AAOS
American Association of Orthopaedic Surgeons

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William N. Parham, III
Director, Division of Information Collections and Regulatory Impacts
Office of Strategic Operations and Regulatory Affairs Division of Regulations Development
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-8013
Submitted electronically to regulations.gov.

Subject: CMS–10884

Prior Authorization Demonstration for Certain Ambulatory Surgical Center (ASC) Services

Dear Director Parham,

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we would like to raise concern about the recent notice on the Centers for Medicare & Medicaid Services (CMS) Prior Authorization demonstration for certain Ambulatory Surgical Center (ASC) Services (CMS–10884), published in the Federal Register on February 16, 2024, to improve procedures for identifying, investigating and prosecuting Medicare fraud occurring in ASCs providing services to Medicare beneficiaries.

In the AAOS CY 2023 Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule Comments, AAOS discussed the increasing burden of PA for both patients and healthcare providers, leading to longer wait times for approval and elevated risks for negative health outcomes.[1] A 2022 report conducted by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) revealed that 13 percent of prior authorization denials in the Medicare Advantage (MA) program were for health services that met the Medicare fee-for-service (FFS) coverage rules, potentially resulting in prevention or delays in patient care.[2]

CMS intends to develop a 5-year demonstration plan on expanding prior authorization in ambulatory surgery centers which originates from the CY 2020 Outpatient Prospective Payment Systems/Ambulatory Surgical Center (OPPS/ASC) Final Rule. This demonstration will use targeted cosmetic procedures and establish a prior authorization process for certain services provided in ASCs in

[1] AAOS CY 2023 Interoperability and Prior Authorization Comments https://www.aaos.org/globalassets/advocacy/action-center/aaos_cy_2023_interoperability_and_patient_access_proposed_rule_comment_letter.pdf
[2] Prior Authorization and Utilization Management Reform Principles Prior Authorization and Utilization Management Reform Principles. https://www.ama-assn.org/system/files/principles-with-signatory-page-forslsc.pdf

the demonstration states. [3] The proposed demonstration aims to ensure that providers in ASCs adhere to Medicare guidelines by requiring them to obtain prior authorization before performing certain services. Non-compliance may lead to prepayment review and potential denial of payment, mainly to prevent fraud, waste, and abuse in healthcare. [3]

While we understand the logic behind requiring prior authorization for cosmetic procedures, AAOS does not support the implementation of enhanced prior authorization requirements for medically necessary procedures and other health care services without adequate medical necessity review and simply as a means for controlling spending.[4] These prior authorization procedures place significant burdens on physicians, undermining their training and professional expertise, and lead to significant delays in patient care. In this 5-year demonstration, new prior authorization requirements for certain Medicare-covered ASC procedures suggests additional burdensome requirements such as, attending educational meetings, training staff on what services require prior authorization, and reviewing training documents. While CMS has acknowledged the extraordinary burden imposed by PA on both providers and patients, this PA ASC Notice fails to acknowledge the nature and scope of this burden. AAOS is concerned that the continued use of these requirements will supersede physician autonomy, increase administrative burden, and negatively impact patient care, [5] as additional resources and energy may be diverted away from optimizing patient care and toward fulfilling these administrative requirements. [5] Requiring prior authorization for medically necessary services that are already covered by Medicare in the ASC setting will likely move back many of these procedures to the hospital inpatient setting, thereby creating unintended financial and operational incentives and increasing expenditure for the Medicare program. Hence, we urge CMS to carefully think through the implementation of this new program. CMS should also study the impact this program will have on Medicare Advantage and commercial insurance plan policies.

CMS also reiterates that "while most prior authorization reviews will be decided within seven days, providers have an opportunity to submit prior authorization requests for expedited review when a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function. A decision will be rendered within the expedited review timeframe of 72-hours for requests that are deemed valid for expedited review." We are pleased with the finalization of this policy in the 2024 Interoperability and Prior Authorization Final Rule but would like to emphasize that delays in the provision of evidence-based and clinically appropriate medical care can pose significant challenges for

[3] CMS-10884 | CMS. (2024). https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10884
[4] AAOS OPPS 2020 Comments. https://www.aaos.org/globalassets/advocacy/issues/aaos_2020_opps_comment_letter.pdf
[5] AAOS OPPS 2021 Comments. https://www.aaos.org/globalassets/advocacy/issues/aaos-2021-opps-comments.pdf

patients, especially older adults or those in rural areas, who may need to make multiple return visits to a physician's office due to the delays.

AAOS is supportive of CMS' proposal to at least mitigate some of the burden associated with the 5-year demonstration plan through the proposed exemptions. We believe that it is reasonable to exempt from the prior authorization process those practitioners who achieve a prior authorization provisional affirmation threshold of at least 90 percent, during an annual assessment. We encourage CMS to consider other ways to minimize the burden for practitioners and patients as they operate within the current framework of prior authorization.

In summary, AAOS continues to advocate for reforms to the prior authorization process that prioritize patient care and reduce administrative burdens on physicians and other healthcare providers. This includes efforts to streamline the prior authorization process, improve transparency and communication between payers and providers, and ensure that prior authorization requirements are evidence-based and clinically appropriate. Overall, AAOS believes that collaboration among stakeholders is essential to address the shortcomings of the current prior authorization system and mitigate its adverse impacts on patient care and healthcare delivery.

We greatly appreciate your time and attention to this matter and hope that you will take immediate action to address concerns regarding utilization in ASC settings, forego implementing the PA ASC demonstration plan, and consider alternative options to address concerns about utilization in ASC settings. Please contact Shreyasi Deb, Ph.D., MBA (deb@aaos.org) should you have any questions.

Sincerely,

Paul Tornetta III, MD, PhD, FAAOS
AAOS President

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