CMS’s New Payment Methodology for Skin Substitutes: What Wound Care Providers Need to Know

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CMS is implementing one of the most significant reimbursement changes for skin substitutes in recent years. As scrutiny around utilization, documentation, and medical necessity continues to increase, the 2026 payment changes signal a broader effort to manage Medicare spending while encouraging appropriate use of these high-cost products.

Why CMS Is Making This Change

Spending on skin substitutes has grown rapidly, prompting increased attention from CMS, commercial payers, and federal regulators. Concerns around inconsistent clinical evidence, rising costs, aggressive marketing practices, and billing patterns have led to more audits, documentation requests, and medical necessity reviews.

The updated payment methodology is intended to better align reimbursement with the care provided while reducing financial incentives that may contribute to unnecessary utilization.

What’s Changing in 2026

Beginning in 2026, CMS will implement a supply-based payment methodology for skin substitutes used in covered application procedures and eliminate the distinction between high-cost and low-cost products in the hospital outpatient setting.

Rather than reimbursing based on the individual product selected, CMS will standardize payment and place greater emphasis on the wound care service itself. The goal is to create greater payment consistency while supporting clinically appropriate treatment decisions.

What This Means for Providers

The new methodology will have both financial and operational implications. Organizations should begin evaluating how the changes may affect their practice by:

- Reviewing product selection strategies and purchasing agreements.
- Assessing the financial impact on reimbursement and revenue cycle performance.

- Updating coding, billing, and charge capture processes to align with the new requirements.
- Preparing for varying implementation timelines among commercial payers, which may add administrative complexity.

Early planning can help minimize disruption and position organizations for a smoother transition.

Documentation Remains Critical

Although reimbursement is changing, documentation expectations are not. Providers should continue maintaining comprehensive records that support:

- Wound assessments and treatment history
- Medical necessity
- Product selection rationale
- Application details
- Patient progress and outcomes

Strong documentation, ongoing clinician education, and regular utilization reviews remain key to reducing audit risk and defending reimbursement.

Preparing for What's Next

CMS's updated payment methodology represents another step toward greater reimbursement oversight in wound care. Providers that proactively evaluate operational impacts, strengthen documentation practices, and refine compliance processes will be better positioned to adapt as payer expectations continue to evolve.

Dean Dorton's healthcare advisors work with providers to navigate reimbursement changes, strengthen compliance programs, evaluate operational impacts, and prepare for an increasingly complex regulatory environment. If you'd like to discuss how these changes could affect your organization, contact our team today.