

**Prior Authorization (PA) Demonstration for Certain Ambulatory Surgical Center (ASC) Services**  
**Operational Guide**

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## **Purpose**

Section 402(a)(1)(J) of the Social Security Amendments of 1967, as amended [42 U.S.C. 1395b-1(a)(1)(J)] authorizes the Secretary to “develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act [the Act].” CMS is using Section 402(a)(1)(J) demonstration authority for the Prior Authorization of Certain Services Provided in Ambulatory Surgical Centers (ASCs) for a limited number of demonstration states<sup>1</sup>. The prior authorization process does not alter existing medical necessity documentation requirements. The purpose of this Operational Guide is to interpret and clarify the review process for the ASC when rendering certain ASC services to Medicare beneficiaries. This guide will advise ASCs on the process of submitting documents in support of the final claim.

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<sup>1</sup> The states included in this demonstration are California, Florida, Texas, Arizona, Ohio, Tennessee, Pennsylvania, Maryland, Georgia, and New York.

## **1- Ambulatory Surgical Center (ASC) Services Benefits**

For any service or item to be covered by Medicare, it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

### **1.1 -Selected Medicare statutory and regulatory requirements**

#### **Social Security Act (Title XVIII) Standard References:**

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of Social Security Act, Section 1862(a)(10). No payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection with, except as required for the prompt repair of accidental injury or improvement of the functioning of a malformed body member.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider or supplier for any claim that lacks the necessary information to process the claim.

#### **Federal Register References:**

- 42 CFR 411.15(h) Particular services excluded from coverage. Cosmetic surgery and related services.

In order to be covered under Medicare, a service shall be reasonable and necessary. As explained in Chapter 13 of Medicare Program Integrity Manual, when applying the reasonable and necessary standard contractors consider whether an item or service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  - Furnished in a setting appropriate to the patient's medical needs and condition.
  - Ordered and furnished by qualified personnel.
  - One that meets, but does not exceed, the patient's medical needs.
  - At least as beneficial as an existing and available medically appropriate alternative.

## **2- Demonstration Overview**

This demonstration will include ASCs that provide certain services in place of service 24 (ASC), type of service F (Ambulatory Surgical Center (Facility Usage for Surgical Services)), specialty code 49 (ASC), and are enrolled in the Medicare FFS program. The states included in this demonstration are California, Florida, Texas, Arizona, Ohio, Tennessee, Pennsylvania, Maryland, Georgia, and New York. The term requester will be used throughout this document to describe the person or entity that submits the prior authorization request (PAR), documentation, and /or claims. The ASCs will obtain prior authorization (PA) before the services are provided to Medicare beneficiaries, or the provider will be subjected to prepayment review.

The ASCs will submit the PARs to their local Medicare Administrative Contractor (MAC) jurisdiction. The MAC will review the information submitted and issue a decision (affirmation, non-affirmation, or partial affirmation) to the provider.

The provider may submit a request for an expedited review of a PAR if delays in receipt of a PA decision could jeopardize the life or health of the beneficiary.

The provider may resubmit a PAR with additional supporting information, upon receipt of a non-affirmation, as many times as necessary to achieve an affirmation decision.

### **Inquiries Regarding the Demonstration:**

ASCs who have questions about the demonstration review process should contact their local MAC jurisdiction.

**Appendix A** includes the specific Healthcare Common Procedure Coding System (HCPCS) codes that are included in the ASC PA demonstration.

**Note:** Codes in Appendix A may be subject to change.

### **2.1- ASC Services for Prior Authorization**

The services included in this prior authorization demonstration are blepharoplasty, botulinum toxin injections, rhinoplasty, panniculectomy, and vein ablation.

This prior authorization demonstration does not change Medicare benefit or coverage requirements, nor does it create new documentation requirements. The documentation required to be included with a prior authorization request is information that ASCs are regularly required to maintain for Medicare payments.

### **3 – Prior Authorization Request (PAR)**

The PAR must be submitted before the service is provided to the beneficiary and before the claim is submitted for processing; otherwise, the claim will be subjected to prepayment review. The PAR will not be accepted after the service has been completed. The PAR must include all necessary documentation to show that the service meets applicable Medicare coverage, coding, and payment rules.

#### **3.1-General PAR Documentation**

Requesters must include the following data elements in all PARs to avoid potential delays in processing. Your MAC may request additional, optional elements for submission of the PAR.

##### **Initial Submission Documentation:**

##### **Beneficiary Information (as written on their Medicare card)**

- Beneficiary Name
- Beneficiary Medicare Number (also known as the MBI)
- Beneficiary Date of Birth

##### **ASC Information**

- Name of facility
- PTAN/CCN
- Facility Address
- Facility National Provider Identifier (NPI)

##### **Physician/Practitioner Information**

- Physician/Practitioner's Name
- Physician/Practitioner's National Provider Identifier (NPI) (optional)
- Physician/Practitioner PTAN (optional)
- Physician/Practitioner's Address
- Physician/Practitioner's Fax Number (optional)

##### **Requester Information**

- Requester Name
- Requester Phone Number
- Requester Email Address
- Requester Fax Number (refer to your MAC jurisdiction)

##### **Other Information**

- HCPCS Code(s)
- Place of Service
- Type of Service

- Provider Specialty Code
- Units of Service
- Indicate if the request is an initial or subsequent review
- Indicate if the request is expedited and the reason why

**Resubmission(s) documentation:**

In addition to the required PAR documentation in the Initial Submission section, the resubmission of the PAR should contain an exact match of the beneficiary's first name, last name, date of birth, and the unique tracking number (UTN) associated with the previous non-affirmation decision.

The medical records submitted with the initial request must also be included in the resubmission, in addition to documentation that supports the reason for non-affirmation.

**3.1.1–Sending a PAR**

Requesters have the following options for submitting PARs to the A/B MACs:

1. mail,
2. fax,
3. electronic submission of medical documentation (esMD), content type 8.7\*, or
4. CMS- approved electronic portal (A/B MAC specific).

\* For more information about submissions through esMD, see [www.cms.gov/esMD](http://www.cms.gov/esMD) or contact your A/B MAC.

MACs Contact Information:

**J15**

CGS

Demonstration State: Ohio

Mailing Address:

CGS Administrators, LLC

PO Box 20203

Nashville, TN 37202

Fax#: 615.664.5937

Customer Service #: 1.866.276.9558

Website: [cgsmedicare.com](http://cgsmedicare.com)

esMD: indicate document/content type “8.7”

**JK**

National Government Services (NGS)

Demonstration State: New York

Mailing Address:

National Government Services

PO BOX 7108  
Indianapolis, IN 46207-7108  
Fax#: 803.462.2702  
Website: [ngsmedicare.com](http://ngsmedicare.com)  
esMD: indicate document/ content type 8.7

**JE**

Noridian Healthcare Solutions LLC  
Demonstration State: California  
Mailing Address:  
PO Box 6774  
Fargo, ND 58108  
Customer Service: 855.609.9960  
Fax: 701.433.3024  
Website: [med.noridianmedicare.com/web/jea](http://med.noridianmedicare.com/web/jea)  
esMD: indicate document/content type "8.7"

**JF**

Noridian Healthcare Solutions LLC  
Demonstration State: Arizona  
Mailing Address:  
PO Box 6700  
Fargo, ND 58108  
Customer Service: 877.908.8431  
Fax: 701.433.3024  
Website: [med.noridianmedicare.com/web/jfa](http://med.noridianmedicare.com/web/jfa)  
esMD: indicate document/content type "8.7"

**JJ**

Palmetto GBA  
Demonstration States: Georgia and Tennessee  
Mailing Address:  
Palmetto GBA  
P.O. Box 100212  
Columbia, SC 29202-3212  
Fax #: 803.462.7313  
Phone Number: 877.567.7271  
Website: [palmettogba.com/JJB](http://palmettogba.com/JJB)  
esMD: indicate document/content type "8.7"

**JL**

Novitas Solutions  
Demonstration States: Maryland and Pennsylvania

Mailing Address (including the P.O. Box):  
Novitas Solutions  
JL Prior Authorization Requests  
PO BOX 3702  
Mechanicsburg, PA 17055  
Fax#: 1.833.200.9268  
Phone #: 855.340.5975 (Prior Auth Customer Service)  
Website: [novitas-solutions.com/](http://novitas-solutions.com/)  
esMD: indicate document/content type “8.7”

**JH**

Novitas Solutions  
Demonstration State: Texas  
Mailing Address (including the P.O. Box):  
Novitas Solutions  
JH Prior Authorization Requests  
PO BOX 3702  
Mechanicsburg, PA 17055  
Fax#: 1.833.200.9268  
Phone #: 855.340.5975 (Prior Auth Customer Service)  
Website: [novitas-solutions.com/](http://novitas-solutions.com/)  
esMD: indicate document/content type “8.7”

**JN**

First Coast  
Demonstration State: Florida  
Mailing Address (including the P.O. Box):  
First Coast Services Options, Inc.  
JN Prior Authorization  
PO Box 3033  
Mechanicsburg, PA 17055-1804  
Fax#: 1.855.815.3065  
Phone # 1.855.340.5975  
Website: <https://medicare.fcso.com/>  
esMD: indicate document/content type “8.7”

## 4- Review of the PAR

The MAC will review the information submitted, and the decision (affirmative, partially affirmative, or non-affirmative) will be issued to the provider. A provisional affirmation will be issued to the provider if it is decided that applicable Medicare coverage, coding, and payment rules are met. A non-affirmation will be issued to the provider if it is decided that applicable Medicare coverage, coding, and payment rules are not met. A UTN will be assigned to each PAR. When the PAR results in a non-affirmative decision, the MAC will provide detailed information about all missing and/or non-compliant information that resulted in the non-affirmative decision.

### 4.1- Review Decisions and Timeframes

The timeframes for conducting PA of certain ASC services will be dependent upon the service(s) selected and documentation submitted for PAR. There are 3 types of review timeframes:

- **Initial Submission**—the first PAR sent to the contractor for review and decision. The MAC will complete its review of medical records and send an initial decision letter that is either postmarked or faxed within **7 calendar days** following the receipt of the initial request.
- **Resubmission**—any subsequent resubmissions to correct an error or omission identified during a PAR review. A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The MAC will postmark or fax notification of the decision of these resubmitted requests to the provider or beneficiary within **7 calendar days** of receipt of the resubmission request.
- **Expedited**—a PA decision that is performed on an accelerated timeframe based on the MAC determination that delays in review and response could jeopardize the life or health of the beneficiary. If the MAC substantiates the need for an expedited decision, the MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request.

#### 4.1.1- Validation Period for Prior Authorization Decisions

PAR decisions and UTNs for these services are valid for 120 days. The decision date shall be counted as the first day of the 120 days. For example: if the PAR is affirmed on January 1, 2026, the PAR will be valid for dates of service through April 30, 2026. For dates of service after the 120 days, the provider will need to submit a new PAR.

#### 4.1.2 –Resubmission of PAR

The provider should review the detailed decision letter that was provided. A provider may resubmit a PAR an unlimited number of times upon receipt of a non-affirmative decision. The UTN will be assigned with each PA resubmission request.

### 4.1.3- Rejected PAR

A PAR is rejected when the MAC is unable to process the request due to incomplete or invalid information. The MAC will notify the submitter that their request was rejected and the reason why. Rejected prior authorization requests are not reviewed for medical necessity and are not considered non-affirmations.

When a PAR is rejected, the submitter should review the reason listed in the rejection letter. The submitter may then correct the error and submit the request again using the same submission procedures. When sending the corrections, all original documentation must also be included. If the rejected request was an initial request, the subsequent request should be marked as an initial request.

The following chart includes common rejection reasons and corrective actions:

<b>Rejection Reason</b>	<b>Additional Explanation</b>	<b>ASCs Corrective Action</b>
The request was submitted to the incorrect MAC.	MAC is typically based where the ASC is located.	Submit the request to the correct MAC responsible for processing requests for the state where the ASC is located.
The beneficiary has a Medicare Advantage Plan or Medicaid.	This demonstration applies to Medicare Fee-for-Service beneficiaries.	Contact the individual Medicare Advantage or Medicaid Plan for information on their prior authorization requirements.
The request contains an invalid/missing/deceased Medicare Beneficiary Identifier (MBI), or beneficiary name.	Providers must include certain data elements in a prior authorization request to be processed.	Submit a new request with the corrected information.
The beneficiary already has an affirmed prior authorization on file for the same service(s).	Each UTN is valid for 120 days. Each procedure requires a new prior authorization request regardless of whether the next service falls within 120 days.	Adjust the information on your prior authorization request and submit the request again. Note: If a PAR is for an additional procedure and date of service is within 120 days, please indicate this on the PAR.
The PAR was missing a Botulinum toxin administration or drug code.	PAR for Botulinum toxin services must contain both an administration code (64612 or 64615) and a drug code (J0585, J0586, J0587, J0588, J0589)	Verify HCPCS code pairs and resubmit if the procedure codes are 64612 or 64615 and the drug codes are J0585, J0586, J0587, J0588, or J0589.

The PAR was submitted with no clinical documentation.	PAR must include medical record documentation to demonstrate compliance with Medicare coverage, coding, and payment rules.	Submit a new request with medical record documentation for review.
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**4.2- Expedited Review of a PAR**

The requester can submit an expedited review of the PAR if it is determined that a delay could seriously jeopardize the beneficiary’s life, health, or ability to regain maximum function. The requester will be notified regarding the acceptance of the PAR for expedited review or if the request will be converted to the standard PA review process. The affirmative or non-affirmative decision will be rendered within the CMS-prescribed expedited review timeframe of 2 business days for requests that are deemed valid for expedited review and provide the decision to the provider via telephone, fax, electronic portal, or other “real-time” communication within the requisite timeframe.

To prevent the claim from being stopped for prepayment review, the provider should ***hold their claim and not submit it*** until the UTN is provided and can be appended to the claim. The MAC will follow the normal process to obtain a UTN from CMS shared systems.

A provider may resubmit a request for expedited review.

**4.3- Decision Letter(s)**

The MAC will send the decision letter with the UTN to the requester using the method the PAR was received postmarked within the timeframes described in Section 4.1 of this guide. The MAC will have the option to send a copy of the decision to the requester via fax if a valid fax number was provided, even if the submission was sent via mail. The requester(s) will be notified to hold their claim and not submit it until the UTN is received (in order to avoid a claims prepayment review) if the MAC exercises the option to send the PA decision without the UTN.

A copy of the decision letter will be sent to the beneficiary as well.

**5- Exemption(s)**

CMS will provide further information regarding exemption.

## **6- Demonstration Specifics**

### **6.1 – Implementation of Prior Authorization**

For California, Florida, Tennessee, Pennsylvania, Maryland, Georgia, and New York, those MACs **began** accepting PARs for ASC services on January 5, 2026, for dates of service on or after January 19, 2026. For Texas, Arizona, and Ohio, those MACs **began** accepting PARs for ASC services on February 2, 2026, for dates of service on or after February 16, 2026.

### **6.2 – Required Documentation**

For detailed documentation requirements, ASCs should refer to their MAC jurisdiction's Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs), where applicable. To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services.

The following ASC services are part of this demonstration:

- (i) Blepharoplasty
- (ii) Botulinum toxin injections
- (iii) Panniculectomy
- (iv) Rhinoplasty
- (v) Vein ablation

#### **6.2.1- Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair**

General Documentation Requirements for Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair:

- Documented subjective patient complaints which justify functional surgery (vision obstruction, unable to do daily tasks, etc.);
- Documented excessive upper/ lower lid skin;
- Signed clinical notes support a decrease in peripheral vision and/or upper field vision causing the functional deficit (when applicable);
- Signed physician's or non-physician practitioner's documentation of functional impairment and recommendations;
- Supporting pre-op photos (when applicable);
- Visual field studies/exams (when applicable).

#### **6.2.2 - Botulinum Toxin Injections**

PA will be obtained when one of the Botulinum Toxin codes (J0585, J0586, J0587, J0588, or J0589) is used **in conjunction with** one of the CPT injection codes (64612, (Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)), or 64615, (Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)) or the provider will be subject to prepayment review. Use of these Botulinum Toxin codes in conjunction/paired with procedure codes other than 64612 or 64615 **are not** subject to PA under this demonstration.

#### General Documentation Requirements for CPT codes 64612 and 64615:

- A covered diagnosis (refer to your MAC's LCA)
- A serotype of Botulinum Toxin for diagnosis being treated
- Dosage and frequency of injections
- Specific site(s) injected/dose administered per site (refer to your MAC's LCD/LCA)
- Documentation of informed clinical decisions for subsequent injections (refer to your MAC's LCD/LCA)
- Objective documentation of the clinical features consistent with the diagnosis
- History of the condition, including severity and duration of symptoms
- Objective documentation of functional disability at baseline and following each injection with the same valid scale specific to the condition being treated
- Documentation demonstrating clinical effectiveness to support continuation of therapy (refer to your MAC's LCD/LCA)
- Documentation of therapies or treatments used in conjunction with botulinum toxin (if applicable).

Migraine Specific Documentation Requirements - (in addition to the general documentation requirements listed above)

- Documentation supporting trials of an inadequate response or contraindication to at least one agent in two of the specified medication classes (refer to your MAC's LCD/LCA)
- Documentation of monthly headache days, monthly migraine days, and duration of migraine episodes, recorded at baseline and following each injection session
- Documentation that biobehavioral therapy (cognitive behavioral therapy, biofeedback, relaxation therapies, mindfulness-based therapies, acceptance and commitment therapy) has been assessed and implemented as appropriate for prevention of and treatment of acute headaches
- Documentation of calcitonin gene-related peptide (CGRP) therapy, if used concurrently or previously with Botulinum Toxin (refer to your MAC's LCD/LCA).

#### **6.2.3- Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services**

General Documentation Requirements for Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services:

- Stable weight loss with BMI less than 35 be obtained prior to authorization of coverage for panniculectomy surgery (when applicable);
- Description of the pannis and the underlying skin;
- Description of conservative treatment undertaken and its results;
- The medical records document(s) that the panniculus causes chronic intertrigo or candidiasis or tissue necrosis that consistently recurs over three months and is unresponsive to oral or topical medication (when applicable);
- Pre-op photograph (if requested);
- Copies of consultations (when applicable);
- Related Operative report(s) (when applicable);
- Any other pertinent information.

For PARs submitted for CPT 15877, providers should, if applicable, document the main procedure that will be performed on the same day as CPT 15877 in the documentation submitted with the PAR.

#### **6.2.4 - Rhinoplasty, and related services**

General Documentation Requirements for Rhinoplasty and related services:

- Medical documentation, with evaluation and management, supporting medical necessity of the service that is to be performed;
- Radiologic imaging if done;
- Photographs that document the nasal deformity (if applicable);
- Documentation supporting unresponsiveness to conservative medical management (if applicable).

#### **6.2.5 - Vein Ablation, and related services**

General Documentation Requirements for Vein Ablation and related services:

- Doppler ultrasound;
- Documentation stating the presence or absence of DVT (deep vein thrombosis), aneurysm, and/or tortuosity (when applicable);
- Documented Incompetence of the Valves of the Saphenous, Perforator or Deep venous systems consistent with the patient's symptoms and findings (when applicable);
- Photographs, if the clinical documentation received is inconclusive;
- Documentation supporting the diagnosis of symptomatic varicose veins (evaluation and complaints), and the failure of an adequate trial of conservative management (before the initial procedure) (refer to your MAC's LCD/LCA).

## **7 – Decisions**

### **7.1 - Provisional Affirmation PA Decision**

A provisional affirmation PA decision is a preliminary finding that a future claim submitted to Medicare for the service(s) requested likely meets Medicare's coverage, coding, and payment requirements. The provisional affirmation PA decision is valid for 120 days from the date decision was made.

### **7.2 - Non-Affirmation PA Decision**

A non-affirmation PA decision is a preliminary finding that a future claim is submitted to Medicare for the requested service(s) does not likely meet Medicare's coverage, coding, and payment requirements.

The MAC will provide the PAR requester notification of what required documentation is missing or noncompliant with Medicare requirements via fax, mail, or the MAC provider portal (when available). The decision letter for an incomplete PAR will be detailed and postmarked within the applicable timeframes described in Section 4.1.

### **7.3 - Provisional Partial Affirmation PA Decision**

A provisional partial affirmation PA decision means that one or more service(s) on the PAR received a provisional affirmation decision and one or more service(s) received a non-affirmation decision.

The MAC will follow the same process for any service(s) within the PA request that is given a provisional affirmation decision as is described in § 7.1 and for any service(s) that are given a non-affirmation decision as is described in § 7.2.

### **7.4 - Resubmitting PAR**

The requester may resubmit the PAR with all required documentation and whatever modifications are needed, as noted in the detailed decision letter. Unlimited resubmissions are permitted. The requester is encouraged to include the original non-affirmed UTN on the resubmitted PAR.

## 8 - Claim Submission

### 8.1 – Affirmed PA Decision on File

Cases where a PAR was submitted, and a provisional affirmation PA decision was granted, including any service(s) that was part of a partially affirmed decision.

- When submitting an electronic 837 professional claim for a prior authorized service, the UTN must be submitted in the 2300 Claim Information loop in the Prior Authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3).
- When submitting a paper CMS 1500 Claim form for a prior authorized service, the UTN must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.
- Should be submitted to the applicable MAC for adjudication.

**Note:** If all Medicare coverage, coding, and payment requirements are met, the claim will likely be paid.

- Claims receiving a provisional affirmation may be denied based on either of the following:
  - Technical requirements that can only be evaluated after the claim has been submitted for formal processing; or
  - Information was not available at the time of a PAR.
- Claims for which there is a provisional affirmation PA decision will be afforded some protection from future audits, both pre- and postpayment; however, review contractors may audit claims if potential fraud, inappropriate utilization, or changes in billing patterns are identified.

### 8.2 – Non-Affirmed PA Decision on File

Cases where a PAR was submitted, and a non-affirmed PA decision was granted, including any non-affirmed service(s) that was part of a partially affirmed decision.

- When submitting an electronic 837 professional claim for a prior authorized service, the UTN must be submitted in the 2300 Claim Information loop in the Prior Authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3).
- When submitting a paper CMS 1500 Claim form for a prior authorized service, the UTN must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15

- Should be submitted to the applicable MAC for adjudication.
- If the claim is submitted to the MAC for payment with a non-affirmative PA decision, it will be denied.
- All appeal rights are then available.
- The denied claim could then be submitted to secondary insurance, if applicable.

### **8.3- Claims Submitted without a PA Decision on File**

Prior authorization is voluntary; however, the MAC will stop an applicable claim for standard Medicare prepayment medical record review if submitted without a PAR decision. ASCs do not need to do anything differently when submitting a claim without a UTN. Providers do not need to put any information in the remarks field or submit any unsolicited documentation at the time of claim submission.

Prepayment medical record review means that the MAC will make a claim determination before claim payment using the standard Medicare prepayment medical record review process:

- The MAC will stop the claim prior to payment and send the ASCs an Additional Documentation Request (ADR) letter through the US Postal Service and/or electronically.
- The ASCs will have 45 days to respond to the ADR with all requested documentation via:
  - Fax,
  - Mail, or
  - esMD (for more information see: [www.cms.gov/esMD](http://www.cms.gov/esMD)).
- The MAC will have 30 days to review the documentation and render a claim determination.

### **8.4-Denials for Related Services**

CMS intends to deny services that are associated with ASC services (blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation) and have received non-affirmation decisions and/or have denied claims. The codes for these associated services are listed in the table located in Appendix B (ASC PA Part B Associated Codes List). This list is subject to change in the future.

## **9 – Special Claim Considerations**

### **9.1 – Advanced Beneficiary Notice (ABN)**

If the ASC receives a non-affirmed PA decision because the service was determined to be not medically reasonable and necessary, the provider should issue an ABN in advance of performing the service if it is expected that payment will be denied. The provider should submit the claim with the GA modifier appended to it. The Contractor will determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30)

If an applicable claim is submitted without a PA decision and is flagged as having an ABN, it will be stopped for additional documentation to be requested, and a review of the ABN will be performed (to determine the validity of the ABN) following standard claim review guidelines and timelines.

The provider should issue ABN and submit the claim with a GX modifier if it is expected that Medicare would deny payment for a service under the statutory exclusion for purely cosmetic services. Under those circumstances, ABN is voluntary and is not required to bill the patient for the service that is denied under the cosmetic services exclusion. However, CMS encourages providers to issue an ABN in this situation to inform the beneficiary of the likelihood of financial liability.

### **9.2 – Claims Exclusions**

The following claim types are excluded from the ASC PA demonstration described in this operational guide unless otherwise specified:

- Veterans Affairs
- Indian Health Services
- Medicare Advantage
- Medicare Advantage sub-category IME only claims
- Railroad Retirement Board

## 10 – Secondary Insurance

This section pertains to the instances where the beneficiary has more than one insurance. In these instances, Medicare must be either the primary or the secondary insurance company.

### 10.1 – Medicare is Primary Insurance

In cases where Medicare is primary, and another insurance company is secondary, the contractors will suspend claims to request documentation and conduct a review of the Advanced Beneficiary Notice (ABN) when there is no PAR and the claim is submitted with the GA modifier appended.

The Contractor will determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30, Section 40).

Providers who choose to use the PA process to obtain a claim denial should follow the below process:

- The requester may submit the **PAR** with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the service, then a non-affirmative PA decision will be sent to the provider and beneficiary, advising that Medicare will not pay for the item.
- After receiving a non-affirmative decision for the PAR, if the associated **claim** is submitted by the provider to the MAC for payment, it will be denied.
- The provider or beneficiary may forward the denied claim to his/her secondary insurance payer as appropriate to determine payment for the service.

In cases where a beneficiary is dually eligible for Medicaid and Medicare, a non-affirmed PA decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage. The provider may need to submit the claim to Medicare first and obtain a denial before submitting the claim to Medicaid for payment<sup>2</sup>.

### 10.2 – Another Insurance Company is Primary

Cases where another insurance company is primary and Medicare is secondary:

- The requester submits the PAR with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the item(s), then a provisional affirmative PA decision will be sent to the provider and to the beneficiary, if specifically requested by the beneficiary, advising them that Medicare **will** pay for the service.
- The provider submits a claim to the other insurance company.
- If the other insurance company denies the claim, the provider or beneficiary can submit a claim to the MAC for payment (listing the UTN on the claim).

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<sup>2</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib011317.pdf>

## **11- Claim Appeals**

Claims subject to PA under the ASC demonstration follow all current appeals procedures. A PAR that is non-affirmed is not an initial determination on a claim for payment for services provided and, therefore, would not be appealable; however, the provider has an unlimited number of opportunities to resubmit a PAR, provided the claim has not yet been submitted and denied.

A non-affirmation PA decision does not prevent the provider from submitting a claim. Submission of such a claim and resulting denial by the MAC would constitute an initial payment determination, which makes the appeal rights available.

A claim submitted without a UTN, which results in an prepayment review including an ADR, has appeal rights available if the medical review decision is a denial.

For further information, please consult the Medicare Claims Processing Manual publication, Chapter 29, Appeals of Claims Decision.

## **12- Suspension of PA process**

CMS may suspend the ASC services PA process generally or for a particular service(s) at any time by issuing a notification on the CMS website.

**Appendix A**

**Final List of Ambulatory Surgical Center Services for Prior Authorization**

The following service categories comprise the list of ambulatory surgical center services for prior authorization beginning for service dates on or after *January 19, 2026 (for California, Florida, Tennessee, Pennsylvania, Maryland, Georgia, and New York)* and service dates on or after *February 16, 2026 (for Texas, Arizona, and Ohio)*.

- (i) Blepharoplasty
- (ii) Botulinum toxin injections
- (iii) Panniculectomy
- (iv) Rhinoplasty
- (v) Vein ablation

Code	(i) Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
Code	(ii) Botulinum Toxin Injection
64612	Chemodeneration of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615	Chemodeneration of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina, 5 units
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a, 1 unit
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit
Code	(iii) Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including

	Lipectomy), and related services <sup>3</sup>
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15877	Suction assisted lipectomy; trunk
Code	(iv) Rhinoplasty, and related services
20912	Cartilage graft; nasal septum
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Code	(v) Vein Ablation, and related services <sup>4</sup>
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein

<sup>3</sup> CPT 15847 (Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)) **was** removed on January 1, 2026.

<sup>4</sup> CPT 36474 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites), 36476 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites), 36479 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites), and 36483 (Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites) **were** removed on January 1, 2026.

	treated
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated

**Appendix B****ASC PA Part B Associated/Related Codes List****Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair**

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
21282	Lateral canthopexy
67830	Correction of trichiasis; incision of lid margin
67840	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67875	Temporary closure of eyelids by suture (eg, Frost suture)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67921	Repair of entropion; suture
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
67950	Canthoplasty (reconstruction of canthus)
67966	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
88300	Level I - Surgical pathology, gross examination only
88302	Level II - Surgical pathology, gross and microscopic examination: Appendix, incidental; Fallopian tube, sterilization; Fingers/toes, amputation, traumatic; Foreskin, newborn; Hernia sac, any location; Hydrocele sac; Nerve; Skin, plastic repair; Sympathetic ganglion; Testis, castration; Vaginal mucosa, incidental; Vas deferens, sterilization
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium; Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue, lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity;
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

### Botulinum Toxin Injections

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
31575	Laryngoscopy, flexible; diagnostic
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)
64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, gonioscopy, stereo-photography)
95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
J0585	Injection, onabotulinumtoxin A, 1 unit
J0586	Injection, abobotulinumtoxin A, 5 units
J0587	Injection, rimabotulinumtoxin B, 100 units
J0588	Injection, incobotulinumtoxin A, 1 unit
J0589	Injection, daxibotulinumtoxin A-lanm, 1 unit

### Panniculectomy

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15877	Suction assisted lipectomy; trunk
31571	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)
88300	Level I - Surgical pathology, gross examination only

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
88302	Level II - Surgical pathology, gross and microscopic examination: Appendix, incidental; Fallopian tube, sterilization; Fingers/toes, amputation, traumatic; Foreskin, newborn; Hernia sac, any location; Hydrocele sac; Nerve; Skin, plastic repair; Sympathetic ganglion; Testis, castration; Vaginal mucosa, incidental; Vas deferens, sterilization
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium; Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue, lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity
88312	Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)

### Rhinoplasty

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
20912	Cartilage graft; nasal septum
21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21282	Lateral canthopexy
30120	Excision or surgical planing of skin of nose for rhinophyma
30140	Submucous resection inferior turbinate, partial or complete, any method
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)
88300	Level I - Surgical pathology, gross examination only
88302	Level II - Surgical pathology, gross and microscopic examination: Appendix, incidental; Fallopian tube, sterilization; Fingers/toes, amputation, traumatic; Foreskin, newborn; Hernia sac, any location; Hydrocele sac; Nerve; Skin, plastic repair; Sympathetic ganglion; Testis, castration; Vaginal mucosa, incidental; Vas deferens, sterilization;
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium; Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
	than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue, lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity;
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

### Vein Ablation

<b>HCPCS Codes</b>	<b>HCPCS Description</b>
01930	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg

HCPCS Codes	HCPCS Description
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions
37799	Unlisted procedure, vascular surgery
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium; Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue, lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity;
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study