

2026 Medicare Physician Fee Schedule: What Orthopaedic and Therapy Practices Should Know

The Centers for Medicare & Medicaid Services (CMS) has finalized the 2026 Medicare Physician Fee Schedule (PFS), introducing a modest reimbursement increase following several years of flat or declining physician payment updates.

While the change is incremental, it provides some financial relief for Orthopaedic and rehabilitation providers navigating rising operational costs and workforce challenges.

Below is a quick summary of what the 2026 rule means for musculoskeletal and therapy practices.

Non-APM Clinicians

\$33.40

Conversion factor

Key Payment Update

For 2026, CMS increased the Medicare conversion factor used to calculate physician payments.

- Non-APM clinicians: \$33.40 conversion factor **(+3.26%)**
- Advanced APM participants: \$33.57 conversion factor **(+3.77%)**

This creates a 0.51% higher payment update for clinicians participating in qualifying Advanced Alternative Payment Models (APMs).

For physical therapy services specifically, the overall payment impact is expected to average approximately a **1–2% increase**, though the exact change will depend on a practice's service mix and RVU adjustments applied to individual CPT codes.

Advanced APM Clinicians

\$33.57

Conversion factor

Additional Policy Updates

- 1 Separate Conversion Factors for APM and Non- APM Clinicians**

For the first time, CMS implemented two payment tracks to encourage participation in value-based care models.
- 2 Continued Support for Remote Care Services**

CMS maintained policies supporting telehealth access and Remote Therapeutic Monitoring (RTM), allowing providers to monitor patient progress and engagement outside traditional clinic visits.
- 3 RVU Adjustments May Offset Some Increases**

While the conversion factor increased, CMS also implemented adjustments to certain relative value units (RVUs). As a result, the net payment impact will vary depending on a practice's procedure mix and care setting.

Why This Matters for Orthopaedic and Rehabilitation Providers

Musculoskeletal conditions remain one of the most common drivers of healthcare utilization among Medicare beneficiaries. Orthopaedic and rehabilitation providers play a critical role in delivering high-value, non-operative care that improves outcomes while reducing overall healthcare costs.

Even modest reimbursement increases can help practices offset:

- Rising staffing and labor costs
- Increasing administrative and compliance requirements
- Investments in care coordination and patient engagement technology

Should Your Practice Consider an APM?

The introduction of separate conversion factors reinforces CMS's continued shift toward value-based reimbursement.

Practices considering participation in an Advanced Alternative Payment Model should evaluate:

- 1 Medicare Patient Volume**
Higher Medicare populations may benefit more from value-based incentives.
- 2 Care Coordination Capabilities**
Successful APM participation requires strong data tracking and outcome measurement.
- 3 Administrative Infrastructure**
Participation involves additional reporting and compliance requirements.
- 4 Referral Network Alignment**
Practices involved in ACOs, bundled payments, or clinically integrated networks may already have the necessary infrastructure.
- 5 Financial Risk Tolerance**
Some models include shared savings and downside risk tied to performance.

Looking Ahead

The 2026 Medicare Physician Fee Schedule represents a modest but positive step toward payment stability for therapy and Orthopaedic providers. While broader payment reform remains a priority, the update reflects continued recognition of the value rehabilitation services bring to patient outcomes and the healthcare system.

Practices that continue investing in care coordination, patient engagement, and data-driven care models will be best positioned to succeed as CMS expands value-based payment initiatives.

Virtual Physical Therapy: Expanding Access and Convenience for Your Patients

Virtual physical therapy—often referred to as telehealth PT—allows therapists to deliver care remotely through secure, HIPAA-compliant video platforms. While it does not replace traditional in-clinic therapy, it can serve as a valuable extension of care that improves patient access, convenience, and engagement.

How Virtual PT Works

Telehealth appointments are scheduled similarly to in-person visits. Patients receive a secure link and connect with their therapist using a smartphone, tablet, or computer. During the live video session, the therapist can:

01

Review Symptoms and Functional Progress

The therapist reviews the patient's symptoms and tracks functional progress since the last visit.

02

Observe Movement Patterns

Observe movement patterns such as squats, gait, or shoulder motion via live video.

03

Guide Therapeutic Exercises in Real Time

Correct technique and posture while guiding the patient through their exercise program.

04

Progress or Modify the Home Exercise Program

Adjust the patient's home exercise program based on observed performance and reported outcomes.

These visits are especially useful for follow-up care, exercise progression, post-operative monitoring, and management of chronic musculoskeletal conditions.

Billing for Telehealth Visits

In many cases, therapists can bill the same CPT codes used for in-person therapy, depending on payer policies. Commonly used codes include:

CPT Code	Description
97110	Therapeutic Exercise
97112	Neuromuscular Re-education
97530	Therapeutic Activities
97116	Gait Training
97535	Self-Care/Home Management Training



Most payers require **Modifier 95** to indicate the service was delivered via telehealth. Practices should verify individual payer requirements, including the appropriate place of service code.

Documentation Requirements

Documentation for virtual visits closely mirrors traditional therapy notes and should include subjective findings, objective observations, assessment, treatment interventions, and time spent.

Additional telehealth documentation should include:

- Patient consent for telehealth services
- The physical location of both the patient and therapist
- Confirmation that the visit was conducted through a secure, real-time audio/video platform

Denials Defense Framework: How Advantum Health Is Strengthening Revenue Protection

Claim denials remain one of the most persistent revenue challenges in healthcare. At Advantum Health, we are developing a Denials Defense Framework designed to help providers proactively reduce denials and recover revenue faster. We do this through intelligent automation and analytics. Our goal is to launch the framework by mid to late Q2.

Our approach focuses on preventing denials before claims are submitted and streamlining appeals when denials do occur. Using advanced AI and analytics, we identify high-risk claims early by analyzing eligibility, prior authorization, coding accuracy, documentation completeness, and historical payer behavior. This allows teams to correct issues upfront and avoid unnecessary rework.

For claims that are denied, our framework leverages AI-guided appeals powered by retrieval augmented generation (RAG). The system references payer policies, medical necessity criteria, and coding guidelines to help assemble compliant appeal documentation with human oversight, improving speed and consistency while maintaining audit readiness.

Together, these capabilities enable:

- ✓ Earlier visibility into denial risk
- ✓ Targeted root-cause insights to drive operational fixes
- ✓ Faster, more consistent appeals workflows
- ✓ Improved cash flow and reduced administrative burden

This Denials Defense Framework is a key part of Advantum Health's broader AI-enabled revenue cycle strategy, helping clients move from reactive denial management to proactive denial prevention.

From reimbursement changes to denial prevention, Advantum Health helps orthopaedic and therapy practices turn complexity into measurable financial performance.

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