SOCIETY FOR VASCULAR ULTRASOUND
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By Electronic Submission to www.regulations.gov

Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-1810

Re: Comments Regarding Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots (CMS-1850-P)

Dear Administrator Oz:

The Society for Vascular Ultrasound ("SVU") thanks the Centers for Medicare and Medicaid Services ("CMS" or the "Agency") for this opportunity to comment on the proposed changes to the Hospital Outpatient Prospective Payment System ("HOPPS") for calendar year ("CY") 2027 (the "Proposed Rule").[1] SVU is a professional society comprised of over 4,200 vascular technologists, sonographers, nurses, surgeons, cardiologists academics, students, and other professionals who provide a variety of high-quality vascular ultrasound and physiologic testing services[2] to Medicare beneficiaries in all relevant sites of care, including hospital outpatient departments, freestanding clinics, and increasingly Ambulatory Surgical Centers ("ASCs").

Ultrasound is a critical diagnostic tool that uses sound waves to obtain images of internal anatomic structures. It offers a highly sensitive, non-invasive, and low-cost means of examining internal organs and vessels. Physiologic testing is an indirect method of assessing the vascular system. The utilization of noninvasive vascular technology (ultrasound and physiologic testing) not only saves Medicare dollars, but also reduces the risks involved with other more expensive or

[1] 91 Fed. Reg. 41734 (July 7, 2026).
[2] Such services include the codes: 93880, 93882, 93886, 93888, 93892, 93893, 93896, 93897, 93898, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93985, 93986, 93990, 76706, and 0876T.

invasive diagnostic imaging modalities, which may present more significant morbidity and mortality risks. With this in mind, SVU offers these comments on the Proposed Rule from the perspective of vascular lab professionals.

HOPPS Payment Rates. We appreciate CMS' proposal to increase the payment rates under the OPPS by an Outpatient Department fee schedule increase factor of 2.4 percent. We understand that this increase factor is based on the proposed hospital inpatient market basket percentage increase of 3.2 percent for inpatient services paid under the hospital inpatient prospective payment system reduced by a proposed productivity adjustment of 0.8 percentage points. We further appreciate that CMS has not proposed any policy changes in this rule that reduce reimbursement for the vascular ultrasound codes, except as noted below.

Method To Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments. SVU opposes CMS' current proposal to implement a "Method To Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments" for imaging codes. We recognize CMS' concern "that beneficiaries are being driven into higher cost settings of care because of financial incentives when they could safely receive care in a lower cost setting."[3] However, CMS' policy is a blunt instrument that could harm patients.

First, SVU's studies are not interchangeable between the inpatient and outpatient setting. There is a difference between a carotid duplex performed for pre-operative planning versus a new stroke workup; a vein duplex performed after a procedure or to diagnose a deep vein thrombosis; an arterial study performed after a bypass or stent or to diagnosis critical limb ischemia.[4] These are different clinical scenarios with different urgencies: some can be performed in an outpatient office with some delay in between study and interpretation; another cannot be delayed and needs to be performed in a hospital.

This real-world experience is contrary to CMS' analysis of a Medicare Payment Advisory Commission ("MedPAC") study that "[i]f freestanding offices had the highest volume for an APC, MedPAC concluded that the services in that APC could be provided safely in freestanding offices for most beneficiaries and that beneficiaries would be able to access the services in that APC. Therefore, for those services, it would be reasonable to align the OPPS payment rates with the PFS payment rates."[5] Even if the individual tasks are the same between settings, one key difference between the outpatient and inpatient settings is availability: offices and imaging centers close; hospitals and SVU members provide these services 24/7 at nearly anytime. Indeed, CMS implicitly recognizes this need in exempting rural sole community hospitals from this policy "to ensure access to high quality care for beneficiaries in rural areas."[6]

Second, SVU's services are not driving CMS' noted service migration. As we discuss each year, SVU focuses on approximately thirty codes and services. Of the list that CMS has published of the top seventy codes driving 95% of the volume of imaging in excepted provider-based

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[3] 91 Fed. Reg. at 41908.
[4] *See, e.g.*, Meaghan K. Frederick, Loria A. Stolz, & Petra E. Duran-Gehring, Vascular Ultrasound, 42 Emergency Med. Clinics of N. Am. 805 (2024).
[5] 91 Fed. Reg. at 41912.
[6] 91 Fed. Reg. at 41917.

departments,[7] SVU's codes make up only *five*.[8] Furthermore, the Society for Vascular Surgery has analyzed the vascular surgery codes implicated by this proposal – less than 4% were of these services are performed in an off-campus site; the overwhelming majority of vascular lab services are performed in other settings. This proposal is thus overinclusive – punishing multiple vascular surgery and ultrasound codes that CMS' own analyses and data indicate are not contributing to the problem CMS is trying to solve.

Third, unlike many of CMS' previous efforts to extend site neutrality, the so-called "PFS relativity adjustor" is not site neutrality, but instead makes cuts that are below that of other settings. Notably, many imaging PFS rates are already capped by the OPPS, which means that by definition the PFS reimbursement is 100% of the OPPS.[9]

CMS has stated that it is trying to proxy the physician fee schedule ("PFS") technical component rates.[10] If that is indeed the goal, applying this relativity adjustor to SVU's codes does not work, as the adjusted rates are well below the applicable rates. Below is a table comparing technical component reimbursement for CPT codes of interest to the OPPS (no geographic or other adjustments)—none of them are compensated at 40% of the OPPS rate:

CPT	CY 2027 PFS Proposed Reimbursement[11]	CY 2027 OPPS Proposed Reimbursement[12]	PFS / OPPS
93896-TC	$137.93	Bundled	Bundled
93897-TC	$186.86	Bundled	Bundled
93898-TC	$206.57	Bundled	Bundled
93981 - TC	$51.56	$118.46	44%
93922-TC	$73.56	$152.43	48%
93980 - TC	$58.79	$118.46	50%
93978 - TC	$147.78	$271.13	55%
93880 - TC	$154.02	$271.13	57%
93970 - TC	$156.65	$271.13	58%
93930 - TC	$166.83	$271.13	62%
76706 - TC	$78.16	$118.46	66%
93925 - TC	$207.23	$271.13	76%
93886 - TC	$212.15	$271.13	78%
93975 - TC	$213.14	$271.13	79%

[7] 91 Fed. Reg. at 41909.
[8] These are 78706, 93970, 93971, 93975, 93978.
[9] Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program. 91 Fed. Reg. 43842, 43870 (Jul. 16, 2026).
[10] 90 Fed. Reg. at 41912 ("The PFS relativity adjuster reflects the estimated overall difference between the payment that would otherwise be made to a hospital under the OPPS for the non-excepted items and services furnished in non-excepted off-campus PBDs and the resource-based payment under the PFS for the technical aspect of those services with reference to the difference between the facility and nonfacility (office) rates and policies under the PFS.").
[11] We use the national, unadjusted technical component for non-Alternative Payment Model reimbursement. We apply the OPPS cap to the PFS rate where applicable.
[12] Similarly, we use national, unadjusted APC reimbursement rate.

CPT	CY 2027 PFS Proposed Reimbursement[11]	CY 2027 OPPS Proposed Reimbursement[12]	PFS / OPPS
93979 - TC	$96.55	$118.46	82%
93971 - TC	$99.18	$118.46	84%
93931 - TC	$101.48	$118.46	86%
93882 - TC	$103.78	$118.46	88%
93888 - TC	$118.46	$118.46	100%
93892 - TC	$118.46	$118.46	100%
93893 - TC	$118.46	$118.46	100%
93926 - TC	$118.46	$118.46	100%
93976 - TC	$118.46	$118.46	100%
93990 - TC	$118.46	$118.46	100%

Although CMS has indicated that it will not look at individual PFS reimbursement,[13] that approach simply fails with the imaging codes. CMS proposal would result in reimbursement falling significantly below the PFS' – sometimes by a factor of 2.

Fourth, CMS' proposal is inconsistent with the Deficit Reduction Act. Section 5102, now codified at 42 U.S.C. § 1395w-4(b)(4), creates a cap on PFS reimbursement for imaging that is based on the OPPS rate. Congress spoke clearly in this provision and provided a choice in statute for imaging reimbursement in outpatient settings – either the PFS-determined rate or the OPPS rate. There was no discussion of the OPPS rate adjusted to achieve some arbitrary site neutrality; proxy; indeed, Congress specified that it did not wish to adjust the OPPS rate: "determined without regard to geographic adjustment under paragraph (2)(D) of such section . . . ."[14] We believe finalizing this policy would conflict with the statute.

340B Reimbursement Change. CMS has proposed to lower reimbursement for 340B drugs from Average Sales Price Plus 6% to Average Sales Price Minus 33.4%. This will harm many of the hospital where SVU members work and practice. SVU urges CMS to not adopt this potentially harmful reimbursement change.

Assign an APC for 0876T. We continue to urge CMS to assign an APC to CPT 0876T. This code allows for computer-aided diagnosis of fistula issues after a limited ultrasound assessment of the fistula. In 2022, spending on patients undergoing dialysis reached an inflation-adjusted $45.3 billion.[15] One analysis has found that approximately one-eighth of end-stage renal disease ("ESRD") admissions are for access complications.[16] And, repeated interventions to

[13] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots, 90 Fed. Reg. 53448, 53816 (Nov. 25, 2025).
[14] 42 U.S.C. § 1395w-4(b)(4)(A)(ii).
[15] NIDDK, USRDS, 2025 Annual Report: Healthcare Expenditures for Persons with ESRD (2025), https://usrds-adr.niddk.nih.gov/2024/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd.
[16] *See* Brendan P. Lovasik et al., Emergency Department Use and Hospital Admissions Among Patients With End-Stage Renal Disease in the United States, 176 JAMA Internal Med. 1563 (2016).

salvage a fistula are more cost-effective than replacing access.[17] Unfortunately, this code has not been assigned an APC and has been assigned $0 reimbursement. SVU urges CMS to assign this potentially lifesaving code to an APC and to establish a reimbursement amount in order to encourage this potentially lifesaving procedure.

We continue to strongly believe in the value and importance of the services our members provide to Medicare beneficiaries. These critical diagnostic imaging services provide low-cost and high quality care to Medicare beneficiaries to help diagnose critical conditions, and we encourage CMS to continue to ensure reimbursement is appropriate and will continue to review and evaluate payment rates accordingly.

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We thank you for your consideration of these comments to the Proposed Rule. We look forward to continuing to work with CMS to improve the health of Medicare beneficiaries.

Respectfully submitted,

Brian Sapp, RVT, RPhS, FSVU
President
Society for Vascular Ultrasound

Anne M. Jones, BSN RVT RDMS FSVU
Chair, Advocacy Committee
Society for Vascular Ultrasound

[17] *See* Benjamin S. Brooke et al., Cost-effectiveness of repeated interventions on failing arteriovenous fistulas, 70 J. Vascular Surgery 1620 (2019).