**SVU – Brief Summary of Calendar Year 2026 Medicare Payment Rules**

In mid-July 2025, the Centers for Medicare and Medicaid Services (CMS) released the 2026 Medicare Physician Fee Schedule (PFS) [Proposed Rule](https://www.federalregister.gov/documents/2025/07/16/2025-13271/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other) and the 2026 Medicare Hospital Outpatient Prospective Payment (OPPS) [Proposed Rule](https://www.federalregister.gov/documents/2025/07/17/2025-13360/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical). In these proposed rules, CMS describes changes to payment provisions in free standing imaging centers, physician offices, and hospital outpatient departments effective January 1, 2026. Below we provide an overview of key areas of interest related to vascular ultrasound policies.

**Calendar Year 2026 Proposed Physician Fee Schedule Rule**

Improvement in Transcranial Doppler Reimbursement

After last year’s changes to transcranial doppler (TCD), all TCD CPT codes are subject to increases in reimbursement.

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| CPT | Long Description | 2025 Rate\* (No Geographic Adjustment) | 2026 Proposed Rate\* (No Geographic Adjustment) | $ Difference | % Difference |
| 93880 - TC | Duplex scan of extracranial arteries; complete bilateral study | $145.56 | $152.73 | $7.17 | 4.93% |
| 93882 - TC | Duplex scan of extracranial arteries; unilateral or limited study | $96.72 | $100.60 | $3.88 | 4.01% |
| 93886 - TC | Transcranial Doppler study of the intracranial arteries; complete study | $205.08 | $228.60 | $23.52 | 11.47% |
| 93888 - TC | Transcranial Doppler study of the intracranial arteries; limited study | $106.34 | $107.41 | $1.07 | 1.01% |
| 93892 - TC | Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection | $106.34 | $107.41 | $1.07 | 1.01% |
| 93893 - TC | Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection | $106.34 | $107.41 | $1.07 | 1.01% |
| 93896-TC | ADD ON: Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete | $133.91 | $147.05 | $13.14 | 9.81% |
| 93897-TC | ADD ON: Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete | $182.11 | $201.19 | $19.08 | 10.48% |
| 93898-TC | ADD ON: Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete | $186.32 | $219.58 | $33.26 | 17.85% |
| \*No geographic adjustment. | | | | | |

PFS Conversion Factor

The conversion factor in the physician fee schedule converts CMS’ measure of work (i.e., inputs that CMS assigns to each code relating to labor, expenses, etc.) into reimbursement. CMS estimates that the CY 2026 conversion factor will rise 3.3% or $1.0744 to $33.4209 – one of the largest increases in recent years. This results in an overall higher level of reimbursement for many services provided in physician offices.

OPPS Cap

Congress has required that CMS cap the reimbursement of many imaging codes at the same rate as payments in the Hospital Outpatient Department (which is priced under the Outpatient Prospective Payment System or OPPS, discussed below). This cap applies to most vascular ultrasound codes – but the cap only ends up affecting reimbursement of a small subset of codes such as (1) TCD codes like CPT 93888, 93892, 93893; (2) some dialysis codes like CPT 93990, and (3) some miscellaneous studies such as CPT 93926, 93976. Because the OPPS also is increasing, reimbursement in these codes is rising, though less than if the cap did not apply. An act of Congress would be needed to change the OPPS cap.

Clinical Labor Rates

CMS has recognized the value of vascular ultrasound technologists and last year completed an upward revision of labor rates to 91¢ per minute compared to 54¢ per minute in 2021. The improved labor rate will continue this year.

Vascular Surgery Changes

CMS has turned its attention to vascular surgery this year. There is an overhaul of CPT codes for lower extremity revascularization (New CPT 37XX1 – 37X46). CMS says that these changes were proposed by the AMA to account for “technological advances, changes in practice settings, and the need to better differentiate between a stenosis (i.e. a straightforward lesion) and an occlusion (that is, a complex lesion) procedures.”

There are also changes to Merit-Based Incentive Payment System (MIPS) – a reimbursement incentive for physicians – that involve vascular surgeons. Participation in the MIPS program is mandatory for physicians that work a certain amount with Medicare patients, but clinicians have options in how they can satisfy this requirement. This year, CMS is proposing a bundle of metrics or MIPS Value Pathway (MVP) that vascular surgeons can adopt in order to earn performance incentives.

**Calendar Year 2026 Proposed Hospital Outpatient Prospective Payment Rule**

Payment Updates

Based on budget neutrality, hospital costs, and productivity, CMS estimates APC reimbursement will rise 2.9%. This will generally result in overall increases to reimbursement in hospital outpatient settings.

APC Updates

OPPS payments are bundled in Ambulatory Payment Classifications (APCs), which bundle the facility costs for a variety of procedures – vascular ultrasound and others. The vast majority of vascular ultrasound procedures are in APC 5523 (Level 3 Imaging without Contrast) and APC 5522 (Level 2 Imaging without Contrast).

There are no major changes to vascular ultrasound APCs.

However, for two of our procedures, CMS proposes to put CPT 93923 (complete noninvasive physiologic testing of upper or lower extremity arteries) and CPT 93924 (noninvasive physiologic studies of lower extremity arteries at rest and with treadmill stress) in more intensive – and thus higher reimbursed – APCs. SVU supports this change.

Site Neutrality

This has been an issue that Congress and CMS have discussed for several years. In short, CMS proposes to pay the same for services – regardless of where performed (hospitals v. physician offices). Typically, Congress and CMS have implemented site neutrality by making it more difficult to qualify as a Hospital Outpatient Department and obtain OPPS rates.

Instead, this year, CMS proposes to bring hospital outpatient rates down to the PFS rate for drug administration.

In addition, CMS is also soliciting comments on APCs 5522 and 5523: “Of particular concern for us are the services within the imaging without contrast APCs (APCs 5521-5524). Imaging without contrast services are some the most costly and frequently provided services at excepted [departments]. We believe that there is a high likelihood that there has been unnecessary growth in this space and that a volume control method would be appropriate to apply here in the future. Would it be appropriate to apply this method to the Imaging Without Contrast APCs?”

Although no changes are proposed this year, if CMS pushes forward, this could affect SVU members who work in hospital outpatient departments that are off-campus from a main hospital or a satellite location.

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The Society for Vascular Ultrasound is pleased to share this update, but we want to hear from you! We will be sharing a survey to give you a chance to share what you are seeing in your own practices.