Medicare Prior Authorization

List effective 10/1/2022

Absolute Total Care requires prior authorization (PA) as a condition of payment for many services. This Notice contains information regarding such prior authorization requirements and is applicable to all Medicare products offered by Absolute Total Care.

Absolute Total Care is committed to delivering cost effective quality care to our members. This effort requires us to ensure that our members receive only treatment that is medically necessary according to current standards of practice. Prior authorization is a process initiated by the physician in which we verify the medical necessity of a treatment in advance using independent objective medical criteria and/or in network utilization, where applicable.

It is the ordering/prescribing provider's responsibility to determine which specific codes require prior authorization.

Please verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered. NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED.

Effective October 1st, 2022, the following are changes to prior authorization requirements:

Service Category	Change	Services	Procedure Codes
Wound Care	Remove PA	Excision of pressure ulcers	15920, 15922, 15931, 15933, 15934, 15935, 15936, 15937, 15940, 15941, 15944, 15945, 15946, 15950, 15951, 15952, 15953, 15956, 15958
		Burn debridement and dressing	16000, 16020, 16025, 16030, 16035, 16036
		Ablative laser treatment, electromagnetic therapy	0491T, 0492T, G0329
	Add PA	Non-selective debridement, negative pressure wound treatment, low-frequency ultrasound	97602, 97605, 97606, 97607, 97608, 97610
	Add PA after 12 visits per calendar year	Wound Debridement	11004, 11005, 11008, 11011, 11012, 11042, 11043, 11044, 11045, 11046, 11047