
TAR and Non-Standard Benefits: Introduction to List

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Overview

The *Treatment Authorization Request* (TAR) and Non-Standard Benefit lists that follow this 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. 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.

Note: 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 procedure code is a Medi-Cal covered benefit, uncertain whether a non-standard benefit procedure code is overridable with a TAR or subject to other benefit restrictions, uncertain about any authorization requirements or suspect that this procedure code list contains 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.

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	<p>The procedure code is not a standard Medi-Cal benefit for the general Medi-Cal population (for example, in “deny” status in the fee-for-service billing system), but the associated service may be provided with an approved TAR demonstrating medical necessity. Medi-Cal has not activated all CPT, PLA or HCPCS procedure codes associated with various covered Medi-Cal services, and there are a variety of reasons for this approach, which include, but are not limited to:</p> <ul style="list-style-type: none"> • DHCS identifying alternative procedure codes that are to be used for the Medi-Cal service, or • The service is provided through an external contract or delivery system other than fee-for-service, which means it is not required to directly bill the fee-for-service system. <p>Even with “non-standard benefit” procedure codes, Medi-Cal may cover and provide reimbursement for services associated with that procedure code on a case-by-case basis for individual Medi-Cal members based on a TAR demonstrating medical necessity submitted by the Medi-Cal provider.</p> <p>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 to claim submission.</p>

Table of Benefit Restrictions and Definitions (continued)

Benefit Restriction	Definition
Requires TAR, Primary Surgeon/Provider	<p>The procedure code is a Medi-Cal benefit (for example, 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.</p> <p>Note: Separate reimbursement is available for Anesthesiologists and Assistant Surgeons who do not need a TAR for the same procedure billed with this code.</p>
Assistant Surgeon Services Not Payable	<p>The procedure code is a Medi-Cal benefit (for example, in “pay” status in the fee-for-service billing system), but Medi-Cal will not separately reimburse for Assistant Surgeon services for procedure codes with this restriction.</p> <p>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 codes.</p>

Requests for Adding Procedure Codes as 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” procedure code a Medi-Cal benefit.

DHCS created the [Medi-Cal Benefit Request](#) (MBR) (DHCS 8712) form, which must be completed by Medi-Cal providers or other, external parties who are requesting DHCS’ consideration for adding a particular procedure code or codes, other than a biomarker or pharmacogenetic test procedure code, as a Medi-Cal benefit. For biomarker or pharmacogenetic tests and associated 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 associated procedure codes.

Completed MBR 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 MBR 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: Coverage Reminder

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” under this section and therefore may nevertheless be covered with an approved TAR demonstrating medical necessity.

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.