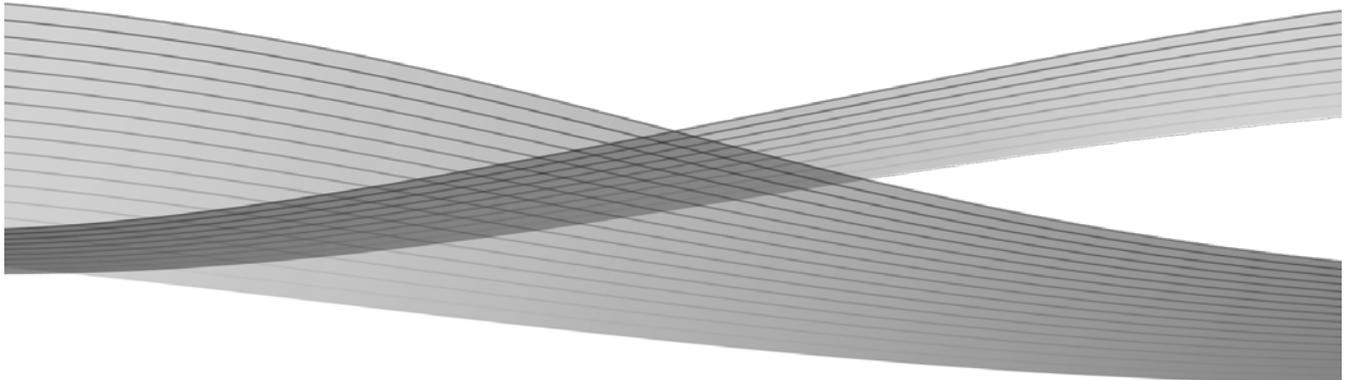




Treatment Authorization Request Medical User Guide 2016

Part 2





The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at <http://www.medi-cal.ca.gov/education.asp>.

Free Services for Providers

Provider Seminars and Webinars

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit

The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

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eTAR Medical User Guide

Module I: View TAR Responses

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Module J: Code Search

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Appendix A Medical Status Codes and Descriptions

Appendix B Functional Limitation Codes and Descriptions

Module E. TAR Summary, Submission & Cancellation

Section 1. TAR Summary

TAR Services

Add Service - Category Unknown
 * Service Code Search

[eTAR Medical Tutorials](#)

Please Select a Service Category
 When finished with all services, click [Submit TAR](#)

| DME Services | LTC Services | Inpatient Services | Outpatient Services | Other Services |
|--|--|---|---|---|
| <ul style="list-style-type: none"> • Apnea Monitor • Beds • Hearing Aid • Incontinence Supplies • IV Equipment • Medical Supplies • Mobility • Orthotics/ Prosthetics • Ox/Respiratory • Pumps (non-IV) • Other | <ul style="list-style-type: none"> • ICF-DD • NFA/NFB Non-Electronic MDS • Short Stay • Subacute | <ul style="list-style-type: none"> • Hospital Days • Hyperbaric Oxygen • Radiology • Surgical/Other Procedures • Transplant Procedure-Kidney • Transplant Procedure-Other | <ul style="list-style-type: none"> • Allergy • Cochlear Implants • CPSP • Dialysis • FPACT • HopTel • Hyperbaric Oxygen • Radiology • Office Visits - Restricted Provider • Office Visits - Restricted • Plasma Pheresis • Portable X-ray • Psychiatry • Surgical/Other Procedures • TeleMed • Transplant Acquisition | <ul style="list-style-type: none"> • AAC • ADHC • Detox • EPSDT Nutritional • Home Health • Hospice • Non-Pharmacy Issued Drug • Respiratory Therapy • Speech/ Occupational /Physical Therapy • Transportation • Vision - Contact Lens / Evaluation • Vision - Low Vision Aids • Vision - Other Eye Appliances |

1. Click **TAR Summary** to review, confirm or correct all information entered on the eTAR.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical Web pages.

TAR Summary, Submission & Cancellation

| Provider Information | | | | |
|--|---|--------------------------|---|---|
| Submitting Provider 0099097830 | Medicare Certified N | | | |
| Provider Name COMMUNITY MEDICAL CLINIC | Phone # (916)920-4606 | Fax # | | |
| Street/Mailing Address 3215 PROSPECT PARK DR | City RNCHO CORDOVA | State CA | Zip Code 95670 | |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | | |
| TAR Completed By M. Torres | | | | |
| 2 <input type="button" value="Update Provider Information"/> | | | | |
| Patient Information | | | | |
| Recipient ID 86754321A95001 | Patient Record # 01741 | | | |
| Special Handling | | | | |
| Last Name Doe | Date of Birth 10/24/1982 | | Gender Female | First Name Jane |
| Phone # (916)321-1234 | Worker's Comp? Unknown | | | |
| Miscellaneous TAR Information | | | | |
| Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | | |
| Last Name | First Name | | Gender | |
| Date Of Birth | | | | |
| Patient's Authorized Representative | | | | |
| Name | | | | |
| Street/Mailing Address | State | Zip Code | | |
| 3 <input type="button" value="Update Patient Information"/> | | | | |
| Service Information | | | | |
| 4 <input type="button" value="Update This Service"/> 5 <input type="button" value="Cancel This Service"/> | | | | |
| Temporary Service Number : 1 | | | | |
| Ind. Surgical/Other Procedure | Service Code 27457 | Modifiers TC | Side LEFT | |
| Service Description | Total Units 1 | From Date 11/10/2011 | Thru Date 12/24/2011 | |
| Admit Date/ Start of Care 11/02/2011 | | | | |
| POS Inpatient Hospital | ICD-CM Type ICD-9 | ICD Code 836.69 | Diagnosis Description | Date of Onset 11/05/2011 |
| Rendering Provider # 1999999990 | Price Indicator 0 - No special condition | | | |
| 6 <input type="button" value="Update Attachment A"/> | | | | |
| Patient Assessment Information (Attachment A) | | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight | |
| In-Home Assistance/Care Giver | | | | |
| Please list current functional limitation/physical condition codes | | | | |
| Please list previous functional limitation/physical condition codes | | | | |
| Please list current medical status codes relevant to requested service(s) | | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | | |
| Date Of Onset | | | | |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | | |
| Service Code | Describe Alternative Tried/Considered | | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | | |
| Prescribing Physician Information | | | | |
| Physician Prescription | | | | |
| Physician's License # | Physician's Name | | | |
| Physician's Phone | Prescription Date | | | |
| 7 <input type="button" value="Provider"/> 8 <input type="button" value="Submit TAR"/> | | | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | | |

Verify and correct all information before submitting the eTAR.

2. Click **Update Provider Information** or **Provider** to return to a specific page to add or edit previously submitted information.
3. Click **Update Patient Information** or **Patient** to return to a specific page to add or edit previously submitted information.
4. Click **Update This Service** to return to a specific page to add or edit previously submitted information.
5. Click **Cancel This Service** to cancel the service.
6. Click **Update Attachment A** to return to a specific page to add or edit previously submitted information.
7. Click **Services** to return to the TAR Services menu to add any additional services.
8. Click **Submit TAR** once all information is verified and completed.

Section 2. Submit eTAR

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

1 I will be uploading attachment(s) now

I will be uploading attachment(s) (within 8 hours)

I will be faxing attachment(s) now

I will be faxing attachment(s) (within 8 hours)

I will be mailing attachment(s) (within 5 days)

I will not be submitting attachment(s)

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

2
3

1. Click the circular **Attachment(s) Submission Option** radio button to reflect how and when the attachments will be submitted. If required attachments are not received within the specific time, the eTAR will be deferred or denied.
2. Click **Continue** to submit the eTAR for review.
3. Click **Return to Summary** to return to the TAR Summary page.

When selecting either **I will be faxing attachment(s) now** or **I will be faxing attachment(s) (within 8 hours)** a window appears to print a completed TAR 3 Attachment Form.

NOTE: Attachments may be submitted in hard copy via fax, U.S. mail, or online. See Module G for more information about faxing attachments.

TAR Summary, Submission & Cancellation

Thank You! Your TAR has been successfully submitted.
If you need to update this TAR, please wait 5 minutes.
* Prior Authorization Does Not Guarantee Claim Payment.

TAR #: 0511923806

Provider Information
Submitting Provider : 0099097830 Patient Record # : D1741

Windows Internet Explorer

Do you want to print a TAR Attachment form for the attachment(s)?
Before printing the TAR Attachment form, please confirm that the Provider FAX # field is completed accurately. Neglecting to do this may cause your attachment to be rejected.

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|---------------------|--------------------------|----------------------------|---------------------|
| 1 | Surgical/Other Procedure | 11102011 | 11242011 |
| Service Code | Modifiers | Service Description | Status |
| 27457 | TC | REALIGNMENT OF KNEE | In Review |
| Service # | Service Ind. | Requested From Date | Requested Thru Date |
| 2 | Surgical/Other Procedure | 11102011 | 11242011 |
| Service Code | Modifiers | Service Description | Status |
| 27457 | 26 | REALIGNMENT OF KNEE | In Review |

4. Click **OK** to print a copy of the TAR 3 Attachment Form. Confirm the information is correct prior to printing the form. Neglecting to do so may cause the eTAR to be deferred or denied.
5. Click **Cancel** if the print feature for the TAR 3 Attachment Form is not needed. See Module G for more information on the TAR 3 Attachment Form.

NOTE: If a window does not appear and the fax attachments option is selected, a pop-up blocker may be active.

TAR Attachment Form

TREATMENT AUTHORIZATION REQUEST - ATTACHMENT FORM
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

INTERNAL CONTROL NUMBER - FI USE ONLY

3

CONFIDENTIAL PATIENT INFORMATION PLEASE TYPE INFORMATION

PART I: PROVIDER INFORMATION

1 SUBMITTING PROVIDER # 2 PATIENT RECORD # 3 PROVIDER PHONE # 4 PROVIDER FAX #

5 PROVIDER NAME 10 MEDICARE CERTIFIED

6 PROVIDER STREET/MAILING ADDRESS 11 PROVIDER CONTACT NAME

7 CITY 8 STATE 9 ZIP CODE 12 PROVIDER CONTACT PHONE #

13 ORIGINAL TAR NUMBER 14 UPDATE RSN 15 SPCL HNDLG 16 RETRO RSN 17 RETRO DATE

PART II: PATIENT INFORMATION

31 MEDI-CAL IDENTIFICATION NUMBER 32 PATIENT NAME, LAST 33 FIRST 34 SEX 35 RES STAT 36 WRC

TO THE BEST OF MY KNOWLEDGE, THE ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER **DATE**

X

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

CONFIDENTIALITY NOTICE: This fax transmission is for the sole use of the intended recipient and may contain confidential and privileged information. Any unauthorized review or use, including disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the fax transmission.

All required fields populate automatically based on the information submitted on the eTAR. It is also possible to edit fields before printing the document. See Module G for instructions on additional fields

Print the TAR 3 Attachments Form and fax to 1-877-270-8779 from inside California, or (916) 384-9000 from outside California.

Mail attachments to:

Medi-Cal
P.O. Box 526011
Sacramento, CA 95852

NOTE: Overnight delivery or FedEx should not be used. A signature is required upon delivery and mailed attachments arrive to a P.O. Box.

TAR Summary, Submission & Cancellation

Thank You! Your TAR has been successfully submitted.
If you need to update this TAR, please wait 5 minutes.
* Prior Authorization Does Not Guarantee Claim Payment.

6 TAR #: 0511923806

Provider Information
Submitting Provider: 1234567890 Patient Record #: D1741

Patient Information
Recipient ID: 87654321A95001 Patient Name: JANE DOE

Service Information

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|---------------------|--------------------------|----------------------------|---------------------|
| 1 | Surgical/Other Procedure | 11102011 | 11242011 |
| Service Code | Modifiers | Service Description | Status |
| 27457 | TC | REALIGNMENT OF KNEE | In Review |

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|---------------------|--------------------------|----------------------------|---------------------|
| 2 | Surgical/Other Procedure | 11102011 | 11242011 |
| Service Code | Modifiers | Service Description | Status |
| 27457 | 26 | REALIGNMENT OF KNEE | In Review |

6. A TAR Control Number (TCN) confirms the eTAR was submitted for processing. It is important to note the TCN for future updates or inquiries.

NOTE: The TCN does not mean the eTAR is approved. The number verifies the eTAR was submitted for review. Once the eTAR is approved, the Pricing Indicator becomes the 11th digit of the TCN for submitting claims. See Module H for more information on the location of the Pricing Indicator.

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR #: 0511923806

7 **Provider Information**
 Submitting Provider: 1234567890 Patient Record #: D1741

8 **Patient Information**
 Recipient ID: 87654321A95001 Patient Name: JANE DOE

9 **Service Information**

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|------------------------------|---------------------------|-------------------------------------|------------------------|
| 1 | Surgical/Other Procedure | 11102011 | 11242011 |
| Service Code | Modifiers | Service Description | Status |
| 27457 | TC | REALIGNMENT OF KNEE | In Review |

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|------------------------------|---------------------------|-------------------------------------|------------------------|
| 2 | Surgical/Other Procedure | 11102011 | 11242011 |
| Service Code | Modifiers | Service Description | Status |
| 27457 | 26 | REALIGNMENT OF KNEE | In Review |

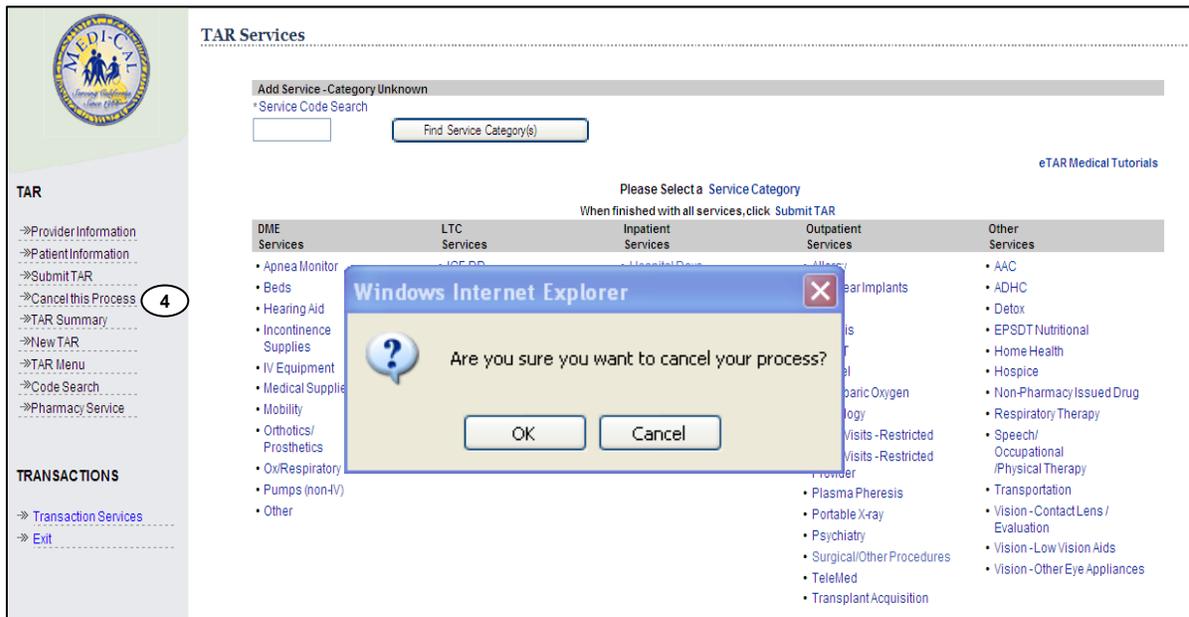
7. The **Provider Information** section verifies the submitting provider’s ID and the Patient Record Number.
8. The **Patient Information** section verifies the recipient’s ID and the name as submitted.
9. The **Service Information** section provides a brief summary of the eTAR services requested and the status for each service line.
10. In Review **Status** indicates the service line was submitted correctly. Rejected status indicates the service line was not submitted because of the reasons listed in the eTAR Confirmation window. To correct and resubmit, the service line must be updated. See Module F for information on updating eTAR services.

Section 3. Cancel from TAR Summary

| Patient Information | | Patient Record # | |
|--|---|--------------------------|-----------------------------------|
| Recipient ID | 86754321A95001 | Patient Record # | 01741 |
| Special Handling | | | |
| Last Name | First Name | | |
| Doe | Jane | | |
| Phone # | Date of Birth | Gender | Worker's Comp? |
| (916)321-1234 | 10241982 | Female | Unknown |
| Miscellaneous TAR Information | | | |
| Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason | Medicare/OHC Denial Date | Medicare/OHC Denial Certification |
| | Under 65, does not have Medicare Coverage | | No |
| | | | OHC Denial Reason |
| | | | No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | First Name | | |
| Date Of Birth | Gender | | |
| Patient's Authorized Representative Name | | | |
| Street/Mailing Address | | | |
| City | State | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> | | | |
| <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | | LEFT |
| Service Description | | | Thru Date |
| | | | 12242011 |
| Admit Date/Start of Care | Date of Onset | | |
| 11022011 | 11052011 | | |
| POS | ICD-CM Type | ICD-9 | |
| Inpatient Hospital | | | |
| Rendering Provider # | | | |
| 1999999990 | | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | Reason | |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | Physician's Name | | |
| Physician's Phone | Prescription Date | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

1. Click **Cancel This Service** to remove the individual service line from the eTAR.
2. Click **Cancel TAR** to cancel the entire eTAR.
3. Click **OK** to confirm canceling the eTAR. See Module F for information on canceling an existing eTAR.

Section 4. Cancel Submitted eTAR



4. Click **Cancel** this Process to cancel the eTAR currently being submitted.

- Click **OK** to confirm the cancellation.
- Click **Cancel** to continue the submission process.

5 Thank You! Your TAR has been cancelled as requested.
* Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923781

Provider Information
Submitting Provider : 1234567890 Patient Record # :

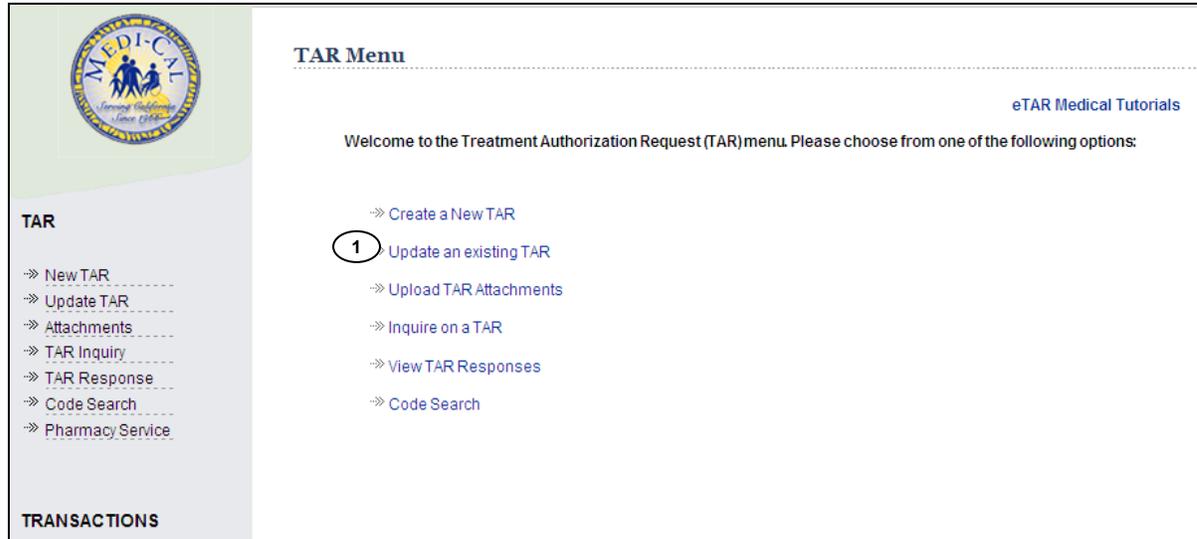
Patient Information
Recipient ID : 87654321A95001 Patient Name : JANE DOE

Service Information
Date & Time : 16-Sep-2011 16:03:01

5. This note confirms the eTAR was cancelled.

Module F. Update an Existing eTAR

Section 1. Update TAR



Only eTARs should be updated online. Wait at least five minutes after submitting the eTAR to submit an update. A denied or canceled TAR cannot be updated.

1. Select **Update an existing TAR**.

Do not use **Update an existing TAR** to update a paper TAR, a cancelled TAR or a denied TAR.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical Web pages.

Update an Existing eTAR

[eTAR Medical Tutorials](#)

Update TAR

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID #

* Original TAR #

* Update Reason

The Submitting Provider number used to log in to Transaction Services automatically populates. If an eTAR needs to be submitted under a different provider number, log out and log in using the correct provider number.

2. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
3. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
4. Use the **Update Reason** drop-down list to select update reason. *Always required.
 - *Add Service* – Used to add additional service lines to a previously submitted eTAR. If additional units are needed, see the update reasons Change in Service or Reauthorization.
 - *Aid Paid Pending* – Currently not in use.
 - *Cancel Individual Service(s)* – Used to cancel specific service lines on a previously submitted eTAR. Once a service is canceled, it should not be updated.
 - *Cancel TAR* – Used to cancel all services on a previously submitted eTAR. Once an eTAR is canceled, it should not be updated.
 - *Change in Service* – Used to update service information on an In Review, Approved or Modified eTAR. This information includes units, procedure codes, dates of service, and diagnosis information. If an extension of service is needed, the Reauthorization update reason should be used. If the service lines have had claims submitted successfully, the only fields that may be updated are units and dates.
 - *Correct Recipient ID* – Recipient information may only be changed with this update reason.
 - *Reauthorization* – Used to request additional units/days/length of care on a previously Approved or Modified eTAR. The only fields that may be changed are the units, thru date, and Miscellaneous TAR Information.
 - *Submit Freeform Attachments* – Used to submit attachments via upload or mail with the eTAR. No update needs to be completed if faxing attachments. Instead, use the TAR 3 Attachment Form as the cover sheet and when submitting attachments, send to 1-877-270-8779.

- *Update Deferred Service* – Used to update service information on a Deferred eTAR.
- *Update Rejected Service* – Used to update service information on a Rejected eTAR

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID #

* Original TAR #

* Update Reason

5

- Add Service
- Aid Paid Pending
- Cancel Individual Service(s)
- Cancel TAR
- Change in Service
- Correct Recipient ID
- Reauthorization
- Submit Freeform Attachments
- Update Deferred Service
- Update Rejected Service

[e Help](#) | [Medi-Ca](#)

5. Click **Update TAR** to continue updating the eTAR.

Section 2. Add Service

Update TAR

eTAR Medical Tutorials

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider# 1234567890

* Original Recipient ID#

* Original TAR#

* Update Reason

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system. *Always required.
3. Use the **Update Reason** drop-down list to select Add Service. *Always required.
4. Click **Update TAR** to add a service on an existing eTAR.

| | | | |
|--|---|---|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | N | | |
| Provider Name COMMUNITY MEDICAL CLINIC | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | Patient Record # | |
| Recipient ID 86754321A95001 | 01741 | | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information | | | |
| Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | OHC Denial Reason No Other Health Coverage | |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative Name | | | |
| Street/Mailing Address | | | |
| City | | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. Surgical/Other Procedure | Service Code 27457 | Modifiers TC | Side LEFT |
| Service Description | | Total Units 1 | From Date 11102011 |
| | | Thru Date 12242011 | |
| Admit Date/ Start of Care 11022011 | | | |
| POS Inpatient Hospital | ICD-CM Type ICD-9 | ICD Code 836.69 | Diagnosis Description |
| | | Date of Onset 11052011 | |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | Physician's Name | | |
| Physician's Phone | Prescription Date | | |
| 5 | | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

- Click **Services** at the bottom of the TAR Summary page to add a service line to the eTAR.

Update an Existing eTAR

Add Service - Category Unknown

* [Service Code Search](#)

6

7

Find Service Category(s)

eTAR Medical Tutorials

Please Select a Service Category

When finished with all services, click **Submit TAR**

| DME Services | LTC Services | Inpatient Services | Outpatient Services | Other Services |
|---|--|---|---|---|
| <ul style="list-style-type: none"> • Apnea Monitor • Beds • Hearing Aid • Incontinence Supplies • IV Equipment • Medical Supplies • Mobility • Orthotics/Prosthetics • Ox/Respiratory • Pumps (non-IV) • Other | <ul style="list-style-type: none"> • Bed Hold • ICF-DD • NFA/NFB Non-Electronic MDS • Short Stay • Subacute | <ul style="list-style-type: none"> • Hospital Days • Hyperbaric Oxygen • Radiology • Surgical/Other Procedures • Transplant Procedure-Kidney • Transplant Procedure-Other | <ul style="list-style-type: none"> • Allergy • Cochlear Implants • CPSP • Dialysis • FPACT • HopTel • Hyperbaric Oxygen • Radiology • Office Visits - Restricted • Office Visits - Restricted Provider • Plasma Pheresis • Portable X-ray • Psychiatry • Surgical/Other Procedures • TeleMed • Transplant Acquisition | <ul style="list-style-type: none"> • AAC • ADHC • Detox • EPSDT Nutritional • Home Health • Hospice • Non-Pharmacy Issued Drug • Respiratory Therapy • Speech/Occupational/Physical Therapy • Transportation • Vision - Contact Lens / Evaluation • Vision - Low Vision Aids • Vision - Other Eye Appliances |

6. Enter the service code in the **Service Code Search** field to identify the service to add to the TAR. If unknown, see Module J for additional information on Code Search.
7. Click **Find Service Category(s)** to initiate the search.

See Module D to Add a Service.

NOTE: TAR webpages do not have numbered fields.

January 2012

Section 3. Cancel Individual Service

Update TAR

[eTAR Medical Tutorials](#)

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider# 1234567890

* Original Recipient ID # 1

* Original TAR # 2

* Update Reason 3

4

This update reason is used when a specific service line needs to be canceled, but not the entire eTAR.

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
3. Use the **Update Reason** drop-down list to select Cancel Individual Service(s). *Always required.
4. Click **Update TAR** to cancel a service on an existing eTAR.

Update an Existing eTAR

| | | | |
|--|---|---|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | | N | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA |
| Contact Name Sandra Vallejo | | Contact Phone # (916)861-5567 | Zip Code 95670 |
| TAR Completed By Melissa Torres | | Contact Extension | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | | |
| Recipient ID 86754321A95001 | | Patient Record # 01741 | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | OHC Denial Reason No Other Health Coverage | |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative Name | | | |
| Street/Mailing Address | | | |
| City | | State | |
| | | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> 5 <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | | Total Units | From Date |
| | | 1 | 11102011 |
| Admit Date/ Start of Care | | Thru Date | |
| 11022011 | | 12242011 | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | |
| Date of Onset | | 11052011 | |
| Rendering Provider # | Price Indicator | | |
| 1999999990 | 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | | Physician's Name | |
| Physician's Phone | | Prescription Date | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

5. Click **Cancel This Service** next to the service that needs to be canceled. Once a service is canceled it should not be updated.

Attachment A

Service Information

* Service Code(HCPCS Code) **Modifiers (if applicable)**

Service Description (40 characters accepted)

* Total Units Ant. Length of Need /

From Date Thru Date * Start of Care Discharge Date

Discharge

Price Pricing Override Request MSRP

Place of Service

Rendering Provider #

* ICD-CM
Type * ICD Code (Decimal Required) Diagnosis Description Date of Onset

Enter Miscellaneous TAR Information (500 characters accepted)

Service

Only Miscellaneous TAR information may be changed.

6. Click **Continue**.

Update an Existing eTAR

| | | | |
|--|---|---|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | N | | |
| Provider Name COMMUNITY MEDICAL CLINIC | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | Patient Record # | |
| Recipient ID 86754321A95001 | 01741 | | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | OHC Denial Reason No Other Health Coverage | |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative | | | |
| Name | | | |
| Street/Mailing Address | | | |
| City | | State | |
| | | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | | Total Units | From Date |
| | | 1 | 11102011 |
| Admit Date/ Start of Care | | Thru Date | |
| 11022011 | | 12242011 | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | |
| | | | Date of Onset |
| | | | 11052011 |
| Rendering Provider # | Price Indicator | | |
| 199999990 | 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | Physician's Name | | |
| Physician's Phone | Prescription Date | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

7. Click **Submit TAR** to continue the cancellation of the specified service.

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

- I will be uploading attachment(s) now
- I will be uploading attachment(s) (within 8 hours)
- I will be faxing attachment(s) now
- I will be faxing attachment(s) (within 8 hours)
- I will be mailing attachment(s) (within 5 days)
- I will not be submitting attachment(s)

8

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) ? Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) ? Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

9 **10**

8. Select **I will not be submitting attachment(s)**.
9. Click **Continue**.
10. Click **Return to Summary** to return to the TAR Summary page.

Update an Existing eTAR

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923807

Provider Information
 Submitting Provider : 1234567890 Patient Record # :

Patient Information
 Recipient ID : 87654321A95001 Patient Name : JANE DOE

Service Information

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|-----------|--------------------------|---------------------|---------------------|
| 1 | Surgical/Other Procedure | | |

| Service Code | Modifiers | Service Description | Status |
|--------------|-----------|---------------------|--------------|
| 27457 | | REALIGNMENT OF KNEE | 11 In Review |

11. If the service line **Status** is “In Review”, the service line is canceled. See Section 9 of this Module if the status is rejected.

Section 4. Cancel TAR

Update TAR

[eTAR Medical Tutorials](#)

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID # 1

* Original TAR # 2

* Update Reason 3

4

This update reason is used to cancel an entire eTAR. Once an eTAR is canceled, it should not be updated.

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
3. Use the **Update Reason** drop-down list to select Cancel TAR. *Always required.
4. Click **Update TAR** to cancel an existing eTAR.

Update an Existing eTAR

Provider Information

| | | | | |
|--|---|---|---------------------------------|--------------------------|
| Submitting Provider 0099097830 | | Medicare Certified N | Phone # (916)920-4606 | Fax # |
| Provider Name COMMUNITY MEDICAL CLINIC | | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Street/Mailing Address 3215 PROSPECT PARK DR | | Contact Phone # (916)861-5567 | Contact Extension | |
| Contact Name Sandra Vallejo | TAR Completed By Melissa Torres | | | |

Patient Information

| | |
|---|--|
| Recipient ID 86754321A95001 | Patient Record # 01741 |
| Special Handling | |
| Last Name Doe | First Name Jane |
| Phone # (916)321-1234 | Date of Birth 10241982 |
| | Gender Female |
| Miscellaneous TAR Information Patient's surgery scheduled for | Worker's Comp? Unknown |
| Residence Status | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Pro Last Name | |
| Date Of Birth | |
| Patient's Authorized Representa Name | |
| Street/Mailing Address | |
| City | |

Service Information

Temporary Service Number : 1

| | | | |
|---|--|-----------------|-----------------------|
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | 11052011 |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | |

Patient Assessment Information (Attachment A)

P.O.T. Adherence Feeding Method Height Weight

In-Home Assistance/Care Giver

Please list current functional limitation/physical condition codes

Please list previous functional limitation/physical condition codes

Please list current medical status codes relevant to requested service(s)

| | | | |
|-------------|----------|-----------------------|---------------|
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
|-------------|----------|-----------------------|---------------|

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable)

If it is known that the patient has ever received the requested or similar service(s), please explain (include dates)

Please summarize the therapeutic goal to be met with the requested service(s)

Please list alternatives tried or considered and the reason why they are not feasible for this patient

| | | |
|--------------|---------------------------------------|--------|
| Service Code | Describe Alternative Tried/Considered | Reason |
|--------------|---------------------------------------|--------|

Please explain why the least costly method of treatment is not being used.

Prescribing Physician Information

Physician Prescription

| | |
|-----------------------|-------------------|
| Physician's License # | Physician's Name |
| Physician's Phone | Prescription Date |

5

Windows Internet Explorer

?

Are you sure you want to cancel your process?

6

OK

Cancel

5. Click **Cancel TAR** at the bottom of the TAR Summary screen to continue the cancellation of the eTAR. A confirmation window appears.

6. Select **OK** to cancel the eTAR.

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

- I will be uploading attachment(s) now
- I will be uploading attachment(s) (within 8 hours)
- I will be faxing attachment(s) now
- I will be faxing attachment(s) (within 8 hours)
- I will be mailing attachment(s) (within 5 days)
- I will not be submitting attachment(s)

7

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) ? Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) ? Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

8 **9**

7. Select **I will not be submitting attachment(s)**.
8. Click **Continue**.
9. Click **Return to Summary** to return to the TAR Summary page.

Update an Existing eTAR

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923807

Provider Information
 Submitting Provider : 1234567890 Patient Record # :

Patient Information
 Recipient ID : 87654321A95001 Patient Name : JANE DOE

Service Information

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|-----------|--------------------------|---------------------|---------------------|
| 1 | Surgical/Other Procedure | | |

| Service Code | Modifiers | Service Description | Status |
|--------------|-----------|---------------------|-----------|
| 27457 | | REALIGNMENT OF KNEE | In Review |

10. If the service line **Status** is “In Review”, the service line is canceled. Once the update has been processed, the status appears as approved with zero unit when inquiring on a TAR.

Section 5. Change in Service

Update TAR

[eTAR Medical Tutorials](#)

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID # 1

* Original TAR # 2

* Update Reason 3

4

This Update Reason is used to change service information on the eTAR.

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
3. Use the **Update Reason** drop-down list to select Change in Service. *Always required.
4. Click **Update TAR** to change a service on an existing eTAR.

Update an Existing eTAR

| | | | |
|--|---|---|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | | N | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA |
| Contact Name Sandra Vallejo | | Contact Phone # (916)861-5567 | Contact Extension |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | | |
| Recipient ID 86754321A95001 | | Patient Record # 01741 | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information | | | |
| Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative Name | | | |
| Street/Mailing Address | | | |
| City | | State | Zip Code |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| 5 <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | | Total Units | From Date |
| | | 1 | 11102011 |
| | | | Thru Date |
| | | | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | |
| | | | Date of Onset |
| | | | 11052011 |
| Rendering Provider # 199999990 | | Price Indicator 0 - No special condition | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | | Feeding Method | Height |
| In-Home Assistance/Care Giver | | | Weight |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | | Physician's Name | |
| Physician's Phone | | Prescription Date | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

5. Click **Update This Service** next to the service to be changed.

Update Reason
Change in Service

Service Code
Z8500

Modifiers

Service Description
ADHC REGULAR DAY OF SERVICE

Total Units
1

Schedule
MF selected

Frequency
2 / Week

From Date
02012008

Thru Date
02272008

Admit Date/Start of Care
02012008

Discharge Date
mmddyyyy

Admit From
Home

Discharge

ICD-CM Type
ICD-9

ICD Code (Decimal Required)
250.0

Diagnosis Description
DIABETES MELLITUS UNCOMP

Date of Onset
mmddyyyy

Pricing Override Request
0 - No special condition

Enter Miscellaneous TAR Information (500 characters accepted)

6

Make any updates to the selected service line. At least one field must be changed. If the service line had previous claims submitted successfully, the only fields that should be altered are units and dates.

6. Click **Continue**.

Update an Existing eTAR

| | | | |
|--|---|----------------------------------|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | | N | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA |
| Contact Name Sandra Vallejo | | Contact Phone # (916)861-5567 | Contact Extension |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | | |
| Recipient ID 86754321A95001 | | Patient Record # 01741 | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information | | | |
| Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative | | | |
| Name | | | |
| Street/Mailing Address | | | |
| City | | State | Zip Code |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | |
| Rendering Provider # 1999999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | | Physician's Name | |
| Physician's Phone | | Prescription Date | |
| 7 | | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

7. Click **Submit TAR** to continue updating the service.

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

- I will be uploading attachment(s) now
- I will be uploading attachment(s) (within 8 hours)
- I will be faxing attachment(s) now
- I will be faxing attachment(s) (within 8 hours)
- I will be mailing attachment(s) (within 5 days)
- I will not be submitting attachment(s)

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) ? Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) ? Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

9 **10**

8. Click the appropriate **Attachment(s) Submission Option** radio button.
9. Click **Continue**.
10. Click **Return to Summary** to return to the TAR Summary page.

Update an Existing eTAR

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923807

Provider Information
 Submitting Provider : 1234567890 Patient Record # :

Patient Information
 Recipient ID : 87654321A95001 Patient Name : JANE DOE

Service Information

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|-----------|--------------------------|---------------------|---------------------|
| 1 | Surgical/Other Procedure | | |

| Service Code | Modifiers | Service Description | Status |
|--------------|-----------|---------------------|-----------|
| 27457 | | REALIGNMENT OF KNEE | In Review |

11. If the service line **Status** is “In Review”, it has been successfully updated. See Section 9 of this module if the status is rejected.

Section 6. Correct Recipient ID

Update TAR

eTAR Medical Tutorials

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID #

* Original TAR #

* Update Reason

If an eTAR is Rejected due to the recipient ID being invalid, the provider must use Correct Recipient ID as the Update Reason, not Update Rejected Service.

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
3. Use the **Update Reason** drop-down list to select Correct Recipient ID. *Always required.
4. Click **Update TAR** to correct a recipient ID on an existing eTAR.

Update an Existing eTAR

| | | | | |
|--|---|---------------------------|--|---|
| Provider Information | | | | |
| Submitting Provider 0099097830 | | Medicare Certified N | | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | | |
| TAR Completed By Melissa Torres | | | | |
| <input type="button" value="Update Provider Information"/> | | | | |
| Patient Information | | | | |
| Recipient ID 86754321A95001 | | Patient Record # 01741 | | |
| Special Handling | | | | |
| Last Name Doe | | First Name Jane | | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown | |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | | |
| Last Name | | First Name | | |
| Date Of Birth | | Gender | | |
| Patient's Authorized Representative | | | | |
| Name | | | | |
| Street/Mailing Address | | | | |
| State | | Zip Code | | |
| <input type="button" value="Update Patient Information"/> | | | | |
| Service Information | | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | | |
| Temporary Service Number : 1 | | | | |
| Ind. Surgical/Other Procedure | Service Code 27457 | Modifiers TC | Side LEFT | |
| Service Description | Total Units 1 | From Date 11102011 | Thru Date 12242011 | |
| Admit Date/ Start of Care 11022011 | | | | |
| POS Inpatient Hospital | ICD-CM Type ICD-9 | ICD Code 836.69 | Diagnosis Description Date of Onset 11052011 | |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | | |
| <input type="button" value="Update Attachment A"/> | | | | |
| Patient Assessment Information (Attachment A) | | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight | |
| In-Home Assistance/Care Giver | | | | |
| Please list current functional limitation/physical condition codes | | | | |
| Please list previous functional limitation/physical condition codes | | | | |
| Please list current medical status codes relevant to requested service(s) | | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | | |
| Service Code | Describe Alternative Tried/Considered | | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | | |
| Prescribing Physician Information | | | | |
| Physician Prescription | | | | |
| Physician's License # | | Physician's Name | | |
| Physician's Phone | | Prescription Date | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | | |

5. Click **Update Patient Information** to update the Recipient ID.

Patient Information

eTAR Medical Tutorials

Please Enter Patient Information

* Recipient ID # Patient Record #

Special Handling

* Patient's Last Name * Patient's First Name

Phone # () - * Date of Birth * Male Female

* Work Related? No Yes Unknown

Residence Status

* Medicare Denial Reason

Medicare/OHC Denial Date * OHC Denial Reason

Mother/Transplant Recipient Providing Medi-Cal Eligibility

Last Name First Name

Date of Birth Male Female

Patient's Authorized Representative

Name

Street/Mailing Address

City State Zip Code

7

6. Update the **Recipient ID** as necessary. Recipient information may also be updated as needed in conjunction with the Recipient ID.

7. Click **Continue**.

NOTE: Recipient information may only be changed with this update reason.

Update an Existing eTAR

| | | | |
|---|---|--------------------------|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | N | | |
| Provider Name COMMUNITY MEDICAL CLINIC | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | Patient Record # | |
| Recipient ID 86754321A95001 | 01741 | | |
| Special Handling | | | |
| Last Name Doe | First Name Jane | | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information | | | |
| Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | First Name | | |
| Date Of Birth | Gender | | |
| Patient's Authorized Representative | | | |
| Name | | | |
| Street/Mailing Address | | | |
| City | State | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | |
| | | | Date of Onset 11052011 |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | Physician's Name | | |
| Physician's Phone | Prescription Date | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="8"/> <input type="button" value="Submit TAR"/> | | | |

8. Click **Submit TAR** to continue to correct the Recipient ID.

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

- I will be uploading attachment(s) now
- I will be uploading attachment(s) (within 8 hours)
- I will be faxing attachment(s) now
- I will be faxing attachment(s) (within 8 hours)
- I will be mailing attachment(s) (within 5 days)
- I will not be submitting attachment(s)

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) ? Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) ? Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

10 **11**

9. Click the appropriate **Attachment(s) Submission Option** radio button.

10. Click **Continue**.

11. Click **Return to Summary** to return to the TAR Summary screen.

Update an Existing eTAR

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923807

Provider Information
 Submitting Provider : 1234567890 Patient Record # :

Patient Information
 Recipient ID : 87654321A95001 Patient Name : JANE DOE

Service Information

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|-----------|--------------------------|---------------------|---------------------|
| 1 | Surgical/Other Procedure | | |

| Service Code | Modifiers | Service Description | Status |
|--------------|-----------|---------------------|-----------|
| 27457 | | REALIGNMENT OF KNEE | In Review |

12. The eTAR displays the updated recipient information. No service information is displayed. Repeat this process if the status is rejected.

Section 7. Reauthorization

Update TAR

eTAR Medical Tutorials

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID #

* Original TAR #

* Update Reason | Reauthorization

This update reason is used when additional units and extended dates are needed on an Approved or Modified TAR with paid claims. Some service categories do not allow reauthorizations for existing service lines. See the Provider Manual to determine if a reauthorization update is allowed for specific service categories.

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
3. Use the **Update Reason** drop-down list to select Reauthorization. *Always required.
4. Click **Update TAR** to reauthorize an existing eTAR.

Update an Existing eTAR

| | | | | |
|--|---|---------------------------|---|---|
| Provider Information | | | | |
| Submitting Provider 0099097830 | | Medicare Certified N | | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | | |
| TAR Completed By Melissa Torres | | | | |
| <input type="button" value="Update Provider Information"/> | | | | |
| Patient Information | | | | |
| Recipient ID 86754321A95001 | | Patient Record # 01741 | | |
| Special Handling | | | | |
| Last Name Doe | | First Name Jane | | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown | |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | | |
| Last Name | | First Name | | |
| Date Of Birth | | Gender | | |
| Patient's Authorized Representative | | | | |
| Name | | | | |
| Street/Mailing Address | | | | |
| City | | State | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | | |
| Service Information | | | | |
| 5 <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | | |
| Temporary Service Number : 1 | | | | |
| Ind. | Service Code | Modifiers | | Side |
| Surgical/Other Procedure | 27457 | TC | | LEFT |
| Service Description | Total Units | From Date | Thru Date | |
| | 1 | 11102011 | 12242011 | |
| Admit Date/ Start of Care 11022011 | | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description | |
| Inpatient Hospital | ICD-9 | 836.69 | Date of Onset 11052011 | |
| Rendering Provider # 1999999990 | Price Indicator 0 - No special condition | | | |
| <input type="button" value="Update Attachment A"/> | | | | |
| Patient Assessment Information (Attachment A) | | | | |
| P.O.T. Adherence | | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | | |
| Please list current functional limitation/physical condition codes | | | | |
| Please list previous functional limitation/physical condition codes | | | | |
| Please list current medical status codes relevant to requested service(s) | | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | | Date of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | | |
| Service Code | Describe Alternative Tried/Considered | | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | | |
| Prescribing Physician Information | | | | |
| Physician Prescription | | | | |
| Physician's License # | | Physician's Name | | |
| Physician's Phone | | Prescription Date | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | | |

5. Click **Update This Service** next to the service that needs to be reauthorized.

Please Enter Service Information.

Service Information
 Service Number
 1
 Update Reason
 Reauthorization
 Service Code
 Z8500
 Modifiers
 Service Description
 ADHC REGULAR DAY OF SERVICE
 Total Units
 1
 Schedule
 MF selected
 Frequency
 2 / Week
 From Date
 02012008
 Thru Date
 02272009
 Admit Date/Start of Care
 02012008
 Discharge Date
 mmddyyyy
 Admit From
 Home
 Discharge
 ICD-CM Type
 ICD-9
 ICD Code (Decimal Required)
 250.0
 Diagnosis Description
 DIABETES MELLITUS UNCOMP
 Date of Onset
 mmddyyyy
 Pricing Override Request
 0 - No special condition
 Enter Miscellaneous TAR Information (500 characters accepted)
 Continue

6. In the **Total Units** field, new units requested must be added in with the existing approved units.
7. In the **Thru Date** field, enter the extended thru dates of service.
8. Click **Continue**.

NOTE: Services specific to LTC do not have a Total Units field to accumulate units. Only the **Thru Date** and **Enter Miscellaneous TAR Information** fields will be changeable.

Update an Existing eTAR

| | | | |
|--|---|----------------------------------|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | | N | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA |
| Contact Name Sandra Vallejo | | Contact Phone # (916)861-5567 | Contact Extension |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | | |
| Recipient ID 86754321A95001 | | Patient Record # 01741 | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information | | | |
| Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative | | | |
| Name | | | |
| Street/Mailing Address | | | |
| City | | State | |
| | | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | |
| | | | Date of Onset 11052011 |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | | Physician's Name | |
| Physician's Phone | | Prescription Date | |
| 9 | | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

9. Click **Submit TAR** to continue the reauthorization.

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

- I will be uploading attachment(s) now
- I will be uploading attachment(s) (within 8 hours)
- I will be faxing attachment(s) now
- I will be faxing attachment(s) (within 8 hours)
- I will be mailing attachment(s) (within 5 days)
- I will not be submitting attachment(s)

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) ? Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) ? Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

11 **12**

10. Click the appropriate **Attachment(s) Submission Option** radio button.

11. Click **Continue**.

12. Click **Return to Summary** to return to the TAR Summary screen.

Update an Existing eTAR

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923807

Provider Information
 Submitting Provider : 1234567890 Patient Record # :

Patient Information
 Recipient ID : 87654321A95001 Patient Name : JANE DOE

Service Information

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|-----------|--------------------------|---------------------|---------------------|
| 1 | Surgical/Other Procedure | | |

| Service Code | Modifiers | Service Description | Status |
|--------------|-----------|---------------------|--------------|
| 27457 | | REALIGNMENT OF KNEE | 13 In Review |

13. If the service line **Status** is “In Review”, it has been successfully updated. See Section 9 of this Module if the status is rejected.

Section 8. Update Deferred Service

Update TAR

[eTAR Medical Tutorials](#)

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID #

* Original TAR #

* Update Reason

This update reason is used to change information on an eTAR that has been Deferred by the field office. If the eTAR was only Deferred for lack of attachments, submit the attachments and the system will automatically update the eTAR.

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
3. Use the **Update Reason** drop-down list to select Update Deferred Service. *Always required.
4. Click **Update TAR** to continue updating a Deferred service on an existing eTAR.

Update an Existing eTAR

| | | | |
|--|---|----------------------------------|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | | N | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA |
| Contact Name Sandra Vallejo | | Contact Phone # (916)861-5567 | Zip Code 95670 |
| TAR Completed By Melissa Torres | | Contact Extension | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | Patient Record # | |
| Recipient ID 86754321A95001 | | 01741 | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative Name | | | |
| Street/Mailing Address | | | |
| City | State | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| 5 | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | Date of Onset 11052011 |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | | Physician's Name | |
| Physician's Phone | | Prescription Date | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

5. Click **Update This Service** above the deferred service that needs to be updated.

Please Enter Service Information.

Service Information
Service Number
1

Update Reason
Update Deferred Service

Service Code
Z8500

Modifiers

Service Description
ADHC REGULAR DAY OF SERVICE

Total Units
1

Schedule
MF selected

Frequency
2 / Week

From Date
02012008

Thru Date
02272008

Admit Date/Start of Care
02012008

Discharge Date
mmddyyyy

Admit From
Home

Discharge

ICD-CM Type
ICD-9

ICD Code (Decimal Required)
250.0

Diagnosis Description
DIABETES MELLITUS UNCOMP

Date of Onset
mmddyyyy

Pricing Override Request
0 - No special condition

Enter Miscellaneous TAR Information (500 characters accepted)

6 Service Continue

Change the information on the selected service line that was deferred.

6. Click **Continue**.

Update an Existing eTAR

| | | | |
|---|---|--------------------------|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | N | | |
| Provider Name COMMUNITY MEDICAL CLINIC | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | | |
| Recipient ID 86754321A95001 | Patient Record # 01741 | | |
| Special Handling | | | |
| Last Name Doe | First Name Jane | | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | First Name | Gender | |
| Date Of Birth | | | |
| Patient's Authorized Representative | | | |
| Name | | | |
| Street/Mailing Address | | | |
| City | State | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | Date of Onset 11052011 |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | Physician's Name | | |
| Physician's Phone | Prescription Date | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="7"/> <input type="button" value="Submit TAR"/> | | | |

7. Click **Submit TAR** to continue updating the eTAR.

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

- I will be uploading attachment(s) now
- I will be uploading attachment(s) (within 8 hours)
- I will be faxing attachment(s) now
- I will be faxing attachment(s) (within 8 hours)
- I will be mailing attachment(s) (within 5 days)
- I will not be submitting attachment(s)

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) ? Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) ? Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

9 **10**

8. Click the appropriate **Attachment(s) Submission Option** radio button.

9. Click **Continue**.

10. Click **Return to Summary** to return to the TAR Summary screen.

Update an Existing eTAR

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923807

Provider Information
 Submitting Provider : 1234567890 Patient Record # :

Patient Information
 Recipient ID : ----- Patient Name :

Service Information

| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|-----------|--------------------------|---------------------|---------------------|
| 1 | Surgical/Other Procedure | | |

| Service Code | Modifiers | Service Description | Status |
|--------------|-----------|---------------------|-----------|
| 27457 | | REALIGNMENT OF KNEE | In Review |

11. If the service line **Status** is “In Review”, it has been successfully updated. See Section 9 of this Module if the status is rejected.

Section 9. Update Rejected Service

Update TAR

eTAR Medical Tutorials

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # 1234567890

* Original Recipient ID #

* Original TAR #

* Update Reason

This update reason is used to correct Rejected service lines.

1. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
2. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
3. Use the **Update Reason** drop-down list to select Update Rejected Service. *Always required.
4. Click **Update TAR** to update a Rejected service on an existing eTAR.

NOTE: If the rejected message is due to the Recipient ID being invalid, the provider must use Correct Recipient ID as the update reason

Update an Existing eTAR

| | | | |
|--|---|----------------------------------|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | | N | |
| Provider Name COMMUNITY MEDICAL CLINIC | | Phone # (916)920-4606 | Fax # |
| Street/Mailing Address 3215 PROSPECT PARK DR | | City RNCHO CORDOVA | State CA |
| Contact Name Sandra Vallejo | | Contact Phone # (916)861-5567 | Zip Code 95670 |
| TAR Completed By Melissa Torres | | Contact Extension | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | | |
| Recipient ID 86754321A95001 | | Patient Record # 01741 | |
| Special Handling | | | |
| Last Name Doe | | First Name Jane | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | | First Name | |
| Date Of Birth | | Gender | |
| Patient's Authorized Representative Name | | | |
| Street/Mailing Address | | | |
| City | | State | Zip Code |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| 5 <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | Date of Onset 11052011 |
| Rendering Provider # 1999999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | | Physician's Name | |
| Physician's Phone | | Prescription Date | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

5. Click the **Update This Service** to continue updating the rejected service.

Please Enter Service Information.

Service Information
Service Number
1

Update Reason
Update Rejected Service

Service Code
7850d

Modifiers

Service Description
ADHC REGULAR DAY OF SERVICE

Total Units
1

Schedule
MF selected

Frequency
2 / Week

From Date
02012008

Thru Date
02272008

Admit Date/Start of Care
02012008

Discharge Date
mmddyyyy

Admit From
Home

Discharge

ICD-CM Type
ICD-9

ICD Code (Decimal Required)
250.0

Diagnosis Description
DIABETES MELLITUS UNCOMP

Date of Onset
mmddyyyy

Pricing Override Request
0 - No special condition

Enter Miscellaneous TAR Information (500 characters accepted)

Service **6** Continue

Change information on the selected service line that was rejected.

6. Click **Continue**.

Update an Existing eTAR

| | | | |
|--|---|--------------------------|---|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | N | | |
| Provider Name COMMUNITY MEDICAL CLINIC | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name Sandra Vallejo | Contact Phone # (916)861-5567 | Contact Extension | |
| TAR Completed By Melissa Torres | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | Patient Record # | |
| Recipient ID 86754321A95001 | 01741 | | |
| Special Handling | | | |
| Last Name Doe | First Name Jane | | |
| Phone # (916)321-1234 | Date of Birth 10241982 | Gender Female | Worker's Comp? Unknown |
| Miscellaneous TAR Information Patient's surgery scheduled for 11/11/11. Will also need 2 days of inpatient hospital stay for monitored recovery time. | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | First Name | | |
| Date Of Birth | Gender | | |
| Patient's Authorized Representative Name | | | |
| Street/Mailing Address | | | |
| City | State | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. | Service Code | Modifiers | Side |
| Surgical/Other Procedure | 27457 | TC | LEFT |
| Service Description | Total Units | From Date | Thru Date |
| | 1 | 11102011 | 12242011 |
| Admit Date/ Start of Care 11022011 | | | |
| POS | ICD-CM Type | ICD Code | Diagnosis Description |
| Inpatient Hospital | ICD-9 | 836.69 | |
| | | | Date of Onset 11052011 |
| Rendering Provider # 199999990 | Price Indicator 0 - No special condition | | |
| <input type="button" value="Update Attachment A"/> | | | |
| Patient Assessment Information (Attachment A) | | | |
| P.O.T. Adherence | Feeding Method | Height | Weight |
| In-Home Assistance/Care Giver | | | |
| Please list current functional limitation/physical condition codes | | | |
| Please list previous functional limitation/physical condition codes | | | |
| Please list current medical status codes relevant to requested service(s) | | | |
| ICD-CM Type | ICD Code | Diagnosis Description | Date Of Onset |
| Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) | | | |
| If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) | | | |
| Please summarize the therapeutic goal to be met with the requested service(s) | | | |
| Please list alternatives tried or considered and the reason why they are not feasible for this patient | | | |
| Service Code | Describe Alternative Tried/Considered | | Reason |
| Please explain why the least costly method of treatment is not being used. | | | |
| Prescribing Physician Information | | | |
| Physician Prescription | | | |
| Physician's License # | Physician's Name | | |
| Physician's Phone | Prescription Date | | |
| <input type="button" value="Provider"/> <input type="button" value="Patient"/> <input type="button" value="Services"/> <input type="button" value="Cancel TAR"/> <input type="button" value="Submit TAR"/> | | | |

7. Click **Submit TAR** to continue updating the rejected service.

Treatment Authorization Request

[eTAR Medical Tutorials](#)

Attachment(s) Submission Option:

- I will be uploading attachment(s) now
- I will be uploading attachment(s) (within 8 hours)
- 8** I will be faxing attachment(s) now
- I will be faxing attachment(s) (within 8 hours)
- I will be mailing attachment(s) (within 5 days)
- I will not be submitting attachment(s)

FAX in California (877)270-8779 - FAX outside of California (916)384-9000

IMPORTANT: You must ALWAYS use the TAR 3, Treatment Authorization Request (TAR) ? Attachment Form as the FAX cover sheet when FAXing eTAR attachments.

To order additional TAR 3, Treatment Authorization Request (TAR) ? Attachment Forms please call: (800) 541-5555 and follow the prompts for eTAR.

NOTE: TARs will be deferred if attachments are not received within the time stated above.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

9 **10**

If the eTAR was originally Rejected and a fax option was selected, the TAR 3 Attachment Form will not display. To view the TAR 3 Attachment Form, a fax option must be selected again.

8. Click the appropriate circular **Attachment(s) Submission Option** radio button.
9. Click **Continue**.
10. Click **Return to Summary** to return to the TAR Summary page.

Update an Existing eTAR

Thank You! Your TAR has been successfully submitted.
 If you need to update this TAR, please wait 5 minutes.
 * Prior Authorization Does Not Guarantee Claim Payment.

TAR # : 0511923807

Provider Information
 Submitting Provider : 1234567890 Patient Record # :

Patient Information
 Recipient ID : 87654321A95001 Patient Name : JANE DOE

Service Information

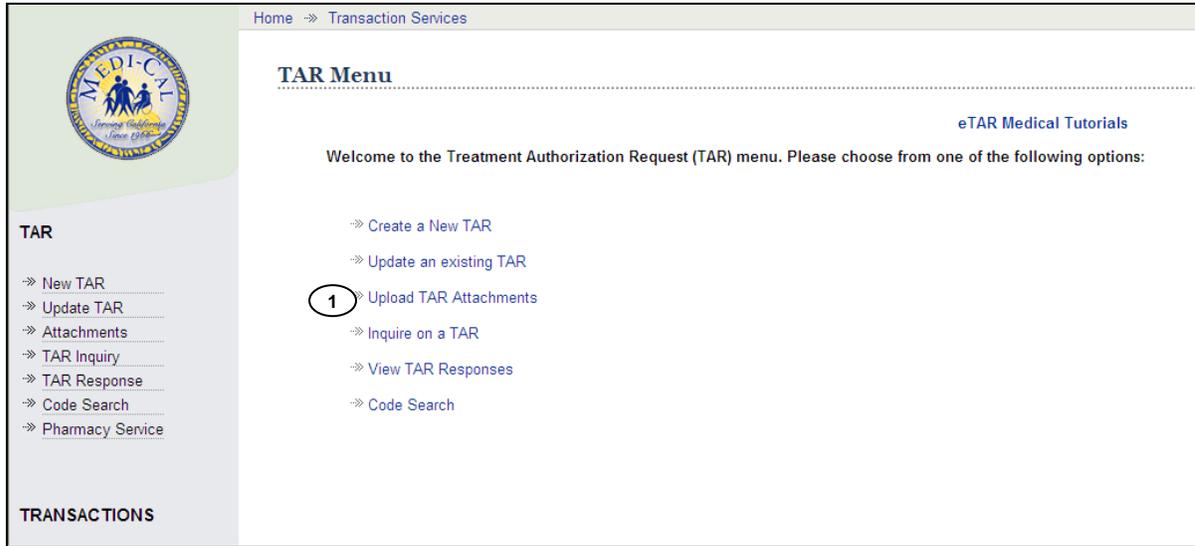
| Service # | Service Ind. | Requested From Date | Requested Thru Date |
|-----------|--------------------------|---------------------|---------------------|
| 1 | Surgical/Other Procedure | | |

| Service Code | Modifiers | Service Description | Status |
|--------------|-----------|---------------------|--------------|
| 27457 | | REALIGNMENT OF KNEE | 11 In Review |

11. If the service line **Status** is “In Review”, it has been successfully updated. See this Section again if the status is rejected.

Module G. Upload Attachments

Section 1. Submit Attachments Online



1. Click **Upload TAR Attachments**.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical Web pages.

Upload Attachments

Update TAR

[eTAR Medical Tutorials](#)

Please enter original TAR information to retrieve your TAR for updating.

* Original Submitting Provider # **2**

* Original Recipient ID #

* Original TAR #

2. The National Provider Identifier (NPI) used to log in to Transaction Services will automatically populate in the **Original Submitting Provider #** field. If attachments need to be uploaded under a different provider number, log out and log in using the correct provider number. Legacy number usage is permitted only to providers authorized by the Department of Health Care Services (DHCS).
3. Enter the **Original Recipient ID #** submitted on the eTAR. *Always required.
4. Enter the **Original TAR #** assigned by the system once the eTAR was successfully submitted. *Always required.
5. Click **Submit Attachment**.

NOTE: Users have a maximum of eight hours to submit attachments depending on the option selected. The sooner attachments are submitted, the less likely the eTAR will be deferred or denied for lack of attachments.

Treatment Authorization Request

eTAR Medical Tutorials

The information you entered has passed validation. Click on Continue to send your attachments or Cancel to return to the TAR Menu.

Verify that all information is correct before you submit your eTAR.
Be sure the following statement is accurate before submitting your eTAR:

"To the best of my knowledge, the information entered in this electronic submission is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient."

6 7

6. Click **Continue** to submit online attachments.
7. Click **Cancel TAR Update** to return to the TAR menu.

Upload Attachments

| | | | |
|-----------------------|---|---------------|---|
| TCN: | <input type="text" value="0400001556"/> | FAX Number: | <input type="text"/> |
| Provider ID: | <input type="text" value="9876543210"/> | Recipient ID: | <input type="text" value="87654321A95001"/> |
| Provider Cntl Nbr: | <input type="text"/> | | |

Medi-Cal recommends that image attachments be greyscale, between 150 and 300 DPI
Medi-Cal only accepts attachments with the following file extensions:
.jpg, .jpeg, .gif, .png, .tif, .bmp, .pdf, .txt

Enter the file name(s) to upload

| | |
|----------------------|--|
| <input type="text"/> | <input type="button" value="Browse..."/> |

Use the Browse button to select the file name from your PC.
After selecting the file(s), click on the Upload File button to upload the file to
Medi-Cal.

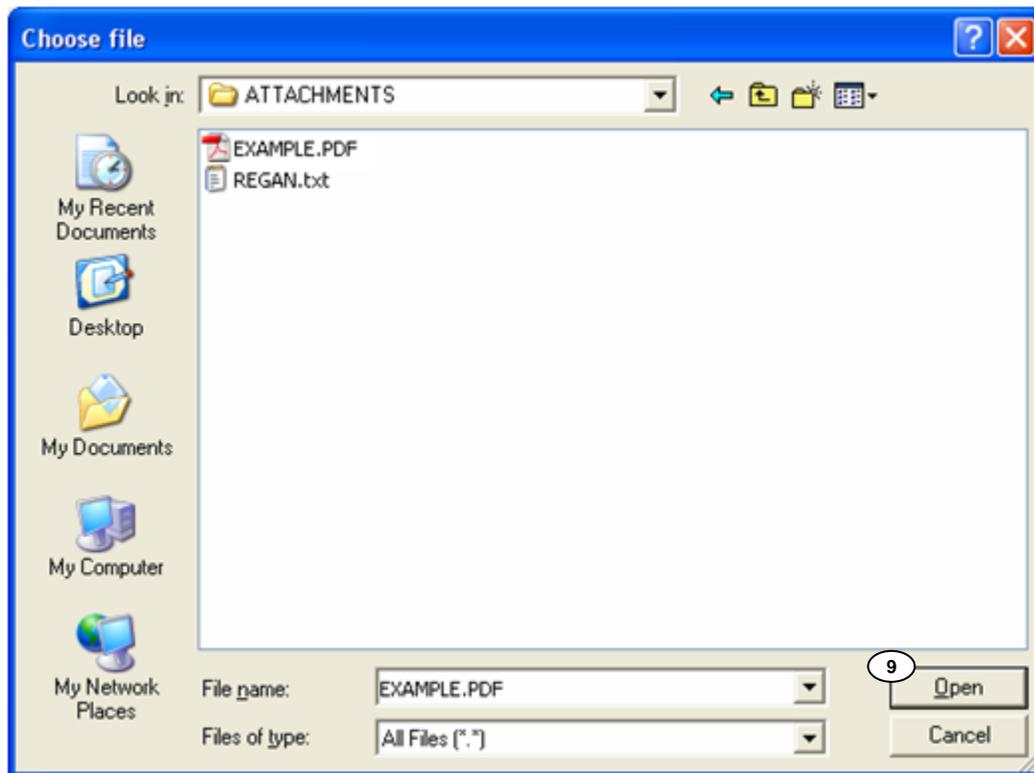
| | |
|---|--------------------------------------|
| <input type="button" value="Upload Files"/> | <input type="button" value="Reset"/> |
|---|--------------------------------------|

Note: If a button labeled "Browse..." does not appear, then your browser does not support File Upload.

Online attachments must be uploaded in either .jpg, .jpeg, .gif, .png, .tif, .bmp, .pdf, or .txt to be accepted by Medi-Cal. Attachments cannot exceed more than 20MB combined. Medi-Cal recommends that image attachments be grayscale.

NOTE: The NPI must be included in the **Provider ID** field.

- 8. Click **Browse** to locate the document to upload as an attachment.



Select the appropriate file to upload.

9. Click **Open** to load the file.

Upload Attachments

| | | | |
|-----------------------|---|---------------|---|
| TCN: | <input type="text" value="0400001556"/> | FAX Number: | <input type="text"/> |
| Provider ID: | <input type="text" value="9876543210"/> | Recipient ID: | <input type="text" value="87654321A95001"/> |
| Provider Cntl Nbr: | <input type="text"/> | | |

Medi-Cal recommends that image attachments be greyscale, between 150 and 300 DPI
 Medi-Cal only accepts attachments with the following file extensions:
 .jpg, .jpeg, .gif, .png, .tif, .bmp, .pdf, .txt

Enter the file name(s) to upload

| | |
|---|--|
| <input type="text" value="D:\Documents and Settings\fzcy5\"/> | <input type="button" value="Browse..."/> |
| <input type="text"/> | <input type="button" value="Browse..."/> |

Use the Browse button to select the file name from your PC.
 After selecting the file(s), click on the Upload File button to upload the file to
 Medi-Cal.

Note: If a button labeled "Browse..." does not appear, then your browser does not support File Upload.

NOTE: The NPI must be included in the **Provider ID** field.

10. Click **Upload Files** to submit attachments.

11. Click **Reset** to clear all files.

eTAR Medical Tutorials
eTAR Pharmacy Tutorial

Thank you for uploading your TAR attachment(s) for TCN 0400001556.
The attachment was saved successfully.

Please verify the following information about your attachment file(s);
D:\Documents and
Settings\fcy5w\Desktop\ATTACHMENTS\REGAN.txt

Your tracking number is: 4155

Start time ==> 2008.01.17 at 11:21:46 PST
End time ==> 2008.01.17 at 11:21:46 PST
Total time ==> 0 seconds.

[12 Return to TAR Menu](#)

[Return to Pharmacy Online TAR](#)

Confirmation message of the file name and tracking number, as well as the start and end times of the uploaded attachment appear after uploading the files.

12. Click **Return to TAR Menu** to return to the TAR Main Menu. To add additional attachments, repeat this process.

Section 2. TAR 3 Attachment Form

TAR Attachment Form

TREATMENT AUTHORIZATION REQUEST - ATTACHMENT FORM
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

INTERNAL CONTROL NUMBER - FI USE ONLY

3

CONFIDENTIAL PATIENT INFORMATION PLEASE TYPE INFORMATION

PART I: PROVIDER INFORMATION

1 SUBMITTING PROVIDER # 2 PATIENT RECORD # 3 PROVIDER PHONE # 4 PROVIDER FAX #

5 PROVIDER NAME 10 MEDICARE CERTIFIED

6 PROVIDER STREET/MAILING ADDRESS 11 PROVIDER CONTACT NAME

7 CITY 8 STATE 9 ZIP CODE 12 PROVIDER CONTACT PHONE #

13 ORIGINAL TAR NUMBER 14 UPDATE RSN 15 SPCL HNDLG 16 RETRO RSN 17 RETRO DATE

123456

PART II: PATIENT INFORMATION

31 MEDI-CAL IDENTIFICATION NUMBER 32 PATIENT NAME, LAST 33 FIRST 34 SEX 35 RES STAT 36 WRC

TO THE BEST OF MY KNOWLEDGE, THE ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER **DATE**

X

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

CONFIDENTIALITY NOTICE: This fax transmission is for the sole use of the intended recipient and may contain confidential and privileged information. Any unauthorized review or use, including disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the fax transmission.

The purpose of the **TAR 3 Attachment Form** is to submit attachments for eTAR by fax or mail.

IMPORTANT: The TAR 3 Attachment Form can be ordered by calling TSC at 1-800-541-5555 and following the appropriate prompts or by downloading the form from the eTAR tab. Use this form as the cover sheet for all faxed and mailed attachments. Do not use any other cover sheet.

TAR Attachment Form

TREATMENT AUTHORIZATION REQUEST - ATTACHMENT FORM
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

INTERNAL CONTROL NUMBER - FI USE ONLY

CONFIDENTIAL PATIENT INFORMATION PLEASE TYPE INFORMATION

3

PART I: PROVIDER INFORMATION

| | | | | |
|--|--|---|---|---|
| 1 SUBMITTING PROVIDER # | 2 PATIENT RECORD # | 3 PROVIDER PHONE # | 4 PROVIDER FAX # | |
| 1 <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | 2 <input style="width: 100%;" type="text"/> | 3 <input style="width: 100%;" type="text"/> | |
| 5 PROVIDER NAME | | 10 MEDICARE CERTIFIED | | |
| 4 <input style="width: 100%;" type="text"/> | | <input type="checkbox"/> | | |
| 6 PROVIDER STREET/MAILING ADDRESS | | 11 PROVIDER CONTACT NAME | | |
| 5 <input style="width: 100%;" type="text"/> | | <input style="width: 100%;" type="text"/> | | |
| 7 CITY | 8 STATE | 9 ZIP CODE | 12 PROVIDER CONTACT PHONE # | |
| 6 <input style="width: 100%;" type="text"/> | 7 <input style="width: 100%;" type="text" value="CA"/> | 8 <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | |
| 13 ORIGINAL TAR NUMBER | 14 UPDATE RSN | 15 SPCL HNDLG | 16 RETRO RSN | 17 RETRO DATE |
| 9 <input style="width: 100%;" type="text" value="123456"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> |

The following fields are required. Type or print neatly.

1. Enter the **Submitting Provider #**. This number must match the information entered on the TAR.
2. Enter the **Provider Phone #**.
3. Enter the **Provider Fax #** where a response or acknowledgement can be sent.
4. Enter the **Provider Name** of the submitting provider.
5. Enter the **Provider Street/Mailing Address**.
6. Enter the **City**.
7. Enter the **State**.
8. Enter the **Zip Code**.
9. Enter the **Original TAR Number** associated with the attachments being submitted. The number assigned must match the TCN created by eTAR.

Upload Attachments

| PART II: PATIENT INFORMATION | | | | | |
|---|-----------------------|----------------------|-------------------------|----------------------|----------------------|
| 31 MEDI-CAL IDENTIFICATION NUMBER | 32 PATIENT NAME, LAST | 33 FIRST | 34 SEX | 35 RES STAT | 36 WRC |
| 10 <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <p>TO THE BEST OF MY KNOWLEDGE, THE ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.</p> | | | | | |
| SIGNATURE OF PHYSICIAN OR PROVIDER | | | DATE | | |
| 11 <input type="text"/> | | | 12 <input type="text"/> | | |
| <p>Note: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.</p> | | | | | |
| <p>CONFIDENTIALITY NOTICE: This fax transmission is for the sole use of the intended recipient and may contain confidential and privileged information. Any unauthorized review or use, including disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the fax transmission.</p> | | | | | |

10. Enter the patient's **Medi-Cal Identification Number** submitted on the eTAR. This number must match the information entered on the eTAR.

11. Sign the attachment form at the **Signature of Physician or Provider**.

NOTE: Due to the Internet/POS Network Agreement form submission, the person completing the eTAR can provide this signature.

12. Enter the **Date** (mmddyyyy).

Section 3. Download TAR 3 Attachment Form



13. Access the eTAR tab on the Transaction Services Menu to download the *TAR 3 Attachment Form*.

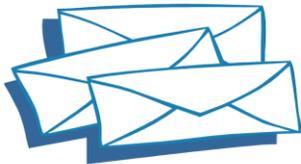
Section 4. Attachment Submission

Use the completed TAR 3 Attachment Form as the fax cover sheet.



**FAX All eTAR Attachments to:
(877) 270-8779
or
From outside California FAX to:
(916) 384-9000**

Complete the TAR 3 Attachment Form clearly. Neglecting to do this will delay the adjudication of your eTAR. If the information on the attachment form does not match the information submitted on the eTAR, the eTAR may be Deferred or Denied for lack of attachments.



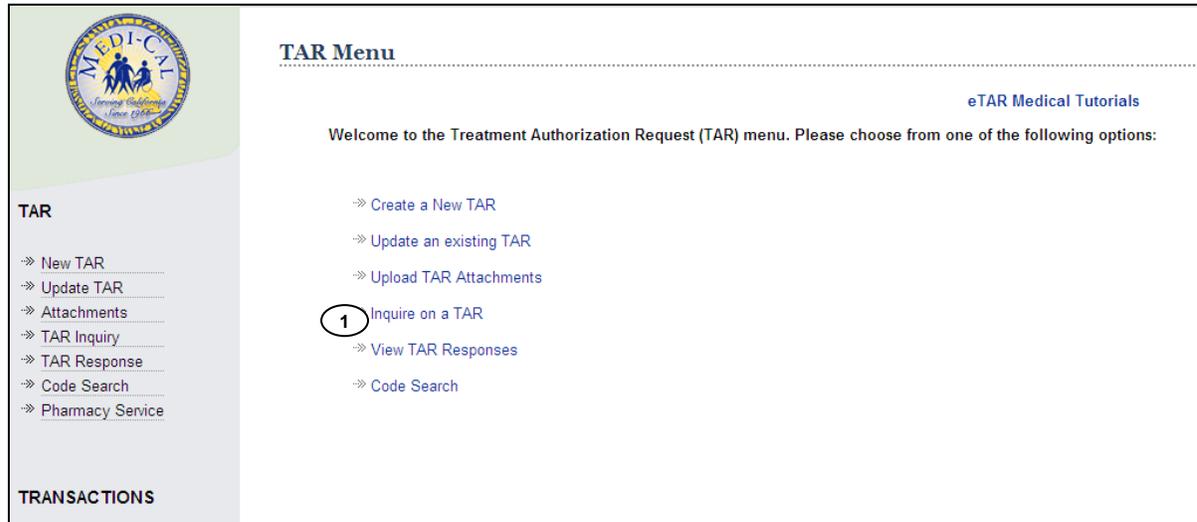
**Mail eTAR Attachments to:
Medi-Cal
P.O. BOX 526011
Sacramento, CA 95852**

NOTE:

- When faxing attachments for multiple TAR Control Numbers (TCNs), submit all attachments for each TCN as its own fax. The fax system does not differentiate attachments for different authorization numbers sent together in one fax.
- It is important to turn off batching function options or auto coversheet options on the fax machines used.
- Attach the completed TAR 3 Attachment Form to mail and fax attachments.
- Overnight delivery or FedEx should not be used. A signature is required upon delivery and mailed attachments arrive to a P.O. Box.

Module H. Inquire on a TAR

Section 1. TAR Inquiry



1. Click **Inquire on a TAR** to view adjudication decisions and field office comments on a TAR. Both View TAR Responses and Inquire on a TAR provide the Pricing Indicator (PI) for an Approved or Modified TAR, which is required to submit a claim. The PI will become the 11th digit of the TAR Control Number.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical Web pages.

NOTE: Entering a rendering provider number on an eTAR will give the provider access to Inquire on a TAR.

Section 2. Selection Criteria

Patient Information

eTAR Medical Tutorials

Please Enter Inquiry Selection Information.

Service Indicator

Provider: 1234567890

TAR Number: (1)

Patient Record: (2)

Recipient ID:

Special Handling

Status

Approved

Deferred

Denied

Modified

In Review

Service Thru Dates Begin: End:

(3) Continue

Microsoft Internet Explorer

 If a TCN was entered, all other values are ignored

(4) OK

1. The provider number used to log in to Transaction Services populates automatically. To view a TAR submitted under a different provider number, log out and log in using the correct provider number.
2. Enter the **TAR Number** to search for the appropriate TAR. Ignore all other fields.
3. Click **Continue** and a window appears on the page.
4. Click **OK** to proceed to the Inquiry Selection page.

The screenshot shows a web form titled "Please Enter Inquiry Selection Information." in the top left. In the top right corner, it says "eTAR Medical Tutorials". The form contains several sections: "Service Indicator" with a dropdown menu (5), "Special Handling" with a dropdown menu (6), and "Status" with five checkboxes: "Approved" (7), "Deferred" (8), "Denied" (9), "Modified" (10), and "In Review" (11). To the right of the status checkboxes are four date range fields: "Receipt Dates Begin/End", "Service Dates Begin/End", "Service From Dates Begin/End", and "Service Thru Dates Begin/End", each with "mmddyyyy" as a placeholder. Above these date fields, there are input fields for "TAR Number", "Patient Record #", and "Recipient ID". At the top right, the "Provider" is listed as "009! 1234567890". A "Continue" button is located at the bottom center of the form.

If a TCN is not available, use the fields for inquiry selection.

5. Use the **Service Indicator** drop-down list to select the type of service for inquiry.
6. Use the **Special Handling** drop-down list to select the special handling reason for inquiry.
7. Click the **Approved** checkbox to view a list of Approved TARs.
8. Click the **Deferred** checkbox to view a list of Deferred TARs.
9. Click the **Denied** checkbox to view a list of Denied TARs.
10. Click the **Modified** checkbox to view a list of Modified TARs.
11. Click the **In Review** checkbox to view a list of TARs waiting to be reviewed

NOTE: More than one status may be selected at one time.

Inquire on a TAR

eTAR Medical Tutorials

Please Enter Inquiry Selection Information.

Service Indicator

Provider: 0099097830

TAR Number:

Patient Record #: (12)

Recipient ID: (13)

Special Handling

Status

Approved

Deferred

Denied

Modified

In Review

Receipt Dates Begin: (14) End: (mmddyyyy)

Service Dates Begin: (15) End: (mmddyyyy)

Service From Dates Begin: (16) End: (mmddyyyy)

Service Thru Dates Begin: (17) End: (mmddyyyy)

(18)

12. Enter the **Patient Record #** submitted on the eTAR.
13. Enter the **Recipient ID** submitted on the TAR.
14. Enter a date range in the **Receipt Dates Begin** and **End** (mmddyyyy) field to search for TARs submitted on a specific dates.
15. Enter a date range in the **Service Dates Begin** and **End** (mmddyyyy) field to search for TARs with specific service dates.
16. Enter a date range in the **Service From Dates Begin** and **End** (mmddyyyy) field to search for TARs with specific From dates.
17. Enter a date range in the **Service Thru Dates Begin** and **End** (mmddyyyy) field to search for TARs with specific Thru dates.
18. Click **Continue** to perform the inquiry.

Section 3. Inquire Selection List

| Response Selection List | | | | | | | | | | | |
|---|------|------------------|----------------|-----------|-------------|--------------|--------------------------|--------------------|-----------|----------|----------|
| eTAR Medical Tutorials | | | | | | | | | | | |
| Please click on the TAR Inquiry you would like to retrieve. | | | | | | | | | | | |
| TCN | P.I. | Patient Record # | Recip ID | Service # | Indicator | Service Code | Service Description | Rendering Provider | Last Name | Received | Status |
| 0400026184 | 0 | | 87654321D95001 | 1 | Home Health | Z6900 | SKILLED NURSING SERVICES | | DOE | 01102008 | Deferred |
| 0400027198 | 0 | | 87654321D95001 | 1 | Home Health | Z6900 | SKILLED NURSING SERVICES | | DOE | 01042008 | Approved |
| 0400026205 | 0 | | 87654321D95001 | 1 | Home Health | Z6900 | SKILLED NURSING SERVICES | | DOE | 12152007 | Deferred |

1. Click the **TCN** of the TAR service line to view the detailed TAR Response information. Results may vary based on the selection criteria used.

Inquire on a TAR

Section 4. TAR Summary

| | | | |
|---|---|--------------------------|--|
| Provider Information | | Medicare Certified | |
| Submitting Provider 0099097830 | | N | |
| Provider Name COMMUNITY MEDICAL CLINIC | Phone # (916)920-4606 | Fax # | |
| Street/Mailing Address 3215 PROSPECT PARK DR | City RNCHO CORDOVA | State CA | Zip Code 95670 |
| Contact Name | Contact Phone # | Contact Extension | |
| TAR Completed By Nicole | | | |
| <input type="button" value="Update Provider Information"/> | | | |
| Patient Information | | Patient Record # | |
| Recipient ID 87654321A95001 | | | |
| Special Handling | | | |
| Last Name Doe | First Name Joe | | |
| Phone # | Date of Birth 10101934 | Gender Male | Worker's Comp? Unknown |
| Miscellaneous TAR Information | | | |
| Residence Status | Medicare Denial Reason Under 65, does not have Medicare Coverage | Medicare/OHC Denial Date | Medicare/OHC Denial Certification No |
| | | | OHC Denial Reason No Other Health Coverage |
| Mother/Transplant Recipient Providing Medi-Cal Eligibility | | | |
| Last Name | First Name | | |
| Date Of Birth | Gender | | |
| Patient's Authorized Representative | | | |
| Name | | | |
| Street/Mailing Address | | | |
| City | State | Zip Code | |
| <input type="button" value="Update Patient Information"/> | | | |
| Service Information | | | |
| <input type="button" value="Update This Service"/> <input type="button" value="Cancel This Service"/> | | | |
| Temporary Service Number : 1 | | | |
| Ind. Home Health | Service Code Z6902 | Modifiers | |
| Service Description | Total Units 10 | From Date 01012008 | Thru Date 02292008 |
| Admit Date/ Start of Care 01012008 | Admit From Home | Discharge Date | Discharge |
| Frequency 1 / Day | | | |
| POS | ICD-CM Type ICD-9 | ICD Code 250.0 | Diagnosis Description Date of Onset 01012007 |
| Price Indicator 0 - No special condition | | | |
| <input type="button" value="1 Responses"/> | | | |

From the TAR Inquiry page, view TAR information submitted on the TAR as well as the TAR's current status.

2. Click **Responses** to view the reasons for adjudication of the TAR service lines and field office consultant comments. Responses are not available if the TAR is being adjudicated by field office reviewers.

Section 5. Response Selection List

| Response Selection List | | | | | |
|--|------------------|----------------------------|---------------|-------------------------|----------------------|
| eTAR Medical Tutorials | | | | | |
| Please click on the TAR Response you would like to retrieve. | | | | | |
| TCN | Service # | Service Description | Status | Patient Record # | Response Date |
| 0400026184 | 1 | SKILLED NURSING SERVICES | Deferred | | 01102008 |
| 0400026184 | 1 | SKILLED NURSING SERVICES | Deferred | | 01082008 |

1. The current and previously adjudicated versions of the TAR are listed. Look for the most recent Response Date to view the response for the current version of the service line being inquired on the TAR.
2. Select the **TCN** of the TAR service line to view the detailed TAR Response information.

Inquire on a TAR

Section 6. TAR Response

| TAR Response | | | |
|---|---------------------|--------------------|-----------------|
| eTAR Medical Tutorials | | | |
| TAR Control # : | P.I. : | Service # : | Response Date : |
| 0400026184 | 0 | 1 | 01082008 |
| Recipient ID : | | | |
| 87654321D95001 | | | |
| Submitting Provider : | | Patient Record # : | |
| 1234567890 | | | |
| Service Code : | | Modifiers : | |
| Z6900 | | | |
| Service Description : | | | |
| SKILLED NURSING SERVICES | | | |
| From Date : | | Thru Date : | |
| 12012007 | | 12312007 | |
| Quantity : | | Units : | |
| | | 16 | |
| Status : | | | |
| Deferred | | | |
| Service Code | Service Description | Total Units | |
| Action Reason List : | | | |
| The request has been deferred. Please see the reviewers comments for deferral reasons. | | | |
| TAR Review Comments : | | | |
| Please submit documentation to support request. | | | |

1. The **PI** for each service line is shown on this page. This digit is required for submitting claims. Once the TAR is Approved, the PI becomes the 11th digit of the TAR Control Number (TCN) for submitting claims.
2. The **Action Reason List** provides specific reasons why the TAR service line was Deferred, Denied, Modified or Approved.
3. The **TAR Review Comments** displays comments entered by the Medi-Cal field office reviewer. See Module F for instructions on updating an existing eTAR.

NOTE: The PI is always zero for Transportation TARs.

TAR Response

[eTAR Medical Tutorials](#)

| | | | |
|-------------------|----------|-------------|-----------------|
| TAR Control # : | P.I. : | Service # : | Response Date : |
| 0400026184 | 0 | 1 | 01082008 |

Recipient ID :
87654321D95001

| | |
|-----------------------|--------------------|
| Submitting Provider : | Patient Record # : |
| 1234567890 | |

| | |
|----------------|-------------|
| Service Code : | Modifiers : |
| Z6900 | |

Service Description :
SKILLED NURSING SERVICES

| | |
|-----------------|-----------------|
| From Date : | Thru Date : |
| 12012007 | 12312007 |

| | |
|------------|----------|
| Quantity : | Units : |
| | 0 |

Status :
Approved

| Service Code | Service Description | Total Units |
|------------------------------|---------------------|-------------|
| Action Reason List : | | |
| Approved as submitted | | |

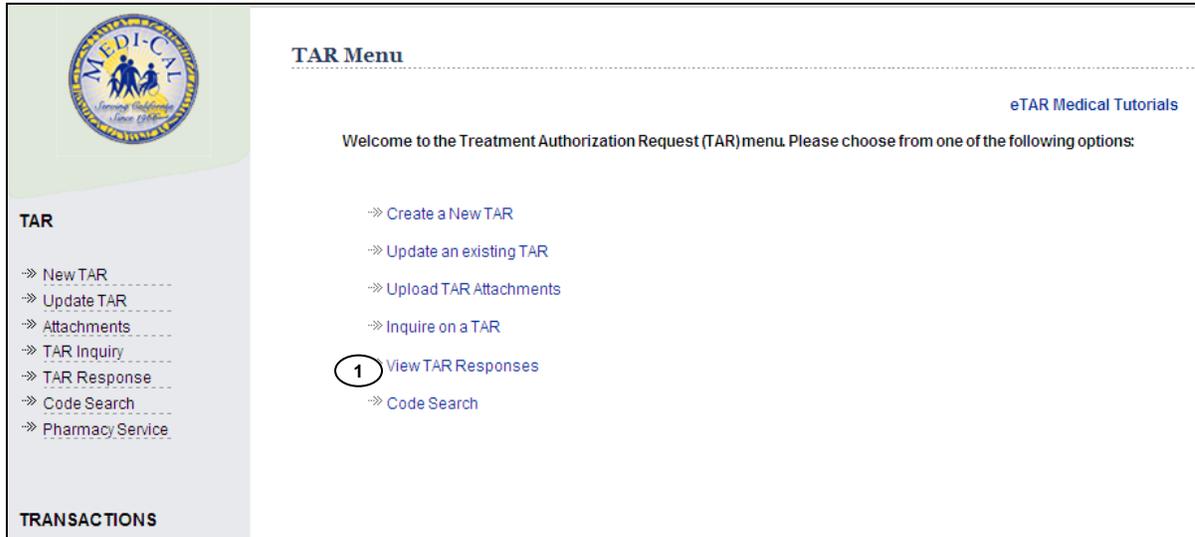
The TAR Response page is displayed to view specific information regarding the adjudication of the TAR.

4. A TAR that has been canceled appears under Inquiry as Approved with zero units. A TAR that has paid units then canceled will show as Approved with only the units paid on the TAR.

NOTE: Generally, Approved with zero units indicates a Canceled TAR. However, most LTC services will appear with zero units when they are not canceled.

Module I. View TAR Responses

Section 1. View TAR Response



1. Select **View TAR Responses** to view adjudication decisions and field office comments on a TAR. Both TAR Inquiry and View TAR Responses provide the Pricing Indicator (PI) for an Approved or Modified TAR which is required to submit a claim. The PI becomes the 11th digit of the TAR Control Number.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

NOTE: Entering a rendering provider number on an eTAR gives the provider access to inquire on an eTAR.

Section 2. Selection Criteria

eTAR Medical Tutorials

Please Enter Response Selection Information.

Service Information

TAR Number 2 Submitting Provider ID
1234567890

Incoming Recipient ID 4 Patient Record Number

Please Choose Service Status

If the Service Status selected is "All", a response date range is required.

Deferred Denied Modified Approved All

Please Choose View Status

If the view status selected is "Viewed", a response date range is required, except when requesting responses for a specific TAR.

Unviewed Viewed

Response Date Range

When selecting Response dates, the End Date must be no more than 31 days after the Begin Date.

Begin Date End Date

1. Enter the **TAR Number** to search for the appropriate TAR. Ignore all other fields.
2. The provider number used to log in to Transaction Services populates automatically. To view a TAR submitted under a different provider number, log out and log in using the correct provider number.
3. Enter the **Incoming Recipient ID** submitted on the TAR.
4. Enter the **Patient Record Number** submitted on the eTAR.
5. Click the circular **Deferred, Denied, Modified, Approved or All** radio button. If **All** is selected, enter a date range.

NOTE: Generally, approved with zero units indicates a canceled TAR. However, most LTC services appear with zero units when they are not canceled.

eTAR Medical Tutorials

Please Enter Response Selection Information.

Service Information

| | |
|-----------------------|------------------------|
| TAR Number | Submitting Provider ID |
| <input type="text"/> | 1234567890 |
| Incoming Recipient ID | Patient Record Number |
| <input type="text"/> | <input type="text"/> |

Please Choose Service Status
If the Service Status selected is "All", a response date range is required.

Deferred Denied Modified Approved All

Please Choose View Status
If the view status selected is "Viewed", a response date range is required, except when requesting responses for a specific TAR.

Unviewed Viewed

Response Date Range
When selecting Response dates, the End Date must be no more than 31 days after the Begin Date.

| | |
|---|---------------------------------------|
| Begin Date | End Date |
| <input type="text" value="mmddyyyy"/> | <input type="text" value="mmddyyyy"/> |
| <input type="button" value="Continue"/> | |

6. Click the circular **Unviewed** or **Viewed** radio button depending on whether the TAR response was previously viewed by others. It may be necessary to choose between unviewed and viewed to reveal all responses for the TAR.
7. Enter the **Begin Date** (mmddyyyy) for the requested start of service date.
8. Enter the **End Date** (mmddyyyy) for the requested end of service date. When using response dates, the End Date may be no more than 31 days after Begin Date.
9. Click **Continue** once the information is complete.

Section 3. Response Selection List

| Response Selection List | | | | | | | | | | | |
|--|------|------------------|----------------|-----------|-------------|--------------|--------------------------|--------------------|-----------|----------|----------|
| eTAR Medical Tutorials | | | | | | | | | | | |
| Please click on the TAR Response you would like to retrieve. | | | | | | | | | | | |
| TCN | P.I. | Patient Record # | Recip ID | Service # | Indicator | Service Code | Service Description | Rendering Provider | Last Name | Received | Status |
| 0400026184 | 0 | | 87654321D95001 | 1 | Home Health | Z6900 | SKILLED NURSING SERVICES | | DOE | 01102008 | Deferred |
| 0400027198 | 0 | | 87654321D95001 | 1 | Home Health | Z6900 | SKILLED NURSING SERVICES | | DOE | 01042008 | Approved |
| 0400026205 | 0 | | 87654321D95001 | 1 | Home Health | Z6900 | SKILLED NURSING SERVICES | | DOE | 12152007 | Deferred |

Click the **TCN** link of the TAR service line to view the detailed TAR Response information. Results may vary based on the selection criteria entered.

Section 4. TAR Response

TAR Response

eTAR Medical Tutorials

TAR Control # : **0400026184** P.I. : **0** Service # : **1** Response Date : **01082008**

Recipient ID : **87654321D95001**

Submitting Provider : **1234567890** Patient Record # :

Service Code : **Z6900** Modifiers :

Service Description : **SKILLED NURSING SERVICES**

From Date : **12012007** Thru Date : **12312007**

Quantity : Units : **16**

Status : **Deferred**

| Service Code | Service Description | Total Units |
|--|---------------------|-------------|
| Action Reason List : | | |
| <p>2 The request has been deferred. Please see the reviewers comments for deferral reasons.</p> | | |
| TAR Review Comments : | | |
| <p>3 Please submit documentation to support request.</p> | | |

1. The **PI** for each service line is shown on this page. This digit is required for submitting claims. Once the TAR is Approved, the PI becomes the 11th digit of the TAR Control Number (TCN) for submitting claims.
2. The **Action Reason List** provides specific reasons why the TAR service line was Deferred, Denied, Modified or Approved.
3. The **TAR Review Comments** displays comments entered by the Medi-Cal field office reviewer. See Module F for instructions on updating an existing eTAR.

NOTE: The PI is always zero for Transportation TARs.

TAR Response

[eTAR Medical Tutorials](#)

| | | | |
|-------------------|----------|-------------|-----------------|
| TAR Control # : | P.I. : | Service # : | Response Date : |
| 0400026184 | 0 | 1 | 01082008 |

Recipient ID :
87654321D95001

| | |
|-----------------------|--------------------|
| Submitting Provider : | Patient Record # : |
| 1234567890 | |

| | |
|----------------|-------------|
| Service Code : | Modifiers : |
| Z6900 | |

Service Description :
SKILLED NURSING SERVICES

| | |
|-----------------|-----------------|
| From Date : | Thru Date : |
| 12012007 | 12312007 |

| | |
|------------|----------|
| Quantity : | Units : |
| | 0 |

Status :
Approved

| Service Code | Service Description | Total Units |
|--------------|---------------------|-------------|
|--------------|---------------------|-------------|

Action Reason List :
Approved as submitted

The TAR Response screen is displayed to view specific information regarding the adjudication of the TAR.

4. A TAR that has been canceled appears under Inquiry as Approved with zero units. A TAR that has paid units then canceled will show as Approved but with only the units paid on the TAR.

NOTE: Generally, Approved with zero units indicates a Canceled TAR. However, most LTC services appear with zero units when they are not canceled.

Module J. Code Search

Section 1. Accessing Code Search

The screenshot shows a web form titled "Other Services" with a sub-header "Please Enter Home Health Information". The form includes the following fields and labels:

- Service Information**
- * Service Code (HCPCS Code):
- * Total Units:
- Discharge Date:
- * Frequency: /
- * Admit Date/Start of Care:
- Modifiers (if applicable):
- From Date:
- Thru Date:

In the top right corner, there is a link labeled "eTAR Medical Tutorials".

Click **Service Code**, **Modifiers** (both shown above), **ICD Code**, **Functional Limitation** or **Medical Status** (not shown) to access Code Search. A new window appears displaying Code Search. Code Search may also be accessed from the TAR Menu.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

Section 2. Using Code Search

[eTAR Medical Tutorials](#)

Code Search

Please choose the type of code to search for:

Procedure
 Modifier
 Accommodation
 Level of Care
 Diagnosis ICD-9
 Diagnosis ICD-10
 Functional Limits
 Medical Status
 Get Service Category from Service Code

Please choose the type of search:

Search by Description
 Search by Code

Please enter text to search for:

1. Select the appropriate code type from the **Please choose the type of code to search for:** to search for the following types of codes or descriptions.
 - Click the circular **Procedure** radio button to search for procedure codes. The Medi-Cal Provider Manual is the final resource to determine if a TAR is required.
 - Click the circular **Modifier** radio button to search for a modifier code.
 - Click the circular **Accommodation** radio button when submitting Long Term Care services code.
 - Click the circular **Level of Care** radio button when submitting Long Term Care or Hospital Day services codes.
 - Click the appropriate circular **Diagnosis** radio button when submitting ICD codes.
 - Click the circular **Functional Limits** radio button to search for functional limitation codes. A list of functional limitation codes is also found in Appendix B.
 - Click the circular **Medical Status** radio button for medical status codes. A list of medical status codes is also found in Appendix A.
 - Click the circular **Get Service Category from Service Code** radio button to determine what service category to select based on the service code.

[eTAR Medical Tutorials](#)

Code Search

Please choose the type of code to search for:

Procedure Modifier Accommodation Level of Care

Diagnosis ICD-9 Diagnosis ICD-10 Functional Limits Medical Status

Get Service Category from Service Code

Please choose the type of search:

Search by Description

Search by Code

Please enter text to search for:

Search

2. Select the appropriate type of search under **Please choose the type of search:**
 - Click the circular **Search by Description** radio button when the service code is unknown.
 - Click the circular **Search by Code** radio button when the description is unknown.
3. In the blank **Please enter text to search for:** field, enter the description or code.
4. Click **Search** to complete the search function.

Section 3. Code Search List

[eTAR Medical Tutorials](#)

Code Search List

5

| Code | Description | Type | TAR Indicator |
|-------|--|-----------|--|
| G0128 | CORF SKILLED NURSING SERVICE | SMA/HCPCS | Generally No TAR, Subject to Billing Limitations |
| Z6702 | IHMC SKILLED NURSING CARE - RN HOURLY | SMA/HCPCS | Generally No TAR, Subject to Billing Limitations |
| 00551 | IHMC SKILLED NURSING CARE - RN HOURLY | SMA/HCPCS | TAR Required |
| 00552 | IHMC SKILLED NURSING CARE HR LVN GENERAL | SMA/HCPCS | TAR Required |
| Z6706 | IHMC SKILLED NURSING CARE LVN SPEC, HRLY | SMA/HCPCS | Generally No TAR, Subject to Billing Limitations |
| 00553 | IHMC SKILLED NURSING CARE LVN SPEC, HRLY | SMA/HCPCS | TAR Required |
| 00572 | MODEL SKILLED NURSING CARE HR LVN GEN | SMA/HCPCS | TAR Required |
| Z6732 | MODEL SKILLED NURSING SERVICES-LVN-HRLY | SMA/HCPCS | Generally No TAR, Subject to Billing Limitations |
| Z6730 | MODEL-SKILLED NURSING SERVICES-RN HOURLY | SMA/HCPCS | Generally No TAR, Subject to Billing Limitations |
| 00571 | MODEL-SKILLED NURSING-RN HOURLY | SMA/HCPCS | TAR Required |

5. A list of all codes and associated descriptions that match the search criteria are displayed.

Appendix A. eTAR Glossary

Medical Status Codes and Descriptions

Service

Patient assessment information for this Service (Attachment A)

* P.O.T. Adherence * Height * Weight lbs. oz.

* Please list current **functional limitation** /physical condition codes

Please list previous **functional limitation** /physical condition codes

* Please list current **medical status** codes relevant to requested service(s)

1. The following is a complete list of all medical status codes used in the eTAR application and their descriptions. For more information on Code Search, see Module J.

Medical Status Codes and Descriptions

- 001 Symptom control: Asymptomatic, no treatment needed at this time
- 002 Symptom control: well controlled with current therapy
- 003 Symptom control: Difficult, affects ADLs; patient needs ongoing monitoring
- 004 Symptom control: poor, patient needs frequent adjustment
- 005 Symptom control: poor, history of hospitalizations
- 011 IV: hydration only
- 012 IV: chemotherapy
- 013 IV: blood/blood products
- 014 IV medication: continuous with/without pump
- 015 IV medication: intermittent with/without pump
- 016 IV medication: bolus
- 017 Parenteral nutrition (TPN or lipids): central
- 018 Parenteral nutrition (TPN or lipids): peripheral
- 019 Enteral nutrition (ng, g-tube, jejunostomy, other artificial entry into alimentary canal)

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- 021 Drainage tube: Chest
- 022 Drainage tube: Nasogastric
- 023 Drainage tube: Gastrostomy
- 024 Drainage tube: Jackson Pratt
- 025 Drainage tube: Hemovac
- 026 Drainage tube: Urinary
- 027 Drainage tube: Intracranial/ intraventricular
- 031 Prognosis: Little or no recovery is expected and/or further decline is imminent
- 032 Prognosis: Partial to full recovery is expected
- 033 Prognosis: Minimal improvement in functional status is expected, decline is imminent
- 034 Prognosis: Marked improvement in functional status is expected
- 035 Life Expectancy: greater than 6 months
- 041 Life expectancy: 6 months or fewer
- 042 Pain Description: Aching
- 043 Pain Description: Throbbing
- 044 Pain Description: Constant
- 045 Pain Description: Intermittent
- 046 Pain Description: Sharp
- 047 Pain Description: Dull
- 048 Pain Description: Widespread
- 049 Pain Description: Localized
- 061 Pain Location: Abdominal
- 062 Pain Location: Chest
- 063 Pain Location: Back
- 064 Pain Location: Head
- 065 Pain Location: Face
- 066 Pain Location: Ear
- 067 Pain Location: Eye
- 068 Pain Location: Mouth
- 069 Pain Location: Throat
- 070 Pain Location: Neck
- 071 Pain Location: Foot
- 072 Pain Location: Leg
- 073 Pain Location: Hand
- 074 Pain Location: Arm
- 075 Pain Location: Pelvis
- 076 Pain Location: Hip
- 077 Pain Location: Buttocks
- 078 Pain Location: Perineal/Genital Area
- 079 Pain Location: Joints (generalized)
- 081 Pain Frequency: Less often than daily
- 082 Pain Frequency: Daily, but not constantly
- 083 Pain Frequency: Constantly
- 091 Pain Management: No current pain management
- 092 Pain management: Non-medication methods

- 093 Pain management: Oral analgesics
- 094 Pain management: Topical analgesics
- 095 Pain management: IM analgesics
- 096 Pain management: IV analgesics
- 097 Pain Management: Pump analgesia (chronic)
- 099 Pain management: Combination (oral/topical/IM/IV)
- 101 Lesion: Head/torso, front
- 102 Lesion: Head/torso, back
- 103 Lesion: LUE
- 104 Lesion: RUE
- 105 Lesion: LLE
- 106 Lesion: RLE
- 111 Open wound(s), head/torso, front
- 112 Open wound(s), head/torso, front: not healing
- 113 Open wound(s), head/torso, back
- 114 Open wound(s), head/torso, back: not healing
- 115 Open wound(s), LUE
- 116 Open wound(s), LUE: not healing
- 117 Open wound(s), RUE
- 118 Open wound(s), RUE: not healing
- 119 Open wound(s), LLE
- 120 Open wound(s), LLE, not healing
- 121 Open wound(s), RLE
- 122 Open wound(s), RLE: not healing
- 131 Surgical wound(s), head/torso, front
- 132 Surgical wound(s), head/torso, front: not healing
- 133 Surgical wound(s), head/torso, back
- 134 Surgical wound(s), head/torso, back: not healing
- 135 Surgical wound(s), LUE
- 136 Surgical wound(s), LUE: not healing
- 137 Surgical wound(s), RUE
- 138 Surgical wound(s), RUE: not healing
- 139 Surgical wound(s), LLE
- 140 Surgical wound(s), LLE, not healing
- 141 Surgical wound(s), RLE
- 142 Surgical wound(s), RLE: not healing
- 151 Pressure ulcer(s), head/torso, front: worst ulcer = Stage I
- 152 Pressure ulcer(s), head/torso, front: worst ulcer = Stage II
- 153 Pressure ulcer(s), head/torso, front: worst ulcer = Stage III
- 154 Pressure ulcer(s), head/torso, front: worst ulcer = Stage IV
- 155 Pressure ulcer(s), head/torso, back: worst ulcer = Stage I
- 156 Pressure ulcer(s), head/torso, back: worst ulcer = Stage II
- 157 Pressure ulcer(s), head/torso, back: worst ulcer = Stage III
- 158 Pressure ulcer(s), head/torso, back: worst ulcer = Stage IV
- 159 Pressure ulcer(s), LUE: worst ulcer = Stage I
- 160 Pressure ulcer(s), LUE: worst ulcer = Stage II

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- 161 Pressure ulcer(s), LUE: worst ulcer = Stage III
- 162 Pressure ulcer(s), LUE: worst ulcer = Stage IV
- 163 Pressure ulcer(s), RUE: worst ulcer = Stage I
- 164 Pressure ulcer(s), RUE: worst ulcer = Stage II
- 165 Pressure ulcer(s), RUE: worst ulcer = Stage III
- 166 Pressure ulcer(s), RUE: worst ulcer = Stage IV
- 167 Pressure ulcer(s), LLE: worst ulcer = Stage I
- 168 Pressure ulcer(s), LLE: worst ulcer = Stage II
- 169 Pressure ulcer(s), LLE: worst ulcer = Stage III
- 170 Pressure ulcer(s), LLE: worst ulcer = Stage IV
- 171 Pressure ulcer(s), RLE: worst ulcer = Stage I
- 172 Pressure ulcer(s), RLE: worst ulcer = Stage II
- 173 Pressure ulcer(s), RLE: worst ulcer = Stage III
- 174 Pressure ulcer(s), RLE: worst ulcer = Stage IV
- 181 Stasis ulcer(s), head/torso, front
- 182 Stasis ulcer(s), head/torso, front: not healing
- 183 Stasis ulcer(s), head/torso, back
- 184 Stasis ulcer(s), head/torso, back: not healing
- 185 Stasis ulcer(s), LUE
- 186 Stasis ulcer(s), LUE: not healing
- 187 Stasis ulcer(s), RUE
- 188 Stasis ulcer(s), RUE: not healing
- 189 Stasis ulcer(s), LLE
- 190 Stasis ulcer(s), LLE: not healing
- 191 Stasis ulcer(s), RLE
- 192 Stasis ulcer(s), RLE: not healing
- 301 Breathing sounds: Clear
- 302 Breathing sounds: Decreased
- 303 Breathing sounds: Increased
- 304 Breathing sounds: Dullness
- 305 Breathing sounds: Rales
- 306 Breathing sounds: Rhonchi
- 307 Breathing sounds: Wheezing, expiratory
- 308 Breathing sounds: Wheezing, inspiratory
- 311 Dyspneic or noticeably SOB: walking > 20 feet
- 312 Dyspneic or noticeably SOB: moderate exertion (while dressing, toileting, walking < 20 feet)
- 313 Dyspneic or noticeably SOB: minimal exertion (while eating, talking, or performing other ADLs)
- 314 Dyspneic or noticeably SOB: at rest
- 315 Dyspneic or noticeably SOB: Orthopneic
- 321 Chest pain: with radiation to RUE/LUE
- 322 Chest pain: progressive
- 323 Chest pain: on exertion
- 324 Chest pain at rest
- 330 Residential respiratory treatments: oxygen: intermittent

- 331 Residential respiratory treatments: oxygen: continuous
- 332 Residential respiratory treatments: oxygen: at night
- 333 Residential respiratory treatments: ventilator: continuously
- 334 Residential respiratory treatments: ventilator: intermittent
- 335 Residential respiratory treatments: ventilator: at night
- 336 Residential respiratory treatments: percussion & drainage: intermittent
- 337 Residential respiratory treatments: percussion & drainage: infrequently
- 338 Residential respiratory treatments: suctioning: oral
- 339 Residential respiratory treatments: suctioning: nasopharyngeal
- 340 Residential respiratory treatments: suctioning: tracheostomy
- 341 Residential respiratory treatments: nebulizer with medication
- 342 Residential respiratory treatments: metered dose inhalers
- 343 Residential respiratory treatments: oximeter
- 344 Residential respiratory treatments: CPAP
- 345 Residential respiratory treatments: Bi-PAP
- 346 Residential respiratory treatments: air mist
- 347 Residential respiratory treatments: IPPB
- 348 Residential respiratory treatments: apnea/cardiac monitor
- 351 Cardiac: palpitation: regular
- 352 Cardiac: palpitation: irregular
- 353 Cardiac: palpitation: paroxysmal
- 354 Cardiac: arrhythmia
- 355 Cardiac: tachycardia
- 356 Cardiac: bradycardia
- 357 Cardiac: pacemaker
- 361 Bowel: incontinence: occasional
- 362 Bowel: incontinence: frequent
- 363 Bowel: incontinence: total
- 364 Bowel: Patient has ostomy for bowel elimination
- 365 Bowel: Blood in stool (melena)
- 366 Bowel: Constipation
- 367 Bowel: Diarrhea
- 371 Urinary: incontinence: occasional
- 372 Urinary: incontinence: frequent
- 373 Urinary: incontinence: total
- 374 Urinary: Intermittent catheterization
- 375 Urinary: Foley catheter (indwelling)
- 376 Urinary: Condom catheter
- 377 Urinary: Urostomy
- 378 Urinary: Urinary conduit
- 379 Urinary: Indwelling/suprapubic catheter
- 380 Urinary: stents
- 381 Urinary: Urinary tract infection
- 382 Urinary: Blood in urine (hematuria)
- 391 Allergy: None known
- 392 Allergy: penicillins

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- 393 Allergy: tetracycline
- 394 Allergy: sulphonamides
- 395 Allergy: other antibiotics
- 396 Allergy: anticholinergic
- 397 Allergy: anti-epileptics
- 398 Allergy: animal serum
- 399 Allergy: pollen
- 400 Allergy: Latex
- 401 Allergy: analgesics
- 402 Allergy: anti-rheumatics
- 411 Risk factor: Smoking
- 412 Risk factor: Obesity
- 413 Risk factor: Eating disorder
- 414 Risk factor: Alcohol dependency
- 415 Risk factor: Drug dependency
- 416 Risk factor: SIDS sibling
- 417 Risk factor: Strong family history of high risk factors
- 421 General patient condition: Pregnancy
- 422 General patient condition: Implanted medical device (non-pacemaker)
- 423 General patient condition: Coughing
- 424 General patient condition: Blood in sputum (hemoptysis)
- 425 General patient condition: Nausea and vomiting
- 426 General patient condition: Vomit with blood (hematemesis)
- 427 General patient condition: Sleep Apnea
- 428 General patient condition: Syncope
- 429 General patient condition: Dizziness/lightheadedness
- 430 General patient condition: Fever (febrile)
- 431 General patient condition: Jaundiced
- 432 General patient condition: Cyanosis
- 433 General patient condition: Seizures
- 434 General patient condition: Tremors
- 435 General patient condition: Edema: generalized
- 436 General patient condition: Edema: peripheral
- 437 General patient condition: Tinnitus
- 438 General patient condition: Herniated disk
- 439 General patient condition: Clubbing
- 451 Patient behavior: Sleep disturbance
- 452 Patient behavior: Recent change in appetite
- 453 Patient behavior: Disruptive, infantile or socially inappropriate behavior: nonverbal
- 454 Patient behavior: Disruptive, infantile or socially inappropriate behavior: verbal
- 455 Patient behavior: Physical aggression towards self
- 456 Patient behavior: physical aggression towards others
- 457 Patient behavior: Suicide attempt
- 458 Patient behavior: Flat affect
- 459 Patient behavior: Mood changes

- 460 Patient behavior: Tearful
- 461 Patient behavior: Delusional
- 462 Patient behavior: Hallucinations
- 463 Patient behavior: Paranoid
- 464 Patient behavior: Anxiety
- 465 Patient behavior: Fearful
- 466 Patient behavior: Wandering episodes

Appendix B. eTAR Glossary

Functional Limitation Codes and Descriptions

Service

Patient assessment information for this Service (Attachment A)

* P.O.T. Adherence * Height * Weight lbs. oz.

* Please list current **functional limitation** /physical condition codes

1

Please list previous **functional limitation** /physical condition codes

1

* Please list current **medical status** codes relevant to requested service(s)

1. The following is a complete list of all functional limitation codes used in the eTAR application and their descriptions. For more information on Code Search, see Module J.

Functional Limitation Codes and Descriptions

- 501 Ambulation: Independent: steady gait
- 502 Ambulation: Independent: unsteady gait
- 503 Ambulation: Independent: history of falls
- 504 Ambulation: Independent: limited distance (less than 20 feet)
- 505 Ambulation: Requires use of device to walk alone
- 506 Ambulation: assistance: cane
- 507 Ambulation: assistance: crutches
- 508 Ambulation: assistance: braces
- 509 Ambulation: assistance: prosthesis
- 510 Ambulation: assistance: walker
- 511 Ambulation: assistance: human help needed for steps or uneven surface
- 512 Ambulation: assistance: human help needed to walk at all times
- 513 Ambulation: assistance: human help needed to stand
- 514 Ambulation: wheelchair-bound: independent
- 515 Ambulation: wheelchair-bound: unable to wheel self

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- 516 Ambulation: bed-bound position self
- 517 Ambulation: bed-bound: requires assistance to position
- 518 Ambulation: bed-bound: requires mechanical assistance to leave bed
- 531 Physical limitation: quadriplegia
- 532 Physical limitation: paraplegia
- 533 Physical limitation: left hemiplegia
- 534 Physical limitation: right hemiplegia
- 535 Physical limitation: bilateral amputee: lower extremities
- 536 Physical limitation: bilateral amputee; upper extremities
- 537 Physical limitation: amputee: LLE
- 538 Physical limitation: amputee: RLE
- 539 Physical limitation: amputee: LUE
- 540 Physical limitation: amputee: RUE
- 541 Physical limitation: contracture(s): LLE
- 542 Physical limitation: contracture(s): RLE
- 543 Physical limitation: contracture(s) LUE
- 544 Physical limitation: contracture(s): RUE
- 545 Physical limitation: generalized weakness
- 547 Physical limitation: weakness: left side
- 548 Physical limitation: weakness: bilateral lower extremities
- 549 Physical limitation: weakness: bilateral upper extremities
- 550 Physical limitation: limited ROM: head/neck
- 551 Physical limitation: limited ROM: trunk
- 552 Physical limitation: limited ROM: LLE
- 553 Physical limitation: limited ROM: RLE
- 554 Physical limitation: limited ROM: LUE
- 555 Physical limitation: limited ROM: RUE
- 561 Vision: sees clearly using eyeglasses
- 562 Vision: sees clearly using contact lenses
- 563 Vision: minimally impaired: sees objects clearly, cannot read print
- 564 Vision: partially impaired: sees, shapes, objects
- 565 Vision: severely impaired: sees light/dark, some shapes
- 566 Vision: blind: one eye
- 567 Vision: blind: both eyes
- 571 Hearing/Comprehension: no deficits, naturally or with a hearing aid
- 572 Hearing/Comprehension: moderate deficits: one-step instruction and brief conversation
- 573 Hearing/Comprehension: severe deficits: simple greetings and short comments
- 574 Hearing/Comprehension: severe deficits: unable to hear and understand consistently
- 575 Hearing/Comprehension: deaf
- 576 Hearing/Comprehension: cochlear implant
- 581 Communication: nonverbal
- 582 Communication: device: board
- 583 Communication: device: writing

- 584 Communication: device: instrument/mechanical/computer
- 585 Communication: American Sign Language
- 586 Communication: speech: slurred
- 587 Communication: speech: stutters
- 588 Communication: speech: aphasia: sensory
- 589 Communication: speech: aphasia motor
- 590 Communication: speech: minimal difficulty expressing ideas and needs
- 591 Communication: speech: moderate difficulty expressing simple ideas or needs
- 592 Communication: speech: severe difficulty expressing basic idea or needs
- 593 Communication: speech: interpreter required
- 594 Communication: unable to express basic needs but is not comatose or unresponsive
- 595 Communication: patient is non- responsive
- 601 Cognitive functioning alert
- 602 Cognitive functioning: oriented
- 603 Cognitive functioning: impaired decision-making
- 604 Cognitive functioning: requires prompting under stressful or unfamiliar condition
- 605 Cognitive functioning: requires assistance and direction in specific situations
- 606 Cognitive functioning: distractibility: requires low stimulus environment
- 607 Cognitive functioning: requires considerable assistance in routine situations
- 608 Cognitive functioning: disorientation, coma, persistent, vegetative state, or delirium
- 609 Confusion: new or complex situation
- 610 Confusion: upon awakening or at night
- 611 Confusion: during sundown/twilight
- 612 Confused: constantly
- 613 Memory deficit: failure to recognize familiar persons or places
- 614 Memory deficit: inability to recall events of past 24 hours
- 615 Memory deficit: to the extent that supervision is required
- 621 Feeding/Eating: independent
- 622 Feeding/Eating: requires meal set-up
- 623 Feeding/Eating: requires intermittent aid or supervision
- 624 Feeding/Eating: requires total feeding assistance/supervision
- 625 Feeding/Eating: mechanical soft diet
- 626 Feeding/Eating: liquid/pureed diet
- 627 Feeding/Eating: takes in nutrients orally AND receives oral supplements
- 628 Feeding/Eating: takes in nutrients orally AND receives enteral supplements
- 629 Feeding/Eating: Total enteral nutrition (ng, g-tube, j-tube, other)
- 630 Feeding/Eating: Unable to take in nutrients orally or by tube feeding
- 631 Feeding/Eating: Dysphagia
- 641 Feeding/Eating: able to prepare light meals
- 642 Feeding/Eating: Unable to prepare light meals on a regular basis
- 643 Feeding/Eating: Unable to prepare ANY light meals
- 651 Medication: able to independently administer all medications

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- 652 Medication: oral: needs dose preparation, daily reminders, or a drug chart
- 653 Medication: oral: must be administered by someone else
- 654 Medication: topical: needs dose preparation, daily reminders, or a drug chart
- 655 Medication: topical: must be administered by someone else
- 656 Medication: inhalants/mist: needs dose preparation, daily reminders, or a drug chart
- 657 Medication: inhalants/mist: must be administered by someone else
- 658 Medication: injections: needs dose preparation, daily reminders, or a drug chart
- 659 Medication: injections: must be administered by someone else
- 660 Medication: patient non-compliant with medication regimen
- 671 Equipment: patient manages all related tasks
- 672 Equipment: patient requires assistance with setup
- 673 Equipment: patient requires assistance to operate
- 674 Equipment: patient is completely dependent on others
- 675 Equipment: caregiver manages all related tasks
- 676 Equipment: caregiver requires assistance with setup
- 677 Equipment: caregiver requires assistance to operate
- 678 Equipment: caregiver is completely dependent on others
- 691 Barriers: stairs: used to access toileting, sleeping and/or eating areas
- 692 Barriers: stairs: used optionally (e.g., to access laundry facilities)
- 693 Barriers: stairs: leading from inside to outside
- 694 Barriers: doorways: narrow or obstructed
- 695 Barriers: hallways: narrow or obstructed
- 696 Barriers: living environment: small or cluttered
- 701 Transportation: able to independently drive a regular or adapted car
- 702 Transportation: uses a regular or handicap-accessible public bus
- 703 Transportation: able to ride in car, taxi, bus, or van
- 704 Transportation: able to use a bus or handicap van with assistance
- 705 Transportation: unable to ride in a car, taxi, bus, or van
- 801 Socioeconomic: lacks electricity
- 802 Socioeconomic: lacks running water
- 803 Socioeconomic: lacks telephone
- 804 Socioeconomic: lacks heat
- 805 Socioeconomic: lacks refrigeration/appliances
- 806 Socioeconomic: lacks food
- 807 Socioeconomic: homeless