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doi:10.36849/JDD.10171

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BRIEF COMMUNICATION

Journal of Drugs in Dermatology

Reining in Medicare Spending on Skin Substitutes: What the 2026 Reforms Mean for Dermatology

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INTRODUCTION

Medicare Part B spending on skin substitute products rose from $256 million in 2019 to more than $10 billion in 2024.[1] A 2025 brief report first documented this trajectory in the dermatologic literature and attributed much of this growth to a 2023 Centers for Medicare & Medicaid Services (CMS) policy that simplified Q-code applications, triggering a rapid proliferation of new and increasingly expensive products.[2] By the second quarter of 2025, the median Medicare average sales price (ASP) had tripled to roughly $403/cm^2.[2] In a parallel modeled cost analysis, management of Mohs surgical defects with placenta-derived skin substitutes ranged from approximately $6,000 to $210,000 per wound, compared with $120 to $480 for second intention healing (ie, clinic-based wound care expenses) despite any demonstrated clinical benefit.[3] The authors of both reports called for payment reform linking Q-code eligibility to proven clinical efficacy.

As of January 1, 2026, CMS implemented a major restructuring of skin substitute reimbursement. Given the prominent role wound care plays in our specialty, a brief synthesis is timely for dermatologists.

Who Has Been Driving the Spending?

For a closer look at whose practice patterns produced the spiking expenditure for skin substitutes, we reviewed the publicly available 2023 CMS Physician/Other Practitioners Public Use File, which captures practitioner-billed Medicare Part B claims.[4] We filtered it to Healthcare Common Procedure Coding System (HCPCS) codes beginning with Q41 or Q42 and current procedural terminology (CPT) codes 15271-15278. Q-codes are temporary HCPCS codes assigned to new products to ensure reimbursement while longer-term coverage is pending. CPT 15271-15278 cover high-cost skin substitute applications. Because this file excludes hospital outpatient and ambulatory surgery center (ASC) settings, where skin substitutes are bundled into ambulatory payment classification (APC) payments rather than separately reimbursed, these office-based claims represent the dominant share of 2023 Medicare skin substitute spending. An important limitation is that this data identifies billing categories but cannot establish wound severity, appropriateness, supervision, or whether care was physician-directed. However, several findings warrant the attention of the dermatologic community.

FIGURE 1. Medicare Part B skin substitute payments by provider category, 2023.

Rank	Provider category	Providers (n)	Total Medicare payment	Avg payment per provider
1	Nurse Practitioner (NPP)*	463	$914 M	$1.97 M
2	Primary Care†, combined	148	$348 M	$2.35 M
3	Podiatry	391	$269 M	$0.69 M
4	Dermatology	292	$119 M	$0.41 M
5	Physician Assistant (NPP)*	104	$68 M	$0.65 M
6	Plastic & Reconstructive Surgery	64	$58 M	$0.91 M

Provider categories ranked by estimated 2023 Medicare Part B payments for skin substitute services, which include claims billed under HCPCS application codes 15271–15278 and skin substitute Q-codes. Payment estimated as the average Medicare payment per service multiplied by total services per provider-HCPCS-place-of-service record, then summed within category. *Nurse practitioners (NPs) and physician assistants (PAs) represent non-physician practitioner (NPP) provider-type designations rather than clinical specialties. †Primary care combines internal medicine (n=57), family practice (n=76), and general practice (n=15). Data source: Centers for Medicare & Medicaid Services Medicare Physician & Other Practitioners by Provider and Service Public Use File, calendar year 2023; records with fewer than 11 beneficiaries are suppressed by CMS.

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First, practitioner-billed skin substitute expenditure was almost entirely concentrated in the office setting (99.5%), with only 0.5% billed in facility settings (hospital outpatient department, ASC, inpatient unit). In the facility setting, the practitioner's professional fee is packaged into a bundled APC payment that is typically a fraction of the office amount. This fee discrepancy explains the heavy skew toward the office setting for skin substitutes claims.

Second, the biller profile is overwhelmingly non-surgical (Figure 1). Nurse practitioners (NPs) accounted for approximately $914 million, or roughly 47% of the $1.93 billion in 2023 practitioner billing for these products. Within this subset of NPs, there were only about 463 unique NPIs, suggesting a very high volume of billing for skin substitutes from a small number of providers. Across all specialties, the top 10 individual providers billed approximately 32% of the national total. The average Medicare payment per beneficiary among the top 5 providers ranged from approximately $500,000 to $1.5 million per patient.

Although claims data cannot establish the medical necessity or intent, recent enforcement actions illustrate why this billing pattern has attracted scrutiny. By January 2025, two Arizona-based wound care company owners pleaded guilty to a $1.2 billion kickback scheme that employed NPs to apply medically unnecessary skin substitutes, specifically targeting elderly Medicare patients.[5] A separate $45 million False Claims Act settlement in November 2025 with a national wound care group suggests these practices were part of broader business models exploiting systemic gaps, rather than isolated outliers.[5]

Third, dermatologists and plastic surgeons account for a small fraction of total spending for skin substitutes. Although these specialties routinely manage post-surgical wounds and chronic ulcers, they are not the primary drivers of skin substitute spending.

Policy Changes Effective January 1, 2026

Effective January 1, 2026, CMS implemented sweeping changes to skin substitute reimbursement. The 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F) replaced the ASP-based payment methodology for skin substitutes in physician offices and hospital outpatient departments with a single fixed rate of $127.14 per square centimeter. CMS has projected that this policy change will reduce gross fee-for-service spending by ~$19.6 billion in 2026, a 90% reduction compared to current spending.

This new methodology groups products by FDA regulatory status: 361 HCT/Ps (Human Cells, Tissues, and Cellular and Tissue-based Products regulated under Section 361 of the Public Health Service Act), to which most current skin substitutes belong; 510(k) cleared devices; and devices approved through premarket approval (PMA). For 2026, CMS set rates uniformly across all three groups, but future reimbursement rates will likely vary based on the rigor of clinical evidence underlying a product's regulatory pathway. Notably, a proposed parallel Local Coverage Determination (LCD), which is essentially a strict guideline for clinical appropriateness used to guide Medicare reimbursement for skin substitute claims, was withdrawn by CMS on December 24, 2025. Without these parallel LCDs, reimbursement reforms went into effect without the clinical framework intended to support them.

Implications for Dermatology

The expansion of skin substitute spending represents one of the largest documented inflations in Medicare Part B history. Dermatologists are uniquely positioned to shape what comes next. As specialists in cutaneous wound care and post-procedural care, we should engage with policymakers to ensure that coverage of skin substitutes is tied to evidence rather than billing convenience. Flat-fee reimbursement and product recategorization remove the financial incentive to select the most expensive products; they do not ensure clinical appropriateness.

Based on 2023 CMS billing data, dermatologists stand distinctly apart from the broader wound care community. Because our specialty has neither driven nor disproportionally benefited from CMS expenditure for skin substitutes, we enter this next phase of reforms with a highly credible voice. These 2026 reforms are merely the beginning of larger policy overhauls, and dermatologists must remain vigilant and proactive within this evolving regulatory landscape.

DISCLOSURES

The authors have no disclosures to report.

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