ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

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**Via Electronic Submission**

September 12th, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1832-P
7500 Security Boulevard
Baltimore, MD 21244

**Re: CMS-1832-P, Medicare and Medicaid Programs: CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program: Proposed Rule, Fed. Reg. Vol. 90, No. 134, (July 16, 2025).**

Dear Administrator Oz:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "APTQI") to the Centers for Medicare and Medicaid Services (CMS) regarding the above referenced "Proposed Rule to Payment Policies Under the Physician Fee Schedule et al." for calendar year 2026, published in the Federal Register on July 16th, 2025, ("Proposed Rule").

By way of introduction, we are among the nation's leading providers of outpatient rehabilitation care and collectively employ or represent over 28,000 physical and occupational therapists and furnish physical and occupational therapy services on an annual basis to tens of thousands of Medicare beneficiaries throughout the United States. APTQI membership consists of affiliate and board member entities of varying size and geographic scope, which in aggregate provide patient care services in over 7,700 outpatient rehabilitation clinical sites.

## I. Preliminary Statement

We appreciate the opportunity to comment on the Proposed Rule. Many of the areas where CMS seeks feedback regarding Medicare Outpatient Part B therapy services are important to the APTQI's core mission: "*Ensuring patient access to value driven physical therapy care.*" We support CMS' commitment to enhance its partnerships with a delivery system in which providers are supported in achieving better patient outcomes at a lower cost for Medicare beneficiaries.

APTQI shares the core belief that any proposals related to physical therapy services should (a) drive payment in line with the value physical therapy services deliver to the patient and other providers in the continuum of care; (b) reduce unnecessary regulatory and administrative burdens unrelated to improving the quality of patient care; and (c) be transparent to patients and all stakeholders. Physical and occupational therapists are the clinical experts in body movement and APTQI applauds CMS' commitment to the promotion of physical activity as an integral part of the Make America Healthy Again agenda.

## II. Updating Equipment Price, Useful Life and Type for Certain Therapy Codes

In order to ensure that codes are valued as accurately as possible, the equipment items listed as part of the direct PE inputs must be up to date. APTQI conducted a review of the inputs in the public use file for equipment for the most common therapy CPT codes and discovered there have been no changes in these codes since at least 2005, which is as far back as the archive would allow. APTQI has identified specific instances where the price, useful life, and type of equipment listed in the public use file is no longer accurate.

First, the price and useful life of parallel bars, listed as item EQ201 in the public use file, are out of date. Parallel bars are much different today than they were over 20 years ago. In order to best serve the patient, it is typical and standard for clinics to purchase parallel bars that have power adjustable heights and solid bases. These features are much more expensive to purchase; however, they offer greater safety for patients who are at risk of falling. APTQI recommends updating the pricing for parallel bars to $18,956 to account for this. Due to the mechanical components, we also recommend adjusting the useful life of parallel bars to 5 years.

Next, treadmills are a major staple of therapy practice. Treadmills have multiple computerized and sensory components that allow for adjustable programs and tracking of vitals. APTQI recommends updating the price for treadmills listed in item EQ243 to $8,120.64. Also, due to the computerized components and sensory contained in treadmills, we recommend updating the useful life to 8 years.

Item EQ118 contains a bundle of six pieces of exercise equipment that are assigned to CPT codes 97110 and 97112. It contains a treadmill, bike, stepper, and upper body ergometer (UBE), pulleys, and a balance board. APTQI urges CMS to remove treadmill from this bundle and include it as a stand-alone piece of equipment for CPT codes 97110 and 97112 with the updated pricing of $8,120.64. In addition, we recommend replacing the stepper in item EQ118 with a Total Gym as they are used typically to provide CPT codes 97110 and 97112. APTQI recommends that the new bundle for item EQ118 should consist of a Total Gym, recumbent bike, and cable columns (pulleys) and remain in CPT codes 97110 and 97112. The adjusted price for item EQ118 should be $16,700.

Finally, the practice of manual therapy (CPT code 97140) and massage therapy (97124) typically includes the use of manual therapy hand instruments. These instruments are not included in the equipment for these codes. APTQI recommends adding manual therapy instruments at a price of $1,800 and a useful life of 15 years for CPT 97140 and 97124.

As we stated we would in our comment letter for the Proposed Rule for CY 2025, APTQI has worked over the last year to collect recent invoices and has shared them with the broader therapy community. Please refer to documents from the American Physical Therapy Association (APTA) as part of their comments for the CY 2026 Proposed Rule for copies of these invoices. These invoices support the pricing for all the requested changes listed in this section.

**In light of the fact that equipment inputs have not been updated since at least 2005, APTQI urges CMS to update equipment pricing, useful life, and type for certain therapy codes for CY 2026.**

## III. Removal of Certain CPT codes from the Efficiency Adjustment List

In the Proposed Rule, CMS states that there are limits to using survey data provided by the American Medical Association (AMA)/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) as a source of code valuation. Among these limits are low survey response rates, low total responses, and the large range in responses. CMS states that the preference is to use empirical evidence to price services more accurately and the intent behind the proposed efficiency adjustment is to account for efficiencies gained in work RVUs for non-timed services while also preserving the value of services that are primarily a function of the time the clinician spends with the patient by shielding those services from the adjustment.

By that rationale, CMS must remove CPT codes 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97113, 97124, 97140, 97533 and G0283 from the list of codes subject to the efficiency adjustment for the following reasons.

First, CPT codes 97032, 97033, 97034, 97035, 97036, 97113, 97124, 97140 and 97533 are time-based codes and only reportable as long as the therapist is in direct contact or constant attendance with the patient. Similar to E/M services, the work portion of these codes is primarily a function of the time the clinician spends with the patient. Second, empirical evidence shows that the intraservice time for these procedures is dependent on the time it takes for the desired physiological response to occur in the patient rather than the experience level of the therapist. For example, research shows that when manual therapy (CPT 97140) is performed for at least 10-15 minutes along with exercise, the patient's disability, function, and satisfaction are improved over exercise alone and the duration of manual therapy required for clinical improvement does not decrease with experience.[12] Similar empirical evidence can be found for the time and service-based modalities represented by the CPT codes in the 97010-97036 range.[3456] Simply put, if a patient is suffering from acute edema from a soft tissue injury, no amount of experience will allow a therapist to perform vasopneumatic compression (CPT 97016) in 5 minutes as opposed to 15 minutes and still have the desired outcome of flushing the excess fluid out of the tissue in order reduce the swelling.

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[1] (Michener, et al., 2024)
[2] (Abbott, et al., 2013)
[3] (Lehman & DeLateur, 1990)
[4] (Draper, Castel, & Castel, 1992)
[5] (Cameron, 2017)
[6] (Chesterton & al, 2003)

The duration is dictated by human physiology and is not shortened by experience. Similarly, evidence shows that greater intensity and higher frequency of aquatic therapy (CPT 97113) lead to significantly greater benefits in decreased pain and increased quality of life in patients with low back pain.[7] There are numerous clinical examples with the same rationale for the codes listed above. Empirical evidence shows that the CPT codes listed above share more in common with the E/M services CMS is attempting to shield from passive devaluation under the constraints of budget neutrality than the surgical interventions and procedures to remove skin tags that are cited as examples in the Proposed Rule. APTQI would like to point out that none of the service examples provided in the Proposed Rule to support the efficiency adjustment apply to therapy services.

Further, CMS states that another reason for the efficiency adjustment is that there are often many years between a code's introduction and revaluation within the RUC process. CMS states that it estimates there are 25.49 years since a code valuation has been reviewed by the RUC and that average is 17.69 years if codes which were never reviewed are excluded. This is not the case for therapy service codes. In 2017, 19 therapy CPT codes were labelled as potentially misvalued and underwent revaluation by the RUC. Changes due to this review were reflected in the 2018 fee schedule. In addition, the RUC reviewed a smaller subset of therapy codes in 2024 with corresponding changes going into effect in the 2025 fee schedule. Due to the fact that therapy codes have gone under much more recent revaluations than the average code, APTQI believes that therapy codes are not in need of yet another adjustment. Finally, APTQI would like to point out that "always therapy" codes have been subject to Multiple Payment Procedure Reductions (MPPR) since 2011. To institute yet another reduction in the name of efficiency is duplicative runs the risk of undervaluing the role of movement and physical activity in the health of Medicare beneficiaries.

**For the multiple reasons listed above, APTQI urges CMS to remove CPT codes 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97113, 97124, 97140, 97533 and G0283 from the list of codes subject to the efficiency adjustment.**

## IV. Correct the Utilization Assumption for G2211

In a May 2025 letter to CMS, the American Medical Association (AMA) noted that, due to faulty assumptions relating to the adoption of the new G2211 code, that the PFS is underfunded by $1 billion. According to the AMA, in 2024, Medicare began paying for HCPCS code G2211, which was developed to be reported along with office visits when there is a longitudinal relationship between the physician and patient, and the physician serves as the continuing focal point for medical services that are part of ongoing care related to a patient's single, serious condition or a complex condition. Under the Medicare statute, CMS must annually adjust the Medicare CF to maintain budget neutrality, meaning that increases in payment for one service must be offset by corresponding decreases elsewhere, so that overall Medicare spending does not rise solely due to changes in relative value units. To determine the budget neutrality adjustment needed for G2211, the Biden Administration needed to develop an estimate of how frequently G2211 would be billed in 2024. The final estimate that CMS included in the CY 2024 MPFS final rule was that G2211 would be billed with 38 percent of all office/outpatient E/M visits reported in 2024. However, instead of being reported with 38 percent of all office visits, an AMA analysis of the first three

[7] (Baena-Beato, Arroyo-Morales, Delgado-Fernendez, Gatto-Cardia, & Artero, 2013)

quarters of 2024 Medicare claims data found that G2211 was reported with only 10.5 percent of office visits.

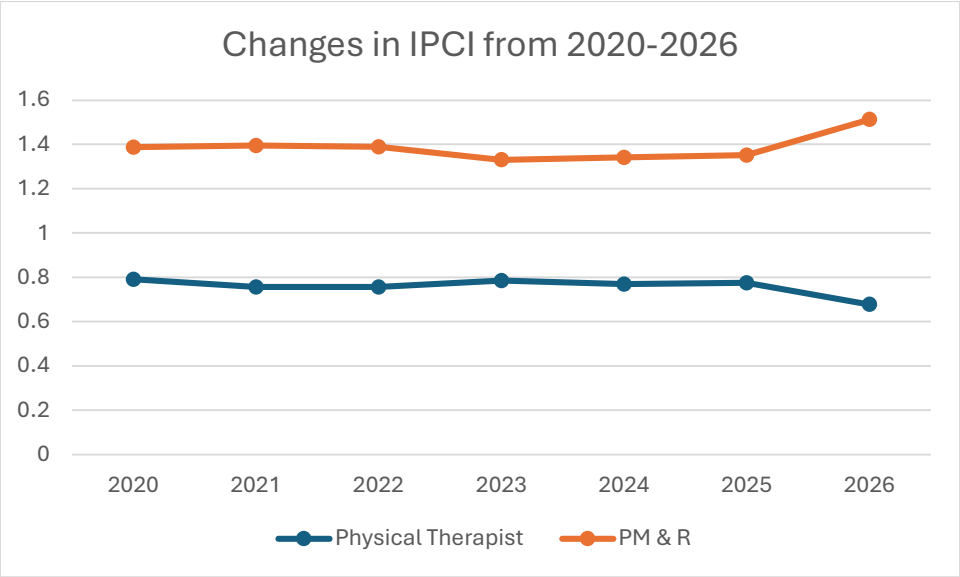
**APTQI supports AMA arguments on G2211 and urges CMS to correct the utilization estimate for G2211 based on actual claims data from 2024 by making a prospective budget neutrality adjustment to the 2026 CF in the 2026 PFS final rule.**

## V. Indirect Practice Expense and Indirect Practice Coste Index (IPCI) Policy

APTQI believes that the large payment differential between facility and non-facility settings has been an issue for providers who practice primarily in the non-facility setting. This is a particular issue for therapists as Medicare data shows that 99% of the most commonly reported therapy codes (CPT 97110, 97112, 97140, 97530 and 97161) in the PFS were billed in the non-facility setting.

In order to address this issue, CMS proposes to reduce the portion of the facility PE RVUs allocated based on work RVUs to 50 percent of the amount allocated to non-facility PE RVUs beginning in CY 2026. The net effect of this change increases non-facility payments by approximately 4%. However, the proposed rule shows that therapy services would increase by a total of only 1.2% for 2026. APTQI has not been able to discern exactly why a service that is provided predominately in the non-facility setting has a relatively minimal benefit from the policy change. **APTQI requests that CMS provide more transparency in their process so that it can ensure therapy services are valued accurately.**

Moreover, CMS has proposed to decrease the IPCI for physical therapists by 12.5% in CY 2026. This is a massive change in IPCI that is not explained in the Proposed Rule. Over the past 5 years, the IPCI for physical therapists has moved within a range of plus or minus 4%. A move that is more than three times the rate of change over recent history begs for a transparent explanation. APTQI was unable to find one in the Proposed Rule. To add to the confusion, the IPCI for Physical Medicine and Rehabilitation is proposed to increase by 12% for 2026. Again, APTQI could find no transparent explanation for why two similar specialties would diverge by such a large margin. The divergence is seen in the graph below.




**APTQI urges CMS to provide transparency on the changes to the IPCI and to revisit the calculations that led to a massive decline in Physical Therapist IPCI.**

## VI. Remote Therapeutic Monitoring (RTM) for MSK Care

APTQI members believe RTM improves patient outcomes and patient compliance with their plan of care. APTQI supports the changes in the Proposed Rule to adopt new RTM codes for 2026, including codes to describe less than 16 days of data transmission per 30-day period and less than 20 minutes of interactive communication per month. In order to avoid confusion, APTQI asks that CMS clarify that the initial set-up and patient education services for CPT 98975 should require a minimum of 2 days of data transmission instead of 16.

**APTQI supports finalizing the adoption of the new RTM codes for 2026 and urges CMS to clarify that 98975 requires a minimum of 2 days of data transmission.**

## VII. Revising PE Methodology to Reflect Costs of Running a Practice and Expenses for Medical Technology

APTQI appreciates CMS mentioning the expenses practices bear for medical technology such as Software and a Service (SaaS) and Artificial Intelligence (AI). These expenses have increased dramatically over the years for therapy practices. The EMR adoption rate for APTQI member clinics is almost 100% across its 7,700 member clinics. The costs can be up to $20,000 - $40,000 per clinic per year for EMR, billing and scheduling software, IT infrastructure, and AI tools. These costs will continue to rise and must be incorporated into practice expense.

**We urge CMS to work with APTQI to revise PE methodology to reflect medical technology expense in order to better reflect the cost of running a practice.**

## VIII. Conclusion

APTQI appreciates the opportunity to provide comments to CMS on the Proposed Rule for CY 2026. We encourage CMS to continue to work with professional societies such as the APTQI through the rulemaking process. APTQI looks forward to continued dialogue with CMS officials about these and other issues affecting therapy services. If you have any questions, or would be interested in further collaboration, please feel free to contact Nikesh "Nick" Patel, PT, DPT Executive Director, at 713-824-6177 or npatel@aptqi.com.

Very truly yours,

**ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION**

By: _____
Nikesh "Nick" Patel, PT, DPT
Executive Director

# References

Abbott, J., Robertson, M., Chapple, C., Pinto, D., Wright, A., Leon de la Barra, S., . . . Campbell, A. (2013). MOA Trail team: Manual Therapy, Exercise Therapy, or both, in Addition to Usual Care, for Osteoarthritis of the Hip or Knee: A Randomized Controlled Trial 1: Clinical Effectiveness. *Osteoarthritis Cartilage* , 524-34.

Baena-Beato, P., Arroyo-Morales, M., Delgado-Fernendez, M., Gatto-Cardia, M., & Artero, E. (2013). Effect of Different Frequencies (2-3 Days/Week) of Aquatic Therapy Program in Adults with Chronic Low Back Pain. A Non-Randomized Comparison Trial. *Pain Medicine*, 145-158.

Cameron, M. (2017). *Physical Agents in Rehabilitation: From Research to Practice.* Elsevier.

Chesterton, L., & al, e. (2003). Transcutaneous electrical nerve stimulation for pain relief in primary care. *Br J Gen Pract*, 311-315.

Draper, D., Castel, J., & Castel, D. (1992). Rate of Temperature Increase in Human Muscle During 1 MHz and 3 MHz Continuous Ultrasound. *J Orthop Sports Phys Ther*, 142-150.

Lehman, J., & DeLateur, B. (1990). *Therapeutic Heat and Cold.* Williams & Wilkins.

Michener, L., McClure, P., Tate, A., Seitz, A., Straub, R., & Thigpen, C. (2024). Adding Manual Therapy to an Exercise Program Improves Long-Term Patient Outcomes Over Exercise Alone in Patients with Subacromial Shoulder Pain: A Randomized Control Trial. *JOSPT Open* , 29-48.