
TAR Overview

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Certain procedures and services are subject to authorization by Medi-Cal before reimbursement can be approved. Authorization requests are made with a *Treatment Authorization Request* (TAR). Authorization requirements are based on Federal and State law.

There are two ways to submit a TAR for review, electronically or by paper.

The TAR processing system will accept TARs via the electronic TAR (eTAR) system. Electronic TAR (eTAR) is a web-based direct data entry system used by Medi-Cal providers. Medi-Cal providers have the ability to use eTAR for the purpose of submitting most TARs and inquiring about TAR decisions. eTARs submitted by providers are entered via a secured location on the Department of Health Care Services (DHCS) Medi-Cal website and reviewed and adjudicated by DHCS consultants. For additional information, refer to the *eTAR Submission Guidelines* in this section.

For TARs submitted on paper, there are several different paper TAR forms to use. Most Medical and Pharmacy providers use the 50-1 TAR form to request authorization. Long Term Care and Subacute Care providers use the *Long Term Care Treatment Authorization Request* (20-1) TAR form. Inpatient providers use both the 50-1 and the *Request for Extension of Stay in Hospital* (18-1) TAR form. Authorization requirements for inpatient hospital stays depend on whether the hospital is paid according to the diagnosis-related groups (DRG) reimbursement methodology.

Important: Information about TAR requirements for DRG-reimbursed hospitals is located in the *Diagnosis-Related Groups (DRG): Inpatient Services* section of the Part 2 *Inpatient Services* provider manual.

Vision Care providers use the 50-3 TAR form to request authorization. Refer to the *TAR Completion for Vision Care* section of the Part 2 Vision Care manual for additional information. For a listing of the forms that may be used to request authorization, refer to “Medi-Cal Authorization Forms” in this section. Additional authorization information is located in the TAR sections of the Part 2 manuals.

Providers generally should request authorization before rendering a service. Services that require authorization are identified in the policy sections throughout Medi-Cal Part 2 manuals. «Outpatient and Medical Services providers also may refer to the *TAR and Non-Standard Benefits List* section of the appropriate Part 2 manual.»

Medical authorization requests can be submitted to the TAR Processing Center. Authorization requests for drugs can be submitted to the TAR Processing Center. Physician administered drugs are submitted for physician adjudication. Medi-Cal consultants adjudicate TARs according to Federal and State regulations and DHCS policy. To facilitate TAR processing, Medi-Cal services are designated as core or regionalized services. For more information, see “Where to Submit TARs” in this section. Adjudication of a TAR may result in one of four decisions: approved as requested, approved as modified, denied or deferred. DHCS communicates the status of the TAR’s adjudication to the submitting provider through an *Adjudication Response (AR)*.

Medi-Cal consultants begin the adjudication of retroactive TARs for acute hospital days by reviewing discharge summaries submitted with other parts of a patient’s medical record. If the discharge summary is detailed and complete, and contains standard terminology, DHCS consultants may be able to adjudicate the TAR more quickly. It would therefore be to a hospital’s benefit to submit medical records containing completed discharge summaries with its TARs.

Include the following information in the discharge summary and submit it with the TAR to help expedite the adjudication process.

- The reason for hospitalization
- Significant findings
- Procedures performed and care, treatment and services provided
- The patient’s condition at discharge
- Information provided to the patient and family, as appropriate

Authorization for Vision Care Providers

Authorization requests for vision care services and eye appliances are processed by the DHCS Vision Service Branch (VSB). Refer to the *TAR Completion for Vision Care* section in the Part 2 Vision Care manual for more information.

TAR Information Requirements

Requests for authorization should be accompanied by documentation supporting the medical necessity of the service(s). The authorization request must include:

- Principal and significant associated diagnoses
- Physician or licensed medical practitioner's signed prescription or inpatient doctor's order
- Medical condition necessitating the services
- Type, number and frequency of services to be rendered by each provider

Medical Necessity

The Medi-Cal program defines medical necessity as the provision of health care services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Authorization may be granted when the services requested are reasonably expected to:

- Restore lost functions
- Minimize deterioration of existing functions
- Provide necessary training in the use of orthotic or prosthetic devices
- Provide the capability for self care, including feeding, toilet activities and ambulation

Authorization may be granted when failure to achieve the goals listed above would result in the loss of life or result in significant disability.

Medi-Cal Authorization Forms

«The following forms are used by the provider type listed to request Medi-Cal authorization. Instructions for submitting these forms and other authorization information are located in the *TAR Completion* section of the appropriate Part 2 manual.»

Table of Medi-Cal Authorization Forms

Form Number	Title	Used By Provider Type	Purpose
18-1	<i>Request for Extension of Stay in Hospital</i>	Inpatient	Authorization for hospital emergency admissions is always requested by the hospital on an 18-1 for the number of days of the stay. This TAR is only authorized for inpatient hospital use and not for the physician, or outpatient hospital in billing specific TAR-required procedures.
18-3	<i>Request for Mental Health Stay in Hospital</i>	Inpatient Mental Health	Used by inpatient hospitals to request approval for inpatient mental health hospital stays.
20-1	<i>Long Term Care Treatment Authorization Request</i>	Long Term Care	Used by nursing facilities. The nursing facility must complete the 20-1 and send it to the TAR Processing Center.
50-1	<i>Treatment Authorization Request</i>	Medical Services Pharmacy	Used by medical and pharmacy providers to request authorization for services. Used by inpatient hospitals as an admit TAR.
50-3	<i>Treatment Authorization Request</i>	Vision Care	Used by Vision Care providers to request authorization for eye appliances services.

TAR Transmittal Forms

Providers may use a transmittal form to help track the submission of their TAR, TAR Appeal and TAR Correction mailed to the TAR Processing Center. The transmittal form should be enclosed with the TAR, TAR Appeal or TAR correction request that is submitted to the TAR Processing Center. Either a provider-developed form or the DHCS *Transmittal Form* (MC 3020) is acceptable.

Refer to the TAR submission section of the appropriate Part 2 manual for MC 3020 completion instructions.

Initial and Reauthorization TARs

A TAR submitted for the first time is referred to as an initial TAR. Any subsequent TAR submitted requesting additional authorization of the same service(s) for the same recipient but different service dates is referred to as a reauthorization TAR. (Refer to “TAR Submission Methods” in this section for additional reauthorization TAR information.)

When Additional Procedure Required

If, during the performance of an approved procedure, providers who determine that an additional procedure is medically necessary, should submit a new TAR for the additional procedure with all appropriate justification, including a copy of the original TAR’s approved *Adjudication Response* (AR).

When Different Procedure Required

If, during the performance of an approved procedure, a provider determines that a different procedure is medically necessary, they should submit a new TAR. The submission should include a reference to the TAR number and procedure previously approved.

TAR Approval Period

Authorization for Medi-Cal benefits will be valid for the number of days specified by the consultant on the TAR and must be rendered during the valid “from-through” period.

Where to Submit TARs

To facilitate TAR processing, Medi-Cal services are designated as core or regionalized services. TARs requesting authorization for core services can be processed at the TAR Processing Center.

Core Services

Core services are identified in a table under the bold heading “Where to Submit TARs” in the *TAR Field Office Addresses* section in the appropriate Part 2 Medi-Cal provider manual.

Regionalized Services

Regionalized services are identified in the county charts located in the *TAR Field Office Addresses* section in the appropriate Part 2 Medi-Cal provider manual.

TAR Submission Methods

TARs are submitted by mail or electronically for some services. For exceptions (such as fax submissions), providers may refer to the TAR submission section of the appropriate Part 2 provider manual.

Reauthorization TAR Submission

With the exception of drug TARs, no reauthorization TARs will be accepted for processing when submitted via telephone or fax.

Fax Capability for Extension of Stay and Hospice TARs

“Extension of Stay” fax TARs (18-2) are available for hospitals enrolled in the fax submission program. Fax TARs (50-2) are available for hospices transferring clients from other levels of care to the general inpatient level of care.

Typed, Complete, Legible TARs

TARs submitted by fax must be typewritten, complete and legible. Hospice providers should refer to the *Hospice Care: General Inpatient Information Sheet* section of the appropriate Part 2 manual. The *Hospice General Inpatient Information Sheet* (DHS 6194) must be submitted with the fax TAR.

Fax Machine Does Not Answer

If the fax machine does not answer after four to six rings, the receiving fax machine may be out of order. Providers should contact the TAR Processing Center by telephone for further directions.

Do Not Reuse TAR Forms

Once a TAR form has been used to transmit a TAR by fax, providers must not use that same TAR (or any copies) again. Duplicate TAR Control Numbers are rejected by the TAR system.

Do Not Fax Correspondence

For paper TAR inquiries, general correspondence and attachments to previously submitted TARs, documents must be sent via fax or regular mail.

Electronic Treatment Request (eTAR) Submission Guidelines

The TAR processing system will accept electronic treatment authorization transactions via the current electronic TAR (eTAR) system. Using the eTAR submission process, providers can create, update, inquire and view responses for TARs online. In addition, providers have access to the Code Search tool for code inquiries. Using eTAR eliminates mail and paper processing time.

Note: Attachments for eTARs submitted via the attachment fax line (1-877-270-8779) must have a completed *TAR 3 Attachment* form as the cover sheet or first page for attachments.

«The web-based treatment authorization transaction is available on the [Medi-Cal Providers](#) website by logging on to “Transactions” and clicking the “Online TAR Applications” link.»

Providers submitting eTARs for a procedure code that does not normally require a TAR must select the special handling description “Cannot bill direct, TAR is required,” which is found in the *Patient Information* section of the eTAR application.

Medi-Cal may provide reimbursement for a non-benefit procedure code with an approved TAR if medical necessity is established. To submit an eTAR for a non-benefit, a provider must select the special handling description “Service is a non-benefit and no TAR requirement on procedure file – REVIEW” on the *Patient Information* section of the eTAR application.

Resubmission Due to Change of Rendering Provider

When a TAR-authorized hospital stay (50-1 or 18-1) must be rendered in a different facility than the authorized facility, the rendering provider must submit a new TAR and written justification for the change and submit it for authorization.

«Table of Situations in Which a Change of Rendering Provider Requires TAR Resubmission»

If...	Then...
Original provider is unable to render approved services	<ul style="list-style-type: none"> • Medi-Cal consultant checks claims billing status for dates of service billed (if any) • Medi-Cal consultant end-dates TAR from old provider
New provider submits TAR, end-dated on the same date as previous TAR	<ul style="list-style-type: none"> • Medi-Cal consultant approves services at same quantity as previous TAR, without requiring additional medical documentation
New provider submits continuation TAR	<ul style="list-style-type: none"> • Medi-Cal consultant reviews TAR for medical necessity • Services considered continuous • Reductions in level of services require appropriate Notice of Action (NOA) sent to recipient
Provider has change of ownership	<ul style="list-style-type: none"> • Provider must submit a replacement TAR with the new National Provider Identifier (NPI) with a statement describing why a replacement is necessary.

Returned/Forwarded TARs

If a TAR is received in a field office, the TAR will be returned to the provider with instructions about where it should be appropriately mailed.

TAR Status on Adjudication Response (AR)

Authorization for Medi-Cal benefits is valid for the number of days specified by the consultant on the *Adjudication Response (AR)*. Services must be rendered during the valid “From Date of Service Thru Date of Service” period. «Vision providers will receive an AR by fax when a valid fax number is included in the appropriate place on their TAR or by mail in all other situations.» All other providers who submit paper TARs will receive an AR by mail. However, providers wishing to have the AR faxed to a different location may enter a fax number in the TAR’s *Verbal Control Number* field. Providers choosing this option will not receive a hard copy via mail. «Providers who use eTAR, other than Vision will not receive ARs and will need to check TAR status online.»

ARs display:

- The status of requested services
- Information required to submit a claim for TAR-approved services
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The TAR consultant’s request for additional information, as appropriate
- The Pricing Indicator (PI) (which should be added at the end of the 10-digit TAR Control Number (TCN) and entered on the claim)

Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

Requests for updates/corrections must include a copy of the AR on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify the change(s) being requested.

ARs will be mailed to the provider’s address on file with the California MMIS Fiscal Intermediary and Contracts Oversight Division, Provider Enrollment Division (PED). Providers should ensure PED has their most current mailing address on file.

The following is an example of an *Adjudication Response*.

State of California - Health and Human Services Agency
Department of Health Care Services

CONFIDENTIAL

Utilization Management Division

ADJUDICATION RESPONSE

Provider Number: 0099219517
NPI TST CLINIC 3.1
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 12/27/2007 04:47 PM
Regarding: Jane Doe
TAR Control Number: 9876543210
Patient Record #: 12345



This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Svc Code	Modifier(s)	From Date of Service	Thru Date of Service	Units	Quantity	% Var	Price	Status	PI
1	123ABC		01-01-2008	01-31-2008	12,345	1,000,000.123		9.99	Approved	1
	Svc Desc :	Service Description 1								
2	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123			Modified	0
	Svc Desc :	Service Description 2								
	Reason(s):	GEN: Modified, refer to comments								
	Comment(s):	Comments from Field Office Consultant 2								
3	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123		9,999,999.99	Denied	3
	Svc Desc :	Service Description 3								
	Reason(s):	GEN: Denied, refer to comments								
	Comment(s):	Comments from Field Office Consultant 3								
4	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123		9,999,999.99	Deferred	5
	Svc Desc :	Service Description 4								
	Reason(s):	GEN: Deferred, refer to comments								
	Comment(s):	Comments from Field Office Consultant 4								

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

“From-Through” TAR Authorization

Approved TARs are returned to providers with a range of dates for which the TAR is valid. To be reimbursed, providers must render services within that range of dates (“from-through” or “from-to”). If treatment warrants, “from-through” authorization for up to a maximum of one year (or up to two years for some nursing facility services) may be approved.

Pricing Indicator

The last column on the AR contains the Pricing Indicator (PI) number. When submitting claims, the PI must be included as the last digit (11th) of the TAR Control Number (TCN). Claims submitted without the PI as the 11th digit will be denied.

Manual of Criteria for Medi-Cal Authorization

«The *Manual of Criteria for Medi-Cal Authorization* may be downloaded from www.dhcs.ca.gov by clicking the “Forms & Publications” icon then “Publications,” followed by “Manuals” and finally the “*Medi-Cal Manual of Criteria.*»”

The manual contains criteria for inpatient and other Medi-Cal services and guidelines that Medi-Cal consultants follow when reviewing TARs. «The manual should assist providers in documenting the need for services and items on TARs (AIIR TARs are excluded).»

Out-of-State Providers

TARs from out-of-state providers (non-border community) and individual border cities, regardless of the service type requested, should be submitted to the TAR Processing Center at one of the following addresses:

TAR Processing Center
820 Stillwater Road
West Sacramento, CA 95605-1630

TAR Processing Center
P.O. Box 13029
Sacramento, CA 95813-4029

TAR Deferral Policy

If necessary, a Medi-Cal consultant may defer a TAR. Deferring a TAR means the information is entered online by the medical consultant. The provider must check back online (eTAR) or wait for the mailed *Adjudication Response* (AR) to see the deferred adjudication status and what information is needed by the medical consultant in order to finalize a decision on the TAR.

«Denial Notice of Action After a Deferral

DHCS issues Medi-Cal recipients a Notice of Action (NOA) when a TAR is submitted for new services or reauthorization of services, the services have not yet been provided, and the decision is denied or modified. Deferral of a TAR occurs when there is insufficient information on or submitted with the TAR to make a clear determination. When a TAR is deferred, the Medi-Cal provider will receive either an *Adjudication Response* (for a paper TAR) or an online response (for an eTAR) with instructions on what information to submit.

If the provider does not submit the requested information within 30 days after the deferral, the TAR will be denied and a NOA will be issued to the recipient, with a copy to the provider, indicating that the provider was requested to submit additional information to substantiate the request and no response was received.»

If the TAR is denied for lack of information or corrections, the provider may submit a new TAR for the service, indicating that the previously requested information is included and that this new TAR is not a duplicate request.

Update Deferred Service on Electronic TARs (eTARs)

Only eTARs should be updated online. A deferred eTAR service needs to be updated with the requested information by logging into the Transactions web page of the Medi-Cal website and selecting “Update an existing TAR” from the TAR menu. Attachments can be uploaded on the eTAR website or faxed to 1-877-270-8779 (within California) or 916-384-9000 (outside California), depending on the selected method when updating the existing eTAR. Attachments being uploaded or faxed must include a *TAR 3 Attachment Form* as the cover sheet. If the requested information is not submitted within 30 days, the TAR will be denied due to lack of information.

Denied and cancelled eTARs cannot be updated. The eTAR will be rejected if it is updated.

For further clarification or questions, providers should contact the Telephone Service Center.

Update Deferred Medical Service on Paper TARs

A deferred medical paper TAR service that needs to be updated with requested information should be mailed to the TAR Processing Center at one of the following addresses:

TAR Processing Center
820 Stillwater Road
West Sacramento, CA 95605-1630

TAR Processing Center
P.O. Box 13029
Sacramento, CA 95813-4029

Additional information being mailed must include the *Adjudication Response* as the cover sheet. If the requested information is not submitted within 30 days, the TAR will be denied due to lack of information. Paper TARs should not be updated online.

Denied and cancelled TARs cannot be updated. The TAR will be rejected if it is updated.

For further clarification or questions, providers should contact the Telephone Service Center.

No TAR Deferral for OHC Denials

Medi-Cal no longer defers TARs for Other Health Coverage (OHC) denials. However, this process does not supersede or eliminate a provider's requirement to submit documentation that OHC has been billed.

Note: Fee-for-service TARs will continue to be denied for recipients enrolled in Medi-Cal managed care plans without a denial from the plan on the services requested.

For information about billing OHC, refer to the *Other Health Coverage (OHC)* and *Other Health Coverage (OHC): CPT® and HCPCS Codes* sections of the appropriate Part 2 manuals.

Aid Paid Pending for Reauthorization of Continuing Services

When DHCS denies or reduces a reauthorization request for services that have been previously approved, the recipient has the right to have Medi-Cal continue to pay for those services pending the outcome of a timely fair hearing. Such approval is called “aid paid pending.” Pursuant to *California Code of Regulations*, Title 22, Section 51014.2, if the recipient wishes to continue receiving the services requested on the TAR, the recipient must request the fair hearing within 10 days from the date of the NOA for denial or reduction or prior to the expiration of the previous TAR that was approved for the same services, whichever is later. The recipient must still be receiving the requested services in order for aid paid pending to be instituted.

Aid paid pending applies only to Medi-Cal services that have not been rendered, and more specifically, for “continuing service” TARs.

For additional information about *Frank v. Kizer*, refer to the *TAR Deferral/Denial Policy (Frank v. Kizer)* section in the Part 2 manual.

Common TAR and Claim Completion Errors

Providers should verify all information on *Adjudication Responses* (ARs). Examples of common provider errors include:

- Incorrect quantity (must match claim form)
- Units billed in excess of those authorized (units billed must not exceed the TAR-approved units)
- Incorrect procedure/drug code
- Incorrect provider ID or NPI number
- TAR-authorized services and non-TAR authorized services billed on the same claim (they must be billed on separate claims)
- Incorrect authorization periods

The CA-MMIS FI Does Not Correct TAR Information

If an error is discovered on the AR, providers should send a written request for a correction to the TAR Processing Center at one of the following addresses:

TAR Processing Center
820 Stillwater Road
West Sacramento, CA 95605-1630

TAR Processing Center
P.O. Box 13029
Sacramento, CA 95813-4029

Recipient information such as name, Medi-Cal Benefits Identification Card (BIC) number, date of birth or gender may be corrected or modified within a year of the TAR's original adjudication date. If greater than one year old, or if the claim has already been submitted, the information will not be corrected.

TARs in “History” Status

TARs that are completely paid or in “approved” status for longer than one year are placed in “History” status on the TAR Master File. Providers submitting a claim, *Claims Inquiry Form* (CIF) or claim appeal for services authorized on a TAR in “History” status should attach or upload a legible copy of the TAR. The TAR will not be reactivated or a replacement TAR authorized.

TAR Status Inquiry and Provider Telecommunications Network

Providers may inquire about the status of paper TARs through the Provider Telecommunications Network (PTN). PTN is available at 1-800-786-4346 from 7 a.m. to 8 p.m., seven days a week. For additional information, refer to the *Provider Telecommunications Network (PTN)* section in this manual.

TAR Notice Sent to Recipients

«Under certain circumstances, DHCS will notify a Medi-Cal recipient when a TAR is denied or modified. This Notice of Action (NOA) contains:»

- Provider's name and address
- Service description(s)
- Type of action taken by the Medi-Cal field office, reason(s) for the action taken and the Medi-Cal field office or Pharmacy Section name that adjudicated the TAR
- Recipient's right to a State Hearing

Submitting Claims for TAR-Authorized Services

Refer to the claim form special billing instructions section of the appropriate Part 2 manual for information about submitting claims for TAR-authorized services.

TAR Appeals

Refer to the *TAR: Submitting Appeals* section in the appropriate Part 2 manual for information about TAR appeals.

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.