APTA
American Physical Therapy Association

The Impact of Administrative Burden on Physical Therapist Services

A Report From the American Physical Therapy Association

November 2025

The Impact of Administrative Burden on Physical Therapist Services

Administrative Requirements Imposed by Payers Continue to Significantly Burden Physical Therapists and Negatively Impact Patient Care

Administrative burden takes many forms, including, but not limited to, obtaining prior authorization of physical therapist services, appealing denied claims, and fulfilling documentation requirements. These administrative mandates not only disrupt operations but also delay patient care and negatively affect clinical outcomes.

This report reviews results from APTA's third administrative burden survey of members across practice settings, conducted in mid-2025, which builds on previous surveys conducted in 2018 and 2022. The 2025 survey was distributed to 18,888 potential respondents with 856 completing the survey. Results of APTA's previous administrative burden surveys were conveyed in infographics reported in 2018 and 2023. For 2025, in addition to a new infographic, APTA has released this report with data from all three surveys to offer a window into the state of administrative burden in physical therapy.

> The results consistently demonstrate, under both commercial and government payers, that care is being shortchanged, providers are strained, and practices are forced to redirect time and money from direct patient care due to administrative burden.

Findings

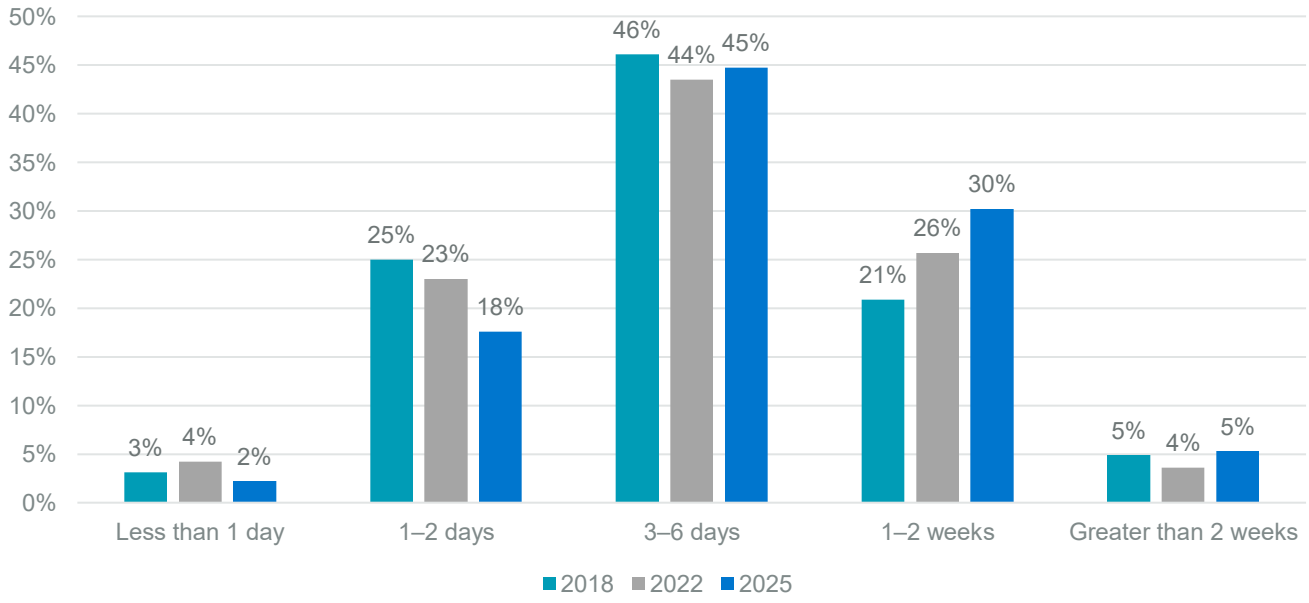
The findings of APTA's 2025 survey confirm the problems of timely care and cost to both patients and physical therapists due to administrative burden remain ever-present. The survey results demonstrate not only that prior authorization delays care for patients in need but also that it leads to worse outcomes for patients and increases the likelihood that they will abandon seeking care altogether.

Care Delays and Abandonment

The increase in time physical therapists wait for a payer to make prior authorization decisions is a key measure of care delay due to administrative burden. Wait times for prior authorization have escalated steadily over the last seven years since APTA's first survey, with nearly a third of respondents now reporting waiting one to two weeks for a prior authorization approval. In contrast, 20.9% of survey respondents reported waiting one to two weeks for a decision in 2018 and 25.7% in 2022. Most recently, 30.2% of respondents to the 2025 survey indicated waiting one to two weeks for a prior authorization approval — an increase of 9 percentage points from seven years ago. For patients requiring physical therapist services, a delay of this magnitude can mean the difference between returning to full function and long-term impairment.

30.2%

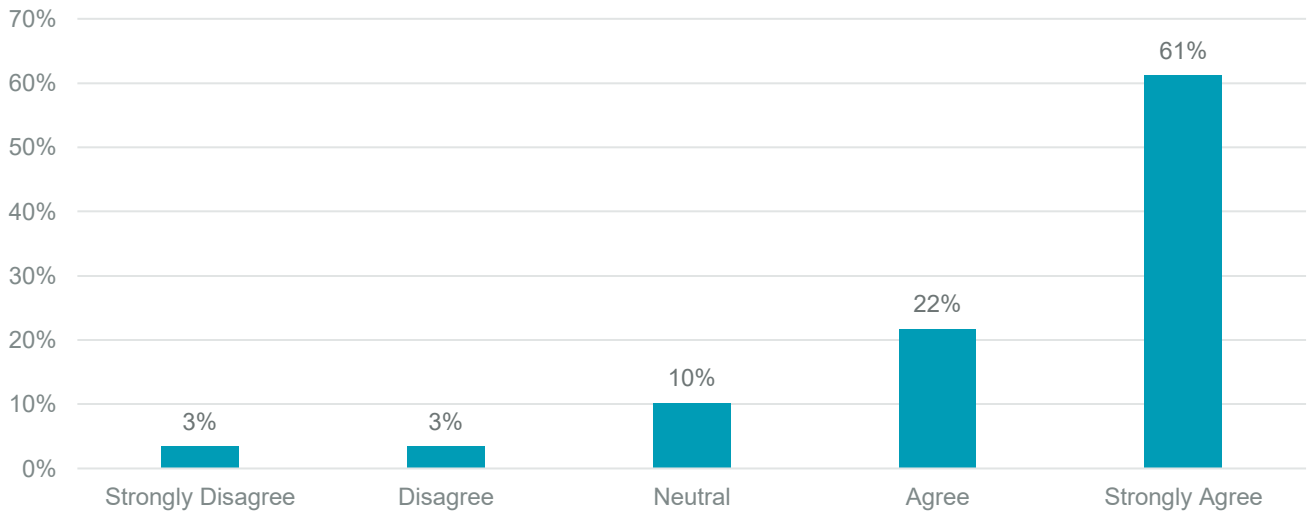
Average Wait Time for a Prior Authorization Decision



For the first time in 2025, APTA measured whether delays in care caused patients seeking care to abandon treatment. Indeed, many patients are abandoning the treatment they seek as they wait longer for approval of visits that require prior authorization.

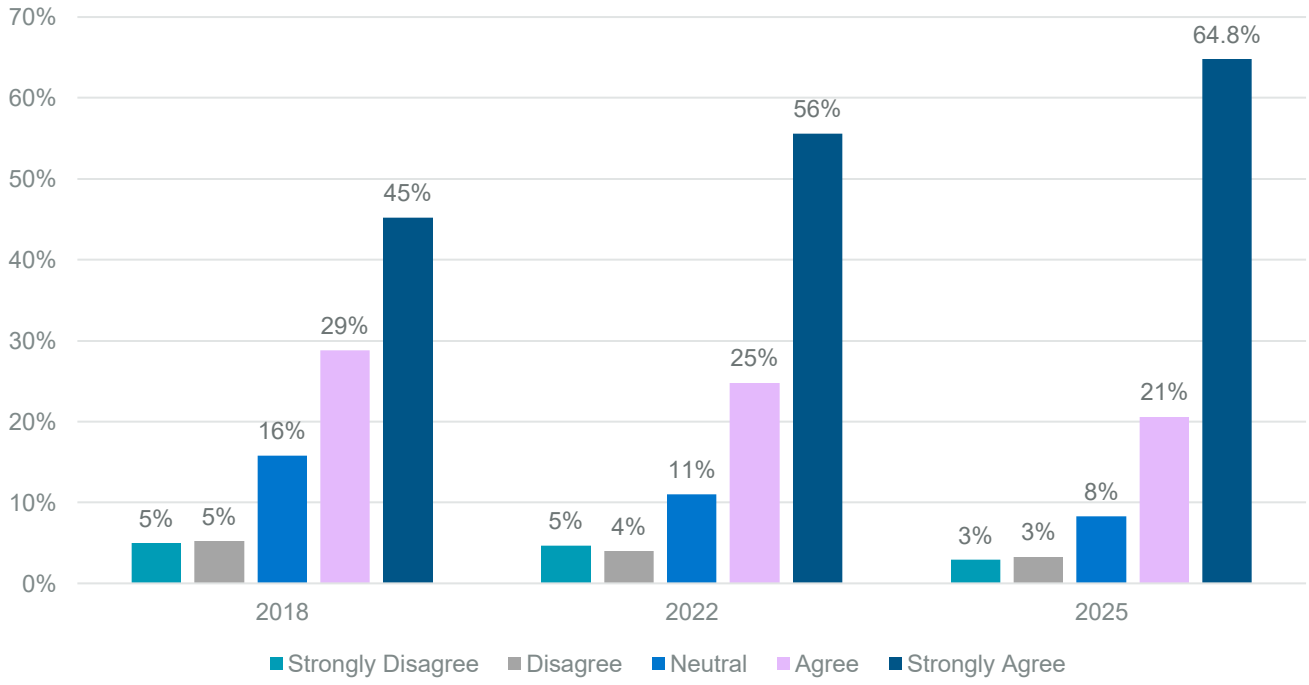
Nearly **83% of respondents** agreed or strongly agreed that prior authorization has caused patients seeking care to abandon treatment.

Prior Authorization Has Led Patients Seeking Care to Abandon Treatment



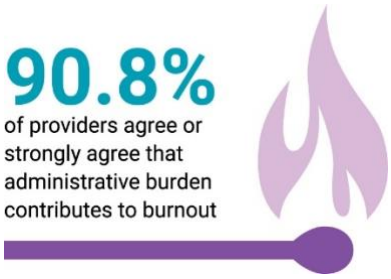
Regarding outcomes, survey respondents have increasingly noted that prior authorization requirements negatively impacted patient clinical outcomes. While less than half of respondents strongly agreed this was the case in 2018, by 2025, almost 65% of respondents strongly agreed.

Prior Authorization Requirements Have Had a Negative Impact on Patient Clinical Outcomes

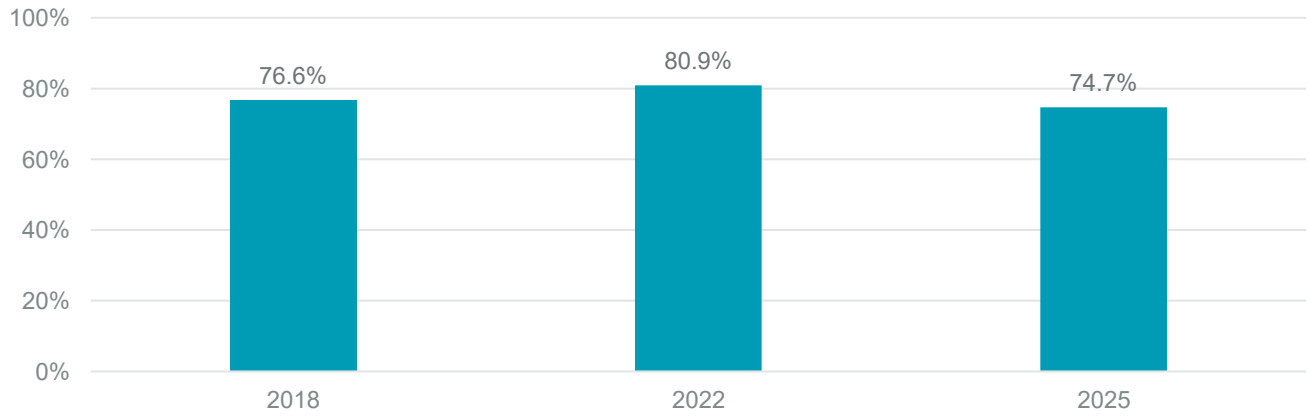


Disruption to Operations

In APTA's 2025 survey, nearly 75% of respondents noted that they have had to hire administrative staff to keep up with the demands of administrative burden. This trend has persisted over time with 76.6% of respondents reporting hiring administrative staff in 2018 and 80.9% hiring staff in 2022. Administrative burden is more than a major and persistent inconvenience: It costs valuable time and money, pulls focus away from patient care, and directly contributes to PT burnout. The increased time and money for this purpose divert from investments in continuing education, clinician compensation, patient care, and other resources needed to effectively operate practices. For some, the added cost and complexity create a barrier to opening new practices and even maintaining existing sites. Fewer practices can lead to fewer patients having access to care, particularly among underserved populations, leaving them without vital PT services.



Percentage of Practices Adding Nonclinical Staff to Meet Demands of Administrative Burden

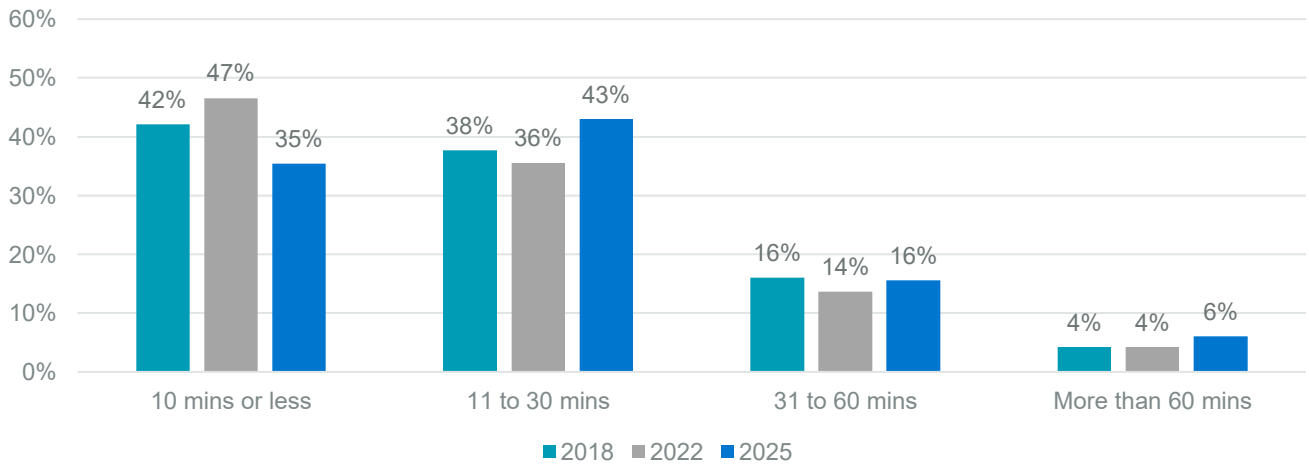


Initial Prior Authorization Requests

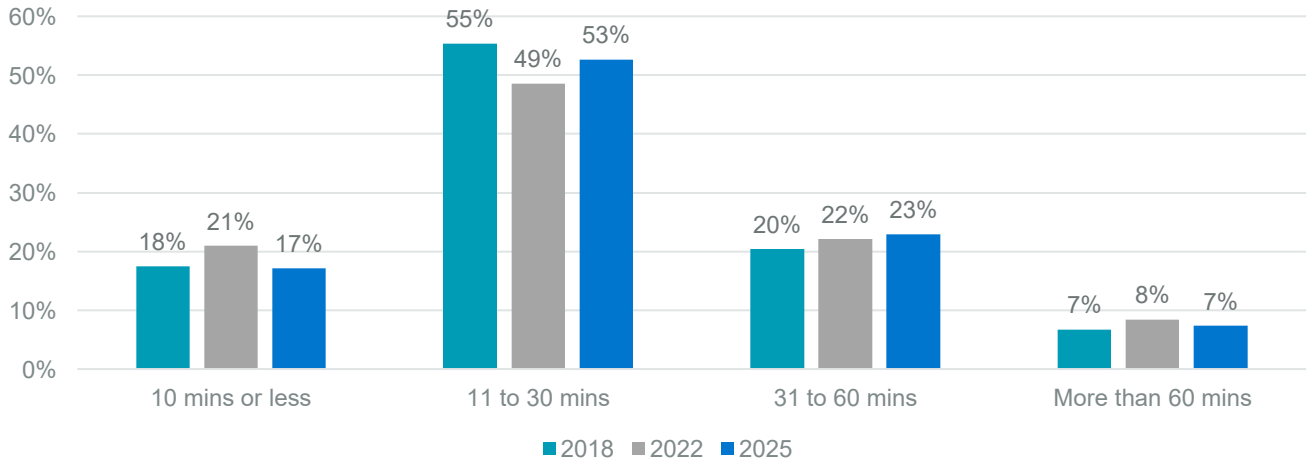
Administrative and clinical staff devote extensive time seeking authorization for both initial and continuing physical therapy visits across all payers. More PTs are spending 11-30 minutes or 31-60 minutes per initial prior authorization compared with those in 2022. By payer, the largest rise is in Medicare Advantage plans — up 7.4 percentage points in the 11- to 30-minute range, which is particularly concerning given the substantial growth in Medicare Advantage enrollment during this period. The share of PTs completing prior authorizations in 10 minutes or less has declined across all payers, indicating a broader shift toward longer processing times.

For administrative staff, there is more variation in which payers require the most time for initial prior authorization. From 2022 to 2025, Medicare Advantage plans saw increases in the 11- to 30-minute range, and both Medicaid and Managed Medicaid saw an increase in the 31- to 60-minute range. When compared with 2018 data, time for initial prior authorization for Medicare Advantage declined in the 11- to 30-minute category in 2022 before climbing as expected in 2025 to 52.6% of respondents. Administrative staff time spent on initial authorizations for commercial and Medicaid payers increased from 2018 to 2025 in the 10 minutes or less category.

Average Clinician Time Spent Per Initial Prior Authorization Request With Medicare Advantage



Average Front Desk/Administrative Staff Time Spent Per Initial Prior Authorization Request With Medicare Advantage



(See Appendices A and B for charts showing average clinician and front desk/administrative staff time spent per initial prior authorization with commercial plans, Medicaid, and Managed Medicaid.)

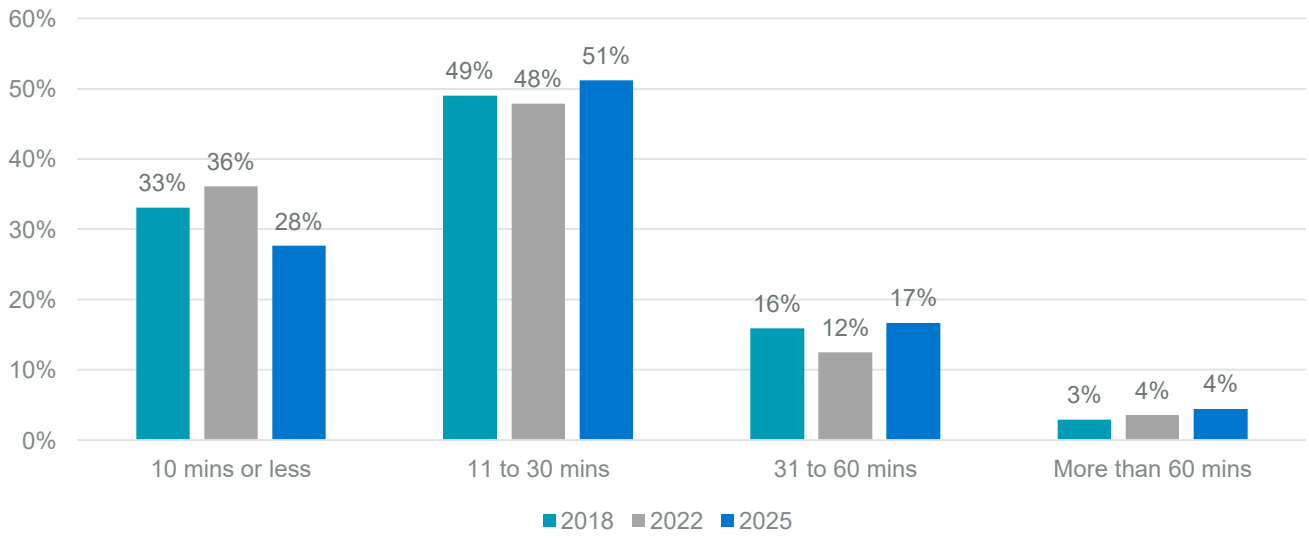
Continued Prior Authorizations for Established Patients

Across all payers, more PTs spent 31 to 60 minutes completing a single continued prior authorization request in 2025 than in 2022, with the biggest increase in Medicare Advantage and commercial plans. This is after a decrease in this category from 2018 to 2022.

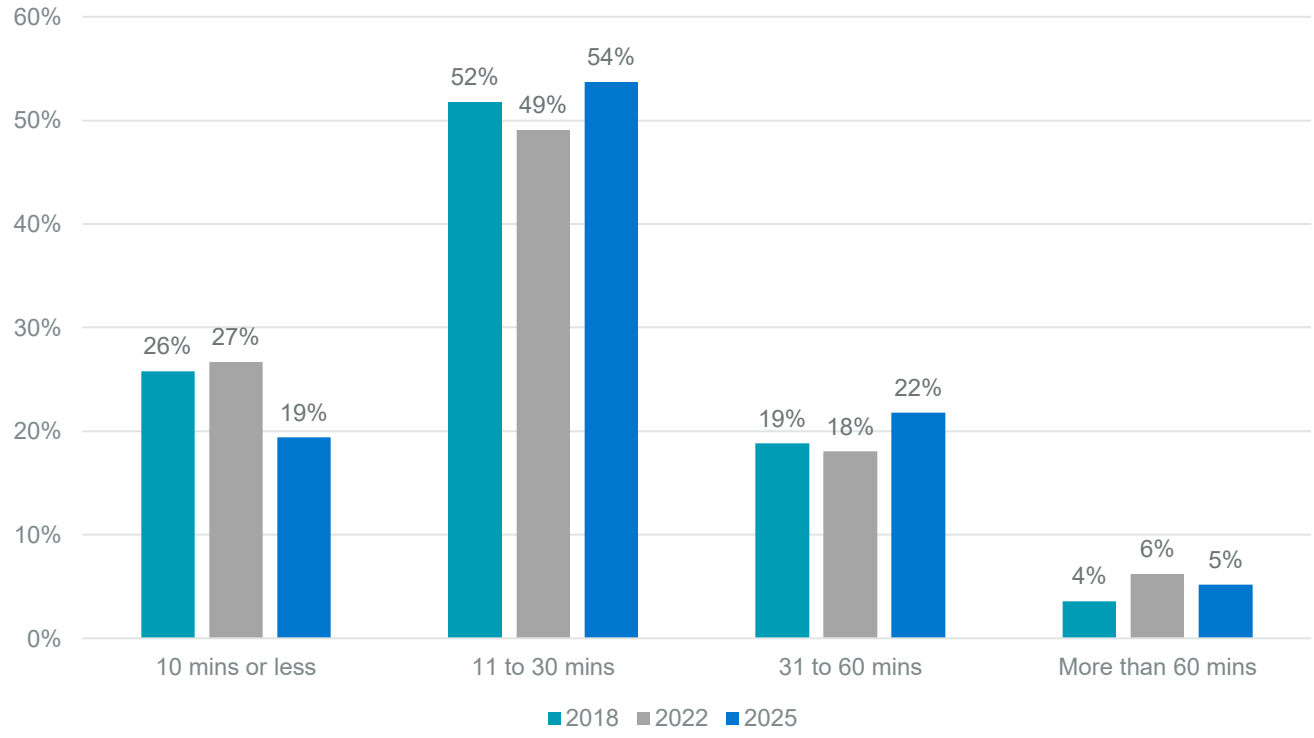
About half of respondents report that administrative staff spend 11 to 30 minutes for prior authorization requests for continued services per each established patient across all payers. Here again, Medicare Advantage saw the largest increase in the percentage of staff in this category from 2022 to 2025.

Staff also spent more time in the 31- to 60-minutes category across payers when comparing 2018 to 2025 (except for workers' compensation where data was not collected in 2018). Overall, Medicare Advantage demonstrates the most consistent increases in time required for continued prior authorization for both clinical and administrative staff from 2022 to 2025, which is particularly concerning given the steady and significant growth in Medicare Advantage enrollment.

Average Clinician Time Spent Requesting Approvals for Continued Visits Per Each Established Patient With Medicare Advantage



Average Front Desk/Administrative Staff Time Spent Requesting Approvals for Continued Visits Per Each Established Patient With Medicare Advantage



(See Appendices C and D for charts showing average clinician and front desk/administrative staff time spent requesting approvals for continued visits for each established patient with commercial plans, Medicaid, and Managed Medicaid.)

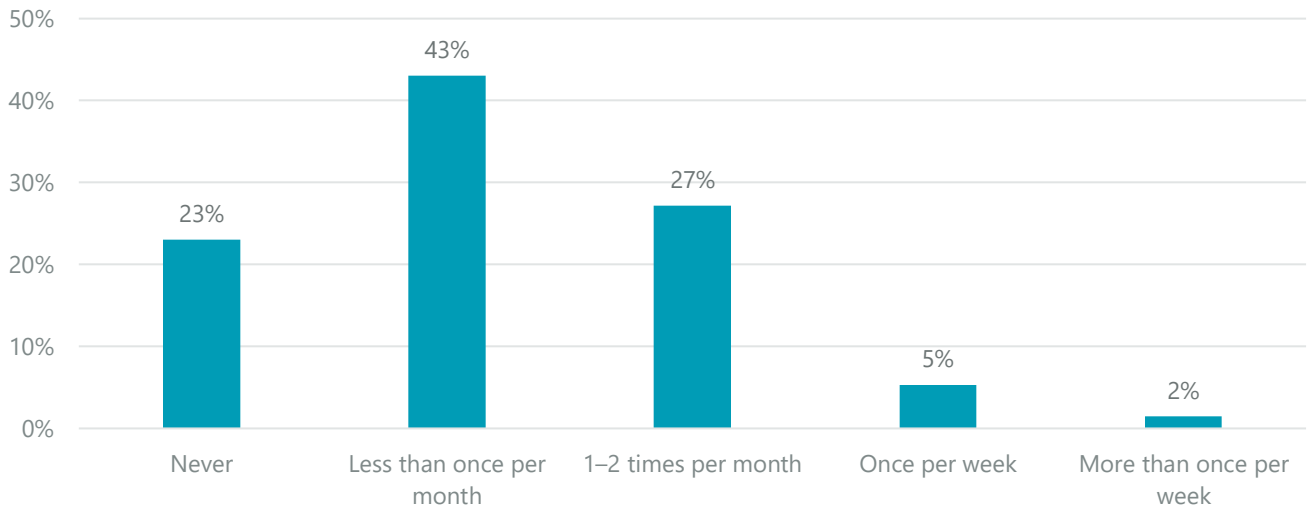
Underqualified Peer-to-Peer Reviewers

While roughly a third of respondents indicated doing at least one peer-to-peer review each month during the prior authorization process, a far greater number, 68%, noted an increase in such reviews occurring over the last five years.

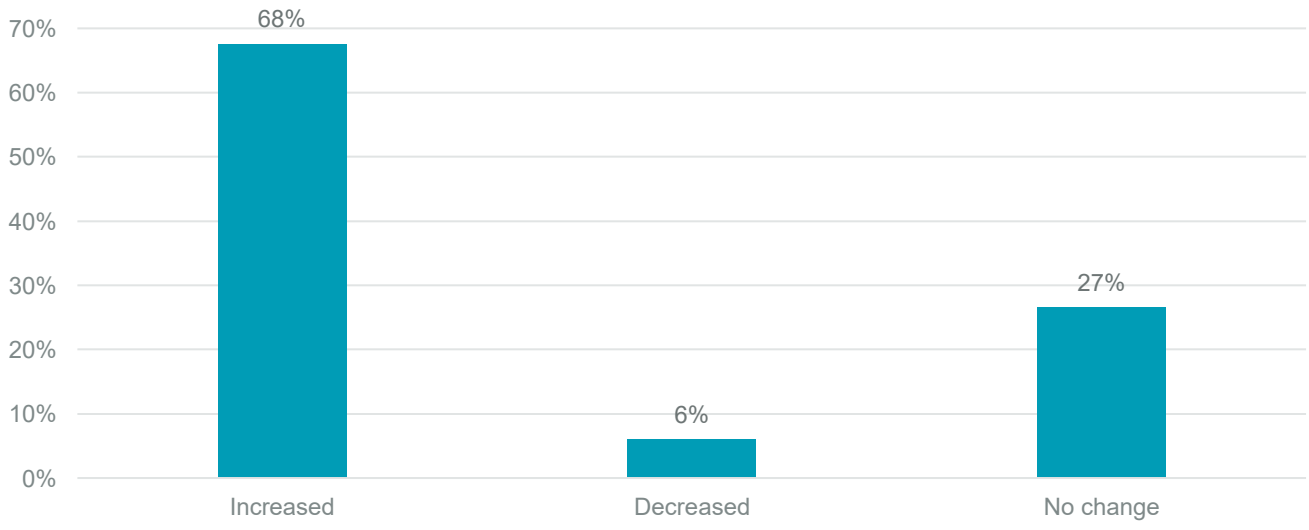
A peer-to-peer review often acts as a gatekeeper for approval of continued visits for a patient. While it might sound like a way to increase access to a payer, the process of these reviews requires clinicians to work around the availability of the peer and can require the PT to step away from a patient. It can be both time consuming and frustrating for the patient and physical therapist, especially when the "peer" lacks appropriate knowledge regarding patient care, which is happening frequently, according to the survey respondents.

A qualified peer is defined as a fellow physical therapist or someone with a physical medicine and rehabilitation background. In 2025, 34% of respondents noted doing at least one peer-to-peer review each month. About two-thirds of respondents noted an increase in peer-to-peer reviews over the last five years yet more than 52% felt the peer performing the review had appropriate qualifications to assess and make the determination less than half the time. If an unqualified peer lacks the expertise to recognize and assess the factors necessitating physical therapy, there is a high risk of flawed and inaccurate determinations compromising or limiting medically necessary patient care.

Frequency of Involvement in a Peer-to-Peer Review

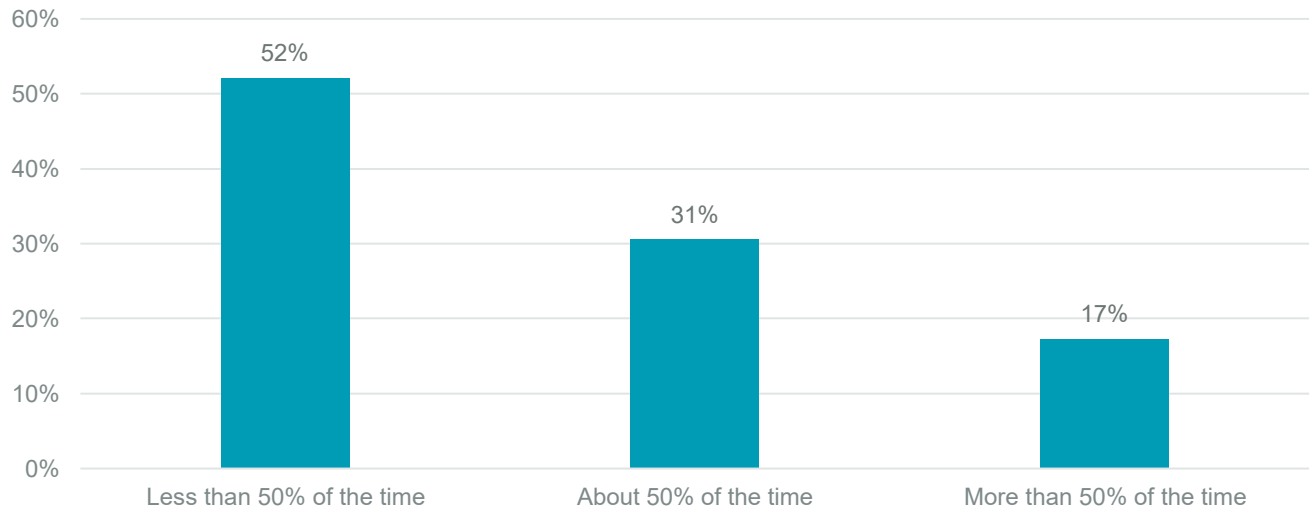


How Has the Frequency of Peer-to-Peer Reviews During the Prior Authorization Process Changed Over the Last Five Years?



Fewer than one in five respondents say that the peer has appropriate qualifications more than half of the time. Clearly, health plans have not prioritized having qualified professionals evaluate prior authorization requests, potentially leading to unwarranted denied claims that require clinical and administrative staff time to appeal.

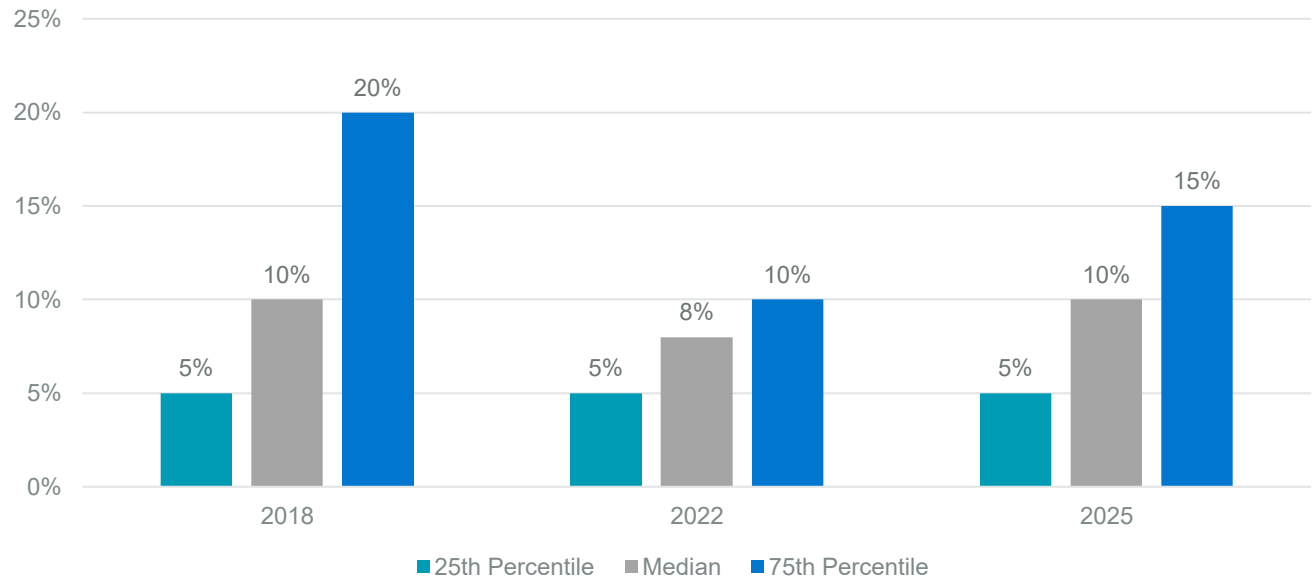
How Often Does the Peer Reviewer Have Appropriate Qualifications?



Claims Denials

Despite time spent on prior authorization of initial and continuing physical therapist visits, respondents indicated that an average of 12.9% of claims are denied by payers. In that case, an average of 72.4% of providers will appeal a claim denial and an average of 49.3% of those appeals are successful. The medians of denied claims and percentage of successful appeals have remained consistent from 2018-2025, demonstrating that it is fairly common for staff to do unnecessary work only to have the claim be approved after appeal.

Percentage of Denied Claims



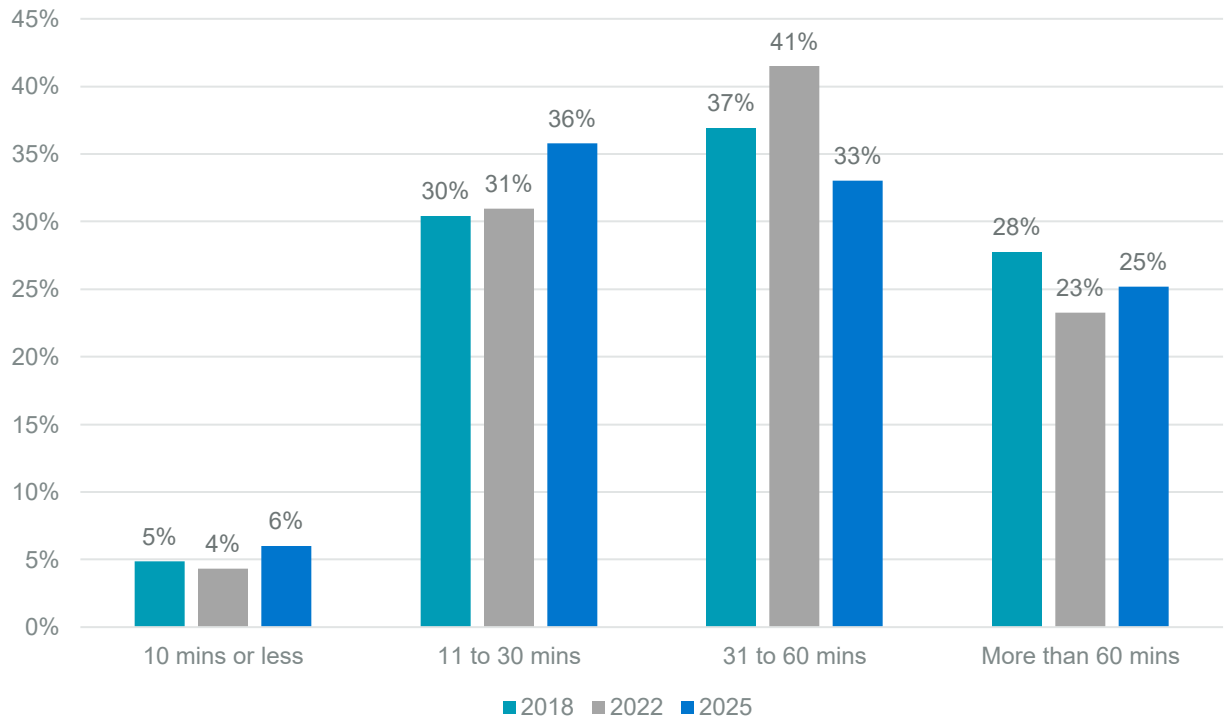
The biggest change has been the average percentage appealed, with 67.1% in 2018, 69.9% in 2022, and 72.4% in 2025. The amount of time spent appealing a claim denial has remained steady since the initial APTA survey in 2018, with nearly 95% of appeals requiring more than 10 minutes of preparation time. Of the time increments, the 11- to 30-minute range saw the largest increase from 2018 to 2025, from 30.4% to 35.8%.

An average of **72% of denied claims** were appealed in 2025

An average of **49% of appealed claims** were successful in 2025

(See Appendix E for the percentage of appealed claims and percentage of successful claims broken down by quartile.)

Average Staff Time Spent Preparing an Appeal for One Claim



Network Status

While physical therapists often have limited options to address rising administrative burden, some practices have chosen — or been forced — to discontinue participation with certain payers or networks. In APTA's 2025 survey, 56.7% of respondents agreed or strongly agreed with the statement: "Administrative burden has led my practice to discontinue participation with a payer or network." (This question was not included in the 2018 or 2022 surveys.)

Tracking this trend over time will be critical, particularly if payers and the health care system more broadly continue to impose excessive and unsustainable administrative demands on physical therapists.

Conclusion and Action Steps

Overall, the data collected by APTA's 2025 survey shows that administrative burden is excessive, unsustainable, and continues to hurt PTs and patients alike. Regardless of payer type, administrative mandates reduce time spent on direct patient care and lead to worse outcomes for patients. Without meaningful reform, these burdens will continue to undermine workforce sustainability and limit patient access to necessary PT services.

Reducing administrative burden remains a top priority for APTA and is included among the "APTA Public Policy Priorities, 2025-2026." APTA continues the fight to rein in excessive administrative burden via both legislative and policy changes.

- Those efforts include APTA urging Congress to pass the Improving Seniors' Timely Access to Care Act (H.R. 3514/S. 1816). This legislation would reduce health care providers' administrative burden by addressing unnecessary preauthorization requirements, ultimately increasing efficiencies in patient care and improving clinical outcomes. The act was introduced on May 20 in the House by Reps. Mike Kelly, R-Pa., Suzan DelBene, D-Wash., Ami Bera, D-Calif., and John Joyce, R-Pa., and in the Senate by Sens. Roger Marshall, R-Kan., and Mark Warner, D-Va. Additional background and information is available in APTA's position paper. Go to the APTA Action Center to contact your members of Congress and urge their support of this important legislation.
- APTA continues to advocate on the issue of prior authorization and payment challenges to state legislators, including through the association's engagement with the National Conference of State Legislatures. In addition, many APTA state chapters have achieved significant victories that reduce administrative burden. In 2023, APTA Maine successfully advocated for state legislation aimed at prior authorization, while APTA state chapters in Mississippi, Vermont, and Wyoming were successful in enacting legislation aimed at addressing prior authorization in 2024. So far in 2025, APTA Indiana and APTA Oregon have been successful in enacting state legislation, while the California Physical Therapy Association is advocating for legislation. Contact your state chapter to learn more about how you can support state-level advocacy aimed at prior authorization.
- The State Payer Advocacy Resource Center, or SPARC, offers resources to help advocate for decreased administrative burden. SPARC, a collaborative effort of APTA, APTA Orthopedics, and APTA Private Practice, includes actionable resources specific to administrative burden, such as utilization management, prior authorization, insurance coverage, and denials and appeals, including external review requests.
- APTA has released two previous reports that provide data and resources to support efforts to address prior authorization. APTA's landmark report "The Economic Value of Physical Therapy in the United States" uses an economic model to calculate the net benefits to patients and the U.S. health care system of choosing physical therapy over alternative treatments for eight conditions. In addition, APTA's recently published report, "State of Direct Access to Physical Therapist Services," offers comprehensive research and strategic insights to assist in advocating for the removal of unnecessary

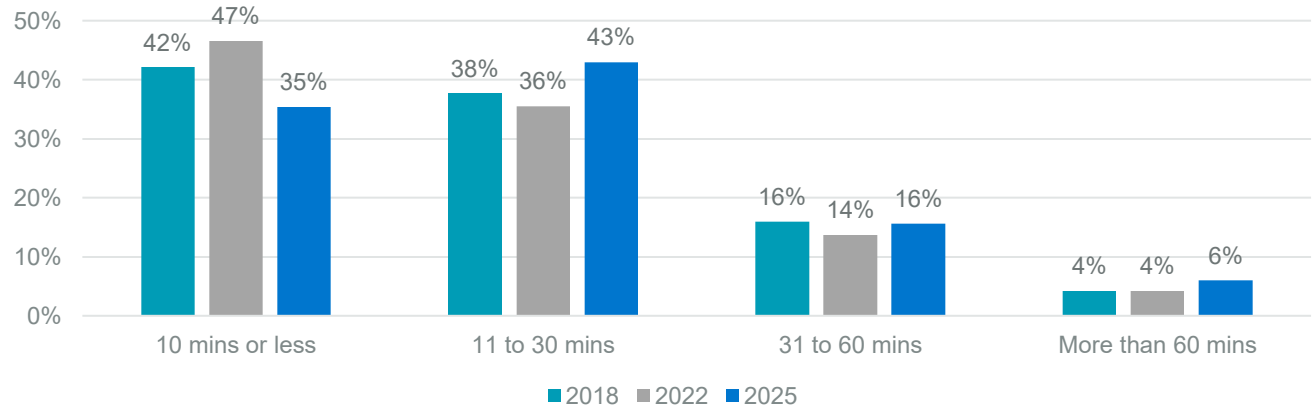
barriers that limit patient access to physical therapist services. Use all three of these reports with policymakers to clearly demonstrate that administrative burden serves neither their constituents nor clients.

APTA calls on payers across the spectrum (regional, national, commercial, and governmental), federal and state regulators, and policymakers to continue to remove unnecessary barriers that burden physical therapists, detract from the delivery of care, and impede access to physical therapist services in the health care system overall.

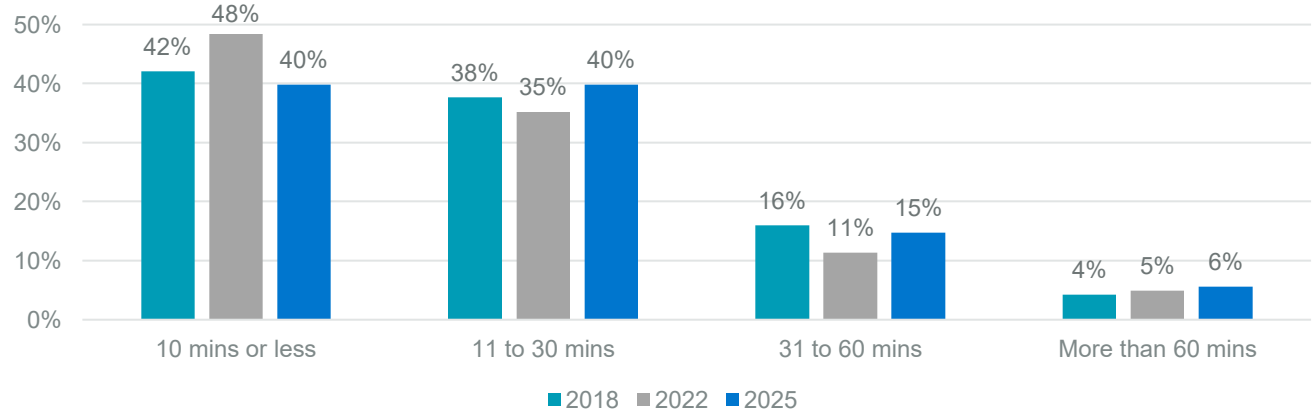
This report and the infographic are tools to help drive change. Use it to open doors, to start or continue the conversation, to challenge unreasonable and outdated policies, and to ensure that more people can access the care they need when they need it.

Appendix A: Average Clinician Time Spent Per Initial Prior Authorization by Health Coverage

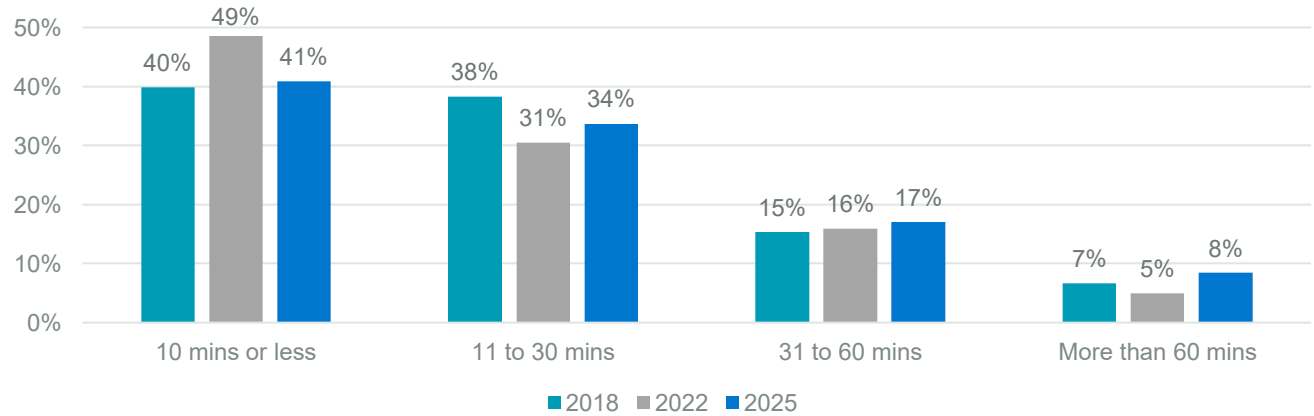
Medicare Advantage



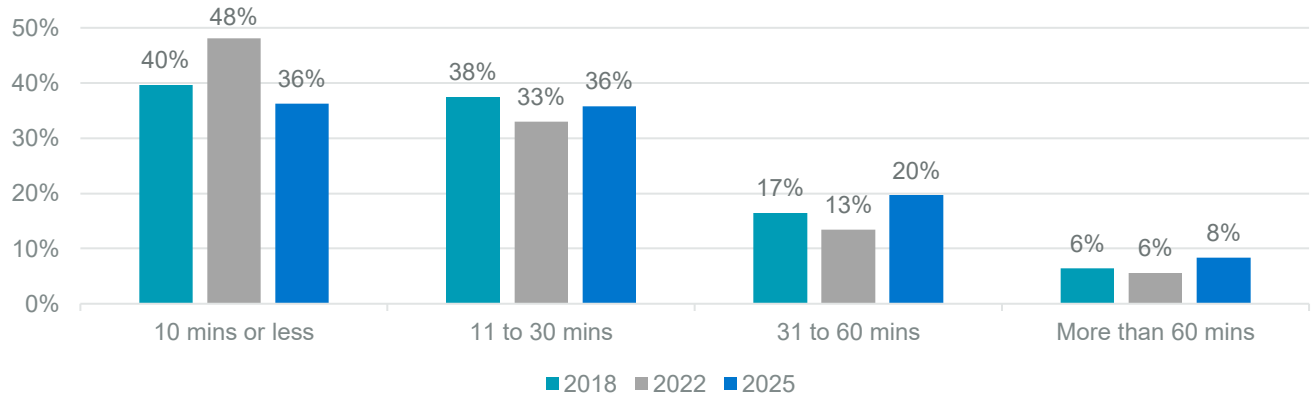
Commercial Plans



Medicaid

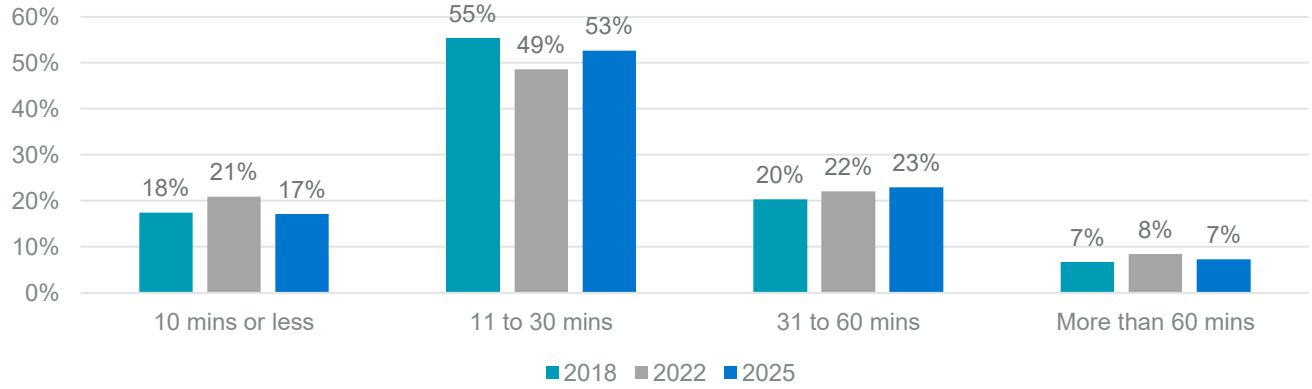


Managed Medicaid

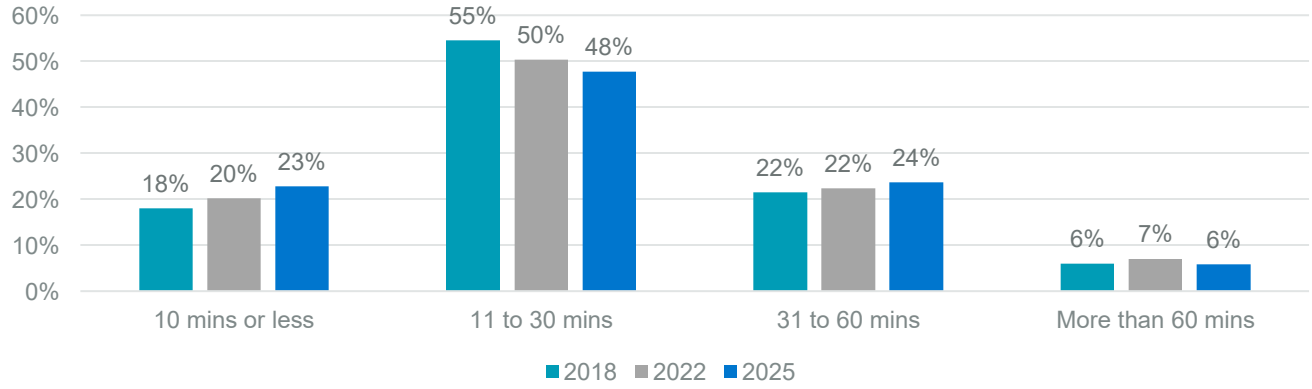


Appendix B: Average Front Desk/Administrative Staff Time Spent Per Initial Prior Authorization by Health Coverage

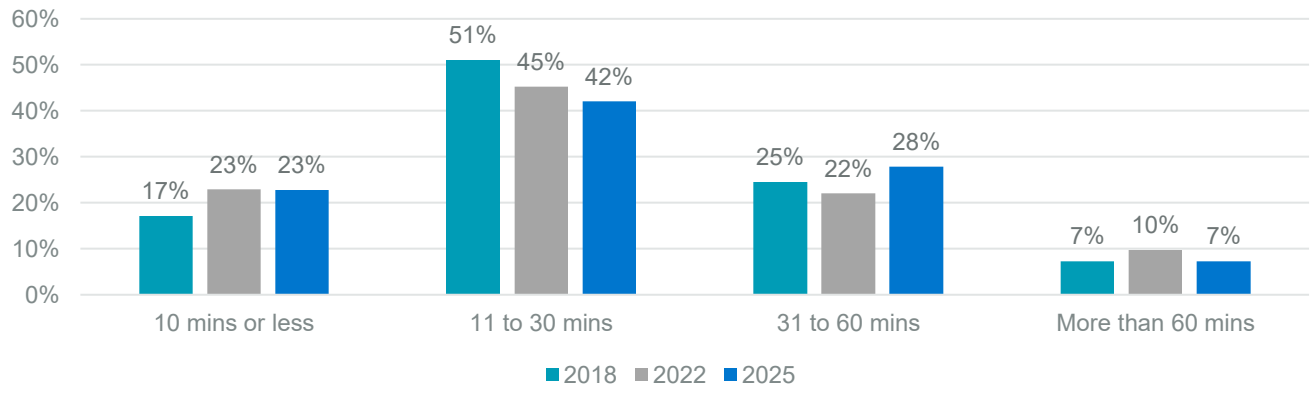
Medicare Advantage



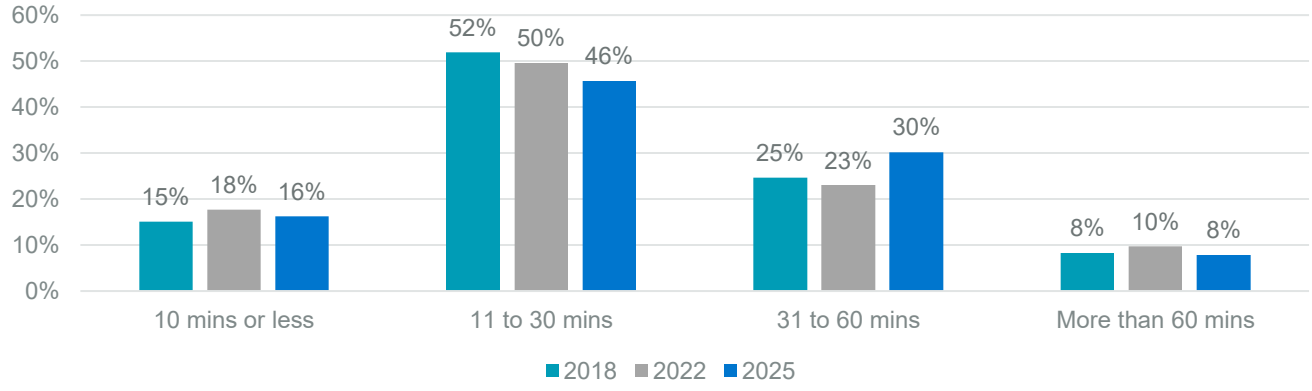
Commercial Plans



Medicaid

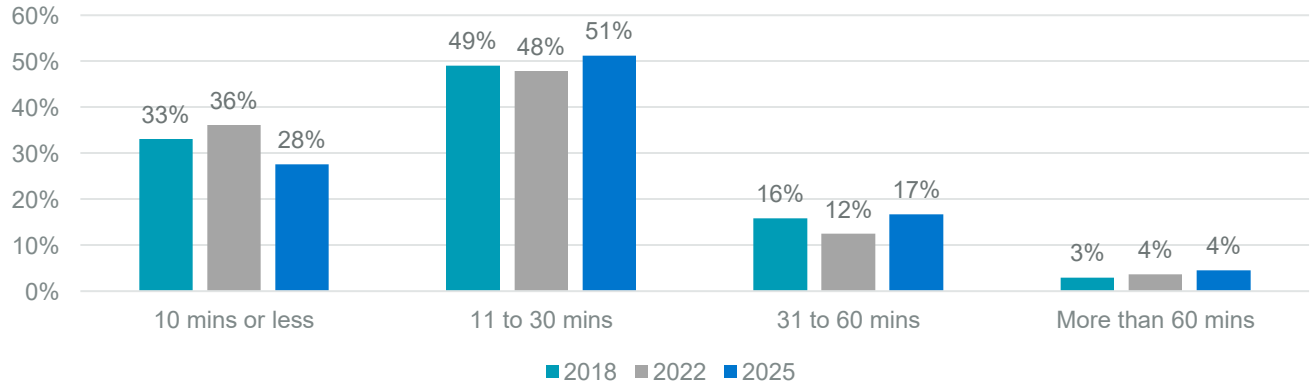


Managed Medicaid

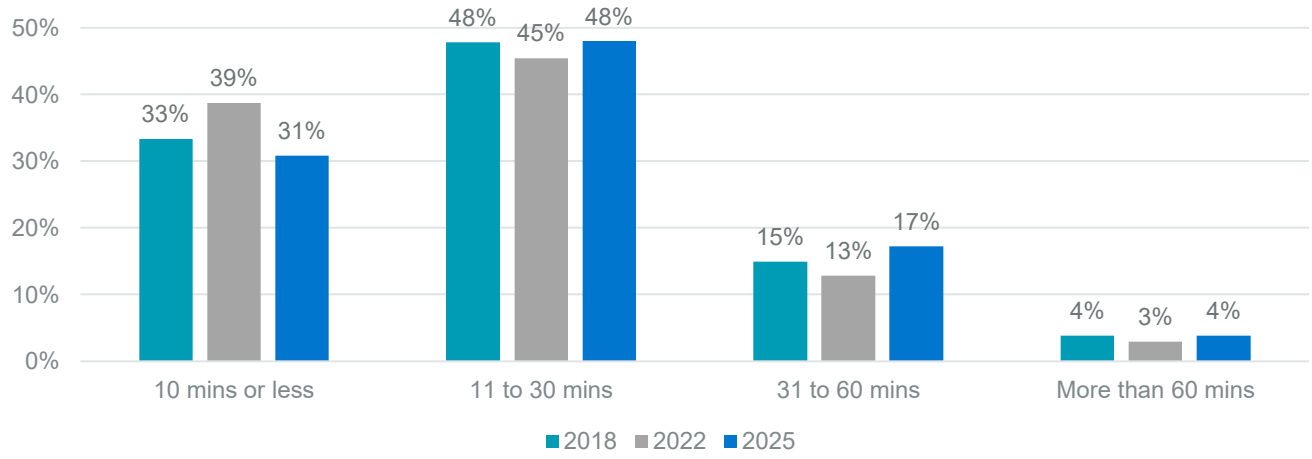


Appendix C: Average Clinician Time Spent Requesting Approvals for Continued Visits Per Each Established Patient

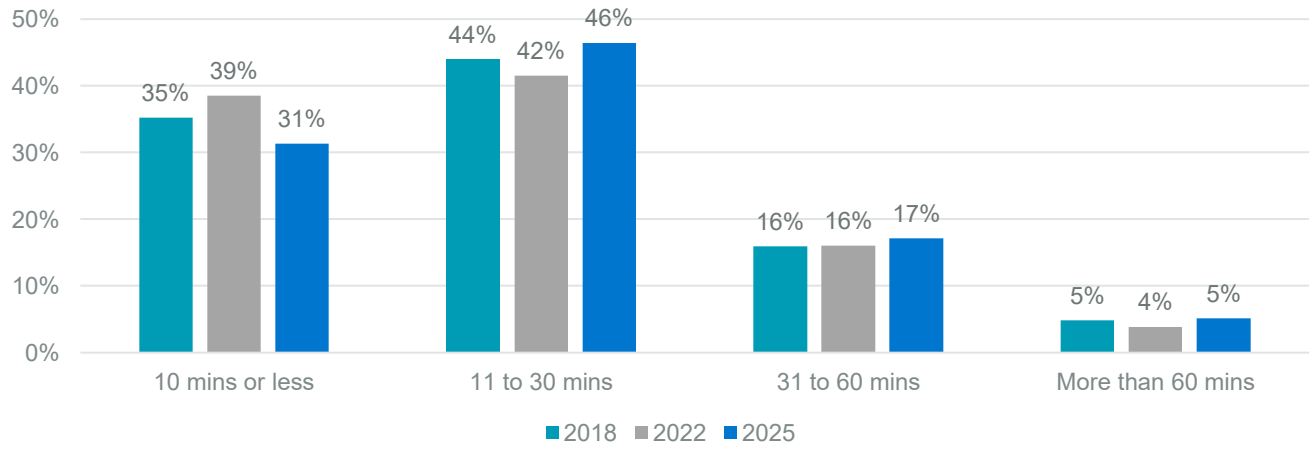
Medicare Advantage



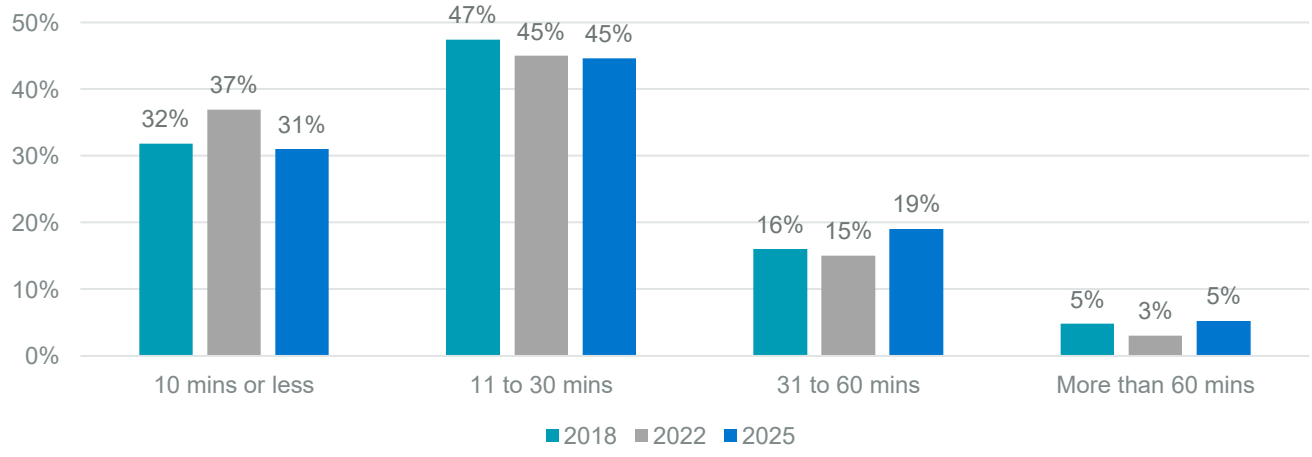
Commercial Plans



Medicaid

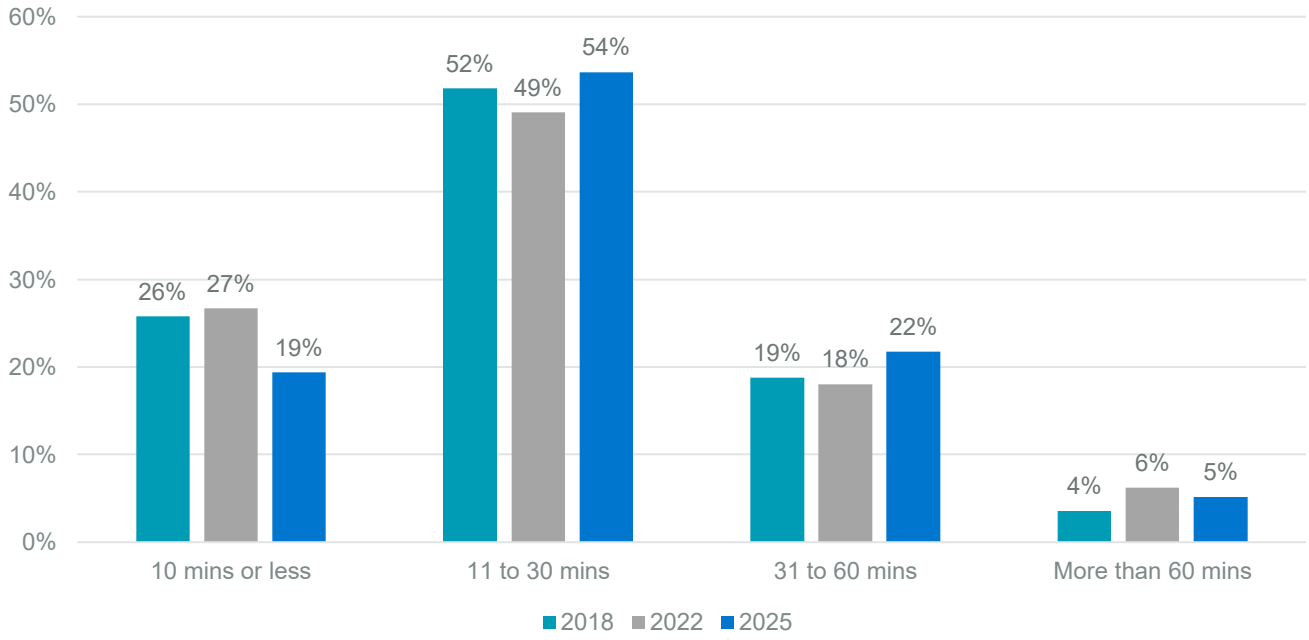


Managed Medicaid

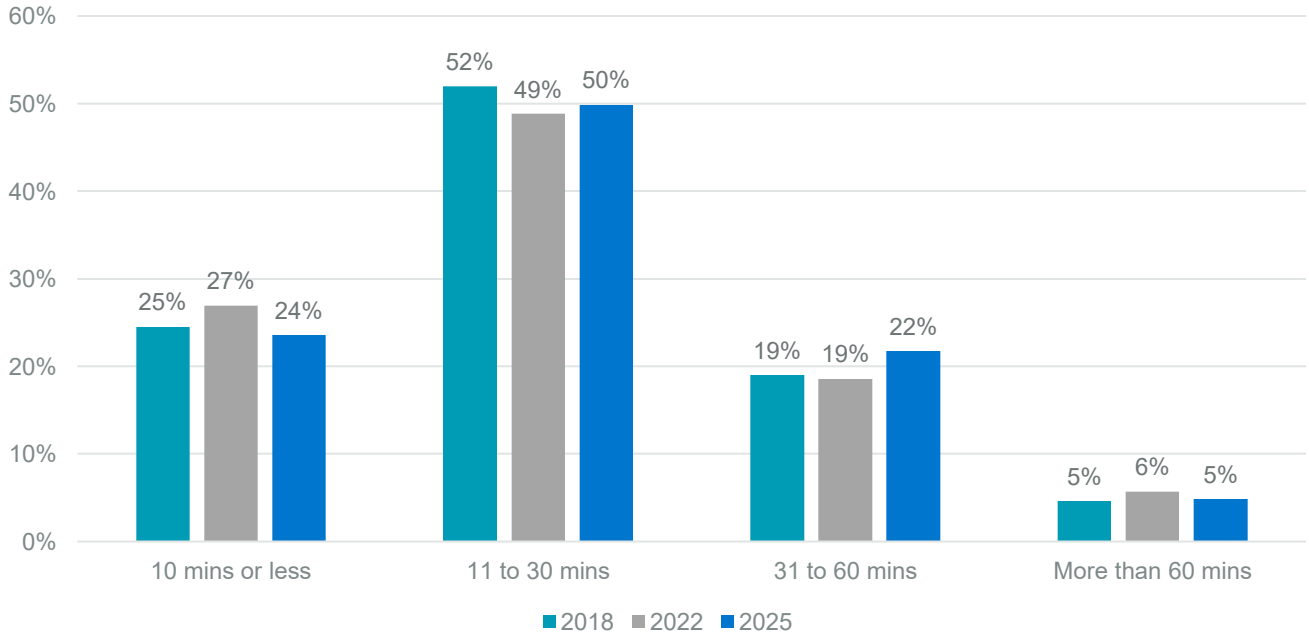


Appendix D: Average Front Desk/Administrative Staff Time Spent Requesting Approvals for Continued Visits Per Each Established Patient

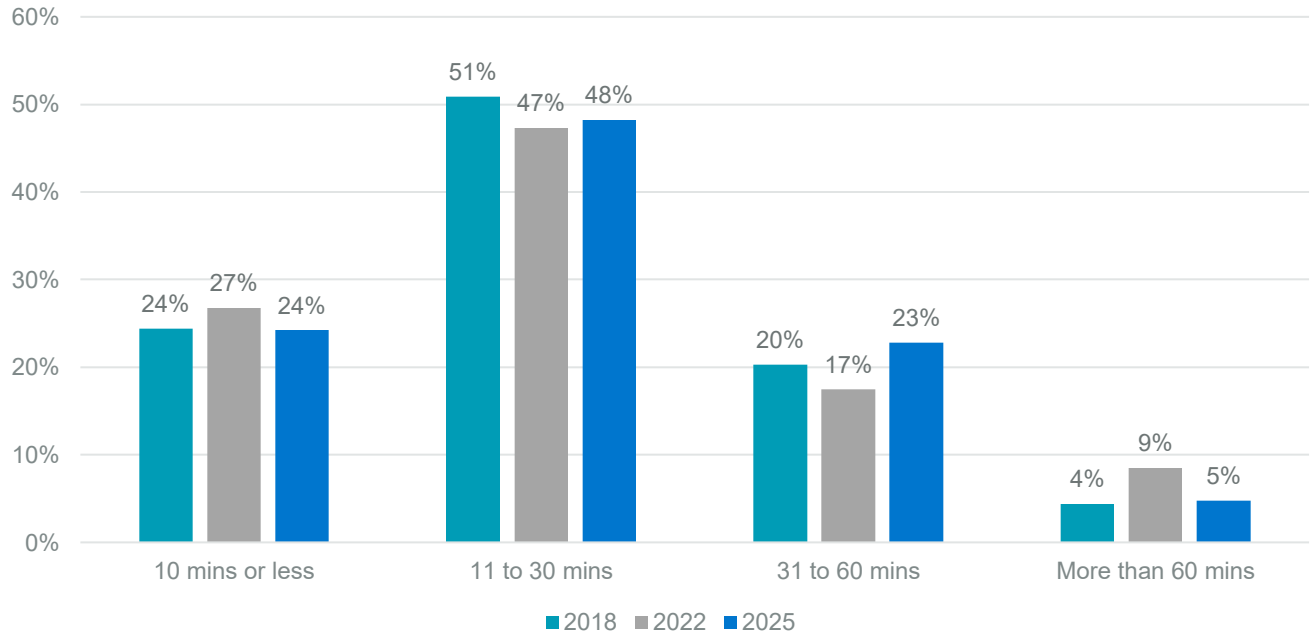
Medicare Advantage



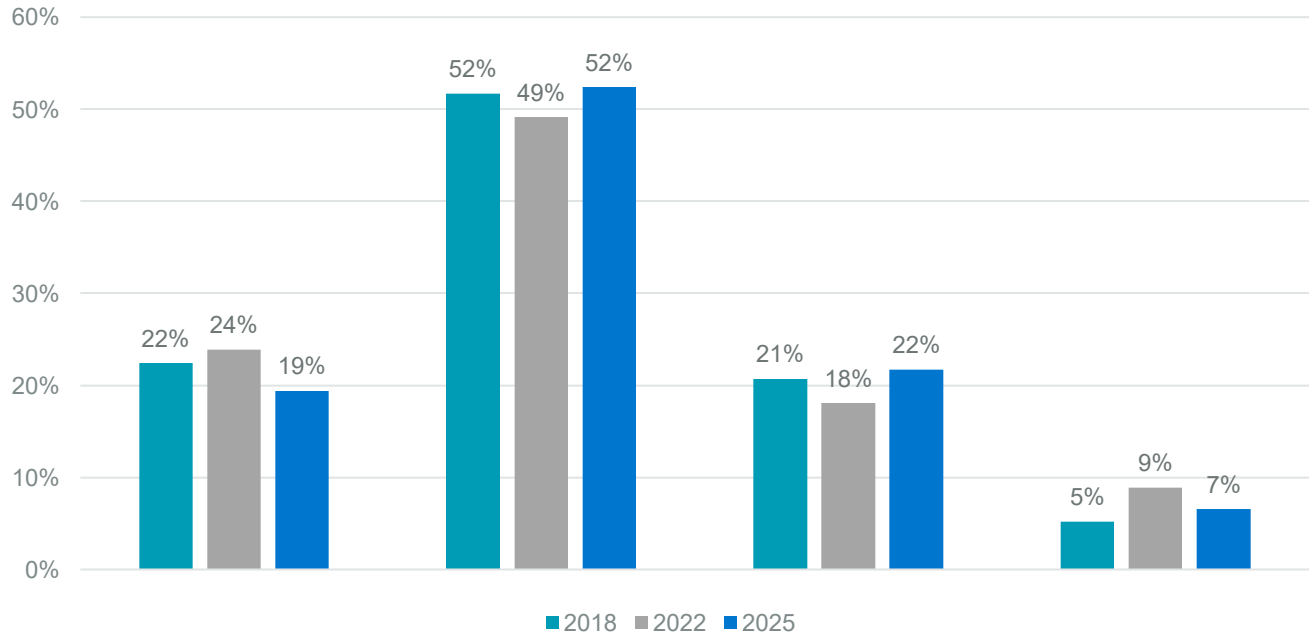
Commercial Plans



Medicaid

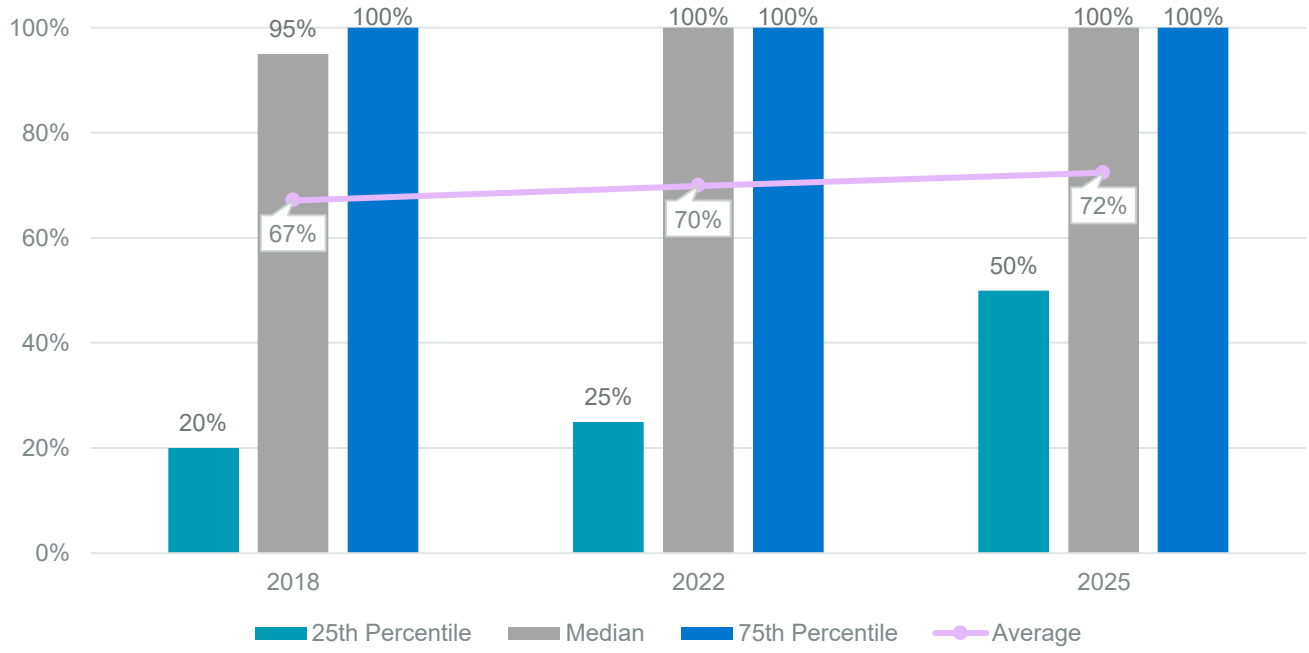


Managed Medicaid



Appendix E: Percentage of Appealed Claims and Percentage of Successful Claims by Quartile

Percentage of Appealed Claims



Percentage of Successful Appeals