November 21, 2025

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[1]. 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.

[1] 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)
- Physician/Practitioner PTAN
- Physician/Practitioner's Address
- Physician/Practitioner's Fax Number (optional)

Requestor Information

- Requestor Name
- Requestor Phone Number
- Requestor Email Address
- Requestor 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 trackng 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 or contact your A/B MAC.

MACs Contact Information:

J15
CGS
Demonstration Sate: 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
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
esMD: indicate document/ content type 8.7

JE
Noridian Healthcare Solutions LLC
Demonstration State: California
Mailing Address:
PO Box 6782
Fargo, ND 58103
Customer Service: 855.609.9960
Fax: 701.433.3024
Website: med.noridianmedicare.com/web/jea
esMD: indicate document/content type "8.7"

JF
Noridian Healthcare Solutions LLC
Demonstration State: Arizona
Mailing Address:
PO Box 6782
Fargo, ND 58103
Customer Service: 877.908.8431
Fax: 701.433.3024
Website: 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
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/
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/
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: 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:

Rejection Reason	Additional Explanation	ASCs Corrective Action
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.

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 will begin 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 will begin 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 will not be subject to PA under this demonstration.

General Documentation Requirements for Botulinum Toxin Injections:

- A covered diagnosis;
- Dosage and frequency of planned injections;
- Specific site(s) injected (refer to your MAC's LCD/LCA);
- Documentation to support the medical necessity when electromyography procedures performed in conjunction with botulinum toxin type A injections to determine the proper injection site(s) (when applicable);
- To support continuous treatment, the documentation should include the clinical effectiveness of two consecutive treatments that preceded the anticipated procedure (refer to your MAC's LCD/LCA);
- Documentation of the management of a chronic migraine diagnosis. A medical record must include a history of migraine and experiencing frequent headaches on most days of the month;
- Documentation of traditional treatments such as medication, physical therapy, and other appropriate methods have been tried and proven unsuccessful (when applicable).

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 requestor 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 requestor 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).
- The MAC will have 30 days to review the documentation and render a claim determination.

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[2].

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).

[2] 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	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)
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

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)
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
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
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

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
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