



QUARTERLY REPORT · Q1 2026

Q1 2026 Surgical Billing Intelligence Report

How the 2026 rules landed in the first quarter

INTRODUCTION

The 2026 Rules Take Effect

If the fourth quarter of 2025 was about decisions, the first quarter of 2026 was about their consequences. On the first business day of the year, the new Medicare conversion factors, the revised outpatient and ASC payment policies, the 2026 procedural code set, and the federal prior-authorization timing requirements all took effect at once. For the surgical revenue cycle, January 1 is the hinge of the year, the day on which price, site of service, coding vocabulary, and administrative rules all reset together, and the first remittances that follow are the test of whether the preceding quarter's preparation held.

This report follows the same research-paper structure as our prior quarterly note. It begins with the broad picture of what became live, then examines each change in turn, quantifies it where the data allow, and draws out the operational consequence for surgical practices and ambulatory surgery centers. The difference in this edition is tense. The fourth-quarter report described what was coming. This report describes what arrived, how it behaved in the first weeks of contact with payer systems, and where the early evidence should direct a practice's attention.

Three observations frame the quarter. First, the 2026 payment changes are real but uneven, and a practice learns its true position only by reconciling its own January and February remittances against a model rather than reading the national headline. Second, the first weeks of a major code turnover always generate a layer of denials that come from payer systems catching up rather than from genuine coding errors, and distinguishing the two is its own discipline. Third, the quarter resolved a long-running source of instability when Congress moved past a brief second telehealth lapse and enacted a two-year extension, which finally replaced a string of short reprieves with real planning runway.

The exhibits in this report quantify those observations, including the multi-year path of the conversion factor now that the 2026 figure is set, the payment updates in effect, the reported progress on prior-authorization reduction, the resolved telehealth timeline, and an illustrative view of where surgical denials concentrate. The analysis that surrounds them is written for a billing leader who has to convert national change into a concrete plan for the next ninety days.

How to read this report

Each numbered section examines one change now in effect. The exhibits present the figures, including the conversion-factor trend, the payment updates by setting, the offsetting forces on a work-weighted procedure, the reported prior-authorization reduction, the telehealth timeline, an illustrative denial composition, and a benchmark set. Directional ranges are labeled as illustrative.

1. Medicare Physician Payment, Now in the Remittances

The CY 2026 Physician Fee Schedule is in effect, and the structural changes that were abstract in the fourth quarter became concrete in the first. Two conversion factors are now live, with the factor for qualifying participants in advanced alternative payment models set slightly above the standard factor. The positive update that the headlines emphasized is genuine, yet for procedural specialties it is partly offset by the efficiency adjustment that reduced the work values of many non-time-based services, so the net effect on any given practice depends on the specific procedures it performs.

Exhibit 1 lists the rules and code sets that became live on January 1, which is a useful single reference for a billing lead confirming that every change has been accounted for in the system. Exhibit 2 places the 2026 standard conversion factor in its multi-year context, and the shape of that line is the strategic story. After four consecutive years of decline, the factor turned up in 2026, but it did not return to where it began the decade, and part of the rebound is a temporary provision that will have to be defended again in the next cycle. A practice reading its 2026 results should hold that trajectory in mind.

The first quarter is therefore a reconciliation exercise. A practice that modeled its top codes in advance can take the January and February remittances and compare allowed amounts line by line against the model, and the variances fall into two categories. Some reflect the genuine policy effect of the new conversion factor working against the efficiency adjustment, which is expected and should match the model. Others reflect a fee schedule that was loaded incorrectly, which is a fixable error rather than a policy outcome. Separating the two before escalating to the payer saves the team from disputing a payment that is in fact correct, and it surfaces the loading errors that would otherwise quietly suppress revenue all year.

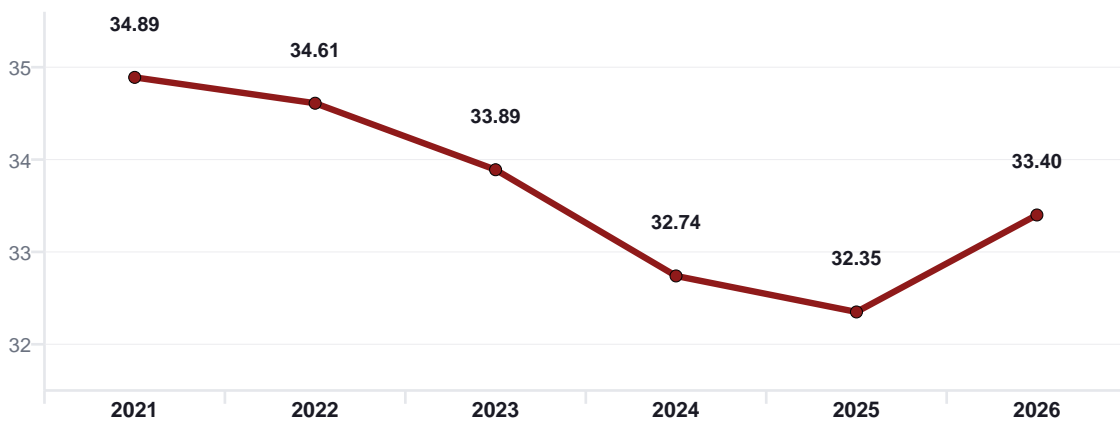
Exhibit 3 illustrates why the headline percentage is the wrong number to plan against. The conversion-factor increase applies to the full payment, while the efficiency adjustment reduces only the work component, so for a work-weighted procedure the realized change lands between the two figures. The discipline that matters in the first quarter is to track allowed amounts on the highest-volume codes against the model and to flag any divergence early, because a small per-claim error compounds quickly across a quarter of surgical volume.

Exhibit 1. What took effect on January 1, 2026

Change	What it does	Status
CY 2026 conversion factors	Two factors replace one, with a positive but partly temporary update	Live
Work-value efficiency adjustment	Reduces work RVUs for many non-time-based services	Live
CY 2026 ASC payment update	About 2.6 percent, with a wider covered-procedures list	Live
Inpatient-only list phase-out	First procedures become payable in the outpatient and ASC setting	Live, year one
CPT 2026 code set	288 new codes and a restructured revascularization family	Live
CMS-0057-F decision timing	Enforceable 72-hour and seven-day payer decision windows	Live

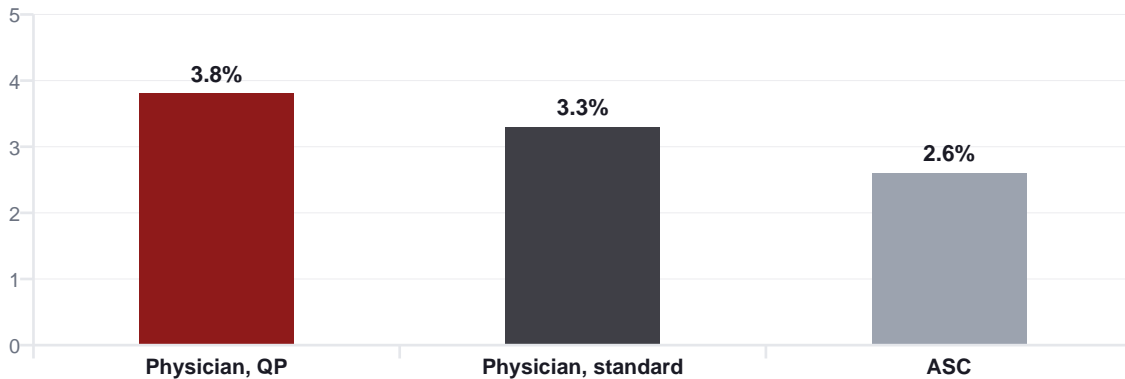
Sources: CMS CY 2026 final rules, the American Medical Association CPT 2026 set, and CMS-0057-F. The FY 2026 ICD-10-CM diagnosis set has been in effect since October 1, 2025.

Exhibit 2. Medicare standard conversion factor, 2021 to 2026 (US dollars, approximate)



Source: CMS annual Physician Fee Schedule final rules. Values are the approximate standard conversion factor, rounded to the cent. The 2026 figure is the standard, non-qualifying factor.

Exhibit 3a. Medicare payment updates in effect for 2026, by setting (percent)



Source: CMS CY 2026 Physician Fee Schedule and OPFS and ASC final rules. Physician figures are conversion-factor increases and do not reflect the separate efficiency adjustment on work values.

Exhibit 3b. Offsetting forces on a work-weighted procedure (illustrative)

Component	Direction	Applies to
Conversion-factor increase	About +3.3 percent (standard)	The full payment amount
Work-value efficiency adjustment	About -2.5 percent	Only the work component of the value

Illustrative, to show method rather than a result. Because the increase applies to the full payment and the adjustment only to the work component, the realized net for a work-weighted procedure typically lands between the two figures. Model your own top codes for an accurate forecast.

For the practice's own budgeting, the right output of this reconciliation is a weighted average realized change across the actual code mix, not a single headline figure borrowed from a trade summary. A surgeon-heavy group will usually find that its realized change trails the standard conversion-factor increase, because the efficiency adjustment bites hardest on the procedural work that dominates its volume, while a group with a larger share of evaluation and management work may track closer to the headline. Building that weighted figure early gives leadership a defensible number for staffing and capital decisions, and it replaces the false comfort of a national percentage with a forecast the practice can actually stand behind.

2. Coding in the First Full Quarter of the New Set

The first quarter is when a code turnover stops being theoretical and meets the reality of thousands of payer adjudication systems, each of which adopts new codes on its own schedule. The CPT 2026 set has been live since January 1, with its 288 new codes, its 84 deletions, and its restructured families, and the FY 2026 ICD-10-CM diagnosis set has been embedded since October. The practical effect in January and February is a temporary rise in code-related rejections, and the important skill is to read those rejections correctly.

A rejection on a deleted code is a true error and reflects a claim built on last year's vocabulary, which points to a coder defaulting to muscle memory rather than to the current set. The lower-extremity revascularization family is the most likely place for this to happen, because its overhaul retired the familiar codes that an experienced coder might reach for automatically. A rejection on a brand-new code, by contrast, is often not a coding error at all. It frequently means the payer has not yet loaded the code into its system, in which case the correct response is to confirm the payer's adoption status and time the resubmission rather than to rework the claim as if the coding were wrong.

The operational answer is to keep a short watch list of the new 2026 codes the practice actually uses and to track which payers have recognized each one. That list turns a confusing wave of early denials into a manageable queue, and it prevents the team from spending February reworking claims that simply needed to be resubmitted a few weeks later. On the diagnosis side, the added specificity of the FY 2026 set is an advantage when it is used, because a more precise diagnosis strengthens the medical-necessity case, and a liability when it is not, because a vague code that cleared in 2025 may now trip an edit. The practices that handle the turnover well treat the first six weeks of the year as a measurement exercise, watching which codes and which payers produce the early rejections and adjusting the queue accordingly.

It is worth setting an internal expectation that the first several weeks of the year will run a higher rejection rate than normal, so that the team does not mistake a temporary adoption lag for a structural coding problem. A practice that communicates this in advance, and that holds a brief daily review of new-code denials through January, will resolve the wave faster and with less alarm than one that treats each rejection as a surprise. The same review surfaces, in real time, which payers are slowest to adopt the new set, which is intelligence the front end can use when it sequences resubmissions.

3. Year One of the Ambulatory Shift

The first group of procedures came off the Medicare inpatient-only list on January 1, weighted heavily toward musculoskeletal cases, and for ambulatory surgery centers and hospital outpatient departments this opened genuine new volume. The opportunity is real, and it is concentrated in the orthopedic and spine work that anchors the ASC business, but it carries a corresponding rise in the stakes around patient selection and documentation.

A more complex procedure performed in the ambulatory setting invites a closer look at whether the site of service was appropriate, and the reframing of the old exclusion criteria as physician safety considerations places that judgment squarely on the surgeon and on the record that supports it. The centers that capture the new volume cleanly are the ones that pair the clinical decision with strong pre-operative documentation, so that the medical-necessity and site-of-service case is already made before a reviewer ever asks.

The commercial dimension remains the gating factor. Commercial payers do not automatically follow Medicare's site-of-service determinations, so a procedure that became payable in the ASC under Medicare still has to be verified against each commercial plan's coverage and site rules before it is scheduled.

Centers that move first should also confirm that their case-costing reflects the true cost of the higher-acuity procedures now arriving, because a procedure that is approved but underpriced erodes the very margin the new volume was meant to create. The first quarter is the right time to run that analysis, while the volume is still ramping and a pricing error can be corrected before it scales.

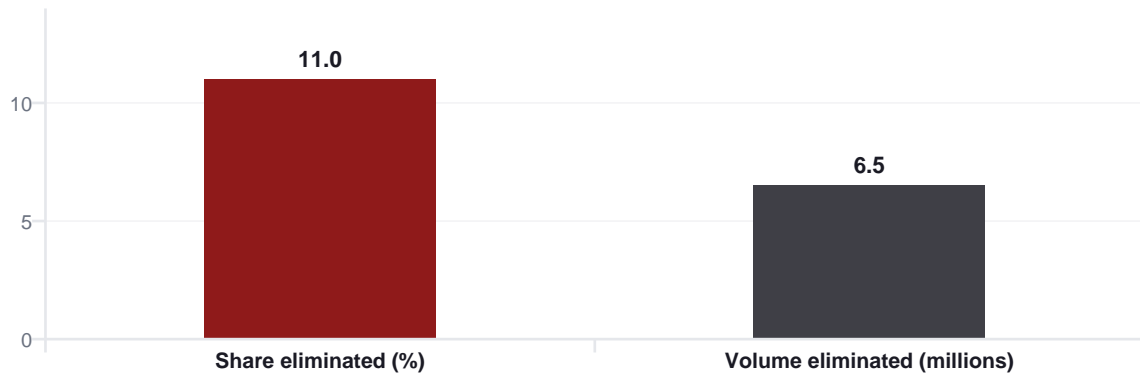
4. Prior Authorization Becomes Operational

The decision-timing requirements of CMS-0057-F are now operational. Affected payers are expected to return expedited decisions within 72 hours and standard decisions within seven calendar days, and for the first time a provider has an enforceable clock rather than an open-ended wait. The voluntary insurer pledge added reductions on top of the binding rule, and the first national progress report tied to the pledge indicated a meaningful but partial result. By the spring, the participating insurers and the industry associations reported that roughly one in nine prior authorizations had been eliminated, on the order of several million fewer authorizations, which is real relief that nonetheless leaves most of the burden in place. Exhibit 4 presents the reported reduction.

The way to convert the new rules into recovered time is procedural rather than aspirational. Logging every submission with a timestamp turns the federal decision windows into something a practice can actually enforce, because a late decision can only be escalated against a deadline that the practice can document. Re-baselining which procedures still require authorization matters just as much, since several payers trimmed their requirement lists at the start of the year, and a request submitted for a procedure that no longer needs one is pure waste that also slows the case. Measuring authorization turnaround by payer each month then shows which plans are genuinely faster and which are paying lip service to the commitment.

Intraoperative neuromonitoring is again a specific beneficiary. Monitoring teams have long contended with slow authorization decisions on cases that cannot easily be rescheduled, and an enforceable decision clock is precisely the remedy that situation called for. As monitored procedures continue to migrate toward the ambulatory setting, confirming the supervision and site-of-service rules of each payer remains part of the discipline.

Exhibit 4. Reported prior-authorization reduction under the insurer pledge



Source: AHIP and the Blue Cross Blue Shield Association progress reporting in spring 2026. The left bar is the reported share of prior authorizations eliminated; the right bar is the approximate volume eliminated, in millions.

A practical measure of whether the new rules are working is the share of authorization decisions that arrive inside the required window, tracked by payer and trended month over month. A payer that consistently misses the standard seven-day mark is both a compliance issue to escalate and a scheduling risk to manage, and the only way to know which payers fall into that category is to measure it rather than to rely on impression. The practices that treat the decision clock as a metric, and not merely as a rule, are the ones that will convert the regulation into shorter cycle times and fewer last-minute case delays.

5. Out-of-Network Disputes and the No Surprises Act in Early 2026

The federal Independent Dispute Resolution process carried its extraordinary 2025 caseload into the new year. Volume remained far above the level the program was built to handle, and the backlog accumulated through 2025 was still being worked down as the first quarter began. For surgical groups with meaningful out-of-network exposure, the process stayed both an essential remedy and a slow one, and nothing in the first quarter altered that underlying tension.

What continued to matter operationally was the economics of bringing a dispute. The reduced per-party administrative fee of 15 dollars remained in effect, which keeps the door open to the smaller eligible claims that were uneconomic under the prior fee. A surgical group entering 2026 should treat its inventory of set-aside out-of-network claims as a live opportunity rather than a settled write-off, because many of those balances now clear the threshold at which a dispute becomes worth pursuing.

The discipline that produces results did not change. A dispute is resolved when a certified entity selects one party's offer rather than averaging the two, so a credible and well-documented offer outperforms an aggressive one. A clean open-negotiation record lets a group file the moment a dispute becomes eligible, and batching similar claims where the rules permit spreads the modest cost across more disputes. In a quarter when every other part of the revenue cycle was absorbing change, the out-of-network process

rewarded the groups that kept their filing pipeline current and disciplined.

6. Telehealth, Resolved for Two Years

The first quarter closed the long-running telehealth question, at least for a defined period. The short extension enacted in November carried Medicare telehealth flexibilities only through January 30, 2026, and the flexibilities lapsed again on January 31 when that window expired. On February 3, 2026, Congress passed a funding bill that extended the flexibilities for two years, through December 31, 2027. After a long run of last-minute, short-horizon extensions, the surgical revenue cycle finally has real planning runway for telehealth.

For surgical practices, the most relevant effect is that pre-operative and post-operative telehealth visits now rest on a stable basis through 2027, which makes it reasonable to build them into standard care pathways rather than treating them as a temporary convenience that might vanish at the next deadline. Exhibit 5 traces the full sequence of lapses and extensions that produced this outcome, which is a useful record of just how fragile the coverage had become before the two-year fix.

Exhibit 5. The telehealth timeline, from lapse to two-year extension

Date	Event
September 30, 2025	Medicare telehealth flexibilities expire
October 1, 2025	Federal government shutdown begins, lasting 42 days
November 12, 2025	Continuing resolution restores flexibilities through January 30, 2026, with retroactive pay
January 31, 2026	Flexibilities lapse again as the short extension expires
February 3, 2026	Congress enacts a two-year extension through December 31, 2027

Sources: APTA, K&L; Gates, and Telehealth.org coverage of the 2025 shutdown and the subsequent Medicare telehealth extensions.

7. The First-Quarter Revenue Cycle and the Deductible Reset

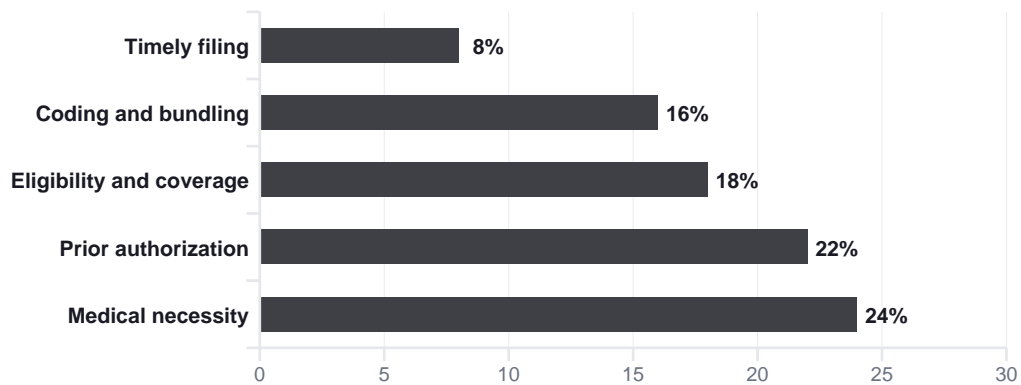
Beyond the regulatory changes, the first quarter has its own seasonal rhythm that interacts with everything above. The annual reset of patient deductibles in January pushes patient responsibility to its highest point of the year, which makes the accuracy of pre-service estimates and the discipline of point-of-service collection matter more in the first quarter than in any other. A practice that collects well at the point of service while deductibles are fresh protects both its cash position and its downstream collection cost.

Denial behavior in the quarter reflected the code turnover layered on the usual themes. Medical necessity and prior authorization remained the leading drivers of surgical denials even with the new timing rules in place, and a temporary rise in code-related rejections accompanied the first weeks of the new set as payers completed their loading. Exhibit 6 presents an illustrative composition of surgical denial themes, which is a directional picture rather than a measured distribution, and it underscores how concentrated the

recoverable categories tend to be. As in prior periods, appeals that cited the payer's current medical policy outperformed generic appeals, because the payer is most readily persuaded by its own published criteria.

Exhibit 7 offers a simple monthly cadence for the quarter, expressed as an operating calendar rather than as a task list, because the value is in the sequence. January is for loading and reconciliation, February is for diagnosing payer adoption and measuring authorization turnaround, and March is for reviewing the quarter's denial trends and moving the top recurring cause upstream into prevention. Throughout, the emphasis on point-of-service collection and on filing eligible out-of-network disputes continues. Exhibit 8 then gives the benchmark ranges against which a practice can judge whether the quarter is trending in the right direction.

Exhibit 6. Surgical denial themes (illustrative composition, percent of denials)



Illustrative composition for orientation only, not a measured Collective distribution. Actual mix varies by specialty and payer. The point is that a small number of categories drive most recoverable denials.

Exhibit 7. A first-quarter operating calendar

When	Focus
January	Load 2026 fee schedules and code sets, then reconcile the first remittances against the model
February	Diagnose payer code adoption on any 2026 codes still denying, and measure authorization turnaround by payer
March	Review quarter-to-date denial trends and move the top recurring cause upstream into prevention
Throughout	Emphasize point-of-service collection while deductibles are fresh, and file eligible disputes as they qualify

A working cadence for surgical billing teams. The value is in the sequence rather than in any single task.

Exhibit 8. Surgical revenue cycle benchmarks to watch (illustrative general ranges)

Metric	General range	Direction
Point-of-service collection	Higher is better, and most important in Q1	Higher is better
Clean claim rate	About 95 percent or higher	Higher is better
Denial rate	About 5 to 10 percent	Lower is better
Days in accounts receivable	About 30 to 45 days	Lower is better
Accounts receivable over 90 days	Often under about 15 to 20 percent	Lower is better

Illustrative general industry ranges, not Collective client figures. In the first quarter, the deductible reset makes the patient-responsibility metrics especially worth watching.

8. The AI-Native Revenue Cycle in a High-Change Quarter

A quarter that changes this much at once is precisely where a learning system, rather than a static rule engine, proves its value. New code sets, new conversion factors, and payers that load those codes at different speeds create a moving target that a fixed set of edits cannot track, because the rules that were correct in December are wrong in January and partly wrong again as each payer catches up. A system that learns from the outcome of every claim can surface the new codes a payer has not yet recognized, catch a fee-schedule variance on the first remittance of the year, prioritize the claims most likely to deny, and keep an audit trail of every automated edit for review.

The dividing line that matters is between pattern detection and judgment. Pattern detection scales naturally with software, which is well suited to watching thousands of claims for the signatures of a payer adoption lag or a loading error. Judgment, including coding determinations, medical-necessity calls, and appeals strategy, remains the work of experienced people, supported by the system rather than replaced by it. In a quarter where the ground was shifting weekly, that combination is what kept well-run operations from absorbing the change as a wave of avoidable denials, and it is the reason the same external shock produces very different results across two otherwise similar practices.

None of this displaces the clinician or the coder. The point of an automated layer in a quarter like this one is to widen the span of attention, so that a small team can watch a large and shifting field of claims without missing the early signal of a payer that has changed its behavior. The judgment about whether a given claim is correct, and how to argue an appeal, stays with experienced people, and it is precisely because that judgment is scarce that it should be spent on the cases that need it rather than on the mechanical detection of patterns a system handles better.

9. A Function-by-Function Playbook for the Quarter

It helps to close by translating the quarter's changes into the specific work each part of the revenue cycle should own, because a change that belongs to everyone in general tends to belong to no one in particular. The front office carries eligibility verification and the authorization workflow, now governed by the new decision clock and by the need to re-confirm which procedures still require authorization at all. When that function timestamps its submissions and tracks payer turnaround, the rest of the cycle inherits a cleaner starting point.

The clinical and coding function owns the 2026 code mapping and the retraining on the restructured families, with the lower-extremity revascularization overhaul as the priority for any practice that performs that work. It also owns the watch list of new codes and their payer-by-payer adoption status, which is what converts a confusing January into a managed queue. The accounts-receivable function owns the reconciliation of remittances against the fee-schedule model and the discipline of separating a real policy effect from a loading error before anything is escalated.

Patient access and patient financial services own the deductible-reset season, where accurate estimates and point-of-service collection protect both cash and downstream cost. Out-of-network management owns the dispute pipeline, reactivated now that the fee no longer deters smaller claims. And leadership owns the synthesis, reading the denial and payment trends each month and deciding which recurring cause to move upstream into prevention. A quarter of this much change rewards the operation that has assigned each of these clearly rather than the one that treats the change as a single undifferentiated problem.

10. Risks and What Could Change

A forward-looking note has to be honest about what could move the picture, because several of the quarter's gains rest on provisions that are temporary or voluntary. The clearest risk is the temporary portion of the 2026 conversion-factor increase, which is scheduled to expire and will have to be renewed or replaced in the next cycle. A practice that built its plan on the full 2026 number, rather than on the durable portion of it, is exposed if the temporary lift is not extended, and that exposure is better modeled now than discovered later.

The prior-authorization commitments are the second area to watch, because the reductions reported so far are voluntary and uneven across markets. A pledge can be narrowed or quietly relaxed, and the binding federal timing rule, while real, does not by itself reduce the number of authorizations a payer requires. The prudent posture is to treat the early relief as welcome but provisional, to keep measuring each payer's behavior, and to avoid building a workflow that assumes a level of relief that may not last.

The third area is the appropriations calendar. The two-year telehealth extension removed one recurring cliff, but the broader pattern of short funding windows and last-minute deals remains, and the surgical revenue cycle has now seen first-hand how quickly a lapse can interrupt coverage and cash flow. A practice that keeps a simple contingency plan for a future lapse, covering which visits and which cash flows are exposed, will absorb the next disruption far more calmly than one that assumes settled policy will

stay settled.

11. Outlook for the Second Quarter

By the second quarter the initial turbulence settles and the data become genuinely useful. A practice will have a clean read on how the 2026 payment changes landed on its specific case mix, on which payers are honoring the new authorization timing in practice rather than on paper, and on whether the ambulatory shift is delivering the volume it promised. The early-quarter noise of code adoption fades, leaving a clearer signal in the denial and payment data.

The second quarter is also when attention turns to the next rulemaking cycle, as the proposed rules that shape the following year begin to appear and the planning horizon extends again. Our Q2 2026 report will track how the first-quarter changes matured into steady-state results, measure the real-world performance of the new prior-authorization timing across payers, and flag the mid-year proposals that will define the next planning cycle for surgical practices and ambulatory surgery centers.

Sources and references

This report is original analysis written from the public, named sources below. Figures, effective dates, and policy details should be verified against the primary source, because rules and guidance are revised over time. Exhibit values drawn from these sources are cited in the exhibit captions, and any directional ranges are labeled as illustrative.

- CMS, Calendar Year 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F), fact sheet and Federal Register notice, released October 31, 2025, with prior-year conversion factors from the corresponding annual final rules.
- CMS, CY 2026 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule, released November 2025, with summaries from Holland and Knight, McDermott+, and ASCO.
- CMS, Interoperability and Prior Authorization Final Rule (CMS-0057-F), fact sheet, with decision-timeframe requirements effective January 1, 2026 and application programming interface requirements effective January 1, 2027.
- American Medical Association, CPT 2026 code set announcement, with summaries from Wolters Kluwer and AAPC, effective January 1, 2026.
- CMS and ACDIS, FY 2026 ICD-10-CM code update, effective October 1, 2025.
- AHIP and the Blue Cross Blue Shield Association, prior-authorization commitments announced July 23, 2025, with progress updates reported through 2026.
- Center on Health Insurance Reforms at Georgetown University and Health Affairs Forefront, federal No Surprises Act IDR data for 2025, with the CMS final rule on IDR administrative fees.
- APTA, K&L; Gates, and Telehealth.org coverage of the 2025 federal government shutdown and the Medicare telehealth extensions of November 2025 and February 2026.

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