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Certain ASCs Face New Prior Authorization Payment Requirements from CMS

Ambulatory surgery centers (ASCs) in 10 states are set to face new prior authorization requirements from the Centers for Medicare & Medicaid Services (CMS) related to coverage for certain procedures in order to confirm medical necessity. CMS has proposed implementing a five-year demonstration project (the Demonstration) to target the procedures of blepharoplasty (eyelid lift), botulinum toxin injections (neurotoxin injections), rhinoplasty (nose repair), panniculectomy (abdominal wall contouring) and vein ablation (treatment for varicose veins) performed in ASCs (the Procedures). This Demonstration will require ASCs in Florida, New York, Tennessee, California, Texas, Arizona, Pennsylvania, Ohio, Maryland and Georgia to either submit a prior authorization request and obtain a provisional affirmation before providing the service or be subject to prepayment review, which could lead to a denial of payment if the services are deemed ineligible upon review.[1]

This CMS Demonstration project follows on CMS' 2020 Outpatient Prospective Payment System Final Rule, which established the same prior authorization process and requirements for the Procedures when they are performed in hospital outpatient departments (HOPDs). Since that time, CMS states it has seen a dramatic decline in spending for such Procedures. Now, however, CMS is concerned about possible unnecessary utilization related to the Procedures migrating to ASCs as the HOPD program continues to scrutinize medical necessity in that setting. CMS has further stated that it reviewed payment data from 2019 to 2021 showing that the Procedures have experienced "significant increases in utilization in the ASC setting." Thus, according to CMS, it expects savings in the ASC setting similar to those seen in the HOPD setting. CMS expects to launch the Demonstration as early as the fall of this year, with a published estimated start date of November 1.

The Demonstration will require ASCs to submit prior authorization requests for the 40 or so service codes associated with the identified Procedures to their local Medicare Administrative Contractor (MAC), which will review and issue a decision of provisional affirmation, non-affirmation or partial affirmation. This decision will be made within seven days, but there is an expedited review time frame of 72 hours available if a delay could risk serious harm to a beneficiary's life, health or "ability to regain maximum function." While a provisional affirmation is a finding that a future claim will likely meet Medicare's rules, a claim can nevertheless be denied based on technical or other requirements that can be reviewed only after the claim has been submitted. A provisional partial affirmation decision means that one or more requested Procedures have received provisional affirmation, while one or more have received a non-affirmation (for example, a prior authorization request for a blepharoplasty in both eyes when it is medically necessary for only one eye).

The good news is that the prior authorization process may not be required for the entire five-year period of the Demonstration, as CMS will implement an exemption process for providers that continually show compliance with meeting coverage requirements. The compliance threshold has not yet been finalized, and ASC providers should expect to file a prior authorization for every Procedure for at least a year in order to provide CMS with enough compliance data. Of course, CMS will also have the right to withdraw an exemption at any time and indeed to suspend the prior authorization process requirements generally or for a particular Procedure at any time by notification on its website. CMS will post additional educational materials for providers on a Demonstration-specific website, but in general, the documentation requirements that MACs already use for the Procedures in the HOPD setting will be applicable to ASC services as well.

In conclusion, to the extent that ASCs in the 10 Demonstration states perform the relevant Procedures for Medicare beneficiaries, they should begin to familiarize themselves with their MAC's policies with respect to the Procedures being offered in HOPDs. They should also begin to familiarize themselves with the electronic prior authorization request procedures, such as CMS' electronic submission of medical documentation and their MAC's electronic portal for provider

document submission. Clearly, these Procedures are on CMS' radar, and it has data to identify improper or fraudulent payments. Day Pitney attorneys have experience in this area and are available to assist ASC clients that have questions related to the Demonstration.

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[1] To clarify, the Demonstration does not apply to Procedures performed for cosmetic reasons, but providers would still need to have Medicare beneficiaries complete advance beneficiary notices to confirm their understanding that there is no Medicare coverage for cosmetic Procedures that are not deemed medically necessary.

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