TAR Completion for Long Term Care

Page updated: March 2023

The *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is used to request authorization for all Medi-Cal recipients admitted to a Nursing Facility (NF). The LTC TAR form is initiated by the NF. For online eTAR submissions, refer to the eTAR User Guide: Inpatient, Outpatient, & Long Term Care Services on the Medi-Cal website.

Note: Nursing Facility Level A (NF-A) replaces Intermediate Care Facility (ICF) references, and Nursing Facility Level B (NF-B) replaces Skilled Nursing Facility (SNF) references.

Code of Federal Regulations (CFR), Title 42, Section 440.155(a)(1) defines nursing facility services as those provided in a facility that "fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital care, but whose mental or physical condition requires services that – (i) are above the level of room and board; and (ii) can be made available only through institutional facilities[.]

Federal law allows continuity of care protections for individuals to receive medically necessary intermediate care services at the NF-B where they are receiving medically necessary skilled nursing services. If a Medi-Cal recipient needs intermediate care services, but the NF-B facility is not licensed to provide intermediate care, the facility can arrange for transfer to a facility that provides intermediate care services if the recipient is ready for transfer and there are beds available in that facility. While the recipient is awaiting transfer, the NF-B shall continue to provide medically necessary services to the recipient until another facility is available.

After the facility receives approval of the LTC TAR, the nine-digit TAR Control Number (TCN) is entered in the appropriate box on the *Payment Request for Long Term Care* (25-1) form.

Do not attach a copy of the LTC TAR to a *Payment Request for Long Term Care* (25-1) form. Enter the TCN only in the appropriate space.

Note: Verbal authorization is not available for NF admissions. For additional information on LTC TARs, refer to the *TAR for Long Term Care: 20-1* Form section in this manual.

Glossary

The following terms apply to NF:

‹‹Preadmission Screening and Resident Review (PASRR)

PASRR is a federally mandated program that applies to all individuals being admitted to a Medicaid certified NF. The PASRR program determines the appropriate level of care and specialized services for all Medicaid certified NF admissions that have been identified with a serious mental illness (MI) or intellectual/developmental disability (ID/DD) or related conditions (RC). The PASRR must be completed prior to the individual's admission to the Medicaid certified NF. For more information, refer to the *Preadmission Screening and Resident Review* (PASRR) section in this manual.

PASRR Level I Screening

Level I is the first level of screening for PASRR. The purpose of the Level I is to screen or assess if individuals admitting to Medicaid certified NFs have a diagnosis or suspicion of a MI/ID/DD/RC. The Level I screening must be submitted in the PASRR online system by the provider. If a suspected or diagnosed MI is identified on the Level I screening, then the Level I will automatically be sent to the state's third party contractor for a possible Level II evaluation. If a suspected or diagnosed ID/DD/RC is identified on the Level I screening, then the Level I will automatically be sent to the Department of Developmental Services for a possible Level II evaluation.

PASRR Level II Evaluation

The PASRR Level II evaluation determines the appropriateness for NF care and if there is a need for specialized services. For MI, the Level II evaluation is performed by the state's third party contractor. For ID/DD/RC, the Level II evaluation is performed by DDS. For more information, refer to the Preadmission *Screening and Resident Review* (PASRR) section in this manual.

Minimum Data Set for Nursing Home Resident Assessment and Screening (MDS 3.0)

The State has designated the *Minimum Data* (*Set (MDS) – Version 3.0 for Nursing Home Resident Assessment and Care Screening* (MDS 3.0) form as the Resident Assessment Instrument (RAI) to be used by NFs certified by the State to participate in the Medicare and Medi-Cal programs. These NFs are required to conduct resident assessments on a regular basis using the MDS information. For further information on the MDS 3.0 and the *Quarterly Assessment Form* 2.0, refer to the *TAR for Long Term Care.*››

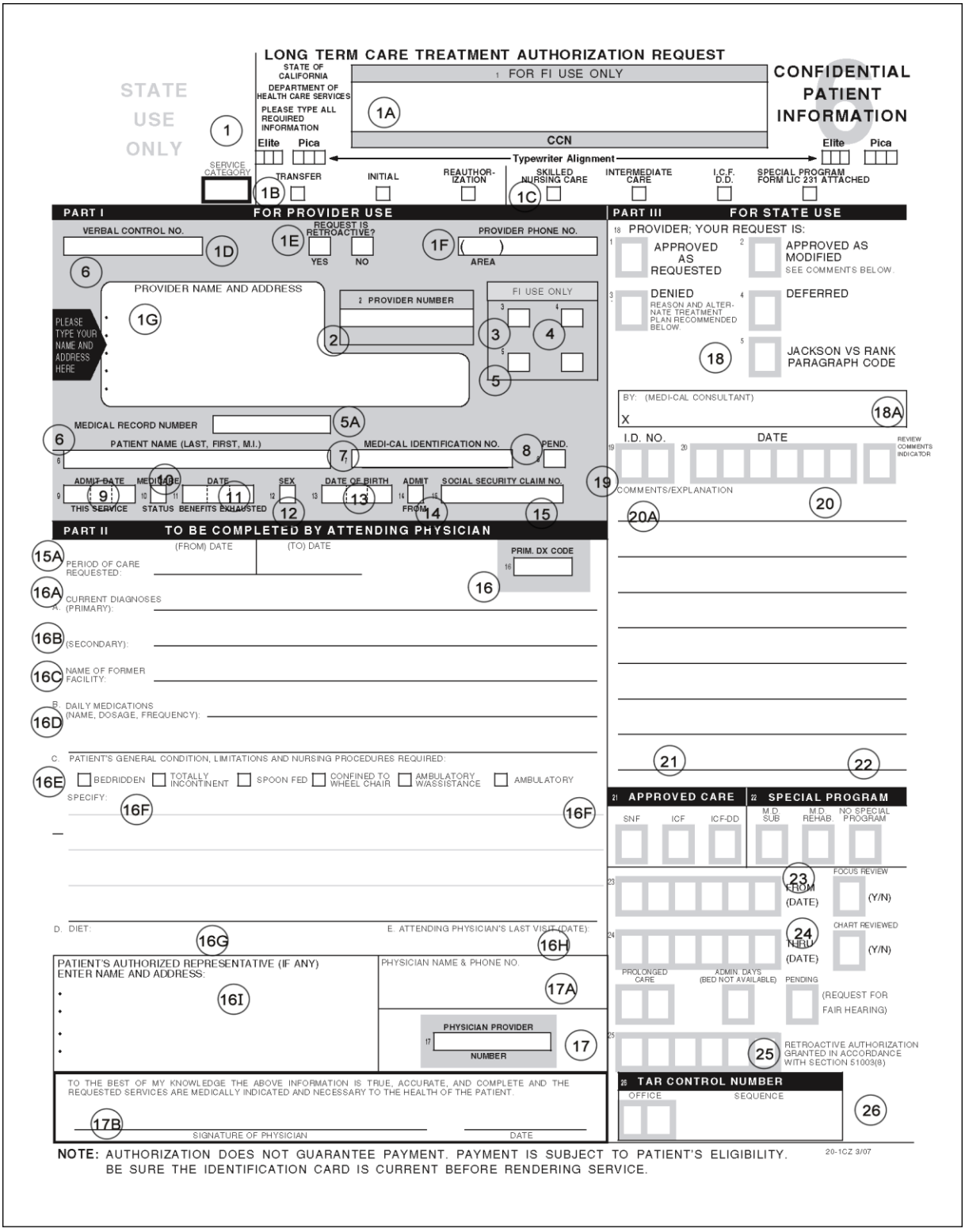


Figure 1: Sample *Long Term Care Treatment Authorization Request* (Form 20-1).

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *Long Term Care Treatment Authorization Request* (Form 20-1) on a previous page in this section.

Table of Form 20-1 Items and Explanations: Top Segment of Form

Form Item	Description
1.	**State Use Only.** Leave blank.
1A	**Claim Control Number (CCN).** For FI use only. Leave blank.
1B	**Transfer, Initial, Reauthorization.** Enter an "X" in the appropriate box. **Transfer:** Indicates admission to an NF-B from another NF-B or admission to an ICF/DD-H or ICF/DD-N from another ICF/DD-N. **Initial:** Indicates new admission other than a transfer. **Reauthorization:** Indicates request for extension of an authorized period.
1C	**Skilled Nursing Care, Intermediate Care, ICF/DD, Special Program *Certification For Special Treatment Program Services* Form (HS 231) Attached.** Enter an "X" in the appropriate box. Subacute facilities annotate S/A next to the SNF box to clarify level of care requested. **Skilled Nursing Care (SNF):** Care given a recipient who does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who requires skilled nursing care on a continual basis. This is now known as NF-B. **Intermediate Care (ICF):** Care given to a recipient whose medical condition requires an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of their ability. This is now known as NF-A. **ICF/DD-H and ICF/DD-N:** Care given a recipient with chronic developmental disability. (**Note:** Attach Form HS 231 to the LTC TAR.)

Table of Form 20-1 Items and Explanations: Top Segment of Form (continued)

Form Item	Description
1C (continued)	**Skilled Nursing Care, Intermediate Care, ICF/DD, Special Program Certification For Special Treatment Program Services Form (HS 231) Attached (continued).** Facilities certified to bill for special programs (such as the Mentally Disordered Rehabilitation Program) and facilities approved for ICF-DD level of care must attach form HS 231 to the LTC TAR when requesting initial authorization and reauthorization. Form HS 231 may be approved for up to two years, depending on the type of special program involved. Once the approved period on form HS 231 expires, a new form must be filled out and signed by the appropriate agency. Form HS 231 should be submitted with all initial and reauthorization TARs identified above. Subsequent HS 231 forms are to be maintained on file by the facility and must be reviewed by the Medi-Cal consultant. **Note:** If the facility does not receive form HS 231 before the initial written LTC TAR is submitted, the facility should submit the LTC TAR anyway. The LTC TAR will be date-stamped on receipt and returned to the facility without approval. When form HS 231 is received, the facility should resubmit the LTC TAR for approval with form HS 231 attached. If you check the *Special Program Form 231 Attached* box, you must check either the *Skilled Nursing Care* box or *Intermediate Care* box.

Table of Form 20-1 Items and Explanations: Part I, For Provider Use

Form Item	Description
1D	**Verbal Control Number.** Leave blank. Verbal authorization is not available.
1E	**Retroactive Request.** Enter an "X" in the appropriate box to indicate whether the request is retroactive. Guidelines for obtaining retroactive authorization are outlined in Title 22, Section 51003(b), (1), (2), (3), (4), (5) and (6).
1F	**Provider Phone No.** Optional.
1G	**Provider Name And Address.** Enter the provider name, address and nine-digit ZIP code. **Note:** The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.
2	**Provider Number.** Enter your provider number.
3 thru 5	**F.I. Use Only.** Leave blank.
5A	**Medical Record Number.** This is an optional field. Enter the recipient's medical record number or account number in this field (maximum of five characters – either numbers or letters).
6	**Patient Name.** Enter the last name, first name, and middle initial, if known. Avoid nicknames or aliases.
7	**Medi-Cal Identification No.** When entering the recipient identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. Do not enter any characters (dashes, hyphens, special characters, etc.) in the remaining blank positions of the Medi-Cal ID field. The county code and aid code must be entered just above the recipient *Medi-Cal Identification Number* box (see the example in figure 2 below)
8	**Pend.** If the recipient's Medi-Cal eligibility is not yet established and the Medi-Cal number is not known, insert the letter "P" in Box 12 to indicate "Pending."
9	**Admit Date This Service.** Enter the recipient's admission date to the facility in six-digit format (for example, November 1, 2006 = 110106).

Table of Form 20-1 Items and Explanations: Part I, For Provider Use (continued)

Form Item	Description
10	**Medicare Status.** Leave blank if recipient is Medicare eligible. If not, enter one of the following codes: **0**: Under 65, does not have Medicare coverage. **1**: Benefits exhausted (documentation required). **2**: Utilization committee denial or physician non-certification (documentation required). **3**: No prior hospital stay. **4**: Facility denial (documentation required). **5**: Non-eligible provider (documentation required). **6**: Non-eligible recipient (documentation required). **7**: Medicare benefits denied or cut short by Medicare intermediary (documentation required). **8**: Non-covered services. **9**: PSRO denial (documentation required).
11	**Date Benefits Exhausted.** If Medicare Status Code "1" (Benefits Exhausted) is indicated in Box 10, and you are billing for NF-B or Subacute Care, enter the date that Medicare benefits were exhausted. Documentation supporting benefit exhaustion must be submitted with TAR.
12	**Sex.** Use the capital "M" for male, or "F" for female
13	**Date of Birth.** Enter the recipient's date of birth in a six-digit format.
14	**Admit From.** Enter the code number from the following list: **1**: Acute Hospital Care. **2**: Hospital Skilled Nursing Care. **3**: NF-B Facility. **4**: NF-A, ICF/DD, ICF/DD-H, ICF/DD-N Facility. **5**: Board and Care Home. **6**: Home.
15	**Social Security Claim Number.** Not required by Medi-Cal.

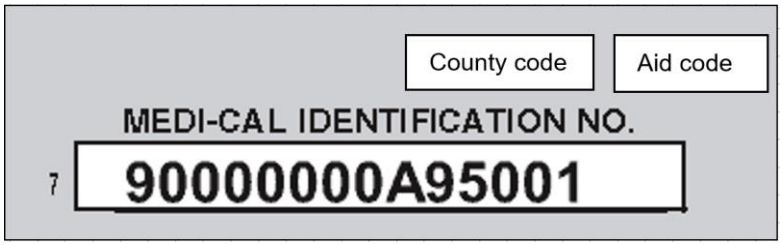


Figure 2: Example of Box 7 on the TAR (20-1) Form.
This also shows the placement of the county code and aid code on the form above Box 7.

Table of Form 20-1 Items and Explanations: Part II, To Be Completed By Attending Physician

Form Item	Description
15A	**Period of Care Requested.** Enter the “From Date”
16	**Primary DX (Diagnosis) Code.** Enter the appropriate primary ICD-10-CM diagnosis code.
16A	**Current Diagnoses (Primary).** Always enter the English description of the primary diagnosis corresponding to the ICD-10-CM diagnosis code entered in Box 16.
16B	**Current Diagnoses (Secondary).** If necessary, provide the description of the secondary diagnosis.
16C	**Name of Former Facility.** Enter the name of the facility where the recipient previously resided. Enter “Home” if the recipient is being admitted from home.
16D	**Daily Medications (Name, Dosage, Frequency).** Enter the name, dosage and frequency of medications given to the recipient on a daily basis.
16E	**Patient's General Condition, Limitations And Nursing Procedures Required.** Enter an “X” in the appropriate boxes to show Bedridden, Totally Incontinent, Spoon Fed, Confined to Wheel Chair, Ambulatory w/Assistance, or Ambulatory conditions.

Table of Form 20-1 Items and Explanations: Part II, Section C: To Be Completed By The Nursing Facility

Form Item	Description
16F	**Specify.** Specify the reason for the recipient's limitation(s) on the first line. Fill out the following three lines as indicated below. This information is only required for recipients being admitted to a Nursing Facility.

Table of Form 20-1 Items and Explanations: Part II, To Be Completed By Attending Physician (continued)

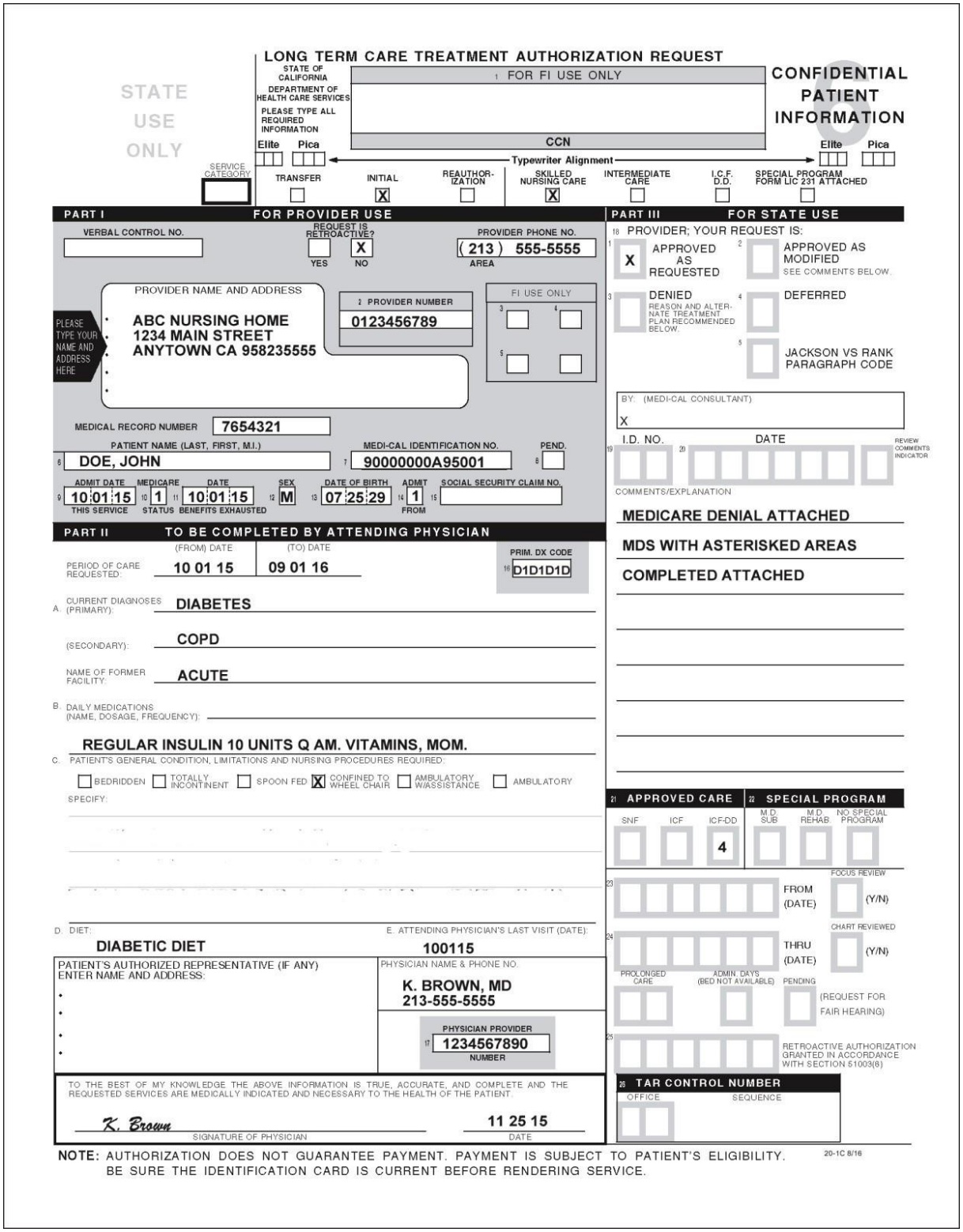
Form Item	Description
16G	**Diet.** Enter the type of diet prescribed.
16H	**Attending Physician's Last Visit (Date).** Enter the attending physician's last visit in six-digit format.
16I	**Patient's Authorized Representative (If Any) Enter Name And Address.** If applicable, enter the name and address of the recipient's authorized representative, representative payee, conservator over the person, legal representative or other representative handling the recipient's medical and personal affairs.
17	**Physician Provider Number.** Enter the rendering provider number in this area.
17A	**Physician Name And Phone Number.** Enter the physician name and telephone number.
17B	**Signature Of Physician.** Must be signed and dated by the admitting or primary physician. An original signature is required.

Table of Form 20-1 Items and Explanations: Part III, For State Use

Form Item	Description
18 thru 26	**For State Use.** Leave this area blank. Consultant's or on-site nurse's determination is entered in this section.
18	Only submit your claim if Box 1 (Approved as Requested) or Box 2 (Approved as Modified) is marked. The *Denied* and *Deferred* boxes indicate that the provider's request has not been approved.
19	The consultant will write his or her ID number in this box.
20	The consultant will write the date the LTC TAR was reviewed in this box.

Table of Form 20-1 Items and Explanations: Part III, For State Use

Form Item	Description
20A	The consultant may use this section to list the approved procedures or any further information the provider must submit with the claim or resubmit with the LTC TAR. The on-site nurse uses this area to indicate the length of stay and level of care approved.
21 & 22	The consultant will indicate the approved care and special program in these boxes.
23 & 24	The consultant will indicate the valid dates of authorization for this LTC TAR.
25	The consultant will enter a retroactive authorization code in this box, if applicable.
26	The consultant will enter a two-digit prefix to the pre-imprinted seven-digit number. This entire nine-digit number must be added on the claim form when this service is billed. Do not attach a copy of the LTC TAR to the claim form.



LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
PLEASE TYPE ALL REQUIRED INFORMATION

STATE USE ONLY

1 FOR FI USE ONLY

CCN

CONFIDENTIAL PATIENT INFORMATION

Elite Pica

Typewriter Alignment

SERVICE CATEGORY

TRANSFER ☐ | INITIAL ☒ | REAUTHORIZATION ☐ | SKILLED NURSING CARE ☒ | INTERMEDIATE CARE ☐ | I.C.F. D.D. ☐ | SPECIAL PROGRAM FORM LIC 231 ATTACHED ☐

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? YES ☐ NO ☒

PROVIDER PHONE NO. (213) 555-5555 (AREA)

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

ABC NURSING HOME
1234 MAIN STREET
ANYTOWN CA 958235555

2 PROVIDER NUMBER 0123456789

FI USE ONLY 3 4 5

MEDICAL RECORD NUMBER 7654321

6 PATIENT NAME (LAST, FIRST, M.I.) DOE, JOHN

7 MEDI-CAL IDENTIFICATION NO. 90000000A95001

8 PEND.

9 ADMIT DATE THIS SERVICE	10 MEDICARE STATUS	11 DATE BENEFITS EXHAUSTED	12 SEX	13 DATE OF BIRTH	14 ADMIT FROM	15 SOCIAL SECURITY CLAIM NO.
10 01 15	1	10 01 15	M	07 25 29	1	

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE 10 01 15 (TO) DATE 09 01 16

16 PRIM. DX CODE D1D1D1D

A. CURRENT DIAGNOSES (PRIMARY): DIABETES

(SECONDARY): COPD

NAME OF FORMER FACILITY: ACUTE

B. DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY): REGULAR INSULIN 10 UNITS Q AM. VITAMINS, MOM.

C. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:

☐ BEDRIDDEN ☐ TOTALLY INCONTINENT ☐ SPOON FED ☒ CONFINED TO WHEEL CHAIR ☐ AMBULATORY W/ASSISTANCE ☐ AMBULATORY

SPECIFY:

D. DIET: DIABETIC DIET

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 100115

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PHYSICIAN NAME & PHONE NO.
K. BROWN, MD
213-555-5555

PHYSICIAN PROVIDER NUMBER 17 1234567890

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

K. Brown (SIGNATURE OF PHYSICIAN) 11 25 15 (DATE)

PART III FOR STATE USE

18 PROVIDER; YOUR REQUEST IS:

1 ☒ APPROVED AS REQUESTED
2 ☐ APPROVED AS MODIFIED (SEE COMMENTS BELOW.)
3 ☐ DENIED (REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED BELOW.)
4 ☐ DEFERRED
5 ☐ JACKSON VS RANK PARAGRAPH CODE

BY: (MEDI-CAL CONSULTANT) X

19 I.D. NO. 20 DATE REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

MEDICARE DENIAL ATTACHED
MDS WITH ASTERISKED AREAS
COMPLETED ATTACHED

21 APPROVED CARE			22 SPECIAL PROGRAM		
SNF	ICF	ICF-DD	M.D. SUB.	M.D. REHAB.	NO SPECIAL PROGRAM
		4			

23 FROM (DATE) FOCUS REVIEW (Y/N)

24 THRU (DATE) CHART REVIEWED (Y/N)

PROLONGED CARE | ADMIN. DAYS (BED NOT AVAILABLE) | PENDING (REQUEST FOR FAIR HEARING)

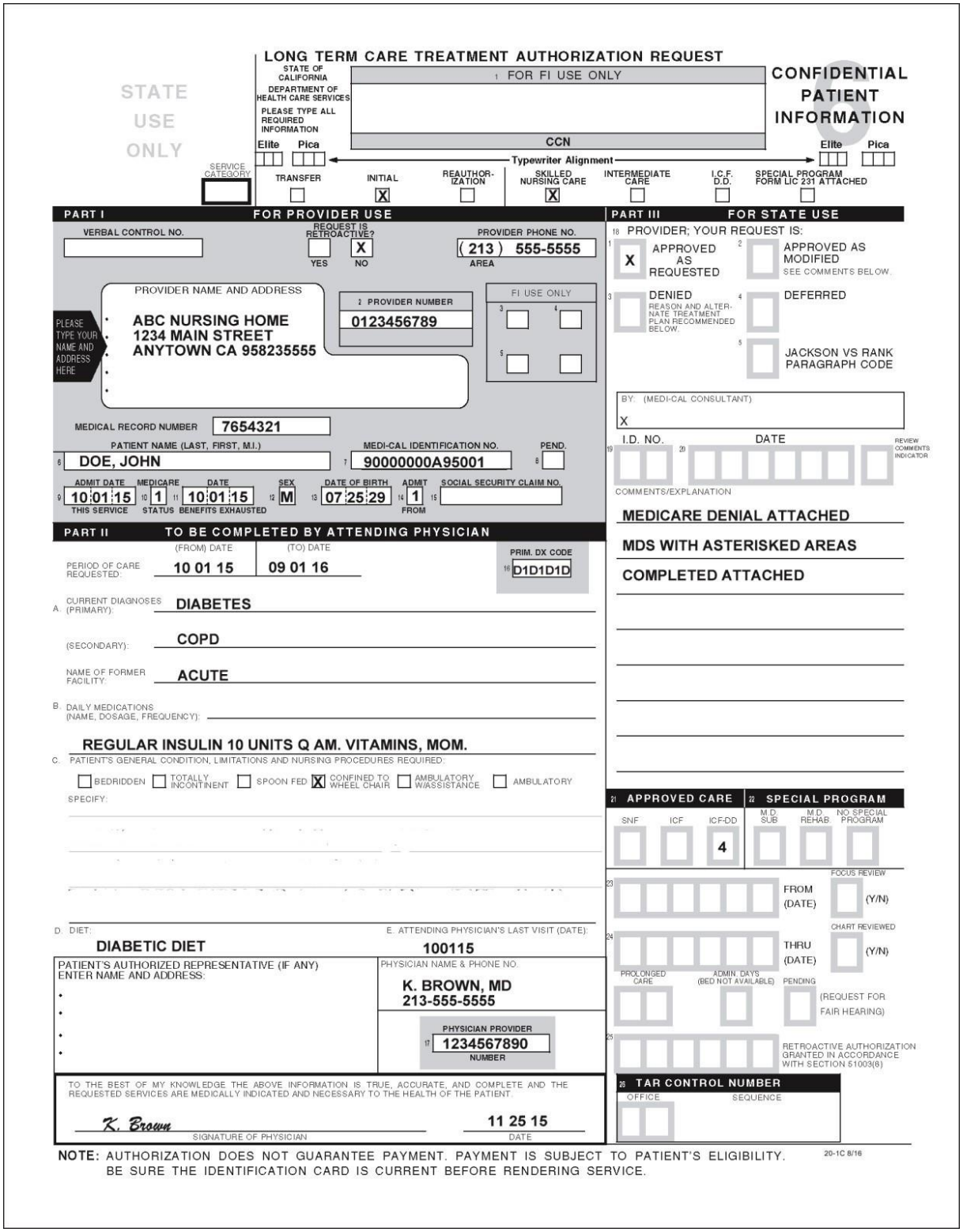
25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(6)

26 TAR CONTROL NUMBER
OFFICE SEQUENCE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

20-1C 8/16

Figure 3: Sample Initial LTC TAR.



LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
PLEASE TYPE ALL REQUIRED INFORMATION

STATE USE ONLY

1 FOR FI USE ONLY

CCN

CONFIDENTIAL PATIENT INFORMATION

Elite Pica

Typewriter Alignment

SERVICE CATEGORY | TRANSFER | INITIAL [X] | REAUTHORIZATION | SKILLED NURSING CARE [X] | INTERMEDIATE CARE | I.C.F. D.D. | SPECIAL PROGRAM FORM LIC 231 ATTACHED

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? YES | NO [X]

PROVIDER PHONE NO. (213) 555-5555 (AREA)

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

ABC NURSING HOME
1234 MAIN STREET
ANYTOWN CA 958235555

2 PROVIDER NUMBER 0123456789

FI USE ONLY 3 4 5

MEDICAL RECORD NUMBER 7654321

6 PATIENT NAME (LAST, FIRST, M.I.) DOE, JOHN

7 MEDI-CAL IDENTIFICATION NO. 90000000A95001

8 PEND.

9 ADMIT DATE THIS SERVICE	10 MEDICARE STATUS	11 DATE BENEFITS EXHAUSTED	12 SEX	13 DATE OF BIRTH	14 ADMIT FROM	15 SOCIAL SECURITY CLAIM NO.
10 01 15	1	10 01 15	M	07 25 29	1	

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE 10 01 15 (TO) DATE 09 01 16

16 PRIM. DX CODE D1D1D1D

A. CURRENT DIAGNOSES (PRIMARY): DIABETES

(SECONDARY): COPD

NAME OF FORMER FACILITY: ACUTE

B. DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY):

REGULAR INSULIN 10 UNITS Q AM. VITAMINS, MOM.

C. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:

BEDRIDDEN | TOTALLY INCONTINENT | SPOON FED | CONFINED TO WHEEL CHAIR [X] | AMBULATORY W/ASSISTANCE | AMBULATORY

SPECIFY:

D. DIET: DIABETIC DIET

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 100115

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PHYSICIAN NAME & PHONE NO.
K. BROWN, MD
213-555-5555

17 PHYSICIAN PROVIDER NUMBER 1234567890

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

K. Brown (SIGNATURE OF PHYSICIAN) 11 25 15 (DATE)

PART III FOR STATE USE

18 PROVIDER; YOUR REQUEST IS:

1 [X] APPROVED AS REQUESTED
2 [ ] APPROVED AS MODIFIED — SEE COMMENTS BELOW.
3 [ ] DENIED — REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED BELOW.
4 [ ] DEFERRED
5 [ ] JACKSON VS RANK PARAGRAPH CODE

BY: (MEDI-CAL CONSULTANT) X

19 I.D. NO. 20 DATE REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

MEDICARE DENIAL ATTACHED
MDS WITH ASTERISKED AREAS
COMPLETED ATTACHED

21 APPROVED CARE			22 SPECIAL PROGRAM		
SNF	ICF	ICF-DD	M.D. SUB.	M.D. REHAB.	NO SPECIAL PROGRAM
		4			

23 FROM (DATE) FOCUS REVIEW (Y/N)

24 THRU (DATE) CHART REVIEWED (Y/N)

PROLONGED CARE | ADMIN. DAYS (BED NOT AVAILABLE) | PENDING (REQUEST FOR FAIR HEARING)

25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(6)

26 TAR CONTROL NUMBER — OFFICE | SEQUENCE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

20-1C 8/16

Figure 4: Sample Reauthorization LTC TAR.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.