

## **AAOE Policy Brief: Implications of the CY 2026 Medicare Physician Fee Schedule Final Rule**

On October 31, the Centers for Medicare & Medicaid Services (CMS) released the CY 2026 Medicare Physician Fee Schedule (PFS) Final Rule, introducing structural changes that will significantly affect orthopaedic surgeons and physician practices nationwide. The new rule establishes two separate conversion factors (CFs) beginning in 2026: one for Qualifying Advanced APM participants (QPs), set at \$33.5675 (+3.77%), and another for non-QP physicians, set at \$33.4009 (+3.26%). While this modest increase offers temporary relief, CMS simultaneously finalized an efficiency adjustment of -2.5% to work Relative Value Units (RVUs) and intra-service time for most non-time-based services. This policy aims to account for productivity gains across specialties but effectively reduces valuation for many high-volume procedural codes.

### **Conversion Factor Update**

CMS finalized two separate CFs for CY 2026:

- \$33.57 for Qualifying Advanced APM Participants (QPs) (+3.77%)
- \$33.40 for non-QP clinicians (+3.26%)

***While this marks the first positive CF adjustment in six years, AAOE is dismayed that the update remains insufficient to offset two decades of declining reimbursement. Without linking future updates to the Medicare Economic Index (MEI) or another inflationary benchmark, physicians will continue to face growing financial strain that threatens patient access and practice viability.***

### **Practice Expense (PE) Reallocation**

CMS finalized a policy to reduce the indirect PE RVUs for facility-based services to 50% of the non-facility amount. This change shifts resources toward office-based care but dramatically reduces payments for orthopaedic procedures performed in hospitals or ASCs settings where most orthopaedic surgeries occur.

### **According to CMS estimates, orthopaedic surgeons will see approximately:**

- 3% cut to total allowed charges
- 9% cut for facility-based services
- 5% increase for non-facility (office) services

Because orthopaedic care is predominantly facility-based, the non-facility increase will not offset these losses, creating additional financial pressure on practices and limiting patient access to surgical care.

***AAOE encourages CMS to revisit this policy and work with stakeholders to incorporate updated PPI Survey data and MEI weighting to ensure an equitable approach.***



### **Work RVU “Efficiency Adjustment”**

CMS finalized a –2.5% efficiency adjustment to work RVUs and intra-service time for most non-time-based codes, based on an assumption that procedures become more efficient over time.

***AAOE strongly opposes this adjustment, emphasizing that surgical procedures have become more complex over the years, not less. Today's surgeons manage higher patient acuity, advanced technologies, and greater regulatory and documentation demands than ever before. These evolving realities require more time, expertise, and resources to deliver safe, high-quality care. Reducing payment in this environment does not reflect the true intensity of modern surgical practice and only threatens patient access and the long-term sustainability of physician-led care.***

### **Virtual Supervision and Future Valuation**

The rule also makes virtual direct supervision permanent for many incident-to services, allowing supervising physicians to oversee care via real-time audio-video technology. This change enhances operational flexibility for orthopaedic clinics and can improve patient throughput and staff efficiency. Notably, this policy does not apply to 010- or 090-day global surgical services, meaning that post-operative care under surgical bundles remains governed by traditional inperson supervision standards.

CMS also signaled a renewed interest in re-benchmarking global surgical packages including postoperative work, care coordination, and team-based models which could lead to future revaluation of orthopaedic global codes.

### **Key Takeaways of the Final Rule**

- The reduction to work RVUs will lower payments to orthopaedic practices serving Medicare patients, without addressing duplicate payments or safeguarding private practice sustainability.
- Facility-based payment cuts will negate any modest gains from non-facility service increases, disproportionately impacting orthopaedic practices that primarily operate in hospital or ASC settings.
- Many orthopaedic services cannot be provided in non-facility environments, meaning these reductions will directly threaten reimbursement for essential surgical care.
- The –2.5% efficiency adjustment is based on a flawed assumption that all providers can continually improve efficiency, disregarding real-world complexity and workload demands.
- These cuts will have significant downstream consequences, increasing costs for private practices, accelerating consolidation, and limiting patient access to timely, high-quality orthopaedic care.

