TAR and Non-Standard Benefits: Introduction to List

Page updated: August 2026

Overview

‹‹*The* numerical/alphanumerical *Treatment Authorization Request* (TAR) and Non-Standard Benefit lists that follow this introductory policy section contain Health Insurance Portability and Accountability Act (HIPAA)-compliant Current Procedural Terminology (CPT®) Category I procedure codes, including Proprietary Laboratory Analyses (PLA) procedure codes, and Healthcare Common Procedure Coding System (HCPCS) procedure codes, along with applicable benefit restrictions.››

Note: Refer to the *HCPCS Introduction* section in this provider manual for an explanation of HCPCS.

Not all HIPAA-compliant CPT, PLA or HCPCS procedure codes may be listed in the ensuing *TAR and Non-Benefit* lists.

Refer to American Medical Association or Centers for Medicare & Medicaid Services publications for complete descriptions of the listed CPT, PLA and HCPCS procedure codes.

‹‹If Medi-Cal providers are uncertain about whether a specific non-standard benefit and corresponding procedure code are coverable by Medi-Cal, overridable with a TAR, subject to special billing requirements and/or other benefit restrictions, or believe that any of the numerical/alphanumerical *TAR and Non-Standard Benefit* lists (CPT, HCPCS or both) contain an error, they may reach out to one of the following:››

- For Medi-Cal coverage policy questions, Medi-Cal providers may contact the Department of Health Care Services' (DHCS') Benefits Division via email at Medi-Cal.Benefits@dhcs.ca.gov.
- For Medi-Cal claims, billing or authorization questions, Medi-Cal providers should contact DHCS' Telephone Service Center (TSC) at 1-800-541-5555.

‹‹Policy Scope

For purposes of this introductory policy section and all subsequent, numerical/alphanumerical *TAR and Non-Standard Benefit* lists (both CPT and HCPCS codes), the non-standard benefits (and corresponding procedure codes) must meet all of the following criteria to be within policy scope:

- They must be categorically coverable under a state Medicaid program (for example, Medi-Cal) based upon existing federal authorities,
- They must not be covered by Medi-Cal through another pathway or delivery system, such as a Medi-Cal waiver program or through the county behavioral health delivery system, and
- They must not be explicitly excluded from Medi-Cal coverage based upon current authority in state statute, regulations and/or California's federally approved Medicaid State Plan.

Note: For Medi-Cal members under age 21, DHCS adheres to the medical necessity requirements under the federal Early and Periodic, Screening, Diagnostic, and Treatment benefit.

Medical Benefits

This section and all subsequent, numerical/alphanumerical *TAR and Non-Standard Benefit* lists (both CPT and HCPCS codes) only apply to medical benefits billed on medical claims (for example, the CMS-1500, or electronic equivalent 837P) submitted directly to DHCS for Medi-Cal fee-for-service members or to Medi-Cal managed care plans for Medi-Cal managed care members.

Pharmacy Benefits

This section and all subsequent, numerical/alphanumerical *TAR and Non-Standard Benefit* lists (both CPT and HCPCS codes) do not apply to pharmacy benefits billed on pharmacy claims (for example, the National Council Prescription Drug Programs [NCPDP] standard form) to Medi-Cal Rx (for example, covered outpatient drugs identified by National Drug Code [NDC]).

Note: For pharmacy benefits billed on pharmacy claims (NCPDP standard form) by NDC, refer to the *Medi-Cal Rx Provider Manual* on the Medi-Cal Rx website for more information.››

Definitions

For purposes of this section, the following definitions apply to the “benefits restrictions” listed for each CPT, PLA or HCPCS procedure code:

Table of Benefit Restrictions and Definitions

Benefit Restriction	Definition
Non-Standard Benefit	‹‹The non-standard benefit and corresponding procedure code are not a standard, broad-based Medi-Cal covered benefit for the general Medi-Cal population (for example, they are in “deny” status in the fee-for-service billing system), but may be provided and reimbursed on a case-by-case basis for individual Medi-Cal members with an approved TAR demonstrating medical necessity, so long as all requirements in this policy section and any other applicable Medi-Cal policy sections are met. **Note:** Medi-Cal has not activated all CPT, PLA or HCPCS procedures codes associated with various covered Medi-Cal benefits, and there are a variety of reasons for this approach, which include, but are not limited to: • DHCS identifying alternative procedure codes that are to be used for the Medi-Cal benefit, or • The benefit is provided through an external contract or another delivery system other than Medi-Cal fee-for-service, which means it is not directly billed to the Medi-Cal fee-for-service delivery system. **Note:** Medi-Cal currently does not reimburse most CPT Category II or Category III procedure codes and does not publish a list of such procedure codes. If a provider believes that billing for a CPT Category II or Category III procedure code is medically necessary, they must submit a TAR prior to claim submission.››

Table of Benefit Restrictions and Definitions (continued)

Benefit Restriction	Definition
Requires TAR, Primary Surgeon/Provider	‹‹The benefit and corresponding procedure code are a Medi-Cal covered benefit (for example, they are in “pay” status in the fee-for-service billing system) that requires a TAR demonstrating medical necessity and is billable by the Primary Surgeon or Medi-Cal provider, whether performed on an inpatient or outpatient basis. **Note:** Separate reimbursement is available for Anesthesiologists and Assistant Surgeons who do not need a TAR for the same benefit billed with this procedure code.››
Assistant Surgeon Services Not Payable	‹‹The benefit and corresponding procedure code are a Medi-Cal benefit (for example, they are in “pay” status in the fee-for-service billing system), but Medi-Cal will not separately reimburse for Assistant Surgeon services billed with the corresponding procedure codes that have this restriction. **Note:** Medi-Cal providers may bill for Primary Surgeon/Provider services using the appropriate modifier(s). Providers may not bill the Assistant Surgeon modifier for such procedure codes.››

‹‹Requests for Adding Medi-Cal Benefits

Medi-Cal providers or other, external parties (for example, manufacturers of a particular product or service) may request that DHCS make a “non-standard benefit” and its corresponding procedure code a Medi-Cal covered benefit.

DHCS created the *Medi-Cal Benefit Request* (DHCS 8712) form, which must be completed by Medi-Cal providers or other, external parties who are requesting DHCS’ consideration for adding a particular benefit and corresponding procedure code(s) other than for a biomarker or pharmacogenetic test, as a Medi-Cal covered benefit. For biomarker or pharmacogenetic tests and corresponding procedure codes, Medi-Cal providers or other parties must use the *Medi-Cal Benefit Request: Biomarker and Pharmacogenetic Testing* (DHCS 7106) form, which is specific to these types of tests and corresponding procedure codes.

Completed forms and any supporting document or information must be submitted to DHCS electronically via email at dhcsmedicalpolicy@dhcs.ca.gov.

For more information on the two forms, including background and submission instructions, visit the Medi-Cal Benefits Division web page on the DHCS website.››

Inpatient Hospitalization Stay: Authorization Reminder

Authorization for an inpatient hospital stay may be required, even if the procedure being performed does not require a TAR. Refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in the *Inpatient Services* provider manual.

Authorization may be requested by either the Medi-Cal provider (for example, a physician/surgeon) performing the procedure or the hospital providing the inpatient stay.

‹‹Biomarker and Pharmacogenetic Testing

Medi-Cal covers medically necessary biomarker and pharmacogenomic testing, consistent with applicable state and federal requirements, and as described in the *Proprietary Laboratory Analyses (PLA)* and *Pathology: Molecular Pathology* sections of the Provider Manual. However, Medi-Cal may not cover all CPT, PLA or HCPCS procedure codes associated with particular biomarker or pharmacogenomic tests. In these cases, the particular biomarker or pharmacogenomic test and associated procedure code would be considered a “non-standard benefit” and all policy requirements under this section and any other applicable Medi-Cal policy section(s) would apply.››

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.