



September 14, 2026

By Electronic Submission to www.regulations.gov

Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments to 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 (CMS-1848-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 CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (the “Proposed Rule”).¹ SVU is a professional society comprised of over 4,200 vascular technologists, nurses, sonographers, surgeons, cardiologists, academics, students, and other professionals who provide a variety of high-quality vascular ultrasound and physiologic testing services² 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 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.

Removal of Indirect Practice Cost Index. SVU supports the removal of indirect practice

¹ 91 Fed. Reg. 43842 (Jul. 16, 2025).

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.

cost index, which provided too blunt of an adjustment, penalizing or rewarding entire specialties without integrating in specific data for services. As CMS rightly recognizes, this practice-level index systematically penalized codes performed by vascular surgeons,³ including many of the codes SVU members perform every day. Generally, when such data is available, SVU agrees that code / service-specific information should be used to develop reimbursement policies.

Transcranial Doppler (“TCD”) Reimbursement. We are concerned about CMS’ proposal to generally decrease reimbursement of TCD. TCD, a non-invasive modality using pulsed Doppler to assess cerebral blood flow in real time, does not require intravenous contrast and radiation (as in a CT scan, CT Angiography, or Angiography) or burden the healthcare system with elevated cost (as in an MRI or MR Angiography). As such, it can be repeated as many times as indicated to understand the intracranial physiology and hemodynamics of a patient without exposure to harmful adverse effects. For years, it has been used to assess stroke risk in children with sickle cell disease, and it is a mainstay of the management of subarachnoid hemorrhage—a type of brain bleed—and intracranial stenosis.⁴ Beyond these narrower indications, TCD can be used to assess for cerebrovascular disease or work up patients before carotid surgery, potentially avoiding more complex, costly complications down the line.⁵ In fact, others have suggested that TCD substitute for certain types of echocardiography in assessing heart defects that can predispose to strokes,⁶ and some groups have used the modality to prognosticate recovery after treatment of strokes.⁷

TCD is also a highly operator-dependent modality; the quality of a study depends heavily on the skill and experience of the technologist performing it.⁸ Acquiring and maintaining that proficiency takes considerable time and deliberate training, and while an experienced technologist can make the examination look deceptively simple, it is demanding to learn and to perform well. We are concerned that decreasing reimbursement will intensify pressure on technologists to complete studies more quickly, encouraging shortcuts and the entrenchment of poor scanning practices.

We continue to strongly believe in the value and importance of TCD to Medicare beneficiaries. The literature has actually indicated that the modality remains underused.⁹ If the reliability of TCD erodes, providers will be forced to turn to other, more costly modalities—

³ 91 Fed. Reg. at 44248 tbl. D-85.

⁴ Jonathan D. Kirsch et al., *Advances in Transcranial Doppler US: Imaging Ahead*, 33 *RadioGraphics* E1 (2013).

⁵ *See generally* Seongho Park et al., *Transcranial Doppler as a Screening Tool for High-Risk Patent Foramen Ovale in Cryptogenic Stroke*, 31 *J. Neuroimaging* 165 (2021).

⁶ *See, e.g.*, Madison B. Stafford, Jennifer E. Bagley, & Dora DiGiacinto, *Comparison of Transthoracic Echocardiography, Transesophageal Echocardiography, and Transcranial Doppler in the Detection of Patent Foramen Ovale as the Etiology for Cryptogenic Stroke*, 35 *J. Diagnostic Med. Sonography* 127 (2018).

⁷ *See, e.g.*, Seyed Behnam Jazayeri, Behnam Sabayan, Yasaman Pirahanchi et al., *Transcranial doppler (TCD) in predicting outcomes following successful mechanical thrombectomy of large vessel occlusions in anterior circulation: a systematic review and meta-analysis*, *J. NeuroInterventional Surgery* (2025) (ahead of print).

⁸ *See, e.g.*, Sushmita Purkayastha & Farzaneh Sorond, *Transcranial Doppler Ultrasound: Technique and Application*, 32 *Seminars in Neurology* 411 (2013) (“It is highly operator dependent, with the handheld technique requiring detailed three-dimensional knowledge of cerebrovascular anatomy and its variations.”).

⁹ *See, e.g.*, Matcus A. Esmeraldo, Emanuel R. de Melo, Matheus Fritzen et al., *Updates on Adult Transcranial Doppler, Gray-Scale, and Contrast-enhanced US Techniques*, 46 *Radiographics* e250182, at 2 (2026) (“Despite its growing diagnostic potential, transcranial US in adults remains underused by radiologists, largely because of awareness and training limitations.”).

undermining TCD's cost-effectiveness and clinical value. Reducing reimbursement only worsens this issue. These critical diagnostic services provide low-cost care to Medicare beneficiaries to help diagnose critical conditions, and we encourage CMS to reconsider the decrease in reimbursement to primary code 93886 and add-on codes 93896, 93897, 93898. The RVU decreases along with a decrease of conversion factor will make these critical services more difficult to provide and will harm children with sickle cell disease as well as adults with subarachnoid hemorrhage, stroke, and variations in anatomy.

Reimbursement for Abdominal Aortic Aneurysm (“AAA”) Screening. We are concerned at the decrease in RVUs and overall decrease in reimbursement for AAA screening from a national, unmodified rate of \$80.16 to \$78.16 or 2.5% – more than the drop in the conversion factor. This is a U.S. Preventative Services Task Force-recommended screening for certain individuals.¹⁰ This low-cost screening is already underutilized.¹¹ Reducing reimbursement will not help improve utilization, and SVU urges that reimbursement be adjusted to at least allow stability with inflation.

Reimbursement for Penile Arterial Studies. We are similarly concerned with the decrease in reimbursement for CPT codes 93980 from a national, unmodified rate of \$61.12 to \$58.79 or 3.8% and 93981 from \$52.44 to \$51.56 or 1.7% – both at or higher than the drop in the conversion factor. Again, this is an important modality that helps in the workup of erectile dysfunction, a key quality of life condition for Medicare beneficiaries as well as an indicator of vascular and coronary artery disease.¹² Reducing reimbursement could deprive Medicare beneficiaries of this life-improving and potentially lifesaving service.

Reimbursement for CPT 0876T. We continue to urge CMS to assign a Relative Value Unit (“RVU”) and reimbursement 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.¹³ One analysis has found that approximately one-eighth of end-stage renal disease (“ESRD”) admissions are for access complications.¹⁴ And, repeated interventions to salvage a fistula are more cost-effective than replacing access.¹⁵ Unfortunately, this code has not been assigned an RVU and has been assigned

¹⁰ USPTF, Abdominal Aortic Aneurysm: Screening (Dec. 10, 2019),

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening>.

¹¹ See, e.g., Aderike C. Anjorin, Melissa A. Greiner, Sreekanth Vemulapalli et al., Underutilization of Guideline-based Abdominal Aortic Aneurysm Screening in an Academic Health System, 83 *Annals of Vascular Surgery* P184 (2022).

¹² See, e.g., Dae Chul Jung, Sung Yoon Park, & Joo Yong Lee, Penile Doppler ultrasonography revisited, 37 *Ultrasonography* 16, 16-17 (2018) (“Additionally, penile CDUS has come to play an increasing role in the detection of silent coronary artery disease (CAD) in men presenting with ED. ED is now recognized as one of the earliest manifestations of endothelial dysfunction and peripheral vascular disease. A Doppler workup of the penile vessels can be used to determine the need for further cardiac assessments in high-risk patients with CAD, and it can be used as a noninvasive method for evaluating endothelial dysfunction. Recent developments in elastography and contrast-enhanced ultrasonography techniques might help provide valuable information on penile pathology.”).

¹³ 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>.

¹⁴ 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).

¹⁵ See Benjamin S. Brooke et al., Cost-effectiveness of repeated interventions on failing arteriovenous fistulas, 70 *J. Vascular Surgery* 1620 (2019).

\$0 reimbursement. SVU urges CMS to assign this potentially lifesaving code an RVU and reimbursement in order to encourage this potentially lifesaving procedure.

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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,

A handwritten signature in black ink, appearing to read "B. Sapp", with a stylized, cursive script.

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

A handwritten signature in black ink, appearing to read "Anne M. Jones", with a cursive script.

Anne M. Jones, BSN RVT RDMS FSVU
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