

Where The CY2027 Cuts Come From

A code-level analysis of the proposed Medicare Physician Fee Schedule for dermatology, ophthalmology, and plastic surgery, and the single provision that accounts for most of the impact.

FINDINGS

Three findings

Most summaries of the CY2027 rule identify practice expense reform as the main driver. For the specialties facing the largest reductions, the same-day evaluation and management proposal is larger, and the two behave differently between now and January.

01 The published specialty figures exclude the conversion factor

CMS impact tables report the change from relative value and policy changes only. Add the conversion factor and dermatology is looking at roughly 11.6 percent for a non-QP clinician and 11.1 for a QP. Neither is 9. Roughly four in five dermatologists are non-QP, because Advanced APMs are built around primary care and fit episodic specialties poorly.

02 Modifier 25 is larger than practice expense

The same-day evaluation and management proposal accounts for 7.5 of dermatology's 11.6 points. Practice expense accounts for 2.6. For otolaryngology the split is 7.7 against 1.7. Orthopedic surgery is the exception where practice expense dominates.

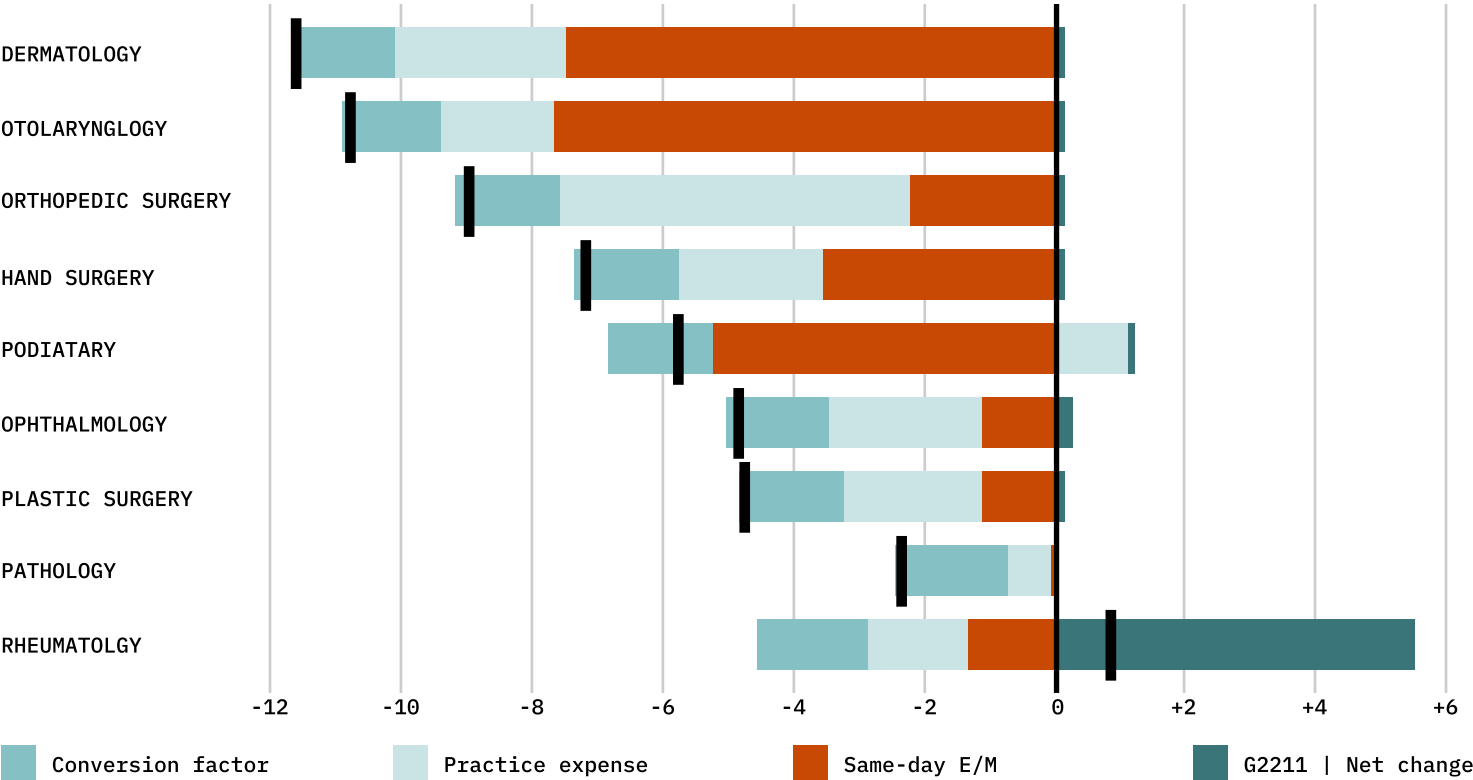
03 Rheumatology gains 0.8 percent

The G2211 conversion lifts rheumatology 5.4 points, enough to turn it net positive at +0.8 percent despite the conversion factor cut. This is redistribution toward longitudinal visit-based care, not an across-the-board reduction.

DECOMPOSITION

Impact decomposition by specialty

Each bar decomposes a specialty’s proposed change in Medicare allowed charges into its four policy channels. Negative components extend left of zero, positive components right. The vertical tick marks the net.



Percentage points of CY2026 allowed charges, non-qualifying APM conversion factor. Components are multiplicative and may not sum exactly to the net. Source: authors’ analysis of CMS-1848-P Addendum B, CMS-1832-F Addendum B, and the CY2027 utilization file crosswalked to 2027 code definitions.

THE BRICK RED SEGMENT

That segment is the same-day evaluation and management proposal. For dermatology, otolaryngology, and podiatry it is the largest single thing in the rule by a wide margin.

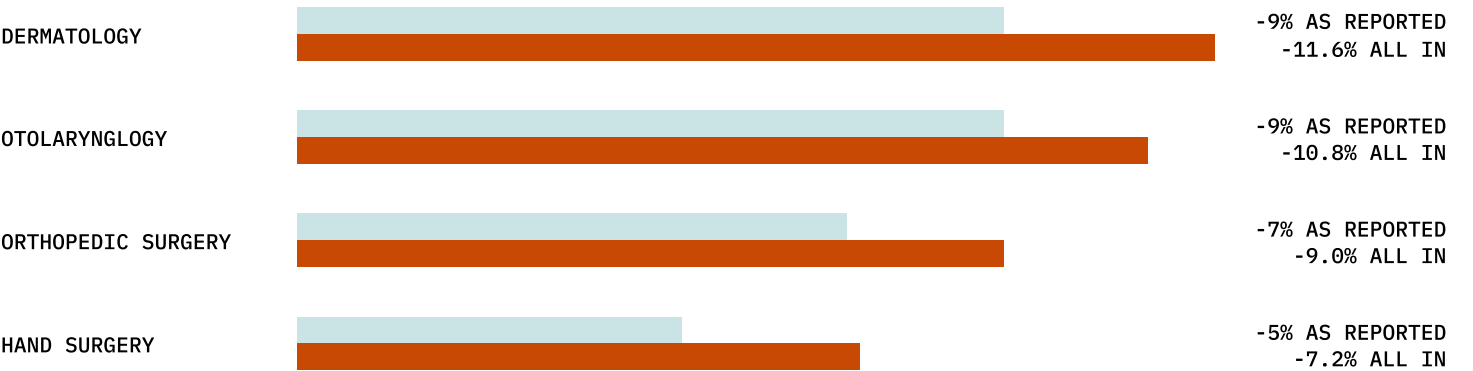
For podiatry, practice expense changes are favorable and modifier 25 accounts for the entire reduction.

FINDING 01

The published figures exclude the conversion factor

CMS publishes specialty impact estimates in the proposed rule’s regulatory impact analysis. Those estimates measure the effect of relative value and policy changes. They do not include the change in the conversion factor, because the conversion factor applies to everyone equally and therefore redistributes nothing.

That is a reasonable way for CMS to present redistribution. It is a poor basis for a practice budget, because the conversion factor is real money.



Light bars are the figures CMS published and trade coverage repeated. Red bars are the all-in change for a clinician who is not a qualifying APM participant. Qualifying participants fare about half a point better.

What this changes

A dermatology practice that budgeted against 9 percent has understated its Medicare exposure by roughly a quarter. On a practice collecting four million dollars at a 45 percent Medicare mix, the difference between the reported figure and the all-in figure is about \$47,000 a year.

IF PHYSICIAN PAY RUNS ON WORK RVUS

Almost none of this change reaches work RVUs. They move 0.05 percent for dermatology and essentially zero for ophthalmology and plastic surgery, while payment falls between 4.8 and 11.6 percent. The reduction lands on practice expense and on payment policy instead. A practice that pays physicians on work RVU production will hold compensation flat while revenue falls, and the entity absorbs the entire difference. Orthopedic surgery is the exception, with work RVUs down 4.3 percent.

FINDING 02

The proposal targets one very common care model

CMS proposes that when a separately identifiable office visit is furnished by the same practice on the same day as a procedure carrying a 0, 10, or 90-day global period, the most expensive service is paid at 100 percent and everything else that day at 50 percent. Operationally it reaches a single common workflow: diagnose a problem and treat it in the same encounter. Any physician who routinely appends modifier 25 is exposed.

HCPCS	DESCRIPTION	CY2026	PROPOSED	CHANGE
99213	OFFICE VISIT, ESTABLISHED, LOW	\$95.19	\$74.29	-22.0%
17000	DESTRUCTION, PREMALIGNANT LESION	\$66.47	\$44.30	-33.4%
11102	TANGENTIAL BIOPSY, SINGLE LESION	\$95.53	\$79.96	-16.3%
17110	DESTRUCTION, BENIGN LESION	\$110.89	\$94.52	-14.8%
99214	OFFICE VISIT, ESTABLISHED, MODERATE	\$135.61	\$126.18	-7.0%
17311	MOHS, FIRST STAGE, HEAD AND NECK	\$666.68	\$632.84	-5.1%

What this changes

Mohs surgery, which is procedurally intensive and rarely billed with a same-day office visit, falls about 5 percent. The office visit and lesion destruction codes that anchor general medical dermatology fall two to six times as much.

THE NUMBER TO PULL THIS WEEK

Your share of Medicare encounters where an E/M is billed with modifier 25 alongside a same-day global-period procedure. That single ratio is your exposure to the largest provision in the rule, and no specialty average can tell it to you.

Payment rates are national, unadjusted for geography. 56.9 percent of all dermatology allowed charges sit on lines CMS proposes to discount.

FINDING 03

G2211 moves money in the opposite direction

+08%

**Rheumatology,
Net Change**

-11.6%

**Dermatology,
Net Change**

Under one rule, in one year, two specialties move in opposite directions by more than twelve points. The mechanism is the G2211 conversion.

CMS proposes turning the visit complexity add-on from a standalone code into a modifier that raises the associated E/M by 16 percent, with a second modifier worth 32 percent for practitioners in a Shared Savings Program ACO. For procedural specialties this is worth a tenth of a point. For a visit-heavy cognitive specialty it is worth 5.4.

What the pairing tells you

Put the modifier 25 proposal and the G2211 conversion side by side and the direction is legible. CMS is moving money away from same-day procedural encounters and toward longitudinal, visit-based, accountable care. Agree with the policy or not, the strategic implication is the same.

ACO PARTICIPATION NOW CARRIES A FEE SCHEDULE PREMIUM

The proposed 32 percent modifier for Shared Savings Program participants is a direct rate increase on a common code family, available for every beneficiary the participant treats rather than only assigned ones. It is independent of any shared savings. Anyone who last evaluated ACO participation on shared savings alone was working from a different calculation.

COMPARRISON

Three specialties, three different positions

SPECIALTY	MEDICARE BOOK	ALL-IN CHANGE	DOMINANT DRIVER
DERMATOLOGY	\$3.58 BN	-11.6%	MODIFIER 25
OPHTHAMOLOGY	\$4.53 BN	-4.9%	PRACTICE EXPENSE, CF
PLASTIC SURGERY	\$0.27 BN	-4.8%	PRACTICE EXPENSE, CF

Dermatology

The most exposed of the three, and the only one where modifier 25 dominates. Evaluation and management codes are 31 percent of the specialty’s allowed charges and CMS’s factors imply a 14.5 percent average reduction on those lines.

Opthamology

A milder and far more uniform story, driven by practice expense and the conversion factor. One exception worth naming: intravitreal injection falls 9.6 percent because it is frequently billed with a same-day visit. A retina-weighted practice is meaningfully more exposed than a cataract practice.

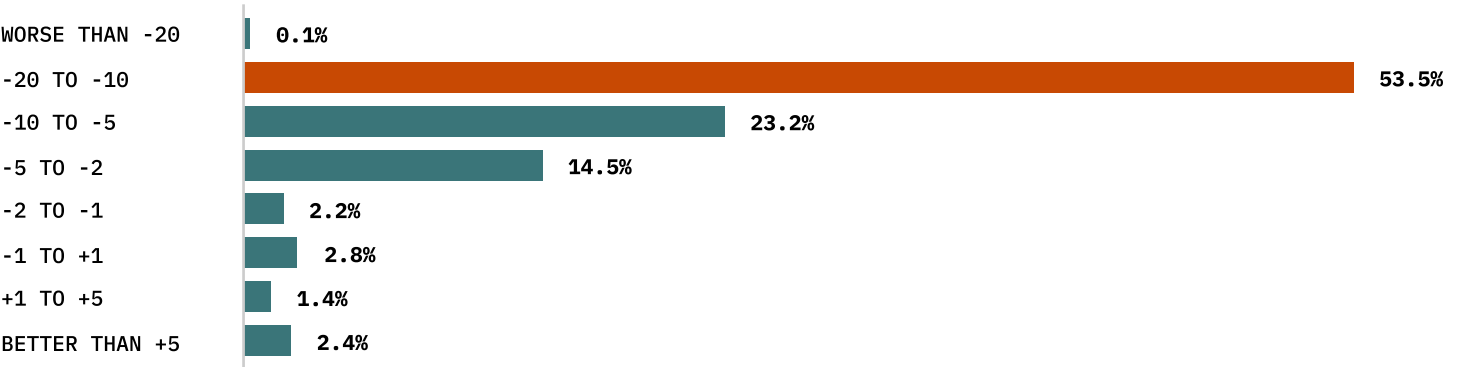
Plastic Surgery

The least exposed of the three, with a small Medicare book in absolute terms at \$267 million nationally. A large share of plastic surgery revenue is cosmetic and self-pay, entirely outside the fee schedule. For a cosmetically weighted practice this rule is close to a non-event.

DISTRIBUTION

A majority of dermatologists face a double-digit cut

CMS publishes a practitioner-level file. It gives the distribution of individual clinicians within each specialty by change in total relative value units. For dermatology the distribution is concentrated at the severe end.



Illustrative payer mixes applied to a practice collecting \$4 million. Green bars are the change in Medicare allowed charges. Teal bars are the resulting change in total practice revenue.

76.8%

Of dermatologists face a cut worse than 5 percent

2.8%

Sit in the roughly neutral band

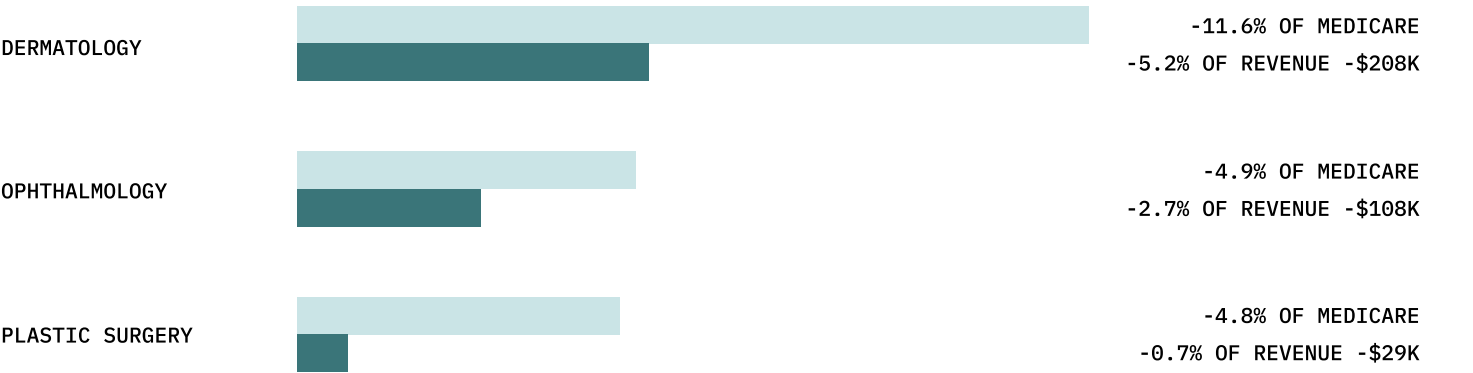
The same is not true elsewhere

Roughly 70 percent of ophthalmologists fall between negative 5 and negative 1 percent. For that specialty the average is a reasonable predictor for an individual practice. For dermatology it is not, and a general dermatology practice and a Mohs-heavy practice inside the same specialty face reductions differing by a factor of four.

TRANSLATION

Every percentage published about this rule is Medicare-only

Medicare impact percentage, multiplied by your Medicare share of revenue, equals the impact on total revenue. This is the step practices most often skip, and it moves the answer more than any policy variable in the rule.



Light bars are the figures CMS published and trade coverage repeated. Dark bars are the all-in change for a clinician who is not a qualifying APM participant. Qualifying participants fare about half a point better.

The same is not true elsewhere

The ordering differs from the Medicare percentages. Ophthalmology has less than half of dermatology’s Medicare exposure but a heavier Medicare mix, which closes much of the gap. Plastic surgery has a similar Medicare percentage to ophthalmology and a fraction of the revenue effect.

Two practices in the same specialty, one at 20 percent Medicare and one at 60, are in materially different situations under an identical rule.

ONE TIMING POINT PRACTICES CONSISTENTLY MISS

Commercial contracts indexed to a percentage of Medicare pass fee schedule changes through automatically. Contracts with fixed fee schedules do not. Knowing which of yours are indexed determines whether a Medicare change is a Medicare problem or a whole-book problem, and it is worth establishing before the final rule lands.

PRACTICAL

The four-step analysis

A defensible practice-level estimate takes four steps and about a day of analyst time.

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01 Reprice your top codes

Take the top twenty to thirty CPT codes by Medicare allowed charges and reprice them against proposed CY2027 relative value units and whichever conversion factor applies to you. CMS publishes Addendum B and a CY2026-to-CY2027 analytic crosswalk alongside the proposed rule.

02 Split by site of service

Apply the facility and non-facility differential to your actual volume distribution. Since CY2026, where you deliver care is a revenue variable independent of anything clinical.

02 Multiply by Medicare share

Skipping step 2 understates exposure for dermatology, otolaryngology, and podiatry. Skipping step 4 overstates it for everyone.

DATE	WHAT HAPPENS
SEPTEMBER 14,2026	COMMENT PERIOD CLOSES AT 11:59 PM
EARLY NOVEMBER,2026	FINAL RULE EXPECTED, BASE ON HISTORIAL TIMING
DECEMBER 31,2026	CY2026 STATUTORY 2.5% INCREASE EXPIRES
JANAURY 1, 2027	CY2027 RATES TAKE EFFECT; CMS-0057-F API REQUIREMENTS BEGIN; AMBULATORY SPECIALTY MODEL PERFORMANCE YEAR ONE

Proposals do change. CMS narrowed the CY2026 efficiency adjustment between proposed and final rules, and the modifier 25 concept is itself a revival of a CY2019 proposal CMS chose not to finalize. Build two budget scenarios, not one.

METHOD

Method and validation

We matched every allowed service line to its CY2026 final and CY2027 proposed relative value units on HCPCS code, modifier, and facility indicator, priced each at the applicable conversion factor, and weighted by CMS’s discount-adjusted allowed services. Policy effects were isolated using the adjustment factors CMS published alongside the rule rather than an estimate of our own, which removes a large source of analyst discretion.

FILES USED	SOURCE
ADDENDUM B, CY2027 PROPOSED	CMS 1848-P
ADDENDUM B, CY2026 FINAL	CMS 1832-F
2025 UTILIZATION CROSSWALKED TO 2027	CMS 1848-P
SPECIALTY IMPACTS BY PRACTITIONER	CMS 1848-P

Validation, stated honestly

Reproducing CMS’s own published methodology, which excludes the conversion factor, our model returns –10.1 percent for dermatology against CMS’s 9, –9.3 for otolaryngology against 9, –7.5 for orthopedic surgery against 7, and –5.6 for hand surgery against 5.

The model runs more negative than CMS in every case, by 0.3 to 1.1 points, and preserves the ordering. The residual is most plausibly the small share of unmatched code lines, budget neutrality redistribution we do not model, and CMS reporting whole percentages without decimals.

THE BOUNDED CLAIM

The model is reliable for ranking specialties and for decomposing drivers within a specialty, which is what this report uses it for. In absolute level it carries a downside bias on the order of half a point to one point. Treat the point estimates as the more pessimistic end of a plausible range.

NEXT STEPS

What to do between now and January

For most of the past decade the physician payment conversation was about the conversion factor and whether Congress would patch the annual cut. That conversation still happens, and CY2027 still turns on the expiration of a one-year patch.

But the larger movements are now structural. CMS is rebuilding practice expense methodology, has added a recurring efficiency adjustment falling on procedural work, has made site of service a payment variable, and proposes to apply a multiple procedure reduction to same-day evaluation and management. For dermatology the conversion factor accounts for 1.5 of an 11.6 point reduction. The same-day proposal accounts for 7.5.

For every specialty we examined, the conversion factor is the smallest of the four channels.

The addenda are published. The utilization files with CMS's own adjustment factors are published. The practitioner-level distributions are published. None of this is a surprise to anyone who reads it, and all of it can be run against a specific practice today.

What we would argue against

Reading this as a reason to sell. Physician-owned groups still outperform hospital-owned peers on cost control, and after a decade of research the evidence that consolidation reduces spending remains absent. What has changed is that independence became a more quantitative decision than it used to be. The practices treating it that way are the ones still independent in five years.

Where the margin comes back

This rule cuts revenue, not physician production — so the offset has to work at the entity level too.

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IF YOU WANT YOUR OWN NUMBER

We will run the CY2027 analysis against your code mix, payer mix, and site of service, and we will do it whether or not it goes anywhere commercially. The model is built and the marginal cost of one more specialty is an afternoon.

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