Treatment Authorization Request (TAR)

Introduction

Purpose

The purpose of this module is to provide an overview of the *Treatment Authorization Request* (TAR) process and to review completion requirements for the *Treatment Authorization Request* (50-1) form, as well as the *Request for Extension of Stay in Hospital* (18-1) form.

Module Objectives

- Explain how to determine when authorization is required
- Discuss the medical justification that is required for a TAR approval
- Review documentation on a TAR
- Discuss attachments
- Identify the critical data areas required to complete a *Treatment Authorization Request* (50-1) form and a *Request for Extension of Stay in Hospital* (18-1) form
- Review the *Adjudication Response* (AR)

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (*www.medi-cal.ca.gov/mcss*).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

TAR Overview (tar)

Part 2

TAR and Non-Benefit List (tar and non)
TAR Completion (tar comp)
TAR Field Office Addresses (tar field)
TAR Request for Extension of Stay in Hospital (Form 18-1) (tar req ext)

Other References

The *Manual of Criteria for Medi-Cal Authorization*
California Code of Regulations Title 22

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

TAR Description

Authorization requirements are applied to specific procedures and services according to state and federal law. Certain medical procedures and services require authorization from the Department of Health Care Services (DHCS) before reimbursement is approved.

To acquire treatment authorization, mail the *Treatment Authorization Request* (50-1) form or the *Request for Extension of Stay in Hospital* (18-1) form to:

Xerox TAR Processing Center
820 Stillwater Road
West Sacramento, CA 95605-1630

NOTE

The *50-3 Treatment Authorization Request* for vision care services will not be discussed in this training session.

Refer to the “Resource Information” section of this module for provider manual references that apply to TAR procedures discussed in this workbook.

Documentation Requirements

Medical Justification

It is the provider's responsibility to provide all necessary documentation and justification for TAR processing. Information regarding proper medical justification is found in the *TAR Overview* section (tar) in the Part 1 provider manual.

Medical Necessity

Providers must justify that the services they are requesting are medically necessary. The Medi-Cal program definition of medical necessity limits the provision of health care services to the following scenarios:

- Take actions that are reasonable and necessary to protect life
- Prevent significant illness
- Aid individuals with significant disability
- Alleviate severe pain

TAR 50-1 Form

Form Completion Process

Physicians, podiatrists, pharmacies, medical supply dealers, outpatient clinics, Community-Based Adult Services (CBAS) and laboratories use the TAR 50-1 form to request approval from a Medi-Cal TAR field office consultant for certain procedures/services.

Refer to the *TAR Completion* section (tar comp) in the appropriate Part 2 provider manual. The following pages include excerpts from the *TAR Completion* section (tar comp).

If you are unsure if a procedure requires authorization, contact the DHCS Fiscal Intermediary (FI) Telephone Service Center (TSC) at 1-800-541-5555.

NOTES

Treatment Authorization Request (50-1) Form

STATE USE ONLY (1) SERVICE CATEGORY

5 TYPEWRITER ALIGNMENT Elite Pica

CONFIDENTIAL PATIENT INFORMATION (40) F.I. USE ONLY

1 FOR F.I. USE ONLY (1A)

CCN

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

TYPEWRITER ALIGNMENT Elite Pica (43)

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO. (1B) — TYPE OF SERVICE REQUESTED: DRUG, OTHER (2) — REQUEST IS RETROACTIVE? YES NO — IS PATIENT MEDI-CARE ELIGIBLE? YES NO — PROVIDER PHONE NO. ( ) (2A)

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS (2B) (3)

3. PROVIDER NUMBER

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS: (32A) (33)

NAME AND ADDRESS OF PATIENT

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

MEDI-CAL IDENTIFICATION NO. (5) CC CORRECT (6) (55) (27)

SEX (7) AGE DATE OF BIRTH (8)

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ( )

PATIENT STATUS: HOME, BOARD & CARE, SNF / ICF, ACUTE HOSPITAL (8A)

DIAGNOSIS DESCRIPTION: (8B) ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION: (8C)

(9)

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS: 1 APPROVED AS REQUESTED, DENIED, DEFERRED; 2 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED), JACKSON VS RANK PARAGRAPH CODE

BY MEDI-CAL CONSULTANT I.D. # (34) DATE (35) REVIEW COMMENTS INDICATOR (44)

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b) (36) 1 2 3 4 5 6

LINE NO.	AUTHORIZED Y / N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9	10	(10) (10A) (10B)		11 (11)	12 (12)	$ (12A)
2	13	14			15	16	$
3	17 (13)	18			19	20	$
4	21	22			23	24	$
5	25	26			27	28	$
6	29	30			31	32 (32)	$

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

(39A) SIGNATURE OF PHYSICIAN OR PROVIDER — TITLE — DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED 37 FROM DATE (37) 38 TO DATE (38)

TAR CONTROL NUMBER

39 OFFICE (39) SEQUENCE NUMBER PI

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

PROVIDER COPY 50-1 03/07

Brainteaser

List two requirements for a retroactive TAR.

1)_____, 2)_____

Answer Key: **1)** retroactive request; **2)** service date for retroactive request

TAR 50-1 Form Fields

Locator #	Form Field	Instructions
1	STATE USE ONLY	Leave this area blank.
1A	CLAIM CONTROL NUMBER	For FI Use ONLY. Leave blank.
1B	VERBAL CONTROL NUMBER	Providers may enter a fax number in this field to receive an AR for the submitted TAR by fax, instead of standard mail. If a fax number is entered, an AR will not be mailed to the provider for the related TAR that was submitted.
2	TYPE OF SERVICE REQUESTED/ RETROACTIVE REQUEST/MEDICARE ELIGIBILITY STATUS	Enter an “X” in the appropriate boxes to show DRUG or OTHER, RETROACTIVE request, “Yes” or “No” and MEDICARE eligibility status “Yes” or “No”.
2A	PROVIDER PHONE NUMBER	Enter the telephone number and area code of requesting provider.
2B	PROVIDER NAME & ADDRESS	Enter provider name and address, including nine-digit ZIP code.
3	PROVIDER NUMBER	Enter the National Provider Identification (NPI) number for the Medi-Cal rendering provider in this area. When requesting authorization for an elective hospital admission, the hospital NPI number must be entered in this box. (Enter the hospital name in the *Medical Justification* field. If this information is not present, the TAR will be returned to the provider unprocessed.)
4	PATIENT NAME, ADDRESS, AND TELEPHONE NUMBER	Enter recipient information in this area.
5	MEDI-CAL IDENTIFICATION NUMBER	When entering only the recipient’s identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. For Family PACT requests, enter the client’s Health Access Programs (HAP) card ID number, instead of the BIC number. The county code and aid code must be entered just above the recipient Medi-Cal Identification Number field. Do not enter any characters (dashes, hyphens or special characters) in remaining blank positions of the Medi-Cal Identification Number field or in the Check Digit box.
6	PENDING	Leave blank.
7	SEX AND AGE	Use the capital “M” for male or “F” for female. Enter the age of the recipient in the Age box.
8	DATE OF BIRTH	Enter the recipient’s date of birth in a six-digit format (MMDDYY). If the recipient’s full date of birth is not available, enter the year of the recipient’s birth preceded by “0101.”
8A	PATIENT STATUS	Enter the recipient’s residential status. If the recipient is an inpatient of a Nursing Facility (NF) Level A or B, enter the name of the facility in the *Medical Justification* field.

Locator #	Form Field	Instructions
8B	DIAGNOSIS DESCRIPTION AND ICD-9-CM DIAGNOSIS CODE	Always enter the English description of the diagnosis and its corresponding code from the ICD-10-CM codebook.
8C	MEDICAL JUSTIFICATION	Provide sufficient medical justification for the consultant to determine whether the service is medically justified. If necessary, attach additional information. If the recipient is a patient in an NF-A or NF-B, enter the name of the facility in the *Medical Justification* field. Family PACT: Enter "Family PACT Client" on the first line of this field. Enter a secondary ICD-10-CM diagnosis code when the TAR is for complications of a secondary related reproductive health condition. If applicable, attach a copy of the *Family PACT Referral* form from the enrolled Family PACT provider.
9	AUTHORIZED YES/NO	Leave blank. Consultant will indicate on the AR if the service line item is authorized.
10	APPROVED UNITS	Leave blank. Consultant will indicate on the AR the number of times that the procedure, item or days have been authorized.
10A	SPECIFIC SERVICES REQUESTED	Indicate the name of the procedure, item or service.
10B	UNITS OF SERVICE	Leave blank.
11	NDC/UPC OR PROCEDURE CODE	Enter the anticipated code (five-character HCPCS, five-digit CPT-4 [followed by a two-digit modifier when necessary] or an 11-digit NDC code). When requesting hospital days, the stay must be requested on the first line of the TAR with the provider entering "Day" or "Days."
12	QUANTITY	Enter the number of times a procedure or service is requested, or the number of hospital days requested. Drugs requested should have the amount to be dispensed on each fill. Enter the total number of tablets, capsules, volume of liquid (ml) or quantity of ointments/creams (grams).
12A	CHARGES	Indicate the usual and customary dollar amount for the service(s) requested. If an item is a taxable medical supply, include the applicable state and county sales tax. For additional information, refer to the *Taxable and Non-Taxable Items* section (tax) in the appropriate Part 2 provider manual.
13 – 32	ADDITIONAL LINES 2 – 6	Additional TAR lines. Up to six drugs or supplies may be requested on one TAR.
32A	PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS	If applicable, enter the name and address of the recipient's authorized representative, representative payee, conservator, legal representative or other representative handling the recipient's medical and/or personal affairs.

Locator #	Form Field	Instructions
33 – 36	FOR STATE USE	Leave blank. Consultant's determination and comments will be returned on the AR. **NOTE** Only submit the claim if the AR decision is Approved as Requested or Approved as Modified. Denied and deferred decisions indicate that the provider's request has not been approved.
37 – 38	AUTHORIZATION IS VALID FOR SERVICES PROVIDED FROM DATE/TO DATE	Leave blank. The AR will indicate valid dates of authorization for the TAR.
39	TAR CONTROL NUMBER	Leave blank. The AR will indicate the 11-digit number that must be entered on the claim form when this service is billed. This number will show that authorization has been obtained. Do not attach a copy of the AR to the claim form. The TAR Control Number on a TAR 50-1 may serve as the initial admit TAR # on an elective admission for the hospital.
39A	SIGNATURE OF PHYSICIAN OR PROVIDER	Form must be signed by the physician, pharmacist or authorized representative.
40 – 43	F.I. USE ONLY	Leave blank.

Request for Extension of Stay in Hospital (18-1) Form

Form Completion Process

Information about form 18-1 is located in the *TAR Request for Extension of Stay in Hospital (Form 18-1)* section (tar req ext) in the Part 2 *Inpatient Services* provider manual. The following pages include excerpts from the TAR 18-1 form section.

Hospitals must request authorization for emergency admissions on a *Request for Extension of Stay in Hospital* (18-1) form for the number of days of the stay. This TAR is only authorized for inpatient hospital use and is not for physicians or outpatient hospitals billing specific TAR-required procedures. Physicians must submit a TAR (50-1) for surgical procedures that require authorization.

Elective Acute Admissions

All elective acute inpatient admissions, except for certain excluded admissions, are reviewed for medical necessity and authorized, as appropriate, using a TAR (50-1).

NOTES

Request for Extension of Stay in Hospital (TAR 18-1) Form

STATE USE ONLY

SERVICE CATEGORY

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

REQUEST FOR EXTENSION OF STAY IN HOSPITAL

1. CLAIMS CONTROL NUMBER (1) | F.I. USE ONLY

F.I. USE ONLY (2) (3) (4) (5)

CONFIDENTIAL PATIENT INFORMATION

PLEASE TYPE ALL INFORMATION

TYPEWRITER ALIGNMENT

ELITE PICA

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) (6) | ADMIT DATE (7) MMDDYY | AUTH. EXP. (8) MMDDYY | EMER. ADMIT (9)

PROVIDER NUMBER (10) | PROVIDER PHONE NO. (10A) ( ) | VERBAL CONTROL (10B)

PROVIDER NAME (10C)

PROVIDER STREET/MAILING ADDRESS

PROVIDER CITY, STATE AND ZIP CODE

PATIENT MEDI-CAL ID NO. (11) | CONTROL NO. (12) | SEX (13) | DATE OF BIRTH (14) MMDDYY | AGE (14A)

PATIENT NAME (14B) | MEDICARE STATUS (15) | OTHER COV. (16)

NUMBER OF DAYS REQUESTED (17) | TYPE OF DAYS (18) | RETRO-ACTIVE (19) | DISCHARGE DATE (20) MMDDYY | ADMITTING ICD9-CM (21)

ADMITTING DIAGNOSIS DESCRIPTION (21A)

FOR PHYSICIAN- PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

CURRENT DIAGNOSIS (22) | CURRENT ICD9-CM CODE (22)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS (18A) (22A)

DESCRIBE CURRENT CONDITION REQUIRING EXTENSION, INCLUDE PERTINENT LAB AND X-RAY REPORTS WITH DATES.

WHAT PLANNED PROCEDURES WILL REQUIRE THIS EXTENSION, INCLUDE DATES WHEN POSSIBLE.

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

SIGNATURE OF PROVIDER | DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN

SIGNATURE OF RESPONSIBLE PHYSICIAN X (22B) | DATE

MEDI-CAL CONSULTANT- VALIDATING INFORMATION AND EXPLANATION (22C)

FOR STATE USE ONLY

28 X DENIED (23)

29 X DEFERRED

X APPROVED AS REQUESTED | 24 FROM M M D D Y Y

X APPROVED AS MODIFIED | 26 THRU M M D D Y Y

27 DAYS D D | ACUTE | ACUTE ADMIN. | SUB ADMIN VENT. | SUB ADMIN INVENT.

30 DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS)

31 X JACKSON VS RANK PARAGRAPH CODE (42A)

32 M M D D | 36 M M D D | 39 M M D D

33 M M D D | 37 M M D D | 40 M M D D

34 M M D D | 38 M M D D | 41 M M D D

DATES OF DAYS DENIED

35 M M D D (42) | 1 2 3 4 5 6 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (B)

CHART REVIEWS

REVIEW COMMENTS INDICATOR

MEDI-CAL CONSULTANT (43) | ID. NO. (44) | DATE M M D D Y Y

BY (42B)

45 TAR CONTROL NUMBER (45)

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

18-1 3/07

TAR 18-1 Form Fields

Locator #	Form Field	Instructions
1	CLAIMS CONTROL NUMBER	Leave blank. For FI use only.
2 – 5	F.I. USE ONLY	Leave blank.
6	ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER)	Enter the 11-digit TAR Control Number from the original admitting TAR when additional hospital days are requested. For emergency admits, refer to Item 9. The *Emergency Admit* field (Box 9) must be left blank when the *Admit TAR Number* field is completed.
7	ADMIT DATE	Enter the date of admission using the six-digit format (MMDDYY).
8	AUTHORIZATION EXPIRES	If there is a previous TAR for this admission, coverage by another health care provider or State program, enter the expiration date of the previous TAR last date covered by the other insurance or State program. If no previous TAR, leave blank.
9	EMERGENCY ADMIT	Enter an “X” if a patient was admitted to the hospital under these conditions: without a previously approved TAR, an emergency, or a direct admission and this is the initial authorization. Leave blank on subsequent extension TARs for recipient.
10	PROVIDER NUMBER	Enter the Provider Number/NPI that uniquely identifies the facility or program.
10A	PROVIDER PHONE NUMBER	Enter the provider’s telephone number including area code.
10B	VERBAL CONTROL	Providers may enter a fax number in this field to receive an AR for the submitted TAR by fax instead of standard mail. If a fax number is entered in this field, an AR will not be mailed to the provider for the related TAR that was submitted.
10C	PROVIDER NAME AND ADDRESS	Enter the name of the hospital, street address, city, state and nine-digit ZIP code.
11	PATIENT MEDI-CAL ID NUMBER AND CHECK DIGIT	Enter the recipient’s 14-digit Medi-Cal ID number from the BIC. Enter the county code and aid code below Box 11.
12	PEND	Leave blank.
13	SEX	Enter the patient’s gender. • “F” for female • “M” for male
14	DATE OF BIRTH	Enter the recipient’s date of birth in six-digit format (MMDDYY).
14A	AGE	Enter the recipient’s age.
14B	PATIENT NAME	Enter the recipient’s last name, first name and middle initial.

Locator #	Form Field	Instructions
15	MEDICARE STATUS	If Medicare is not billed, enter the appropriate Medicare status code number. Refer to the *UB-04 Completion: Inpatient Services* section in the manual for a listing of Medicare status codes. **NOTE** If a patient's EVC label shows a "2" indicating Medicare coverage, and Medicare is not billed, the Medicare status code must be other than "0" regardless of the age of the patient.
16	OTHER COVERAGE	Enter an "X" if the recipient has other insurance or Other Health Coverage (OHC).
17	NUMBER OF DAYS	Enter the number of days requested on the TAR. DRG Admit TAR: Enter "1". Daily TAR: Enter the number of days requested.
18	TYPE OF DAYS	Enter the code indicating type of days requested. 0 Acute 2 Administrative 3 Subacute administrative ventilator dependent 4 Subacute administrative non-ventilator dependent
19	RETROACTIVE	Enter a capital "X" if Medi-Cal eligibility was approved retroactively.
20	DISCHARGE DATE	Enter the date the patient was discharged from the facility. DRG: Enter the date following the date of admission.
21	ADMITTING ICD-9-CM	Enter the numeric code for the admitting diagnosis from the ICD-10-CM codebook.

Locator #	Form Field	Instructions
21A	ADMITTING DIAGNOSIS DESCRIPTION AND ICD-9-CM DIAGNOSIS CODE	Always enter the English description of the diagnosis from the ICD-10-CM codebook.
22	CURRENT DIAGNOSIS	Enter the current ICD-10-CM diagnosis code and medical justification. Provide sufficient medical justification for the Medi-Cal consultant to determine whether the service is medically necessary. Attach additional information, if necessary.
22A	PATIENT'S AUTHORIZED REPRESENTATIVE	Enter the name and address (if known) of the patient's authorized representative, representative payee, conservator, legal representative or other representative handling the recipient's medical and personal affairs.
22B	SIGNATURE OF RESPONSIBLE PHYSICIAN	Must be signed and dated by the admitting physician or other licensed personnel with admitting privileges. The provider assumes full legal responsibility to DHCS for the information provided by the representative. Original signatures are required.
23 – 42	FOR STATE USE ONLY	Leave blank.
42A	SUB. ADMIN. VENT/SUB ADMIN N-VENT	The Medi-Cal field office consultant will mark the appropriate box. If billing for subacute care, enter the accommodation code on the claim that corresponds to the checked box on the TAR.
42B	MEDI-CAL CONSULTANT	Leave blank.
43 – 44	ID. NO./DATE	Medi-Cal consultant completes.
45	TAR CONTROL NUMBER	This number is imprinted on the form and will have a prefix and suffix added to it by the Medi-Cal consultant.

Authorization Findings

Adjudication Response

Providers no longer receive TAR adjudication results on a paper TAR. Instead, providers receive an *Adjudication Response* (AR) via the Internet with the following information, as appropriate:

- The status of the requested services
- Information required to submit a claim for TAR-approved services
- The reason(s) for the decision(s)
- TAR decisions resulting from an approved or modified appeal
- The TAR consultant's request for additional information, if necessary
- The Pricing Indicator (PI) needs to be added to the TAR Control Number (TCN) when submitting a claim

Providers should keep a copy of the AR for resubmitting a deferred paper TAR, or when requesting an update or correction to a previously approved or modified paper TAR.

State of California - Health and Human Services Agency
Department of Health Care Services

CONFIDENTIAL

ADJUDICATION RESPONSE

Provider Number: 0099219517
NPI TST CLINIC 3.1
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 12/27/2007 04:47 PM
Regarding: Jane Doe
TAR Control Number: 9876543210
Patient Record #: 12345

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Svc Code	Modifier(s)	From Date of Service	Thru Date of Service	Units	Quantity	% Var	Price	Status	PI
1	123ABC		01-01-2008	01-31-2008	12,345	1,000,000.123		9.99	Approved	1
	Svc Desc :	Service Description 1								
2	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123			Modified	0
	Svc Desc :	Service Description 2								
	Reason(s):	GEN: Modified, refer to comments								
	Comment(s):	Comments from Field Office Consultant 2								
3	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123		9,999,999.99	Denied	3
	Svc Desc :	Service Description 3								
	Reason(s):	GEN: Denied, refer to comments								
	Comment(s):	Comments from Field Office Consultant 3								
4	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123		9,999,999.99	Deferred	5
	Svc Desc :	Service Description 4								
	Reason(s):	GEN: Deferred, refer to comments								
	Comment(s):	Comments from Field Office Consultant 4								

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

TAR Control Number and Pricing Indicator

The last column on the AR will contain the Pricing Indicator (PI) number.

When submitting claims, the PI number should be included as the last digit (11th) of the TAR Control Number (TCN). Failing to use the PI when billing will cause the claim to be denied.

State of California - Health and Human Services Agency
Department of Health Care Services

CONFIDENTIAL

ADJUDICATION RESPONSE

Provider Number: 0099219517
NPI TST CLINIC 3.1
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 12/27/2007 04:47 PM
Regarding: Jane Doe
TAR Control Number: 9876543210
Patient Record #: 12345

TCN

PI

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Svc Code	Modifier(s)	From Date of Service	Thru Date of Service	Units	Quantity	% Var	Price	Status	PI
1	123ABC		01-01-2008	01-31-2008	12,345	1,000,000.123		9.99	Approved	1
	Svc Desc :	Service Description 1								
2	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123			Modified	0
	Svc Desc :	Service Description 2								
	Reason(s):	GEN: Modified, refer to comments								

Brainteaser

What is the 11-digit TCN that will be used when submitting a claim for service #1?

— — — — — — — — — — —

NOTES

Answer Key: 98765432101

TAR Form Submission

Submission Method

Providers are encouraged to use electronic TAR (eTAR) submission, which offers faster and more efficient document turn-around and payments. Providers may also submit TARs by mail. All paper TARs must be submitted to the Xerox TAR Processing Center (refer to page 2).

Submission Locations

Care should be taken to ensure that TAR forms are sent to the West Sacramento TAR Processing Center. To understand which field office adjudicates which services, they are separated into two categories: core services and regionalized services.

Core Services

- Core services are services that are adjudicated within the geographic area where the provider's service address is located.
- Examples: Elective hospital surgeries, Home Health Agencies, Magnetic Resonance Imaging (MRI) and kidney transplants.

Regional Services

- Regionalized services are services that are adjudicated only at specified field offices based on the service requested.
- Examples: Nursing facilities (San Bernardino Medi-Cal Field Office), hearing aids, orthotics and prosthetics (Sacramento Medi-Cal Field Office) and Durable Medical Equipment (multiple field offices depending on what is being requested: refer to the *TAR Field Office Addresses* [tar field] section in the Part 2 Provider Manual).

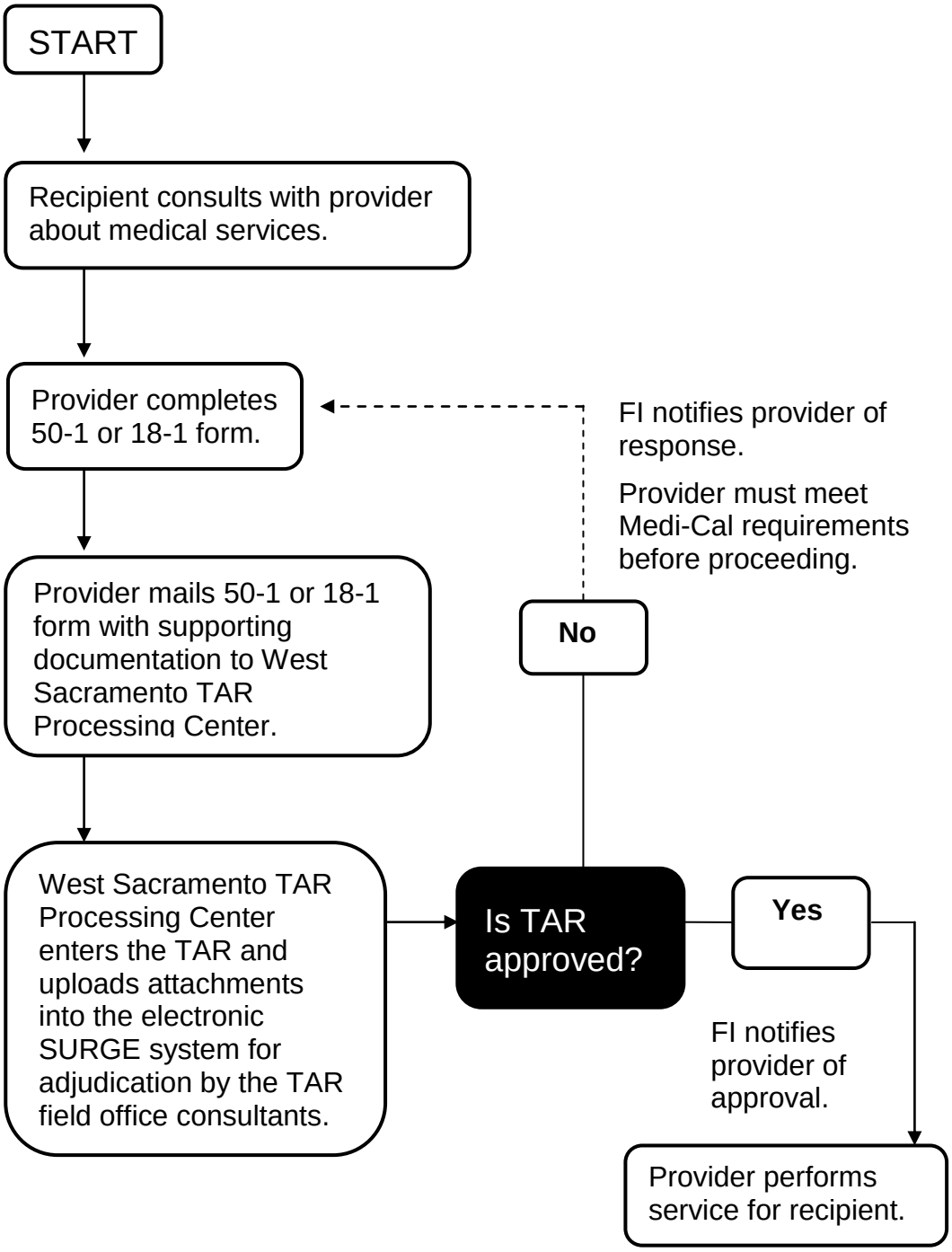
Requests for drug authorizations are faxed to either the Northern or Southern Medi-Cal Pharmacy offices.

Resource Information

Additional information can be found in the provider manual.

- The *TAR Field Office Addresses* section (tar field) in Part 2 of the provider manual lists the Medi-Cal field offices and the regionalized services for each process.
- For more information about drug TARs, refer to the *TAR Submission: Drug TARs* section (tar sub drug) in the Medi-Cal Pharmacy provider manual.
- Providers may contact the Telephone Service Center (TSC) at 1-800-541-5555 with TAR related inquiries.

TAR Completion Flowcharts

Paper TAR Form and Attachment Submission

The flowchart below depicts the process providers use when requesting Medi-Cal authorization to perform medical services with a 50-1 or 18-1 TAR form.