APTA Private Practice
A Section of the American Physical Therapy Association

September 14, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Submitted Electronically

RE: CMS-1848-P; RIN 0938-AV82; Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Oz:

On behalf of the nearly 4,000 members of APTA Private Practice, a section of the American Physical Therapy Association (APTA), we appreciate the opportunity to comment on the Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule (the Proposed Rule). APTA Private Practice represents physical therapists in independently owned practices across the United States who furnish medically necessary outpatient rehabilitation services to Medicare beneficiaries. Our members help beneficiaries recover from injury and illness, manage chronic conditions, avoid falls and unnecessary procedures, and remain independent in their homes and communities.

This Proposed Rule contains meaningful reforms to practice expense valuation that may improve payment for many physical therapy services. APTA Private Practice supports CMS's effort to reduce reliance on outdated specialty-specific practice expense data and to recognize clinical labor more accurately. Those gains, however, do not cure the Rule's underlying instability. CMS proposes to reduce the CY 2027 conversion factor for nonqualifying Alternative Payment Model (APM) participants by 1.68 percent, from $33.40 to $32.84, after expiration of the temporary 2.5 percent statutory increase for CY 2026. The vast majority of physical therapists are subject to that non-QP conversion factor, because existing APM pathways generally do not accommodate their participation.

Our comments therefore distinguish among CMS proposals that should be finalized, proposals that require modification, and structural problems that CMS should address through the authorities available to it. Throughout the letter, we focus on actions CMS can take in the Final Rule to protect beneficiary access, improve payment accuracy, reduce unnecessary administrative burden, and preserve the viability of community-based physical therapy practices.

Executive Summary

APTA Private Practice appreciates CMS's efforts to modernize the Medicare Physician Fee Schedule (PFS), improve payment accuracy, expand participation in value-based care, and reduce unnecessary administrative burden. Independent private practice physical therapists share these objectives because they strengthen beneficiary access to timely, high-quality outpatient rehabilitation while allowing clinicians to devote more time to patient care. We urge CMS to finalize those proposals that improve the accuracy and transparency of Medicare payment while modifying proposals that would unnecessarily restrict access to care, increase administrative complexity, or undermine the viability of independent community-based practices.

Payment Stability and Practice Expense Methodology (Sections I and II). APTA Private Practice strongly supports CMS's proposed modernization of the practice expense methodology, including elimination of the Indirect Practice Cost Index (IPCI), incorporation of clinical labor into the indirect practice expense allocator, and improved transparency in relative valuation. These reforms represent an important step toward more accurately valuing clinician-intensive services such as outpatient physical therapy. However, they do not resolve the continuing erosion of the Medicare conversion factor or the long-term instability of the Physician Fee Schedule. CMS should finalize the proposed practice expense reforms while continuing to document the need for a permanent, inflation-sensitive statutory payment update and ensuring that direct practice expense inputs accurately reflect the resources required to furnish physical therapist services.

Remote Therapeutic Monitoring (Section III). APTA Private Practice supports CMS's efforts to strengthen program integrity while preserving clinically appropriate use of Remote Therapeutic Monitoring (RTM). We support requirements that reinforce the relationship between RTM and an established course of treatment but urge CMS to avoid restrictions that would eliminate legitimate, clinically integrated RTM programs operated by independent practices. CMS should withdraw the proposed prohibition on contracted clinical staff, retain current practice expense inputs until representative resource data support revaluation, and preserve the existing modular RTM coding structure rather than adopting bundled G-codes that reduce clinical flexibility.

Value-Based Care, Quality Measurement, and Telehealth Measures (Section IV). APTA Private Practice supports CMS's long-term transition toward clinically meaningful value-based payment and quality measurement. Participation pathways must be feasible for independent rehabilitation practices, yet available evidence shows that current pathways remain impracticable for many of them. CMS should emphasize meaningful patient outcomes rather than process compliance, preserve flexibility in the transition to MIPS Value Pathways (MVPs), expand access to meaningful functional outcome measures, use claims-based data whenever possible to reduce reporting burden, and ensure that interoperability and technology requirements reflect the realities of the rehabilitation marketplace. Within the Ambulatory Specialty Model, CMS should also recognize the essential role of physical therapy in evidence-based management of low back pain by incorporating measures that encourage timely access to appropriate conservative care. Finally, we respectfully urge CMS to define "virtual telehealth platform" in the final rule and provide examples of arrangements that are expressly included and excluded from the definition prior to the issuance of subregulatory guidance.

CPT/RUC Request for Information (Section V). APTA Private Practice appreciates CMS's willingness to examine the long-term structure of physician coding and valuation. Any future reforms should broaden stakeholder representation, improve transparency, incorporate objective empirical data alongside clinical expertise, preserve stable national coding standards, and ensure that physical therapists have meaningful participation in the development and valuation of codes affecting rehabilitation services. Modernization should improve payment accuracy without reducing beneficiary access or increasing administrative complexity.

The Proposed Rule presents CMS with an opportunity to improve both payment accuracy and the long-term sustainability of community-based outpatient rehabilitation. APTA Private Practice urges CMS to finalize the recommendations contained in this letter to support beneficiary access, strengthen independent practice, reduce unnecessary administrative burden, and ensure that Medicare payment appropriately reflects the value of physical therapist services.

I. Medicare Payment Stability and the Conversion Factor

CMS proposes a CY 2027 conversion factor of approximately $33.17 for qualifying APM participants and $32.84 for clinicians who are not qualifying APM participants. Those amounts represent reductions of 1.19 percent and 1.68 percent, respectively, from CY 2026. The immediate cause is the expiration of the one-year 2.5 percent statutory increase for CY 2026, partially offset by the statutory update factors of 0.75 percent for QPs and 0.25 percent for non-QPs and by the proposed budget-neutrality adjustment. APTA Private Practice recognizes that the basic update factors and expiration of the temporary increase are established by statute and that CMS cannot simply substitute a permanent inflationary update in the Final Rule.

That limitation does not make the resulting payment reduction economically neutral. It is important to recognize that the non-QP conversion factor governs payment for the overwhelming majority of outpatient physical therapists. For those clinicians, the proposed reduction applies before considering sequestration, the 15 percent payment differential for services furnished in whole or in part by physical therapist assistants, the Multiple Procedure Payment Reduction (MPPR), geographic adjustments, and code-level valuation changes. A nominal specialty-level increase generated by practice expense redistribution does not erase these continuing deductions or the cumulative decline in the proposed conversion factor’s purchasing power.

Private practices cannot absorb annual reductions indefinitely. They purchase labor, rent, insurance, information technology, cybersecurity, clinical supplies, and professional services in markets where prices have increased significantly. They must recruit and retain licensed clinicians in a workforce market shaped by wage inflation, educational debt, and competition from hospitals and other employers. They must also fund uncompensated administrative work associated with enrollment, claims, appeals, prior authorization, documentation, quality reporting, audits, and compliance. None of those costs fall when the statutory conversion factor falls.

Recommendations
For the CY 2027 Final Rule, APTA Private Practice respectfully recommends that CMS:

- Finalize the proposed conversion factors only as required by current law, while clearly acknowledging that the resulting 1.68 percent reduction for non-QP clinicians does not reflect a decline in the resources required to furnish outpatient physical therapy.
- Finalize sound practice expense reforms independently of the conversion-factor update and avoid characterizing the estimated physical therapy specialty increase as a substitute for a stable, inflation-sensitive annual payment update.
- Minimize discretionary policies that create avoidable budget-neutrality pressure on physical therapy and other clinician-intensive services, and publish the specialty-level effects of each major discretionary valuation policy.
- Publish transparent and reproducible impact analyses that separately identify the effects of the conversion factor, budget neutrality, practice expense methodology, code-level valuation, sequestration, the PTA payment differential, and MPPR.
- Monitor beneficiary access to outpatient rehabilitation using participation, practice-location, wait-time, geographic, and post-acute utilization indicators in addition to aggregate claims volume, with focused analysis on rural, underserved, and small-practice markets.
- Continue providing Congress with data and technical assistance supporting a permanent update tied to the Medicare Economic Index or another objective measure of practice-cost inflation.
- Evaluate the effect of outpatient physical therapy access on downstream Medicare utilization and total cost of care when developing future payment policies and Innovation Center models.

A. The Proposed Practice Expense Gains are Welcome But Are No Substitute for Payment Stability
CMS estimates that the Proposed Rule will increase aggregate PFS payments to physical therapy by approximately 3 percent, principally because of proposed changes to practice expense methodology. APTA Private Practice strongly supports the direction of those reforms. The proposed specialty impact is evidence that longstanding methodology has understated the resources associated with clinician-intensive services and that reducing reliance on outdated specialty-level constraints can improve relative payment accuracy.

CMS should not, however, treat a favorable redistribution in one component of the relative-value system as compensation for an inadequate annual update. The two policies answer different questions. Practice expense methodology determines the relative allocation of a budget-neutral pool; the conversion factor determines the dollar value assigned to the resulting RVUs. Correcting relative valuation is necessary, but it does not ensure that the total payment amount keeps pace with the cost of furnishing care. A practice can receive a larger share of a shrinking or stagnant pool and still lose the capacity to serve Medicare beneficiaries.

The distinction is especially important in a budget-neutral system. A specialty-level impact estimate is an average, not a guarantee for an individual practice, code mix, locality, or beneficiary population. Practices that furnish a different mix of services may experience results that diverge materially from the specialty estimate. Future code revaluations, utilization shifts, and budget-neutrality adjustments can reverse the apparent gain. CMS should therefore finalize sound practice expense reforms on their merits while

describing them accurately as relative-valuation improvements—not as a solution to the Proposed Rule's long-term adequacy problem.

B. Continued Instability Threatens Beneficiary Access to High-Value Conservative Care
For independent physical therapy practices, payment inadequacy produces predictable operational responses: reduced acceptance of new Medicare patients, longer wait times, fewer clinic locations, shorter operating hours, delayed hiring, and reduced investment in technology or specialized services. Practices may also leave payer networks or close altogether. Small and medium-sized practices generally lack the cross-subsidies, capital reserves, and negotiating leverage available to large health systems. When Medicare payment fails to cover the resources required to furnish care, an independent practice has few places to shift the loss.

The consequences fall on beneficiaries first. Medicare patients rely on physical therapists to manage arthritis, chronic pain, vestibular disorders, balance impairment, neurologic conditions, and progressive functional decline. They also need physical therapy following joint replacement, fracture, stroke, hospitalization, and other acute events. Delays in care can mean loss of mobility, increased fall risk, avoidable use of medication and imaging, preventable emergency-department visits, institutional care, or surgery. For a beneficiary who no longer drives or who lives in a rural or underserved area, the closure of a nearby clinic may be the practical loss of access to the health system—not merely a change of provider.

Payment policy should reflect physical therapy's role as a comparatively low-cost intervention that can prevent or reduce more expensive downstream care. This does not mean every episode produces the same savings or that payment should be based on unsupported assumptions. It means CMS should evaluate access to outpatient rehabilitation as part of its program-integrity and total-cost responsibilities. A policy that reduces Part B spending on therapy but contributes to greater use of hospitals, imaging, injections, opioids, surgery, or post-acute institutional care is not fiscally prudent for Medicare as a whole.

C. The Proposed Rule Disproportionately Exposes Small Practices to Costs They Cannot Control
The Proposed Rule's instability is compounded by the structure of modern outpatient care. A physical therapy visit is clinician intensive. Its principal resource is the time and judgment of the physical therapist and, when used, the physical therapist assistant. Productivity cannot be increased indefinitely without compromising individualized evaluation, progression of treatment, patient education, safety, or outcomes. Unlike a scalable product, the core service cannot be reproduced at negligible marginal cost.

At the same time, regulatory and technological expectations continue to expand. Practices are expected to maintain secure electronic records, comply with privacy and cybersecurity requirements, report quality information where applicable, respond to audits and medical review, confirm enrollment information, coordinate care, and communicate with beneficiaries and referring clinicians. Rehabilitation-specific electronic systems often lack the economies of scale and certification pathways available to larger physician-oriented platforms. These costs are real practice expenses even when the PFS does not recognize them fully as direct inputs in the annual update.

Medicare payment also directly impacts commercial payment. Many private contracts are tied directly or indirectly to Medicare rates, RVUs, or coding conventions. A reduction in the Medicare conversion factor can therefore spread beyond Medicare rather than remain confined to one book of business. Independent practices may face the same declining benchmark across multiple payers while having limited ability to renegotiate based on limited market power. CMS should endeavor to account for this broader market effect when assessing whether the Proposed Rule's payment policy will preserve a diverse outpatient delivery system.

D. CMS Has Meaningful Actions Available in the Final Rule
Although permanent Medicare payment reform requires Congress, CMS is not powerless. First, CMS should avoid discretionary policies that create additional, unnecessary budget-neutrality pressure or shift resources toward services without persuasive evidence of greater relative resource use. Every discretionary increase financed through budget neutrality should be tested for its effects on a broader list of medical services such as physical therapy, especially when they have limited access to Advanced APM incentives and few viable alternatives to fee-for-service payment.

Second, CMS should provide transparent, specialty-specific impact information that separates the effects of the conversion-factor update, budget neutrality, practice expense methodology, code-level valuation, and other payment adjustments. Aggregate specialty estimates alone can obscure important variation. CMS should publish sufficient data for stakeholders to reproduce the estimates, identify which services drive the result, and evaluate effects on small, rural, and independent practices.

Third, CMS should monitor beneficiary access using more than claims volume. Reduced utilization can reflect improved health, but it can also reflect longer waits, practice closures, nonparticipation, geographic maldistribution, or beneficiaries abandoning care. CMS should examine enrollment and participation trends, time and distance to an available provider, changes in the number and location of outpatient therapy practices, and utilization patterns following hospitalization or surgery. Where the agency identifies access deterioration, it should report the findings and use available regulatory, demonstration, technical-assistance, and data authorities to respond.

Fourth, CMS should continue providing Congress with a clear empirical record concerning the difference between PFS updates and the cost of operating a practice. The agency is uniquely positioned to quantify cumulative changes in the conversion factor, the Medicare Economic Index, clinician participation, service availability, and beneficiary access. That record is necessary for durable legislation establishing a predictable annual update tied to an objective measure of practice-cost inflation.

CMS's proposed practice expense changes are an important step toward more accurate relative valuation. APTA Private Practice supports preserving those improvements. But a payment system cannot remain stable if the dollar value of accurately calculated RVUs continues to erode. The Final Rule should therefore pair the proposed valuation reforms with maximum transparency, disciplined use of discretionary authority, meaningful access monitoring, and a clear record supporting permanent statutory payment reform.

II. Practice Expense Methodology Reform

APTA Private Practice strongly supports CMS's proposed modernization of the methodology used to calculate practice expense (PE) relative value units. In particular, we support CMS's proposals to incorporate both work RVUs and clinical labor RVUs into the indirect PE allocator, phase out the Indirect Practice Cost Index (IPCI), and establish a stabilization mechanism to limit excessive year-to-year changes in PE RVUs. Taken together, these changes move the PFS toward a more transparent, resource-based methodology and away from an approach that has allowed increasingly outdated specialty-level cost data to constrain code-level valuation. CMS itself acknowledges that the existing methodology can privilege historical survey data over more recent service-level inputs and produce results that are both unpredictable and difficult for the public to understand.[1]

These reforms are particularly important for outpatient physical therapy. Physical therapy is a clinician-intensive service. The resources required to furnish care arise principally from the time, skill, and continuous involvement of clinical personnel rather than from expensive diagnostic equipment, implantable devices, or capital-intensive technology. Yet the current PE methodology has not consistently reflected that cost structure. APTA's analysis indicates that physical therapy currently has an IPCI of only 0.67646, while the profession's most frequently furnished services contain substantial clinical labor resources. Accordingly, eliminating the IPCI and incorporating clinical labor more consistently into the indirect allocator should improve the relative valuation of many therapy services.
CMS's own Proposed Rule impact analysis points in that direction. CMS estimates an approximately 3 percent aggregate increase in PFS payments to physical therapy attributable to PE changes. APTA's code-level analysis likewise identifies proposed increases in PE RVUs for frequently furnished services, including therapeutic exercise, neuromuscular reeducation, aquatic therapy, gait training, manual therapy, physical therapy evaluations, therapeutic activities, and other rehabilitation services. As discussed in Section I, these relative-value improvements should not be confused with an adequate annual payment update. They are nevertheless important corrections to the allocation of PE resources and should be finalized.

Recommendations
For CY 2027, APTA Private Practice respectfully recommends that CMS:

- Finalize proposed Step 8, including both work RVUs and clinical labor RVUs in the indirect PE allocator as proposed.
- Finalize the elimination of IPCI-based Steps 12 through 17 and complete the transition away from the IPCI over two years.
- Finalize the proposed PE stabilization adjustment, while ensuring that it moderates annual volatility without permanently preventing codes from reaching resource-supported PE values.
- Publish code-level information identifying the effects of the revised indirect allocator, IPCI transition, stabilization adjustment, and budget-neutrality adjustments, so stakeholders can independently evaluate annual PE changes.
- Ensure that the clinical labor and other direct PE inputs feeding the revised methodology accurately reflect the resources required to furnish outpatient rehabilitation services, as discussed in Section III.
- Evaluate the revised PE methodology as an integrated whole, including its interaction with direct PE valuation and the therapy MPPR, rather than treating each component as an isolated payment policy.

A. CMS Should Finalize the Elimination of the Indirect Practice Cost Index
APTA Private Practice supports CMS's proposal to remove the IPCI from the PE methodology. Under the current methodology, Steps 12 through 17 use specialty-specific PE/hour data to calculate specialty-specific indirect scaling factors and ultimately a service-level IPCI. That index is then applied to the service-level indirect PE allocator. CMS explains that the specialty-level practice-cost data underlying this methodology derive primarily from the 2007 PE/hour survey and have become increasingly dated. CMS further identifies limitations arising from small and selective survey samples and concludes that continued reliance on these data can prevent improvements in code-level inputs and allocation methodologies from being fully reflected in PE RVUs.[2]

That is a significant methodological problem. A resource-based payment system should permit better information about the resources associated with a particular service to affect the value of that service. When a specialty-level index effectively re-scales the result back toward historical expenditure

relationships, improvements elsewhere in the methodology may have little practical effect. The result risks transforming historical cost relationships into self-perpetuating payment relationships.
The problem becomes more significant as the underlying data age. Contemporary independent physical therapy practices bear substantial indirect costs associated with electronic health records, cybersecurity, revenue-cycle management, regulatory compliance, quality reporting, outcome-measurement systems, scheduling and patient-communication technology, credentialing, billing and appeals, staff recruitment, and other infrastructure required to operate a modern healthcare practice. The relevant question for Medicare payment policy is not whether the relative distribution of those expenses resembles the distribution reported nearly two decades ago. It is whether the methodology reasonably reflects the resources required to furnish services today.

CMS's proposed approach is therefore preferable. Rather than using the IPCI to constrain the final allocation according to historical specialty relationships, CMS would eliminate Steps 12 through 17 and calculate total PE RVUs from the direct-cost PE RVUs and the indirect-cost PE RVUs produced through the revised allocation methodology, subject to budget neutrality and the proposed stabilization mechanism.[3]

Eliminating the IPCI also improves transparency. Stakeholders can more meaningfully evaluate a methodology based on identifiable service-level resources than one in which those resources are subsequently modified by a specialty index derived from dated historical clinical survey data. Greater transparency is especially important because PE valuation affects thousands of services and because errors in Medicare relative valuation can extend beyond Medicare when commercial payers benchmark reimbursement to the PFS. APTA Private Practice therefore recommends that CMS finalize the proposed elimination of the IPCI and complete its removal after the proposed two-year transition period.

B. CMS Should Finalize the Addition of Clinical Labor RVUs to the Indirect PE Allocator
APTA Private Practice also strongly supports CMS's proposed revision to Step 8. Under current policy, the indirect PE allocator for most services generally relies upon direct PE RVUs and work RVUs, with clinical labor RVUs incorporated only under specified circumstances. CMS proposes instead that, for services other than codes with 010- and 090-day global periods, the allocator includes both work RVUs and clinical labor RVUs. The proposed formula would therefore incorporate the indirect PE percentage, direct PE RVUs, work RVUs, and clinical labor RVUs.[4]

That change better recognizes the economics of outpatient physical therapy. Clinical labor is not incidental to physical therapy; it is the central resource required to furnish the service. A physical therapist must evaluate the beneficiary's condition, select and modify interventions, monitor response to treatment, maintain safety, educate the patient and caregiver, document skilled services, and exercise clinical judgment throughout the encounter. Many treatment services also require clinical staff time associated with preparation, positioning, cleaning, equipment management, and other activities necessary to furnish the service safely.

Those labor resources generate indirect costs as well. A practice employing clinicians must maintain the infrastructure that allows those clinicians to furnish care: space, management, scheduling, billing, human resources, information technology, compliance systems, cybersecurity, insurance, and other administrative functions. A methodology that recognizes clinical labor in calculating direct PE but inadequately recognizes its relationship to indirect expense can systematically disadvantage clinician-intensive services.

CMS's proposal addresses that disconnect. By adding clinical labor RVUs to the indirect allocator alongside work RVUs, CMS would more consistently connect indirect PE allocation to the resources used to furnish individual services. That is a sounder principle than allowing the allocation to be constrained by historical specialty-level cost relationships.

Importantly, APTA Private Practice does not support this change merely because the Proposed Rule produces a favorable specialty-level result for physical therapy. The policy should be finalized because it is methodologically superior. A resource-based fee schedule should respond when the measurable resources associated with a service change.
The favorable effect on therapy services nevertheless provides useful evidence about the existing methodology. APTA's analysis shows increases in PE RVUs for many commonly furnished therapy codes under the proposed methodology, while CMS estimates an overall 3 percent specialty-level increase for physical therapy attributable to PE. Given physical therapy's current IPCI of 0.81915 and its substantial clinical labor inputs, that result is consistent with the conclusion that the existing methodology has constrained PE valuation for clinician-intensive rehabilitation services.[5]

APTA Private Practice therefore recommends that CMS finalize proposed Step 8 and incorporate both work RVUs and clinical labor RVUs into the indirect PE allocator as proposed.

C. The Proposed Stabilization Adjustment Is a Reasonable Safeguard Against Excessive Volatility
Eliminating the IPCI removes not only a source of distortion but also a mechanism that, because it was anchored in relatively static specialty-level PE/hour data, tended to constrain year-to-year changes in PE RVUs. CMS appropriately recognizes that greater responsiveness to current inputs should not result in excessive annual volatility.

CMS therefore proposes a new Step 19 under which, after application of the cognitive-services floor and other applicable code-level adjustments, PE RVUs generally could not increase or decrease by more than 5 percent in a single year. CMS proposes exceptions for new and revised codes, newly nationally priced codes that were formerly contractor priced, and revalued codes. The stabilization adjustment would operate before the separate statutory phase-in applicable to certain significant reductions in total RVUs.[6]

APTA Private Practice supports the basic objective of the stabilization proposal. Independent practices need reasonably predictable reimbursement to make decisions regarding staffing, leases, technology, equipment, and participation in Medicare. A methodology that produces abrupt swings in PE RVUs because of relatively small changes in utilization or input data would undermine that predictability.
At the same time, stabilization must not become a substitute for accurate valuation. CMS should ensure that the 5 percent limitation moderates the *timing* of legitimate valuation changes rather than permanently suppressing them. Where updated resource information demonstrates that a service is materially undervalued, the methodology should ultimately permit the service to reach its appropriate relative value. CMS should also publish sufficient information for stakeholders to determine when the stabilization adjustment has affected a code. Without that transparency, a stakeholder reviewing the annual fee schedule could incorrectly attribute a change—or the absence of an expected change—to the underlying resource methodology rather than to the stabilizer.

APTA Private Practice therefore recommends that CMS finalize the stabilization mechanism while providing code-level transparency regarding its application and ensuring that the mechanism does not permanently prevent PE RVUs from reaching values supported by the underlying resource data.

D. The Revised Methodology Will Be Only as Accurate as the Inputs It Uses
Our support for CMS's indirect PE reforms comes with an important qualification**:** a better allocation formula cannot correct inaccurate underlying resource inputs.

This issue is particularly significant for outpatient rehabilitation. APTA Private Practice has raised longstanding concerns regarding the direct PE inputs assigned to Physical Medicine and Rehabilitation services, including reductions in clinical labor associated with the RUC/HCPAC valuation process. CMS itself previously concluded that a payment reduction should not have been applied to clinical labor time for 19 therapy codes because doing so would be duplicative of the Multiple Procedure Payment Reduction subsequently applied during claims processing. APTA Private Practice has continued to identify therapy codes whose direct PE inputs do not reflect the resources required to furnish the services.

The CY 2027 proposal makes resolution of those concerns more—not less—important. Under proposed Step 8, clinical labor becomes an explicit component of the indirect PE allocator. If clinical labor inputs for therapy codes are understated at the code level, that understatement can affect both the direct PE assigned to the service and the indirect PE allocated through the revised methodology. In other words, incorporating clinical labor more appropriately into the formula increases the importance of ensuring that the clinical labor values entering that formula are correct.

APTA's internal review reaches the same conclusion: although elimination of the IPCI and increased reliance on clinical labor are expected to benefit physical therapy, the revised indirect calculation would continue to operate from direct PE inputs for PM&R codes that APTA believes have been reduced below the resources supported by the underlying survey recommendations.

This concern does **not** justify retaining the IPCI or delaying the broader methodological reforms. Those reforms correct a separate defect in the PE methodology and should proceed. Rather, CMS should use the Final Rule and subsequent rulemaking to ensure that the improved allocation methodology operates from accurate code-level inputs.

Section III of these comments addresses the PE/hour data and direct PE inputs in detail, and Section IV addresses the interaction between therapy valuation and the MPPR. The critical point for purposes of this section is that these policies must operate coherently. CMS should not replace an outdated specialty-level constraint with a more resource-sensitive methodology while leaving known distortions in the resources being measured.

The CY 2027 proposals represent a meaningful improvement in PE methodology. CMS has correctly identified the weakness inherent in allowing increasingly outdated specialty-level survey data to override improvements in service-level resource valuation. Eliminating the IPCI, consistently recognizing clinical labor in the indirect allocator, and controlling excessive year-to-year volatility provide a stronger foundation for a transparent and genuinely resource-based PFS.
For independent physical therapy practices, that reform is particularly important. Medicare should value the resources actually required to furnish contemporary outpatient rehabilitation—not preserve historical payment relationships simply because they have been embedded in the methodology for many years. APTA Private Practice therefore urges CMS to finalize these reforms while simultaneously correcting the direct PE inputs upon which the revised methodology will depend.

III. Remote Therapeutic Monitoring

APTA Private Practice supports Medicare coverage and appropriate payment for Remote Therapeutic Monitoring (RTM). For outpatient physical therapy, RTM is not a stand-alone technology product or a substitute for skilled care. It is a clinical tool that allows the treating physical therapist to monitor therapeutic adherence and response between visits, identify barriers or deterioration earlier, communicate with the patient or caregiver, and modify the plan of care when warranted. Against the backdrop of a growing national physical therapist shortage and surging patient demand, RTM plays a critical role in preserving limited in-clinic capacity while maintaining continuous, high-quality care for patients between their in-person visits.[7] Used appropriately, RTM extends the clinician's awareness beyond the clinic without replacing the evaluation, clinical judgment, or hands-on interventions that remain central to rehabilitation.

The CY 2027 Medicare Physician Fee Schedule Proposed Rule would make several consequential changes to RTM. CMS proposes to: (1) limit RTM to established patients; (2) require a separately reportable initiating visit furnished by the billing practitioner; (3) permit payment for clinical-staff RTM services only when the staff member is a direct employee of the practitioner or practice; (4) reduce or eliminate direct practice expense inputs across the RTM code family; and (5) potentially replace the current modular coding structure with two bundled RTM G-codes.[8] These proposals must be evaluated separately. Some appropriately reinforce the relationship between RTM and an ongoing plan of care. Others would impose restrictions or payment reductions that are not supported by the evidence CMS identifies and would disproportionately harm small and independent practices.

Recommendations

For CY 2027, APTA Private Practice respectfully recommends that CMS:

- Finalize the established-patient requirement only with clarification that a covered physical therapy evaluation or treatment visit establishes the relationship and that no waiting period is required.
- Clarify that an evaluation, reevaluation, or treatment visit at which RTM is assessed, discussed, and consented to, satisfies the initiating-visit requirement; do not require a duplicative encounter.
- Withdraw the employee-only restriction and permit contracted clinical staff under targeted safeguards that ensure integration, supervision, documentation, and practitioner accountability.
- Expressly preserve the use of third-party software, devices, technical support, training, and other nonclinical infrastructure.
- Retain current direct PE inputs for CPT codes 98975–98986 and do not eliminate PE inputs for treatment-management codes until representative resource and pricing data support a transparent revaluation.[9]
- Decline to finalize GRTM1 and GRTM2 for CY 2027 and preserve the current modular code family, including shorter data-transmission and treatment-management options.
- Use claims analysis, documentation standards, and prohibitions on unsolicited recruitment and vendor-driven patient selection to address program-integrity risks.
- Monitor the effects of any finalized changes on beneficiary access, rural communities, small-practice participation, outcomes, and Medicare spending before adopting additional restrictions.

A. RTM Advances Patient-Centered Rehabilitation

CMS relies principally on Office of Inspector General findings concerning Remote Physiologic Monitoring (RPM), including cold calling, a lack of prior patient relationships, and episodes in which beneficiaries did not receive all three components of remote monitoring. Those concerns justify targeted safeguards, but they do not justify treating every contracted staffing arrangement as clinically fragmented, presuming that RTM services are overvalued because CMS lacks pricing data, or replacing a flexible code family with a bundle that requires services a beneficiary may not need in every month. RTM and RPM are not equivalent. RTM is furnished within a therapy plan of care and differs materially from arrangements that generated the cited concerns. Any Final Rule should address the conduct that creates risk rather than eliminate legitimate care models that permit independent practices to offer RTM.

The clinical value of RTM in physical therapy arises from the reality that recovery occurs largely between scheduled visits. A home exercise program is effective only when the patient can perform it safely, understands the prescribed dosage, and can report symptoms and functional response in time for the clinician to act. RTM can make that process visible. It may allow the physical therapist to identify nonadherence caused by pain, fear, transportation barriers, technology limitations, or misunderstanding; distinguish an expected response from a clinically significant change; reinforce patient education; and intervene before a problem results in an avoidable office visit, emergency department visit, or interruption in care.

This capability is particularly important for Medicare beneficiaries who have mobility limitations, live in rural and underserved areas, depend on caregivers for transportation, or require a gradual progression of therapeutic activity. RTM may also help practices use in-person visits more effectively by providing longitudinal information about adherence and response before the patient arrives. These capabilities matter more as workforce constraints tighten. Many outpatient rehabilitation providers report physical therapist recruitment and retention difficulties, particularly in rural and underserved markets. RTM does not substitute for the skilled in-person care those clinicians furnish, but it allows the treating physical therapist to maintain continuous clinical awareness between scheduled visits, so that limited clinician availability translates into fewer gaps in monitoring and fewer avoidable interruptions in an episode of care. The service therefore complements—not replaces—in-person physical therapy and supports CMS's objectives of prevention, coordinated care, beneficiary engagement, and efficient use of Medicare resources.

Independent practices have made substantial investments to furnish RTM responsibly, including platform and device costs, cybersecurity and privacy protections, patient onboarding, clinical workflow redesign, staff training, documentation protocols, ongoing data review, and integration of information into the medical record and plan of care. APTA's member advocacy has emphasized that these services improve engagement, adherence, and outcomes, while practice-facing analysis confirms that many small clinics rely on external technology and support infrastructure because they lack the scale to build every component internally. CMS should not make those investments stranded costs or reserve RTM in practice for large organizations with sufficient internal staffing.

B. Established-Patient and Initiating-Visit Requirements

APTA Private Practice agrees that RTM should be connected to a genuine treatment relationship. CMS proposes to require RTM to be furnished only to an established patient because the practitioner should possess the history, examination findings, and other information needed to determine that monitoring is appropriate.[10] That rationale generally fits physical therapy. A physical therapist ordinarily performs an evaluation, establishes a plan of care, and determines whether RTM will provide clinically useful information. Evidence from private practice clinics indicates that adding RTM to in-person physical therapy can improve patient engagement, plan-of-care adherence, and functional outcomes.[11] Requiring

an established relationship can deter cold-call arrangements without interfering with properly integrated RTM.

CMS should, however, clarify that a beneficiary becomes established through the physical therapist's otherwise covered evaluation, reevaluation, or treatment visit and that no arbitrary waiting period applies. RTM may be clinically appropriate at the start of an episode, including after surgery or acute functional decline. An established-patient rule should not be interpreted to require an unnecessary prior visit before RTM may be initiated when the practitioner has already completed the evaluation necessary to establish the relationship and determine medical necessity.

The proposed initiating-visit requirement needs similar clarification. CMS would require the billing practitioner to furnish a separately reportable face-to-face visit, in person or by telehealth, associated with the onset of RTM; RTM must be discussed at that visit, and a service that is not separately payable cannot qualify.[12] A covered physical therapy evaluation, reevaluation, or treatment visit at which the physical therapist assesses the beneficiary, determines that RTM is appropriate, explains the service, and obtains consent should satisfy the requirement. CMS should not require a second visit devoted solely to RTM, nor should it require a new initiating visit when RTM is added during an existing episode of care after a change in the patient's needs.

CMS also should define "associated with the onset" flexibly. A rigid same-day requirement would create scheduling and billing problems without improving program integrity. The record should instead demonstrate that, before RTM begins, the billing practitioner evaluated the patient's needs, ordered or incorporated RTM into the therapy plan of care, discussed the service, and obtained consent. Those substantive elements—not a redundant encounter or narrow timing rule—protect the beneficiary and Medicare program.

We respectfully recommend that CMS finalize the established-patient policy only with express confirmation that the practitioner's covered therapy evaluation, reevaluation, or treatment visit establishes the relationship and may serve as the initiating visit. Do not require a duplicative visit, a waiting period, or a new initiating visit merely because RTM begins later in an active episode of care.

C. CMS Should Withdraw the Employee-Only Restriction

CMS proposes to disallow payment when clinical-staff components of RTM are furnished by contracted personnel, even if those personnel work under the billing practitioner's general supervision and all other requirements are met. Yet the governing regulation defines "auxiliary personnel" to include independent contractors. 42 C.F.R. § 410.26(a)(1). Beginning January 1, 2027, only time furnished by clinical staff who are direct employees of the practitioner or practice would count.[13] CMS acknowledges that staff need not be physically located in the practice, but the proposal would categorically bar contracted clinical staff.

APTA Private Practice strongly opposes this categorical restriction. Employment status is a poor proxy for clinical integration, supervision, or quality. A remote employee can be poorly integrated into a patient's care, while a contracted clinician can follow the practice's protocols, use its medical record, communicate routinely with the treating physical therapist, and function as part of the care team. The relevant questions are whether the billing practitioner selected the patient, determined medical necessity, established the plan of care, maintains access to the data and documentation, supervises the service, and remains responsible for clinical decisions—not whether the practice issues the staff member a W-2.

Medicare already permits contracted personnel in many supervised clinical arrangements; RTM does not warrant a categorical departure from that approach. For example, certain hospital-based services,

including radiology, emergency medicine, and anesthesia, often use independent-contractor arrangements. Permitting such arrangements for RTM would therefore not be novel. It must also be recognized that there is no functional difference for a therapy practice that includes two or more clinics hiring a PT or PTA to monitor RTM on all of the practices' patients. The PT or PTA may be based in one office or work remotely from home. They would have little to no relationship with the beneficiary or other members of the care team and have little to no interaction with the office staff and billing practitioner since they are either only in one location or working remotely from home. Classification as a W-2 employee rather than an independent contractor does not, by itself, change the clinical service or its cost.

The distinction is especially arbitrary in a multisite practice. A practice may employ a physical therapist or physical therapist assistant at one location to monitor RTM patients across several clinics or permit that employee to work remotely. That employee may interact with the patient and local care team in precisely the same manner as a qualified contractor. The employment label does not determine whether the individual is integrated into the patient's care.

The proposal would also fall most heavily on the practices and communities least able to absorb it. Large health systems and multisite organizations may have sufficient patient volume, capital, compliance staff, and technology personnel to internalize RTM operations. Many independent physical therapy practices, particularly in rural areas, do not. In addition, many community clinics will not reach the critical mass needed to support dedicated RTM staff. Practices and clinics may use a vendor for technology, training, workflow support, and limited clinical staffing while the treating physical therapist retains responsibility for the plan of care and all clinical decisions. The proposed restriction would operate arbitrarily with respect to individual beneficiaries, particularly where a practice relies on contracted or temporary physical therapists to address staffing constraints. Under a categorical employment test, two beneficiaries with identical clinical profiles, treated in the same clinic under the same plan of care, could receive different services: one would receive integrated remote monitoring because the clinical-staff time was furnished by a W-2 employee, while the other would not, solely because the same qualified individual was engaged under contract. Employment classification bears no relationship to the beneficiary's clinical need, the adequacy of supervision, or the integrity of the claim. CMS should clarify in the Final Rule how the proposed restriction applies when a contracted or temporary physical therapist is the practitioner whose professional work the RTM treatment-management codes describe, as distinct from clinical staff furnishing services under a billing practitioner's supervision. The Proposed Rule does not address that distinction. In practical terms, the Proposed Rule would not prevent the purchase of software or technical services, but the bar on contracted clinical-staff time could nonetheless make Medicare RTM operationally infeasible for small clinics. That result would reduce beneficiary access and consolidate a useful service within larger organizations.

Prohibiting contracted clinical staff also conflicts with current health care labor-market realities. Many outpatient rehabilitation practices rely on temporary, traveling, or contracted physical therapists to maintain clinical operations and manage patient volume. Under the proposed direct-employment requirement, a beneficiary could receive RTM when treated by a W-2 therapist but lose access to the same clinically indicated service when treated by an equally qualified temporary or contracted therapist in the same facility. That distinction would create a two-tiered system based on staffing mechanics rather than clinical need, undermine patient-centered plan-of-care design, and exacerbate access problems in workforce-shortage areas.

RTM's coding and documentation requirements add to the operational challenge. The code family uses different data-transmission periods and time thresholds, and practices must document each billed element accurately. Contracted physical therapists and physical therapist assistants with specialized RTM training

can help practices meet those requirements in collaboration with the beneficiary's in-person physical therapist.

Independent physical therapists already balance full treatment schedules, required documentation, and the identification of patients for whom RTM is clinically appropriate. Without integrated operational support, practices may be unable to sustain the monitoring and follow-up that help patients adhere to home exercise programs and complete their plans of care. Evidence indicates that RTM integrated with in-person physical therapy can improve engagement and functional outcomes.[14] The transition period compounds that problem. A report on stakeholder reaction to the proposal explains that many providers will be unable to build internal remote-monitoring infrastructure between publication of the Proposed Rule and the proposed January 1, 2027, effective date.[15] Industry representatives predicted that many organizations would end their programs rather than recreate vendor capabilities within approximately six months. Although the utilization and outcome examples discussed in that report primarily concern RPM, CMS proposes the same direct-employment restriction for RPM and RTM. The operational warning therefore applies directly: a blanket staffing rule may eliminate clinically integrated programs along with the disconnected arrangements CMS seeks to stop, with the greatest effects on small and rural providers. CMS's stated concern is legitimate, but its proposed line is overinclusive. The OIG findings cited by CMS involve practices or vendors with no meaningful prior relationship with the patient, cold-call solicitation, weak involvement by the billing practitioner, and incomplete service delivery.[16] CMS can prohibit those arrangements directly. It need not prohibit contracted personnel who are integrated into a legitimate treating practice.

Stakeholder responses summarized by DistilInfo reinforce that distinction. Clinically integrated remote-monitoring organizations support eliminating fraudulent, low-quality, and disconnected programs but argue that direct employment does not define integration. They recommend guardrails tied to evidence-based protocols, documented clinical integration, practitioner involvement, and timely clinical response. Those are more precise measures of quality and accountability than payroll status and are consistent with the alternative framework APTA Private Practice recommends below.

A more targeted final policy should permit contracted clinical staff when all the following are met:

- the billing practitioner, not the vendor, determines that RTM is medically necessary and incorporates it into the patient's therapy plan of care;
- the patient is established with the billing practice and affirmatively consents after receiving an explanation of RTM and any applicable cost sharing;
- the contracted personnel meet the definition of clinical staff, are licensed or otherwise qualified when required, and furnish services under the billing practitioner's general supervision and written protocols;
- the billing practitioner and practice have contemporaneous access to the RTM data, communications, and documentation in or linked to the medical record;
- the treating physical therapist reviews clinically significant alerts and remains responsible for treatment-plan changes;
- the written agreement addresses training, privacy, security, escalation, record retention, and audit access;
- neither the vendor nor its personnel cold call Medicare beneficiaries, independently select patients, or establish medical necessity; and
- the claim and record identify the billing practitioner and support each required element and unit of service.

These safeguards respond directly to fragmentation, insufficient oversight, and abusive solicitation. They also preserve the ability of independent practices to obtain specialized support while keeping clinical accountability where it belongs—with the treating practitioner and billing practice. CMS could supplement them through targeted claims edits, documentation review, vendor-related data analysis, and focused audits of high-risk billing patterns.

We respectfully recommend that CMS withdraw the direct-employee requirement. We urge CMS to permit qualified contracted clinical staff when they are integrated into the billing practice, operate under the billing practitioner's general supervision and written protocols, document services in a record accessible to the treating clinician, and do not independently solicit or select beneficiaries.

D. CMS Has Not Established That RTM Practice Expense Is Overvalued

CMS proposes significant changes to direct PE inputs. For CPT code 98975, initial setup and patient education, CMS proposes to crosswalk the direct PE inputs from CPT code 99473, which describes self-measured blood-pressure education, training, and device calibration. For CPT codes 98976, 98977, 98978, 98984, 98985, and 98986, CMS proposes a crosswalk from CPT code 93270, an external electrocardiographic event-recording service. CMS states that existing RTM valuation "may not accurately reflect" resource costs and expresses concern that the codes are overvalued but repeatedly acknowledges that it has received very little invoice, pricing, device, or workflow information.[17]

That evidentiary sequence is backwards. A lack of data does not establish overvaluation. Nor does it support replacing RTM inputs with inputs from clinically and operationally dissimilar services. RTM setup may require configuring a platform or device for a therapeutic plan, enrolling and authenticating the patient, teaching the patient or caregiver to enter or transmit information, confirming that the patient can use the technology, explaining alert and communication expectations, addressing accessibility needs, and connecting the data to the practice's workflow.

It also requires significant and recurring expenses for RTM vendors, which in turn affect practitioner costs. First, RTM providers must maintain FDA medical device registration and Quality Management System (QMS) compliance including post-market surveillance and ongoing risk management. Second, platforms require continuous cybersecurity oversight, SOC2 Type II audits, HIPAA compliance updates, end-to-end data encryption, and enterprise cloud hosting infrastructure (e.g., AWS or Azure). Third, maintaining electronic health record (EHR) interoperability via HL7 and FHIR application programming interfaces (APIs) requires ongoing software engineering to prevent clinician documentation duplication. Fourth, platforms continually update embedded clinical decision support (CDS) logic and clinical content libraries based on evolving clinical practice guidelines and real-world evidence. A blood-pressure training service is not a reliable substitute for those resources. Likewise, an attended ECG event recorder does not necessarily reflect the cost structure of musculoskeletal RTM devices, software licenses, data access, patient-facing applications, technical support, security, or integration.

The costs incurred by private practices are also not limited to the price of a physical device. Depending on the model, practices may pay per patient, per episode, per billable unit of licensed software or device access, per clinician, per location, or through a subscription that bundles software, data access, support, and hardware. Volume discounts available to large systems may not be available to small practices. CMS expressly requests information about whether prices include software, hardware, or both and about discounts and other typical pricing details. That request confirms that the record is not yet adequate to impose a nationwide crosswalk based on an assumed "typical device." Devaluing PE RVUs causes Medicare reimbursement to fall below basic software acquisition costs, creating an unsustainable financial gap for many therapy practices.

CMS separately proposes to eliminate PE inputs for CPT codes 98979, 98980, and 98981 because it believes the resources are captured in work RVUs and the typical workflow would not involve clinical-staff time.[18] That assumption does not reflect many therapy practices. Treatment management requires more than the practitioner's minutes of work. Practices incur costs for platform access, data presentation, secure communications, documentation systems, scheduling, consent and cost-sharing workflows, compliance oversight, and personnel who route information or support the interaction. Even where clinical-staff time is not separately counted toward the code's time threshold, the practice still incurs indirect and direct resources necessary to make the practitioner's work possible. Work RVUs compensate for professional work; they are not a substitute for PE. As CMS is aware, the PTA is included in the PE RVU as a direct PE input and not in the work RVU.

CMS should retain current direct PE inputs while collecting representative, auditable data from multiple practice sizes, vendor models, therapeutic categories, and geographic areas. Any future revaluation should distinguish hardware from software and clinical services; account for bundled subscriptions and volume discounts; identify the typical service rather than the cheapest available product; and use a crosswalk with comparable workflow and resource use. CMS should also provide stakeholders with the proposed input-level effects and an opportunity to comment before adopting a material reduction.

We respectfully recommend that CMS not finalize the proposed crosswalks or elimination of PE inputs for RTM in CY 2027. CMS should instead retain current inputs while collecting representative device, software, workflow, and pricing data, then address any revaluation through transparent notice-and-comment rulemaking.

E. CMS Should Not Replace the Current RTM Codes with GRTM1 and GRTM2

CMS is considering replacing the modular remote-monitoring code family with four G-codes—two for RPM and two for RTM. These comments address the two RTM G-codes: GRTM1 for initial setup and patient education and GRTM2 for a monthly bundle of device supply or data access, at least two days of data transmission, and at least 20 minutes of treatment management with one real-time interactive communication. CMS suggests that the bundle could reduce the number of codes and ensure that beneficiaries receive all components.[19]

APTA Private Practice does not support finalizing GRTM1 and GRTM2 for CY 2027. The current code structure is modular because patient needs are not identical from month to month. A beneficiary may need setup and education, device access, or a shorter amount of management in one period and more intensive management in another. Recent CPT changes recognized shorter data-transmission periods and a 10-minute treatment-management increment. Replacing that flexibility with a mandatory 20-minute bundle would deny payment when a clinically appropriate month does not include every bundled element, encourage delivery of time or interactions solely to satisfy a billing threshold, and make RTM less viable for patients whose needs fluctuate.

The OIG statistic on which CMS relies does not establish that every beneficiary should receive all three components in every month. CMS itself acknowledges that it has not required practitioners to bill all three components. The absence of a separately billed component may reflect the stage of the episode, patient need, billing rules, or a service furnished but not separately reported; it is not, by itself, evidence that care was incomplete. Moreover, the cited OIG reports principally concern RPM. CMS should not impose a new RTM bundle without RTM-specific analysis of service patterns, outcomes, beneficiary experience, and the reasons particular components were or were not billed.

The proposed valuation is also insufficiently developed. CMS suggests crosswalking GRTM1 to blood-pressure training inputs and GRTM2 to 0.62 work RVUs from CPT code 98980 plus direct PE inputs from an ECG event-recording service.[20] As explained above, those services do not establish the resources for a heterogeneous RTM bundle. Practices do not purchase a discrete monitoring device; they purchase continuing access to a regulated and maintained clinical platform, and the supplier's recurring costs are recovered in the price the practice pays. Those recurring costs include, where the product is a regulated medical device, registration and quality-system obligations, including post-market surveillance and ongoing risk management; continuing cybersecurity and privacy oversight, including independent security assessments such as SOC 2 Type II audits where applicable, encryption in transit and at rest, and enterprise hosting; sustained software engineering to maintain electronic health record interoperability through HL7 and FHIR interfaces; and periodic updates to embedded clinical decision-support logic and clinical content as practice guidelines evolve. None of these recurring obligations is reflected in the resource profile of self-measured blood-pressure training or an external electrocardiographic event recorder. CMS has not specified how the bundle would address months with 10 minutes of management, additional 20-minute increments, different device categories, multiple therapeutic parameters, replacement devices, treatment changes, or concurrent in-person therapy. Nor has CMS shown that one bundled payment would cover the actual costs borne by small practices.

Reducing the number of billing codes does not necessarily reduce administrative burden. A bundle can shift complexity into eligibility determinations, internal tracking, documentation of every required element, patient cost-sharing explanations, and denied-claim appeals. It can also obscure utilization data that CMS needs to distinguish setup, device access, and professional management. If CMS believes a bundle merits further study, the agency should convene rehabilitation stakeholders, analyze RTM-specific claims and outcomes, test alternative structures, publish complete descriptors and valuations, and propose the policy in a later rulemaking rather than finalize it from this preliminary solicitation.

We respectfully recommend that CMS not finalize GRTM1 or GRTM2 for CY 2027. We urge CMS to reserve the current modular RTM code family and its shorter-duration options. Any future bundle should be developed with RTM-specific evidence, stakeholder input, complete valuation data, and a separate opportunity for notice and comment.

F. Program Integrity Should Be Targeted to Actual Risk

APTA Private Practice supports safeguards that ensure beneficiaries receive medically necessary RTM from an accountable treating practitioner. The Final Rule should focus on arrangements that present actual risk: unsolicited beneficiary recruitment; billing without a prior clinical relationship; vendor selection of patients[21]; lack of practitioner access to data; templated records that do not show individualized review or management; billing for time not furnished; and episodes in which required code elements are absent. CMS should also scrutinize vendor compensation tied to the number of units billed or the amount collected, which gives the vendor a financial stake in the claim and may conflict with Medicare's rules governing payment to billing agents.[22]

Vendor compensation determined by the number of units billed or amounts actually collected raises a distinct concern because it gives the vendor a direct financial interest in the amount billed or collected. Arrangements in which a vendor's revenue rises with the volume or value of RTM claims may also implicate the federal anti-kickback statute. CMS should address such arrangements through targeted program-integrity requirements, not by replacing the modular RTM code family with a bundled code. These risks can be addressed without barring contracted support, presuming that all RTM services are overvalued, or forcing every month into a single bundle.

CMS should also distinguish clinical services from technology and administrative support. Practices must remain free to purchase software, devices, connectivity, training, cybersecurity, analytics, and nonclinical technical support. Any Final Rule should state this expressly so that contractors and Medicare Administrative Contractors do not misread any supervision policy as a prohibition on ordinary technology vendors. Clear guidance should describe which activities constitute clinical-staff services, which may be furnished by technical personnel, how practitioner time must be documented, and how RTM interacts with concurrently furnished therapy and care-management services.

Before imposing further restrictions, CMS should monitor beneficiary access, practice participation, claim denial patterns, geographic and rural effects, and differential impact by practice size. RTM policy should promote responsible adoption rather than create a compliance environment in which only large organizations can bear the fixed costs.

RTM is most valuable when it remains part of an individualized therapy plan of care and the treating physical therapist retains responsibility for clinical decisions. CMS can strengthen those principles without dismantling the operational models that allow independent practices to furnish RTM. Any Final Rule should protect beneficiaries from abusive arrangements; bar cold calling; require a preexisting treating relationship; and require the medical record to support every billed element and unit of service, while preserving access to legitimate, integrated, and clinically necessary remote therapeutic monitoring.

IV. Value-Based Care and Quality Measurement

APTA Private Practice supports CMS's continued efforts to transition Medicare toward value-based payment models that reward high-quality, patient-centered, and cost-effective care. Independent private practices have long demonstrated that outpatient physical therapy improves function, restores mobility, and helps beneficiaries avoid unnecessary downstream utilization. Value-based payment should recognize those contributions while remaining operationally feasible for the small and medium-sized community practices that furnish much of Medicare's outpatient rehabilitation.

The Proposed Rule continues implementation of the Ambulatory Specialty Model (ASM) while advancing CMS's transition from traditional MIPS toward MIPS Value Pathways (MVPs). CMS explains that these initiatives are intended to improve quality, strengthen care coordination, reduce unnecessary utilization, and better align Medicare payment with value rather than volume.[23] APTA Private Practice supports those objectives. However, successful implementation requires clinically meaningful measures, feasible participation pathways, and administrative requirements proportionate to the capabilities of independent rehabilitation practices.

Recommendations

For the CY 2027 Final Rule, APTA Private Practice respectfully recommends that CMS:

- Continue development of value-based payment models that recognize the contribution of outpatient physical therapy to improved function, reduced downstream utilization, and lower total cost of care.
- Incorporate clinically appropriate access to conservative physical therapy into future musculoskeletal quality measurement and value-based payment initiatives.
- Preserve meaningful patient-reported functional outcome measurement and avoid replacing outcome measures with process measures whenever feasible.
- Continue the transition toward MIPS Value Pathways only as clinically meaningful rehabilitation measures and operationally feasible participation pathways become available.

- Maintain small-practice protections and minimize unnecessary administrative burden through greater reliance on claims-based data and simplified reporting requirements.
- Ensure that interoperability, certified technology, and electronic prior authorization requirements remain achievable for independent rehabilitation practices before they become mandatory.
- Continue collaborating with rehabilitation stakeholders to develop quality measures and value-based payment models that appropriately recognize the contribution of physical therapists to beneficiary outcomes.
- Define "virtual telehealth platform" in the final rule and provide examples of arrangements that are expressly included and excluded from the definition before the issuance of subregulatory guidance.

A. Value-Based Care Should Recognize Conservative Musculoskeletal Management

CMS has appropriately recognized that early clinical decision-making influences downstream utilization, patient outcomes, and Medicare spending.[24] Physical therapy is a principal component of evidence-based conservative management for musculoskeletal conditions, particularly low back pain, yet current Medicare quality programs do not consistently recognize timely access to physical therapy as an indicator of high-value care.

A growing body of research demonstrates that earlier access to physical therapy is associated with lower utilization of advanced imaging, opioid prescribing, emergency department services, surgery, and other higher-cost interventions for many patients with low back pain.[25] Although physical therapy is not appropriate for every beneficiary or every diagnosis, Medicare's value-based payment models should encourage appropriate conservative management when clinically indicated rather than focusing primarily on downstream procedural utilization.

Accordingly, CMS should continue developing quality measures that recognize clinically appropriate access to conservative rehabilitation while preserving meaningful measurement of functional improvement. Patient-centered outcome measures evaluating mobility, pain, independence, and daily function more accurately reflect the goals of rehabilitation than process measures documenting only that an assessment occurred. CMS itself has recognized the importance of preserving meaningful patient-reported outcome measurement as existing quality measures evolve.[26]

APTA Private Practice does not recommend mandatory participation by independent physical therapy practices in physician-oriented payment models that were designed for substantially different provider types. Instead, CMS should strengthen collaboration between participating physicians and physical therapists while developing future participation pathways that appropriately reflect rehabilitation practice.

B. Quality Measurement Must Be Clinically Meaningful and Operationally Feasible

APTA Private Practice supports CMS's long-term transition toward MIPS Value Pathways provided rehabilitation providers have realistic opportunities to participate successfully. CMS estimates that its expanding MVP inventory will provide coverage for most clinician specialties while simultaneously acknowledging that some clinicians continue to lack sufficient applicable measures or workable reporting pathways.[27] These implementation realities should guide the pace of transition.

For rehabilitation providers, quality measurement should emphasize meaningful patient outcomes rather than documentation processes. CMS should continue developing broadly available, non-proprietary functional outcome measures while relying wherever possible on claims-based and other Medicare-held data instead of requiring duplicative provider reporting.

Independent private practices continue to bear disproportionately high compliance costs associated with registry participation, software implementation, workflow redesign, annual regulatory updates, and quality reporting. Those fixed administrative costs are considerably more burdensome for small practices than for large integrated health systems. CMS has appropriately proposed several small-practice accommodations within the Proposed Rule, and APTA Private Practice encourages CMS to continue applying proportionality as a guiding principle throughout future MVP implementation.[28]

C. Technology Should Reduce Administrative Burden

CMS's interoperability initiatives have significant potential to reduce administrative burden when implemented in a manner consistent with the rehabilitation technology marketplace. APTA Private Practice supports CMS's efforts to simplify quality reporting, reduce unnecessary attestations, and improve electronic exchange of clinical information.[29]

At the same time, interoperability requirements should not become barriers to participation in Medicare quality programs. Many rehabilitation providers continue to utilize specialty electronic health record systems that differ substantially from those used by physician practices and hospitals. CMS should therefore ensure that certified technology requirements, interoperability standards, and future electronic prior authorization requirements become mandatory only after compatible technology is broadly available and economically feasible for rehabilitation providers. Modernization should simplify provider workflows—not shift unresolved payer administrative burdens onto clinicians.

APTA Private Practice supports Medicare's continued movement toward value-based care. Success should be measured not by the number of reporting requirements imposed on providers, but by whether Medicare beneficiaries experience better outcomes, improved access to conservative treatment, reduced administrative burden, and a payment system that appropriately recognizes the value delivered by independent physical therapy practices.

D. CMS Should Clarify the Requirements of Any Qualifying "Virtual Telehealth Platform"

We respectfully request that CMS clarify the intended scope and operation of the proposed telehealth modifiers, "BB and BC," which implement statutory provisions enacted by Congress in H.R. 1, the One Big Beautiful Bill Act (Pub. L. 119-21), regarding telehealth platform arrangements and incident-to telehealth services. Specifically, it is unclear whether the circumstances described in subparagraphs (A) and (B) are intended to function as separate, independent triggering conditions for modifier reporting or whether both conditions must be satisfied for a modifier to be required on a claim.

APTA interprets the statutory language to establish two distinct categories of claims subject to modifier reporting. The phrase "in the case of" precedes two separately enumerated subclauses, each of which begins with the phrase "claims for" and identifies a distinct billing scenario. Under this interpretation, the conjunction joining subparagraphs (A) and (B) serves to identify multiple reporting situations rather than requiring that both conditions be met simultaneously. This interpretation also appears consistent with CMS's proposal to create separate modifiers corresponding to the different circumstances identified in the statute.

If this interpretation is correct, the application of the modifier requirement would extend beyond incident-to arrangements referenced in (B). While subparagraph (B) is expressly limited to services furnished incident to a physician's or practitioner's professional service, subparagraph (A) could be read to apply more broadly to any telehealth service furnished through a virtual telehealth platform when the billing practitioner has a contractual, compensation-based, ownership, or other payment arrangement with the

entity operating that platform. Under such a reading, the requirement could potentially apply to a broad range of Medicare telehealth practitioners, including physical therapists and other practitioners authorized to furnish Medicare telehealth services that utilize third-party telehealth technology vendors.

Accordingly, we request that CMS explicitly confirm in the final rule whether subparagraphs (A) and (B) constitute independent reporting scenarios and provide illustrative examples identifying the claims that would be subject to each modifier. We further request that CMS provide additional clarification regarding the meaning of the term "virtual telehealth platform." Neither the statute nor the proposed regulatory discussion appears to provide a sufficiently clear definition of this term to enable practitioners to determine with certainty whether commonly used telehealth technologies fall within its scope. As drafted, the term could be interpreted broadly enough to encompass virtually any software, communications platform, or technology solution used to facilitate a telehealth encounter. If that interpretation is intended, a substantial share, if not all, of Medicare telehealth claims could become subject to modifier reporting, raising questions regarding the practical utility of the resulting data. Alternatively, CMS may intend the term to refer more narrowly to entities whose business model is centered on furnishing, arranging, managing, or marketing virtual care services through a dedicated telehealth platform, rather than general-purpose technology products that support telehealth as one feature among a broader suite of functions. Because the proposed rule does not clearly distinguish between these scenarios, stakeholders are unable to determine the intended scope of the reporting requirement.

Therefore, we urge CMS to define "virtual telehealth platform" in the final rule and provide examples of arrangements that are expressly included and excluded from the definition prior to the issuance of subregulatory guidance. Such clarification would promote consistent compliance, reduce unnecessary reporting burden, and ensure that the modifiers accurately capture the relationships Congress intended CMS to monitor.

V. Modernizing the CPT and RUC Processes Without Sacrificing Clinical Accuracy, Stability, or Access

CMS requests information on the effects of the American Medical Association's control of CPT licensing, whether the CPT code-development process accounts for medical necessity, possible alternatives to CPT as the national coding standard, more objective alternatives to the CPT and RUC committee processes, and the use of ICD-10-PCS or other groupers as a basis for procedural payment.[30] Although CMS has not proposed a specific replacement system, the RFI raises foundational questions about how Medicare describes and values professional services.

Those questions are justified. Medicare's payment system relies heavily on recommendations produced through private processes in which the professions and specialties whose services are being valued have an unavoidable financial interest. CMS notes MedPAC's longstanding concern that the agency has over-relied on specialty societies with a financial stake in valuation and the National Academies' recent recommendation that CMS use alternative sources of data and expertise.[31] The problem is not that clinical experts participate; their expertise is indispensable. The problem is that expertise is not consistently balanced by independent data, transparent methodology, or representation that reflects the full range of clinicians furnishing Medicare services.

Physical therapy illustrates the representational problem. Physical therapists furnish a substantial volume of Medicare services, yet the institutions that create and value codes remain centered on physician

organizations and physician specialty representation. Nonphysician practitioners may contribute through advisory structures and individual code-development efforts, but they do not possess influence commensurate with their responsibility for beneficiary care or their exposure to the payment consequences. A modernization effort should correct that imbalance rather than merely transfer decision-making from one institution to another.

Recommendations

APTA Private Practice supports CMS's examination of the CPT and RUC processes and recommends that CMS develop, through a transparent and staged process, an independent evidence-informed mechanism that supplements—not abruptly replaces—the existing national coding system. Any reform should:

- Give physical therapists and other nonphysician practitioners meaningful and proportionate representation.
- Rely on auditable empirical data in addition to specialty surveys.
- Preserve clinical granularity and stable national coding.
- Prohibit diagnosis alone from determining payment for therapy services.
- Be tested through public pilots and notice-and-comment rulemaking before it affects payment.

A. CMS Should Build an Independent, Data-Informed Supplemental Valuation Process

APTA Private Practice does not recommend immediate abandonment of CPT. A single national code set supports claims processing, coverage administration, clinical documentation, quality measurement, research, and coordination across Medicare and private payers. A rapid move to competing proprietary code sets would impose substantial conversion, training, software, and compliance costs on small practices. It could also create inconsistent definitions of the same service across payers—contrary to the administrative-simplification objectives Congress established through HIPAA, under which HHS has designated the applicable code sets by regulation.[32] Replacing a designated code set would require a separate HHS standards rulemaking.

CMS should instead develop an independent supplemental process capable of validating or rebutting CPT and RUC recommendations. That process should be housed within, or commissioned by, CMS under public governance and should include physical therapists, occupational therapists, speech-language pathologists, physicians, other nonphysician practitioners, health-services researchers, coding experts, economists, beneficiaries, and small-practice representatives. Membership, conflicts, data sources, analytic methods, meeting materials, and rationales should be public, subject only to legitimate protections for beneficiary-level or proprietary data.

The process should replace excessive dependence on small, self-selected specialty surveys with multiple sources of evidence. Relevant evidence may include Medicare claims, practice-level time studies, electronic workflow data, cost-accounting data, invoices, wage and rent information, clinical labor inputs, validated patient-complexity measures, and structured expert review. CMS should publish the evidence used, explain material departures from external recommendations, and establish a predictable reconsideration and appeals pathway. No single dataset will be sufficient; claims data describe what was billed, not necessarily the full resources required to furnish appropriate care. Empirical data must therefore inform—not displace—clinical judgment.

CMS should begin with a limited number of code families for which evidence shows persistent anomalies, substantial disagreement, rapid technological change, or weak survey response. It should compare the independent process with existing RUC recommendations, publish the results, assess distributional and access effects, and seek further comment before using the approach broadly. This

would permit CMS to improve objectivity without destabilizing the national coding infrastructure or allowing budget neutrality to turn methodological reform into an indiscriminate reduction in payment.

B. Diagnosis-Based Payment Is a Poor Substitute for Service-Based Coding in Outpatient Therapy
APTA Private Practice strongly cautions against using ICD-10 diagnosis or procedure codes as the principal basis for payment for outpatient physical therapist services. Diagnosis identifies a condition; it does not reliably describe the service furnished, the time required, the intensity of skilled intervention, the beneficiary's functional limitations, the number of body regions involved, relevant comorbidities, caregiver needs, or the resources necessary to achieve a safe outcome. Two beneficiaries with the same diagnosis may require materially different evaluations and treatment plans. Conversely, similar skilled interventions may be appropriate across many diagnoses.

ICD-10-PCS is also designed for inpatient procedure reporting and is not a ready substitute for professional-service coding in independent outpatient practices. Grouping therapy into broad diagnosis-based bundles modeled on MS-DRGs or APCs would risk underpayment for beneficiaries with neurologic conditions, multiple chronic conditions, substantial functional loss, cognitive or communication barriers, or complex post-surgical needs. Unless rigorously risk-adjusted, such groupers could create incentives to avoid high-need beneficiaries, shorten clinically necessary episodes, or substitute standardized protocols for individualized skilled care.

CMS may appropriately study episode-based or condition-based payment as a complement to fee-for-service payment, but any such model must incorporate functional status, severity, comorbidity, prior level of function, social and caregiver factors, and changes in clinical condition. It must also define the services included in a bundle, preserve beneficiary choice and access to independent practitioners, provide outlier protection, and prevent hospitals or other conveners from capturing therapy payment without accountability for the care furnished. Diagnosis codes alone cannot satisfy these requirements.

C. Medical Necessity Should Remain a Coverage Standard, Not a Gatekeeper for Code Creation
CMS also asks whether medical necessity should be identified during CPT code development. Coding and coverage are related but distinct. A code should accurately describe a service that is performed and sufficiently established to warrant standardized reporting. Whether Medicare covers that service for a particular beneficiary depends on statute, evidence, clinical circumstances, and applicable coverage policy. Requiring a generalized finding of Medicare medical necessity before a code can exist could suppress emerging services, impede data collection, and allow coverage judgments to distort the neutral descriptive function of a code set.

CMS should nevertheless require code-development and valuation bodies to disclose the expected clinical use of a proposed code, the population for whom it is intended, the evidence supporting the resource assumptions, and known risks of misuse or duplication. That information would improve valuation and later coverage decisions without collapsing coding, coverage, and payment into a single opaque determination.

D. Required Guardrails for Any Future CMS Proposal
Before proposing any structural change to CPT or the RUC process, CMS should publish a detailed options paper and convene a technical advisory panel with balanced representation. Any later proposal should include a regulatory impact analysis addressing implementation costs for small practices; effects on therapy payment and beneficiary access; interoperability with commercial, Medicaid, workers' compensation, and other payer systems; effects on quality measurement and prior authorization; and transition requirements for electronic health records, clearinghouses, and claims systems.

Most importantly, modernization must not become a vehicle for across-the-board devaluation. Payment accuracy requires objective data, meaningful clinical input, and correction of both overvaluation and undervaluation. For physical therapist services—already subject to cumulative payment pressure, the multiple procedure payment reduction, and substantial administrative burden—the success of reform should be measured by whether it produces more accurate resource valuation and preserves access, not simply whether it reduces aggregate spending.

APTA Private Practice is prepared to participate in a balanced technical process and to assist CMS in identifying representative physical therapist practices, relevant workflow and cost data, and therapy code families suitable for carefully designed validation. CMS should use the RFI as the beginning of that public process, not as a predicate for abrupt replacement of the current national coding system.

VI. Conclusion

The CY 2027 Medicare Physician Fee Schedule presents CMS with an important opportunity to improve payment accuracy while strengthening beneficiary access to high-quality outpatient rehabilitation. APTA Private Practice appreciates CMS's willingness to modernize practice expense valuation, examine long-standing assumptions underlying physician payment, strengthen program integrity, and continue Medicare's transition toward value-based care. These efforts represent meaningful progress, but they must be implemented in ways that preserve access to independent community-based physical therapy practices that serve millions of Medicare beneficiaries each year.

APTA Private Practice urges CMS to finalize the proposed practice expense methodology reforms, including elimination of the Indirect Practice Cost Index and greater recognition of clinical labor, while continuing to improve the accuracy of direct practice expense inputs for therapy services. CMS should also ensure that these important valuation improvements are not viewed as substitutes for long-term payment stability. The continued erosion of the Medicare conversion factor remains a significant threat to beneficiary access and cannot be solved through budget-neutral redistribution alone.

We also encourage CMS to adopt a balanced approach to Remote Therapeutic Monitoring that protects Medicare from abusive billing arrangements without restricting legitimate, clinically integrated care models that expand beneficiary access. Likewise, CMS should continue advancing value-based payment through quality measures that emphasize meaningful functional outcomes, feasible participation pathways, and administrative requirements proportional to the capabilities of independent rehabilitation practices. Finally, CMS should use its Request for Information regarding the CPT and RUC processes to improve transparency, broaden stakeholder participation, and strengthen the empirical foundation for future coding and valuation decisions.

These recommendations reflect a common objective: ensuring that Medicare payment policy appropriately recognizes the value of conservative, evidence-based rehabilitation while reducing unnecessary administrative burden on the clinicians who deliver that care. Payment adequacy, accurate valuation, meaningful quality measurement, and manageable regulatory requirements are not separate policy issues. Together, they determine whether independent physical therapy practices can continue serving Medicare beneficiaries in communities throughout the country.

APTA Private Practice appreciates the opportunity to comment on the Proposed Rule and welcomes continued collaboration with CMS as the agency finalizes these policies. We respectfully urge CMS to

adopt the recommendations contained in this letter to improve payment accuracy, strengthen independent practice, reduce unnecessary administrative burden, and preserve beneficiary access to timely, high-quality outpatient physical therapy services.

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
APTA Private Practice

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[1] 91 Fed. Reg. 43850–51 (July 16, 2026).
[2] 91 Fed. Reg. at 43850.
[3] Id. at 43850–51.
[4] Id. at 43849–50.
[5] Id. at 43850.
[6] Id. at 43850–51.
[7] In 2022, there were an estimated 233,890 FTE physical therapists in the workforce. A projected shortfall of 12,070 FTEs (5.2%) in 2022 was identified relative to population demand. Although projected supply growth from 2022 to 2037 (39,170 FTEs) exceeds demand growth (36,280 FTEs), a national shortfall remains in most forecast scenarios. By 2037, the physical therapist supply is expected to reach 273,070 FTEs, while demand will increase to 282,230 FTEs, resulting in a projected shortfall of 9,120 FTEs (3.3%) in the main scenario. See https://www.apta.org/apta-and-you/news-publications/reports/2025/apta-supply-demand-forecast-2022-2037 and Physical Therapy, Volume 105, Issue 3, March 2025, pzaf014, https://doi.org/10.1093/ptj/pzaf014.
[8] Id. at 43892–95.
[9] MedBridge, RTM vs. RPM: Understanding the Key Differences, https://www.medbridge.com/blog/rtm-vs-rpm-understanding-the-key-differences.
[10] Id. at 43892.
[11] Marshall T, Goldman A, Lyles R, et al. Retrospective case-control study on the effect of in-person physical therapy with remote therapeutic monitoring on functional outcomes and plan of care adherence amongst individuals with musculoskeletal conditions. Arch Rehabil Res Clin Transl. 2025;7(3):100466. doi:10.1016/j.arrct.2025.100466.
[12] Id.
[13] Id. at 43892–93.
[14] Marshall T, Goldman A, Lyles R, et al. Retrospective case-control study on the effect of in-person physical therapy with remote therapeutic monitoring on functional outcomes and plan of care adherence amongst individuals with musculoskeletal conditions. Arch Rehabil Res Clin Transl. 2025;7(3):100466. doi:10.1016/j.arrct.2025.100466.
[15] DistilINFO, CMS Proposes Remote Patient Monitoring Ban (July 16, 2026), https://distilinfo.com/2026/07/16/remote-patient-monitoring-ban-cms/.
[16] 91 Fed. Reg. at 43892–93.
[17] Id. at 43893–94.

[18] Id. at 43894.
[19] 91 Fed. Reg. at 43894–95.
[20] Id. at 43895.
[21] Current rules disallow vendor and provider payment relationships based on the number of units billed or actual collections, as vendors are barred from holding a financial stake in the claim's outcome. Existing rules also bar the vendor from receiving payment as a billing agent under such structures. See 42 C.F.R. § 424.73(b)(3)(i)–(ii).
[22] 42 C.F.R. § 424.80(a)–(b) (2025); 42 U.S.C. § 1320a-7b(b).
[23] Id. at 43842–49.
[24] Id.
[25] Frogner BK, Harwood K, Andrilla CHA, Schwartz M, Pines JM. Physical therapy as the first point of care to treat low back pain: an instrumental variables approach to estimate impact on opioid prescription, health care utilization, and costs. Health Serv Res. 2018;53(6):4629–4646; Fritz JM, Brennan GP, Hunter SJ. Physical therapy or advanced imaging as first management strategy following a new consultation for low back pain in primary care: associations with future health care utilization and charges. Health Serv Res. 2015;50(6):1927–1940; Magel J, et al. Time between an emergency department visit and initiation of physical therapist intervention: health care utilization and costs. Phys Ther. 2020;100(10):1782–1792.
[26] 91 Fed. Reg. at 44250–53.
[27] Id. at 43842–49.
[28] Id.
[29] Id.
[30] 91 Fed. Reg. at 43952–53.
[31] Id. at 43952.
[32] See 45 C.F.R. § 162.1002.