June 10, 2025

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

RE: CMS–3444–NC – Request for Information: Ensuring Lawful Regulation and Unleashing Innovation to Make Americans' Lives Better

To Whom It May Concern:

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

For an economic analysis of the impact of the conservative care provided by physical therapists, please see ValueofPT.com. The report available at this url outlines the cost-effectiveness and economic value of physical therapist services (PT) for a broad range of common conditions. The report uses an all-factors economic model to calculate the net benefits to patients and the health care system of choosing physical therapy over alternative treatments for eight conditions, including:

- Osteoarthritis of the knee ($13,981 in savings)
- Carpal tunnel syndrome ($39,553 in savings)
- Low back pain ($4,160 in savings)

The Report reinforces the importance of physical therapists (PTs) and physical therapist assistants (PTAs) in improving patient outcomes and decreasing downstream costs. We urge CMS to review and use this report to inform de-regulatory efforts for health care delivery and payment under Medicare, Medicaid, and with commercial payers under the purview of the agency. Our comment focuses on four major changes:

1. The 8-minute rule.
2. Multiple Procedure Payment Reduction (MPPR).
3. The 10th visit progress report.
4. Medicare's exception to Plan of Care (POC) certification.

We commend CMS for launching this initiative to reassess the regulatory landscape through the lenses of legality, efficiency, and innovation. In that spirit, we urge CMS to prioritize regulatory reforms that

directly alleviate the disproportionate burden carried by physical therapy private practices. We recommend eliminating or revising outdated and duplicative regulatory requirements that limit access to care and impose unnecessary administrative costs.

1: Eliminate the 8-Minute Rule

The 8-minute rule is a Medicare billing regulation that requires physical therapists to add up the minutes of all 15-minute time-based services provided in a single calendar day to determine the number of 15-minute time-based units that can be billed. Designed to ensure accurate billing for time-based services, the rule has become a source of significant administrative burden and clinical disruption - particularly in small, private physical therapy practices. While well-intentioned, the rule's practical consequences hinder access, efficiency, and innovation in patient care. In addition, the 8-minute rule goes against the definition of a "substantial portion" of a time-based code by the American Medical Association who creates and owns the codes.

Private practices are often lean operations where physical therapists balance direct patient care with administrative responsibilities. In this setting, the precise time calculations required by the 8-minute rule introduce complexity that consumes time better spent on clinical decision-making and patient engagement. Each treatment session must be charted meticulously, with therapists often needing to stop and calculate whether each component of care meets the threshold for billing. When services fall just short of 8 minutes, they become unbillable—even when clinically appropriate and valuable to the patient's recovery. This discourages flexibility and responsiveness in care.

These limitations hit small practices hardest. Larger institutions may employ billing specialists or clinical assistants to help ensure compliance, but in a solo or small-group clinic, every additional administrative task falls on the treating provider. Over time, the cumulative toll of navigating the 8-minute rule contributes to clinician burnout and drives up operational costs. For practices operating on slim margins, this can be the difference between remaining open and being forced to consolidate or close.

The impact also extends to patient access. When small practices struggle with unsustainable administrative requirements, they may reduce their participation in Medicare or limit the number of visits they can offer. This disproportionately affects older adults and people with disabilities—precisely the populations that depend on Medicare for access to physical therapy. In rural or underserved areas where private practices are often the only providers, the 8-minute rule's consequences can result in care deserts and worse health outcomes.

A more rational alternative would be to adopt the midpoint rule as defined by the American Medical Association and used by Commercial and Workers Compensation insurers allowing billing for a single unit of service once 8 minutes. We support the proposal in the APTA's 2025 Regulatory Relief Position Paper to eliminate this rule in favor of a cumulative, clinically appropriate billing standard, such as the midpoint rule used in other CMS payment systems. Implementation of the midpoint rule would preserve program integrity while dramatically simplifying compliance and empowering therapists to focus on patient-centered care.

2. Recognize or Eliminate MPPR

The MPPR, which reduces payment when multiple therapy services are provided to the same patient on the same day, was originally justified as a cost-containment measure assuming duplicative practice

expense inputs. However, MPPR penalizes the efficient and clinically appropriate delivery of comprehensive therapy sessions and particularly harms small practices that cannot offset these payment cuts through volume.

In addition, APTA has repeatedly argued in comments to the fee schedule and in conversations with CMS that the MPPR is already "built into" CPT code relative values impacted by the MPPR. In fact, CMS has urged the Relative Value Update Committee (RUC) to recognize the dual application of the penalty under current rules. The RUC has not adequately responded. We urge CMS to continue their efforts to ensure this inequity is corrected. Alternatively, we would respectfully urge CMS to repeal the MPPR for therapy services entirely. It disincentivizes multidisciplinary, coordinated care and disproportionately affects solo and small group practices where flexible scheduling and tailored interventions are the norm.

MPPR policy imposes a financial penalty on physical therapists when they provide more than one unit of service to a patient during the same visit. In addition, MPPR crosses disciplines when both physical and occupational therapy are provided to the same beneficiary on the same date of service by the same private practice. Originally implemented by Medicare to account for assumed redundancies in practice expense, MPPR reduces reimbursement by 50% for the practice expense component of the second and subsequent therapy procedures delivered during a single session. While this may seem like a minor budgetary adjustment at first blush, the consequences to private physical therapy practices are significant and damaging.

In private practice settings—especially solo or small group clinics—therapists often design each session to include multiple therapeutic interventions tailored to the patient's needs. For example, a session might consist of manual therapy, neuromuscular re-education, and therapeutic exercise. These are not duplicative services but complementary approaches necessary for effective rehabilitation. Yet under MPPR, these services are devalued, and practices are reimbursed as if they had incurred only a fraction of the cost of care designed for a particular patient's rehabilitation needs.

The MPPR directly undermines clinical autonomy and discourages best-practice care planning. Therapists in small practices are faced with a difficult choice: either limit services within each session to avoid financial loss or absorb the cuts and risk financial instability. Larger healthcare systems may have the resources to offset the losses through economies of scale, but small practices operate on tight margins. MPPR thus has the unintended effect of encouraging consolidation and reducing diversity in the provider landscape—counter to CMS's stated goals of improving access and supporting innovation. Moreover, MPPR disproportionately impacts high-need patients. Older adults or patients recovering from surgery often require multiple interventions in a single visit. Under MPPR, providing appropriate, bundled care is financially penalized. This disincentivizes efficient and effective treatment planning leading to either more visits which heighten system cost and patient inconvenience. In addition, for practices in underserved or rural areas, where patients may travel long distances and therapy sessions must be comprehensive, the financial penalties from MPPR can make Medicare participation unsustainable. This can limit access and exacerbate disparities in care availability. MPPR also adds another administrative layer to already burdensome billing practices. Therapists and billing staff must navigate complex coding hierarchies and track which procedures are subject to reductions, further increasing overhead for compliance.

Eliminating the MPPR would send a strong signal that CMS values clinically driven, patient-centered care and recognizes the importance of small practice providers. It would reduce the financial disincentive to comprehensive care and support more efficient treatment planning, ultimately leading to better outcomes at potentially lower cost.

3. Eliminate the 10th Visit Progress Report Requirement

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

Progress in physical therapy is not uniform across conditions, nor is it always linear. Some patients may demonstrate significant progress in just a few visits, while others may require more time to exhibit measurable gains. Mandating a progress report at the 10th visit regardless of diagnosis, severity, or complexity imposes a one-size-fits-all standard that is misaligned with the individualized nature of care.

For small practices, the 10th visit rule imposes a disproportionate administrative load. Therapists must pause care to generate a detailed report that may not reflect meaningful change, especially in cases of chronic conditions or slow recovery trajectories. The time spent writing progress reports is time taken away from patient care, completing billing and prior authorization paperwork, staff development, or other business-critical tasks. Moreover, the requirement creates compliance anxiety. If a therapist inadvertently misses the 10th-visit window, they risk denials or payment delays. This forces clinics to implement complicated tracking systems—often managed manually—just to meet the arbitrary 10th visit progress report requirement. For small practices without full-time administrative staff, this can be overwhelming and drain critical and limited staff time. The 10th visit progress report requirement also interferes with continuity of care. Instead of allowing clinical judgment to guide when a re-evaluation is necessary, the 10-visit threshold enforces documentation that may not reflect actual clinical need. In some cases, it can even lead to unnecessary visits or duplicated documentation, adding inefficiencies to an already resource-strapped system.

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

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

4. Support and Expand Medicare's Exception to the POC Certification Requirement

In all states, physical therapists are legally authorized to evaluate and treat patients without a physician referral, a model known as "direct access." These laws reflect the growing recognition that physical therapists are autonomous, doctorate-level providers trained to manage musculoskeletal conditions. However, Medicare policy lagged behind the states by enforcing physician certification of plans of care even when state law does not require it.

In the Final Rule of the 2025 Medicare Physician Fee Schedule, CMS established a welcome exception to the POC signature requirement for initial certification. Applicable to claims with dates of service on or after Jan. 1, 2025, when a patient is referred for physical therapy from a physician or other qualified nonphysician practitioner (NPP), this exception allows a signed and dated order or referral to meet the certification requirements as long as the order is in the patient's medical record and there is evidence that the POC was submitted to the referring provider within 30 days of the initial evaluation.

Previously, in addition to submitting the POC to the referring provider within 30 days of initial treatment, the PT depended on the provider to return a signed and dated copy of the POC as evidence of certification. This meant following up with physicians for signatures, often submitting multiple requests for, and confirming the existence of, the provider's signature on the POC before Medicare Part B outpatient therapy services could be provided and reimbursed. In effect, claims that otherwise met medical necessity requirements were not paid for lack of a timely physician signature.

Under the new exception, once the PT has transmitted the POC, the onus shifts to the referring provider to either return the plan of care with indicated changes. Absent this action, silence serves as an ascent to the PT's submitted POC. In effect, the new rule places increased emphasis and trust on the PT's clinical judgment, requiring only documentation evidencing the order or referral and that the POC was sent to the physician/NPP within 30 days of the evaluation.

We welcome the change as the prior process was cumbersome. Communication between providers, especially across different electronic medical record systems, often requires faxes, follow-up phone calls, and repeated reminders. In practice, patients sometimes arrive for visits before the physician recertification is returned. This creates an unnecessary compliance risk for small practices, as claims may be denied if documentation is incomplete.

We believe that this model should be extended another step. We urge that an updated plan of care through recertification also be acceptable if a physician or NPP writes an order for continued physical therapy and that this order is signed and dated by the physician or NPP. This order would then serve as acceptable documentation of recertification for continued outpatient physical therapy. Under current rules, PTs are required to send an updated plan of care to the physician or NPP and have them sign, date and return it. This red tape burden unnecessarily limits access to continued PT services, which can worsen health outcomes.

The best structure to empower Medicare patients to use direct access is to eliminate the need of both the physician referral or signed and dated POC by the physician/NPP. We respectfully ask CMS to eliminate the need for a physician/NPP referral or signed plan of care for a Medicare beneficiary to receive

outpatient physical therapy services.

For small practices, this requirement introduces time-consuming steps that delay care and add administrative burden. Therapists must obtain a physician's signature before Medicare will approve the plan of care—regardless of whether the physician has seen the patient or is familiar with the therapist's treatment approach. This causes delays that can stall recovery, frustrate patients, and burden referring physicians who are already overloaded.

Allowing physical therapists to establish and carry out a continuing or recertified POC independently would also reinforce the role of PTs as primary providers of musculoskeletal care, which would improve access, especially for early intervention. As stated above, this would reduce downstream healthcare costs such as imaging, medication, and surgery.

In summary, expanding Medicare's exception to the POC certification requirement would enhance clinical efficiency, support the sustainability of small private practices, and expand access to timely, evidence-based physical therapy care.

Conclusion

As CMS continues to modernize its regulatory framework, we respectfully urge prioritization of reforms that would allow small, community-based physical therapy practices to focus on clinical excellence rather than administrative compliance. Eliminating outdated policies like the 8-minute rule and MPPR, streamlining credentialing, and removing unnecessary documentation and physician sign-off requirements are straightforward ways to advance innovation, improve patient access, and reduce cost.

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

Sincerely,

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