RESEARCH BRIEF

The Source You Trust

August 2026

By Jon Sinclair, Amelia Carroll, and Jack Anderson

Medicare Fee Schedules and Workers Compensation in 2026

The Centers for Medicare and Medicaid Services (CMS) updates its reimbursement rules and rates for medical services each year. This report highlights key changes in the 2026 update and the potential impact on workers compensation (WC) medical costs.

INTRODUCTION

The National Council on Compensation Insurance (NCCI) monitors changes in CMS reimbursement rules and rates that impact WC medical costs. The impacts of these changes on WC medical costs vary by state. The medical service categories covered by medical fee schedules, the extent to which each fee schedule incorporates the CMS rules and rates, and the distribution of medical costs all influence how each state is impacted. NCCI's report, Medicare Fee Schedules and Workers Compensation in 2025, highlighted noteworthy aspects of the 2025 update.

This report highlights the 2026 changes to the following CMS fee schedules:

- The Physician Fee Schedule which covers services provided by physicians, physical therapists, nurses, and other professionals
- The Facility Payment Systems for inpatient and outpatient hospitals and ambulatory surgical centers (ASC)
- The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

KEY FINDINGS

- The 2026 physician conversion factor increased by 3.3% from the 2025 conversion factor, marking the first increase following five years of declines
- The 2026 physician Relative Value Units (RVUs) were rebalanced, resulting in increased payment rates for Evaluation and Management services and decreased payment rates for Surgical services
- Facility base rates saw moderate increases that were in line with the changes seen in prior years
- The 2.0% increase to the CMS DMEPOS update factor in 2026 is in line with the increase from last year

Physician Fee Schedule Changes

Physician costs account for about 40% of countrywide[1] WC medical expenditures. Physician fee schedules in WC are often based on factors published in the annual CMS Physician Fee Schedule (PFS).

There are two general components involved in the calculation of the maximum allowable reimbursement (MAR) for a given physician service: an RVU and a conversion factor. RVUs are procedure-specific weights that represent the relative expense to perform the procedure. The physician conversion factor is a constant factor applied to all non-anesthesia physician procedures that converts RVUs into dollars.

CMS publishes the RVUs and physician conversion factor annually. CMS determines the conversion factor by beginning with the prior year's conversion factor and adjusting it with respect to multiple factors. The physician conversion factor update in 2026 is affected by statutory requirements from legislation, ongoing changes, and the budget neutrality factor.

For the first time in recent years, the 2026 conversion factor increased compared to the prior year. This is largely driven by the one-year increase of 2.5% required by statute.[2] Additionally, a +0.25% increase is part of the annual update methodology going forward as stipulated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The final component of the change to the conversion factor is related to CMS compliance with budget neutrality, which requires that changes in RVUs must not result in an increase or decrease in total Medicare spending. CMS increased the conversion factor by +0.49% to offset a projected 0.49% decrease in overall RVUs.

Of note, there is currently no inflationary adjustment to account for changes to the prices of goods and services reflected in the annual update to the physician conversion factor. For reference, each year the CMS calculates a measure of cost inflation for operating a physician practice, the Medicare Economic Index (MEI), even though it is not used to update payments. In 2026, the MEI increased by 2.7% according to CMS.

The table below shows the conversion factors for physician services for the latest five calendar years:

	Effective Date					
	1/1/2022	1/1/2023	1/1/2024	3/9/2024	1/1/2025	1/1/2026
Conversion Factor	34.6062	33.8872	32.7442	33.2875	32.3465	33.4009
Percentage Change From Prior Year	–0.8%	–2.1%	–3.4%	–1.8%	–2.8%	+3.3%

For states that incorporate the physician conversion factor from CMS, the conversion factor applies to all non-anesthesia physician services on the fee schedule. Therefore, an increase to the physician conversion factor will impact the majority of physician services in those Medicare-based states.

The second key piece of the physician MAR formula is the RVU. The RVU for an individual service includes three components: work, practice expense, and malpractice insurance. Work and practice expense make up the majority of the total RVU. The exact split between these two components varies by type of service. For 2026, CMS made two meaningful changes. First, CMS introduced a –2.5% decrease as an efficiency adjustment to the work portion of non-time-based services. This change reduced payment rates for non-time-based services such as surgical services. Time-based services like evaluation and management or physical therapy were not impacted by this change. Second, CMS reallocated the practice expense component to better reflect current clinical practice. This change reduced payment rates for services typically performed in a facility setting, such as surgical services. Payment rates were increased for services more commonly provided in-office, such as evaluation and management.

While CMS offsets RVU changes through the conversion factor, the offset is calculated using the mix of services provided to Medicare patients. However, WC has a different mix of services than Medicare. Notably, surgical services make up a larger share in WC due to the nature of injuries treated. Both the introduction of the efficiency adjustment and the reallocation of the practice expense component reduced payment rates for surgical services.

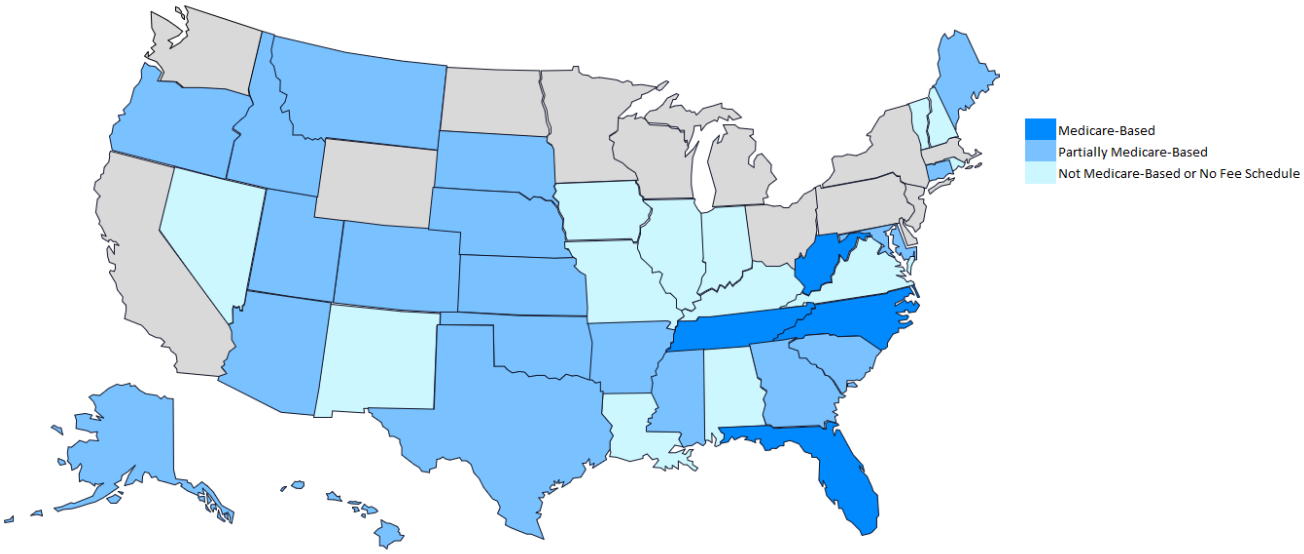
---

[1] Based on NCCI's Medical Data Call. Includes data from the following jurisdictions: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV. Unless stated otherwise, statistics are for Service Year 2024 WC data.

[2] Section 71202 of the One Big Beautiful Bill Act which amends Section 1848(t) of the Social Security Act (42 U.S.C. 1395w-4(t)).

Based on the higher share of surgical services in WC, the 2026 changes to RVUs are expected to decrease average WC payments by –1.2% as compared to the –0.49% determined by CMS.

The map below displays each state's level of reliance on the physician payment rates that are published annually by the CMS.



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2026.

- **Medicare-Based:** These states incorporate both the CMS-published conversion factor and RVUs into their fee schedules
- **Partially Medicare-Based:** These states use state-specific conversion factors in combination with CMS-published RVUs
- **Not Medicare-Based:** These states do not incorporate the CMS-published conversion factor or RVUs

The impact of the 2026 changes on WC medical costs will vary by state depending on the state's reliance on CMS values when setting MARs. The interaction between the increase in the conversion factor and decrease in RVUs may result in a small increase in physician costs for states that incorporate the CMS conversion factor. States that publish their own conversion factor(s) will incorporate the –1.2% decrease in RVUs, and their overall change in physician reimbursements will be based on updates to their factors.

Facility Fee Schedule Changes

In WC, facility costs also account for about 40% of countrywide medical expenditures.

CMS publishes annual updates to the payment systems that govern payment rates for services performed in the following types of facility: hospital outpatient, ASC, and hospital inpatient.

The table below displays the CMS payment system associated with each facility type:

Facility Type	CMS Payment System
Hospital Outpatient	Outpatient Prospective Payment System (OPPS)
ASC	ASC Payment System
Hospital Inpatient	Inpatient Prospective Payment System (IPPS)

As is the case with physician services, for each facility type, CMS determines the payment rate for any given service by considering two main factors: relative weights (which are based on resource and service intensity) and base rates. The base rates are analogous to the physician conversion factor; they apply to all facility procedures and convert the relative weight for each procedure into a dollar amount.

Unlike physician services, the CMS annual updates to the base rates for facility services account for changes in the prices of goods and services used by hospitals in treating Medicare patients. This is referred to as the market basket update. In 2026, the final market basket update is a 2.6% increase. This is made up of a 3.3% inflationary increase offset by a –0.7% adjustment for increases in productivity.

The national base rates are additionally adjusted for budget neutrality, among other changes. The changes in the national base rates for the most recent five calendar years are shown below:

		Base Rate				
Facility Type	Payment System	2022	2023	2024	2025	2026
Hospital Outpatient	OPPS	$84.18	$85.59	$87.38	$89.17	$91.42
ASC	ASC Payment System	$49.92	$51.85	$53.51	$54.90	$56.32
Hospital Inpatient	IPPS	$6,594.24	$6,859.53	$7,001.60	$7,136.53	$7,276.77

Facility Type	Payment System	2022	2023	2024	2025	2026
Hospital Outpatient	OPPS	+1.7%	+1.7%	+2.1%	+2.0%	+2.5%
ASC	ASC Payment System	+2.0%	+3.9%	+3.2%	+2.6%	+2.6%
Hospital Inpatient	IPPS	+2.6%	+4.0%	+2.1%	+1.9%	+2.0%

In 2026, hospital outpatient and ASC national base rates increased in line with the market basket update of +2.6%. The increase for hospital inpatient was slightly lower, at +2.0%.

To account for differences among hospitals, the national base rates are modified by additional factors to calculate a hospital-specific base rate. CMS offsets changes to these additional factors with budget neutrality adjustments to the national base rates. For inpatient hospitals in 2026, CMS applied a budget neutrality adjustment of –0.6% to offset changes to the average wage index resulting from hospital reclassifications. The wage index is intended to account for geographic differences in wage levels. For some hospitals, the wage level of the geographic area in which they are located may not align with the wage level of the labor market from which they source their employees. For example, a rural hospital in a low-wage geographic location a few miles outside of a metropolitan area may have to pay doctors and nurses higher wages to compete with hospitals in the nearby metropolitan area. CMS allows hospitals to reclassify to areas which are more closely aligned with the labor market in which they source their staff.

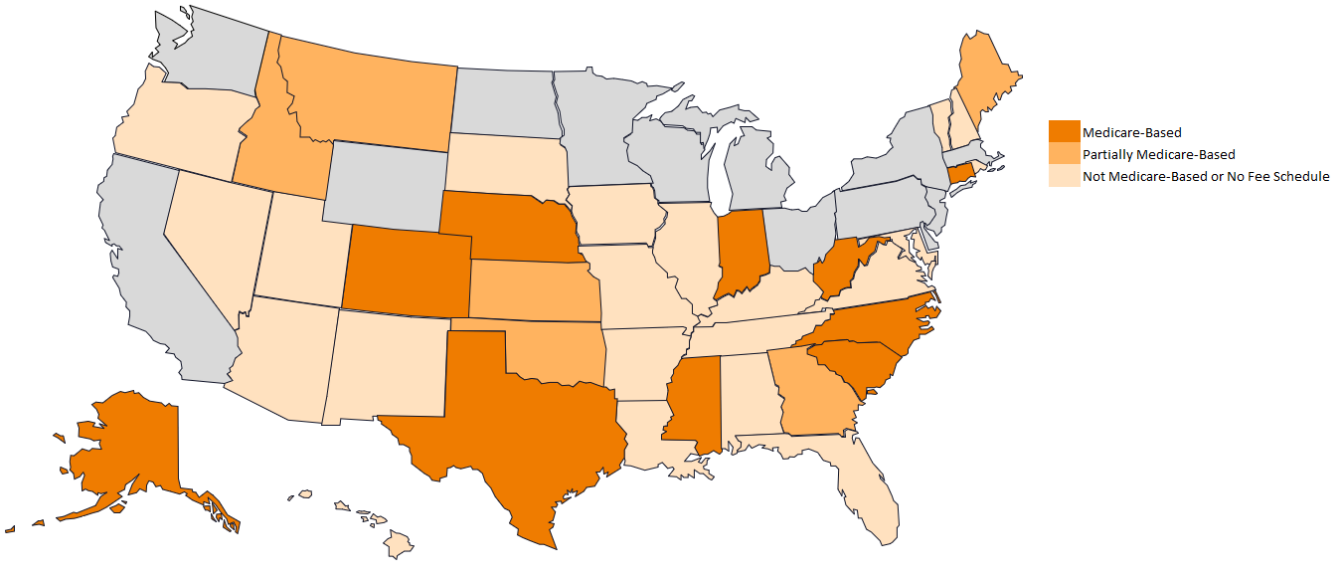
Changes to the relative weights for individual services can also impact overall costs. For 2026, however, the changes to the CMS relative weights for hospital inpatient, hospital outpatient, and ASC services in 2026 were minor.

In addition to the base rates and relative weights, other factors can impact maximum payment levels. One such factor is the fixed-outlier threshold used to determine payment rates for especially resource-intensive hospital inpatient episodes. CMS uses the fixed outlier threshold to identify and determine reimbursement for inpatient episodes with costs that are significantly higher than usual. In 2026, CMS decreased the outlier threshold from $46,217 to $40,397, a 13% decrease3. Ten jurisdictions incorporate the CMS fixed-loss outlier threshold in their WC inpatient outlier provisions: Alaska, Colorado, Connecticut, District of Columbia, Indiana, Mississippi, North Carolina, South Carolina, Texas, and West Virginia. The lower threshold may increase costs as more inpatient episodes could reach this threshold and qualify for additional outlier reimbursement. The level of impact will depend on various factors, such as how each state incorporates the factor in its individual outlier provision as well as the prevalence of high-cost outlier episodes in each state.

The impact of the 2026 CMS facility payment rate changes on WC medical costs will vary by state depending on the state's reliance on CMS values when setting rates. The interaction between the increase in the base rates and minor changes in relative weights may result in a moderate increase in facility costs for states that incorporate the CMS base rates.

The maps below display each state's level of reliance on the facility payment rates that are published annually by the CMS.

Inpatient:

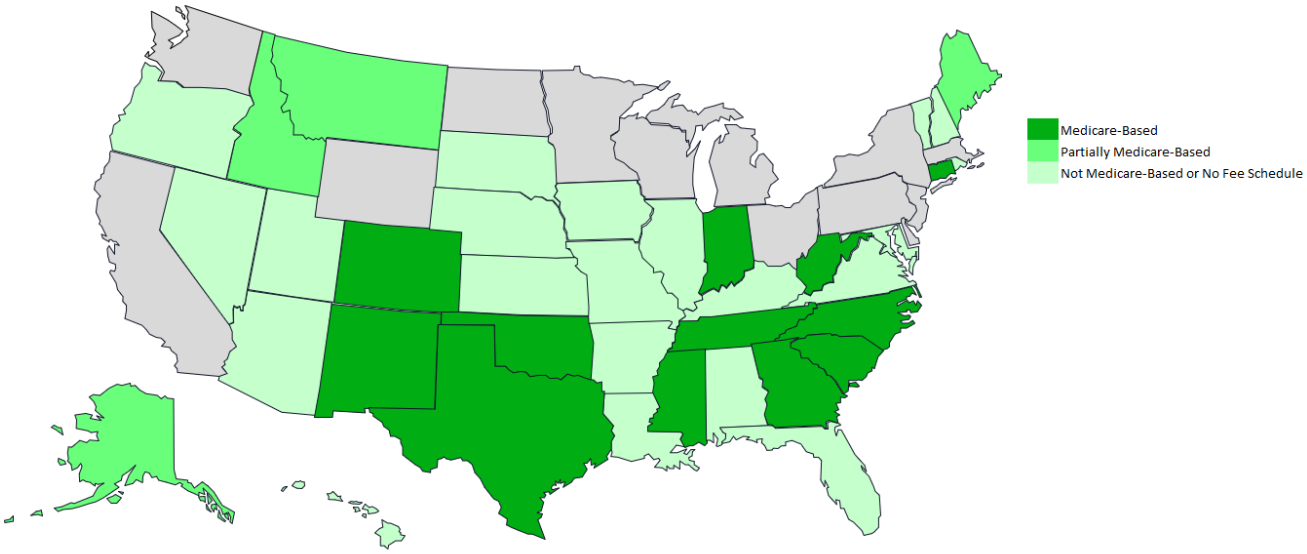


Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2026.

- **Medicare-Based:** These states incorporate both the CMS-published IPPS base rates and relative weights into their fee schedules
- **Partially Medicare-Based:** These states use state-specific base rates in combination with CMS-published IPPS relative weights
- **Not Medicare-Based:** These states do not incorporate the CMS-published base rates or relative weights

[3] The fixed-loss outlier threshold is calculated by CMS based on observed payment and is set such that 5% of total payments for IPPS episodes would be expected to be classified as an outlier episode.

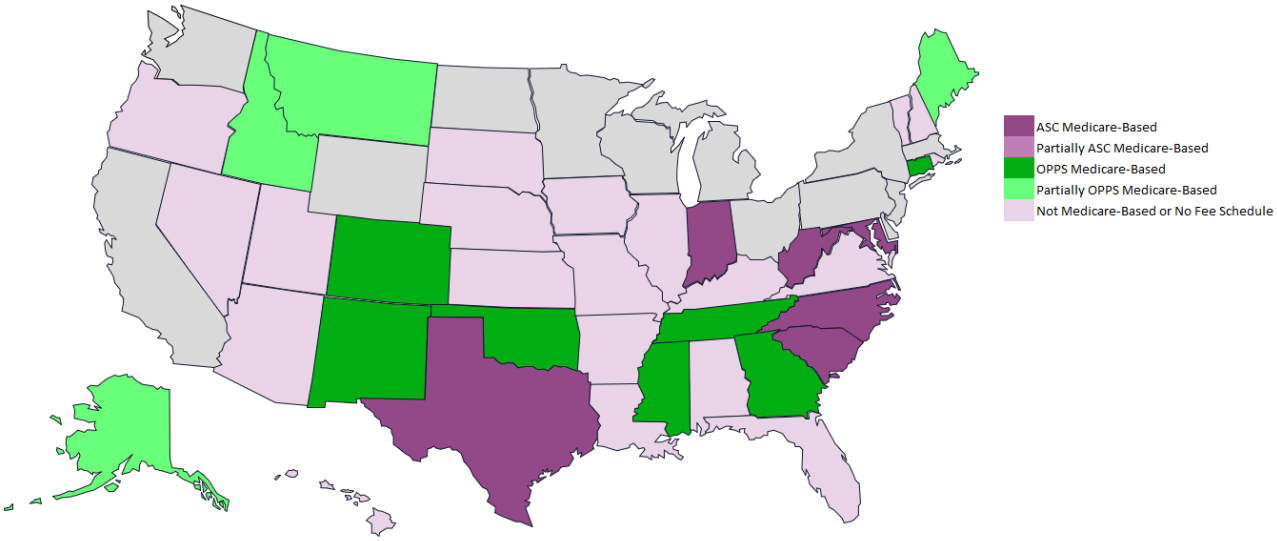
Outpatient:



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2026.

- **Medicare-Based:** These states incorporate both the CMS-published OPPS base rates and relative weights into their fee schedules
- **Partially Medicare-Based:** These states use state-specific base rates in combination with CMS-published OPPS relative weights
- **Not Medicare-Based:** These states do not incorporate the CMS-published base rates or relative weights

ASC:



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2026.

- **ASC Medicare-Based:** These states incorporate both the CMS-published ASC Payment System base rates and relative weights into their fee schedules
- **Partially ASC Medicare-Based:** These states use state-specific base rates in combination with the CMS-published ASC Payment System relative weights
- **OPPS Medicare-Based:** These states incorporate both the CMS-published OPPS base rates and relative weights into their fee schedules
- **Partially OPPS Medicare-Based:** These states use state-specific base rates in combination with the CMS-published OPPS relative weights
- **Not Medicare-Based:** These states do not incorporate the CMS-published base rates or relative weights

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

The share of costs that DMEPOS represents varies by state, ranging between 4% and 13% of WC medical costs.

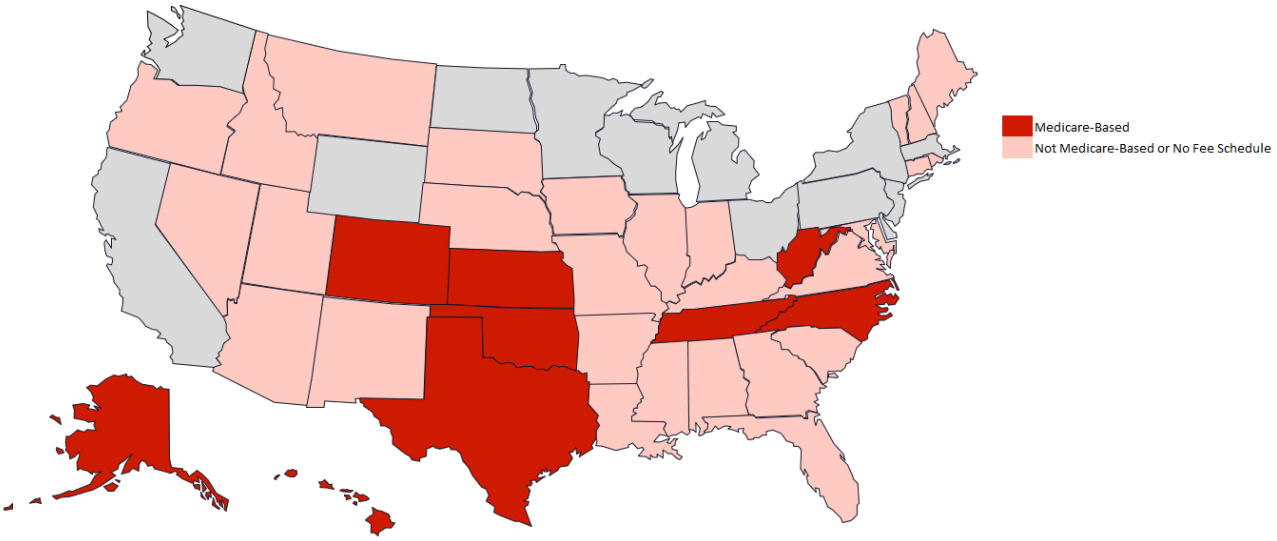
CMS categorizes codes into two groups for the purpose of adjusting the DMEPOS fee schedule each year. The first group consists of codes subject to the DMEPOS Competitive Bidding Program. The second group, which comprises the majority of DMEPOS payments in WC, consists of codes not subject to the Competitive Bidding Program. A CMS-calculated factor, which is composed of the Consumer Price Index for All Urban Consumers (CPI-U) and a productivity adjustment, updates the reimbursable amount for the latter group.

The table below shows the CMS-published fee schedule update factors for DMEPOS services for the five most recent calendar years:

2022 Fee Schedule Update Factor	2023 Fee Schedule Update Factor	2024 Fee Schedule Update Factor	2025 Fee Schedule Update Factor	2026 Fee Schedule Update Factor
+5.1%	+8.7%	+2.6%	+2.4%	+2.0%

The impact of the 2026 CMS DMEPOS payment rate changes on WC medical costs will vary by state depending on the state's reliance on CMS values in its rate setting.

The map below displays each state's level of reliance on the DMEPOS payment rates that are published annually by the CMS.



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2026.

- **Medicare-Based:** These states incorporate CMS-published DMEPOS payment rates into their fee schedules
- **Not Medicare-Based:** These states do not incorporate the DMEPOS payment rates published by CMS

CONCLUDING REMARKS

The 2026 physician conversion factor has increased by 3.3% from the 2025 factor. Facility base rates saw moderate increases in line with prior years. As in 2025, the factors published by CMS are **not** expected to be a significant source of upward pressure on overall WC medical costs. The impacts of these changes on WC medical costs vary by state. The medical service categories covered by medical fee schedules, the extent to which each fee schedule incorporates the CMS rules and rates, and the distribution of medical costs all play a role in how each state is impacted.