ASSEMBLY THIRD READING
AB 2497 (Johnson)
As Amended May 22, 2026
Majority vote

SUMMARY

Makes various changes to the practice of physical therapy under the Physical Therapy Practice Act, including: authorizing physical therapists (PTs) to diagnose conditions of the movement system, removing the 45-day, two-visit limitation on directly accessing PT services, increasing the number of physical therapist assistants (PTAs) a PT can supervise from two to three, repealing the requirement for electromyographical certification, and expanding, revising, and recasting definitions under the act.

Major Provisions

1) Define "movement system" to mean the collection of all bodily systems that interact to move the body or its parts.

2) Redefine "physical therapist" and "physiotherapist" to mean a health care professional who is licensed to practice physical therapy on a person and is part of the primary care team who works in a variety of settings to help improve function of the movement system.

3) Redefine "physical therapy" and "physiotherapy" to mean services specified under the Physical Therapy Practice Act that are provided as follows:

   a) By or under the direction and supervision of a PT.

   b) To facilitate motion, force, energy, and motor control through the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, movement, and active, passive, and resistive exercise to maximize health, well-being, function, and community participation across the diversity of age, sex, gender, culture, environment, and psychosocial and socioeconomic status.

   c) For prevention, habilitation, rehabilitation, promotion of health and well-being of bodily and mental conditions, disease or movement-based impairments, activity limitations, and participation restrictions.

4) Expand the practice of physical therapy to include the following services:

   a) Examination and evaluation of the movement system and the system's relation to health-related and disabling conditions, including a review of systems and medication regimen to identify developmental, mechanical, physiological, and biopsychosocial impairments of the movement system, participation restrictions, or other conditions to determine diagnosis of conditions of the movement system, prognosis, and intervention, and assess outcomes.

   b) The design, implementation, and modification of interventions to alleviate impairments, functional limitations, and participation restrictions related to the movement system or other health-related conditions.

c) Furnishing, ordering, fabrication, and application of assistive, adaptive, orthotic, prosthetic, protective, and supportive devices and equipment consistent with the Pharmacy Law.

5) Specify that physical therapy *techniques and procedures* include, but are not limited to: therapeutic exercise; gait training; functional training; self-care; in-home, community, or work integration or reintegration; manual therapy, including soft tissue mobilization *joint* mobilization or *manipulation;* therapeutic massage; lymphatic drainage; neuromuscular reeducation; blood flow restriction; pulmonary management and airway clearance; integumentary protection and active repair; biophysical agents or modalities, including electrical, sound, light, mechanical, electromagnetic, or thermal; movement system counseling and education; nutritional education and counseling; pain and stress management; prevention or reduction of risk of injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and wellness; administration, consultation, education, and research; referring for other indicated services and tests for consultation with other providers, decision making, and patient management.

6) Delete the 45-day or 12-visit restriction on directly accessing a PT without physician or podiatrist approval of the treatment plan and the associated disclosures, limitations, and interpretation and construction provisions.

7) Specify that nothing in the Physical Therapy Practice Act may be construed to require a referral or prior authorization for a patient to directly access PT services.

8) Require a PT to refer a patient to a physician and surgeon or other appropriately licensed health care provider when the situation or condition of the patient is beyond the scope of the education and training of the PT.

9) Replace the existing authority to perform tissue penetration for electromyographical testing with the authority, when authorized by a physician and certified by the Physical Therapy Board of California (PTBC), with the general authority to use electrode needles to perform tissue penetration for the purpose of evaluating and interpreting performance of the neuromusculoskeletal system.

10) Delete provisions relating to the electromyographical testing certification program, including application, renewal, and fee provisions.

11) Make various technical, conforming, or nonsubstantive changes.

COMMENTS

Background. PTs are licensed health care providers who specialize in the movement system of the human body. Within the PT profession, the movement system is described as the combination of cardiovascular, pulmonary, endocrine, integumentary, nervous, and musculoskeletal systems interacting to move the body.

PTs evaluate and assess patient pain, mobility, function, and other aspects of the movement system to develop a treatment plan and recommend or apply interventions, such as therapeutic exercise or other specifically dosed movements. PTs also utilize adjunctive modalities, such as heat, electrical stimulation, or ultrasound to facilitate healing.

PTs work in a wide range of settings, from organized health systems to private clinics. Physical therapy is commonly prescribed for rehabilitation after surgery, recovery from trauma, management of chronic conditions that affect the movement system.

PT Scope of Practice. The PT license authorizes the practice of physical therapy, which is defined as:

> the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services.[1]

The practice of physical therapy is further defined to include "the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions."[2] According to the sponsor, this bill is intended to "modernize" this scope to reflect advancements in the profession and in other states.

Physical Therapy Practice Act "Modernization." The last major legislative overhaul of the Physical Therapy Practice Act was in 2013, which updated terminology, reorganized the structure of the act, and made general code clean-up. The last significant expansion of the scope of practice of physical therapy was "direct access" in 2013. Direct access is the term used to describe the authority for a PT to see patients for a limited amount of time without the patient having to first obtain a physician or podiatry diagnosis or referral—the patient could directly access the PT. While minor updates have been made to that authority, such as the availability of telehealth visits for ongoing treatment approvals, there have been no changes to the services PTs can provide. Arguably the last actual scope change was the addition of physical fitness and related health and wellness interventions in 2004.

Authority to Diagnose. The Physical Therapy Practice Act expressly prohibits a PT from "diagnosing disease."[3] A 1982 Attorney General opinion opined that PTs could not treat a condition if there was no diagnosis to confirm what was being treated.[4] As a result, before the current 45-day/12-visit restriction on direct access was established in 2013, patients were required to obtain a medical diagnosis from a physician before seeing a PT.

However, even with direct access, the prohibition against diagnosis means the PT scope is limited to physical therapy evaluation of disfunction up to the point of a medical diagnosis. In other states such as Colorado, Arizona, Utah, Maryland, Massachusetts, North Dakota, and Oregon, the PT can, within the physical therapy scope of practice, make a diagnosis for the patient to use within the medical system.

This bill would authorize PTs to diagnose conditions of the movement system, but not disease, which addresses the diagnosis limitation identified by the AG.

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[1] BPC § 2620.
[2] *Id*.
[3] BPC § 2620.
[4] 65 Ops.Cal.Atty.Gen. 21 (1982).

According to the Author

The Physical Therapy Practice Act dates back to the 1950s. Very few alterations have been made to it, despite progression in the profession, in moving from a requirement of a Bachelor's Degree to a Master's Degree to today's standard, which calls for all to come from an education and training program ending in a Doctorate in Physical Therapy (DPT). [This bill] moves the profession forward in California in a way that benefits patients in the state, is representative of the education and training they receive to practice, and brings California more in line with what Physical Therapists are able to provide in patient care in other states.

Arguments in Support

The *California Physical Therapy Association* (sponsor) writes in support:

> [This bill] clarifies and modernizes the scope of physical therapy practice, explicitly recognizing physical therapists as movement system experts who evaluate, diagnose movement impairments, and design interventions accordingly. In complex neurological cases, physical therapists are often the providers most consistently monitoring functional changes. Enabling us to fully practice at the top of our license improves care coordination, reduces duplication of services, and allows physicians to focus on medical management while therapists manage rehabilitation.
>
> *Improving timely access to care*
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> Patients with neurological injuries and other disabling conditions are especially sensitive to delays in care. Research consistently shows that early rehabilitation improves functional outcomes, reduces long-term disability, and lowers overall healthcare costs. Patients often require timely, coordinated, and highly specialized care to optimize recovery, prevent complications, and maintain independence. [This bill] represents a critical step toward improving access, efficiency, and quality of care for these vulnerable populations and for all Californians seeking physical therapy services.
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> [This bill] strengthens direct access by removing outdated administrative barriers, allowing patients to receive physical therapy services more efficiently without unnecessary delays. For patients recovering from stroke or spinal cord injury, even small delays can mean the difference between regaining independence and requiring lifelong assistance.
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> *Use of modern diagnostic tools to improve outcomes*
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> The bill authorizes physical therapists to perform and interpret musculoskeletal ultrasound imaging and to refer patients for imaging when appropriate. For patients with neurological and musculoskeletal complications (such as spasticity, tendon injuries, or joint instability), timely imaging can significantly improve diagnostic accuracy and treatment planning. This reduces unnecessary delays, lowers costs associated with redundant referrals, and accelerates recovery. It is also a skill taught in all physical therapy programs today and allowed in practice in 22 states. While not prohibited in California, this will clarify that physical therapists can order medically necessary imaging that will help in the evaluation and treatment process of each patient.

Supporting the rehabilitation workforce and patient access

[This bill] modestly increases the number of physical therapist assistants a therapist may supervise, improving clinic efficiency and expanding access to care. Given the growing demand for rehabilitation services, driven by an aging population and increased survival from serious injuries, this change helps ensure more patients receive needed care without compromising quality or safety.

Comprehensive, patient-centered care

The bill reinforces that physical therapy includes prevention, rehabilitation, and health promotion across the lifespan, addressing impairments, activity limitations, and participation restrictions. For patients with stroke, traumatic brain injury, or spinal cord injury, recovery is not just about physical function. It is about returning to family, work, and community. [This bill] supports this broader, patient-centered model of care.

Recognition of current skills

Our practice act originated in the 1950s and has had relative few updates since. The changes in [this bill] update the act to recognize important treatment techniques recognized by many, if not most, other states. An example of this is the specific technique of "dry needling." This technique is recognized for use by physical therapists in 47 states, with only California, Hawaii, and New York physical therapists prohibited from using it. Additionally, as the attached letter from the largest malpractice insurer of physical therapists states, it has resulted in ZERO increase to liability of physical therapists, including NO premium increases related to use of this skill for the profession.

Arguments in Opposition

A coalition of acupuncture groups, including the *California Acupuncture Coalition,* the *American Association of Chinese Medicine and Acupuncture,* and numerous others write in opposition:

We are specifically opposed to the language that adds Section 2620.5 to the Business and Professions Code allowing physical therapists to practice acupuncture without any additional training.

Physical therapists typically refer to the practice of acupuncture as dry needling, which is not a new or separate therapy. While acupuncture is a traditional Eastern Asian medicinal technique, studies have found that the practices are essentially the same. In 1983, a study by Dr. Janet Travell showed that 92% of dry needling trigger points overlap with acupuncture points. A 2009 study concluded that a 91% correlation between trigger point pain referral patterns and acupuncture meridians demonstrates that they are the same physiological phenomenon. To pretend otherwise is misleading to patients and dangerous to public health.

Acupuncturists in California are required to have a three to four-year master's degree, a total of 3,000 hours with 950 hours of clinical training in order to practice in the State. The proposed addition to the Business and Professions Code would

bypass these safeguards entirely. The bill, as currently written, adds no additional education requirements for physical therapists in order to practice acupuncture.

California has deliberately established rigorous standards for acupuncture to protect patient safety. Licensed acupuncturists complete thousands of hours of didactic and clinical education in anatomy, sterile technique, point location, differential diagnosis, and complication management. The proposed bill would permit physical therapists to perform the same invasive procedure with dramatically less specialized training, effectively bypassing the safeguards the Legislature has put in place.

A coalition of physician groups that includes the *California Academy of Family Physicians*, the *California Medical Association*, the *California Neurology Society*, the *California Orthopedic Association*, the *California Radiological Society*, the *California Society of Anesthesiologists*, the *California Society of Dermatology & Dermatologic Surgery*, and the *Psychiatric Physicians Alliance of California* writes in opposition to the March 19, 2026, version of this bill, which still contained the prescription provisions discussed in the letter but have since been removed:

While we deeply value the contributions of all members of the health care team, we are concerned that this bill moves beyond appropriate team-based care and risks compromising patient safety and quality of care.

This bill would extensively expand the scope of practice for PTs, without any additional education or residency level training. This bill would allow PTs to be considered a primary care provider and removes any requirement for a referral from a physician or any other health care provider for PT services. Additionally, this bill would give PTs expansive prescriptive authority for oral and topical medications, excluding opioids. PTs would also be authorized to provide extensive imaging services including ordering x-rays and performing ultrasounds without any physician involvement. Lastly, this bill would allow PTs to perform dry needling without the required training or certification, creating a major patient safety issue.

Due to the issues listed above this bill will lead to fragmentation of patient care, over ordering of medical tests and services, an increase in emergency room visits, and most importantly undermining the physician-led care model. All of these issues will disproportionately impact our most vulnerable communities.

Physicians undergo extensive education and training, including four years of medical school and a minimum of three to seven years of residency training, amounting to over 10,000 hours of supervised clinical experience. This preparation is essential to developing the diagnostic acumen and clinical judgment required to manage complex and undifferentiated patient conditions. Expanding independent scope of practice to PTs with significantly fewer clinical training hours creates a two-tiered system of care and increases the risk of misdiagnosis, delayed treatment, and inappropriate management.

Health care delivery is increasingly complex. Patients often present with multiple comorbidities, atypical symptoms, and evolving conditions that require comprehensive medical oversight. The collaborative, physician-led team model ensures that patients benefit from the full expertise of each provider while

> maintaining a clear standard of accountability. [This bill] undermines this model by promoting unsupervised practice rather than strengthening coordinated care.
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> Additionally, there is insufficient evidence that scope expansions meaningfully improve access to care in underserved areas. Workforce shortages are driven by geographic, economic, and infrastructure challenges—not solely by provider type. Policies that invest in physician workforce development, incentivize practice in underserved communities, and expand team-based care models are more effective and safer solutions.

Patient safety must remain the Legislature's highest priority. Scope of practice decisions should be guided by education, training, and evidence—not by workforce substitution.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) The PT Board estimates the need for a permanent analyst to conduct investigations, an additional two-year limited-term analyst to promulgate regulatory packages, and consulting with the Office of Professional Examination Services (OPES) in 2026-27 and other expert consultants in 2027-28 and ongoing, for total costs of $211,000 in 2026-27, $369,000 in 2027-28, and $193,000 in 2028-29 and ongoing (Physical Therapy Fund).

2) Additional, absorbable costs of $5,000 to the Office of Information Services to retire specialty modifiers and specialty transactions from the information systems.

VOTES

ASM BUSINESS AND PROFESSIONS: 10-8-1
YES: Berman, Johnson, Addis, Alanis, Chen, Elhawary, Hadwick, Hart, Lowenthal, Macedo
NO: Ahrens, Bains, Bauer-Kahan, Caloza, Haney, Irwin, Jackson, Nguyen
ABS, ABST OR NV: Pellerin

ASM APPROPRIATIONS: 10-2-3
YES: Wicks, Hoover, Aguiar-Curry, Calderon, Dixon, Mark González, Krell, Pacheco, Solache, Tangipa
NO: Caloza, Fong
ABS, ABST OR NV: Pellerin, Sharp-Collins, Ta

UPDATED

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