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Part B News
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In this issue

PBN Perspectives

After WISeR, new ASC prior authorization demo signals a growing trend

On the heels of the Wasteful and Inappropriate Services Reduction (WISeR) demonstration model for prior authorization comes a new demo targeting ambulatory surgery centers (ASC). Some observers, including physicians and practice consultants, worry that this new development signals a trend toward increased prior authorization in traditional Medicare.

CMS announced in a September 4 transmittal the demonstration model requiring prior authorization "of certain services provided in ASCs in ten states," to cover some services for "blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation procedures."

CMS explains that "these targeted services can potentially be provided as cosmetic procedures, rather than medically necessary procedures, resulting in improper or fraudulent payments." Under the model, providers in California, Florida, Texas, Arizona, Ohio, Tennessee, Pennsylvania, Maryland, Georgia and New York "must request prior authorization for these service categories, or they will be subject to prepayment review."

The agency provided further detail in a concurrent Medicare Fee-for-Service Compliance Programs page, informing providers they "can submit prior authorization requests beginning on December 1, 2025, for dates of service on or after December 15, 2025," and including a list of 41 codes for procedures covered by the model.

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ASCs draw scrutiny

Outpatient procedures have long been under the watch of CMS for wasteful spending and, while performing them at ASCs is generally considered more cost-efficient than performing them in hospitals, the agency clearly doesn't believe that alone fixes the problem.

Henry Norwood, of counsel with Kaufman Dolowich in San Francisco, notes that, in the most recent Medicare Payment Advisory Commission (MedPAC) report to Congress, the watchdog agency says that while operations in ASCs cost less than those in hospital outpatient departments, "Medicare spending per FFS beneficiary on ASC services rose at an average annual rate of 7.8% from 2018 through 2022 and by 15.4% in 2023."

In the same report, MedPAC adds: "Policymakers know little about the costs that ASCs incur in treating beneficiaries because Medicare does not require ASCs to submit cost data, unlike its requirements for other types of facilities. As a result, it is not possible to properly evaluate the level of Medicare's payments relative to costs for ASCs."

In the proposed 2026 outpatient prospective payment system (OPPS) rule, the agency requests feedback on the question, "What other methods may be warranted to control unnecessary increases in the volume of outpatient services besides changes to payment rates, *including prior authorization* or other utilization management policies?" [Emphasis added]

Medicare PA: Rare, targeted

While prior authorization is widespread in Medicare Advantage, it is rare under traditional Medicare. Interestingly, some of the Medicare programs currently requiring prior authorization of selected service types also started as more limited demos such as WISeR and the ASC demo.

In 2014, CMS ran a model for prior authorization of "repetitive, scheduled non-emergent ambulance transport" in three states, and thereafter expanded it until it became nationwide in 2021. In 2012, the agency ran a demo for "certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items" that it deemed "frequently subject to unnecessary use" in seven states; the demo became a standing national program in 2015, though CMS occasionally changes the codes that are covered in certain states.

Another prior authorization program for "certain hospital Outpatient Department (OPD) services" was established on a national basis in the 2020 OPPS rule.

Also, two pre-claim-review-related demonstration models were recently introduced: A "Review Choice Demonstration for Home Health Agencies," which also began as a demonstration model and currently affects seven states, while a similarly designed "Review Choice Demonstration for Inpatient Rehabilitation Facility Services" began in Alabama in 2023 and expanded to

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Pennsylvania in 2024. These two models offer providers a choice of pre-claim review or postpayment review.

In a Sept. 16 "Prior Authorization and Pre-Claim Review Overview" of the OPD program, CMS tracked Medicare spending on the outpatient interventions and procedures they've targeted and how they were affected by its prior authorization requirements. In the categories that are the same as in the new ASC demo, CMS found that, since they were added to the demo's OPD prior authorization requirements in 2020, spending on those procedures actually went up, from $22 million to $38 million per half-year.

Thin end of the PA wedge?

Lately CMS has pushed for some reforms in prior authorization in Medicare Advantage, and some MA payers have even made modest gestures toward reforming their PA processes (*PBN 8/11/25*). Yet this prior authorization demo for traditional Medicare is the second in less than three months, as the WISeR demo, which covers six states and requires providers to either do prepayment review or prior authorization, was announced in June (*PBN 7/14/25*).

Expert observers see this as trend that's likely to accelerate.

Kat Alvarez, founder and CEO of health care consultancy Katalyst & Co. in Palm Beach, Fla., thinks that in addition to trying to scale back overspending on the named procedures, CMS is using the demos to test the "administrative feasibility" of expanded use of prior authorization. "It's a signal that prior authorization is no longer just a tool for private insurers, but a policy mechanism CMS itself is willing to deploy" she says.

"Republicans would like to get rid of government-run Medicare primary and just have privately run Medicare Advantage," says Alexandra Tien, M.D., a family physician with Medical Associates of Rhode Island in Bristol, R.I. "Medicare members do not need a [prior authorization] to get a head CT, for example — but MA members do. It's a slippery slope and that's how these things always start."

William Soliman, founder and CEO of the Accreditation Council for Medical Affairs (ACMA) in Oradell, N.J., believes that CMS may even tighten up prior authorization for prescription drugs covered under Part B and Part D: "With more specialty drugs being approved by the FDA and bigger push back from health insurers," he says, "expect to see more prior authorization hassles in the future." Soliman says the push for the FDA to approve drugs more quickly, and for prescribers to get prescriptions approved via application programming interfaces (API), will add to the pressure.

If you're in one of the states

If your state is subject to the ASC demo, and you don't work for the ASC but perform procedures in it, Norwood warns that your billing arrangements almost certainly won't exempt you from the terms if you provide billed services for the procedures. "It is important to note that, in addition to the services specified above, related professional services will also be subject to the prior authorization requirements, such as anesthesiology or related physician services," he says.

If you're directly employed or an officer of an ASC in these states, Norwood says you should "take steps ahead of time to revise internal policies and procedures to bring them in line with new prior authorization requirements." It wouldn't be a bad idea to reach out to your Medicare contractor for guidance, especially given the tight compliance deadline. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- CMS Transmittal 13396/ Change Request: 14199, "SUBJECT: Provider Education for Prior Authorization (PA) of Certain Services in the Ambulatory Surgical Center (ASC) Setting," Sept. 4, 2025: *www.cms.gov/files/document/r13396otn.pdf*
- CMS, Medicare Fee-for-Service Compliance Programs, "Prior Authorization Demonstration for Certain Ambulatory Surgical Center ASC Services," Sept. 4, 2025: *www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-demonstration-certain-ambulatory-surgical-center-asc-services*
- CMS, "Prior Authorization and Pre-Claim Review Program Stats for Fiscal Year 2024 September 16, 2025 Fiscal Year (FY): October 1, 2023 — September 30, 2024, Prior Authorization and Pre-Claim Review Overview," Sept. 16, 2025: *www.cms.gov/files/document/pre-claim-review-program-statistics-document-fy-24.pdf*
- MedPAC, "March 2025 Report to the Congress: Medicare Payment Policy," March 13, 2025: *www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/*
- CMS, "Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Proposed Rule (CMS-1834-P)," July 15, 2025: *www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-and-ambulatory-surgical*

Ask Part B News

Review the limits of Medicare's telehealth exceptions

Question: *I know we can have audio-only telehealth visits for patients who are being treated for behavioral and mental health conditions after the telehealth waivers expire.*

Also, Medicare plans to permanently change direct supervision rules to allow doctors to be "immediately available" through a virtual connection. Does that mean a physician, such as a psychiatrist, could meet the "immediately available" requirement for a mental health or substance abuse encounter, if they're available by phone?

Answer: A phone call is not enough for direct supervision. The supervising provider must be available through a real-time, audio/video (A/V) connection if Medicare finalizes its plan to permanently expand the definition of direct supervision. "The presence of the physician (or other practitioner) required for direct supervision may include virtual presence through audio/video real-time communications technology (excluding audio only) for services without a 010 or 090 global surgery indicator," states the proposed 2026 Medicare physician fee schedule (*PBN 7/28/25*).

You also need to follow HIPAA privacy and security rules. Your practice must use a HIPAA-secure audio/video platform and connection. Audio-only connections, which Medicare will allow for some services after Sept. 30, are exempt from HIPAA requirements unless the connection captures and stores electronic protected health information (*PBN 4/24/23*).

When most telehealth waivers come to an end at 11:59 p.m. on Sept. 30, audio-only telehealth visits will continue to be an option for Medicare patients in any geographic location who receive mental health treatments, behavioral health treatments, care related to the diagnosis or treatment of strokes or monthly end-stage renal disease (ESRD) assessments, if the patient is at home during the encounter. However, the treating provider must be able perform the encounter through a real-time A/V connection at the time of the encounter.

In addition, if your practice offers telehealth services it can — and should — tell qualifying patients that audio-only telehealth is an option. If the patient wants telehealth for one or more visits, they decide whether they want an A/V or audio-only telehealth visit. Practices and providers can't require patients to have an audio-only encounter. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCE

- CMS MLN — Telehealth & Remote Patient Monitoring: *www.cms.gov/files/document/mln901705-telehealth-remote-patient-monitoring.pdf*

Ask Part B News

Docs can use signature stamps if 'disabled,' and can prove it

Question: *I just saw a Medicare Learning Network (MLN) fact sheet on "Complying with Medicare Signature Requirements," updated in July. The new text says that while CMS doesn't usually accept stamped signatures on medical documents to indicate they've written or reviewed them, "according to the Rehabilitation Act of 1973, we allow a rubber stamp for a signature if the author has a physical disability and provides proof of their inability to sign due to their disability." Can my provider with arthritis start using a stamp now?*

Answer: Though it took a while for MLN to catch up, Medicare released a transmittal about this in 2013. The Rehabilitation Act, like other federal legislation on the civil rights of the disabled, says that "no otherwise qualified individual with a disability in the United States … shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

The reasoning is that a provider can't be excluded from Medicare just because their impairment prevents them from grasping and signing with a writing implement.

But the Medicare regulations don't explain any further than that.

"Neither Transmittal 465 nor later CMS/MAC guidance specifies the type, timing or format of acceptable proof," says Connor D. Jackson, principal partner at Jackson LLP, a health care law firm based

(continued on p. 6)

Benchmark of the week

After big change in hospital E/M reporting, use held steady

Despite significant changes in standards that came in 2023 for hospital inpatient and observation E/M codes, 2024 was a year of stasis for service utilization — and denials.

Guidelines for use of inpatient and observation care codes changed dramatically in 2023, with the deletion of observation codes **99217-99220** and **99224-99226**, and their inclusion in what had been inpatient codes, which are now "inpatient or observation" codes: initial inpatient or observation care codes **99221-99223**; subsequent inpatient or observation care codes **99231-99233**; and inpatient or observation discharge service codes **99238-99239** (*PBN 7/11/22, 12/12/22*).

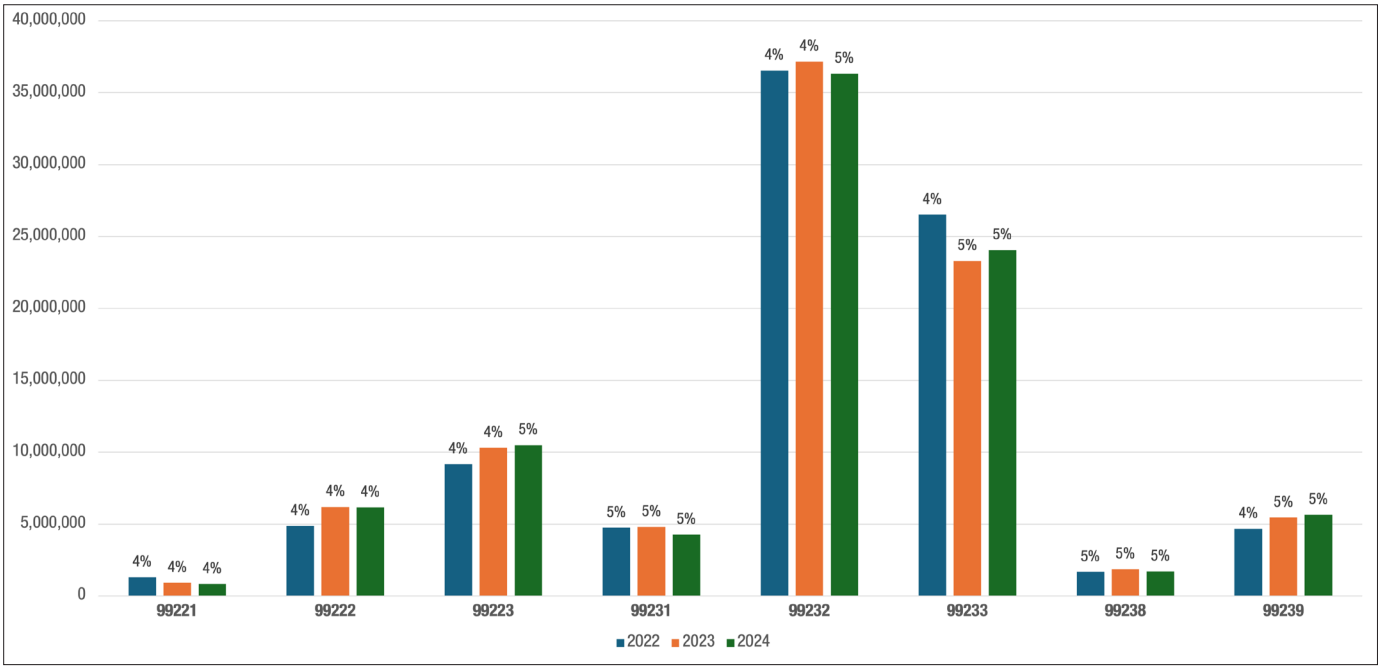
However, utilization of the remaining codes has shifted very little since the change. Total usage went from 89,544,269 claims in 2022 to 89,512,967 in 2024. And their low and steady denial rates in this period suggest that providers had no problem adapting to the new reporting standards.

As is the pattern with new and existing outpatient E/M codes, the Level 1s for both initial and subsequent hospital E/M codes are little used, and in 2024 they dropped by 9%, from 920,875 to 836,574, for initial claims, and by 11%, from 4.8 million to 4.3 million, for subsequent.

The Level 2s and Level 3s either fell slightly (e.g., 99232, which dropped about 2%) or rose slightly (e.g., 99233, which went up about 3%). Among specialties, nurse practitioners reported the most Level 1s and internal medicine providers the most Level 2s and 3s.

Note: Pay attention to CMS' continuing moves on these codes. For example, NCCI edits that go into effect on Oct. 1 will remove edit pairs that currently bundle the initial inpatient or observation care codes into per-month end stage renal disease (ESRD) home visits (**90963-90966**) (*PBN 9/29/25*). — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

Hospital inpatient and observation codes, utilization and denial rates, 2022-2024



Source: Part B News *analysis of 2022-2024 Medicare claims data*

(continued from p. 4)

in Chicago. "It remains unclear whether this means a medical record, a physician's certification, ADA accommodation paperwork, a Social Security disability determination, or another form of documentation."

You must rely on common sense and good faith as a guide. Jackson believes "the safest approach is to submit clear, credible medical evidence and, where possible, coordinate with the relevant Medicare contractor in advance." He also suggests some formats that should pass muster:

- A medical certification or attestation from a treating physician confirming the disability prevents handwritten signatures;
- Documentation from another disability determination (e.g., ADA, Social Security) showing limitations on manual dexterity; or
- A sworn affidavit by the provider describing their disability, ideally accompanied by third-party medical validation.

Jackson believes the first option is the strongest, particularly if it comes from the affected provider's own physician. Preferably, that physician works in a practice other than the provider's own, as that "could raise independence questions." Jackson advises against having the provider self-attest, even if medically qualified.

You mention arthritis, which raises the question: Would a condition that makes signing painful and/or difficult, as opposed to impossible, constitute a valid exemption? "The regulation speaks in terms of 'inability' to sign," Jackson notes, "which suggests functional inability rather than mere difficulty. That said, under the Rehabilitation Act, severe limitations — such as advanced arthritis making signing medically inadvisable — may still qualify if supported by medical documentation."

That's all the more reason to submit such proof as you have to your MAC in advance, rather than wait for a challenge to a stamped signature.

(**Note:** The new MLN guidance also mentions that notes taken by "artificial intelligence technology" must, like a scribe's notes, be signed by the provider, though providers "don't need to document who or what transcribed the entry." It also details the response procedure for when a MAC or other review contractor requests your signature attestation or log.) — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

RESOURCES

- MLN Fact Sheet, "Complying with Medicare Signature Requirements," revised July 2025: www.cms.gov/files/document/mln905364-complying-medicare-signature-requirements.pdf
- CMS Transmittal 465/ Change Request 8219, " Use of a Rubber Stamp for Signature," May 17, 2013: www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r465pi.pdf
- U.S. Dept. of Labor, Office of the Assistant Secretary for Administration & Management, "Section 504, Rehabilitation Act of 1973": www.dol.gov/agencies/oasam/centers-offices/civil-rights-center/statutes/section-504-rehabilitation-act-of-1973

Compliance

Run data, prepare staff for expanded RADV audits in MA space

As CMS accelerates audits across all Medicare Advantage (MA) contracts for payment years (PY) 2018-2024, your practice must prepare for record demands, coder shortages and complex compliance challenges.

CMS has launched a sweeping new initiative to audit all eligible MA plans for each PY. Unlike prior years, when CMS sampled a limited number of plans and reviewed only a small set of records, the new approach will encompass all eligible contracts and vastly increase record review volume.

CMS' goal is to complete risk adjustment data validation (RADV) audits for these PYs by early 2026. The agency expects to recover significant overpayments, driven by unsupported diagnoses and coding inconsistencies.

All plans, all years, more records

CMS is moving from sampling a handful of MA plans each year to auditing all plans — potentially up to 3,700 — and auditing about 35 records per plan to as many as 200.

"With sampling all plans and a larger number of records, physician offices and hospitals are going to be significantly hit with record requests," says Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, chief operating officer of First Class Solutions Inc.

Practices must also prepare for the fact that, going forward, MA organizations (MAO) will be requesting and reviewing records before submission to CMS. MAOs will likely turn to health care providers for additional support and clarity.

Check your contracts, brace for record requests

Not every hospital or physician group will be obligated to comply with MAO requests.

The answer may lie in the fine print of your agreements, Dunn says. She notes advice from Day L. Egusquiza, president of AR Systems Inc., and an MA expert, who recommends that practices carefully review their contracts with MAOs. If the agreement doesn't specifically require the submission of records for CMS' audit of the plan, providers may not be obligated to comply with those requests.

"If those contracts are silent, leadership needs to understand what the impact could be and take a position on whether or not they're going to hold their ground," she says.

However, if the contract does include such a clause, organizations should be prepared for a substantial impact, Dunn says.

"If your contract does say that with these plans, then you have a big hit approaching quickly," she says.

Coder demand will skyrocket

To manage its expanded audit workload, CMS announced it will increase its team of medical coders from 40 to approximately 2,000 by September 2025. CMS' coding hiring surge could have direct consequences for staffing across hospitals and physician practices.

"From a coding professional's perspective, individuals who have their RHIT, CCSP, CPC, and/or CRC are going to be in high demand by the government," Dunn says. "In turn, folks who are currently working for health care organizations might bail out to work with the government."

CMS is not the only entity looking to add more coding staff. MAOs will also need skilled professionals to review records internally before they're submitted to the agency.

"We're going to have a huge demand for coding professionals that have certain skill sets, specifically with ICD-10-CM," Dunn says. "These people aren't sitting out there on the bench right now. Currently employed professionals will be tapped by recruiters."

Unsupported diagnoses are the priority

When asked what kind of documentation gaps or coding errors practices should focus on, Dunn says the issues have already been clearly identified by regulators.

"I don't think the red flags are coming," she says. "The red flags have already been raised. If you look at the many lawsuits and investigations that are happening right now with the Office of Inspector General (OIG) and the [Department of Justice] on some of the top dogs in the MA industry, they already know what to look for."

The OIG has already distributed a toolkit to MAOs that includes algorithms and Structured Query Language (SQL) code to help them detect common issues, such as acute conditions coded in outpatient settings or typographical errors like transposed diagnosis codes. This toolkit is available to health care entities as well.

"They are handing you the apple pie on a plate, with a fork and ice cream on the side," Dunn says. "They're giving you the programming tools, recommending you to run this against your data files and fix your errors now."

Extrapolation raises the financial stakes

One of the most significant elements of CMS' RADV expansion is the agency's use of extrapolation, in which it takes a small sample of erroneous records and applies the error rate across the full population.

"So, the government can now take the data and extrapolate it from this sample of 200 records and apply it against the full complement of cases," Dunn says.

This could lead to far larger recoveries than in previous audits and likely trigger legal challenges by MA plans.

"The current administration is trying to find any dollar they can," Dunn says. "This extrapolation approach is going to be a biggie, which means there is probably going to be some court cases fighting against it. It is going to be sitting in the courts for the next five years."

Steps to conduct proactive internal audits

For practices looking to get ahead of the audit wave, Dunn suggests mirroring the RADV medical record reviewer guidelines. These include the basics, such as validating that records are signed, providers are acceptable under CMS rules, and encounters are properly dated and attributed to the correct payment year.

From a documentation standpoint, it is critical for teams not to code diagnoses based on incomplete records.

"From a RADV perspective, you're not supposed to code until you have the complete medical record," Dunn says. "The doctor's dictation of their discharge summary can't say, 'Dictated but not read.' It must say, 'Authenticated by,' or something similar that indicates the provider has read and validated the documentation."

On the physician office side, Dunn recommends using the OIG coding toolkit to identify common missteps.

"The OIG toolkit gives a list of the common conditions that are common mistakes," she says. "Providers can quickly apply the SQL to their claims data and correct those."

Planning ahead

Even for providers that choose to comply, preparation will be key. Dunn recommends giving physicians and medical staff a clear heads-up about the potential impacts and increase in record requests, as well as helping them determine the next steps.

Health care organizations should consider running the OIG SQL algorithms against their ambulatory and physician practice data to proactively flag unsupported or unlikely diagnoses. If problems are found, claims may need to be corrected and resubmitted before the audit data is locked in.

Dunn also suggests considering support from a release of information (ROI) services contractor and consulting with IT and compliance teams about possibly allowing MAOs direct access to the electronic health record (EHR) to streamline the record retrieval process.

"You're not going to be able to run that SQL from the toolkit without IT support, too," she notes. "This is going to require some involvement of leadership, compliance, HIM and IT all the way around."

Billions at stake

Dunn is clear-eyed about what is driving this aggressive expansion. With tens of billions of dollars in potential overpayments on the table, the current administration is motivated to close budget gaps, she says. MA audits are one way to do this.

"The administration is looking at billions in expected recovered funds, which is fine," she says. "They need a couple of trillion, but it's a start. Let's hope they find money that ends up back in the Medicare fund. I'm in that Medicare, red-white-and-blue stage. I've got my card. I want the money to be there for the services that I need."

Despite the complexity and disruption ahead, Dunn believes this effort is necessary and long overdue. The pressure will be immense and immediate.

With audits beginning "immediately," there's no time to wait. Practices should act now to assess their contracts, evaluate internal documentation practices, engage legal and IT teams, and prepare their medical staff.

CMS may be correcting a long-standing oversight, but for HIM leaders, the real test lies in how they respond.

Immediate steps to take

1. **Review all MA contracts.** Determine whether your organization is contractually obligated to submit records for CMS audits of MA plans. If contracts are silent, leadership may decide not to comply. However, legal counsel should be consulted either way.
2. **Notify physicians and medical staff.** Let providers know that record requests may be coming, and explain how documentation practices could affect audit outcomes, particularly for risk-adjusted diagnoses. This is especially important if the providers are participating in a risk adjustment contract.
3. **Run the OIG SQL toolkit.** Use the OIG's algorithms to scan your ambulatory and outpatient data for common errors, such as miscoded acute conditions and transposed numbers.
4. **Prepare for record volume and staffing needs.** Evaluate your current ROI workflows and coder availability. Consider engaging contractors or planning for staff reallocation if volume surges.
5. **Collaborate with IT and compliance.** Explore the feasibility of giving MAOs direct access to your EHR. Ensure you have IT support for running SQL queries and compliance oversight for any data-sharing decisions. — *Dom Nicastro* (*pbnfeedback@decisionhealth.com*) ■

RESOURCES

- May 21 press release: *www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits*
- OIG toolkit: *https://oig.hhs.gov/reports/all/2023/toolkit-to-help-decrease-improper-payments-in-medicare-advantage-through-the-identification-of-high-risk-diagnosis-codes/*