

Valuation of Orthopedic Services: Reimbursement

As discussed in the second installment of this five-part *Health Capital Topics* series regarding the valuation of orthopedic services, the competitive environment for orthopedic services is characterized by growing demand and constrained supply.¹ This third installment examines the reimbursement environment for orthopedic services, including the Medicare Physician Fee Schedule (MPFS), recent legislative changes affecting physician reimbursement, and the emergence of value-based payment models relevant to orthopedics.

Overview of Medicare Physician Reimbursement

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid, and has a strong influence on reimbursement to hospitals and physicians. In 2024, Medicare and Medicaid accounted for an estimated \$1.118 trillion and \$931.7 billion in healthcare spending, respectively.² Health spending is projected to reach 20.3% of gross domestic product (GDP) by 2033.³ The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter and being used as a benchmark for private reimbursement rates.

Medicare pays for physician services through its Physician Fee Schedule, which calculates payments according to Medicare's Resource Based Relative Value Scales (RBRVS) system, which assigns relative value units (RVUs) to individual procedures based on the resources required to perform each procedure. Under this system, each procedure in the MPFS is assigned RVUs for three categories of resources. Physician work RVUs (wRVUs) represent the physician's contribution of time and effort to the completion of a procedure; the higher the value of the code, the more skill, time, and work it takes to complete. Practice expense RVUs (PE RVUs) are based on direct and indirect physician practice expenses involved in providing healthcare services, including clinical labor, medical supplies, medical equipment, administrative labor, office expenses, and other expenses. Malpractice expense RVUs (MP RVUs) correspond to the relative malpractice practice expenses for medical procedures; these values are updated at least every five years and typically comprise the smallest component of the RVU.

Each procedure's RVUs are adjusted for local geographic differences using Geographic Practice Cost Indexes (GPCIs) for each RVU component. Once the procedure's RVUs have been modified for geographic variance, they are summed, and the total is then multiplied by a conversion factor (CF) to obtain the dollar amount of governmental reimbursement. There are currently 109 GPCI payment localities.⁴

2026 MPFS Changes & Impact on Orthopedic Surgery

The 2026 MPFS introduces the most significant structural changes to the payment system since the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted. For the first time, the Centers for Medicare & Medicaid Services (CMS) is implementing two separate conversion factors.⁵ Qualifying participants in Advanced Alternative Payment Models (APMs) will receive a conversion factor of \$33.5675, representing a 3.77% increase from 2025.⁶ Non-qualifying participants, including those in the Merit-based Incentive Payment System (MIPS), will receive a conversion factor of \$33.4009, representing a 3.26% increase from 2025.⁷

These increases incorporate a temporary 2.5% boost from the One Big Beautiful Bill Act signed in July 2025, as well as permanent MACRA updates of 0.75% for qualifying APM participants and 0.25% for non-qualifying participants. The increases also include a 0.49% budget neutrality adjustment.⁸

Despite the overall conversion factor increases, orthopedic surgery faces a negative 9% payment impact for facility-based services under the 2026 MPFS, while non-facility (office-based) services see a positive 5% increase.⁹ This differential stems from two policy changes. First, CMS applied a negative 2.5% efficiency adjustment to work RVUs for non-time-based codes, which includes most surgical procedures.¹⁰ Second, CMS reduced facility practice expense RVUs to 50% of non-facility allocation based on its assertion that employed physicians no longer maintain separate office costs.¹¹ Moreover, the Consolidated Appropriations Act that was signed into law in February 2026 requires hospitals to obtain and use separate National Provider Identifiers (NPIs) for each off-campus outpatient department by 2028, a move that many interpret as the first step toward enactment of site-neutral payment policies.¹²

The American Academy of Orthopaedic Surgeons (AAOS) has strongly opposed the first two of these changes (but supports site-neutrality), noting that 54% of orthopedic surgeons remain in private practice, the second-highest rate among surgical specialties.¹³ The AAOS argues that the CMS rationale for reducing facility PE RVUs is particularly problematic for orthopedic surgery given this high proportion of private practitioners who do maintain separate office infrastructure.¹⁴ These payment differentials between facility and non-facility settings may accelerate the shift of orthopedic procedures to ambulatory surgery centers and office-based settings.

Value-Based Payment Models

The reimbursement environment for orthopedic services is also being shaped by the continued development of value-based payment models. The Bundled Payments for Care Improvement-Advanced (BPCI-A) model ended on December 31, 2025, while the Comprehensive Care for Joint Replacement (CJR) model concluded on December 31, 2024.¹⁵ Replacing these programs, the Transforming Episode Accountability Model (TEAM) launched on January 1, 2026, with mandatory participation for 741 hospitals in selected metropolitan areas.¹⁶ TEAM covers lower extremity joint replacement, surgical hip fracture treatment, and spinal fusion, among other episodes, with

a 30-day episode duration.¹⁷ CMS estimates the model will generate \$481 million in Medicare savings over five years.¹⁸ The mandatory nature of TEAM for hospitals in selected markets represents a significant shift from the voluntary bundled payment models that preceded it and may affect how hospitals structure their relationships with orthopedic surgeons in these markets.

Conclusion

The reimbursement environment for orthopedic services is undergoing significant transformation. The 2026 MPFS introduces substantial payment disparities between facility and non-facility settings for orthopedic surgery, with facility-based services experiencing a 9% reduction and office-based services seeing a 5% increase. Simultaneously, the shift toward value-based payment models, particularly the mandatory TEAM bundled payment program, is changing the economic framework within which orthopedic services are delivered and compensated.

The next installment of this *Health Capital Topics* series will examine the regulatory environment for orthopedic services, including the federal fraud and abuse laws that govern financial relationships between orthopedic surgeons and healthcare organizations.

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5 “Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F)” Centers for Medicare & Medicaid Services, October 31, 2025, <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f> (Accessed 3/25/26).

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8 *Ibid.*

9 “AAOS CY 2026 MPFS Comment Letter” American Academy of Orthopaedic Surgeons, September 12, 2025, <https://www.aaos.org/globalassets/advocacy/rules/aaos-cy-2026-mpfs-comment-letter.pdf> (Accessed 1/15/26).

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the U.S. House of representatives, which would stop the 2.5% cut. “New legislation aims to address CMS ‘efficiency adjustment’ and protect access to surgical care” By Joel L. Mayerson, AAOS Now, February 27, 2026, <https://www.aaos.org/aaosnow/2026/feb/advocacy/advocacy02/> (Accessed 3/25/26).

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13 “AAOS CY 2026 MPFS Comment Letter” American Academy of Orthopaedic Surgeons, September 12, 2025, <https://www.aaos.org/globalassets/advocacy/rules/aaos-cy-2026-mpfs-comment-letter.pdf> (Accessed 1/15/26).

14 *Ibid.*

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