REIMAGINING PHYSICAL THERAPY'S ROLE IN OCCUPATIONAL HEALTH: A CASE FOR PHYSICAL THERAPISTS AS GATEKEEPERS OF MUSCULOSKELETAL DISORDERS

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ABSTRACT

Background and Purpose: Work-related musculoskeletal disorders (WRMSDs) are common and often resolve without invasive care, yet medical-first pathways can delay function-focused treatment. This commentary examines physical therapists as first-contact providers for WRMSDs within evolving primary care models. **Clinical Question**: Can physical therapists function effectively as autonomous first-contact gatekeepers for WRMSDs to improve outcomes and efficiency? **Findings**: In occupational health, a growing body of evidence supports that early access to physical therapy shortens case duration, reduces visits, and limits unnecessary imaging and use of opioids. Although direct access within workers' compensation systems has been less studied, evidence for musculoskeletal disorder management in emergency departments, military health systems, and civilian practice consistently shows that minimizing delays to physical therapy initiation improves outcomes. Building on this foundation, recent legislative advances in Arizona (expanded imaging privileges), Utah (primary health care designation), and Montana (treating physician status under workers' compensation) create an unprecedented opportunity to realize these benefits in the workers' compensation setting. **Clinical Relevance**: Physical therapists have the competencies, historical role, and increasingly the legal authority to triage and manage uncomplicated WRMSDs, provided clear referral pathways exist for medical escalation. **Conclusion**: Physical therapist-led triage models in occupational health are feasible, evidence-informed, and ready for targeted pilot implementation.

INTRODUCTION

Musculoskeletal injuries remain a leading source of occupational disability and expense, accounting for approximately 30% of nonfatal occupational injuries in the United States.[1] Current clinical pathways typically start with physician evaluations and radiographic imaging, often delaying necessary physical therapy intervention.[2] Gottlieb and Bernard[3] recently reported that the most common intervention in the emergency department (ED) was opioids (40.7%), followed by acetaminophen (37.8%), non-steroidal anti-inflammatories (22.6%), muscle relaxants (18.4%), benzodiazepines (12.8%), and corticosteroids (5.5%). Gottlieb and Bernard recommended that the initiation of physical therapy in the ED may improve care for patients. This medical-first approach may contribute to unnecessary health care spending, extended case duration, and delayed functional recovery.[4]

Physical therapists have long played crucial roles in occupational health through functional assessment and return-to-work planning. However, historical regulatory barriers, including imaging privileges and direct access limitations, restricted their role as first-contact providers.[2] However, recent legislative changes and policy shifts are rapidly dismantling these barriers, positioning physical therapists to play a more significant primary care role in musculoskeletal management.[5]

CLINICAL QUESTION

Can physical therapists effectively assume the role of first-contact gatekeepers for work-related musculoskeletal disorders (WRMSDs), thereby optimizing health care outcomes and resource utilization?

FINDINGS

Comparative studies indicate that direct access and early physical therapy not only reduce case duration but also lead to lower health care costs, higher patient satisfaction, and quicker return-to-function outcomes when compared to delayed physical therapy pathways.[4,6,7] These findings reinforce physical therapists' suitability as first-contact providers for musculoskeletal injuries. Our recent analysis of 83,846 acute WRMSD cases across seven distinct body regions found that initiating physical therapy within 0 to 2 days post-injury was associated with median case durations of 14 days compared with 17, 21, and 28 days when initiation occurred at 3 to 7, 8 to 12, and ≥13 days, respectively. Physical therapy utilization was also lower, with a median of 4 visits when initiated within 7 days compared with 5 visits when initiated after 7 days. These effects were consistent across all body regions analyzed, underscoring the broad applicability of very early physical therapy access in occupational health pathways.[6] These findings align with previous research emphasizing the value of early intervention.[7,8]

Clinical commentaries have highlighted that early physical therapy management in the workplace improved clinical outcomes and reduced downstream health care utilization,

including imaging and opioid prescriptions.[2,9] Internationally, similar trends emerge; a recent Australian workers' compensation cohort showed that early physical therapy initiation (within 7 days) reduced disability duration significantly compared to delayed initiation beyond 30 days.[10]

Systematic reviews validate these findings, consistently indicating that early physical therapy initiation reduces chronic pain risk, unnecessary imaging, and associated health care costs.[4,11,12] A critical consideration is the psychosocial component of WRMSDs, where early physical therapy interventions can significantly mitigate fear-avoidance behaviors and promote quicker functional recovery through patient education and structured activity progression.[13]

However, the benefits of early physical therapy are often constrained by structural barriers specific to workers' compensation, including state statutes that prohibit direct access to physical therapy for work-related injuries.[5,14] These restrictions delay initiation of care, reducing the likelihood of achieving the optimal outcomes associated with timely physical therapy access. Recent legislative developments have substantially enhanced physical therapy practice capabilities. Arizona House Bill 2583 explicitly authorizes physical therapists to order diagnostic imaging, substantially increasing their diagnostic autonomy.[15] Similarly, Utah Senate Bill 196 allows physical therapists immediate care initiation under specified workers' compensation statutes.[16] These legislative advancements align directly with the American Physical Therapy Association's (APTA) primary care initiative, promoting physical therapists as competent first-contact providers in musculoskeletal care as well as the recently passed House of Delegates motion approving Primary Care as a certification and specialization (July 2025).[17]

The military health care system has long demonstrated the successful integration of physical therapists as primary evaluators with imaging privileges.[18] Recent studies confirm that physical therapists in military settings accurately order diagnostic imaging, with appropriateness ratings aligning closely with the American College of Radiology guidelines.[19,20] Civilian studies also indicate consistent adherence to imaging guidelines among physical therapists, suggesting better clinical efficiency and reduced unnecessary health care expenditures.[21]

The Department of Defense and Veterans Affairs have effectively implemented direct access physical therapy pathways, demonstrating reduced reliance on imaging, decreased prescription drug use, and improved clinical efficiency.[18,21]

While evidence robustly supports physical therapists as safe and effective direct access providers in both commercial and military health care systems,[4,21-23] research specifically examining physical therapists as first-contact providers within occupational health systems is limited. Although studies consistently show that very early intervention (within days of injury) improves WRMSD outcomes,[6,10] there is a research gap in investigations that have directly evaluated the implementation of physical therapist-led pathways as the first point of contact in workers' compensation environments.

DISCUSSION

The evolving evidence and legislative landscapes strongly support expanding physical therapists' roles in occupational health. Equipped with robust diagnostic skills and growing legal authority, physical therapists are well positioned to serve as first-contact gatekeepers, potentially transforming WRMSD management. However, this research gap underscores the need for pilot programs and policy initiatives to evaluate physical therapists' performance as gatekeepers in occupational health—particularly in jurisdictions where current legislation supports such models.[14-16] Therefore, the most pressing question is no longer whether physical therapists can fulfill this role, but how we, as a profession, can remove the institutional and policy barriers that prevent physical therapists from practicing at the top of their license in this context.

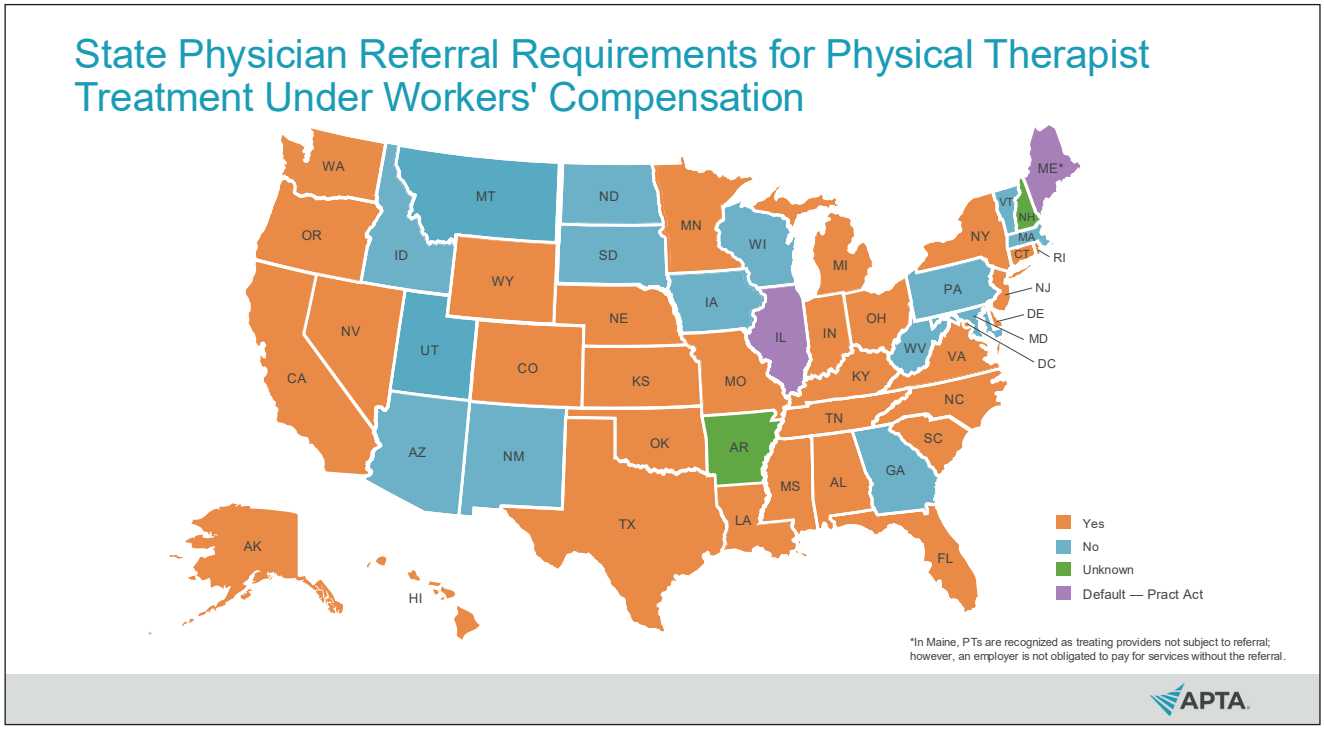
While clinical practice change is essential, systemic factors such as employer communication, availability of job demand information, transitional work policies, and payment conventions play an equally critical role in determining the success of early physical therapy access.[24] As of 2023, 30 US states still require a physician referral before initiating physical therapy treatment under workers' compensation. Only 17 states explicitly allow physical therapy without a referral, while 4 states (AR, IL, ME, NH) either operate under ambiguous statutes or default to the state practice act (**Figure**).[5,14] Recent progress in Montana offers a notable exception: legislation revised the definition of "treating physician" under the state's workers' compensation law to explicitly include physical therapists, improving payment pathways and enabling direct access to physical therapy services.[25] Despite such advances, many states still face employer unawareness and fragmented referral systems that inhibit timely, functionally focused intervention.[26]

Overcoming these barriers will require strategic, multi-level action. First, engagement with payers is essential to revise reimbursement and prior authorization policies that unnecessarily gatekeep physical therapy services. Second, educating employers about physical therapists' full capabilities can improve early access and reduce case duration. Legislative advocacy must also continue at the state level to align workers' compensation statutes with existing direct access and imaging laws. Additionally, pilot programs and demonstration projects should collect outcome data—such as disability duration, total cost of care, and downstream health care utilization to build the case for broader adoption of physical therapist-led triage models specific to occupational health.

Clear referral mechanisms and integrated care systems are essential to successful implementation. Peterson and Heick[27] emphasize that well-structured referral processes not only improve patient outcomes but also reduce unnecessary health care utilization. These are critical elements in validating physical therapist-led models. Strategic pilot programs embedded within existing occupational health frameworks, featuring timely specialist referrals and collaborative care pathways, are urgently needed to advance the feasibility and scalability of physical therapist-first occupational health models.

In addition to clinical expertise, physical therapists working in occupational health must understand relevant Occupational Safety and Health Administration (OSHA) regulations, particularly the definitions and applications of first aid and recordability. These distinctions directly affect how workplace injuries are documented and reported, influencing both compliance and employer decision-making. A clear understanding of OSHA criteria ensures that physical therapists

Figure. Sate Physician Referral Requirements for Physical Therapist Treatment Under Workers' Compensation Map*



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can accurately classify interventions, prevent unnecessary recordable cases, and support injury management strategies that align with federal requirements. Integrating this regulatory knowledge into practice strengthens the physical therapist's role as a trusted advisor in workplace health and safety.[28]

CONCLUSION

Expanding the role of physical therapists into primary providers for WRMSDs is supported by clinical evidence, historical roles in occupational health, and contemporary legislative advancements. Implementing physical therapist-led models through structured pilots, with clear referral mechanisms, could significantly enhance care outcomes, reduce health care expenditures, and streamline occupational health care delivery.

CLINICAL APPLICATIONS

- Employers and payers should consider physical therapist-led triage pilot programs for WRMSDs.
- Occupational health physical therapists should pursue additional training in diagnostic imaging and referral decision-making.
- Legislation supporting physical therapist imaging privileges and direct access should be consistently promoted and expanded.
- Structured referral pathways and collaborative care models must be clearly established for optimal outcomes.

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