September 2026

NORIDIAN ASC Connection

Prior Authorization Demonstration for Certain Ambulatory Surgical Center (ASC) Services in AZ and CA

Key Updates You Need to Know

- Prior authorization through this demonstration requires a valid Part B PTAN and NPI
- All documentation must include two valid patient identifiers on each page. At least two identifiers from the coversheet—such as the beneficiary's name, date of birth, or MBI—must also appear within the submitted documentation. Photographs should include the beneficiary's name, date of birth, and date taken on every page.
- Verify prior authorization requirements before scheduling procedures by using the Prior Authorization Lookup Tool and Jurisdictions E & F website resources.
- For procedures performed on a single date of service, submit 1 unit for unilateral procedures and 2 units for bilateral procedures (1 unit per side). Planned laterality must be documented in the medical record. CPT code 15823 can be billed for RT and LT, but CPT code 30465 is a bilateral service itself, and if completed unilaterally, it should be billed with the appropriate modifier.
- ASC submitters must have facility access in the Noridian Medicare Portal (NMP) to view authorization statuses and determination letters. See the NMP User Guide for details.

Upcoming Webinars

September 10 at 3-3:30 CT

- CA: Botulinum Toxin Injections Prior Auth
- AZ: Botulinum Toxin Injections Prior Auth

September 23 at 3-3:30 CT

- CA: Panniculectomy and Rhinoplasty Prior Auth
- AZ: Panniculectomy and Rhinoplasty Prior Auth

ASC Spotlight: Documentation Best Practices

Complete and accurate documentation helps support timely prior authorization decisions and claim processing.

Tips for Success:

- Submit medical records that support medical necessity and meet applicable CMS Local Coverage Determination (LCD) requirements.
- Provide physician orders, operative plans, and clinical documentation.
- Ensure the submitted documentation clearly identifies the requested procedure and supports the CPT/HCPCS code(s) requested.
- Confirm all records are complete and legible.

Why It Matters: Complete submissions help minimize review delays and requests for additional information.

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Part B ASC Prior Authorization Process

Step 1: Request Submission
Step 2: Submission Review
Step 3: Decision
Step 4: Service Delivery
Step 5: Claim Submission

Top Prior Authorization Tips

The following issues commonly contribute to non-affirmation decisions and processing delays:

1. **Documentation Does Not Support Medical Necessity**
   Submitted records do not demonstrate that the requested service meets the medical necessity criteria outlined in the applicable Local Coverage Determination (LCD).
2. **Missing Clinical Support**
   Submitted documentation does not include sufficient clinical information to support the requested service.
3. **Incorrect Place of Service**
   The place of service selected does not align with the prior authorization request type (Part A versus Part B).
4. **Procedure or Code Discrepancies**
   The requested procedure, diagnosis, or HCPCS/CPT codes do not match the submitted supporting documentation.

Success Tip: Review the applicable LCD and billing article before submission and ensure all documentation supports medical necessity.

Provider Resources

Jurisdiction E and F website

- JE Part B CA
- JF Part B AZ
- Noridian Medicare Coverage Database JE (LCD Search)
- Noridian Medicare Coverage Database JF (LCD Search)

Common Part B ASC Demonstration Questions and Answers

- JE ASC Questions and Answers
- JF ASC Questions and Answers

CMS ASC Operational Guide
CMS ASC Services

FAQ of the Quarter

Q: How do I determine whether a prior authorization request should be submitted under Part A or Part B?

A: The service location determines the appropriate prior authorization program. The Part A hospital outpatient department (OPD) Program applies to select services performed in a OPD and billed on a Type of Bill 13X. The Part B Ambulatory Surgical Center (ASC) Demonstration applies to select services performed in a Medicare Fee-for-Service ASC enrolled under Specialty Code 49, billing Type of Service F, and providing services in Place of Service 24. Verify the service location before submitting your request to ensure it is routed through the correct prior authorization program.