TAR Criteria for DP/NF Authorization (Hudman v. Kizer)

Page updated: August 2020

The purpose of this section is to inform providers of the circumstances in which Distinct-Part Nursing Facility (DP/NF) care will be authorized based on the court order of Hudman v. Kizer.

This court order applies to all eligible Medi-Cal recipients in need of long-term skilled nursing care. Long term care does not include patients needing post-surgical rehabilitation or therapy services which are time limited.

TAR Criteria for DP/NF

Authorization

A *Treatment Authorization Request* (TAR) from a DP/NF will be authorized by the Medi-Cal consultant at the distinct-part reimbursement rate if the following criteria are met:

1) Medical necessity for long term nursing care is documented, and
2) All administrative requirements have been met, and
   a. There is no Free-Standing Nursing Facility (FS/NF) within 15 miles of the patient's established residence prior to admission and the DP/NF is within a shorter travel time than the closest FS/NF able and willing to accept the patient, or
   b. There is an FS/NF within 15 miles of the patient's established residence prior to admission, but after reasonable placement efforts, no FS/NF within that distance is able and willing to accept the patient, and the DP/NF submitting the TAR is within a shorter travel time than the closest FS/NF able and willing to accept the patient, or
   c. There is no FS/NF within 30 minutes actual travel time from the established residence address of the immediate family member who certifies that he/she is the family member who will be most frequently visiting and helping with the personal needs of the patient. Also, the DP/NF must be within a shorter travel time than the closest FS/NF able and willing to accept the patient. The *Family Certification* form at the end of this section must be completed and submitted with the TAR. A copy must also be retained in the patient's record, or
   d. There is an FS/NF within 30 minutes actual travel time from the established residence address of the immediate family member who certifies that he/she will be most frequently visiting and helping with the personal needs of the patient.

      However, there is no FS/NF able and willing to accept the patient after the DP/NF has completed reasonable placement efforts in contacting the appropriate FS/NFs. The DP/NF must be within a shorter travel time than the closest FS/NF able and willing to accept the patient. The *Family Certification* form at the end of this section must be completed and submitted with the TAR. A copy must also be retained in the patient's record, or

e. The immediate family member who certifies that he/she will be most frequently visiting and helping with the personal needs of the patient cannot, because of established health reasons, travel to an FS/NF that is able and willing to accept the patient and is within thirty (30) minutes actual travel time. However, he/she is able to travel to the DP/NF. The *Family Certification* form at the end of this section must be completed and submitted with the TAR. A copy must also be retained in the patient's record, or

f. The patient has a spouse residing in the same DP/NF, or

g. The hospital's discharge planner, with input from the patient's physician, determines that the patient requires short-term nursing facility care for post-surgical rehabilitation or therapy services which are curative rather than palliative in nature, or

h. The patient was residing in a DP/NF on June 1, 1992 and was admitted prior to that date. For patients who have met this requirement and are later hospitalized, a TAR at the DP/NF rate will be reinstated if the patient returns to the same DP/NF during the statutory bed-hold period of seven (7) days. Otherwise, to reside in a DP/NF, the patient must meet the conditions set forth in this agreement unless the patient's attending physician documents that a transfer to a FS/NF would cause physical or psychological harm to the patient. This documentation (M.D. progress notes, letter, etc.) must be presented with the TAR, or

i. The patient is currently, at the time approval is sought, residing in a DP/NF and has been continuously residing in that DP/NF for at least 120 consecutive days, and payment has been made or approved during the last 120 consecutive days by Medicare, other health insurance, or Medi-Cal at a DP/NF rate. For patients who have met this requirement and are later hospitalized, a TAR at the DP/NF rate will be reinstated if the patient returns to the same DP/NF during the statutory bed-hold period of seven (7) days. Otherwise, to reside in a DP/NF, that patient must meet the conditions previously set forth unless the patient's attending physician documents that a transfer to a FS/NF would cause physical or psychological harm to the patient. This documentation (M.D. progress notes, letter, etc.) must be presented with the TAR.

Key Definitions

Reasonable Placement Efforts

For the purposes of this agreement "reasonable placement efforts" means that during the 25-day time period beginning with the date that approval for the Medi-Cal DP/NF rate is first sought, the hospital or DP/NF shall do the following:

1. Contact on a daily basis (not including Saturdays, Sundays or holidays) Medi-Cal certified FS/NFs within the applicable travel time to determine whether each such FS/NF is able and willing to take the patient. In meeting this requirement, facilities shall contact only those FS/NFs that they, in good faith, believe may be able and willing to accept the patient, taking into account previous contacts. FS/NFs within the applicable travel time are those within the appropriate travel time set forth under "TAR Criteria for DP/NF" on a previous page, and
2. Document that the facility spoke to a person responsible for admission decisions during each required contact, document the date and time of each contact with an FS/NF, document the name and title of each person to whom spoken, document the reason given for the FS/NF not being able or willing to accept the patient on the day contacted, and document the date, if any, when the FS/NF would be willing and able to accept the patient. (Refer to the *Call List For NF Placement* form at the end of this section), and
3. ‹‹Submit the documentation specified in #2 on a previous page at the conclusion of the 25-day placement effort period with the TAR››.
    a. Administrative days will be approved at hospitals seeking to place a patient into the hospital's own DP/NF for a patient determined to need long term skilled nursing facility care, subject to the placement efforts outlined in #1 and #2 on a previous page being met.

       If a contacted FS/NF was able and willing to accept the patient during the 25-day period, the hospital's *Treatment Authorization Request* (TAR) will be subsequently authorized for approval of administrative days up until the date the FS/NF accepts the patient. The administrative day TAR should indicate the name and type of accepting facility and the day of discharge from the acute hospital. If the basis on which DP/NF approval is sought is due to the lack of any FS/NF able and willing to take the patient after reasonable placement efforts, such approval will not be given for any days of care prior to the completion of the reasonable placement effort period. Acute administrative days may be approved prior to completion of the reasonable placement period. If it is established that no FS/NF within the applicable travel time will now or ever be able or willing to accept the patient, further placement efforts will not be required.

b. If a patient was admitted to a DP/NF from a non-hospital setting, such as home, residential care, FS/NF or from a hospital other than the DP's own hospital, or was a DP/NF resident who converted from another payment source (i.e., Medicare), a TAR will be approved at the DP/NF rate for a patient determined to need long term skilled nursing facility placement subject to the placement efforts outlined in #1 and #2 on a previous page being met. Documentation of placement efforts should be submitted with a TAR to the TAR Processing Center after the 25-day placement period is completed. There is no timeliness requirement.

   If a contacted FS/NF is able and willing to accept the patient during the 25-day reasonable placement effort period, the DP/NF's TAR will be subsequently authorized for approval at the DP/NF rate up until the date the FS/NF accepts the patient. The DP/NF TAR should indicate the name and type of accepting facility and the day of discharge from the DP/NF. If the basis on which DP/NF authorization is sought is due to the lack of any FS/NF able and willing to take the patient after reasonable placement efforts, such approval will not be given until after the completion of the reasonable placement efforts period. Days of care during the placement period will be authorized if all of the criteria set forth under "TAR Criteria For DP/NF" on a previous page have been met.

c. If a patient was admitted from the acute hospital to the hospital-based DP/NF and the required placement process has been completed and approved on the hospital's administrative day TAR, the DP/NF is not required to initiate new placement efforts. The DP/NF must indicate on the 20-1 TAR that Hudman v. Kizer criteria have been met by listing the TAR Control Number of the administrative day TAR. (For an example of an administrative day TAR for a hospital admitting a patient to its own DP/NF, refer to *Figure 1* on a following page.)

Note: Reasonable placement efforts are also applicable under the following circumstances:

- If Medicare, Other Health Coverage, or Medi-Cal has not paid for or approved a full 120 consecutive day stay, the DP/NF must make reasonable placement efforts as outlined in #1 and #2 on a previous page for the days not covered. For example, if only 100 days are covered, the DP/NF must make placement calls for the remaining 20 days. Documentation of placement efforts must be submitted with the TAR.
- If the patient is determined retroactively eligible for Medi-Cal, the DP/NF must make a reasonable placement effort for a 25-day period beginning the day notification of Medi-Cal eligibility is received. Documentation of placement efforts and date of notification of Medi-Cal eligibility must be submitted with the TAR.

Actual Travel Time

"Actual travel time" is the amount of time it would take a person to travel between two specific points by means of whatever transportation would be available to him/her, taking into account actual road and weather conditions.

Discharge Planning

If an acute hospital discharge planner plans to admit a patient to its own DP/NF, the admission must meet the criteria set forth under "TAR Criteria for DP/NF" before authorization will be approved.

For an example of a DP/NF TAR and a FS/NF TAR, refer to *Figures 2* and *3* on the following pages.

PASRR

‹‹Hudman v. Kizer has no impact on PASRR requirements and procedures. A General Acute Care Hospital should continue to perform PASRR for DP/NF admissions, including admissions to its own DP/NF.››

DP/NF Requests FS/NF Provider Number

If a DP/NF desires of its own volition to take, at the FS/NF rate, a patient needing skilled nursing care, the Department will approve a TAR submitted for authorization at that rate. In addition to their regular provider number, DP/NFs must obtain an FS/NF provider number for use on the TAR. A DP/NF objecting to the FS/NF rate in any other circumstance shall not be deemed to have waived its rights to administrative appeal and further review.

Questions should be directed to the TAR Processing Center,1-800-541-5555. See the *TAR Field Office Addresses* section for the address.

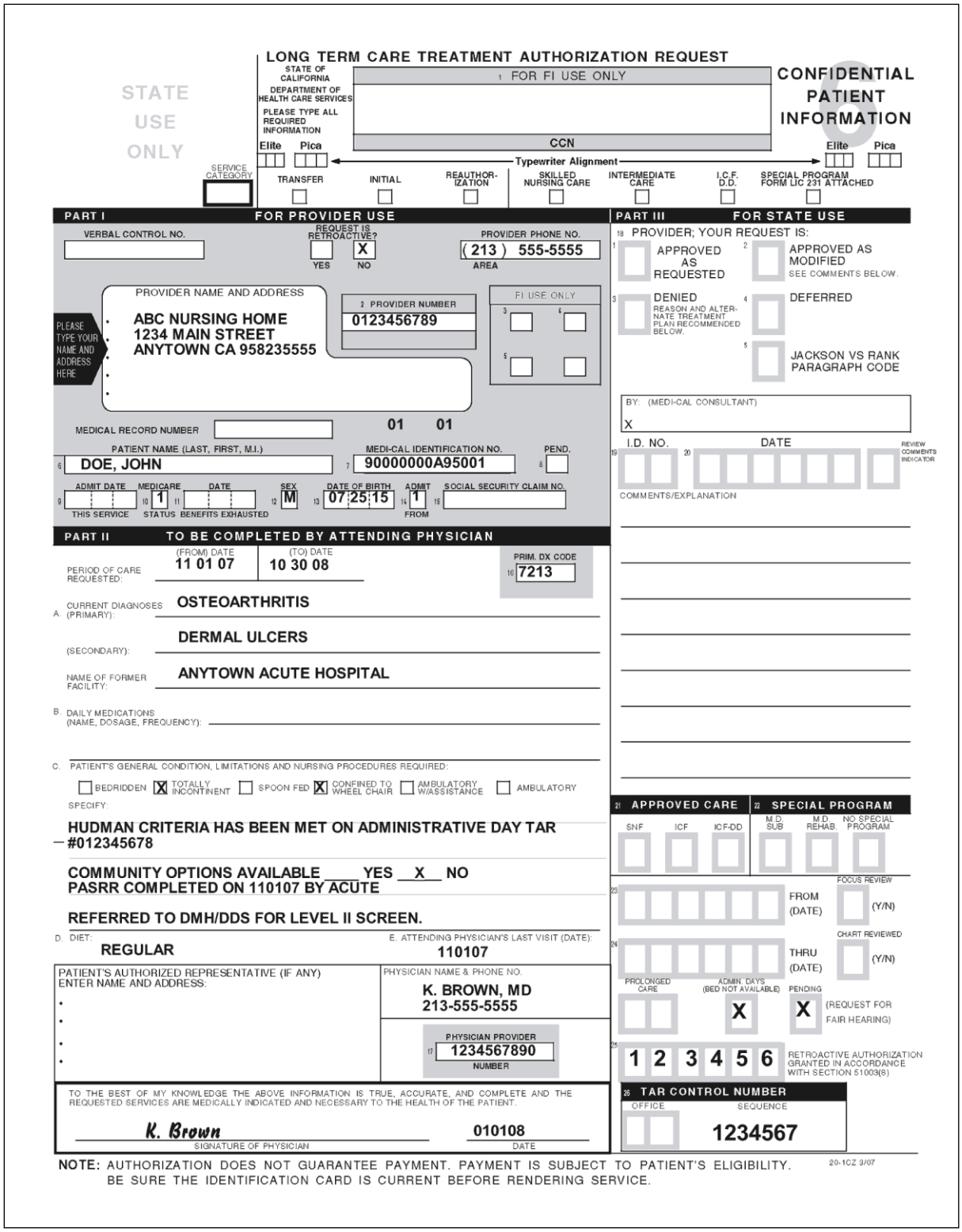
Forms

Medi-Cal Information Sheet for Hospital-Based Nursing Facility Patients

The *Medi-Cal Information Sheet For Hospital-Based Nursing Facility Patients* provides general information and placement criteria for admission in a distinct-part nursing facility. This material, in English and Spanish, should be given to the Medi-Cal recipient upon admission to the hospital's distinct-part nursing facility. The *Medi-Cal Information Sheet For Hospital-Based Nursing Facility Patients* is included at the end of this section and may be duplicated.

Other Forms

The *Family Certification* form, *Medical Certification* form and *Call List For NF Placement* form are located at the end of this section. Copies of these forms may be made and submitted as directed.



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 — Elite Pica

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 [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

01 01

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

MEDI-CAL IDENTIFICATION NO. 7 90000000A95001

PEND. 8

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

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE 11 01 07 (TO) DATE 10 30 08

PRIM. DX CODE 16 7213

A. CURRENT DIAGNOSES (PRIMARY): OSTEOARTHRITIS

(SECONDARY): DERMAL ULCERS

NAME OF FORMER FACILITY: ANYTOWN ACUTE HOSPITAL

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

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

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

SPECIFY:

HUDMAN CRITERIA HAS BEN MET ON ADMINISTRATIVE DAY TAR #012345678

COMMUNITY OPTIONS AVAILABLE ___ YES __X__ NO
PASRR COMPLETED ON 110107 BY ACUTE

REFERRED TO DMH/DDS FOR LEVEL II SCREEN.

D. DIET: REGULAR

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 110107

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

010108 — 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

21 APPROVED CARE: SNF [ ] ICF [ ] ICF-DD [ ]

22 SPECIAL PROGRAM: M.D. SUB [ ] M.D. REHAB. [ ] NO SPECIAL PROGRAM [ ]

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

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

PROLONGED CARE [ ] ADMIN. DAYS (BED NOT AVAILABLE) [X] PENDING [X] (REQUEST FOR FAIR HEARING)

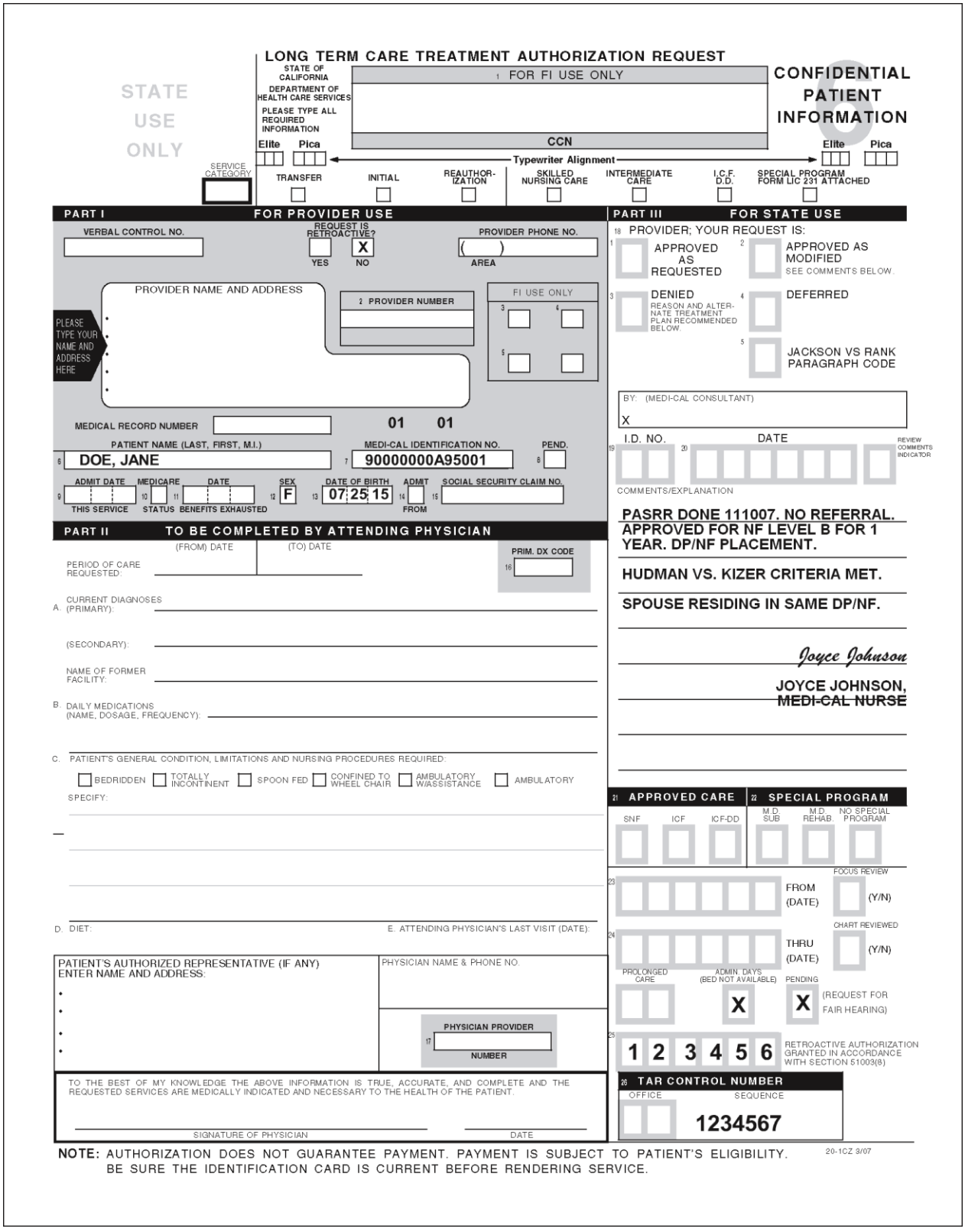
25 1 2 3 4 5 6 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

26 TAR CONTROL NUMBER
OFFICE SEQUENCE 1234567

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

20-1CZ 3/07

Figure 1: Administrative Day TAR for Hospital Admitting Patient to Its Own DP/NF



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

Elite Pica

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 [X]

PROVIDER PHONE NO. ( ) AREA

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

2 PROVIDER NUMBER

FI USE ONLY 3 4 5

MEDICAL RECORD NUMBER

01 01

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

MEDI-CAL IDENTIFICATION NO. 7 90000000A95001

PEND. 8

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

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE (TO) DATE

16 PRIM. DX CODE

A. CURRENT DIAGNOSES (PRIMARY):

(SECONDARY):

NAME OF FORMER FACILITY:

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

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:

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

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

PHYSICIAN NAME & PHONE NO.

17 PHYSICIAN PROVIDER NUMBER

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.

SIGNATURE OF PHYSICIAN 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

PASRR DONE 111007. NO REFERRAL.
APPROVED FOR NF LEVEL B FOR 1 YEAR. DP/NF PLACEMENT.

HUDMAN VS. KIZER CRITERIA MET.

SPOUSE RESIDING IN SAME DP/NF.

Joyce Johnson

JOYCE JOHNSON, ~~MEDI-CAL NURSE~~

21 APPROVED CARE: SNF | ICF | ICF-DD

22 SPECIAL PROGRAM: M.D. SUB | M.D. REHAB. | NO SPECIAL PROGRAM

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

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

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

25 1 2 3 4 5 6 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

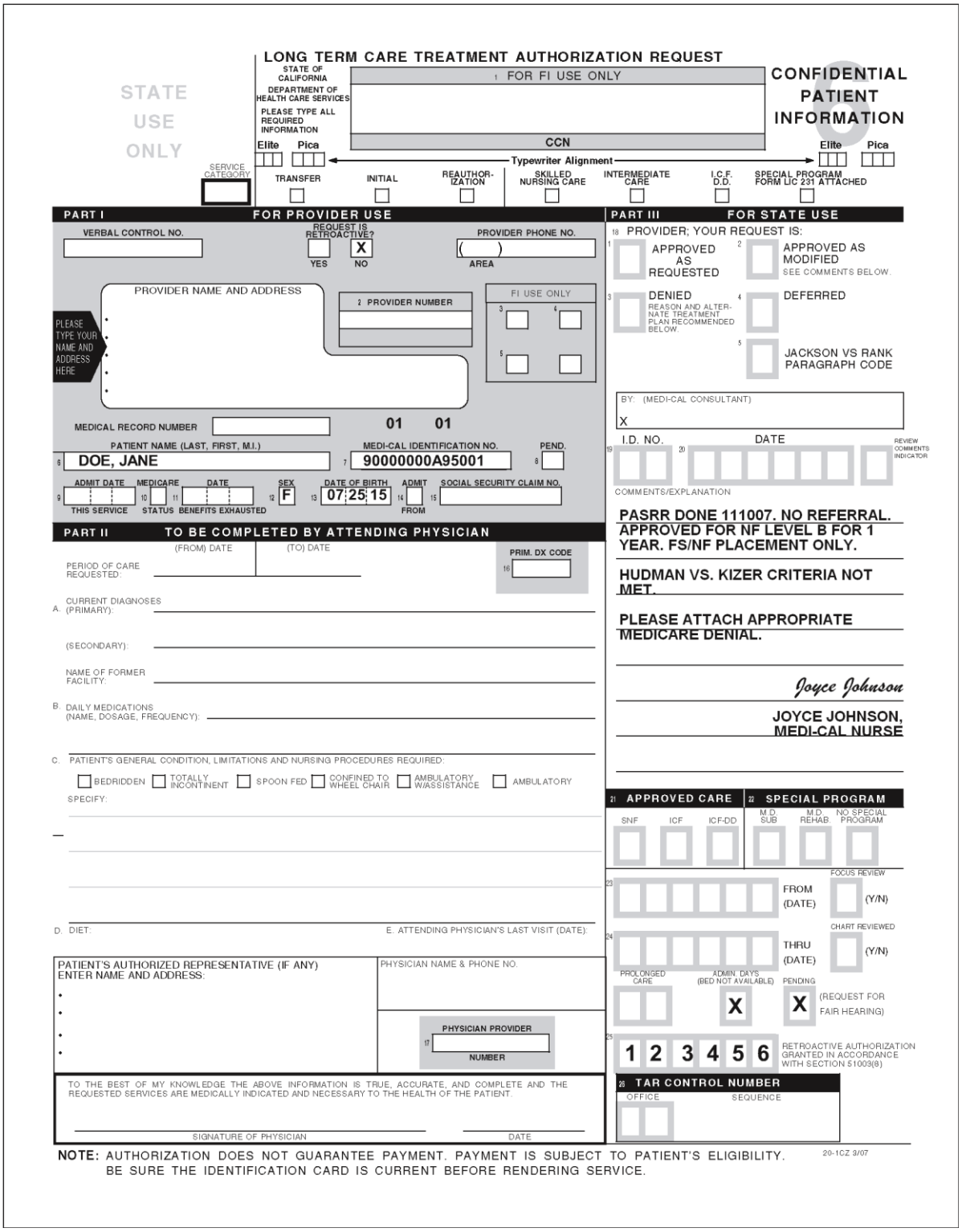
26 TAR CONTROL NUMBER
OFFICE SEQUENCE
1234567

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

20-1CZ 3/07

Figure 2: DP/NF TAR

Part 2 – TAR Criteria for DP/NF Authorization (Hudman v. Kizer)



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

Elite Pica

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 [X]

PROVIDER PHONE NO. ( ) AREA

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

2 PROVIDER NUMBER

FI USE ONLY 3 4 5

MEDICAL RECORD NUMBER

01 01

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

MEDI-CAL IDENTIFICATION NO. 7 90000000A95001

PEND. 8

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

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE (TO) DATE

PRIM. DX CODE 16

A. CURRENT DIAGNOSES (PRIMARY):

(SECONDARY):

NAME OF FORMER FACILITY:

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

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:

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

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

PHYSICIAN NAME & PHONE NO.

PHYSICIAN PROVIDER NUMBER 17

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.

SIGNATURE OF PHYSICIAN 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

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

COMMENTS/EXPLANATION

PASRR DONE 111007. NO REFERRAL. APPROVED FOR NF LEVEL B FOR 1 YEAR. FS/NF PLACEMENT ONLY.

HUDMAN VS. KIZER CRITERIA NOT MET.

PLEASE ATTACH APPROPRIATE MEDICARE DENIAL.

Joyce Johnson

JOYCE JOHNSON, MEDI-CAL NURSE

21 APPROVED CARE: SNF | ICF | ICF-DD

22 SPECIAL PROGRAM: M.D. SUB | M.D. REHAB. | NO SPECIAL PROGRAM

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

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

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

25 1 2 3 4 5 6 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

26 TAR CONTROL NUMBER: OFFICE | SEQUENCE

20-1CZ 3/07

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

Figure 3: FS/NF TAR

Part 2 – TAR Criteria for DP/NF Authorization (Hudman v. Kizer)

‹‹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.