

health, or ability to regain maximum function being in serious jeopardy.

(d) *Reviews*—(1) *Review of prior authorization request*. Upon receipt of a prior authorization request, CMS or its contractor will review the request for compliance with applicable Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act.

(i) CMS or its contractor will issue a provisional affirmation to the provider if it is determined that applicable Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act are met.

(ii) CMS or its contractor will issue a non-affirmation to the provider if it is determined that applicable Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act are not met.

(iii) The provisional affirmation or non-affirmation will be issued within 10 business days of receipt of the prior authorization request.

(2) *Review of expedited review request*. Upon receipt of a request for expedited review, CMS or its contractor will complete an expedited review of the prior authorization request if it is determined that a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function, and issue a provisional affirmation or non-affirmation decision in accordance with paragraph (d)(1) of this section within 2 business days of the expedited review request.

(e) *Resubmission*. (1) A provider may resubmit a prior authorization request, upon receipt of a non-affirmation, consistent with the requirements in paragraph (c)(1) of this section.

(2) A provider may resubmit a request for expedited review consistent with the requirements in paragraph (c)(1) of this section.

**§ 419.83 List of hospital outpatient department services requiring prior authorization.**

(a) *Service categories for the list of hospital outpatient department services requiring prior authorization*. (1) The following service categories comprise the list of hospital outpatient department

services requiring prior authorization beginning for service dates on or after July 1, 2020:

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

(2) The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after July 1, 2021:

- (i) Cervical Fusion with Disc Removal.
- (ii) Implanted Spinal Neurostimulators.

(3) The Facet Joint Interventions service category requires prior authorization beginning for service dates on or after July 1, 2023.

(b) *Adoption of the list of services and technical updates*. (1) CMS will adopt the list of hospital outpatient department service categories requiring prior authorization and any updates or geographic restrictions through formal notice-and-comment rulemaking.

(2) Technical updates to the list of services, such as changes to the name of the service or Current Procedural Terminology (CPT) code, will be published on the CMS website.

(c) *Exemptions*. CMS may elect to exempt a provider from the prior authorization process in § 419.82 upon a provider's demonstration of compliance with Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act through such prior authorization process.

(1) An exemption will remain in effect until CMS elects to withdraw the exemption.

(2) Notice of an exemption or withdrawal of an exemption will be provided at least 60 days prior to the effective date.

(d) *Suspension of prior authorization process or services*. CMS may suspend the outpatient department services prior authorization process requirements generally or for a particular service(s) at any time by issuing notification on the CMS website.

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