

## TAR Completion

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 field office consultant for certain procedures/services. For a list of CPT-4 procedures requiring a TAR, refer to the *TAR and Non-Benefit List* section in the appropriate Part 2 manual. For addresses and telephone numbers of designated Medi-Cal field offices for a geographic area or specific service, refer to the *TAR Field Office Addresses* section of this 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.)

### **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 local Medi-Cal field office, 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's 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.

### **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 field office 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](http://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 by the Medi-Cal field office.

**Drug Authorizations**

Authorization for drugs can be obtained by fax, eTAR or mail. Providers with fax capabilities can send drug TAR forms directly to the Northern or Southern Pharmacy sections. Providers submitting TARs to a Medi-Cal field office for approval of drugs and medical supplies must segregate the drugs on a separate TAR from the medical supply items. Providers must submit one TAR for drugs and a second TAR for medical supply items. Failure to follow this procedure may result in a denial by the Medi-Cal field office.

The Pharmacy sections will not accept telephone calls from providers to process verbal TARs for pharmaceutical services. Providers may refer to the *TAR Submission: Drug TARs* section in the Part 2 Pharmacy manual for more information about drug authorization requirements.

**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 field offices 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 field office 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.

tar comp  
4

STATE USE ONLY **1**

**5** TYPEWRITER ALIGNMENT Elite Pica

**CONFIDENTIAL PATIENT INFORMATION** **40** F.I. USE ONLY

FOR F.I. USE ONLY

**1A**

C C N

**TREATMENT AUTHORIZATION REQUEST** **43**

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

**FOR PROVIDER USE (PLEASE TYPE)**

VERBAL CONTROL NO. **1B**

TYPE OF SERVICE REQUESTED **2** DRUG OTHER

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MEDICARE ELIGIBLE? YES NO **2A**

PROVIDER PHONE NO. **2A**

PROVIDER NAME AND ADDRESS **2B**

3. PROVIDER NUMBER **3**

NAME AND ADDRESS OF PATIENT **4**

PATIENT NAME (LAST, FIRST, M.I.) **4**

MEDI-CAL IDENTIFICATION NO. **5**

SEX **7** AGE **8** DATE OF BIRTH **8**

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER (AREA)

PATIENT STATUS: HOME BOARD & CARE **8A**

SNF / ICF ACUTE HOSPITAL **8B**

DIAGNOSIS DESCRIPTION: **8B**

MEDICAL JUSTIFICATION: **8C**

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

**32A**

**33**

**FOR STATE USE**

33 PROVIDER; YOUR REQUEST IS:

1  APPROVED AS REQUESTED  DENIED  DEFERRED

2  APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)  JACKSON VS RANK PARAGRAPH CODE

BY: \_\_\_\_\_

I.D. # \_\_\_\_\_ MEDI-CAL CONSULTANT DATE \_\_\_\_\_ REVIEW COMMENTS INDICATOR

34 \_\_\_\_\_ 35 \_\_\_\_\_ 44 \_\_\_\_\_

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36 1 2 3 4 5 6 **36**

LINE NO.	APPROVED Y/M	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9 <input type="checkbox"/>	10 <input type="checkbox"/>	<b>10A</b>	<b>10B</b>	<b>11</b>	<b>12</b>	<b>12A</b>
2	13 <input type="checkbox"/>	14 <input type="checkbox"/>					
3	17 <input type="checkbox"/>	18 <input type="checkbox"/>					
4	21 <input type="checkbox"/>	22 <input type="checkbox"/>					
5	25 <input type="checkbox"/>	26 <input type="checkbox"/>					
6	29 <input type="checkbox"/>	30 <input type="checkbox"/>				<b>32</b>	

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.

**39A** SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED FROM DATE **37** DATE **38**

TAR CONTROL NUMBER

OFFICE **39** SEQUENCE NUMBER PI

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

50-1 03/07

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*.

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.

Item    Description

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.

		County code	Aid code
<b>MEDI-CAL IDENTIFICATION NO.</b>			
5	12345678905001		CD HEG KRT

**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.

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 the diagnosis and its corresponding code from the ICD-9-CM code book.

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<u>Item</u>	<u>Description</u>
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- |     |  |
|-----|--|
| 8C. | <b>MEDICAL JUSTIFICATION.</b> 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-9-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.

Drug Authorization Request  
Paper and Fax

If the TAR is requesting a drug, indicate in the *Medical Justification* field whether the request is for an initial, reauthorization, or prescription limit TAR.

For six-prescription limit requests, list the six drug claim lines that do not exceed the six-per-month claim line limit in the *Medical Justification* field. If additional space is necessary, the list of the six drug claim lines may be attached to the TAR.

For Schedule II and III Controlled Substance Drugs, include the prescriber's Drug Enforcement Agency (DEA) number in the *Medical Justification* field.

Providers using the fax process to request drug TAR authorization should include their fax number in the *Medical Justification* field. On requests submitted by a non-medical provider, the name and telephone number of the prescriber must also appear in the lower left corner of this section (for example, ABC Medical Supply, (916) 555-1111).

	<u>Item</u> <u>Description</u>
Percent Variance	<p data-bbox="646 338 1401 554">If requesting a percent variance, indicate the name of each drug and the percent variance in the bottom portion of the <i>Medical Justification</i> field. Percentage of variance may be requested for 1 through 998 percent of the authorized quantity. See the <i>TAR Submission: Drug TARs</i> section in the Part 2 <i>Pharmacy</i> manual for more information and a percent variance example.</p> <p data-bbox="602 583 1401 674">9. <b>AUTHORIZED YES/NO.</b> Leave blank. Consultant will indicate on the <i>Adjudication Response</i> (AR) if the service line item is authorized.</p> <p data-bbox="586 737 1401 827">10. <b>APPROVED UNITS.</b> Leave blank. Consultant will indicate on the AR the number of times that the procedure, item or days have been authorized.</p> <p data-bbox="570 890 1401 949">10A. <b>SPECIFIC SERVICES REQUESTED.</b> Indicate the name of the procedure, item or service.</p>

Pharmacy Providers

Indicate name, strength, principal labeler of the drug or medical supply, directions for use and quantity of item requested.

See the *TAR Submission: Drug TARs* section in the Part 2 *Pharmacy* manual for more information about billing drugs and a percent variance example.

TARs for HCPCS Code Conversions

On one service line, enter the old local code, the appropriate units and quantity for the service period before the code conversion effective date. On the following service line, enter the new Level II code, the appropriate units and quantity for the service period on and after the code conversion effective date.

For more information about code conversion TARs, see “Local-to-HCPCS Code Conversion Guidelines” in this section.

Item   Description

10B.   **UNITS OF SERVICE.** Leave blank.

Pharmacy Providers

Enter the total number of times authorization for the dispensed quantity is requested (for example, 3 = original + 2 refills).

11.   **NDC/UPN OR PROCEDURE CODE.** Enter the anticipated code (five-character HCPCS, five-digit CPT-4 [followed by a two-digit modifier 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."

Item    Description

11.    **NDC/UPN OR PROCEDURE CODE (continued)**

Pharmacy Providers

When requesting authorization for drugs, enter the NDC, Universal Product Number (UPN) or Health Related Items (HRI) code of the drug to be billed.

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:

<u>Package Number</u>	<u>Zero Fill</u>	<u>11-digit NDC</u>
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.

Only diabetic testing supplies, Family PACT (Planning, Access, Care and Treatment) contraceptive supply items, inhalant assistance devices, peak flow meters and enteral formulas may be billed through the Point of Service (POS) network by Pharmacy providers.

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Item   Description

12.   **QUANTITY.** Enter the number of times a procedure or service is requested. Drugs requested should have the amount to be dispensed on each fill. Enter the total number of tablets, capsules, volume of liquid (in mls) or quantity of ointments/creams (in grams).

Pharmacy Providers

The *Quantity* field (Box 12) accepts only whole numbers, up to five digits long. If the metric quantity is not a whole number, round up to the nearest whole number. For example, three 35.44 gm tubes of ointment result in a quantity of 106.32. The correct entry in the *Quantity* field would be 107.

**Note:** When determining the amount to include in the *Charges* field (Box 23) of the 30-1 claim form, providers should bill for the exact metric quantity, which would be 106.32 in the example above.

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.

- 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

Do not enter charges for drugs. For medical supply requests, enter the usual and customary fee for service(s).

- | <u>Item</u> | <u>Description</u>   |
|-------------|--|
| 13 – 32.    | <b>ADDITIONAL LINES 2 THROUGH 6.</b> Additional TAR Lines. You may request up to six drugs or supplies on one TAR form.  |
| 32A.        | <b>PATIENT’S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS.</b> 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. – 36.   | <b>FOR STATE USE.</b> Leave blank. Consultant’s determination and comments will be returned on the <i>Adjudication Response</i> (AR).<br><br><b>Note:</b> 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.   | <b>AUTHORIZATION IS VALID FOR SERVICES PROVIDED – FROM DATE/TO DATE.</b> Leave blank. The AR will indicate valid dates of authorization for this TAR.  |
| 39.         | <b>TAR CONTROL NUMBER.</b> 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. <u>Do not attach a copy of the AR to the claim form.</u><br><br>The TCN for a 50-1 TAR may serve as the initial admit TAR number on an elective admission for the hospital. |
| 39A.        | <b>SIGNATURE OF PHYSICIAN OR PROVIDER.</b> Form must be signed by the physician, pharmacist or authorized representative.  |
| 40. – 43.   | <b>F.I. USE ONLY.</b> Leave blank.   |

**Pharmacy TAR Tips**

Providers can expedite the processing of pharmacy TARs for drugs exceeding the six-per-month claim line limit as follows:

- For recipients on large drug regimens, attach to the TAR a cover letter or drug profile listing the entire regimen. (Six individual drugs can be requested on each TAR and multiple TARs can be submitted for each recipient.)
- Clearly state the medical necessity for requested drugs. List all drugs that have been tried or considered. As with all drug TARs, the drug(s) being requested must be appropriate for the recipient's diagnosis or treatment.
- Justify duplications for patients whose drug regimen includes more than one drug in the same therapeutic category.
- Double-check all information. Make sure the National Drug Code (NDC) is correct and includes 11 digits. TARs cannot be processed without the correct NDC number.
- If the drug(s) being requested includes Schedule II or III Controlled Substances, include the prescriber's Drug Enforcement Agency (DEA) number in the *Medical Justification* field. TARs will be deferred if the DEA number is not present.
- Providers may request a TAR to include the number of refills or the anticipated duration of therapy. For drugs that are required to be taken on a chronic basis, the Department of Health Care Services (DHCS) may authorize requests for up to one-year duration of therapy before authorization renewal is necessary.

**Local-to-HCPCS Code Conversion Guidelines**

HIPAA-mandated efforts requiring the code conversion of local billing codes to HCPCS codes happen with some frequency. Each code conversion effort affects specific benefit categories and provider communities, and has a specified effective date when the old codes are discontinued in favor of the HCPCS codes.

A TAR previously approved for local billing codes being converted to HCPCS codes may have a begin date that starts before and ends after the effective date of the code conversion. In such a case, the following guidelines apply for the "transition" TAR.

A 90-day grace period will be allowed beyond the code conversion effective date: providers can continue to submit claims using the old local codes until the end of the grace period. A TAR whose thru date goes beyond the 90-day grace period must be resubmitted to cover any remaining service beyond the grace period.

The provider should write the words "Code Conversion TAR" and the previously approved TAR number in the *Medical Justification* area (see example below).

After the end of the 90-day grace period, a TAR service line using only a local code will not be reimbursable.

MEDICAL JUSTIFICATION:  
**Code Conversion TAR: Previous TAR number: 12345678901.**

**Note:** If the resubmitted TAR is for the purpose of updating the codes for the same authorization period, it will not be reviewed for medical necessity. If the resubmitted TAR also extends the previously authorized service period, a new medical necessity review will be required.

TARs with affected codes submitted with a requested service period beginning on or after the effective date of a code conversion must use the HCPCS codes with the appropriate units and quantity fields filled in.

When local-to-HCPCS code conversions are announced, providers are encouraged to use the following guidelines for submitting TARs using codes being converted, and whose service period spans the effective date of the code conversion.

TARs submitted before the effective date should have the local code and the new HCPCS code on separate lines, with the appropriate units and quantity fields filled in for each line. For example, a provider submits a TAR with a service period from March 1, 2009 through August 31, 2009:

- On one service line, the old local code, the appropriate units and quantity are entered for the service period before the code conversion effective date.
- On the following service line, the new HCPCS code, the appropriate units and quantity are entered for the service period on and after the code conversion effective date.

LINE NO.	AUTHORIZED	APPROVED	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
	Y/R	UNITS					
1	9	10	Service Period 3/1/2009 thru 3/31/2009		11 Old Local "99" Code	12	\$
2	13	14	Service period 4/1/2009 thru 8/31/2009		15 New HCPCS II Code	16	\$