

CY 2027 Medicare PFS and OPPS proposed rules: key implications for wound care across facility and non-facility settings

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule contains several provisions with direct implications for wound care delivery. The proposals include lower physician conversion factors, a new 50% payment reduction when separately identifiable office/outpatient evaluation and management (E/M) services are furnished on the same day as 0-, 10-, or 90-day global procedures, replacement of HCPCS G2211 with percentage-based modifiers, continued evolution of cellular, acellular, and matrix-like product (CAMP) payment, national valuation of real-time bacterial fluorescence wound imaging, practice-expense reform, and changes to remote physiologic and therapeutic monitoring. The same-day E/M proposal is especially important for wound clinicians because interventions such as sharp surgical debridement are commonly performed and medically necessary during wound care encounters. Importantly, as currently drafted, the proposal is limited to office/outpatient E/M services, which in wound care are commonly furnished in private physician offices and hospital outpatient departments (HOPDs). It does not currently extend to appropriately reported home/residence or nursing-facility E/M services, including those furnished in POS 12, 13, 31, and 32. CMS is seeking comment on whether the policy should later extend to other E/M categories. Facility and non-facility effects also differ because hospital outpatient departments receive separate facility reimbursement while independent office and mobile practices bear practice expense directly. This summary reviews the proposed policies most relevant to wound care and distinguishes their expected application across common sites of service.

Introduction

On July 16, 2026, the Centers for Medicare & Medicaid Services (CMS) published the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1848-P), which includes proposed changes to physician payment and other Medicare Part B policies effective on or after January 1, 2027. The proposal is particularly relevant to wound care because services are delivered across multiple settings including physician offices, patient residences, nursing facilities, and hospital outpatient departments (HOPDs), and reimbursement differs substantially depending on site of service, the applicable E/M code family, and whether a separate facility payment is available.¹

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Working in concert, the Wound and Hyperbaric Association (WHA) and the American Professional Wound Care Association (APWCA) reviewed the proposal and identified several provisions of particular relevance to wound care, including physician reimbursement, same-day E/M and procedure payment, G2211 restructuring, CAMP payment, bacterial fluorescence wound imaging, practice expense relative value units (RVUs) and setting or site of care, 340B reimbursement, and remote monitoring.²

Physician payment and conversion factors

Beginning in 2026, Medicare uses separate PFS conversion factors for qualifying Alternative Payment Model (APM) participants and for clinicians who are not qualifying APM participants. For CY 2027, CMS projects a qualifying APM conversion factor decrease of 1.19% and a non-qualifying APM conversion factor decrease of 1.68% from CY 2026. Under the PFS, Medicare payment for physician and other practitioner services is calculated by applying a conversion factor to the geographically adjusted RVUs assigned to each service. For CY 2027, CMS proposes conversion factors of approximately \$33.17 (-\$0.40 or 1.19%) for qualifying APM providers and \$32.84 (-\$0.56 or 1.68%) for nonqualifying APM providers.¹

For wound care providers, the reduction in the conversion factor affects the professional reimbursement component in both facility and non-facility settings. In the HOPD, however, the professional claim must be distinguished from the hospital facility payment. The separate CY 2027 OPPS proposed rule would increase hospital outpatient payment rates by 2.4% for hospitals meeting applicable quality-reporting requirements. That OPPS update is paid to the hospital and does not offset a reduction in the physician professional claim.³ Key proposed policy changes and their relevance to wound care are summarised in [Table 1](#).

TABLE 1 | Key CY 2027 proposals with wound care relevance

Policy area	CY 2027 proposal	Wound care relevance
PFS conversion factor	Approx. -1.19% or \$33.17 CF for qualifying APM participants and a decrease -1.68% or \$32.84 CF for non-qualifying APM clinicians	Reduces professional reimbursement across all sites of care
Same-day E/M + global procedure	Highest-valued service paid at 100%; other qualifying E/M/procedural services paid at 50%	Potentially important for procedural encounters with separately identifiable E/M work when modifier 25 is supported and appropriate
G2211 replacement	Proposed MOD1 adds 16% to eligible E/M payment; MOD2 adds 32% for specified ACO participants	May support longitudinal management, but interactions with modifier 25 remain important
Universal cellular, acellular, and matrix-like product (CAMP) reimbursement	CY 2026 framework largely carried forward while additional 2026 data accrue	Provides short-term stability but future rate-setting remains important
Bacterial fluorescence imaging	New Category I CPT 976XX proposed for national valuation	National valuation could improve payment consistency, but the adequacy of the proposed 0.80 work RVU, physician time, practice-expense inputs, and payment when performed with debridement remains uncertain
Practice expense	Further reform and site-of-service review	Phase-out of the prior IPCI -based methodology with implementation of a Practice Expense Stabilization Adjustment that generally limits annual code-level PE RVU changes to 5%, together with continued review of site-of-service assumptions and underlying cost data. Potentially important for non-facility office and mobile wound care practices that directly bear staffing, space, supplies, equipment, transportation, infection-control, administrative, and other practice costs. The stabilization adjustment may reduce abrupt annual volatility but does not prevent cumulative PE reductions over time or payment changes resulting from other components of the PFS.
Remote physiologic monitoring (RPM)/Remote therapeutic monitoring (RTM)	Initiating visit and direct-employment requirements proposed	May require workflow changes for practices using outsourced monitoring staff

Same-day E/M and procedure payment: a major wound care issue

CMS proposes to reduce payment when a separately identifiable office/outpatient E/M visit is furnished by the same provider, or a provider in the same group practice, on the same day as a procedure with a 0-, 10-, or 90-day global period. Under the proposal, the highest-valued service would be paid at 100%, while other qualifying surgical procedure(s) or separately supported E/M service would be paid at 50%.

This reduction may also apply when more than one distinct surgical procedure is appropriately reported during the same encounter; use of a modifier such as modifier 59 to establish that two procedures are separately reportable does not, by itself, exempt the lower-valued procedure from the proposed payment reduction. CMS states that the proposal is intended to account for efficiencies and potential overlap in pre-service, post-service, and practice-expense resources.¹

This issue is particularly relevant to wound care because debridement may represent only one component of a broader encounter. A patient undergoing CPT 11042, for example, may simultaneously require separate evaluation and management of infection, perfusion, edema, diabetes, and malnutrition.

When modifier 25 requirements are met, that E/M work is separately identifiable from the procedural service. The proposed payment reduction does not eliminate the requirement that the E/M service be significant and separately identifiable or above/beyond the work associated with the planned wound procedure, rather, it changes the amount Medicare would pay when the criteria for separate reporting are satisfied.¹

The place-of-service distinction

The proposal should not be described as a blanket 50% reduction across all wound care settings or place of service. CMS explicitly states that it is proposing to apply the policy only to office/outpatient E/M visits (99202-99215), which in wound care are commonly furnished in private physician offices and hospital outpatient departments (HOPDs), and is seeking comment on whether the policy should later extend to other E/M categories, such as inpatient visits (99231-99233 for example). Accordingly, the operative distinction is primarily the E/M code family, not simply whether the setting is labeled facility or non-facility.¹ The application of the proposed same-day E/M policy across common wound care settings is outlined in [Table 2](#).

TABLE 2 | Application of the proposed same-day E/M policy in common wound care settings

Setting	Typical POS	Applicable E/M code family	Current scope of proposed 50% policy
Physician office	11	Office/outpatient E/M (99202-99215)	Yes, when paired with a qualifying 0-, 10-, or 90-day global procedure
Off-campus HOPD	19	Office/outpatient E/M professional claim (99202-99215)	Yes, on the practitioner professional claim
On-campus HOPD	22	Office/outpatient E/M professional claim (99202-99215)	Yes, on the practitioner professional claim
Patient home	12	Home/residence E/M (99341-99345; 99347-99350)	Outside current proposal
Assisted living/residence	13	Home/residence E/M (99341-99345; 99347-99350)	Outside current proposal
Skilled nursing facility	31	Nursing-facility E/M (99304-99306; 99307-99310)	Outside current proposal
Nursing facility	32	Nursing-facility E/M (99304-99306; 99307-99310)	Outside current proposal
Inpatient hospital	21	Hospital inpatient E/M (99221-99223; 99231-99233)	Outside current proposal; CMS is seeking comment on possible extension

For example, an office/outpatient E/M encounter reported as 99214-25 with CPT 11042 would potentially be subject to the proposed 100%/50% payment methodology because CPT 11042 carries a 0-day global period. Under the proposal, the highest-paid applicable service would be paid at 100%, while the other applicable procedure or office/outpatient E/M service would be paid at 50%. By contrast, a properly reported nursing-facility E/M service furnished on the same day as a

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wound procedure would not fall within the proposal as currently drafted. This is more precise than describing a particular place of service as “exempt,” because CMS has proposed the reduction specifically for separately identifiable office/outpatient E/M services furnished on the same day as a 0-, 10-, or 90-day global procedure and has separately requested comment on whether the policy should be extended to other E/M service families.¹

A practical example illustrates the distinction. A wound care provider treating a Medicare beneficiary in the patient’s home (POS 12) may perform a medically necessary home/residence E/M service, reported with modifier 25 when the service is significant and separately identifiable from the work inherent in the procedure. For example, the provider may separately evaluate and manage cellulitis of the right lower extremity (ICD-10-CM L03.115) and chronic venous hypertension of the right lower extremity (I87.311), including assessment of the infection, vascular and edema status, medication management, and treatment planning.

During the same encounter, the provider may also perform CPT 11042 for excisional debridement of a non-pressure chronic ulcer of the right calf with fat layer exposed (L97.212), when the documented wound depth and tissue removed support debridement through subcutaneous tissue. In this example, L97.212 would be linked to CPT 11042 as the diagnosis supporting the debridement, while L03.115 and, when separately evaluated and managed, I87.311 may support the home/residence E/M service.

Although using distinct diagnosis-code linkage in this example helps demonstrate the separate clinical work, Medicare does not require different diagnoses for reporting an E/M service with modifier 25. The determining factor is whether the documentation demonstrates a significant and separately identifiable E/M service above and beyond the usual pre- and post-procedure work associated with the debridement.

If the documentation supports medical decision-making distinct from the routine work inherent in debridement—for example, assessment of cellulitis severity and extent; review, initiation, or modification of antimicrobial therapy; evaluation of venous hypertension and edema; determination of the appropriateness of compression; assessment of perfusion; evaluation for systemic signs or symptoms of infection; consideration of diagnostic testing or referral; or development or modification of the overall wound-management plan—the home/residence E/M service may be separately reportable with modifier 25.

Under the CY 2027 PFS proposed rule as currently drafted, that home/residence E/M service would not be subject to the proposed same-day 50% payment reduction solely because CPT 11042 was also performed during the encounter. The proposal is directed specifically to separately identifiable office/outpatient E/M services furnished on the same day as a 0-, 10-, or 90-day global procedure. Home/residence E/M services are a different E/M code family and therefore are outside the scope of the proposal as presently written. The same general distinction applies to appropriately reported nursing-facility E/M services. CMS has, however, requested comment on whether this payment policy should be expanded to other E/M service families in future rulemaking. Billing under an individual physician’s or nurse practitioner’s NPI does not itself determine whether the reduction applies; the relevant issue is the E/M service category reported, the accompanying global procedure, and whether the requirements for modifier 25 are otherwise satisfied.¹

G2211 transition to percentage-based modifiers

CMS proposes to replace HCPCS G2211 with a modifier, currently identified as MOD1, applied to the underlying eligible E/M code. MOD1 would increase payment for the associated E/M service by 16%. CMS also proposes MOD2, which would increase the associated E/M payment by 32% for eligible practitioners participating in the Medicare Shared Savings Program or the Long-term Enhanced ACO Design (LEAD) Model. MOD2 may be appended to eligible office/outpatient or home/residence E/M services by qualifying participants.⁴

For wound care, the proposed structure could be relevant to longitudinal management of patients with chronic wounds, but it does not eliminate the same-day E/M issue. CMS proposes to maintain the current limitations on use of the G2211 successor modifiers with modifier 25, while also seeking comment on whether MOD1 or MOD2 should be permitted when a private office/HOPD outpatient E/M service is performed on the same day as a 0-, 10-, or 90-day global procedure.¹

CAMP payment: relative stability with future rate-setting implications

For CY 2027, CMS largely continues the CY 2026 approach to payment for sheet-form CAMPs while additional utilization and pricing information becomes available. In CY 2026, CMS implemented a universal single payment level

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of approximately \$127 per cm² across the principal FDA regulatory groupings used for payment. The CY 2027 proposal also addresses national payment for non-sheet-form products rather than continued contractor pricing.⁵

For non-facility wound practices, CAMPs remain clinically and financially distinct from hospital facility payment because the practice directly bears acquisition and inventory risk. A universal Medicare payment amount does not imply that acquisition costs are uniform across products. Future recalibration using ASP and other market data will therefore remain important. If market prices during a transition period reflect temporary discounting, inventory liquidation, or manufacturer exit, those data may not represent a normalized long-term market; this is a policy concern that warrants continued evaluation rather than an established CMS finding.

Real-time bacterial fluorescence wound imaging

In September 2025, the CPT Editorial Panel created a new Category I code, identified in the proposed rule as CPT 976XX, for real-time fluorescence wound imaging performed with clinical darkness to identify the presence, location, and load of bacteria and to measure wound size. Because the specialty society did not conduct a successful relative value scale update committee (RUC) survey, contractor pricing was recommended. CMS instead proposes national valuation because of persistent geographic payment variability for predecessor Category III codes 0598T and 0599T.¹

CMS proposes a work RVU of 0.80 and 26 minutes of physician time, including 6 minutes of pre-evaluation, 15 minutes of intraservice work, and 5 minutes of immediate post-service work. The agency also proposes direct practice-expense inputs for the non-facility setting. CMS specifically sought comment on concurrent reporting with wound debridement codes, noting that predecessor fluorescence-imaging codes were frequently billed with debridement and asking whether any practice-expense inputs would duplicate resources already recognized in debridement services.¹

For wound care, conversion from temporary Category III codes to a permanent Category I code with proposed national valuation could improve consistency in access and reimbursement. Appropriate valuation of physician work, clinical labor, equipment, supplies, and any concurrent use with debridement will determine whether the payment reflects actual resource use.

Practice expense and site-of-care neutrality

CMS proposes a significant transition in the methodology used to calculate practice-expense (PE) RVUs. The agency proposes to reduce reliance on older specialty-specific practice-expense survey data, including phasing out the Indirect Practice Cost Index (IPCI) component of the current methodology, while implementing a Practice Expense Stabilization Adjustment. Under the proposal, annual changes in a code's PE RVU attributable to the methodology transition generally would be limited to 5%. CMS describes this as part of a broader multi-year effort to move toward more objective, routinely updated, and auditable cost data.

The 5% stabilization mechanism should not be interpreted as limiting the total Medicare payment change for an individual service to 5%. It applies to the PE RVU component associated with the methodology transition. Final PFS payment may still change because of adjustments in work RVUs, malpractice RVUs, geographic adjustments, the conversion factor, and other payment policies. In addition, repeated annual downward adjustments could accumulate over time for services whose calculated PE values remain below their existing values.

Under the PFS, procedures that may be furnished in both facility and non-facility settings have separate practice-expense RVUs. Non-facility payment incorporates resources that the practice directly provides, whereas facility practice expense (PE) RVUs generally exclude resources for which Medicare separately pays the facility. For CY 2027, CMS also proposes additional changes to indirect PE allocation and continues to seek information about how costs differ according to site of care and physician employment arrangements.¹

This issue is particularly important for office and mobile wound care. Non-facility practices may directly bear the costs of personnel, clinical space, wound measurement and documentation, supplies, equipment, infection-control infrastructure, inventory, billing and compliance. Mobile and community-based practices may additionally incur travel time, transportation costs, portable equipment expense, and staffing inefficiencies when caring for homebound or geographically isolated beneficiaries.

Accordingly, changes in PE methodology may have disproportionate importance for wound care delivered outside hospital facilities because these practices directly absorb many of the costs that are recognized separately through

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facility reimbursement in the HOPD setting. Even with the proposed stabilization adjustment, cumulative changes in PE valuation could materially alter reimbursement for certain wound-care services over time.¹

Hospital outpatient and 340B considerations

Facility-based wound care must be considered through two payment streams: the practitioner professional claim under the PFS and the hospital facility payment under OPPTS. CMS proposes a 2.4% OPPTS payment update for qualifying hospitals in CY 2027. The OPPTS proposal also would change payment for 340B-acquired drugs to ASP minus 33.4% and accelerate the separate 340B remedy-related reduction to the OPPTS conversion factor for affected non-drug items and services from 0.5% to 3.0% beginning in 2027. These policies may have broader institutional effects for health systems operating wound care alongside infusion, oncology, infectious disease, and other outpatient services.³

Remote physiologic and therapeutic monitoring

The CY 2027 proposal would make several changes to remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM). CMS proposes a separately reportable initiating visit requirement for RPM and RTM and would limit RTM to established patients. Importantly, the initiating face-to-face encounter may occur either in person or through telehealth; it should not be characterized as requiring an exclusively in-person visit. CMS also proposes that clinical-staff work used to satisfy RPM or RTM service requirements be performed by staff directly employed by the billing practitioner or practice rather than by contracted third-party clinical personnel.¹

For wound programs using outsourced remote-monitoring platforms, the employment requirement could require substantial operational change even when the technology itself remains clinically useful. Programs should therefore distinguish requirements related to the initiating encounter from requirements governing who may furnish the clinical-staff component of monitoring services.

Facility versus non-facility implications

The practical implications of the CY 2027 proposals differ between facility-based and non-facility wound care models, as summarised in *Table 3*.

TABLE 3 | Practical comparison for wound care delivery

Issue	Non-facility wound care (ie, POS 11, 12)	Facility-based wound care (ie, POS 19, 22)
Professional payment	Subject to lower PFS conversion factor	Same reduction to practitioner professional payment
Facility payment	No separate hospital facility payment	HOPD receives a separate OPPTS facility payment; CMS proposes an approximately 2.4% increase in hospital outpatient payment rates for CY 2027
Same-day private office/ HOPD outpatient E/M + procedure	Applies in the office when the office/outpatient E/M family is used; home/residence E/M is outside the current proposal	Applies to the professional office/outpatient E/M claim in the HOPD; does not directly reduce the hospital facility payment
Practice expense	Practice bears personnel, supplies, equipment, space, inventory and administrative costs directly	Many technical/facility resources recognized through separate facility payment
CAMPs	Practice bears acquisition/inventory risk	Product payment accompanied by separate facility payment for application service
RPM/RTM	May require changes if clinical staff are outsourced	Same professional-service requirements; institutional arrangements may differ
340B	Generally not applicable to independent office/ mobile practice	Potentially significant institutional impact for participating hospitals

Discussion

The CY 2027 proposals illustrate why Medicare wound care reimbursement should not be evaluated solely through the annual conversion factor. The interaction between E/M payment, global surgical policy, practice expense, separate facility reimbursement, CAMP acquisition cost, and site of service can create materially different effects for clinicians providing similar clinical care in different settings.

The proposed same-day E/M payment policy provides the clearest example. It may directly affect a private office-based or HOPD professional encounter involving an office/outpatient E/M code and debridement, yet the same policy does not currently extend to home/residence or nursing-facility E/M code families. This creates a potentially meaningful site-

of-care differential that is not captured by simply categorizing care as facility or non-facility. Likewise, CMS's proposed correction for nursing-facility E/M payment recognizes that professional resource costs may not track neatly with the historical facility/non-facility binary.

The practice-expense discussion may have longer-term significance. Independent wound practices and mobile providers directly absorb many costs that are recognized separately through facility payments in the HOPD. CMS is explicitly considering how employment relationships and actual cost responsibility should influence PE allocation. Future refinements could therefore materially alter relative payment across wound care delivery models.

The proposed PE reforms also occur within a broader policy debate regarding the long-term stability of Medicare physician reimbursement. Separate bipartisan congressional proposals, including the Provider Reimbursement Stability Act, have sought to modify statutory budget-neutrality requirements, increase the threshold triggering budget-neutrality adjustments, improve the frequency of practice-expense updates, and limit large annual changes in the PFS conversion factor. These legislative proposals are distinct from CMS's CY 2027 regulatory PE methodology changes but reflect a related concern: repeated redistributive adjustments within a budget-neutral physician fee schedule may create substantial payment volatility for individual services and specialties even when aggregate Medicare spending remains constrained.

Conclusion

The CY 2027 PFS proposed rule contains several policies that could materially affect wound care delivery. The most immediate issues are the proposed reduction in payment for separately identifiable same-day office/outpatient E/M services, restructuring of G2211, continued evolution of CAMP payment, national valuation of bacterial fluorescence wound imaging, changes in practice-expense methodology, and RPM/RTM operational requirements. The effects will not be uniform across sites of care.

For independent office and mobile wound-care practices, the proposed transition in PE methodology may have particular long-term significance because these practices directly bear many of the personnel, equipment, supply, infrastructure, transportation, and administrative costs incorporated into non-facility PE valuation. Although CMS proposes a stabilization mechanism generally limiting annual PE RVU changes associated with the methodology transition, that mechanism does not eliminate the possibility of cumulative changes in PE valuation or broader shifts in relative payment among services over time.

For wound clinicians, the same-day E/M proposal should be interpreted precisely: it is currently limited to the office/outpatient E/M code family rather than all E/M services or all places of service. Office and HOPD professional claims reported with applicable office/outpatient E/M codes may therefore be affected, while appropriately reported home/residence and nursing-facility E/M services remain outside the proposal as drafted. As CMS moves from proposed to final rulemaking, wound care stakeholders should evaluate both the direct payment changes and the broader implications for practice sustainability, site-of-care neutrality, access to technology, and beneficiary access to clinically appropriate wound care.

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Conflicts of interest

The authors' organizational affiliations are listed above. The authors have no other conflicts of interest to declare.

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