

Medicare's Physician Fee Schedule: What the 2026 Final Rule Means



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With the recent release of the CY 2026 Physician Fee Schedule (PFS) final rule effective January 1, 2026, the Centers for Medicare & Medicaid Services (CMS) solidified the reimbursement landscape for the coming year. While CMS' announcement relates exclusively to Medicare, many commercial payers leverage the federally-maintained resource-based relative value scale (RBRVS) for payment. Therefore, the implications of the ruling reach far beyond care delivered to America's senior population.

The federal agency didn't hold back its frustration with historical payment determinations and feedback from the American Medical Association (AMA), which has had a significant influence on the calculations that underpin the RBRVS. In questioning the AMA's contributions: CMS states: "Our initial review of the new data raises substantive concerns about their accuracy, utility, and suitability." Referring to another input: "[W]e are left with doubts about not just the amount of data collected, but its quality as well." "Such

incomplete, small sample, potentially biased or inaccurate resource input costs may distort our valuation...” continues the agency. This backdrop helps us understand the agency’s direction.

Let’s unpack the impact on the coming year:

- **Conversion factor split.** Under current law, CMS must apply two separate conversion factors beginning in 2026: one for physicians and advanced practice providers who are “qualifying participants” (QPs) in advanced alternative payment models and one for non-qualifying practitioners. In the final rule, that means that the non-QP conversion factor is \$33.4009 and the QP conversion factor is set at \$33.5675, representing increases of more than 3% from the prior factor of \$32.3465. These conversion factors *include* the one-year increase of +2.5% stipulated by the One Big Beautiful Bill, passed into law this summer.
- **New efficiency adjustment.** Before celebrating the small increase in payment, however, CMS has applied a new “efficiency factor” to the The efficiency adjustment of –2.5% - coincidentally the same percentage as outlined in the federal law - is applied to the work RVUs and intra-service times of nearly all non-time-based codes to account for efficiency gains from increasing clinician experience and technological advancement. The agency explains: “these changes address concerns about distorted payment values that have existed for years.” Most evaluation and management codes are excluded from the 7,000+ codes that will be adjusted downward, which effectively means that specialists will bear the burden of this new adjustment. Because many practices use work RVUs to monitor physician productivity, this adjustment is critical to understand particularly for those practices that use relative value units in their compensation plan.
- **Hospital-based practices targeted.** For services furnished in hospital outpatient clinics or other facility settings, the portion of indirect practice expense tied to work RVUs is reduced by 50%. This will lower payments for professional services in hospital clinics by upwards of 20% - or more. The rationale: given the increasing integration of physician practices into hospital systems, CMS believes that many “indirect costs” (e.g., administration, compliance, utilities) are borne by the hospital and thus should not be double counted in the physician practice expense assumption. For physicians who are practicing in a hospital-based clinic, this will translate into a significant payment cut from Medicare.
- **Quality Payment Program stable.** CMS maintains the performance threshold at 75 points for the 2026 performance period (which is applied to the 2028 payment year). There are a few changes coming down the pike, however. For the 2026 performance period, CMS removed 10 quality measures, added five new ones, and updated all the specialty-based Merit-based Incentive Payment System (MIPS) Value Pathways.
- **Telemedicine not resolved.** Despite some hope for a resolution, the final rule did not extend the pandemic-era flexibilities for telemedicine. Further, the new codes released by the AMA in 2025 for telemedicine – CPT® codes 98000-98015 – are not valid for payment by Medicare, according to CMS. However, the agency decided to

soften its policy to allow direct supervision for some services and removed the distinction between provisional and permanent services.

- **Ambulatory Specialty Model (ASM) debut.** Physicians treating heart failure and low back pain will be in the first cohort of the mandatory ASM in 2027. The new program parallels the QPP, with participants experiencing boosts – or penalties – of 9%. We've got the coming year to find out the details of this new mandatory program, which will impact cardiologists, orthopaedic surgeons, pain specialists, and physiatrists in particular.

While we've highlighted the key points for medical practices, it's a great opportunity to read more. Check out the summary of the final rule [here](#).

The 2026 PFS final rule offers something of a mixed bag for medical practices: a meaningful conversion-factor increase, but also built-in offsets and structural shifts that will impact how physicians generate revenue, manage costs, and engage in value-based care.

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