TAR Completion

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Physicians, podiatrists, pharmacies, medical supply dealers, outpatient clinics and laboratories use the *Treatment Authorization Request* (TAR, 50-1) to request approval from a Medi-Cal consultant for certain procedures/services. For a list of CPT® procedures requiring a TAR, refer to the *TAR and Non-Benefit List* section in the appropriate Part 2 manual.

Should it be necessary for a Medi-Cal recipient to remain in a hospital for more days than authorized on the original TAR, the hospital is responsible for completing and submitting a *Request for Extension of Stay in Hospital* (18-1). (Not applicable for full-scope recipients receiving services at diagnosis-related groups [DRG]-reimbursed facilities with the exception of administrative or rehabilitative services). ‹‹Instructions on how to complete an 18-1 can be found in the *TAR Request for Extension of Stay in Hospital (Form 18-1)* section of the appropriate Part 2 manual.

Day of Admission Definition

A Medi-Cal recipient's day of admission for acute care is based on the written or ordered date of admission by the admitting physician.

Inpatient admissions may or may not require a TAR. Providers reimbursed according to the DRG reimbursement methodology should refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in the *Inpatient Services* provider manual for instructions about admissions that require a TAR.

The TAR should be submitted to the TAR Processing Center accompanied by documentation supporting the medical necessity of the service(s). The TAR must include a signed admission order by the admitting physician.

Note: Medi-Cal day of admission definition shall not be construed as contrary to the meaning of the *California Code of Regulations*, Title 22, Section 51108.

Inpatient Hospital Stays

All elective acute inpatient admissions are reviewed for medical necessity.

Note: See important information about inpatient admission TARs under the preceding "Day of Admission Definition" entry.

‹‹Inpatient Services That Require 18-1

The following acute inpatient services require an 18-1 upon initial admission:

- Acute Inpatient Intensive Rehabilitation (AIIR) Services
- Acute Administrative Days (AAD)

See the *TAR Request for Extension of Stay in Hospital (Form 18-1)* section of the appropriate Part 2 manual for more instructions.››

Emergency Admissions

Authorization for hospital emergency admissions is always requested on a *Request for Extension of Stay in Hospital* (18-1). The request covers the inpatient days, not procedures rendered during the inpatient stay. The physician must submit a TAR (50-1) for any inpatient surgical procedure that requires authorization.

Note: If a Medi-Cal consultant denies authorization for a given hospital inpatient day, none of the services rendered to the recipient in the hospital for that date of service are reimbursable. This includes physician or ancillary services and emergency room, diagnostic, therapeutic, surgical and recovery services.

BCCTP TARs

A TAR for an urgent Breast and Cervical Cancer Treatment Program (BCCTP) service may receive expedited adjudication with documentation of "URGENT/BCCTP" in the *Medical Justification field* (Box 8C) of the TAR form.

For online eTAR submissions, refer to the eTutorial on the Medi-Cal website *(www.medi-cal.ca.gov).* Follow the instructions for "Special Handling" as an option for BCCTP providers for urgent TAR adjudication.

TARs will be adjudicated on a non-urgent basis for recipients with a BCCTP aid code for procedures unrelated to breast or cervical cancer.

Elective Admissions

A TAR for an elective admission for an inpatient hospital stay is most frequently initiated by the recipient's physician or podiatrist on the 50-1 form. A TAR submitted as an admit TAR for the entire inpatient stay includes a "1" in the *Quantity* fields (Boxes 12, 16, 20, etc.), as appropriate. TARs submitted for services that require the specific number of hospital days for which authorization is requested, should include the number of days requested in the *Quantity* fields (Boxes 12, 16, 20, etc.), as appropriate. Most TARs submitted for a DRG-reimbursed hospital will be admit TARs with a "1" in the *Quantity* field. In addition, the TAR includes additional specific procedures requiring a TAR that will be performed by the physician or podiatrist.

In this circumstance, the National Provider Identifier (NPI) number listed on the TAR must be the 10-digit number for the inpatient hospital, even though the physician will be using the same TAR. The requesting physician or podiatrist must enter the word "DAY" or "DAYS" on the first line of the TAR in the *NDC/UPN or Procedure Code* fields (Boxes 11, 15, 19, etc.), as appropriate. The number of days requested must be entered in the *Quantity* fields. Any additional TAR-requiring services must be requested on lines 2 through 6.

DME and Medical Supplies

Durable Medical Equipment (DME) and medical supplies can be placed on the same TAR only if the same NPI is used and the provider is authorized to bill for both categories of service. If different NPIs are necessary to obtain authorization, each service must be requested with a separate TAR (for example, one TAR for requested DME items and a second TAR for requested medical supply items). Failure to follow this procedure may result in a denial.

Multiple TARs

To request authorization for more than six items for a single recipient, the provider must submit more than one TAR. Six items are entered on the first TAR and the remaining items on subsequent TARs. Providers must cross-reference the TAR Control Numbers (TCNs) in the *Medical Justification* areas on each TAR (for example, TAR 00631304076 relates to TAR 00631304077).

Negotiated Prices

Medi-Cal consultants can negotiate and set reduced prices for selected services during the TAR adjudication process. Providers who are amenable to price negotiations should indicate the requested price in the TAR Charge field. Providers seeking negotiated prices may not list a procedure code more than once on a TAR. If authorization of a duplicate procedure code is requested, it must be submitted on another TAR. The Medi-Cal consultant may contact providers for further price negotiations following TAR receipt.

Adjudication Response (AR)

Authorization for Medi-Cal benefits will be valid for the number 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. Providers should refer to "TAR Status on Adjudication Response" in the *TAR Overview* section of the Part 1 manual to explain which provider types will receive ARs, and under what circumstances.

TAR Control Number and Pricing Indicator

For additional information about ARs, including important information about entering TAR Control Numbers and Pricing Indicators on claims, providers may refer to "TAR Status on Adjudication Response" in the *TAR Overview* section of the Part 1 manual.

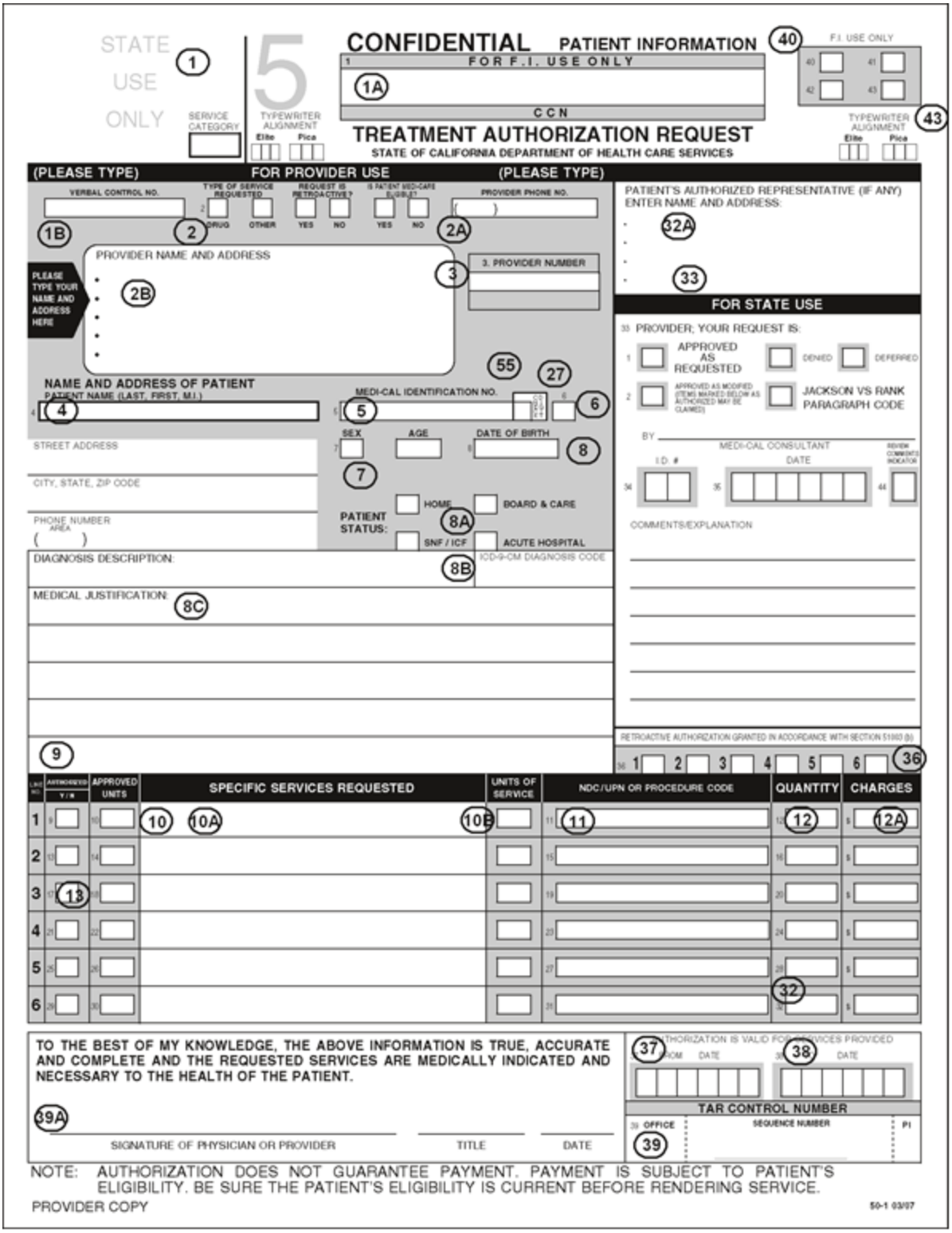

Figure 1: Sample of a *Treatment Authorization Request* Form (50-1).

Explanation of Form Items

The following item numbers and descriptions correspond to *Figure 1.*

Explanation of Form Items

Item	Description
1	**State Use Only.** Leave blank.
1A	**Claim Control Number**. For F.I. use only. Leave blank.
1B	**Verbal Control Number.** Providers may enter a fax number in this field to receive an AR for the submitted TAR by fax instead of standard mail. If a fax number is entered in this field, an AR will not be mailed to the provider for the related TAR that was submitted. All other providers will not receive an AR by fax and should leave this field blank.
2	**Type of Service Requested/Retroactive Request/Medicare Eligibility Status**. Enter an "X" in the appropriate boxes to show Drug or Other, Retroactive request, and Medicare eligibility status.
2A	**Provider Phone No.** Enter the telephone number and area code of the requesting provider.
2B	**Provider Name and Address.** Enter provider name and address, including nine-digit ZIP code.
3	**Provider Number.** Enter the rendering provider number in this area. When requesting authorization for an elective hospital admission, the hospital provider number must be entered in this box. (Enter the name of the hospital in the *Medical Justification* area. If this information is not present, the TAR will be returned to the provider unprocessed.)
4	**Patient Name, Address, Telephone Number**. Enter recipient information in this space.
5	**Medi-Cal Identification No**. When entering the recipient's identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. For Family PACT requests, enter the client's Health Access Programs (HAP) card ID number, instead of the BIC number. Do not enter any characters (dashes, hyphens, special characters) in the remaining blank positions of the *Medi-Cal ID* field or in the *Check Digit* box. The county code and aid code must be entered just above the recipient *Medi-Cal Identification Number* box. ‹‹See *Figure 2* below.›› Providers may refer to the *Eligibility: Recipient Identification* section in the Part 1 manual for the definition of county code**.**

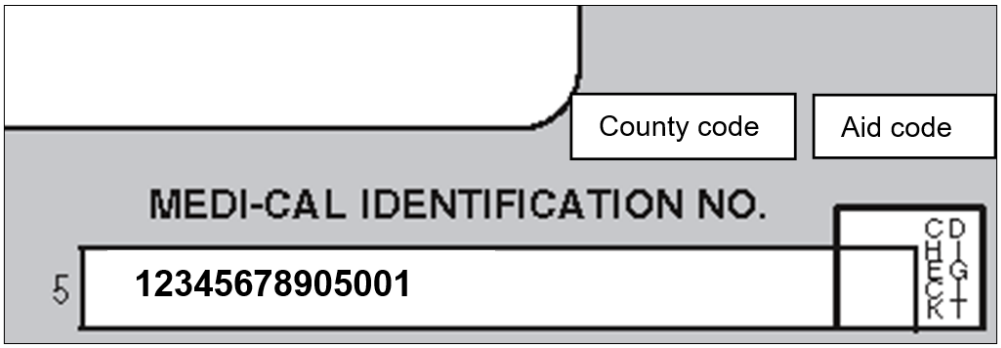

Figure 2: Box 5 of TAR (50-1): (Leave Check Digit box blank.) This example also shows placement of the county code and aid code on the form above Box 5.

Explanation of Form Items (continued

Item	Description
6	**Pending.** Leave this box blank
7	**Sex and Age.** Use the capital “M” for male, or “F” for female. Enter age of the recipient in the *Age* box.
8	**Date of Birth.** Enter the recipient’s date of birth in a six-digit format. If the recipient’s full date of birth is not available, enter the year of the recipient’s birth preceded by “0101.”
8A	**Patient Status.** Enter the recipient’s residential status. If the recipient is an inpatient in a Nursing Facility (NF) Level A or B, enter the name of the facility in the *Medical Justification* field.
8B	**Diagnosis Description and ICD-9-CM Diagnosis Code**. Always enter the English description of a diagnosis and its corresponding code from the ICD-10-CM code book. **Note:** This form has not been updated to reflect an ICD-10-CM field label name.

Explanation of Form Items (continued)

Item	Description
8C	**Medical Justification**. Provide sufficient medical justification for the consultant to determine whether the service is medically justified. If necessary, attach additional information. If the recipient is an inpatient in a NF-A or NF-B, enter the name of the facility in the *Medical Justification* field. **Note for Family PACT requests**: Enter "Family PACT Client" on the first line of this field. Enter a secondary ICD-10-CM code when the TAR is for complications of a secondary related reproductive health condition. If applicable, attach a copy of the *Family PACT Referral* form from the enrolled Family PACT provider. **Note for BCCTP requests**: Providers requesting services of an urgent nature in relation to breast and cervical cancer treatment for a recipient with a BCCTP aid code should enter the words "URGENT/BCCTP" in bold, black letters in this field. **TARs for HCPCS Code Conversions**: Providers should write "Code Conversion TAR" and the previously approved TAR number in this area. For more information about code conversion TARs, see "Local-to-HCPCS Code Conversion Guidelines" in this section.
9	**Authorized Yes/No.** Leave blank. Consultant will indicate on the *Adjudication Response* (AR) if the service line item is authorized.
10	**Approved Units**. Leave blank. Consultant will indicate on the AR the number of times that the procedure, item or days have been authorized.
10A	**Specific Services Requested.** Indicate the name of the procedure, item or service. <u>TARs for Pediatric Day Health Care (PDHC) and Private Duty Nursing (PDN)</u> Indicate when rendering for PDHC or PDN services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit by including "EPSDT PDHC" or "EPSDT PDN."
10B	**Units of Service.** Leave blank.

Explanation of Form Items (continued)

Item	Description
11	**NDC/UPN or Procedure Code**. Enter the anticipated code (five-character HCPCS or five-digit CPT [followed by one or more two-character modifier(s) when necessary], or an 11-digit National Drug Code [NDC] or Universal Product Number [UPN]). When requesting hospital days, the stay must be requested on the first line of the TAR with the provider entering the word “DAY” or “DAYS.” ‹‹All NDC numbers must be 11 digits long. NDCs printed on packages often have fewer than 11 digits with a dash (-) separating the number into three segments. For a complete 11-digit number, the first segment must have five digits, the second segment four digits and the third segment two digits. Add leading zeros wherever they are needed to complete a segment with the correct number of digits. For example, see the Zero-Fill NDC Numbers table below.››

Zero-Fill NDC Numbers Table

Package Number	Zero Fill	11-digit NDC
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312
2-22-2	(00002-0022-02)	00002002202

If requesting authorization for a compounded preparation, enter the 11-digit number “99999999996” in the *NDC/UPN or Procedure Code* field (Box 11).

Medical Supplies

When requesting authorization for an unlisted medical supply, indicate the name of the supply in the *Specific Services Requested* field (Box 10A). The TAR Control Number (TCN) and Pricing Indicator (PI) must be entered on the claim. Providers must submit the *Adjudication Response* (AR) with appropriate documentation (for example, invoice or manufacturing catalog page) with the claim.

Explanation of Form Items (continued)

Item	Description
12	**Quantity.** Enter the number of times a procedure; product, or service is requested Inpatient Providers Hospitals reimbursed according to the diagnosis-related group (DRG) model will enter a “1” in the *Quantity* field for admit TARs that cover the entire hospital stay and the specific number of inpatient days being requested for daily TARs (restricted aid codes, administrative service and rehabilitation services require daily TAR approval). Refer to the “Admit TAR and Daily TAR” entry in the *Diagnosis-Related Groups (DRG): Inpatient Services* section of the *Inpatient Services* provider manual for more information.

Explanation of Form Items (continued)

Item	Description
12A	**Charges**. Indicate the dollar amount of your usual and customary charge for the service(s) requested. If an item is a taxable medical supply, include the applicable state and county sales tax. For additional information, refer to the Taxable and Non-Taxable Items section in the appropriate Part 2 manual. Pharmacy Providers For medical supply requests, enter the usual and customary fee for service(s).
13 thru 32	**Additional Lines 2 through 6**. Additional TAR Lines. You may request up to six drugs or supplies on one TAR form.
32A	**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, legal representative, or other representative handling the recipient's medical and/or personal affairs.
33 thru 36	**For State Use Only.** Leave blank. Consultant's determination and comments will be returned on the *Adjudication Response* (AR). **Note:** Only submit the claim if the AR decision is Approved as Requested or Approved as Modified. Denied and deferred decisions indicate that the provider's request has not been approved.
37 & 38	**Authorization is Valid for Services Provided – from Date/to Date**. Leave blank. The AR will indicate valid dates of authorization for this TAR.
39	**Tar Control Number**. Leave blank. The AR will indicate the Pricing Indicator that must be combined with a TAR Control Number (TCN) to form the 11-digit number that must be entered on the claim form when this service is billed. This number will show that authorization has been obtained. Do not attach a copy of the AR to the claim form. The TCN for a 50-1 TAR may serve as the initial admit TAR number on an elective admission for the hospital.
39A	**Signature of Physician or Provider**. Form must be signed by the physician, pharmacist or authorized representative.
40 thru 43	**F.I. Use Only**. Leave blank.

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.