September 12, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: [CMS–1832–P]; RIN 0938–AV50 Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

To Whom It May Concern:

On behalf of the Private Practice Section of the American Physical Therapy Association (APTA Private Practice), we appreciate the opportunity to submit comments in response to the above-referenced proposed regulation (the Proposed Rule). APTA Private Practice represents nearly 4,000 members engaged in physical therapy private practices across the country. These practices are deeply committed to improving patient outcomes, advancing innovation in musculoskeletal care, and ensuring the sustainability of high-value, community-based physical therapy.

We commend CMS for its commitment to transparency and to aligning payment systems with value-based care. However, we are deeply concerned about the proposed Relative Value Unit (RVU) adjustments for physical therapy services. If left uncorrected, these adjustments will threaten the financial viability of private practices, restrict patient access, and undermine Medicare's broader goals of prevention, cost efficiency, and health promotion. Our comment focuses on nine major areas:

I. Making America Healthy Again
II. Conversion Factor (CF) Update and the State of the Physical Therapy Profession
III. Relative Value Unit (RVU) Adjustments
IV. Eliminate Application of the Multiple Procedure Payment Reduction Policy
V. Documentation and Audits
VI. Replace Medicare's 8-Minute Rule
VII. Expand Plan of Care Signature Exception to Direct Access Patients and Recertification
VIII. Remote Therapeutic Monitoring (RTM)
IX. PTA Supervision
X. Telehealth
XI. Make Merit-Based Incentive Payment Program (MIPS) Participation Voluntary

XII. Other Value-Based Care Models and the Ambulatory Specialty Model (ASM)
XIII. Other Items

I. Making America Healthy Again

Physical therapists in private practice share the alarm of CMS and HHS about the state of the health of United States citizens. The need for action is clear:

- Today in the U.S., more than 1 in 5 children over 6 years old are obese. This is a more than 270% increase compared to the 1970s.
- Prevalence of pre-diabetes in teens is more than 1 in 4 teens, having more than doubled over the last 2 decades.
- Childhood cancer incidence has risen by nearly 40% since 1975, especially in children aged 0-19.

We fully agree with Secretary Kennedy that we must end the childhood chronic disease crisis by tackling its root causes directly—rather than just treating the symptoms. Physical therapists are ready to help improve health outcomes for pediatric and other US citizens.

Physical therapists are healthcare professionals who specialize in evaluating, diagnosing, and treating movement disorders. They work with patients of all ages and abilities to improve mobility, reduce pain, and restore function. Physical therapists:

- Assess and diagnose movement impairments
- Develop and implement individualized treatment plans
- Provide manual therapy, such as massage, stretching, and joint mobilization
- Prescribe exercises and activities to strengthen muscles, improve range of motion, and coordinate movements
- Educate patients on self-care techniques and injury prevention
- Collaborate with other healthcare professionals, such as doctors, nurses, and occupational therapists

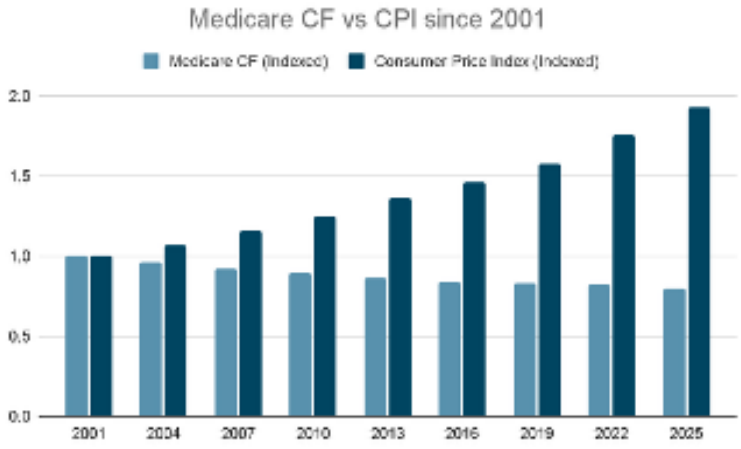
To become a physical therapist, one must complete a Doctor of Physical Therapy (DPT) program, which typically takes four years of post-graduate studies. After graduation, physical therapists must pass a national licensing exam to practice.

II. Conversion Factor (CF) Update and the State of the Physical Therapy Profession

Based on Congressional mandate, CMS set forth a 3.3% increase to the conversion factor in the Proposed Rule; however, this is offset by significant changes that prioritize certain primary care providers while leaving other providers, like physical therapists, behind. This decision will be devastating for our patients and physical therapy practices.

CMS needs only look to the current state of physical therapy to understand the reason the decision to effectively erase the 3.3% increase to the conversion factor is so problematic. Over the last four years, rehabilitation therapy providers as a group have received some of the largest cuts of any health care providers because of the fee schedule's budget neutrality policies. In a survey of our membership last year, private practice physical therapists had to make difficult decisions to avoid complete financial ruin

by closing clinics, reducing clinic hours, and/or waitlisting patients. As physical therapy is not an acute service, patients with limited access may see further decline in their condition and may not easily be able to find a convenient alternative for ongoing care if the conversion factor is erased. If not addressed, these payment cuts risk further exacerbating these problems, ultimately leaving patients with fewer low-cost, highly effective conservative options to receive care.



At the same time, physical therapists are subject to significant legacy reductions to payment for services that date back to the days of the sustainable growth rate formula, as well as excessive and burdensome administrative costs and barriers to participation in innovative and value-based programs. The medical community continues to contend with the residual impacts of the COVID-19 pandemic, record levels of burnout, workforce shortages, and ongoing reductions to Medicare Part B payment and, as a result, private payer reimbursement, which is often based on a percentage of Medicare rates. Private practice physical therapists face an increasingly challenging environment in providing Medicare beneficiaries with access to timely and quality care, which is particularly important for underserved and rural areas. Patient access for some of the most vulnerable populations will be further compromised by these cuts. While Congress has taken action to address some of these fiscal challenges by mitigating some of the recent fee schedule cuts, Medicare's payment to physical therapists continues to decline.

These year-over-year cuts, combined with a paucity of available alternative payment and value-based care models for physical therapists, clearly demonstrate that the Medicare payment system is broken. While the incentives under the Quality Payment Program (QPP) were intended to bridge the payment gap following MACRA, they were generally designed for physician practices and do not adequately fit with the vast majority of physical therapy practices. As a result, the costs of participating in any part of the QPP, including the Musculoskeletal MVP (discussed below), are a challenge for PTs. Very few applicable measures are available for the specialty, and compliant health information technology is almost non-existent. The inadequacy of value-based models in the context of physical therapy, as well as other systemic issues outlined above, will continue to generate significant instability for physical therapists in the future, threatening patients' timely access to essential physical therapy services.

Paradoxical decisions by CMS continue to undermine access to physical therapy, running counter to CMS's stated goal of supporting high-value medical interventions. Simply put, more physical therapy saves Medicare money. For an economic analysis of the impact of the conservative care provided by physical therapists, please see ValueofPT.com. The Report shows that across eight high-prevalence conditions, the average savings per completed course of care is $13,540. When these per-case savings are

applied to the number of Medicare beneficiaries and other U.S. adults who seek care annually, the result is an estimated $380 billion in avoided healthcare expenditures each year. These savings, along with the broader positive impact on healthcare delivery, have the potential to significantly reduce the nearly $1 trillion in waste currently burdening the healthcare system. While physical therapy services are covered under the Medicare program, CMS continually undervalues the time and resources dedicated to preventing impairments of bodily functions and structures, reducing the risk of injury, and optimizing overall health in patients. CMS should recognize the importance of physical therapy by appropriately valuing the time and resources that go into providing services to Medicare patients.

III. RVU Adjustments

While CMS proposes a 3.3% increase to the conversion factor for nonqualifying Alternative Payment Model participants, the Agency fails to recognize that this increase is effectively nullified by inappropriate and unexplainable adjustments to the RVUs for Physical Medicine & Rehabilitation (PM&R) codes. CMS proposes a 2.5% downward adjustment in work RVUs and intraservice time for certain services. While this concept is intended for diagnostic and non-time-based procedures, CMS has erroneously applied it to several time-based therapy codes. This error devalues core PT services, penalizing clinicians for interventions that, by definition, require time-intensive patient interaction and skilled decision-making. Changes to the work expense are a direct result of the proposed efficiency adjustment, which would reduce the work RVU of non-time-based codes to account for efficiencies over time. Unfortunately, CMS incorrectly lists numerous timed PM&R codes as subject to the adjustment. This is a blatant error that we urge CMS to rectify immediately.

APTA Private Practice strongly opposes applying the efficiency adjustment to any time-based PM&R codes, as these services are already subject to the Multiple Procedure Payment Reduction policy (MPPR), making the efficiency adjustment a repetitive and unjustified cut. Additionally, changes to the practice and professional liability RVUs found in the addenda are not explained in the text of the Proposed Rule. These adjustments are also unjustified, given that PM&R codes have undergone recent review by the American Medical Association (AMA) Relative Value Unit Update Committee (RUC). As has been stated, while the changes vary by code, the overall impact across the entire specialty will cancel out any increase to the conversion factor and decrease overall Medicare payment at the same time, most other providers will benefit from an increase.

RVUs are the backbone of the Medicare Part B payment system. For outpatient physical therapy, their accuracy is not a technical detail but a matter of patient access and practice survival. In the context of Therapeutic Exercise (97110), Neuromuscular Reeducation (97112), Therapeutic Activities (97530), and Manual Therapy (97140), these time-based codes must reflect the skilled labor and intensity of care delivered, not assumptions drawn from diagnostic or equipment-driven services. For Evaluation and Re-Evaluation Codes (97161–97164), correct valuation would help ensure that physical therapists have the resources to conduct comprehensive assessments and design individualized care plans—critical to medical necessity and outcomes tracking. And for all codes, Practice Expense Inputs also appear miscalculated. Post-pandemic costs for staffing, software, cybersecurity, compliance, and equipment remain high. Any reallocation of practice expense (PE) RVUs, particularly the proposed reduction of

facility-based PE weighting, must be carefully modeled to avoid destabilizing physical therapy practices.

CMS also proposes to reduce the proportion of facility PE RVUs tied to work RVUs in order to correct perceived overvaluation. While conceptually reasonable, this approach risks underestimating the real-world costs of private physical therapy practices, which already operate under razor-thin margins. The misapplication of the efficiency adjustment and the redistribution of practice expense inputs do not occur in isolation. They intersect with and magnify existing systemic vulnerabilities, creating cascading risks for patients, other therapy providers, and Medicare's overall cost-containment strategy.

If time-based codes are subjected to the 2.5% cut, practices may shorten visits or reduce the number of sessions provided, particularly for complex cases like stroke recovery, fall prevention, or multi-joint arthritis. This would lead to worse outcomes, longer recovery times, and higher downstream medical costs. In addition, applying "efficiency" assumptions to clinician-time-dependent codes is nonsensical. Given the time-based nature of our codes, any efficiencies created would simply result in therapists being able to provide additional interventions during a respective period of time. Paradoxically, for time-based codes, the ability to provide more services in a shorter period of time would seem to indicate an undervaluation and justify an increase in reimbursement, not a decrease. Practices would be forced to increase patient throughput or cut staff, undermining care quality and straining small-business viability.

The cuts will also impact different regions in various ways. Rural practices, with lower patient volumes and higher per-patient costs, will face the greatest risk of closure. Patients in these areas will lose access to local physical therapy services, forcing reliance on more expensive hospital care or simply going untreated. In addition, rural health centers carry higher compliance, staffing, and technology costs than office-based settings. Reducing facility PE weighting risks underfunding these realities, forcing departments to reduce hours, postpone upgrades, or close entirely. Facility cuts may drive consolidation of physical therapy practices into more concentrated, centralized locations, undermining community-based access. Rural and safety-net providers are disproportionately at risk. Patients in rural and underserved communities—often with the greatest rehabilitation needs—will be left with fewer local therapy options, worsening disparities. For private practices in rural and other regions, complex redistributions add compliance costs that private practices cannot absorb, diverting time and resources from direct patient care.

Reduced reimbursement also generally exacerbates burnout and turnover, undermining recruitment into private practice and further straining the physical therapy workforce. By undervaluing therapy services, CMS also undermines the benchmarks for alternative payment models (APMs). Providers will find budgets insufficient to cover therapy-intensive interventions, discouraging participation in models that are meant to encourage prevention and long-term savings, core components of the Administration's Make America Healthy Again strategy.

From a technical perspective, the combined effect of efficiency misapplication and PE redistribution accelerates a self-reinforcing cycle of undervaluation. Services are underpaid, practices cut visits or close, patient access and outcomes decline, total cost of care rises due to avoidable falls, hospitalizations, and surgeries, and value-based care models, built on flawed benchmarks, fail to reward prevention.

To forestall these cascading negative consequences, APTA Private Practice urges CMS to correct the misinformed application of its efficiency adjustment. CMS should explicitly exclude all time-based therapy codes (97110, 97112, 97530, 97140, 97161–97164, etc.) from work RVU and time reductions. CMS should also reissue corrected impact tables showing how therapy practices are affected. CMS must use current data to reflect the true costs of outpatient settings and provide sensitivity testing and transparent modeling to show geographic and practice-size impacts. CMS should also work to ensure transitional stability by implementing any major methodology shifts gradually over multiple years, prioritizing the provision of impact calculators and technical assistance to small practices. Finally, CMS should support value-based participation by adjusting APM budgets to reflect corrected RVUs and preserving appropriate payment for therapy codes that have proven to reduce downstream medical spending.

IV. Eliminate Application of the Multiple Procedure Payment Reduction Policy.

During CPT code valuation, the RUC applies a multiple procedure payment reduction to PM&R modalities and therapy procedures based on an assumption of an average of 3.5 units per visit and an inaccurate assumption that all practice expenses are duplicative across these units. At the point of claim submission, Medicare applies a duplicative multiple procedure payment reduction of 50% of all practice expenses to "always therapy" CPT codes submitted on the same day of service. This reduction applies across all procedures and all providers. CMS acknowledged this duplication in the 2024 final rule, indicating that after reviewing the clinical labor time entries for the PM&R modality and therapeutic procedure codes, they did not believe a payment reduction should have been applied by the RUC since the payment valuation reduction would be duplicative of the MPPR applied at claims processing. Despite this acknowledgment, both the RUC and CMS continue to apply a duplicative MPPR to these codes.

While APTA Private Practice challenges the legitimacy of MPPR as it relates to most practice expense line items, at the very least, it is time to eliminate the duplicative reduction, which cannot be defended under any scenario. This duplicative devaluation of therapy services is one of the significant factors leading to the challenge to Medicare beneficiaries' ability to access timely, high value physical therapist care and the inability of physical therapists' practices to continue to operate.

APTA Private Practice poses two questions to highlight just how flawed a single application of MPPR is and to emphasize the absolute irrationality of applying it twice.

- How can there be any duplication in practice expense when two different providers of two different disciplines, often in two different locations, see a patient at two different times in the day for two distinctly different plans of care?
- How can there be any duplication in setting up and cleaning equipment for two different procedures for which entirely different equipment is used?

Given the evidence provided, APTA Private Practice urges CMS to eliminate the duplicative application of MPPR from Medicare claims processing.

V. Documentation and Audits

Documentation and audit practices within Medicare continue to represent a significant source of administrative burden and regulatory risk for physical therapists in private practice. While accurate,

timely documentation is essential to demonstrate medical necessity and quality of care, current requirements combined with inconsistent audit practices consume disproportionate amounts of clinical time and jeopardize access to services for beneficiaries. APTA Private Practice urges CMS to modernize documentation expectations and standardize audit protocols to reduce unnecessary burden while maintaining program integrity.

At present, physical therapists face documentation mandates that often go well beyond clinical necessity. Requirements such as redundant reporting of objective measures, overly prescriptive progress note intervals, and duplicative justification of medical necessity add hours of non-clinical work each week. The "10th visit progress report" requirement, in particular, is outdated, arbitrary, and not aligned with patient progress trajectories or evidence-based practice. This requirement consumes valuable clinician time without improving care outcomes, and it often serves as a trap for technical denials during audits. Eliminating or revising this requirement would meaningfully reduce administrative waste.

Audits themselves also continue to be a major concern. Practices face inconsistent interpretations of documentation standards across MACs, Recovery Audit Contractors (RACs), and Unified Program Integrity Contractors (UPICs). What one auditor accepts as sufficient justification, another may deny, creating a climate of uncertainty and fear which limits access for patients to the care they need. For private practices, even a handful of audit denials can threaten financial stability. CMS should require audit contractors to use uniform criteria aligned with published guidance, and it should expand education and transparency in the audit process.

The burden of pre-payment and post-payment reviews is particularly acute. For private practices, responding to extensive records requests pulls therapists away from patient care and can delay payroll or hiring decisions. CMS should consider limiting the scope of documentation requested in routine audits and providing more reasonable timelines for submission. In addition, CMS should consider implementing an audit "gold card" program for therapy providers with a proven history of compliant billing and documentation, thereby reducing unnecessary reviews and allowing resources to be focused on outliers.

Technology also presents an opportunity to reduce documentation burden. CMS should encourage and support the use of standardized outcome measures, electronic medical record (EMR) templates, and interoperability solutions that align documentation with value-based metrics rather than requiring redundant narratives. Incentivizing the use of validated tools to demonstrate functional progress would be a far more meaningful approach than requiring arbitrary visit-based progress reports.

APTA Private Practice urges CMS to recalibrate documentation and audit requirements to focus on clinical relevance and program integrity rather than setting up meaningless technical traps that hinder patient access by distracting physical therapists from providing care. Streamlining documentation, eliminating outdated requirements like the 10th visit progress report, ensuring audit consistency, and creating pathways for reduced burden among compliant providers would free physical therapists to focus on delivering high-quality, cost-effective care. For private practices, this reform is not just a matter of efficiency; it is essential to sustaining access for Medicare beneficiaries.

VI. Replace Medicare's 8-Minute Rule

Under Medicare's 8-Minute Rule, introduced in December 1999, rehabilitative therapists are required to add all service minutes across different CPT codes during a therapy session and apply a tiered decision matrix to determine unit billing. The rule is both confusing and time-consuming; the instructions and examples on applying the policy cover three pages in the Medicare Claims Policy Manual and are an oft-cited source of significant strain and uncertainty among therapy providers. Further, the impact of this rule is highly disproportionate to therapy providers, who are among the only clinicians that bill timed codes that also have the 8-minute rule applied to them.

As it stands, the policy narrowly targets the provision of therapy services, including clinically necessary therapeutic exercise and other interventions. Ultimately, the rule needlessly discourages therapists from making decisions solely based on their clinical expertise and instead forces the therapist to consider arbitrary thresholds dictated by CPT reporting policy, particularly around the use of mixed remainders.

The term "mixed remainders" refers to the time remaining from a billed unit from one service, which can be combined with the remainder of a separate service to meet the 8-minute threshold, allowing the clinician to bill for the service with the greater contribution to the mixed remainder. For example, a therapist may have five leftover minutes of therapeutic exercise and three leftover minutes of manual therapy during a session. Individually, neither remainder meets the eight-minute threshold under the rule, but when combined, they amount to the full eight minutes—under Medicare's 8-minute rule, this means the therapist can bill one additional unit of the service with the highest time total.

To illustrate the practical issue with this policy, take the following example from Net Health for a single service: "If physical therapists provide 12 minutes of therapeutic exercises, they can charge Medicare for one billable unit. If the one-on-one treatment of therapeutic exercises extends to 23 minutes, this one unit now turns into two billable physical therapy billing units." However, if the therapist were to provide 35 total minutes of therapeutic exercises, they would still only be able to bill two units—in order to bill three units, the therapist would have to provide 38 minutes under the policy matrix. This creates a situation where the therapist is left to either provide an additional three minutes of care or bill for one less unit. Over time and across patients, these decisions compound rapidly and gain complexity, commanding an inordinate amount of the therapist's time and energy.

In fact, in clinical practice, therapists commonly provide several distinct therapy services during a session. Here, the 8-minute rule takes on additional complexities, and the calculus can be overwhelming, repetitive, and confusing for many therapists. As a simple example, say a therapist provides 10 minutes of therapeutic activities and 11 minutes of manual therapy. Despite providing two unique services that both extend beyond 8 minutes, under the 8-minute rule, the provider can only bill one unit because the threshold for two units is 22 total minutes. APTA Private Practice regularly fields and answers questions on interpretations of the 8-minute rule, which causes a great deal of anxiety and frustration for members who only seek to provide care in compliance with the rules.

CMS should replace the 8-minute rule with the AMA's Midpoint rule, a similar, but administratively simpler standard. Under the Midpoint Rule, each timed service is evaluated individually based on its time threshold, simplifying calculations and reducing billing errors. The AMA's standard aligns with CPT coding standards and is used by most payers and across healthcare disciplines, promoting consistency and

facilitating seamless adoption across affected providers. Ultimately, alignment with CPT guidelines simplifies reporting and encourages more flexible, patient-centered care by allowing therapists to bill for services based on clinical needs.

For physical therapists facing annual payment cuts and seeking to maximize their clinical expertise, there are scenarios where the 8-minute rule's "mixed remainders" policy will allow them to bill for additional services where the midpoint rule would not, and vice versa. There is no meaningful data suggesting one is more valuable than the other, but therapists have overwhelmingly indicated that the primary benefit of the modification is its administrative simplicity, which allows therapists to focus less on billing and more on patient care. And, as mentioned above, not only is the standard simpler, but since the midpoint is applied across all timed CPT codes per the CPT manual, most providers will not need additional education or guidance, making for a seamless orientation and application of the new standard.

VII. Expand Plan of Care Signature Exception to Direct Access Patients and Recertification

Expand the Plan of Care Signature Exception to Direct Access Patients

Under 42 CFR § 424.24(c), outpatient physical therapy services must be furnished under a plan of treatment that has been certified by a physician or nonphysician practitioner. The PT is required to submit the plan of care to the referring provider within 30 days of treatment to receive payment for any services rendered.

Previously, the PT was also required to have that provider return a signed and dated copy of the POC as evidence of certification. This meant following up with physicians for signatures, often submitting multiple requests for—and confirming the existence of—the provider's signature on the plan of care to be paid for Medicare Part B outpatient therapy services. In effect, claims that otherwise met medical necessity requirements may not have been paid for lack of a timely physician signature.

Under a new exception, finalized in the CY 2025 Physician Fee Schedule rule and codified under the new 424.24(c)(5), once the PT has transmitted the POC, the onus now is on the referring provider to either return the signature or indicate changes; absent either action, silence serves as assent to the PT's submitted POC. In effect, the new rule places increased emphasis on and trust in the PT's clinical judgment, requiring only documentation evidencing the order or referral.

However, one major caveat is that only claims for services provided to patients with an order or referral are eligible for the exception. CMS indicated that the exception is limited to claims for orders or referrals because the existence of an order or referral reflects the referring provider's intent. Services provided via direct access, according to the agency, do not reflect this intent and are therefore not covered under the exception.

While services provided via direct access reflect a portion of physical therapy care, APTA Private Practice believes that a signature exception can and should be expanded to apply to direct access patients. There is no statutory or legislative requirement that a referral or order is necessary for a physical therapist to treat a Medicare patient, nor does CMS require a physician's signature on the POC for a physical therapist to begin treatment. In fact, the statute indicates only that the physical therapist establishes the POC, and that it be "periodically reviewed by a physician." 42 U.S.C. 1395n (a)(C).

In short, the signature requirement is simply a prerequisite to ensure this review has taken place before the physical therapist can be paid for their services. And in practice, the certification requirement forces physical therapists to make a choice: begin treatment in the best interests of the patient, or delay care to ensure that payment can be obtained. Under the regulation, there is no requirement that the physician review the POC's clinical appropriateness. The new exception to the POC signature requirement, which permits the signed order to serve as evidence of an approved POC, codifies what is already well understood in practice: physical therapists are rehabilitative care experts and are afforded near total clinical deference in the design of the therapy POC.

There is little functional difference in permitting a more lenient standard for referral-based practice simply because of the referring provider's premeditated intent. This is especially true when the POC would still be transmitted to the beneficiary's physician. Again, by forwarding the plan of care to a physician overseeing the patient's care, it fundamentally confirms that the patient's plan can be reviewed by that practitioner. Once the beneficiary's physician has received the POC, whether or not they referred the patient for therapy services should not matter because the therapist will only provide reasonable and necessary services to the beneficiary as determined by the initial evaluation. Where patients freely access physical therapy services without a referral, they should not have access delayed due to a technical billing requirement. If the exception were expanded to direct access patients, the therapist would be responsible for identifying the patient's MD/RN/PA for transmitting the POC. When the patient is not under the care of an MD/RN/PA, the therapist cannot transmit the POC, and thus, the therapist cannot meet the Medicare requirements, so the exception does not apply.

Further, PTs should not have to dedicate a disproportionate amount of time to tracking physician signatures to receive payment for medically necessary services. This was one of the stated problems CMS sought to address through the original signature exception, but where PT services are accessed without referral, and where recertifications are concerned, PTs are still beholden to these onerous requirements to provide services that will meet medical necessity regardless of whether the physician reviews the plan or not. APTA Private Practice believes that transmission of a plan of care to a physician overseeing the beneficiary's care is adequate to fulfill the charge of the statute and permits more beneficiary freedom without disincentivizing certain options.

By expanding the exception to direct access to patients, providers experience less burden, patients have more meaningful choices in accessing care, and physicians maintain the opportunity to review the plan of care at their leisure. Whether a patient is under the care of a physician can be evidenced in more convenient and less burdensome ways than the current demands of the signature requirement. APTA Private Practice asserts that it is within CMS's discretion to determine the best method to accomplish this, but patient records, claims submissions, or other automated methods can assist in that regard. Ultimately, if the PT can affirmatively identify a direct access patient's current medical provider to whom to transmit the POC, and document that transmission in compliance with the new exception, then those direct access patients, their treating therapists, and their physicians should receive the same burden reduction benefits that patients referred to PT do.

Expand the Plan of Care Signature Exception to Recertification

Additionally, the new certification signature exception described elsewhere in this submission is only

available for initial certification of the POC. The signature (and other) requirements under the recertification process remain the same: the existing recertification payment and coverage conditions require that the POC must be reviewed "as often as necessary but at least whenever it is certified or recertified to complete the certification requirements."

Recertifications should document the need for "continued or modified therapy and should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initiation of treatment under the plan of care." This means that if a patient does (or will) require physical therapy for 90 or more days under the POC, the PT still must follow the signature requirements as currently written, without exception, which also means that they cannot guarantee payment for medically necessary services simply because the referring provider does not return a signature.

CMS should expand the application of the POC signature exception to recertifications. Since Jan. 1, 2025, the exception's recent implementation date, APTA Private Practice has already seen physicians who, enamored with the burden reduction of the exception, have elected not to return signatures in any form, whether for certifications or recertifications. APTA Private Practice knows that both therapists and physicians have seen immense burden reduction through the exception policy, but Medicare patients often require care for more than 90 days, at which point the recertification requirements are automatically triggered.

CMS did not propose an exception to the signature requirement for purposes of recertification of the therapy plan of treatment, noting that it believed "that physicians and NPPs should still be required to sign a patient's medical record to recertify their therapy treatment plans, in accordance with § 424.24(c)(4), to ensure that a patient does not receive unlimited therapy services without a treatment plan signed and dated by the patient's physician/NPP." But still, the point remains that if the POC is transmitted to the physician, their lack of acknowledgement should not serve as a deterrent to providing timely care, especially since the physician overseeing the beneficiary's care will still receive the POC for recertification promptly.

However, under the current rules, to be paid for medically necessary therapy services, the therapist must still hunt down the signature solely because it requires recertification. The exception policy's purpose was to alleviate both therapists and physicians from this burden, and avoid care being delayed while awaiting a physician's signature, which could place the beneficiary's health at risk due to the delay in obtaining outpatient therapy services. As the agency mentioned last year, CMS allows treatment to begin before the physician's/NPP's signature is obtained, but PTs, OTs, and SLPs in private practice do so at their own risk, knowing that they might not be paid for the services if the physician's office does not send back the signed plan of treatment.

Notably, early implementation of the POC signature exception has presented issues that neither CMS nor its stakeholders foresaw. Large orthopedic practices, the source of numerous physical therapy referrals, have attempted to circumvent the remaining recertification barrier. These orthopedic practices have informed therapy providers that they will no longer sign and return any signature requests, including for recertification. Instead, these practices indicate that they will only provide new referrals for existing patients, which would conveniently fall under the signature exemption for initial certifications.

The exception policy represents one of the largest burden reduction actions for PTs in the Medicare program, and should be maintained and refined at all costs. However, without affirmative approval of the

orthopedists' interpretation, it inappropriately places the physical therapist in the same bind CMS sought to relieve therapists from: that therapists are held accountable for the action or inaction of physicians/NPPs who may be overwhelmed with paperwork, exposing the therapist to nonpayment because the physicians who have no vested interest and no financial incentive to return signatures.

In other words, physicians can assume the position that this practice is appropriate to reduce their own burden, leaving only the therapists to bear the financial risk, which is then passed on to patients who may receive delayed care or prematurely ended care as a result of the decision. Expanding the signature exception to recertification allows both parties to receive the benefit of reduced burden while also offering an adequate opportunity to inform the physician of the patient's status and continued need for therapy services, so that the physician can intervene. Meanwhile, inaction on the part of the physician does not prevent the therapist from providing medically necessary care without performing unnecessary evaluations.

VIII. Remote Therapeutic Monitoring

We appreciate CMS's recognition of the role that Remote Therapeutic Monitoring (RTM) plays in expanding access to physical therapy care, supporting adherence, and enhancing value-based outcomes for Medicare beneficiaries. RTM represents one of the most promising developments in care delivery innovation for physical therapy, particularly in underserved and rural areas.

CMS is proposing to maintain the same work and practice expense RVUs for CPT codes 98980 and 98981. CMS did not accept the RVS Update Committee's recommendation of increasing the work relative unit for 98980 from 0.62 to 0.78. In addition, CMS did not accept the RVS Update Committee's recommendation of increasing the work relative unit for 98981 from 0.61 to 0.70.

Beginning in CY 2026, certain RTM codes will have new descriptions:

- **98976**: Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of the respiratory system, 16-30 days in 30 days.
- **98977**: Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of the musculoskeletal system, 16-30 days in 30 days.
- **98978**: Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in 30 days.

Beginning in CY 2026, there will be four new RTM CPT codes:

- **98xx4**: Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of the respiratory system, 2-15 days in 30 days.
- **98xx5**: Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of the musculoskeletal system, 2-15 days in 30 days.
- **98xx6**: Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital

therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in 30 days.
- **98xx7**: Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes.

When the AMA releases the 2026 CPT codes in September 2025, the 5-digit numerical code for each new RTM CPT code will be finalized, which will eliminate the "X" designation in these new codes.

Current RTM services (CPT codes 98975–98981) hold the promise to enable physical therapists to extend care beyond the clinic walls by monitoring adherence to home exercise programs, tracking functional outcomes, and identifying barriers to recovery. RTM improves patient engagement by reinforcing prescribed therapeutic activities outside the clinic; supports early intervention when patients deviate from their care plan, preventing exacerbations and avoidable downstream costs; advances value-based care goals by reducing re-injury rates, improving long-term adherence, and lowering avoidable utilization such as imaging, injections, or hospital visits. For private practice physical therapists, RTM allows effective management of larger caseloads while maintaining individualized oversight of patient progress.

While APTA Private Practice appreciates CMS's leadership in adopting RTM codes, several challenges limit the ability of private practices to implement these services effectively. Current RVU valuation of RTM codes does not fully reflect the clinical labor, data review, and communication time required for successful implementation. For many practices, the cost of RTM platform subscriptions and staff time often outweighs reimbursement.

Challenges due to the lack of clarity in RTM rules remain. Clarification is needed on documentation and medical necessity requirements to prevent administrative overreach by Medicare Administrative Contractors (MACs) and commercial carriers. Confusion also persists around whether RTM services furnished by physical therapist assistants (PTAs) are subject to the 15% payment reduction modifier. APTA Private Practice strongly recommends that CMS exclude RTM codes 98975, 98980, 98981, and 98xx7 from the PTA differential because RTM is inherently a team-based service requiring ongoing clinician oversight but often involving routine delegation.

Many RTM platforms require significant upfront investment, training, and EHR integration. Private and rural practices are disproportionately burdened, risking a widening digital divide. Without appropriate support, Medicare beneficiaries in these areas will have less access to RTM-enabled care. In terms of value-based care, RTM holds potential as a cornerstone for these models by demonstrating adherence, outcomes, and cost savings. However, current APMs do not adequately recognize RTM data. CMS should explicitly incentivize RTM utilization in APM benchmarks and reporting requirements.

To ensure RTM fulfills its promise as an accessible, sustainable, and high-value service for Medicare beneficiaries, APTA Private Practice urges CMS to accept the RVS Update Committee's recommendation of increasing the work relative unit for 98980 from 0.62 to 0.78 to reflect the true clinician and staff effort

required for monitoring, communication, and intervention. In addition, APTA Private Practice urges CMS to accept the RVS Update Committee's recommendation of increasing the work relative unit for 98981 from 0.61 to 0.70 to reflect the true clinician and staff effort required for monitoring, communication, and intervention.

CMS should also update practice expense inputs to capture subscription, data storage, and cybersecurity costs associated with digital platforms. CMS should also explicitly exclude RTM codes from the PTA 15% payment differential and streamline documentation expectations so that RTM does not become administratively prohibitive for private practices.

To make it possible for private practices to adopt RTM, CMS should consider targeted technical assistance or grants to help small businesses and rural practices acquire and implement RTM platforms, and also ensure that practice expense methodologies recognize the higher per-patient cost of RTM adoption for low-volume clinics with high complexity patients. CMS could also encourage the integration of RTM into value-based programs by recognizing RTM adherence and outcome data in APM benchmarks and quality measures and encouraging the use of RTM data to demonstrate functional gains and reductions in avoidable utilization. Remote Therapeutic Monitoring represents a critical opportunity to extend physical therapy care into patients' daily lives, ensuring adherence, promoting function, and preventing costly complications. However, without appropriate valuation, administrative clarity, and support for private practice adoption, RTM will remain out of reach for many providers and their patients. APTA Private Practice urges CMS to refine RTM policy in any final rule to ensure that Medicare beneficiaries, regardless of geography or practice size, can access the benefits of digitally-supported rehabilitation.

IX. PTA Supervision

Supervision requirements for physical therapist assistants (PTAs) continue to be a critical regulatory issue for outpatient private practices participating in Medicare. APTA Private Practice emphasizes that supervision standards must align with real-world practice realities and recognize the competence of PTAs as licensed professionals.

We applaud CMS for making PTA supervision for outpatient services consistent with all other settings. Even with this positive decision, we respectfully urge CMS to go further. CMS could decrease the administrative complexity of supervision documentation so that it will not weigh as heavily on private practices. While CMS has issued clarifications in recent rulemaking, significant confusion persists among contractors and auditors regarding how supervision should be documented, particularly in multi-site practices or when telehealth and RTM services are involved. Conflicting interpretations can lead to unwarranted denials and repayment demands. CMS should issue binding guidance to contractors to ensure consistency and prevent misapplication of supervision rules. This binding guidance should clearly state that services provided by a physical therapist assistant and billed under the NPI of a physical therapist are to be assumed that the physical therapist met the general supervision guidelines and was available if required by the physical therapist assistant. No special documentation is required in the medical record by either the physical therapist or the physical therapist assistant.

In addition, we urge CMS to eliminate the 15% PTA payment differential, implemented via the CQ modifier, which remains an ongoing threat to practice sustainability. This policy, combined with potential increases in supervision burden, effectively disincentivizes the use of PTAs even when clinically appropriate. The unintended consequence is a reduction in patient access, especially in those practices in rural and underserved communities that rely on PTAs to extend therapy capacity. APTA Private Practice strongly encourages CMS to reconsider this reduction or, at a minimum, exempt time- and resource-intensive services such as RTM from the differential to reflect their collaborative nature.

Finally, we highlight the importance of flexibility in supervision across care models in terms of PTA supervision. With the continued expansion of telehealth and remote care technologies, private practice physical therapists should have the ability to supervise PTAs through real-time digital communication when direct oversight is not feasible. The pandemic demonstrated that flexible supervision methods are safe, effective, and aligned with modern care delivery. Restrictive interpretations that mandate physical co-location are inconsistent with both evidence and beneficiary needs.

In summary, we stress that CMS PTA supervision policies need to strike the correct balance. The policies must maintain quality and safety while avoiding unnecessary administrative or financial barriers that hinder access. General supervision should remain the standard; burdensome modifiers and differential payments should be reconsidered, and clearer national guidance should be issued to contractors to avoid inappropriate denials. Doing so will protect patient access to medically necessary physical therapy while sustaining the viability of private practices that rely on PTAs as essential members of the care team.

X. Telehealth

CMS failed to recommend adding physical therapy codes to the permanent list of codes eligible for payment when provided via telehealth in the 2025 final rule, despite heavy advocacy by APTA Private Practice and other providers in both the regulatory and legislative arenas. Physical therapy codes remain at provisional status, as they have been since the onset of the COVID-19 pandemic's public health emergency in March 2020. As of now, that provisional status runs through Dec. 31, 2025. In this proposed rule, CMS is proposing to have all codes listed on the List of Telehealth Services as permanent. This would include codes commonly billed by physical therapists and physical therapist assistants. APTA Private Practice thanks CMS for this proposal and urges CMS to finalize this proposal in the final rule.

In addition, CMS is proposing to revise the 5-step review process for reviewing requests to the Medicare Telehealth Services List. CMS is proposing to remove Step 4 (Consider whether the service elements of the requested service map to the service elements of services on the list that has a permanent status described in previous final rulemaking) and Step 5 (Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system) from CMS' review criteria and retain Steps 1 through 3.

APTA Private Practice applauds CMS for this proposal and urges CMS to finalize this proposal in the final rule. Looking at the larger issue, as in the past, CMS suggests that it lacks the statutory authority to change its list of approved telehealth providers to include PTs. Bipartisan legislation introduced in the last

Congress, the U.S. House of Representatives would have done exactly that, and we support APTA's continued advocacy efforts on that front.

XI. Make MIPS Participation Voluntary

With the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS discontinued the use of the SGR as a basis for clinician payments. The Quality Payment Program established a model of funding that was intended to reward high-value, high-quality Medicare clinicians with payment increases, while at the same time reducing payments to those clinicians who weren't meeting performance standards. QPP was purported to improve the quality and safety of care for all individuals and to reduce the administrative burden on clinicians, allowing more time to focus on person-centered care and improving health outcomes. Physical therapists who meet certain benchmarks are required to report under the *Merit-based Incentive Payment System (MIPS)* program.

MIPS is a component of the Quality Payment Program (QPP) that provides Medicare Part B payment adjustments to eligible clinicians based on their performance across four categories: Quality, Improvement Activities, Cost, and Promoting Interoperability. Physical therapists earn a final score, which determines their payment adjustment, with higher scores potentially leading to bonus payments. CMS is proposing to maintain the performance threshold at 75 points for the CY 2026 – 2028 MIPS Performance Periods/2028 – 2030 MIPS Payment Years. We are pleased that CMS has added Quality Measure 317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented to the Physical Therapy Specialty Code Set, but are concerned about the proposed deletions of Quality Measures 487 (Screening for Social Drivers of Health) and 498 (Connection to Community Service Provider). The removal of these codes from the Specialty set not only decreases the flexibility of private practice physical therapists to meet the demands of MIPS but also continues to inject instability into the program. Private practice physical therapists believe that MIPS has been much too volatile and that this volatility contributes to the problematic nature of the program. Simply put, the administrative burden and annual changes to the program do not create a business case for its adoption by private practice physical therapists. There is a widespread belief that MIPS is more trouble than it is worth for practices, and while well-intentioned, CMS has not ameliorated these challenges in implementation.

The expense and administrative burden associated with MIPS far exceeds any potential financial incentive and, if anything, provides an additional barrier to high-quality person-centered care. APTA Private Practice regularly hears from high-performing providers who elect not to submit quality data because the cost of participating outweighs the highest positive adjustment achievable in the program.

There is no statutory requirement for CMS to designate certain providers as mandatory MIPS participants under the Medicare Access and CHIP Reauthorization Act of 2015, 42 USC 1305, Sec. q, Subsection (c). Only physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists are required as MIPS eligible under the statute, and it is also within CMS' authority to determine the mandatory or voluntary nature of any participation in MIPS for "other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary."

For these reasons, we ask CMS to use its authority to make MIPS participation optional for physical therapists until such time that the QPP and MIPS meet the following criteria to fully and meaningfully

allow physical therapists to participate:

- Include measures that appropriately distinguish high-value, compared to low-value care;
- Provide financial and operational support for the integration of CEHRT and ensure that the use of CEHRT will, in fact, result in interoperability and administrative burden reduction;
- Recognize the contribution of physical therapists to a patient's outcome(s); and
- Provide financial incentives commensurate with the contribution of the provider.

XII. Other Value-Based Care Models and the Ambulatory Specialty Model (ASM)

APTA Private Practice supports CMS's efforts to advance value-based care, but cautions that program design must reflect the preventive and function-focused nature of physical therapy. In the case of physical therapists, the QPP has failed to meet its objectives. Ten years into the program, it still lacks quality measures that are reflective of the impact of physical therapy. Additionally, physical therapists are expected to meet interoperability requirements that threaten the financial viability of most practices without any support, as was provided to physician practices. Additionally, the majority of systems lack the ability or intent to create interfaces that would actually support the objectives of interoperability.

CY 2026 Rehabilitative Support for Musculoskeletal Care MVP (the MVP)

The CY 2026 Rehabilitative Support for Musculoskeletal Care MVP (MIPS Value Pathway) is a quality reporting pathway for the QPP designed for specialists and groups focused on musculoskeletal care, including physical therapy, occupational therapy, and chiropractic care. In effect, the MVP should simplify the traditional MIPS by pre-selecting quality measures, improvement activities, cost measures, and foundational performance categories relevant to physical therapy into a single pathway, helping clinicians and groups report quality data.

For the MVP, CMS is proposing even more significant changes than in traditional MIPS: the addition of the following measures:

- Quality Measure 134 (Preventive Care and Screening: Screening for Depression and Follow-Up Plan)
- Quality Measure 182 (Functional Outcome Assessment).

CMS also proposes the deletion of Quality Measure 487 (Screening for Social Drivers of Health).

In terms of improvement activities, CMS proposes the following additions:

- IA_BE_15 (Engagement of Patients, Family and Caregivers in Developing a Plan of Care)
- IA_BE_16 (Evidence-based techniques to promote self-management into usual care)IA_AHW_X (Chronic Care and Preventive Care Management for Empaneled Patients)

CMS proposes to delete the following Improvement Activities:

- IA_AHE_9 (Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols)
- IA_AHE_12 (Practice Improvements that Engage Community Resources to Address Drivers of Health)
- IA_CC_1 (Implementation of Use of Specialist Reports Back to Referring Clinician or Group to

Close Referral Loop)
- IA_PM_26 (Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B).

Beyond the fact that it has been almost impossible for private physical therapy practices to qualify for the MVP, these changes create the same system perturbation caused by the frequent changes to MIPS. The initial design of the model was a clinically incoherent pathway, included unapproved cost measures, excluded widely used functional assessment tools, and was much too difficult for physical therapists in private practice to effectively report and benefit from the MVP. The MVP was not fully aligned with the realities of practice and patient care, hindering meaningful participation and a true assessment of value in musculoskeletal care.

During the last comment period, we urged against the inclusion of the Low Back Pain (LBP) cost measure due to its recent field-testing and prior lack of approval for the Medicare Merit-Based Incentive Payment System (MIPS) program. We also continue to harbor concerns regarding the CMS decision to omit widely used and crucial Instrumented Remote Monitoring System (IRMS) functional measures, which are essential tools for assessing patient function in musculoskeletal care. Leaving these out creates significant barriers and potential hardship for providers. The LBP cost measure, in particular, also focuses on cost using claims data, which is limited in its ability to accurately assess patient outcomes or appropriately stratify and subgroup patients. We also believe that the MVP framework fails to effectively break down silos between performance categories and does not provide an accurate assessment of overall value in the musculoskeletal field.

The CY 2026 Ambulatory Specialty Model (ASM)
The ASM is a proposed mandatory CMS Innovation Center payment model, announced in the Proposed Rule, that targets specialists treating heart failure and low back pain. Beginning January 1, 2027, the ASM will make specialists accountable for improving chronic disease management, aiming to reduce avoidable hospitalizations, promote early detection, and improve patient outcomes through performance-based adjustments to their Medicare Part B payments. If designed correctly, the ASM could position physical therapy as a cornerstone of cost reduction and quality improvement. We urge the following changes and consideration of the following issues as the model is rolled out:

1. Accurate Benchmarks
ASM benchmarks must be grounded in corrected RVU values. If therapy services are undervalued in the fee schedule, those errors will be magnified in value-based budgets, making participation unsustainable. CMS should also ensure risk adjustment captures patient complexity, including multimorbidity, fall risk, and post-surgical needs.

2. Functional Outcomes as Quality Metrics
PT outcomes should be measured with validated functional tools (PROMIS, FOTO, AM-PAC), not just process measures. These tools directly reflect improvements in independence, mobility, and fall prevention—areas where PT demonstrates clear cost savings.

3. Participation Pathways for Private Practices
Private practices often lack the capital reserves and administrative staff to take on downside risk. ASM should provide:

- Tiered participation levels (upside-only shared savings as an entry point).
- Technical assistance and simplified reporting.
- Options for collaborative networks of private practices to participate together.

4. Integration of Telehealth and RTM
ASM should explicitly incorporate telehealth and RTM as value-driving interventions. Tracking adherence, exercise compliance, and patient engagement will provide CMS with real-time evidence of therapy's preventive impact.

5. Equity and Access Incentives
ASM should provide bonus adjustments or favorable benchmarks for providers serving high-risk populations—including rural, minority, and dual-eligible patients—recognizing the higher resource intensity required to meet their needs.

6. Alignment Across Programs
ASM should align with MIPS, APMs, and other value-based initiatives to reduce redundancy. Reporting requirements should be streamlined, with a focus on meaningful functional measures rather than overlapping, inconsistent quality sets.

7. Rewarding Prevention
Physical therapy reduces emergency department visits, opioid prescriptions, imaging, and elective surgeries. ASM design should explicitly reward these avoided costs. This requires attribution methodologies that recognize PT's role in keeping beneficiaries functional and independent.

The ASM will succeed only if it is built on accurate payment benchmarks, meaningful outcome measures, and accessible participation pathways. Physical therapy practices—particularly private, independent clinics—must be empowered to participate fully, not sidelined by flawed valuation or excessive administrative burden.

XIII. Other Items
Eliminate Enforcement of the KX Modifier
On July 16, 2025, CMS failed to include the update to the KX modifier in the 2026 Physician Fee Schedule. On August 14, 2025—nearly one month after the proposed rule was first issued—CMS released a correcting document with the KX modifier establishing September 12, 2025, as the deadline for public comment. CMS invoked the exception in Section 553(b)(B) of the Administrative Procedure Act, which permits an agency to dispense with the full notice-and-comment process upon a finding of "good cause" that such procedures are impracticable, unnecessary, or contrary to the public interest. CMS further asserted that the correcting document did not constitute rulemaking but merely resolved "inadvertent errors" to ensure that the CY 2026 MPFS accurately reflected the intended policies.

The omission of the KX Modifier in its entirety from the initial proposed rule cannot be described as a simple error. Unlike a misplaced punctuation mark or a misspelled word, this omission removed an entire section of the PFS that patients and providers depend on to initiate and continue plans of care. To classify this as an "inadvertent error" risks undermining the integrity of the rulemaking process and sets an undesirable precedent for the treatment of substantive proposals in future rulemaking.

Because the KX Modifier has historically been included in the PFS each year and has consistently been subject to a full 60-day comment period, CMS must preserve this practice. Stakeholders require adequate time to analyze, assess, and comment on policies that directly affect patient access to care and provider compliance. Therefore, stakeholders must be given the full 60 days to respond to this portion of the PFS.

Eliminate the mandatory progress report requirement.
Under current Medicare rules, physical therapists are required to complete a formal progress report by the 10th visit of a patient's therapy episode. While documentation to assess patient progress is a critical part of clinical care, this rigid requirement is administratively burdensome, clinically arbitrary, and particularly harmful to private physical therapy practices.

Progress in physical therapy is not uniform across conditions, nor is it always linear. Some patients may demonstrate significant progress in just a few visits, while others may require more time to exhibit measurable gains. Mandating a progress report at the 10th visit regardless of diagnosis, severity, or complexity imposes a one-size-fits-all standard that is misaligned with the individualized nature of care. For private practices, the 10th visit rule imposes a disproportionate administrative load. Therapists must pause care to generate a detailed report that may not reflect meaningful change, especially in cases of chronic conditions or slow recovery trajectories. The time spent writing progress reports is time taken away from patient care, completing billing and prior authorization paperwork, staff development, or other business-critical tasks. Moreover, the requirement creates compliance anxiety. If a therapist inadvertently misses the 10th-visit window, they risk denials or payment delays. This forces clinics to implement complicated tracking systems—often managed manually—just to meet the arbitrary 10th visit progress report requirement. For private practices without full-time administrative staff, this can be overwhelming and drain critical and limited staff time. The 10th visit progress report requirement also interferes with continuity of care. Instead of allowing clinical judgment to guide when a re-evaluation is necessary, the 10-visit threshold enforces documentation that may not reflect the actual clinical need. In some cases, it can even lead to unnecessary visits or duplicated documentation, adding inefficiencies to an already resource-strapped system.

Eliminating the fixed 10th visit progress report rule and replacing it with a clinician-determined schedule based on treatment plan complexity and duration would preserve accountability while significantly reducing burden. Therapists would still be responsible for monitoring progress and documenting medical necessity, but they would be able to do so in a way that aligns with actual patient care patterns and outcome measurement. CMS should trust licensed professionals to make these determinations. Physical therapists are doctoral-level professionals trained to assess function, track outcomes, and justify continued care when appropriate. Enabling clinicians to set reporting intervals based on clinical milestones or episode duration would encourage documentation that is more relevant, more efficient, and more likely to

inform better care decisions.

We urge CMS to eliminate the 10th visit rule to reduce unnecessary administrative tasks, support clinical judgment, and improve the ability of private practices to focus on what matters most: delivering high-quality, personalized care to their communities.

Conclusion

The Proposed Rule, if its provisions become final, risks destabilizing the delivery of physical therapy and undermining Medicare's broader goals of better health, strengthened prevention, and value-based care. By correcting the efficiency adjustment, reducing documentation burdens, refining PE and RTM policy, modernizing PTA supervision, making telehealth permanent, and designing value-based care and the ASM to fully incorporate physical therapy, CMS could preserve beneficiary access, maintain the integrity of Medicare, and support the long-term sustainability of independent practices. APTA Private Practice stands ready to collaborate with CMS to refine these proposals and to ensure that the final rule sustains patient access, practice sustainability, and the success of value-based care.

We appreciate CMS's leadership in opening this public dialogue and stand ready to partner in shaping a regulatory environment that works better for patients, providers, and the Medicare program. Please contact Robert Hall at RHall@ppsapta.org with any questions or for more information.

Sincerely,

Mike Horsfield, PT, MBA
President
Private Practice Section of the American Physical Therapy Association