



Dry Needling Competencies Require a Minimum of Specialized Skills

This article is based on a presentation by Leslie Adrian, PT, DPT, FSBPT Director of Professional Standards, at the 2015 FSBPT Annual Meeting.

For several years, jurisdictions have sought information from FSBPT regarding the ability of physical therapists 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. The primary objective was to first identify knowledge, skills, and abilities (KSAs) that are specifically needed for competency in dry needling. The second objective was to identify where PTs acquire these KSAs: entry-level PT education or specialized training.

FSBPT first looked at who should do dry needling and decided on professionals whose education provides the basic knowledge and skills needed to acquire dry needling proficiency. Those could include PTs, acupuncturists, and chiropractors, among others.

Right now a tug of war exists among providers about who is best qualified to provide dry needling, with the patient in the middle. Limiting scope of practice and the ability of patients to access dry needling to one profession limits patient access and hurts the patient.

A hot topic for jurisdictions is whether or not dry needling competencies should be defined and what a PT needs to know to safely and effectively perform dry needling on a patient. It is the responsibility of regulators, however, to define competence based on the best available evidence. Unfortunately, the best available evidence has been lacking.

It was important to maintain transparency when developing a competency standard so detractors aren't able to accuse the Federation of coming up with false standards or to advance their scope of practice without good reasons. To that end, FSBPT went through an RFP process and interviewed several outside firms to conduct the study. HumRRO won the bid based on having the best grasp of what FSBPT was trying to accomplish. HumRRO was tasked with identifying the KSAs needed by PTs to perform dry needling safely and effectively. FSBPT wanted to know if the KSAs were acquired during entry-level PT training or if specialized training was necessary. HumRRO are not subject matter experts, however, so a seven-member task force of

experienced and licensed PTs who currently use dry needling in their practices also was convened. Task force member PT experience ranged from 14 to 31 years and all have multi-year experience with dry needling. They were recruited also on geographical, training background, entry-level degrees, and gender factors. All also have regulatory or legislative experience.

Prior to the task force convening, HumRRO performed an extensive background review and literature search on the techniques, indications, contraindications, and safety issues on dry needling. To go beyond the expertise of the task force, a practitioner survey was sent out to licensed PTs who actively use dry needling in their practices. More than 350 responded. HumRRO also analyzed the National Physical Therapist Exam (NPTE) to identify entry-level KSAs relevant to dry needling. There also was a need to define dry needling and the standard for competence.

The definition created for dry needling is very similar to definitions used in Arizona and Tennessee, which APTA likes. The definition of competence was easy: safe and effective care.

The task force then reviewed and refined dry needling tasks and identified the knowledge, skills, and abilities required through entry-level and specialized training. FSBPT does a practice analysis for the NPTE, so the same was done for dry needling. Dry needling became its own practice analysis.

The definition devised by FSBPT is designed to be both vague and clear. It reads:

“Dry needling: 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.”

The term “filiform needles” was used to differentiate from injection and other types of needles. And, yes, they are the same needles used in acupuncture and have been used for a long time. Lengths of needles was intentionally left out because it depends on the procedure and size of the patient. PTs are trained in anatomy so the size the needle depends on the patient and the treatment, something the HumRRO study made clear. It was a three- to four-hour process just to decide on the definition. Participants wanted it to be as vague as possible while being as clear as possible.

The standard for competence, as previously noted, is simply that the treatment be safe and effective. A definition for effective standards, while elastic, nonetheless includes appropriate uses and documenting sequencing in the treatment plan.

The process determined that 86% of the skills and knowledge PTs need to safely and efficiently perform dry needling are acquired during basic PT education. Only 14% of the required skills and knowledge come from specialized training.

Skills requiring specialized training include psychomotor skills needed to handle the needles and advanced skills in specialized palpation. All other skills were picked up in entry-level PT training.

Dry needling also requires constant assessment and reassessment, so PTs must be competent in

assessment, diagnosis, clinical reasoning, and decision making.

In the future, of course, entry-level PT education could evolve to include some or all of the 16 knowledge items necessary for safe and effective dry needling, in addition to the two skill sets.

In response to questions, it was noted that while dry needling is not an entry-level skill and requires additional training, the Federation does not want to be overly prescriptive and make lists of who can and can't do the job. It's a slippery slope of being too defined because not all PTs do everything they are trained to do. Some may not do pediatric PT, for example, although they are trained to do so. Should that also be a delineated competency?

Another question centered on a case in Georgia. Georgia requires 50 hours of advanced training for dry needling. A relatively new PT with advanced training performed dry needling on a 15-year-old without mom's knowledge and then had her do corner stretches. The patient had a visceral reaction to the dry needling and collapsed. The incident necessitated a case and sanction against the provider.

In response, it was noted that disciplinary cases are going to come up in PT, and not only with dry needling. Things go wrong. That is seen in everything PTs do.

An insurance carrier noted that incidences related to dry needling are very low compared to other practices, including the use of hot and cold compacts. Two issues are percolating among opponents of PTs performing dry needling, one being PTAs performing dry needling. However, that should not be an issue because dry needling would not fall under a treatment that could be delegated to PTAs, regardless of classes available for PTAs on dry needling techniques. The other issue is athletic trainers being allowed to perform dry needling - our thought is to let the athletic trainers make their own case.

Another question centered on the number of specialized training hours required to perform dry needling. Training needs to be focused less on hours of specialized training and more on the specific skills PTs must be trained for.

Attendees were urged to read the full report on the study available on the [Regulatory Resources](#) section of the FSBPT website.



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