPHATIC SYSTEMS	
Physical Therapy Examination	
1.	Cardiovascular/pulmonary systems tests/measures, including outcome measures, and their applications according to current best evidence
2.	Anatomy and physiology of the cardiovascular/pulmonary systems as related to tests/measures
3.	Movement analysis as related to the cardiovascular/pulmonary systems (e.g., rib cage excursion)
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
4.	Cardiovascular/pulmonary systems diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
5.	Nonpharmacological medical management of the cardiovascular/pulmonary systems (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
6.	Pharmacological management of the cardiovascular/pulmonary systems
7.	Differential diagnoses related to diseases/conditions of the cardiovascular/pulmonary systems
8.	Lymphatic system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
9.	Nonpharmacological medical management of the lymphatic system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
10.	Differential diagnoses related to diseases/conditions of the lymphatic system
Interventions	
11.	Anatomy and physiology of the cardiovascular/pulmonary systems as related to physical therapy interventions, daily activities, and environmental factors
12.	Secondary effects or complications from physical therapy and medical interventions on the cardiovascular/pulmonary systems
13.	Secondary effects or complications on the cardiovascular/pulmonary systems from physical therapy and medical interventions used on other systems
14.	Anatomy and physiology of the lymphatic system as related to physical therapy interventions, daily activities, and environmental factors
15.	Secondary effects or complications from physical therapy and medical interventions on the lymphatic system
16.	Secondary effects or complications on the lymphatic system from physical therapy and medical interventions used on other systems
MUSCULOSKELETAL SYSTEM	
Physical Therapy Examination	
17.	Musculoskeletal system tests/measures, including outcome measures, and their applications according to current best evidence
18.	Anatomy and physiology of the musculoskeletal system as related to tests/measures
19.	Movement analysis as related to the musculoskeletal system
20.	Joint biomechanics and their applications
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
21.	Muscular and skeletal diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
22.	Nonpharmacological medical management of the musculoskeletal system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
23.	Pharmacological management of the musculoskeletal system
24.	Differential diagnoses related to diseases/conditions of the muscular and skeletal systems
25.	Connective tissue diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis

ID#	Knowledge
26.	Differential diagnoses related to diseases/conditions of the connective tissue
27.	Musculoskeletal system physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
28.	Anatomy and physiology of the musculoskeletal system as related to physical therapy interventions, daily activities, and environmental factors
29.	Secondary effects or complications from physical therapy and medical interventions on the musculoskeletal system
30.	Secondary effects or complications on the musculoskeletal system from physical therapy and medical interventions used on other systems
NEUROMUSCULAR & NERVOUS SYSTEMS	
Physical Therapy Examination	
31.	Neuromuscular/nervous systems tests/measures, including outcome measures, and their applications according to current best evidence
32.	Anatomy and physiology of the neuromuscular/nervous systems as related to tests/measures
33.	Movement analysis as related to the neuromuscular/nervous systems
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
34.	Neuromuscular/nervous system (CNS, PNS, ANS) diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
35.	Nonpharmacological medical management of the neuromuscular/nervous systems (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
36.	Pharmacological management of the neuromuscular/nervous systems
37.	Differential diagnoses related to diseases/conditions of the neuromuscular/nervous system (CNS, PNS, ANS)
Interventions	
38.	Neuromuscular/nervous systems physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
39.	Anatomy and physiology of the neuromuscular/nervous systems as related to physical therapy interventions, daily activities, and environmental factors
40.	Secondary effects or complications from physical therapy and medical interventions on the neuromuscular/nervous systems
41.	Secondary effects or complications on the neuromuscular/nervous systems from physical therapy and medical interventions used on other systems
42.	Motor control as related to neuromuscular/nervous systems physical therapy interventions
43.	Motor learning as related to neuromuscular/nervous systems physical therapy interventions
INTEGUMENTARY SYSTEM	
Physical Therapy Examination	
44.	Integumentary system tests/measures, including outcome measures, and their applications according to current best evidence
45.	Anatomy and physiology of the integumentary system as related to tests/measures
46.	Movement analysis as related to the integumentary system (e.g., friction, shear, pressure, and scar mobility)
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
47.	Integumentary system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
48.	Nonpharmacological medical management of the integumentary system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
49.	Pharmacological management of the integumentary system
50.	Differential diagnoses related to diseases/conditions of the integumentary system

ID#	Knowledge
Interventions	
51.	Anatomy and physiology of the integumentary system as related to physical therapy interventions, daily activities, and environmental factors
52.	Secondary effects or complications from physical therapy and medical interventions on the integumentary system
53.	Secondary effects or complications on the integumentary system from physical therapy and medical interventions used on other systems
METABOLIC & ENDOCRINE SYSTEMS	
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
54.	Metabolic and endocrine systems diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
55.	Nonpharmacological medical management of the metabolic and endocrine systems (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
56.	Pharmacological management of the metabolic and endocrine systems
57.	Differential diagnoses related to diseases/conditions of the metabolic and endocrine systems
Interventions	
58.	Anatomy and physiology of the metabolic and endocrine systems as related to physical therapy interventions, daily activities, and environmental factors
59.	Secondary effects or complications from physical therapy and medical interventions on the metabolic and endocrine systems
60.	Secondary effects or complications on the metabolic and endocrine systems from physical therapy and medical interventions used on other systems
GASTROINTESTINAL SYSTEM	
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
61.	Gastrointestinal system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
62.	Nonpharmacological medical management of the gastrointestinal system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
63.	Differential diagnoses related to diseases/conditions of the gastrointestinal system
Interventions	
64.	Anatomy and physiology of the gastrointestinal system as related to physical therapy interventions, daily activities, and environmental factors
65.	Secondary effects or complications from physical therapy and medical interventions on the gastrointestinal system
66.	Secondary effects or complications on the gastrointestinal system from physical therapy and medical interventions used on other systems
GENITOURINARY SYSTEM	
Physical Therapy Examination	
67.	Genitourinary system tests/measures, including outcome measures, and their applications according to current best evidence
68.	Anatomy and physiology of the genitourinary system as related to tests/measures
69.	Physiological response of the genitourinary system to various types of tests/measures
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
70.	Genitourinary system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
71.	Nonpharmacological medical management of the genitourinary system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)

ID#	Knowledge
72.	Pharmacological management of the genitourinary system
73.	Differential diagnoses related to diseases/conditions of the genitourinary system
Interventions	
74.	Genitourinary system physical therapy interventions and their applications for rehabilitation and health promotion according to current best evidence (e.g., bladder programs, biofeedback, pelvic floor retraining)
75.	Anatomy and physiology of the genitourinary system as related to physical therapy interventions, daily activities, and environmental factors
76.	Secondary effects or complications from physical therapy and medical interventions on the genitourinary system
77.	Secondary effects or complications on the genitourinary system from physical therapy and medical interventions used on other systems
SYSTEM INTERACTIONS	
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
78.	Diseases/conditions where the primary impact is on more than one system to establish and carry out a plan of care, including prognosis
79.	Nonpharmacological medical management of multiple systems (e.g., diagnostic imaging and other medical tests, surgical procedures)
80.	Pharmacological management of multiple systems, including polypharmacy
81.	Differential diagnoses related to diseases/conditions where the primary impact is on more than one system
82.	Impact of comorbidities/coexisting conditions on patient/client management (e.g., diabetes and hypertension, obesity and arthritis, hip fracture and dementia)
83.	Psychological and psychiatric conditions that impact patient/client management (e.g., depression, schizophrenia)
THERAPEUTIC MODALITIES	
84.	Thermal modalities
85.	Electrotherapy modalities, excluding iontophoresis
86.	Pneumatic compression modalities
SAFETY & PROTECTION	
87.	Factors influencing safety and injury prevention
88.	Patient positioning techniques (e.g., side-lying, prone, supine) and their effect on anatomy and physiology
89.	Draping techniques
90.	Infection control procedures (e.g., standard/universal precautions, isolation techniques, sterile technique)
91.	Environment cleaning and sanitization procedures
92.	Equipment cleaning and sanitization procedures (not including needles)
93.	Local laws and regulations regarding the disposal of needles and medical waste
94.	Regulations and standards regarding infection prevention (e.g., Occupational Safety and Health Administration Standards)
95.	Medical waste disposal equipment
96.	Signs/symptoms of physical, sexual, and psychological abuse and neglect
PROFESSIONAL RESPONSIBILITIES	
97.	Standards of documentation
98.	Patient/client rights (e.g., ADA, IDEA, HIPAA)
99.	Human resource legal issues (e.g., OSHA, sexual harassment)

ID#	Knowledge
100.	Roles and responsibilities of physical therapist assistants in relation to physical therapists and other health-care professionals
101.	Roles and responsibilities of other health-care professionals and support staff
DRY NEEDLING-SPECIFIC KNOWLEDGE	
Anatomy and Physiology	
102.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
Emergency Preparedness and Response	
103.	Emergency preparedness (e.g., CPR, first aid, disaster response)
104.	Emergency preparedness and/or response procedures related to secondary physiological effects or complications associated with dry needling (e.g., shock, vasovagal)
105.	Emergency preparedness and/or response procedures related to secondary emotional effects or complications associated with dry needling (e.g., claustrophobia, anxiety, agitation)
106.	Standards for needle handling (e.g., hand hygiene, application of single-use needles)
Safety & Protection	
107.	Personal protection procedures and techniques as related to dry needling (e.g., positioning self to access treatment area, use of personal protective equipment)
108.	Theoretical basis for dry needling (e.g., applications for rehabilitation, health promotion, fitness and wellness, performance)
109.	Theoretical basis for combining dry needling with other interventions
110.	Secondary effects or complications associated with dry needling on other systems (e.g., gastrointestinal, cardiovascular/pulmonary, musculoskeletal)
111.	Theoretical basis of pain sciences, including anatomy, physiology, pathophysiology, and relation to body structures and function
112.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions)
113.	Palpation techniques as related to dry needling
114.	Needle insertion techniques
115.	Needle manipulation techniques
116.	Physiological responses to dry needling
117.	Solid filament needles (e.g., physical characteristics)

Appendix G
Knowledge Requirements NOT Related to Competency in Dry Needling

ID#	Knowledge Requirement
CARDIOVASCULAR/PULMONARY & LYMPHATIC SYSTEMS	
Interventions	
1.	Cardiovascular/pulmonary systems physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
2.	Lymphatic system physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
MUSCULOSKELETAL SYSTEM	
Interventions	
3.	Physical therapy ultrasound imaging of the musculoskeletal system
INTEGUMENTARY SYSTEM	
Interventions	
4.	Integumentary system physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
METABOLIC & ENDOCRINE SYSTEMS	
Physical Therapy Examination	
5.	Metabolic and endocrine systems physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
GASTROINTESTINAL SYSTEM	
Interventions	
6.	Pharmacological management of the gastrointestinal system
7.	Gastrointestinal system physical therapy interventions and their applications for rehabilitation and health promotion according to current best evidence (e.g., positioning for reflux prevention, bowel programs)
EQUIPMENT & DEVICES	
Interventions	
8.	Assistive and adaptive devices
9.	Prosthetic devices
10.	Protective, supportive, and orthotic devices
THERAPEUTIC MODALITIES	
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
11.	Iontophoresis
12.	Phonophoresis
13.	Ultrasound modalities, excluding phonophoresis
14.	Mechanical modalities (e.g., mechanical motion devices, traction devices)
15.	Biofeedback
16.	Electromagnetic radiation (e.g., diathermy)
SAFETY & PROTECTION	
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
17.	Function, implications, and precautions related to intravenous lines, tubes, catheters, and monitoring devices

ID#	Knowledge Requirement
RESEARCH & EVIDENCE-BASED PRACTICE	
18.	Research design and interpretation (e.g., qualitative, quantitative, hierarchy of evidence)
19.	Data collection techniques (e.g., surveys, direct observation)
20.	Measurement science (e.g., reliability, validity)
21.	Statistics (e.g., t-test, chi-square, correlation coefficient, ANOVA, likelihood ratio)
Dry Needling-specific Knowledge	
	Emergency preparedness and response procedures related to secondary effects or complications from:
	...perforation of underlying organs (e.g., pneumothorax)
22.	...perforation of blood vessels and arteries (e.g., bleeding, bruising)
23.	...trauma to the skin (e.g., cellulitis)
24.	...trauma to nerves (e.g., neuropraxia, axonotmesis, neurotmesis)
25.	...skeletal punctures (e.g., broken/bent needle)
26.	Emergency preparedness and response procedures related to secondary psychological effects or complications (e.g., shock, claustrophobia, depression, drowsiness)
27.	Clean needle techniques (e.g., needle site disinfection, hand hygiene, application of single-use needles, needle reinsertion guidelines, grasping and positioning needles, needle re-sheathing)
28.	Equipment sterilization procedures
29.	Environment sterilization procedures
30.	Personal protection procedures and techniques (e.g., positioning to access treatment area, use of personal protective equipment)
31.	Federal laws and regulations regarding infection prevention (e.g., Occupational Safety and Health Administration Standards)
32.	Theoretical basis for dry needling interventions, including applications for rehabilitation, health promotion, and performance according to current best evidence
33.	Theoretical basis for combining dry needling with other manual techniques and modalities
34.	Theoretical basis for pain, including pathways, physiology, pathophysiology, and relation to movement impairment
35.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)
36.	Tissue palpation techniques, including pressure, duration, and hand placement
37.	Needle insertion techniques, including depth, direction, velocity, manipulation, and duration
38.	Targeted physiological responses to dry needling
39.	Targeted psychological responses to dry needling
40.	Solid filament needles, including type, dimensions, and applications
41.	Hollow filament, beveled needles, including type, dimensions, and applications
42.	Diagnostic equipment and devices (e.g., magnetic resonance imaging devices, ultrasound elastographic devices, and intramuscular electromyographic devices)
43.	Supportive devices and equipment (e.g., pillows, cushions, wedges)

Appendix H
Skills and Abilities Needed for the Competent Performance of Dry Needling

Skill/Ability	O*NET Definition
Communicating with patients	
1. Active Listening	Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times.
2. Reading Comprehension	Understanding written sentences and paragraphs in work related documents.
3. Writing	Communicating effectively in writing as appropriate for the needs of the audience.
4. Speaking	Talking to others to convey information effectively.
5. Active Learning	Understanding the implications of new information for both current and future problem-solving and decision-making.
6. Critical Thinking	Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.
Adapting behavior or treatment to accommodate patient's needs/preferences	
7. Coordination	Adjusting actions in relation to others' actions.
8. Social Perceptiveness	Being aware of others' reactions and understanding why they react as they do.
Reflecting on and evaluating own competence to perform dry needling	
9. Judgment and Decision Making	Considering the relative costs and benefits of potential actions to choose the most appropriate one.
Abiding by professional and ethical standards	
10. Judgment and Decision Making	Considering the relative costs and benefits of potential actions to choose the most appropriate one.
Handling and controlling needles and palpating tissues	
1. Arm-Hand Steadiness	The ability to keep your hand and arm steady while moving your arm or while holding your arm and hand in one position.
2. Finger Dexterity	The ability to make precisely coordinated movements of the fingers of one or both hands to grasp, manipulate, or assemble very small objects.
3. Gross Body Coordination	The ability to coordinate the movement of your arms, legs, and torso together when the whole body is in motion.
4. Gross Body Equilibrium	The ability to keep or regain your body balance or stay upright when in an unstable position.
5. Manual Dexterity	The ability to quickly move your hand, your hand together with your arm, or your two hands to grasp, manipulate, or assemble objects.
6. Speed of Limb Movement	The ability to quickly move the arms and legs.
7. Wrist-Finger Speed	The ability to make fast, simple, repeated movements of the fingers, hands, and wrists.

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FSBPT Addendum to Report

Selection of HumRRO

HumRRO was selected from an RFP process from among five qualified vendors. All of the proposals were deemed acceptable but HumRRO's proposal had the best understanding of the needs of the licensing jurisdictions.

The Human Resources Research Organization (HumRRO) is a non-profit, applied research and consulting company with a rich, 64-year history of providing services related to the development, validation, and implementation of assessments for credentialing and employment selection purposes. HumRRO employs 80 professional staff members, many of whom have advanced training in measurement fields, including Industrial-Organizational (I-O) Psychology, Education, Psychometrics, and Statistics. HumRRO's staff includes nationally recognized experts in the field of I-O Psychology who have an established history of collaborating with private- and public-sector organizations to develop scientifically robust, legally-defensible high-stakes assessment processes and programs.

HumRRO has conducted hundreds of job analyses to develop test blueprints, performance assessments, job descriptions, and training curricula for professions, specialty areas within and across professions, and entire workforces within an organization. Although there are some fairly uniform best practices, HumRRO designs each method according to the purpose for which it is performed and the available data sources.

To maintain the highest quality, HumRRO uses a multi-level quality assurance process to ensure rigorous standards of technical performance. The first level involves the project staff. Everyone who is involved in a project has the responsibility of maintaining product quality. At the next level, project directors communicate a standard of quality to the project team and conduct quality checks at critical times in the development of each deliverable. This process includes checks for both technical quality and clarity. Our Quality Management Liaison, a senior researcher, consults with all project directors at project outset and periodically thereafter to identify and monitor opportunities to ensure high quality. Finally, before a product is delivered, it receives additional review by other team members for quality, appearance, and suitability to the prospective user, with final approval coming from the project director. As an additional quality measure, the Research Division Directors conduct periodic quality checks both during development and at project completion. These checks involve reviews of technical accuracy, substance, completeness, coherence, clarity, and usefulness.

6. Code of Virginia, Chapter 34.1 of Title 54.1 – Physical Therapy

Code of Virginia

Chapter 34.1 of Title 54.1 – Physical Therapy

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§ 54.1-3473. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Board" means the Board of Physical Therapy.

"Physical therapist" means any person licensed by the Board to engage in the practice of physical therapy.

"Physical therapist assistant" means any person licensed by the Board to assist a physical therapist in the practice of physical therapy.

"Practice of physical therapy" means that branch of the healing arts that is concerned with, upon medical referral and direction, the evaluation, testing, treatment, reeducation and rehabilitation by physical, mechanical or electronic measures and procedures of individuals who, because of trauma, disease or birth defect, present physical and emotional disorders. The practice of physical therapy also includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures within the scope of practice of the

physical therapist. However, the practice of physical therapy does not include the medical diagnosis of disease or injury, the use of Roentgen rays and radium for diagnostic or therapeutic purposes or the use of electricity for shock therapy and surgical purposes including cauterization.

(2000, c. 688; 2001, c. 858.)

§ 54.1-3474. Unlawful to practice without license; continuing competency requirements.

A. It shall be unlawful for any person to practice physical therapy or as a physical therapist assistant in the Commonwealth without a valid unrevoked license issued by the Board.

B. The Board shall promulgate regulations establishing requirements to ensure continuing competency of physical therapists and physical therapist assistants, which may include continuing education, testing, or such other requirements as the Board may determine to be necessary.

C. In promulgating continuing competency requirements, the Board shall consider (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

D. The Board may approve persons who provide or accredit programs to ensure continuing competency.

(2000, c. 688; 2001, c. 858.)

§ 54.1-3475. Board of Physical Therapy; appointment; qualifications; officers; nominations.

A. The Board of Physical Therapy shall regulate the practice of physical therapy and carry out the provisions of this chapter regarding the qualifications, examination, licensure and regulation of physical therapists and physical therapist assistants and shall have the general powers and duties of a health regulatory board pursuant to § 54.1-2400.

B. The Board shall be appointed by the Governor and shall be composed of seven members, five of whom shall be physical therapists who have been in active practice for at least seven years prior to appointment with at least three of such years in Virginia; one shall be a licensed physical therapist assistant; and one shall be a citizen member. Members shall be appointed for terms of four years and shall serve until their successors are appointed. The initial appointments shall provide for staggered terms with two members being appointed for a one-year term, two members being appointed for a two-year term, two members being appointed for a three-year term, and one member being appointed for a four-year term. Vacancies occurring other than by expiration of term shall be filled for the unexpired term. No person shall be eligible to serve on the Board for more than two successive full terms.

C. The Board shall annually elect a president and a vice-president.

D. Nominations for the professional members of the Board may be chosen by the Governor from a list of at least three names for each vacancy submitted by the Virginia Physical Therapy Association, Inc. The Governor may notify the Association of any professional vacancy other than by expiration of a term and nominations may be submitted by the Association. The Governor shall not be bound to make any appointments from among such nominees.

(2000, c. 688.)

§ 54.1-3476. Exemptions.

This chapter shall not apply to the performance of the duties of any commissioned or contract physical therapist or physical therapist assistant while practicing in the United States Armed Services, United States Public Health Service or United States Veterans Administration as based on requirements under federal regulations for state licensure of health care providers, or to a physical therapist or a physical therapist assistant licensed or certified and in good standing with the applicable regulatory agency in the state, District of Columbia, or Canada where the practitioner resides when the practitioner is in Virginia temporarily to practice for no longer than sixty days (i) in a summer camp or in conjunction with patients who are participating in recreational activities, (ii) in continuing education programs, or (iii) by rendering at any site any health care services within the limits of his license or certificate, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

(2000, c. 688.)

§ 54.1-3477. Requirements for licensure as a physical therapist.

An applicant for licensure as a physical therapist shall submit evidence, verified by affidavit and satisfactory to the Board, that the applicant:

1. Is eighteen years of age or more;

2. Is a graduate of a school of physical therapy approved by the American Physical Therapy Association or is a graduate of a school outside of the United States or Canada which is acceptable to the Board; and

3. Has satisfactorily passed an examination approved by the Board.

(2000, c. 688.)

§ 54.1-3478. Requirements for licensure as a physical therapist assistant.

An applicant for licensure as a physical therapist assistant shall submit evidence, verified by affidavit and satisfactory to the Board, that the applicant:

1. Is eighteen years of age or more;

2. Is a graduate of a two-year college-level education program for physical therapist assistants acceptable to the Board; and

3. Has satisfactorily passed an examination approved by the Board.

(2000, c. 688.)

§ 54.1-3479. Licensure by examination or endorsement; traineeships.

A. The Board shall provide for the examinations to be taken by applicants for licensure as physical therapists and physical therapist assistants. The Board shall, on the basis of such examinations, issue or deny licenses to applicants to practice physical therapy or perform the duties of a physical therapist assistant. Any applicant who feels aggrieved at the result of his examination may appeal to the Board.

B. The Board, in its discretion, may issue licenses to applicants upon endorsement by boards of other appropriate authorities of other states or territories or the District of Columbia with which reciprocal relations have not been established if the credentials of such applicants are satisfactory and the examinations and passing grades required by such other boards are determined to be equivalent to those required by the Virginia Board.

C. The Board, in its discretion, may provide for the limited practice of physical therapy by a graduate physical therapist or physical therapist assistant enrolled in a traineeship program as defined by the Board under the direct supervision of a licensed physical therapist.

D. In granting licenses to out-of-state applicants, the Board may require physical therapists or physical therapist assistants to meet the professional activity requirements or serve traineeships according to regulations promulgated by the Board.

(2000, c. 688.)

§ 54.1-3480. Refusal, revocation or suspension.

A. The Board may refuse to admit a candidate to any examination, may refuse to issue a license to any applicant, and may suspend for a stated period of time or indefinitely or revoke any license or censure or reprimand any person or place him on probation for such time as it may designate for any of the following causes:

1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of physical therapy;

2. Substance abuse rendering him unfit for the performance of his professional obligations and duties;

3. Unprofessional conduct as defined in this chapter;

4. Intentional or negligent conduct that causes or is likely to cause injury to a patient or patients;

5. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public;

6. Restriction of a license to practice physical therapy in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction;

7. Conviction in any state, territory or country of any felony or of any crime involving moral turpitude;

8. Adjudged legally incompetent or incapacitated in any state if such adjudication is in effect and the person has not been declared restored to competence or capacity; or

9. Conviction of an offense in another state, territory or foreign jurisdiction, which if committed in Virginia would be a felony. Such conviction shall be treated as a felony conviction under this section regardless of its designation in the other state, territory or foreign jurisdiction.

B. The Board shall refuse to admit a candidate to any examination and shall refuse to issue a license to any applicant if the candidate or applicant has had his certificate or license to practice physical therapy revoked or suspended, and has not had his certificate or license to so practice reinstated, in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction.

(2000, c. 688; 2001, c. 858; 2003, cc. 753, 762; 2004, c. 64.)

§ 54.1-3480.1. Continuing education.

As a prerequisite to renewal of a license or reinstatement of a license, each physical therapist shall be required to take biennial courses relating to physical therapy as approved by the Board. The Board shall prescribe criteria for approval of courses of study and credit hour requirements. The Board may approve alternative courses upon timely application of any licensee. Fulfillment of education requirements shall be certified to the Board upon a form provided by the Board and shall be submitted by each licensed physical therapist at the time he applies to the Board for the renewal or reinstatement of his license. The Board may waive individual requirements in cases of certified illness or undue hardship.

(2001, c. 315.)

§ 54.1-3481. Unlawful designation as physical therapist or physical therapist assistant; penalty.

A. It shall be unlawful for any person who is not licensed under this chapter, or whose license has been suspended or revoked or who licensure has lapsed and has not been renewed, to use in conjunction with his name the letters or words "R.P.T.," "Registered Physical Therapist," "L.P.T.," "Licensed Physical Therapist," "P.T.," "Physical Therapist," "Physio-therapist,"

"P.T.T.," "Physical Therapy Technician," "P.T.A.," "Physical Therapist Assistant," "Licensed Physical Therapist Assistant," or to otherwise by letters, words, representations or insignias assert or imply that he is a licensed physical therapist. The title to designate a licensed physical therapist shall be "P.T." The title to designate a physical therapist assistant shall show such fact plainly on its face.

B. No person shall advertise services using the words "physical therapy" or "physiotherapy" unless those services are provided by a physical therapist or physical therapist assistant licensed pursuant to this chapter.

C. A complaint or report of a possible violation of this section by any person who is licensed, certified, registered, or permitted, or who holds a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions shall be referred to the applicable board within the Department for disciplinary action.

D. Nothing in this section shall be construed to restrict or limit the legally authorized scope of practice of any profession licensed, certified, registered, permitted, or recognized under a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions prior to January 1, 2010.

(2000, c. 688; 2010, cc. 70, 368.)

§ 54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants.

A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed physical therapist, upon the referral and direction of 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, except as provided in this section.

B. A physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 30 consecutive days after an initial evaluation without a referral under the following conditions: (i) the patient is not receiving care from any 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 for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services or (ii) the patient is receiving care from 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 at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services and (a) 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; (b) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and (c) 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. Treatment for more than 30 consecutive days after evaluation of such patient shall only be upon the referral and direction of 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. A physical therapist may contact the practitioner identified by the patient at the end of the 30-day period to determine if the practitioner will authorize additional physical therapy services until such time as the patient can be seen by the practitioner. A physical therapist shall not perform an initial evaluation of a patient under this subsection if the physical therapist has performed an initial evaluation of the patient under this subsection for the same condition within the immediately preceding 60 days.

C. A physical therapist who has not completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has not obtained a certificate of authorization pursuant to § 54.1-3482.1 may conduct a one-time evaluation that does not include treatment of a patient without the referral and direction of 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; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.

D. Invasive procedures within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of 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.

E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed nurse practitioner practicing in accordance with his practice agreement when such patient's medical condition is determined, at the time of evaluation or treatment, to be beyond the physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to an appropriate practitioner.

F. Any person licensed as a physical therapist assistant shall perform his duties only under the direction and control of a licensed physical therapist.

G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to (i) a student athlete participating in a school-sponsored athletic activity while such student is at such activity in a public, private, or religious elementary, middle or high school, or public or private institution of higher education when such services are rendered by a

licensed physical therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties; (ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics; (iii) special education students who, by virtue of their individualized education plans (IEPs), need physical therapy services to fulfill the provisions of their IEPs; (iv) the public for the purpose of wellness, fitness, and health screenings; (v) the public for the purpose of health promotion and education; and (vi) the public for the purpose of prevention of impairments, functional limitations, and disabilities.

2000, c. 688; 2001, c. 858; 2002, cc. 434, 471; 2003, c. 496; 2005, c. 928; 2007, cc. 9, 18; 2015, cc. 724, 746.

§ 54.1-3482.1. Certain certification required.

A. The Board shall promulgate regulations establishing criteria for certification of physical therapists to provide certain physical therapy services pursuant to subsection B of § 54.1-3482 without referral from 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. The regulations shall include but not be limited to provisions for (i) the promotion of patient safety; (ii) an application process for a one-time certification to perform such procedures; and (iii) minimum education, training, and experience requirements for certification to perform such procedures.

B. The minimum education, training, and experience requirements for certification shall include evidence that the applicant has successfully completed (i) a transitional program in physical therapy as recognized by the Board or (ii) at least three years of active practice with evidence of continuing education relating to carrying out direct access duties under § 54.1-3482.

2007, cc. 9, 18; 2015, cc. 724, 746

§ 54.1-3483. Unprofessional conduct.

Any physical therapist or physical therapist assistant licensed by the Board shall be considered guilty of unprofessional conduct if he:

1. Engages in the practice of physical therapy under a false or assumed name or impersonates another practitioner of a like, similar or different name;

2. Knowingly and willfully commits any act which is a felony under the laws of this Commonwealth or the United States, or any act which is a misdemeanor under such laws and involves moral turpitude;

3. Aids or abets, has professional contact with, or lends his name to any person known to him to be practicing physical therapy illegally;

4. Conducts his practice in such a manner as to be a danger to the health and welfare of his patients or to the public;

5. Is unable to practice with reasonable skill or safety because of illness or substance abuse;

6. Publishes in any manner an advertisement that violates Board regulations governing advertising;

7. Performs any act likely to deceive, defraud or harm the public;

8. Violates any provision of statute or regulation, state or federal, relating to controlled substances;

9. Violates or cooperates with others in violating any of the provisions of this chapter or regulations of the Board; or

10. Engages in sexual contact with a patient concurrent with and by virtue of the practitioner/patient relationship or otherwise engages at any time during the course of the practitioner/patient relationship in conduct of a sexual nature that a reasonable patient would consider lewd and offensive.

(2000, c. 688; 2001, c. 858.)

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7. Regulations Governing the Practice of Physical Therapy – 18 VAC 112-20-10 et seq. (May 5, 2017)

Commonwealth of Virginia

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

REGULATIONS GOVERNING THE PRACTICE OF PHYSICAL THERAPY

Title of Regulations: 18 VAC 112-20-10 et seq.

Statutory Authority: Chapter 34.1 of Title 54.1of the ***Code of Virginia***

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CHAPTER 20

REGULATIONS GOVERNING THE PRACTICE OF PHYSICAL THERAPY

Part I. General Provisions.

18VAC112-20-10. Definitions.

In addition to the words and terms defined in § 54.1-3473 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Active practice" means a minimum of 160 hours of professional practice as a physical therapist or physical therapist assistant within the 24-month period immediately preceding renewal. Active practice may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

"Approved program" means an educational program accredited by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association.

"CLEP" means the College Level Examination Program.

"Contact hour" means 60 minutes of time spent in continuing learning activity exclusive of breaks, meals or vendor exhibits.

"Direct supervision" means a physical therapist or a physical therapist assistant is physically present and immediately available and is fully responsible for the physical therapy tasks or activities being performed.

"Discharge" means the discontinuation of interventions in an episode of care that have been provided in an unbroken sequence in a single practice setting and related to the physical therapy interventions for a given condition or problem.

"Evaluation" means a process in which the physical therapist makes clinical judgments based on data gathered during an examination or screening in order to plan and implement a treatment intervention, provide preventive care, reduce risks of injury and impairment, or provide for consultation.

"FCCPT" means the Foreign Credentialing Commission on Physical Therapy.

"FSBPT" means the Federation of State Boards of Physical Therapy.

"General supervision" means a physical therapist shall be available for consultation.

"National examination" means the examinations developed and administered by the Federation of State Boards of Physical Therapy and approved by the board for licensure as a physical therapist or physical therapist assistant.

"PRT" means the Practice Review Tool for competency assessment developed and administered by FSBPT.

"Re-evaluation" means a process in which the physical therapist makes clinical judgments based on data gathered during an examination or screening in order to determine a patient's response to the treatment plan and care provided.

"Support personnel" means a person who is performing designated routine tasks related to physical therapy under the direction and supervision of a physical therapist or physical therapist assistant within the scope of this chapter.

"TOEFL" means the Test of English as a Foreign Language.

"Trainee" means a person seeking licensure as a physical therapist or physical therapist assistant who is undergoing a traineeship.

"Traineeship" means a period of active clinical practice during which an applicant for licensure as a physical therapist or physical therapist assistant works under the direct supervision of a physical therapist approved by the board.

"TSE" means the Test of Spoken English.

"Type 1" means continuing learning activities offered by an approved organization as specified in 18VAC112-20-131.

"Type 2" means continuing learning activities which may or may not be offered by an approved organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning.

18VAC112-20-20. (Repealed)

18VAC112-20-25. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any licensee shall be validly given when mailed to the latest address of record provided or when served to the licensee. Any change of name or change in the address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC112-20-26. Criteria for delegation of informal fact-finding proceedings to an agency subordinate.

A. Decision to delegate.

In accordance with § 54.1-2400 (10) of the Code of Virginia, the board may delegate an informal fact-finding proceeding to an agency subordinate upon determination that probable cause exists that a practitioner may be subject to a disciplinary action.

B. Criteria for delegation. Cases that may not be delegated to an agency subordinate include, but are not limited to, those that involve:

1. Intentional or negligent conduct that causes or is likely to cause injury to a patient;

2. Mandatory suspension resulting from action by another jurisdiction or a felony conviction;

3. Impairment with an inability to practice with skill and safety;

4. Sexual misconduct;

5. Unauthorized practice.

C. Criteria for an agency subordinate.

1. An agency subordinate authorized by the board to conduct an informal fact-finding proceeding may include board members and professional staff or other persons deemed knowledgeable by virtue of their training and experience in administrative proceedings involving the regulation and discipline of health professionals.

2. The executive director shall maintain a list of appropriately qualified persons to whom an informal fact-finding proceeding may be delegated.

3. The board may delegate to the executive director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being heard.

18VAC112-20-27. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Licensure by examination.

1. The application fee shall be $140 for a physical therapist and $100 for a physical therapist assistant.

2. The fees for taking all required examinations shall be paid directly to the examination services.

C. Licensure by endorsement. The fee for licensure by endorsement shall be $140 for a physical therapist and $100 for a physical therapist assistant.

D. Licensure renewal and reinstatement.

1. The fee for active license renewal for a physical therapist shall be $135 and for a physical therapist assistant shall be $70 and shall be due by December 31 in each even-numbered year.

2. The fee for an inactive license renewal for a physical therapist shall be $70 and for a physical therapist assistant shall be $35 and shall be due by December 31 in each even-numbered year.

3. A fee of $25 for a physical therapist assistant and $50 for a physical therapist for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 for a physical therapist and $120 for a physical therapist assistant and shall be submitted with an application for licensure reinstatement.

E. Other fees.

1. The fee for an application for reinstatement of a license that has been revoked shall be $1,000; the fee for an application for reinstatement of a license that has been suspended shall be $500.
2. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

3. The fee for a returned check shall be $35.

4. The fee for a letter of good standing/verification to another jurisdiction shall be $10.

5. The application fee for direct access certification shall be $75 for a physical therapist to obtain certification to provide services without a referral.

Part II. Licensure Requirements.

18VAC112-20-30. General requirements.

Licensure as a physical therapist or physical therapist assistant shall be by examination or by endorsement.

18VAC112-20-40. Education requirements: graduates of approved programs.

A. An applicant for licensure who is a graduate of an approved program shall submit documented evidence of his graduation from such a program with the required application and fee.

B. If an applicant is a graduate of an approved program located outside of the United States or Canada, he shall provide proof of proficiency in the English language by passing TOEFL and TSE or the TOEFL iBT, the Internet-based tests of listening, reading, speaking and writing by a score determined by the board or an equivalent examination approved by the board. TOEFL iBT or TOEFL and TSE may be waived upon evidence that the applicant's physical therapy program was taught in English or that the native tongue of the applicant's nationality is English.

18VAC112-20-50. Education requirements: graduates of schools not approved by an accrediting agency approved by the board.

A. An applicant for initial licensure as a physical therapist who is a graduate of a school not approved by an accrediting agency approved by the board shall submit the required application and fee and provide documentation of the physical therapist's certification by a report from the FCCPT or of the physical therapist eligibility for licensure as verified by a report from any other credentialing agency approved by the board that substantiates that the physical therapist has been evaluated in accordance with requirements of subsection B.

B. The board shall only approve a credentialing agency that:

1. Utilizes the FSBPT Coursework Evaluation Tool for Foreign Educated Physical Therapists, based on the year of graduation, and utilizes original source documents to establish substantial equivalency to an approved physical therapy program;

2. Conducts a review of any license or registration held by the physical therapist in any country or jurisdiction to ensure that the license or registration is current and unrestricted or was unrestricted at the time it expired or was lapsed; and

3. Verifies English language proficiency by passage of the TOEFL and TSE examination or the TOEFL iBT, the Internet-based tests of listening, reading, speaking and writing or by review of evidence that the applicant's physical therapy program was taught in English or that the native tongue of the applicant's nationality is English.

C. An applicant for licensure as a physical therapist assistant who is a graduate of a school not approved by the board shall submit with the required application and fee the following:

1. Proof of proficiency in the English language by passing TOEFL and TSE or the TOEFL iBT, the Internet-based tests of listening, reading, speaking and writing by a score determined by the board or an equivalent examination approved by the board. TOEFL iBT or TOEFL and TSE may be waived upon evidence that the applicant's physical therapist assistant program was taught in English or that the native tongue of the applicant's nationality is English.

2. A copy of the original certificate or diploma which has been certified as a true copy of the original by a notary public, verifying his graduation from a physical therapy curriculum.

If the certificate or diploma is not in the English language, submit either:

a. An English translation of such certificate or diploma by a qualified translator other than the applicant; or

b. An official certification in English from the school attesting to the applicant's attendance and graduation date.

3. Verification of the equivalency of the applicant's education to the educational requirements of an approved program for physical therapist assistants from a scholastic credentials service approved by the board:

D. An applicant for initial licensure as a physical therapist or a physical therapist assistant who is not a graduate of an approved program shall also submit verification of having successfully completed a 1,000-hour traineeship within a two-year period under the direct supervision of a licensed physical therapist. The board may grant an extension beyond two years for circumstances beyond the control of the applicant, such as temporary disability or mandatory military service.

1. The traineeship shall be in accordance with requirements of 18VAC112-20-140.

2. The traineeship requirements of this part may be waived if the applicant for a license can verify, in writing, the successful completion of one year of clinical physical therapy practice as a licensed physical therapist or physical therapist assistant in the United States, its territories, the District of Columbia, or Canada, equivalent to the requirements of this chapter.

18VAC112-20-60. Requirements for licensure by examination.

Every applicant for initial licensure by examination shall submit:

1. Documentation of having met the educational requirements specified in 18VAC112-20-40 or 18VAC112-20-50;

2. The required application, fees and credentials to the board; and

3. Documentation of passage of the national examination as prescribed by the board.

18VAC112-20-65. Requirements for licensure by endorsement.

A. A physical therapist or physical therapist assistant who holds a current, unrestricted license in the United States, its territories, the District of Columbia, or Canada, may be licensed in Virginia by endorsement.

B. An applicant for licensure by endorsement shall submit:

1. Documentation of having met the educational requirements prescribed in 18VAC112-20-40 or 18VAC112-20-50. In lieu of meeting such requirements, an applicant may provide evidence of clinical practice consisting of at least 2,500 hours of patient care during the five years immediately preceding application for licensure in Virginia with a current, unrestricted license issued by another U. S. jurisdiction;

2. The required application, fees, and credentials to the board;

3. A current report from the Healthcare Integrity and Protection Data Bank (HIPDB);

4. Evidence of completion of 15 hours of continuing education for each year in which the applicant held a license in another U.S. jurisdiction, or 60 hours obtained within the past four years;

5. Documentation of passage of an examination equivalent to the Virginia examination at the time of initial licensure or documentation of passage of an examination required by another state at the time of initial licensure in that state; and

6. Documentation of active practice in physical therapy in another U. S. jurisdiction for at least 320 hours within the four years immediately preceding his application for licensure. A physical therapist who does not meet the active practice requirement shall:

a. Successfully complete 320 hours in a traineeship in accordance with requirements in 18VAC112-20-140; or

b. Document that he meets the standard on the PRT within the two years preceding application for licensure in Virginia and successfully complete 160 hours in a traineeship in accordance with the requirements in 18VAC112-20-140.

C. A physical therapist assistant seeking licensure by endorsement who has not actively practiced physical therapy for at least 320 hours within the four years immediately preceding his application

for licensure shall successfully complete 320 hours in a traineeship in accordance with the requirements in 18VAC112-20-140.

18VAC112-20-70. Traineeship for unlicensed graduate scheduled to sit for the national examination.

A. Upon approval of the president of the board or his designee, an unlicensed graduate who is registered with the Federation of State Boards of Physical Therapy to sit for the national examination may be employed as a trainee under the direct supervision of a licensed physical therapist until the results of the national examination are received.

B. The traineeship, which shall be in accordance with requirements of 18VAC112-20-140, shall terminate two working days following receipt by the candidate of the licensure examination results.

C. The unlicensed graduate may reapply for a new traineeship while awaiting to take the next examination. A new traineeship shall not be approved for more than one year following the receipt of the first examination results.

18VAC112-20-80. (Repealed)

18VAC112-20-81. Requirements for direct access certification.

A. An applicant for certification to provide services to patients without a referral as specified in § 54.1-3482.1 of the Code of Virginia shall hold an active, unrestricted license as a physical therapist in Virginia and shall submit evidence satisfactory to the board that he has one of the following qualifications:

1. Completion of a transitional program in physical therapy as recognized by the board; or

2. At least three years of postlicensure, active practice with evidence of 15 contact hours of continuing education in medical screening or differential diagnosis, including passage of a postcourse examination. The required continuing education shall be offered by a provider or sponsor listed as approved by the board in 18VAC112-20-131 and may be face-to-face or online education courses.

B. In addition to the evidence of qualification for certification required in subsection A of this section, an applicant seeking direct access certification shall submit to the board:

1. A completed application as provided by the board;

2. Any additional documentation as may be required by the board to determine eligibility of the applicant; and

3. The application fee as specified in 18VAC112-20-27.

Part III. Practice Requirements.

18VAC112-20-90. General responsibilities.

A. The physical therapist shall be responsible for managing all aspects of the physical therapy care of each patient and shall provide:

1. The initial evaluation for each patient and its documentation in the patient record;

2. Periodic reevaluation, including documentation of the patient's response to therapeutic intervention; and

3. The documented status of the patient at the time of discharge, including the response to therapeutic intervention. If a patient is discharged from a health care facility without the opportunity for the physical therapist to reevaluate the patient, the final note in the patient record may document patient status.

B. The physical therapist shall communicate the overall plan of care to the patient or his legally authorized representative and shall also communicate with a referring doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, nurse practitioner or physician assistant to the extent required by §54.1-3482 of the Code of Virginia.

C. A physical therapist assistant may assist the physical therapist in performing selected components of physical therapy intervention to include treatment, measurement and data collection, but not to include the performance of an evaluation as defined in 18 VAC 112-20-10.

D. A physical therapist assistant's visits to a patient may be made under general supervision.

E. A physical therapist providing services with a direct access certification as specified in § 54.1-3482 of the Code of Virginia shall utilize the Direct Access Patient Attestation and Medical Release Form prescribed by the board or otherwise include in the patient record the information, attestation and written consent required by subsection B of § 54.1-3482 of the Code of Virginia.

18VAC112-20-100. Supervisory responsibilities.

A. A physical therapist shall be fully responsible for any action of persons performing physical therapy functions under the physical therapist's supervision or direction.

B. Support personnel shall only perform routine assigned tasks under the direct supervision of a licensed physical therapist or a licensed physical therapist assistant, who shall only assign those tasks or activities that are nondiscretionary and do not require the exercise of professional judgment.

C. A physical therapist shall provide direct supervision to no more than three individual trainees at any one time.

D. A physical therapist shall provide direct supervision to a student in an approved program who is satisfying clinical educational requirements in physical therapy. A physical therapist or a physical

therapist assistant shall provide direct supervision to a student in an approved program for physical therapist assistants.

18VAC112-20-110. (Repealed).

18VAC112-20-120. Responsibilities to patients.

A. The initial patient visit shall be made by the physical therapist for evaluation of the patient and establishment of a plan of care.

B. The physical therapist assistant's first visit with the patient shall only be made after verbal or written communication with the physical therapist regarding patient status and plan of care. Documentation of such communication shall be made in the patient's record.

C. Documentation of physical therapy interventions shall be recorded on a patient's record by the physical therapist or physical therapist assistant providing the care.

D. The physical therapist shall reevaluate the patient as needed, but not less than according to the following schedules:

1. For inpatients in hospitals as defined in §32.1-123 of the Code of Virginia, it shall be not less than once every seven consecutive days.

2. For patients in other settings, it shall be not less than one of 12 visits made to the patient during a 30-day period, or once every 30 days from the last reevaluation, whichever occurs first.

3. For patients who have been receiving physical therapy care for the same condition or injury for six months or longer, it shall be at least every 90 days from the last reevaluation.

Failure to abide by this subsection due to the absence of the physical therapist in case of illness, vacation, or professional meeting, for a period not to exceed five consecutive days, will not constitute a violation of these provisions.

E. The physical therapist shall be responsible for ongoing involvement in the care of the patient to include regular communication with a physical therapist assistant regarding the patient's plan of treatment.

Part IV. Renewal or Relicensure Requirements.

18VAC112-20-130. Biennial renewal of license.

A. A physical therapist and physical therapist assistant who intends to continue practice shall renew his license biennially by December 31 in each even-numbered year and pay to the board the renewal fee prescribed in 18VAC112-20-27.

B. A licensee whose licensure has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC112-20-27.

C. In order to renew an active license, a licensee shall be required to:

1. Complete a minimum of 160 hours of active practice in the preceding two years; and

2. Comply with continuing competency requirements set forth in 18VAC112-20-131.

18VAC112-20-131. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a physical therapist or a physical therapist assistant shall complete at least 30 contact hours of continuing learning activities within the two years immediately preceding renewal. In choosing continuing learning activities or courses, the licensee shall consider the following: (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

B. To document the required hours, the licensee shall maintain the Continued Competency Activity and Assessment Form that is provided by the board and that shall indicate completion of the following:

1. A minimum of 20 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants shall be in Type 1 courses. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the clinical practice of physical therapy and approved or provided by one of the following organizations or any of its components:

a. The Virginia Physical Therapy Association;

b. The American Physical Therapy Association;

c. Local, state or federal government agencies;

d. Regionally accredited colleges and universities;

e. Health care organizations accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation;

f. The American Medical Association -Category I Continuing Medical Education course; and

g. The National Athletic Trainers Association.

2. No more than 10 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants may be Type 2 activities or courses, which may or may not be offered by an approved organization but which shall be related to the clinical practice of physical therapy. Type 2 activities may include but not be limited to consultation with colleagues, independent study, and research or writing on subjects related to practice. Up to two of the Type 2 continuing education hours may be satisfied through delivery of physical therapy services, without

compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services.

3. Documentation of specialty certification by the American Physical Therapy Association may be provided as evidence of completion of continuing competency requirements for the biennium in which initial certification or recertification occurs.

4. Documentation of graduation from a transitional doctor of physical therapy program may be provided as evidence of completion of continuing competency requirements for the biennium in which the physical therapist was awarded the degree.

5. A physical therapist who can document that he has taken the PRT may receive 10 hours of Type 1 credit for the biennium in which the assessment tool was taken. A physical therapist who can document that he has met the standard of the PRT may receive 20 hours of Type 1 credit for the biennium in which the assessment tool was taken.

C. A licensee shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure by examination in Virginia.

D. The licensee shall retain his records on the completed form with all supporting documentation for a period of four years following the renewal of an active license.

E. The licensees selected in a random audit conducted by the board shall provide the completed Continued Competency Activity and Assessment Form and all supporting documentation within 30 days of receiving notification of the audit.

F. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

G. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

H. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC112-20-135. Inactive license.

A. A physical therapist or physical therapist assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required renewal fee of $70 for a physical therapist and $35 for a physical therapist assistant, be issued an inactive license.

1. The holder of an inactive license shall not be required to meet active practice requirements.

2. An inactive licensee shall not be entitled to perform any act requiring a license to practice physical therapy in Virginia.

B. A physical therapist or physical therapist assistant who holds an inactive license may reactivate his license by:

1. Paying the difference between the renewal fee for an inactive license and that of an active license for the biennium in which the license is being reactivated;

2. Providing proof of 320 active practice hours in another jurisdiction within the four years immediately preceding application for reactivation.

a. If the inactive physical therapist licensee does not meet the requirement for active practice, the license may be reactivated by completing 320 hours in a traineeship that meets requirements prescribed in 18VAC112-20-140 or documenting that he has met the standard of the PRT within the two years preceding application for reactivation of licensure in Virginia and successfully completing 160 hours in a traineeship in accordance with requirements in 18VAC112-20-140.

b. If the inactive physical therapist assistant licensee does not meet the requirement for active practice, the license may be reactivated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140.

3. Completing of the number of continuing competency hours required for the period in which the license has been inactive, not to exceed four years.

18VAC112-20-136. Reinstatement requirements.

A. A physical therapist or physical therapist assistant whose Virginia license is lapsed for two years or less may reinstate his license by payment of the renewal and late fees as set forth in 18VAC112-20-27 and completion of continued competency requirements as set forth in 18VAC112-20-131.

B. A physical therapist or physical therapist assistant whose Virginia license is lapsed for more than two years and who is seeking reinstatement shall:

1. Apply for reinstatement and pay the fee specified in 18VAC112-20-27;

2. Complete the number of continuing competency hours required for the period in which the license has been lapsed, not to exceed four years; and

3. Have actively practiced physical therapy in another jurisdiction for at least 320 hours within the four years immediately preceding applying for reinstatement.

a. If a physical therapist licensee does not meet the requirement for active practice, the license may be reinstated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140 or documenting that he has met the standard of the PRT within the two years preceding application for licensure in Virginia and

successfully completing 160 hours in a traineeship in accordance with requirements in 18VAC112-20-140.

b. If a physical therapist assistant licensee does not meet the requirement for active practice, the license may be reinstated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140.

18VAC112-20-140. Traineeship required.

A. The traineeship shall be approved by the board, and under the direction and supervision of a licensed physical therapist.

B. Supervision and identification of trainees:

1. There shall be a limit of two physical therapists assigned to provide supervision for each trainee.

2. The supervising physical therapist shall countersign patient documentation (i.e., notes, records, charts) for services provided by a trainee.

3. The trainee shall wear identification designating them as a "physical therapist trainee" or a "physical therapist assistant trainee."

C. Completion of traineeship.

1. The physical therapist supervising the trainee shall submit a report to the board at the end of the required number of hours on forms supplied by the board.

2. If the traineeship is not successfully completed at the end of the required hours, as determined by the supervising physical therapist, the president of the board or his designee shall determine if a new traineeship shall commence. If the president of the board determines that a new traineeship shall not commence, then the application for licensure shall be denied.

3. The second traineeship may be served under a different supervising physical therapist and may be served in a different organization than the initial traineeship. If the second traineeship is not successfully completed, as determined by the supervising physical therapist, then the application for licensure shall be denied.

18VAC112-20-150. (Repealed.)

18VAC112-20-151. (Repealed.)

Part IV. Standards of Practice.

18VAC112-20-160. Requirements for patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage and keep timely, accurate, legible and complete patient records.

D. Practitioners who are employed by a health care institution, school system or other entity, in which the individual practitioner does not own or maintain his own records, shall maintain patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

c. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

2. From March 30, 2010, post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC112-20-170. Confidentiality and practitioner-patient communication.

A. A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

B. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Before any invasive procedure is performed, informed consent shall be obtained from the patient and documented in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

C. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

18VAC112-20-180. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow persons under his supervision to jeopardize patient safety or provide patient care outside of such person's scope of practice or area of responsibility. Practitioners shall delegate patient care only to persons who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in § 37.2-100 of the Code of Virginia, or hospital as defined in § 32.1-123 of the Code of Virginia.

Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, § 1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.

C. A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

D. A practitioner shall report any disciplinary action taken by a physical therapy regulatory board in another jurisdiction within 30 days of final action.

18VAC112-20-190. Sexual contact.

A. For purposes of § 54.1-3483 (10) of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-3483 (10) of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on

patient care. For purposes of this section, key third party of a patient shall mean spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC112-20-200. Advertising ethics.

A. Any statement specifying a fee, whether standard, discounted or free, for professional services that does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.

B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment that is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be waived by agreement of the patient and the practitioner.

C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.

D. A licensee shall not use the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for his practice unless he holds certification in a clinical specialty issued by the American Board of Physical Therapy Specialties.

E. A licensee of the board shall not advertise information that is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.

F. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.

8. Other States' Selected Regulations and Code Sections Regarding Dry Needling (Maryland, Utah, Tennessee, Colorado, Delaware, Mississippi, Kansas (Proposed))

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PROPOSAL and SPECIAL DOCUMENT

PROPOSAL
Maryland Register
Issue Date: November 14, 2016
Volume 43 • Issue 23 • Pages 1287—1289

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 38 BOARD OF PHYSICAL THERAPY EXAMINERS

10.38.12 Dry Needling

Authority: Health Occupations Article, §§13-101 and 13-206, Annotated Code of Maryland

Notice of Proposed Action

[16-291-P]

The Secretary of Health and Mental Hygiene proposes to adopt new Regulations **.01—.04** under a new chapter, **COMAR 10.38.12 Dry Needling**. This action was considered at a public meeting held on October 20, 2015, notice of which was given by

publication on the Board's website at http://dhmh.maryland.gov/bphte pursuant to General Provisions Article, §3-302(c)(3)(ii), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to establish guidelines for the provision of dry needling as an intervention performed by physical therapists.

See "Background and Analysis of Proposal to Establish Guidelines for Dry Needling" in the Special Documents section of this issue of the Maryland Register for further details.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. Physical therapists who have not completed the required training required for dry needling may incur a cost to obtain that training.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(-)	Indeterminable
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D. To the extent that a physical therapist has or has not completed the required training to perform dry needling, there will be a cost to the physical therapist. This amount cannot be determined as it will vary between each individual physical therapist.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through December 14, 2016. A public hearing has not been scheduled.

.01 Scope.

This chapter establishes standards for the provision of dry needling as an intervention performed by physical therapists.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Board" means the State Board of Physical Therapy Examiners.

(2) "Dry needling" means a physical therapy intervention, also known as intramuscular manual therapy, that:

(a) Involves the insertion of one or more solid needles, a mechanical device, into the muscle and related tissues to affect change in muscle and related tissues;

(b) Requires ongoing evaluation, assessment, and re-evaluation of the impairments;

(c) Is only utilized in parts of the body with neuromuscular or musculoskeletal links to the impairments; and

(d) Is not performed for:

(i) The purposes of acupuncture as defined in Health Occupations Article, §1A-101, Annotated Code of Maryland; or

(ii) Any purpose outside the scope of physical therapy.

.03 Minimum Education and Training Necessary to Perform Dry Needling.

A. In order to perform dry needling, a physical therapist shall have at least 80 total hours of instruction, which includes:

(1) A total of at least 40 hours of instruction in the following dry needling-specific course content areas:

(a) Theory and application of dry needling;

(b) Dry needling technique, including spine and extremities;

(c) Dry needling indications and contraindications;

(d) Infection control, the Occupational Safety and Health Administration's Bloodborne Pathogen Protocol, and safe handling of needles;

(e) Emergency preparedness and response procedures related to complications associated with dry needling; and

(f) Appropriate documentation of dry needling; and

(2) At least 40 hours of practical, hands-on instruction in the application and technique of dry needling, under the supervision of a licensed health care practitioner competent in dry needling procedures who has:

(a) Completed the requisite course work under §A(1) of this regulation; and

(b) Practiced dry needling for at least 5 years.

B. The instruction required under §A(1) of this regulation shall be provided by a continuing education course sponsored by the:

(1) American Physical Therapy Association;

(2) The APTA of Maryland; or

(3) The Federation of State Boards of Physical Therapy.

C. A continuing education course taken before the effective date of this regulation shall qualify for instruction if the same course, in substantially similar form, is later sponsored by the American Physical Therapy Association, the APTA of Maryland, or the Federation of State Boards of Physical Therapy.

D. All instruction required under this regulation shall include an assessment of competency.

E. The instruction required under §A(1) of this regulation shall be offered:

(1) In person at a face-to-face session; or

(2) In real time through electronic means that allow for simultaneous interaction between the instructor and the participants.

F. A physical therapist may not fulfill any portion of the practical, hands-on instruction required under §A(2) of this regulation with online or distance learning.

G. A physical therapist shall have practiced physical therapy for at least 2 years before performing dry needling in the State.

H. Registration.

(1) A physical therapist shall be registered with the Board as having the appropriate education and training required by this regulation before the physical therapist may practice dry needling.

(2) In order to be registered to practice dry needling, a physical therapist shall:

(a) Submit a completed application on a form supplied by the Board; and

(b) Pay a registration fee as established by COMAR 10.38.07.

I. A physical therapist who practices dry needling without the education and training required by this regulation shall be subject to discipline pursuant to COMAR 10.38.10.04A(4).

J. This regulation shall take effect 1 year after the effective date of the rest of this chapter.

.04 Standards of Practice in Performing Dry Needling.

A. A physical therapist shall:

(1) Fully explain dry needling to the patient in advance of treatment; and

(2) Obtain written informed consent specific to dry needling that shall be included in the patient's medical record.

B. A physical therapist shall perform dry needling in a manner consistent with standards set forth in the Maryland Occupational Safety and Health Act, Labor and Employment Article, Title 5, Annotated Code of Maryland.

C. A physical therapist shall document the provision of dry needling services in accordance with the documentation requirements of COMAR 10.38.03.02-1.

D. A physical therapist who practices dry needling in a manner inconsistent with the standards of practice enumerated in this regulation shall be subject to discipline pursuant to COMAR 10.38.10.04A(14).

Utah

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Historical Code

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Index Utah Code
Title 58 Occupations and Professions
Chapter 24b Physical Therapy Practice Act
Part 5 Unlawful and Unprofessional Conduct
Section 505 Trigger point dry needling -- Experience required -- Registration. *(Effective 5/13/2014)*

Effective 5/13/2014

58-24b-505. Trigger point dry needling -- Experience required -- Registration.

(1) A physical therapist may practice trigger point dry needling if the physical therapist:

(a) has held a license to practice physical therapy under this chapter, and has actively practiced physical therapy, for two years;

(b) has successfully completed a course in trigger point dry needling that:

(i) is approved by the division; and

(ii) includes at least 300 total course hours, including at least:

(A) 54 hours of in-person instruction; and

(B) 250 supervised patient treatment sessions;

(c) files a certificate of completion of the course described in Subsection (1)(b) with the division;

(d) registers with the division as a trigger point dry needling practitioner; and

(e) meets any other requirement to practice trigger point dry needling established by the division.

(2) The division shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that establish:

(a) the criteria for approving a course described in Subsection (1)(b); and

(b) the requirements described in Subsection (1)(e).

(3) The division may charge, in accordance with Section 63J-1-504, a fee for the registration described in Subsection (1)(d).

Enacted by Chapter 354, 2014 General Session

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(1) a full-time equivalent physical therapist can supervise no more than three full-time equivalent supportive personnel unless approved by the board and Division; and

(2) a physical therapist shall provide treatment to a patient at least every tenth treatment but no longer than 30 days from the day of the physical therapist's last treatment day, whichever is less.

Reg

R156-24b-505. Trigger Point Dry Needling - Education and Experience Required - Registration.

(1) A course approved by one of the following organizations meets the standards of Section 58-24b-505 if it includes the hours and treatment sessions specified in Section 58-24b-505:

(a) American Physical Therapy Association (APTA) or any of its sections or local chapters; or

(b) Federation of State Boards of Physical Therapy (FSBPT).

KEY: licensing, physical therapy, physical therapist, physical therapist assistant
Date of Enactment or Last Substantive Amendment: December 29, 2016
Notice of Continuation: October 6, 2016
Authorizing, and Implemented or Interpreted Law: 58-24b-101; 58-1-106(1)(a); 58-1-202(1)(a)

Tennessee

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Chapter 1150-01
General Rules Governing the Practice of Physical Therapy

Amendments

Rule 1150-01-.08 Examinations is amended by deleting paragraph (9) in its entirety and substituting instead the following language, so that as amended, the new paragraph (9) shall read:

(9) Effective July 1, 2015, the Board will no longer approve individualized structured remediation plans. However, those remediation plans already in effect prior to July 1, 2015 must be completed by the applicant. An applicant who fails the examination two (2) or more times after July 1, 2015 must submit proof of ten (10) hours of additional clinical training and ten (10) hours of additional coursework to the Board administrator before the Board will approve a reapplication for subsequent testing beyond two attempts. These ten (10) hours of additional clinical training and ten (10) hours of additional coursework are required after each subsequent failure beyond two (2) times before an applicant can be approved for reapplication for subsequent testing.

Authority: T.C.A. §§ 63-13-301, 63-13-304, 63-13-306, and 63-13-307.

New Rule
1150-01-.22

Dry Needling

New Table of Contents

1150-01-.01 Definitions
1150-01-.02 Scope of Practice and Supervision
1150-01-.03 Necessity of Licensure
1150-01-.04 Qualifications for Licensure
1150-01-.05 Procedures for Licensure
1150-01-.06 Fees
1150-01-.07 Application Review, Approval and Denial
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1150-01-.09 Renewal of License
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1150-01-.16 Duplicate (Replacement) License
1150-01-.17 Change of Address and/or Name
1150-01-.18 Mandatory Release of Client Records
1150-01-.19 Board Meetings, Officers, Consultants, Records, and Declaratory Orders
1150-01-.20 Consumer Right-To-Know Requirements
1150-01-.21 Professional Peer Assistance
1150-01-.22 Dry Needling

New Rule: 1150-01-.22 Dry Needling

(1) In order to perform dry needling, a physical therapist must obtain all of the educational instruction described in paragraphs (2)(a) and (2)(b) herein. All such educational instruction must be obtained in person and may not be obtained online or through video conferencing.

(2) Mandatory Training - Before performing dry needling, a practitioner must complete educational requirements in each of the following areas:

(a) Fifty (50) hours of instruction, to include instruction in each of the four (4) areas listed herein, which are generally satisfied during the normal course of study in physical therapy school:

1. Musculoskeletal and Neuromuscular systems;
2. Anatomical basis of pain mechanisms, chronic pain, and referred pain;
3. Trigger Points;
4. Universal Precautions; and

(b) Twenty-four (24) hours of dry needling specific instruction.

1. The twenty-four (24) hours must include instruction in each of the following six (6) areas:

   (i) Dry needling technique;

   (ii) Dry needling indications and contraindications;

   (iii) Documentation of dry needling;

   (iv) Management of adverse effects;

   (v) Practical psychomotor competency; and

   (vi) Occupational Safety and Health Administration's Bloodborne Pathogens Protocol.

2. Each instructional course shall specify what anatomical regions are included in the instruction and describe whether the course offers introductory or advanced instruction in dry needling.

3. Each course must be pre-approved or approved by the Board or its consultant, or the Board may delegate the approval process to recognized health-related organizations or accredited physical therapy educational institutions.

(3) A newly-licensed physical therapist shall not practice dry needling for at least one (1) year from the date of initial licensure, unless the practitioner can demonstrate compliance with paragraph (2) through his or her pre-licensure educational coursework.

(4) Any physical therapist who obtained the requisite twenty-four (24) hours of instruction as described in paragraph (2)(b) in another state or country must provide the same documentation to the Board, as described in paragraph (2)(b), that is required of a course provider. The Board or its consultant must approve the practitioner's dry needling coursework before the therapist can practice dry needling in this state.

(5) Dry needling may only be performed by a licensed physical therapist and may not be delegated to a physical therapist assistant or support personnel.

(6) A physical therapist practicing dry needling must supply written documentation, upon request by the Board, that substantiates appropriate training as required by this rule.

(7) All physical therapy patients receiving dry needling shall be provided with information from the patient's physical therapist that includes a definition and description of the practice of dry needling and a description of the risks, benefits, and potential side effects of dry needling.

Authority: T.C.A. §§ 63-13-304 and 63-13-305.

Colorado

211. Requirements for Physical Therapists to Perform Dry Needling

A. Dry needling (also known as Trigger Point Dry Needling) is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Dry needling does not include the stimulation of auricular or distal points.

B. Dry needling as defined pursuant to this rule is within the scope of practice of physical therapy.

C. A Physical Therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the Physical Therapist's scope of practice. Except as part of a course of study on dry needling pursuant to paragraph D.2 of this Rule, a Physical Therapist shall not perform dry needling unless competent to do so.

D. To be deemed competent to perform dry needling, a Physical Therapist must:

1. have practiced for at least two years as a licensed Physical Therapist; and
2. have successfully completed a dry needling course of study that consists of a minimum of 46 hours of in-person (i.e. not online) dry needling training.

E. A provider of a dry needling course of study must meet the educational and clinical prerequisites as defined in this rule, paragraph D above and demonstrate a minimum of two years of dry needling practice techniques. The provider is not required to be a Physical Therapist.

F. Physical Therapists performing dry needling in their practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information:

1. Risks and benefits of dry needling; and
2. Physical Therapist's level of education and training in dry needling; and
3. The Physical Therapist will not stimulate any distal or auricular points during dry needling.

G. When dry needling is performed, it must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique, as well as the outcome after the procedure.

H. Dry needling shall not be delegated and must be directly performed by a qualified, licensed Physical Therapist.

I. Dry needling must be performed in a manner consistent with generally accepted standards of practice, including clean needle techniques, and the guidelines and recommendations of the Centers for Disease Control and Prevention ("CDC").

J. The Physical Therapist shall supply written documentation, upon request by the Board, which substantiates appropriate training as required by this Rule. Failure to provide written documentation, upon request, is a violation of this Rule, and is prima facie evidence that the Physical Therapist is not competent and not permitted to perform dry needling

State Training Guidelines

The source for the following materials is the Federation of State Boards.

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Colorado

News: September 2013: Colorado Governor signs into law that Dry Needling is in the scope of practice for Physical Therapy.

Colorado Physical Therapy Licensure Rules and Regulations

4 CCR 732-1 RULE 11 – REQUIREMENTS FOR PHYSICAL THERAPISTS TO PERFORM DRY NEEDLING

A. Dry needling is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Dry needling does not include the stimulation of auricular or distal points.

B. Dry needling as defined pursuant to this rule is within the scope of practice of physical therapy.

C. A physical therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the physical therapist's scope of practice.

D. To be deemed competent to perform dry needling, a Physical Therapist must:
1. have practiced for at least two years as a licensed Physical Therapist;
and
2. have successfully completed a dry needling course of study that consists of a minimum of 46 hours of in-person (i.e. not online) dry needling training.

E. A provider of a dry needling course of study must meet the educational and clinical prerequisites as defined in this rule, paragraph D above and demonstrate a minimum of two years of dry needling practice techniques. The provider is not required to be a physical therapist.

F. A physical therapist performing dry needling in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information:
1. Risks and benefits of dry needling
2. Physical therapist's level of education and training in dry needling
3. The physical therapist will not stimulate any distal or auricular points during dry needling.

G. When dry needling is performed this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure.

H. Dry needling shall not be delegated and must be directly performed by a qualified, licensed physical therapist.

I. Dry needling must be performed in a manner consistent with generally accepted standards of practice, including clean needle techniques, and standards of the center for communicable diseases.

J. The physical therapist must be able to supply written documentation, upon request by the Director, which substantiates appropriate training as required by this rule. Failure to provide written documentation is a violation of this rule, and is prima facie evidence that the physical therapist is not competent and not permitted to perform dry needling.

District of Columbia

District of Columbia Municipal Regulations Title 17, Chapter 67, Physical Therapy

6715 SCOPE OF PRACTICE A physical therapist may also perform intramuscular manual therapy, which is also known as dry needling, if performed in conformance with the requirements of section 6716.

6716 REQUIREMENTS FOR PHYSICAL THERAPISTS TO PERFORM INTRAMUSCULAR MANUAL THERAPY

6716.1 Intramuscular manual therapy may be performed by a licensed physical therapist who meets the requirements of this section.

6716.2 Intramuscular manual therapy shall be performed directly by the licensed physical therapist and shall not be delegated.

6716.3 Intramuscular manual therapy shall be performed in a manner that is consistent with generally accepted standards of practice, including clean needle techniques, and other applicable standards of the Centers for Disease Control and Prevention.

6716.4 Intramuscular manual therapy is an advanced procedure that requires specialized training. A physical therapist shall not perform intramuscular manual therapy in the District of Columbia unless he or she has documented proof of completing:

(a) A board-approved professional training program on intramuscular manual therapy. The training program shall require each trainee to demonstrate cognitive and psychomotor knowledge and skills. The training program shall be attended in person by the physical

therapist, shall not be attended online or through any other means of distance learning, and shall not be a self-study program

(b) A professional training program on intramuscular manual therapy accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). The training program shall require each trainee to demonstrate cognitive and psychomotor knowledge and skills. The training program shall be attended in person by the physical therapist, shall not be attended online or through any other means of distance learning, and shall not be a self-study program; or

(c) Graduate or higher-level coursework in a CAPTE-approved educational program that included intramuscular manual therapy in the curriculum.

6716.5 A physical therapist shall only perform intramuscular manual therapy following an examination and diagnosis, and for the purpose of treating specific anatomic entities selected according to physical signs.

6716.6 A physical therapist who performs intramuscular manual therapy shall obtain written informed consent from each patient who will receive intramuscular manual therapy before the physical therapist performs intramuscular manual therapy on the patient.

6716.7 The informed consent form shall include, at a minimum, the following:

(a) The patient's signature;

(b) The risks and benefits of intramuscular manual therapy;

(c) The physical therapist's level of education and training in intramuscular manual therapy; and

(d) A clearly and conspicuously written statement that the patient is not receiving acupuncture.

6716.8 A physical therapist who performs intramuscular manual therapy shall maintain a separate procedure note in the patient's chart for each intramuscular manual therapy. The note shall indicate how the patient tolerated the intervention as well as the outcome after the intramuscular manual therapy.

6716.9 A physical therapist who performs intramuscular manual therapy shall be required to produce documentation of meeting the requirements of this section immediately upon request by the board or an agent of the board.

6716.10 Failure by a physical therapist to provide written documentation of meeting the training requirements of this section shall be deemed prima facie evidence that the physical therapist is not competent and not permitted to perform intramuscular manual therapy.

Georgia

Currently drafting rules for the statute.

Kentucky

KRS 327.070(2)

While dry needling is within the scope of practice of physical therapy, a physical therapist must practice only those procedures that the physical therapist is competent to perform. The board can discipline a physical therapist for "engaging or permitting the performance of substandard patient care by himself or by persons working under their supervision due to a deliberate or negligent act or failure to act, regardless of whether actual injury to the patient is established."

Louisiana

Subchapter B. General Provisions

§123. Definitions

A. As used in this Title, the following terms and phrases, defined in the practice act, La. R.S.37:2401–2424, shall have the meanings specified here. Dry Needling—a physical intervention which utilizes filiform needles to stimulate trigger points in a patient's body for the treatment of neuromuscular pain and functional movement deficits. Dry Needling is based upon Western medical concepts and does not rely upon the meridians utilized in acupuncture and other Eastern practices. A physical therapy evaluation will indicate the location, intensity and persistence of neuromuscular pain or functional deficiencies in a physical therapy patient and the propriety for utilization of dry needling as a treatment intervention. Dry needling does not include the stimulation of auricular points.

§311. Treatment with Dry Needling

A. The purpose of this rule is to establish standards of practice, as authorized by La. R.S. 37:2405 A.(8), for the utilization of dry needling techniques, as defined in §123, in treating patients.

B. Dry needling is a physical therapy treatment which requires specialized physical therapy education and training for the utilization of such techniques. Before undertaking dry needling education and training, a PT shall have no less than two years experience working as a licensed PT. Prior to utilizing dry needling techniques in patient treatment, a PT shall provide documentation to the executive director that he has successfully completed a board–approved course of study consisting of no fewer than 50 hours of face–to–face instruction in intramuscular dry needling treatment and safety. Online and other distance learning courses will not satisfy this requirement. Practicing dry needling without compliance with this requirement constitutes unprofessional conduct and subjects a licensee to appropriate discipline by the board.

C. In order to obtain board approval for courses of instruction in dry needling, sponsors must document that instructors utilized have had no less than two years experience utilizing such techniques. Instructors need not be physical therapists, but should be licensed or certified as a healthcare provider in the state of their residence.

D. A written informed consent form shall be presented to a patient for whom dry needling is being considered, telling the patient of the potential risks and benefits of dry needling. A copy of a completed form shall be preserved in the patient treatment record and another copy given to the patient.

E. Dry needling treatment shall be performed in a manner consistent with generally accepted standards of practice, including sterile needle procedures and the standards of the U.S. Centers for Disease Control and Prevention. Treatment notes shall document how the patient tolerated the technique and the outcome of treatments.

Maryland

Currently drafting

Mississippi (APTA statement here)

A.To be deemed competent to perform intramuscular manual therapy a physical therapist must meet the following requirements:

1. Documented successful completion of a intramuscular manual therapy course of study; online study is not considered appropriate training. a. A minimum of 50 hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training. b. Three years of practice as a licensed physical therapist prior to using the intramuscular manual therapy technique.
2. The physical therapist must have board approved credentials for providing intramuscular manipulation which are on file with the board office prior to using the treatment technique.

B. The provider of the required educational course does not need to be a physical therapist. A intramuscular manual therapy course of study must meet the educational and clinical prerequisites as defined in this rule,

C(1)(a)&(b) and demonstrate a minimum of two years of intramuscular manual therapy practice techniques.

D. A physical therapist performing intramuscular manual therapy in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information:

1. Risks and benefits of intramuscular manual therapy.
2. Physical therapist's level of education and training in intramuscular manual therapy
3. The physical therapist will not stimulate any distal or auricular points during intramuscular manual therapy.

E. When intramuscular manual therapy is performed, this ust be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure.

F. Intramuscular manual therapy shall not be delegated and must be directly performed by a qualified, licensed physical therapist.

G. Intramuscular manual therapy must be performed in a manner consistent with generally accepted standards of practice, including but not limited to, aseptic techniques and standards of the center for communicable diseases.

Montana

Currently drafting

Nebraska

A physical therapist who wished to perform tissue penetration for the purpose of dry needling must meet the following requirements:

1. Complete pre-service or in-service training. The pre-service or in-service training must include:

    a. Pertinent anatomy and physiology;
    b. Choice and operation of supplies and equipment;
    c. Knowledge of technique including indications and contraindications;
    d. Proper technique of tissue penetration;
    e. Sterile methods, including understanding of hazards and complications; and
    f. Post intervention care; and
    g. Documentation of application of technique in an educational environment.

2. The training program shall require training to demonstrate cognitive and psychomotor skills. Also, the training program must be attended in person by the physical therapist.

3. Maintain documentation of successful completion of training.

Ohio

It is the position of the Physical Therapy Section that nothing in the Ohio Physical Therapy Practice Act prohibits a physical therapist from performing dry needling techniques. As with any specialized procedure, the physical therapist must have training and demonstrate competency in the modality. The manner in which the training is obtained and competency demonstrated are not addressed in the Practice Act.

The PT Board recommends you contact the OPTA for approved coursework in dry needling at www.ohiopt.org .

Tennessee

New Rule: 1150-01-.22 Dry Needling

(1) In order to perform dry needling, a physical therapist must obtain all of the educational instruction described in paragraphs (2)(a) and (2)(b) herein. All such educational instruction must be obtained in person and may not be obtained online or through video conferencing.

(2) Mandatory Training – Before performing dry needling, a practitioner must complete educational requirements in each of the following areas:

(a) Fifty (50) hours of instruction, to include instruction in each of the four areas listed herein, which are generally satisfied during the normal course of study in physical therapy school:

1. Musculoskeletal and Neuromuscular systems;
2. Anatomical basis of pain mechanisms, chronic pain, and referred pain;
3. Trigger Points;
4. Universal Precautions; and

(b) Twenty-four (24) hours of dry needling specific instruction.

1. The twenty-four (24) hours must include instruction in each of the following six (6) areas:

(i) Dry needling technique;
(ii) Dry needling indications and contraindications;
(iii) Documentation of dry needling;
(iv) Management of adverse effects;
(v) Practical psychomotor competency; and
(vi) Occupational Safety and Health Administration's Bloodborne Pathogen Protocol.

2. Each instructional course shall specify what anatomical regions are included in the instruction and describe whether the course offers introductory or advanced instruction in dry needling.

3. Each course must be pre-approved by the Board or its consultant. For a course to be preapproved, the provider must provide to the Board administrator the name of the course provider, a synopsis and description of the course, and a copy or description of any course materials used.

(3) A newly-licensed physical therapist shall not practice dry needling for at least one (1) year from the date of initial licensure, unless the practitioner can demonstrate compliance with paragraph (2) through his or her pre-licensure educational coursework.

(4) Any physical therapist who obtained the requisite twenty-four (24) hours of instruction as described in paragraph (2)(b) in another state or country must provide the same documentation to the Board, as described in paragraph (2)(b), that is required of a course provider. The Board or its consultant must approve the practitioner's dry needling coursework before the therapist can practice dry needling in this state.

(5) Dry needling may only be performed by a licensed physical therapist and may not be delegated to a physical therapist assistant or support personnel.

(6) A physical therapist practicing dry needling must supply written documentation, upon request by the Board, that substantiates appropriate training as required by this rule. (7) All physical therapy patients receiving dry needling for the first time shall be provided written documentation from the patient's physical therapist that includes a definition and description of the practice of dry needling, a description of the education and training taken by the physical therapist which qualifies the therapist to practice dry needling, and a description of any potential side effects of dry needling, and the patient must give written informed consent after acknowledging the risks before dry needling may begin.

Virginia

Guidance Document 112-9

Board of Physical Therapy Guidance on Dry Needling in the Practice of Physical Therapy

Upon recommendation from the Task Force on Dry Needling, the board voted that dry needling is within the scope of practice of physical therapy but should only be practiced under the following conditions:

Dry needling is not an entry level skill but an advanced procedure that requires additional training.

A physical therapist using dry needling must complete at least 54 hours of post professional training including providing evidence of meeting expected competencies that include demonstration of cognitive and psychomotor knowledge and skills.

The licensed physical therapist bears the burden of proof of sufficient education and training to ensure competence with the treatment or intervention.

Dry needling is an invasive procedure and requires referral and direction, in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing and specific for dry needling; if the initial referral is received orally, it must be followed up with a written referral.

If dry needling is performed, a separate procedure note for each treatment is required, and notes must indicate how the patient tolerated the technique as well as the outcome after the procedure.

A patient consent form should be utilized and should clearly state that the patient is not receiving acupuncture. The consent form should include the risks and benefits of the technique, and the patient should receive a copy of the consent form. The consent form should contain the following explanation:

Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A
complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.

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until all residency competencies for on-the-field care have been satisfied. Such competencies shall include, but are not limited to:

- Administer acute emergency care
- Make recommendations concerning return to play
- Apply external bandages, dressings, and supports
- Provide health status information and recommendations to coaches, parents, and physicians
- Recommend activity limitations based on environmental conditions
- Recommend modifications to playing environments
- Select, fit and maintain athletic equipment; and

15.3.2.2.3 After the 100 hours have been completed, is indirectly supervised until the results of the next offered SCS examination are obtained; or

15.3.2.3 Supervised hours: The licensee is a licensed physical therapist obtaining experience hours under direct supervision by an approved supervisor at all times when on-the-field care is provided; and

15.3.2.3.1 Maintains CPR and first aid certification at the minimal level of Basic Life Support for Healthcare Providers by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website; and

15.3.2.3.2 Completes SCS certification within a four-year period, with the hours documented, including the confirmation signature of the primary supervisor.

15.3.3 All licensees providing care pursuant to subsection 15.3 shall provide proof of certification or documentation of training to the Board or public on demand.

15.4 Dry Needling

15.4.1 Dry needling is "an intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying muscular tissue, connective tissues and myofascial trigger points for the management of neuromusculoskeletal pain and movement impairments; is based upon Western medical concepts; and requires a physical therapy examination and diagnosis." 24 **Del.C.** §2602(6). Dry needling is within the scope of practice for a Physical Therapist. 24 **Del.C.** §2602(10)(a). It is not in the scope of practice for Athletic Trainers, Physical Therapy Assistants or Physical Therapy Aides.

15.4.2 Requirements for Physical Therapists to perform dry needling:

15.4.2.1 Dry needling may be performed by a licensed Physical Therapist who meets the requirements of subsection 15.4.

15.4.2.2 The Physical Therapist shall have no less than 2 years of active clinical experience in the treatment of patients as a licensed Physical Therapist and shall hold a current license in good standing.

15.4.2.3 The Physical Therapist shall have current CPR certification by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website.

15.4.2.4 Dry needling shall be performed directly by the Physical Therapist and shall not be delegated.

15.4.2.5 Dry needling shall be performed in a manner that is consistent with generally accepted standards of practice, including clean needle techniques and the bloodborne pathogen standards of the Occupational Safety and Health Administration ("OSHA").

15.4.2.6 Dry needling is an advanced procedure that requires specialized training. A Physical Therapist shall not perform dry needling in Delaware unless he or she has and maintains documented proof of completing a Board-approved training program on dry needling.

15.4.2.6.1 The program shall be a minimum of 54 hours, which shall be completed within no more than two years;

15.4.2.6.2 The Physical Therapist shall successfully complete the minimum passing criteria for the dry needling program; and

15.4.2.6.3 The Physical Therapist shall only utilize the specific techniques for which he or she has demonstrated competency.

15.4.3 Physical Therapists who are performing dry needling at the time of enactment of this regulation, and who have completed 25 hours of dry needling education, may continue to practice dry needling, upon

submission of proof of experience and education to the Board. Such Physical Therapists shall complete the required 54 hours of education within two years after enactment of this regulation.

15.4.4 Board approved dry needling training program: A dry needling training program shall include the following to be eligible for Board approval:

15.4.4.1 A dry needling training program shall require each trainee to demonstrate successful psychomotor and cognitive performance through practical and written examination.

15.4.4.2 A dry needling program shall be attended in person by the Physical Therapist, shall not be attended online or through any other means of distance learning and shall not be a self-study program.

15.4.4.3 The program curriculum shall include the following:

15.4.4.3.1 History and current literature review of dry needling and evidence based practice;

15.4.4.3.2 Pertinent anatomy and physiology;

15.4.4.3.3 Choice and operation of supplies and equipment;

15.4.4.3.4 Knowledge of technique including indications/contraindications and precautions for use;

15.4.4.3.5 Proper technique of tissue penetration;

15.4.4.3.6 Knowledge of hazards and complications;

15.4.4.3.7 Safe practice guidelines and generally accepted standards of practice including clean needle techniques and OSHA's bloodborne pathogen standards;

15.4.4.3.8 Post intervention care, including an adverse response or emergency;

15.4.4.3.9 Documentation of successful completion of psychomotor and cognitive performance through practical and written examination; and

15.4.4.3.10 Supervised training.

15.4.4.3.11 The dry needling program, including the required supervised training, shall be taught by a Physical Therapist who meets the qualifications of subsection 15.4.

15.4.5 Scope of Practice

15.4.5.1 A Physical Therapist may not perform dry needling on a patient until completion of at least 25 hours of education in a Board approved dry needling program.

15.4.5.2 A Physical Therapist may not perform dry needling on high risk areas until completion of at least 54 hours of education in a Board approved dry needling program. As used in this regulation, high risk areas are the anterior cervical region, abdominal region, and the region directly over the ribs, unless the pincher technique is performed.

15.4.6 Examination and Informed Consent

15.4.6.1 Examination: A Physical Therapist shall only perform dry needling following an examination and diagnosis for the purpose of treating specific anatomic entities selected according to physical signs.

15.4.6.2 Informed consent: At the first visit, a Physical Therapist performing dry needling shall obtain written informed consent from the patient before the Physical Therapist performs dry needling on the patient. The patient shall receive a copy of the informed consent, and the Physical Therapist shall retain a copy in the patient's record. The informed consent shall include, at a minimum, the following:

15.4.6.2.1 The patient's signature;

15.4.6.2.2 The risks and benefits of dry needling;

15.4.6.2.3 The Physical Therapist's level of education regarding supervised hours of training in dry needling; and

15.4.6.2.4 A clearly and conspicuously written statement that the patient is not receiving acupuncture, including the following language: "Dry needling is a technique used in physical therapy practice to treat myofascial, muscular, and connective tissues for the management of neuromuscular pain and movement dysfunction. Dry needling technique should not be confused with an acupuncture treatment performed by a licensed acupuncturist."

15.4.7 Referral required: A physician referral specific for dry needling is required. If the initial referral is received orally, it must be followed up with a written referral.

15.4.8 Procedure notes: A Physical Therapist who performs dry needling shall maintain documentation in the patient's chart or record for each dry needling session. The note shall include the treatment received, the response to treatment and any adverse response.

15.4.9 Documentation of training: The Physical Therapist bears the burden of proof of sufficient education and training to ensure competence with the treatment or intervention. If requested by the Board or a member of the public, the Physical Therapist practicing dry needling shall provide documentation of completion of the training required by this regulation. Failure to provide written documentation to the Board of meeting the training requirements shall be deemed prima facie evidence that the Physical Therapist is not competent and shall not be permitted to perform dry needling.

18 DE Reg. 469 (12/01/14)

18 DE Reg. 899 (05/01/15)

20 DE Reg. 913 (05/01/17)

16.0 Voluntary Treatment Option for Chemically Dependent or Impaired Professionals

16.1 If the report is received by the chairperson of the regulatory Board, that chairperson shall immediately notify the Director of Professional Regulation or his/her designate of the report. If the Director of Professional Regulation receives the report, he/she shall immediately notify the chairperson of the regulatory Board, or that chairperson's designate or designates.

16.2 The chairperson of the regulatory Board or that chairperson's designate or designates shall, within 7 days of receipt of the report, contact the individual in question and inform him/her in writing of the report, provide the individual written information describing the Voluntary Treatment Option, and give him/her the opportunity to enter the Voluntary Treatment Option.

16.3 In order for the individual to participate in the Voluntary Treatment Option, he/she shall agree to submit to a voluntary drug and alcohol screening and evaluation at a specified laboratory or health care facility. This initial evaluation and screen shall take place within 30 days following notification to the professional by the participating Board chairperson or that chairperson's designate(s).

16.4 A regulated professional with chemical dependency or impairment due to addiction to drugs or alcohol may enter into the Voluntary Treatment Option and continue to practice, subject to any limitations on practice the participating Board chairperson or that chairperson's designate or designates or the Director of the Division of Professional Regulation or his/her designate may, in consultation with the treating professional, deem necessary, only if such action will not endanger the public health, welfare or safety, and the regulated professional enters into an agreement with the Director of Professional Regulation or his/her designate and the chairperson of the participating Board or that chairperson's designate for a treatment plan and progresses satisfactorily in such treatment program and complies with all terms of that agreement. Treatment programs may be operated by professional Committees and Associations or other similar professional groups with the approval of the Director of Professional Regulation and the chairperson of the participating Board.

16.5 Failure to cooperate fully with the participating Board chairperson or that chairperson's designate or designates or the Director of the Division of Professional Regulation or his/her designate in regard to the Voluntary Treatment Option or to comply with their requests for evaluations and screens may disqualify the regulated professional from the provisions of the Voluntary Treatment Option, and the participating Board chairperson or that chairperson's designate or designates shall cause to be activated an immediate investigation and institution of disciplinary proceedings, if appropriate.

16.6 The Voluntary Treatment Option may require a regulated professional to enter into an agreement which includes, but is not limited to, the following provisions:

16.6.1 Entry of the regulated professional into a treatment program approved by the participating Board. Board approval shall not require that the regulated professional be identified to the Board. Treatment and evaluation functions must be performed by separate agencies to assure an unbiased assessment of the regulated professional's progress.

16.6.2 Consent to the treating professional of the approved treatment program to report on the progress of the regulated professional to the chairperson of the participating Board or to that chairperson's designate or designates or to the Director of the Division of Professional Regulation or his/her designate at such intervals as required by the chairperson of the participating Board or that chairperson's designate or designates or the Director of the Division of Professional Regulation or his/her designate, and such person making such report will not be liable when such reports are made in good faith and without malice.

Mississippi

Intramuscular Manual Therapy (Dry Needling) Requirements

Each physical therapist who has achieved certification for using intramuscular manual therapy/dry needling for patient care must meet the following guidelines in order to be approved to practice dry needling in Mississippi:

1. Documented successful completion of an intramuscular manual therapy course of study; online study is not considered appropriate training.
2. A minimum of 50 hours of face-to-face IMS/dry needling course study;
3. Three years of practice as a licensed physical therapist prior to using the intramuscular manual therapy technique.
4. The physical therapist must have Board approved credentials for providing intramuscular manipulation which are on file with the Board office prior to using the treatment technique.

Part 3103 Rule 1.3 (c)(D) 1-2

In its March 21, 2013 quarterly meeting, the Board voted on the documentation required for the approval of dry needling practice in Mississippi. Physical Therapists must provide for following course documentation to support completion of the requirements listed in the regulations in Part 3103, Rule 1.3 (c)D 1-2.

1. Description and overview of the course selected and completed by the physical therapist
2. Brochure or agenda that provides the number of hours of instruction/training
3. Educational course objectives
4. Resume or CV of instructor presenting the course
5. Certificate(s) of course completion

Please Note: The physical therapist must have received a letter of authorization from the Board prior to commencing the practice of dry needling for patient care.

Remember, the physical therapist must be familiar with Part 3101 Rule 1.3 (c) A-K.

Intramuscular Manual Therapy/Dry Needling Regulations

The practice guidelines for intramuscular manual therapy (dry needling) were adopted by the Mississippi State Board of Physical Therapy on September 10, 2012. These regulations are found in Part 3101 Rule 1.3 (c) (A-K):

c. Intramuscular manipulation may be performed by a licensed physical therapist who has met the criteria as described hereunder:

A. Intramuscular manual therapy is a physical intervention that uses a filiform needle no larger than 25 gauge needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Intramuscular manual therapy does not include the stimulation of auricular or distal points or any points based upon areas of Eastern (Oriental) medicine and acupuncture.

B. Intramuscular manual therapy as defined pursuant to this rule is within the scope of practice of physical therapy.

C. A physical therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the physical therapist's scope of practice.

D. To be deemed competent to perform intramuscular manual therapy a physical therapist must meet the following requirements:

1. Documented successful completion of a intramuscular manual therapy course of study; online study is not considered appropriate training.

   a. A minimum of 50 hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training.

   b. Three years of practice as a licensed physical therapist prior to using the intramuscular manual therapy technique.

2. The physical therapist must have Board approved credentials for providing intramuscular manipulation which are on file with the Board office prior to using the treatment technique.

E. The provider of the required educational course does not need to be a physical therapist. A intramuscular manual therapy course of study must meet the educational and clinical prerequisites as defined in this rule, D(1)(a)&(b) and demonstrate a minimum of two years of intramuscular manual therapy practice techniques.

F. A physical therapist performing intramuscular manual therapy in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information:

1. Risks and benefits of intramuscular manual therapy.

2. Physical therapist's level of education and training in intramuscular manual therapy.

3. The physical therapist will not stimulate any distal or auricular points during intramuscular manual therapy.

G. When intramuscular manual therapy is performed, this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure.

H. Intramuscular manual therapy shall not be delegated and must be directly performed by a qualified, licensed physical therapist.

I. Intramuscular manual therapy must be performed in a manner consistent with generally accepted standards of practice, including but not limited to, aseptic techniques and standards of the center for communicable diseases.

J. Failure to provide written documentation of appropriate educational credentials is a violation of this rule, and is prima facie evidence that the physical therapist is not competent and not permitted to perform intramuscular manual therapy.

K. This rule is intended to regulate and clarify the scope of practice for the physical therapist.

Kansas
(Proposed Regulation)

K.A.R. 100-29-18. Dry needling; education and practice requirements. (a) Dry needling shall be performed only by a physical therapist who is competent by education and training to perform dry needling as specified in this regulation. Online study and self-study for dry needling instruction shall not be considered appropriate training.

(b) Each physical therapist who does not obtain dry needling education and training as part of that individual's graduate or postgraduate education shall be required to successfully complete a dry needling course approved by the board in order to perform dry needling. Each dry needling course shall include a practical examination and a written examination.

(c) Each dry needling course shall include the following components:

(1) Anatomical review for safety and effectiveness;

(2) indications and contraindications for dry needling;

(3) evidence-based instruction on the theory of dry needling practice;

(4) sterile needle procedures, which shall include the standards of one of the following:

(A) The U.S. centers for disease control and prevention; or

(B) the U.S. occupational safety and health administration;

(5) blood-borne pathogens;

(6) postintervention care, including an adverse response or emergency; and

(7) an assessment of the physical therapist's dry needling technique and psychomotor skills.

(d) Each dry needling course shall be taught by a licensed healthcare provider who meets the following requirements:

(1) Has a scope of practice that includes dry needling;

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(2) meets the regulatory minimum educational standard in that individual's respective state or jurisdiction;

(3) has not been disciplined by any state or jurisdictional licensing agency for any act that would be a violation of the physical therapy practice act or the healing arts act; and

(4) has performed dry needling for at least two years.

(e) Each physical therapist taking a dry needling course shall be required to obtain a passing score on all written and practical examinations given in the dry needling course. Each physical therapist shall obtain a certificate or other documentation from the provider of the dry needling course specifying what anatomical regions were covered in the dry needling course and that the physical therapist passed all examinations.

(f) Each dry needling course shall provide sufficient instruction to ensure that each student is able to demonstrate minimum adequate competency in the following:

(1) Current dry needling techniques;

(2) management of dry needling equipment and supplies;

(3) accurate point selection;

(4) accurate positioning of the patient and the education of the patient regarding the amount of movement allowed while needles are inserted;

(5) supervision and monitoring of the patient during treatment;

(6) communication with the patient, including informed consent; and

(7) clinically appropriate patient selection, including consideration of the following:

(A) The patient's contraindications for dry needling;

(B) the patient's ability to understand the treatment and the expected outcome; and

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(C) the patient's ability to comply with treatment requirements.

(g) After completion of a board-approved dry needling course, each physical therapist shall be required to complete 200 patient treatment sessions of dry needling before taking each successive course in dry needling. Each physical therapist shall complete all foundation-level courses before proceeding to an advanced-level course.

(h) Dry needling shall be performed solely for conditions that fall under the physical therapy scope of practice pursuant to K.S.A. 65-2901, and amendments thereto. Each physical therapist performing dry needling shall perform dry needling only in the anatomical region of training completed by the physical therapist. Each physical therapist who performs dry needling shall do so in a manner consistent with generally acceptable standards of practice.

(i) A physical therapist shall not delegate dry needling. (Authorized by K.S.A. 2016 Supp. 65-2911 and 65-2923; implementing K.S.A. 2016 Supp. 65-2901; effective P-
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9. Summary of Public Comment on Proposed Regulations – Dry Needling

Board of Physical Therapy

Public Comment on Proposed Regulations

Dry Needling

Comments received by Regular Mail

Commenter	Comment
American Medical Society for Sports Medicine	AMSSM is in favor of proposed regulation; fully-trained PTs should be allowed to perform dry needling. Dry needling is proven to be a safe and effective treatment for neuromusculoskeletal conditions, pain, movement impairments, and disability. Agrees with written referral and informed consent. Concern about lack of specificity for additional training; more clarity is needed as well as requirement for some portion of CE in dry needling.
Council of Colleges of Acupuncture & Oriental Medicine	CCAOM opposes the proposed regulations for the following reasons: 1) dry needling is acupuncture; is an invasive procedure that uses acupuncture needles & is part of the armamentarium of acupuncture; 2) acupuncture uses biomedical terminology so use of such language cannot be basis for defining dry needling as distinct from acupuncture; 3) physical therapists are prohibited from performing surgery and dry needling is an incisive procedure; 4) no national standard in PT for education and training in dry needling, so risk of public harm; 5) Attendance in dry needling courses not restricted to PTs who have a doctoral level degree; 6) PT regulators must specify training; 7) PT regulators must conduct adverse event monitoring through appropriate reporting; 8) PT in states where dry needling is allowed have exceeded the intended scope of practice
American Academy of Medical Acupuncture	AAMA submitted its policy statement on dry needling. It is an invasive procedure using acupuncture needles that has medical risk. It should only be performed by practitioners with extensive training and licensure to perform these procedures, such as licensed medical physicians or licensed acupuncturists.
American Academy of Physical Medicine and Rehabilitation	AAPM&R submitted its 2012 position paper which is basically identical to the policy statement of the AAMA.
Geller Law Group on behalf of the Acupuncture Society of Virginia (ASVA)	ASVA opposes the proposed regulation and the practice of dry needling by physical therapists for the following reasons: 1) It is an invasive procedure outside the scope of practice for PT; presents a public health and safety risk; and is an overstep of the regulatory authority of the Board. The practice of acupuncture is carved out of the practice of medicine and defined in statute. The AMA position is that the practice should be "performed by practitioner with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists." 2) Nothing in the statutory definition of the practice of PT extends the scope to include insertion of acupuncture needles; 3) the Board has overstep its authority by attempting to add the practice of acupuncture to the practice of PT. Included exhibits on AMA statement and claim report update from CNA on physical therapy liability.

Brigitte Fox, L.Ac. AcuWorks	Opposes the proposed regulations. States that: 1) dry needling is the practice of acupuncture; 2) requirements for licensure to perform acupuncture necessary to protect the public; and 3) proposed regulations lack any minimum training requirement. Practitioners should treat patients in accordance with their expertise and scope of practice.

Comments received by Email

Commenter	Comment
Michelle Wright, L.Ac. Naples, NY	Opposes dry needling by physical therapists, who are not legally and safely qualified to perform acupuncture. Dry needling is one style and technique in acupuncture. Standard for a physician to practice acupuncture is 300 hours of post-doctoral training, and PTs do not have same preparation for invasive procedures. No standard for training practitioner in dry needling and no means of assessment of competency for instructors, so the public is at risk. Dry needling by PT is an intentional misrepresentation to the public. Cites recent reports of serious injuries associated with non-acupuncturists practicing dry needling; lack of education and supervised clinical training could be a direct correlation to such injuries.
Joan Choi, L.Ac.	Acupuncture is a unique profession; dry needing by PT will injure acupuncturists. They need to get acupuncture license; need to protect acupuncture profession.
David S. Groopman, M.D.	Opposes dry needling by physical therapists. It is acupuncture, and extensive training & practice necessary to minimize incidence of adverse events. Weekend courses are no substitute for lengthy and comprehensive training. References the position of the American Academy of Medical Acupuncture (noted above)
Jun Xu, M.D. Greenwich, CT	Dangerous to patient safety to expand PT practice. Reviewed training and education for medical and acupuncture profession and licensure. Unsafe and inadequate training puts patients at risk.
Arthur Yin Fan, PhD L.Ac.	Practice of dry needling just a rebranding of acupuncture. Weekend training is inadequate; education should match requirement for licensed acupuncturists.
Dianna Paulsen	Have gone to a licensed acupuncturist for procedures; would not want a PT without extensive training to practice dry needling.

Comments received at the Public Hearing on February 7, 2017

Commenter	Comment
Susan Ole (in favor)	Had trouble breathing, voice, swallowing, and range of motion in shoulders, arms and neck after cervical surgery. Two months of therapy had no success, but dry needling worked "like a miracle". Voice returned, breathing relieved, neck had range of motion because of dry needling. Therapist was well qualified and did much more than muscle relaxers could. Most outstanding difference between dry needling and acupuncture was the way that acupuncture relates to energies, with no mention of muscles. Physical Therapist works with muscles and bones only.

Tom Bohanon (in favor)	Clinician and past president of the Virginia Physical Therapy Association. Physical therapists are highly educated and get trained at the doctoral level. Based on FSBPT study, 86% of clinical training for dry needling occurs at entry level program (clean and sterile techniques, anatomy with cadaver). Dry needling is a different modality than acupuncture. Physical therapists trained on treatment techniques to the neuromuscular and neuromusculoskeletal system, which trigger point dry needling is.
Blaze Williams (in favor)	Faculty at VCU and current vice president of the sports section of the American Physical Therapy Association. Echo comments of Tom Bohanon. As a physical therapy educator, physical therapists educated in anatomy through gross anatomy, physiology, neuroanatomy, neurophysiology, kinesiology, and functional anatomy. More than ample education to receive additional training in dry needling
Erik Wijtmans (in favor)	30 years as licensed physical therapist, on teaching faculty at ODU, clinical instructor certified by APTA. Teaches dry needling courses to dentists, nurses, nurse practitioners, physicians, physician assistants, chiropractors and acupuncturists. Physical therapy education is at least 8900 hours (5400 in undergraduate, 3400 in graduate school). Dry needling not an entry level skill, taught in post graduate curriculum. Needles being used are solid filiform, specifically made for physical therapists to use in dry needling. Safety and accuracy paramount. Informally surveyed acupuncturists in his classes, they say ashi points are not the same as myofascial trigger points, same for chi response being different from needling response. Dry needling is a tool in the physical therapist tool box. Regulations state that therapist shall obtain full consent from patient; including disclosure that patient is not receiving acupuncture.
Dorthea Martin (in favor)	Agree with previous gentlemen regarding education and continuing education. Previous physical therapists did exercises and manipulation, with no effect. Current one does dry needling, which has been life-changing. Aside from needles, completely different than acupuncture (trigger points, experience).
Judith Vaughn (in favor)	After rectal surgery was in tremendous pain, unaided by physician or specialists. Manipulation also ineffective, but dry needling "literally saved my life". Dry needling has also helped her plantar fasciitis in both feet, frozen shoulder and rotator cuff.
Amy Casdor-Gonzales (in favor)	Pursued numerous modalities for physical pain, but nothing helped until myofascial release physical therapy enhanced by dry needling. Physical therapists who practice this are well trained, studied hard, and know what they are doing
Juanita Puffinbarger (in favor)	My recovery would not be possible without dry needling. When dry needling began she understood it was not acupuncture. What is in place is more than adequate. Patient care should be primary purpose, regulations should keep them informed and covered.
Ian Scott (in favor)	Been all around the world and experienced numerous remedies and solutions, including acupuncture. Used dry needling as alternative to surgery and now pain free, with complete function.
Susan Stuart (in favor)	Quality of life was poor, scared of needles, multiple pain management doctors. Directed to dry needles instead of opioids. Physical therapists explained procedures, showed exactly what they were doing and how muscles linked. Feels like physical therapists taught her more about her own body than Richmond's top neurosurgeon. Has gone in with level 10 pain and left after needling to go shopping, "miraculous".

Bruce Allen (in favor)	Chronic pain in right hip, traditional physical therapy offered no relief. Two session of dry needling did more than all previous therapy combined.
Yun Fan (opposed)	Acupuncture and dry needling is the same as a person changing clothes, they look different, but underneath are the same thing. There is no difference
Rebecca Reynolds (opposed)	Nurse practitioner, also acupuncturist and certified in dry needling. Dry needling acupuncture effective modality. Regulation as they stand now are not adequate to become proficient in dry needling (don't discuss pneumothorax, forbidden points in pregnancy).Orthopedic acupuncture is close to dry needling, which covers item B in proposed changes. Proposing that dry needling is not acupuncture (item C) is an alternative fact, a majority of dry needling points are classis acupuncture points or ashi points. Saying dry needling is not acupuncture is like saying kinesiology is not physical therapy. Dry needling is trigger point localized acupuncture.
Arthur Fan (opposed)	MD, PhD, RAC. Dry needling another name/form for acupuncture, according to WHO. Dry needling brought to Us by acupuncture researcher (Dr. Janet Travell) who used another name to attract more students. Indication and needling activity/techniques are the same as acupuncture. Education requirements are too low, allowing many other people to do it as well (nurse, MD, exercise trainer)
Aubrey Fisher (opposed)	Licensed acupuncturist. Commonwealth of Virginia defines acupuncture as "stimulation of certain points on or near the surface of the body by insertion of needles to prevent or modify the perception of pain or to normalize physiological functions..." Board of Physical Therapy defines dry needling as, "filiform needles to penetrate the skin and/or underlying tissues to affect changes in body structure and function for evaluation and management of neuromuscular conditions, pain, movement, impairments, and disabilities. This is a definition of acupuncture. Language used by Physical Therapists is same as what is already in acupuncture statutes. Acupuncture therapy includes treatment strategy of dry needling, including reactive points also known as hyperirritable loci or trigger points, to relieve musculoskeletal and connective tissue disorders. Acupuncture is more than energy flow and meridians, our channel systems are based on fascial, neurological, circulatory and muscular maps as they relate to body's anatomy and physiology,
Stephanie Penum (opposed)	Licensed acupuncturist in VA and AZ. Dry needling and trigger point dry needling is a term practiced by acupuncturists because it is a treatment strategy, not just a treatment modality. The North Carolina case, which was dismissed without prevalence, only occurred because the NC Board of Acupuncture did not exhaust all of their administrative processes; it was not a ruling in favor of dry needling for physical therapists. There is now another lawsuit pending against the North Carolina Board of Physical Therapy, as the Acupuncture Board has exhausted their methods. When the Texas Attorney General said it would most likely rule in favor of the Physical Therapy Board making trigger point dry needling within the scope of practice, which was an opinion not a ruling. These statements are misleading to the public and those reading the proposal. Adverse action reports have been sent out in other states, just not Virginia (Colorado- skier lung was punctured; Maryland- teachers nerve in leg was punctured; Arizona- needles were inserted through patients clothing and needles were disposed in public recycling bin; Georgia-dry needling was performed on a minor without consent from a parent/guardian).

Sarah Steed (opposed)	National Board Certified Acupuncturist. Had patients come to her practice that were injured by dry needling done by a physical therapist, which needed several treatments to recover. Had other patients who were not helped by pain medication, physical therapy, dry needling or chiropractic. There are side effects to dry needling, we just never hear about them.
Bridget Fox (opposed)	Registered Nurse turned acupuncturist. Specialization has occurred throughout human history, including subspecialties within professions. This is to benefit the patient. Physical therapy was borne out of this specialization, as an alternative to surgery. Good physical therapist should not have to do dry needling, rehab should not include needles. This regulation is grasping at another treatment option, "let me stick needles in him". Four years of acupuncture school only covers the tip of the iceberg, any less training is sad and will do more harm than good.
Sarah Hung (opposed)	Licensed acupuncturist. Dry needling is acupuncture, specifically a form of orthopedic acupuncture (taught in schools and has continuing education classes about). No minimum training standards in the regulations is a public safety concern, even though the American Medical Association recommends a minimum level for physical therapists similar to those for acupuncturists. Proposed courses also don't include clinical supervision. Medical doctors need 100 hours of clinical supervision to do acupuncture; it cannot just be a weekend course. I also support what everyone else on the opposed side has said.
Diane Lowry (opposed)	Licensed acupuncturist. The insertion of FDA regulated acupuncture needles into trigger points for providing therapeutic relief falls under the purview of acupuncture, dry needling is not distinct. Dry needling presents a threat to public safety without adequate education, supervised clinical training and independent competency examination. Dry needling is not safe, and injuries range from pneumothorax to nerve damage. This has caused insurance companies to call it an emerging area of risk. Additionally the draft regulation has no minimum training standard, which is against the American Medical Association policy.
Janet Borgess (opposed)	Licensed Acupuncturist. Modality of dry needling is physical intervention that uses filiform acupuncture needles to stimulate points on the body. Where and how to insert the needle is supposedly based only on Western medical concepts, which was the original intent of Janet Travell. Valuable modality; we all want to help our patients. However, dry needling, motor point needling, myofascial needling, trigger point needling, and integrated dry needling are all styles of acupuncture. The only difference is the training and intent of practitioner inserting needle. Licensed acupuncturists practice all of these styles. Regulations as they stand risk intentionally putting public in danger by allowing physical therapists to independently decide if they have advanced procedural skill. Physical therapists have reportedly been doing dry needling since 2003, without a 100% safety record. Current draft may make it more convenient for Board of Physical Therapy to protect itself from public complaint, but it does not protect public safety. Further, to have a patient sign a disclosure that says they are not receiving acupuncture and then treating with acupuncture is confusing and deceptive.
Ian Hurdibaugh (opposed)	Abstained from comment
Pamela Howard (opposed)	Licensed and board certified acupuncturist. In the last 4 years delivered over 10,000 treatments to over 1,000 patients. As a patient had great success with acupuncture to treat lateral epicondylitis. Continuing education classes for orthopedic acupuncture addresses motor points of

	the muscles of the body (class based on Dr. Janet Travell and Matt Calveston- an acupuncturist).
Kelly Sherman (opposed)	Board certified acupuncturist. Respect physical therapists scope of practice and the care they give their patients. Patient centered care to me is integrative care. That means I can refer patients to physical therapists for care and they can refer patients to me, to help in the form of trigger point therapy.
Matthew Stanley (opposed)	Representing Acupuncture Society of Virginia. The Society is opposed to physical therapists practicing procedure called dry needling, as it falls under scope of practice of acupuncture, defined by Virginia Statute pursuant to section 54.12-900. Not been demonstrated how dry needling does not fit under such definition. No statute that provides legal authority for physical therapists or any other health practitioners to expand scope of practice via regulation to include dry needling. We believe Board of Physical Therapy is in violation of state law. Proposed regulation identifies it as an advanced procedure that requires advanced training but does not recommend or require any specific post graduate training hours (can be completed in as little as a weekend with no prior experience in the safe use of needles). Number of serious injuries from dry needling, which cause the American Medical Association to become critical of the lax regulation and nonexistent standards around this invasive procedure (need to meet standards required for acupuncturists and physicians to keep patients safe). Largest company insuring physical therapists called it an emerging area of risk. No provision of these regulations provides protections for patient safety. Acupuncturists in Virginia need at least 1,365 hours of acupuncture specific training, including 775 hours of didactic material specific to acupuncture and 660 hours of supervised clinical training. Even medical doctors with training in use of invasive medical devices need 300 hours of training in acupuncture (more than a weekend). No difference in training requirements for physical therapists without doctorate level degree and entry level physical therapists with less than two years of training. Virginia Department of Planning and Budget Economic Impact Analysis of the regulation state that "54 hours of professional training is required under the existing guidance, while the proposed regulation does not state a specific number of training hours".

Comments posted on the Virginia Regulatory Townhall

Of the 2051 comments posted on the Townhall, there were 1786 unique comments (not duplicated by multiple entries).

There were 610 in support of the proposed regulation. Comments in support included:

- Great clinical utility (important tool in "toolbox")
  - Should be adjunct modality offered with additional continuing education and certification
    - More specific and effective than ultrasound in releasing chronic contracted muscles
    - Mandate reporting of any patient injuries to track whether training is sufficient

    - Recognition of "open access" to a physical therapist's treatment must be maintained
    - Insurance will usually cover dry needling but not acupuncture
- Physical Therapists help people move better- dry needling provides relief of musculoskeletal/ nervous system deficits
- Not the same as acupuncture
    - Inactivate muscular trigger points; useful in pain control, muscle length/stretching, and neuromuscular re-education
        - Can be done without pain medication
        - Targeting only skeletal muscles
        - Helpful with fibromyalgia, myofascial pain,
            - Trigger points and myofascial dysfunction are muscle disorders. The experts in muscle anatomy, physiology, function, and pathology are physical therapists
    - Focus on hyperirritable loci in muscle tissue
        - Dry needling is an extension of manual stimulation of trigger points
        - Differs from acupuncture in clinical reasoning, technique and goal of treatment
        - Only similarity is needle being used
    - Trigger point dry needling focuses on targeting specific muscles that can lead to pain and looks to minimize the presents of active trigger points which have been associated with various types of pain. Acupuncture focuses on meridians and energy flow to restore balance within the body's system.
- Education requirement for certificate (50ish hours)
    - PTs know anatomy, physiology, neuromuscular re-education, soft tissue dysfunction
    - FSMB study shows 86% of KSA required for dry needling is obtained when graduating from accredited program
- Don't let doctors dictate PT practices
    - Physician referral only adds to bureaucratic issues/red tape

There were 1176 comments opposed to the proposed regulations. Comments in opposition included:

- Educational requirements not strict enough
    - Not as strict educational requirements (20-30 hours vs MD education and 300 hours in acupuncture)
        - Outside scope of practice for physical therapist
            - Could damage internal organs (lungs, liver) along with nerves that PTs don't have training in
            - Invasive procedure

            - Need certification of clean needle techniques
            - Mixture of Eastern and Western Medicine (PTs have no eastern training)
                - Regulations have no minimum for training
            - Follow California's example
    - No independent, agency-accredited training programs for "dry needling," no standardized curriculum, no means of assessing the competence of instructors in the field, and no independently administered competency examinations
    - Give acupuncturist PT designation if dry needling is to fall under that scope of practice
- Comparison to acupuncture
    - Existence of trigger points as primary sources of pain has never been confirmed
        - Does not work beyond contextual effects (neurophysical phenomenon)
        - No animal model to study trigger points, can't confirm existence as local pathophysiology
    - Simplified acupuncture- same techniques, tools, indications, same points (just different names)
        - Trigger points are acupoints or ASHI points
    - WHO, AMA and AAPMR has clear definition that dry needling is acupuncture (non physicians should have 1500 hours training)
        - Constitutes acupuncture under VA and FDA law currently
        - medicalacupuncture.org/Portals/2/PDFs/AAMADryNeedlingPolicyOct15.pdf
        - https://www.aapmr.org/practice/resources/positionpapers/AAPMR%20Documents/AAPMR-Position-on-Dry-Needling.pdf
- Public safety risk having PT's do it (public confusion, lower quality of treatment)
    - Minimizes therapeutic value of acupuncture
- PTs trying to capture market share
- American Society of Acupuncturist position
    - Dry needling pseudonym for acupuncture that has been adopted by health providers who lack legal ability to practice acupuncture within scope of practice
    - American Academy of Medical Acupuncture set industry standard of 300 hours of postdoctoral training with examination at end by independent testing board