PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/PROCEDURE

<table>
<tr><td colspan="4">Policy Number: MPUP3080 (previouslyHKUP3080 & KK UM117</td><td colspan="2">Lead Department: Health Services</td></tr>
<tr><td colspan="6">Title: TAR Process</td></tr>
<tr><td colspan="3">Original Date: 11/16/2005 – Healthy Kids
10/01/2010 - Healthy Families</td><td colspan="3">Reviewed/Revised Date (s): (Healthy Kids - 11/21/07; 11/19/08; 07/21/10); 10/01/10; 07/20/11</td></tr>
<tr><td>Applies to:</td><td>☐ Medi-Cal</td><td>☑Healthy Kids</td><td>☑ Healthy Families</td><td colspan="2">☐ PartnershipAdvantage</td></tr>
<tr><td>Reviewing Entities:</td><td>☐ CREDENTIALING</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>Approving Entities:</td><td>☐ BOARD</td><td>☐ CEO</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH</td><td colspan="2">Approval Date: 07/20/2011</td></tr>
</table>

I. ATTACHMENTS:

A. PHC TAR Requirements list
B. PHC's CPTs Requiring TAR list
C. PHC's Pain Management CPTs Requiring TAR list
D. Treatment Authorization Request Form (TAR)
   1. Healthy Kids
   2. Healthy Families
E. TAR Extension Form
   1. Healthy Kids
   2. Healthy Families

II. PURPOSE:

To describe the procedure used by the PHC UM Department to process Treatment Authorization Requests (TARs) based upon the medical necessity of the request.

Definition of Medical Necessity – Medically necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

III. POLICY:

A. The Partnership Healthplan of California (PHC) pays for authorized services according to the specific terms of each physician, hospital, or other provider contract. PHC reimburses only if individuals are eligible at the time the service is rendered.

B. Resources necessary to help in determining review decisions, include, but are not limited to the published, current InterQual criteria, and PHC internally developed and approved guidelines. Determinations also take into account individual member needs and characteristics of the local delivery system.

   1. The Provider of service must verify eligibility of the member via PHC systems when the service is provided. This verification is necessary for all service authorizations.

   2. The PCP should consult the list of members furnished by PHC at the beginning of each month that lists members for whom the physician has assumed case management responsibility. If the individual is not listed, the provider should contact the PHC's e-Eligibility or IVR System for member eligibility verification.

3. Hospitals and other providers may utilize PHC's eEligibility and IVR Systems to verify eligibility and determine the member's assigned PCP. Information required to verify the eligibility of an individual is as follows:
   a. Name
   b. Date of Birth
   c. Sex
   d. Social Security Number
   e. Member number
   f. Address and name of parent may be necessary in some cases.

C. Submission of TARs

1. Certain procedures, services, and medications require prior authorization from PHC before reimbursement is made. The provider of service must use the KNOX-KEENE TAR REQUEST form to request approval directly from PHC.

2. Services requiring TARS
   a. TARs will be required for all procedure codes listed in the PHC Outpatient Surgical Procedures CPTs Requiring TAR list. (Attachment B)
   b. The "PHC TAR Requirements" list identifies all other services with TAR requirements.
   c. All elective inpatient hospital admissions, except anticipated 48 hour post vaginal delivery stays and 96 hour post C-Section stays, require prior TAR authorization.
   d. All Skilled Nursing facility admissions and re-authorizations of stay require prior TAR approval. (See Skilled Nursing Facility Review Guidelines)

3. Urgent TARs
   a. If the service requested is urgent, the provider should clearly mark the TAR URGENT.
   b. A TAR for elective (non-emergent) surgery submitted urgently due to imminent date of service is NOT considered to be urgent. TARs submitted for these procedures will be processed as a routine TAR.
   c. Urgent requests for services needed within one calendar day should be faxed or submitted via e-TAR to the Health Services Department. The provider should indicate the reason that there is an urgent need for authorization.
   d. The UM Nurse will process the urgent request and notify the provider within one calendar day of the determination.

4. Routine TARs
   a. TARs for members that require services within the next 2 to 10 days should be faxed or electronically submitted to the Health Services Department for review.
   b. TARs for services that are needed by the member beyond 10 days can be mailed or submitted via e-TAR to the Health Services Department for review.
   c. Routine TARs will be processed within 5 business days of receipt of all documentation and the provider will be notified of the decision to approve, modify, pend, or deny the TAR within one (1) working day.

5. The TAR procedure for elective services is as follows:
   a. The provider may submit a request for treatment authorization by mail, fax, electronically with fax, or e-TAR being the preferred method for services that are needed within the next 10 days.
   b. Authorization for elective hospital admissions must be submitted by the admitting physician.
      1) The following must be on the request:
         a) Procedure code or service being performed
         b) Facility where procedure will be performed
         c) Anticipated date of procedure
   c. Please note that PHC will assign a number of approved days; if the patient's condition necessitates hospitalization beyond that time frame, PHC will perform daily concurrent review on the remainder of the stay.
   d. The UM Nurse reviews the information received from the provider utilizing PHC approved review guidelines. The UM Nurse approves the request if it meets medically necessary criteria. Requests that do not meet review guidelines are referred to the Chief Medical Officer/Physician Designee or Director of Health Services for further evaluation.
   e. PHC's Chief Medical Officer or Physician Designee reviews all TARs referred to him/her, taking the action deemed appropriate. He / She may contact the requesting provider for further information. Once the Chief Medical Officer or Physician Designee approves or modifies the request, the TAR will be returned to the UM Nurse for completion. <u>Denials for medical necessity are made only by the</u> Chief Medical Officer or Physician Designee.
   g. Health Services staff designee may authorize denials based on administrative criteria. Administrative denial criteria shall include: TAR not required, member not eligible with PHC on date of service, duplicate request, TAR not submitted on a timely basis, and additional information not received by PHC within 30 days of request. (See Provider Appeals of Health Services Administrative Denials policy). For contracted providers, administrative denials are not subject to the Provider Appeals process.
   h. Decisions for non- urgent services are made within 5 working days of obtaining all requested information.
   i. The authorization number for all requests is entered into PHC's electronic authorization system.
   j. Appropriate letters, either of approval, modification, or denial, are generated by the UM Nurse and sent to the provider requesting the service within established timeframes.
   k. The storage of TARs is twelve months on-site, and then off-site for a total of ten years or until minor reaches legal age, whichever is greater.

6. Emergency admissions and obstetrical deliveries do not require a TAR submission prior to furnishing services. Procedures for these conditions are as follows:
   a. Emergency admissions
      1) The hospital or LTC facility must notify PHC and the member's PCP of the admission as soon as possible, but not later than 24 hours following the emergency admission, or on the next business day if the admission occurs on a weekend day or holiday.

2) In the case of hospital admission – notification must occur via fax of hospital admission face sheet (it is recommended that the provider maintain documentation that transmission has completed) or electronically via e-TAR.
   a) SNF facilities must also submit a TAR to PHC, as per timeline requirements.
   b) The case is reviewed by the UM Nurse and a decision on length of stay is authorized based on PHC established criteria within one calendar day.
   c) The provider is notified of decision within one calendar day.

3) Obstetrical delivery services
   a) The hospital notifies PHC by telephone or electronically via e-TAR within 24 hours of admission for obstetrical delivery.
   b) PHC approves 48 hours for both mother and baby for post vaginal deliveries and 96 hours for a C-Section delivery.
   c) The hospital must notify PHC if the mother and/or baby require additional acute care. The UM Nurse reviews the case for medical necessity during the next UM review.

7. CCS Conditions
   a. For member with any condition defined in California Code of Regulations, Title 22, Division 2, Part 2, Subdivision 7, CCS< Chapter 4 Medical Eligibility, Sections 41800-41872, these are eligible for coverage under the CCS program for services related to those conditions. CCS shall approve for and pay for all services in these instances.
   b. PHC's benefits are exclusive of services for CCS conditions and PHC will not approve for or pay such services.

D. UM Nurse Review of TARs

1. UM nurse can approve, modify, pend the TAR, or deny the TAR for administrative reasons.

2. TARs that are deferred for more information are returned to the UM Coordinator with the appropriate information. The HS Coordinator forwards the information to the provider, and returns the pended TAR to the UM nurse. The UM nurse pends the TAR for a maximum of thirty (30) days if the information requested is not provided. The TAR is denied as not having sufficient information to make a medical determination in 30 days.

3. TARs that require clinician review are pended for Chief Medical Officer or Physician Designee review. The UM nurse attaches all relevant documentation and the Medical Director review worksheet.

4. TARs can be denied, for reasons of medical necessity, only by the Chief Medical Officer or Physician Designee. The UM nurse or HS coordinator attaches the appropriate provider and member letters to the TAR.

5. Services that do not require a TAR, or if the TAR is a duplicate request of a previous TAR, an administrative denial will be issued.
   a. Refer to the Provider Appeals of Health Services Administrative Denials policy for details of the process

E. Chief Medical Officer or Physician Designee Review

1. The Chief Medical Officer or Physician Designee must be available physically or by telephone during business hours to assist with evaluating TAR requests.

2. The Chief Medical Officer or Physician Designee review is done in all cases of potential denial due to medical necessity, interpretation issues, or other issues as requested by the UM staff.

3. The UM nurse attaches the Medical Director review form to the TAR. After the Chief Medical Officer or Physician Designee completes the review, the paperwork is given to the appropriate UM nurse.

4. The Chief Medical Officer or Physician Designee may contact involved providers or consultants for additional information as required to assist him/her in rendering a decision about the case. The Chief Medical Officer or Physician Designee documents the rationale for any decision on the Medical Director worksheet.

5. The Chief Medical Officer or Physician Designee are the only persons authorized to sign denials for medical necessity or to make any exceptions or modifications to the established PHC medical criteria.

6. PHC makes available to physicians a physician reviewer (usually the Chief Medical Officer or Physician Designee) to discuss by telephone determinations based on medical necessity.

F. Processing of TARs

1. TARs are not processed by PHC until the TAR is complete and all necessary documentation has been submitted. PHC does not honor the "date received" stamped on an incomplete TAR and returns it to the provider indicating the information that is required. No action is taken until the TAR is returned to PHC with the requested information and the date returned to PHC is used in determining if appropriate timelines have been met

2. Health Services staff also checks TARs for legibility and member eligibility, as well as review for benefit coverage

3. Authorizations are only valid for the timeframe approved by PHC staff.

4. All TARs (including worksheets, letters, and other documentation) are kept on site for 12 months and archived off site for seven years or until member reaches age 19.

G. Retrospective Review for TAR Required Services

1. Retro TARs must be received by PHC within fifteen (15) business days of the date of service. Retro TARs received after fifteen (15) business days of requested date of service are considered for review only under the following conditions:
   a. The service was EMERGENT in nature
   b. The service was a Delivery that falls within the PHC timeframes as per III.C.6. of this policy

2. For retrospective medical review, the decision for authorization is made within 30 days of obtaining all the necessary information.

3. Determination of the request will be given to the providers within one day and members will be notified in writing within 2 working days.

H. UM Decision Timelines
(FOR REQUESTS OTHER THAN PHARMACY) ***SEE PRESCRIPTION DRUG PRIOR AUTHORIZATION (TAR) PROCEDURE FOR PHARMACY TAR TIMEFRAMES***

1. For precertifications of nonurgent care, PHC makes decisions within five (5) working days of obtaining all the necessary information.

2. For precertifications of nonurgent care, PHC notifies practitioners of the decisions within one working day of making the decision.

3. For precertifications of nonurgent care, PHC gives members written notification of the decisions within two working days.

4. Post Stabilization Services
   Upon receipt of an authorization request from an emergency services provider, UM shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4.

5. For precertification of urgent care, PHC makes decisions and notify practitioners of the decisions within one working day are notified of decision in writing within one working day. PHC provides information on how to initiate an expedited appeal if the determination was a denial of service.

6. For pre-certifications of urgent care, PHC notifies members of the decision in writing within two working days. PHC provides information on how to initiate an expedited appeal if the determination was a denial of service.

7. For concurrent review, PHC makes decisions within one working day of obtaining all the necessary information.

8. For concurrent review, PHC notifies practitioners of decisions within one working day of making the decision.

9. For concurrent review decisions that result in a denial, PHC gives members and practitioners written or electronic confirmation within one working day of the original notification.

10. For concurrent review decisions that result in a denial, PHC notifies both members and practitioners how to initiate an expedited appeal at the time they are notified of the denial.

11. For retrospective review, PHC makes the decision within 30 working days of obtaining all the necessary information.

12. For retrospective review, PHC notifies practitioners and members of denials in writing within five working days of making the decision

I. PHC's Monitoring of the TAR Process

1. Aggregate TAR data is subject to retrospective analysis by PHC's UM Department. This review is designed to:
   a. Identify individual provider practice patterns relative to standards of medical practice
   b. Evaluate over and under utilization of services

2. PHC monitors turnaround times of internal processing for compliance with standards.

3. PHC performs inter-rater reliability audits at least annually on both physician and nurse reviewers.

4. Member & provider grievances, as well as PHC's member and provider satisfaction survey responses, serves as an evaluation tool.

5. Reports regarding PHC's UM Department's monitoring activities are presented to the Quality / Utilization Advisory Committee (Q/UAC) on an annual basis for evaluation and corrective actions as needed.

IV. REFERENCES

A. California Health and Safety Code 1367.01

V. DISTRIBUTION

A. PHC Departmental Directors, PHC Provider Manual

PHC TAR REQUIREMENTS

Effective 01/01/2011

(TAR to be submitted by the provider performing the service)

A. **Hospitalization**
1. The hospital must notify PHC of any admission within 24 hours of the admission.
2. Authorization for elective admission must be requested by the admitting physician.

B. **Long Term Care**
The LTC facilities must notify PHC of any admissions, transfer, bed hold/ leave of absence, or change in payor status within one working day. (Examples include Medicare non-coverage or exhaustion of benefits / hospice election.)

C. **Outpatient Surgical Procedures** – see **CPTs Requiring TAR** list

D. **Pain Management** – see **CPTs Requiring TAR** list

E. **Outpatient Hemo / Peritoneal Dialysis**
(Note: initial authorization will be limited to 90 days and extensions will be granted only after submission of Medicare determination.)

F. **Drugs and Pharmaceuticals** – A TAR is required for all prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) not listed in the PHC formulary.

PLEASE REFER TO PHC FORMULARY

G. **Diagnostic Studies – Both Professional & Facility**
- CT Scans
- MRI
- MRA
- PET scan
- Transcranial Doppler
- Sleep Studies / Polysomnography

H. **Ancillary / Support Services**
RAF authorizes one visit only. Requests for additional visits require the ancillary service provider to submit copies of initial evaluation and treatment plan attached to TAR. TAR must include total visits requested including initial visit.

- Acupuncturist ✖
- Chiropractor ✖
- Nutrition Services
- Podiatry Services
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Home Infusion Therapy *(Nursing Component Only)*
- Home Health Care

✖ *Not Applicable to Healthy Families*

I. **Hospice Care**

J. **Pulmonary Rehabilitation**

K. **Hyperbaric Oxygen Pressurization**

L. **Non-Emergency Medical Transportation**

M. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services

N. **Phototherapy** for dermatological condition

O. **Dental Anesthesia**

P. **CCS/GHPP** - Authorization for services related to eligible condition(s) must be requested from CCS or GHPP office(s).

Q. **Supplies / Equipment**

- ♦ Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item
- ♦ Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item
  And any unlisted / miscellaneous code including:
  - L0999 Addition to spinal orthosis, not otherwise specified
  - L1499 Spinal orthosis, not otherwise specified
  - L2999 Lower extremity orthosis, not otherwise specified
  - L3649 Orthotic shoe, modification, addition or transfer, not otherwise specified
  - L3999 Upper limb orthosis, not otherwise specified
  - L5999 Lower extremity prosthesis, not otherwise specified
  - L7499 Upper extremity prosthesis, not otherwise specified
  - L8039 Breast prosthesis, not otherwise specified
  - L8499 Unlisted procedure for miscellaneous prosthetic services

  ANY CUSTOM MADE ITEM THAT DOES NOT HAVE A MEDI-CAL RATE (BY-REPORT OR BY-INVOICE)
- ♦ Ostomy Supplies – If **monthly** cumulative cost for all related supplies exceeds $150
- ♦ Hearing Aid – All purchases, rentals or repairs exceeding $50 / item
  (Batteries are non-covered except some CCS / EPSDT cases, in which case TAR is required)
- ♦ Oxygen and related supplies
- ♦ Diabetic Supplies are to be provided by Pharmacies ONLY effective 11/1/2004
- ♦ Medical Supplies – ***(If dispensed by PHARMACY, please refer to formulary)***
  Any unlisted or miscellaneous code
- ♦ DME – ***(If dispensed by PHARMACY, please refer to formulary)***
  - Repairs or maintenance over $250.00 / item (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months form the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)
  - Purchase items over $100.00 / item (To be guaranteed for a MINIMUM of six (6) months from the date of purchase)
  - Rental items over $50.00 / month / item (Rental rate includes equipment related supplies.)
  - Any unlisted or miscellaneous code
  - Purchase of any wheelchairs for Medi-Medi members
- ♦ Nutritional Supplements

PARTNERSHIP*ADVANTAGE* (HMO)Outpatient Surgical Procedures - CPTs Requiring TAR

Attachment B

CPT CODE	DESCRIPTION
10040	ACNE SURGERY
15788 thru 15793	CHEMICAL PEEL, FACIAL ET AL
15810-11	SALABRASION
15820 thru 15823	REVISION OF LOWER OR UPPER EYELID
15845	SKIN AND MUSCLE REPAIR, FACE
17360	SKIN PEEL THERAPY
17999	SKIN TISSUE PROCEDURE
19140	MASTECTOMY FOR GYNECOMASTIA
19300	MASTECTOMY FOR GYNECOMASTIA
19316	MASTOPEXY
19318	REDUCTION MAMOPLASTY
19324/25	BREAST AUGMENT; W/O PROSTHETIC IMPLANT
19355	CORRECTION OF INVERTED NIPPLES
19380	REVISE BREAST RECONSTRUCTION
19396	DESIGN CUSTOM BREAST IMPLANT
19499	UNLISTED PROCEDURE, BREAST
20999	MUSCULOSKELETAL SURGERY
21208	AUGMENTATION OF FACIAL BONES
22899	SPINE SURGERY PROCEDURE
22999	ABDOMEN SURGERY PROCEDURE
28290 thru 28299	CORRECTION OF BUNION
28300 thru 28345	OSTEOTOMY / REPAIR / RECONSTRUCTION
30400 thru 30520	RECONSTRUCT OF NOSE
30520	REPAIR NASAL SEPTUM
32999	CHEST SURGERY PROCEDURE
36299	VESSEL INJECTION PROCEDURE
38206, 38231	STEM CELL HARVESTING
38230	BONE MARROW HARVESTING
36511	THERAPEUTIC APHERESIS OF WBC'S
36512	THERAPEUTIC APHERESIS OF RBC'S
38204	UNRELATED HARVESTING OF CELLS
38205	STEM CELL HARVESTING FROM SIBLINGS
38207	STEM CELL STORAGE
41899	GUM SURGERY PROCEDURE
43770	LAPAROSCOPY, SURGICA,LGASTRIC RESTRICTIVE PROCEDURE
43771	LAPAROSCOPY, SURG, REVISION OF ADJUST GASTRIC BAND
43772	LAPAROSCOPY, SURGICAL, REMOVAL OF ADJUSTABLE GASTRIC BAND

PARTNERSHIP*ADVANGE* (HMO) - Outpatient Surgical Procedures - CPTs Requiring TAR (Continued)

CPT CODE	DESCRIPTION
43773	LAPAROSCOPY, SURGICAL, REMOVAL & PLACEMENT OF ADJ GASTRIC BAND
43774	LAPAROSCOPY, SURGICAL, REMOVAL OF ADJUSTABLE GASTRIC BAND
43842	GASTROPLASTY, VERTICL BANDED, FOR MORBID OBESITY
43843	GASTROPLASTY, OTHER THAN VERTICAL-BANDED, FOR MORBID OBESITY
43845	GASTROPLASTY
43846	GASTRIC BYPASS FOR OBESITY
43847	GASTRIC RESTRICTIVE PROCEDURE WI
43848	REVISION OF GASTRIC RESTRICTIVE
43886	GASTRIC RESTRICTIVE PROCEDURE
43887	GASTRIC RESTRICTIVE PROCEDURE, REMOVAL OF SUBCUTANEOUS PORT COMPONENT
43888	GASTRIC RESTRICTIVE PROC, REMOVAL & REPLACEMENT OF SUBCUTANEOUS PORT
49999	ABDOMEN SURGERY PROCEDURE
54152/61	CIRCUMCISION
54360	PENIS PLASTIC SURGERY
54400 thru 54440	PENIAL PROSTHESIS / PLASTIC PROCEDURE FOR PENIS
55175/80	REVISION OF SCROTUM
55200	INCISION OF SPERM DUCT
56800	REPAIR OF VAGINA
58150 thru 58294	HYSTERECTOMY
58350	REOPEN FALLOPIAN TUBE
58550 thru 58554	LAPAROSCOPY, SURGICAL; WITH VAGINAL HYSTERECTOMY WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S) (LAPAROSCOPIC ASSISTED VAGINAL HYSTERECTOMY)
58578/79	UNLISTED PROCEDURE, UTERUS
58750 thru 58770	TUBAL REPAIR
61850 thru 61888	INSERTION, REVISION OR REMOVAL OF CRANIAL NEUROSTIMULATOR
63650 thru 63688	INSERTION, REVISION OR REMOVAL OF SPINAL NEUROSTIMULATOR
67900 thru 67924	REPAIR BROW, PTOSIS, BLEPHAROPTOSIS, LID
67950 thru-66	REVISION OF EYELID
67971-75	RECONSTRUCTION OF EYELID
67999	UNLISTED EYELID PROCEDURE
69300	REVISE EXTERNAL EAR
69399	OUTER EAR SURGERY PROCEDURE

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Pain Management CPTs Requiring TAR

Attachment C

CPT CODE	DESCRIPTION
64470	Injection, anesthetic agent and/or steroid, Para vertebral facet joint or facet joint nerve, cervical or thoracic, single level
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint cervical or thoracic, each additional level
64475	Lumbar or sacral, single level
64476	Lumbar or sacral, each additional level
64479	Injection, anesthetic agent and/or steroid, transforaminal epidural cervical or thoracic, single level
64480	Cervical or thoracic, each additional level
64483	Lumbar or sacral, single level
64484	Lumbar or sacral, each additional level
64622	Destruction by neurolytic agent, paravertebral facet joint nerve. Lumbar or sacral, single level
64623	Lumbar or sacral, each additional level
64626	Cervical or thoracic, single level
64627	Cervical or thoracic, each additional level
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
0027T	Endoscopic lysis of epidural adhesions with direct visualization using mechanical means (e.g., spinal endoscopic catheter system) or solution injection (e.g., normal saline) including radiologic localization and epidurography
0062T	Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level
0063T	Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; one or more additional levels
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy, percutaneous laser discectomy)
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
360 Campus Lane, Suite 100
Fairfield, CA 94534
(707) 863-4133 or (800) 863-4144
(707) 863-4118 FAX

TREATMENT AUTHORIZATION REQUEST FORM (TAR)

(PLEASE TYPE) (FOR PROVIDER USE) (PLEASE TYPE)

REQUEST IS RETROACTIVE ? yes NO

PROVIDER PHONE NO. ( )

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

PROVIDER NO.

*If you do NOT have a PHC HK Provider Number, please contact the Provider Relations Department at 707-863-4100.

FOR PHC USE ONLY

PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUETED | DENIED | DEFERRED

APPROVED AS MODIFIED

BY: ____________________
PHC CONSULTANT'S NAME

DATE M M D D Y Y

REVIEW COMMENT INDICATOR

COMMENTS / EXPLANATION

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)

IDENTIFICATION NO.

STREET ADDRESS

SEX | AGE | DATE OF BIRTH M M D D Y Y

CITY, STATE, ZIP CODE

HOME | ACUTE HOSPITAL

PHONE NUMBER
AREA
( )

DIAGNOSIS DESCRIPTION: CURRENT ICD-9CM CODE

MEDICAL JUSTIFICATION:

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1								
2								
3								
4								
5								
6								

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.

SIGNATURE OF PHYSICIAN OR PROVIDER | TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE M M D D Y Y | TO DATE M M D D M Y Y

TAR CONTROL NUMBER

OFFICE | SEQUENCE NUMBER | PI

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
360 Campus Lane, Suite 100
Fairfield, CA 94534
(707) 863-4133 or (800) 863-4144
(707) 863-4118 FAX

TREATMENT AUTHORIZATION REQUEST FORM (TAR)

Healthy Families

(PLEASE TYPE) **(FOR PROVIDER USE)** **(PLEASE TYPE)**

REQUEST IS RETROACTIVE ? ☐ yes ☐ NO

PROVIDER PHONE NO. ( )

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

PROVIDER NO.

*If you do NOT have a PHC HK Provider Number, please contact the Provider Relations Department at 707-863-4100.

FOR PHC USE ONLY

PROVIDER: YOUR REQUEST IS:

☐ APPROVED AS REQUETED ☐ DENIED ☐ DEFERRED

☐ APPROVED AS MODIFIED

BY: ______________________
PHC CONSULTANT'S NAME

DATE M M D D Y Y

REVIEW COMMENT INDICATOR ☐

COMMENTS / EXPLANATION

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)

IDENTIFICATION NO.

STREET ADDRESS

SEX

AGE

DATE OF BIRTH M M D D Y Y

CITY, STATE, ZIP CODE

☐ HOME ☐ ACUTE HOSPITAL

PHONE NUMBER
AREA
( )

DIAGNOSIS DESCRIPTION:

CURRENT ICD-9CM CODE

MEDICAL JUSTIFICATION:

LINE NO.	AUTHORIZED		APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
	YES	NO						
1								
2								
3								
4								
5								
6								

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.

SIGNATURE OF PHYSICIAN OR PROVIDER | TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE M M D D Y Y

TO DATE M M D D M Y Y

TAR CONTROL NUMBER

OFFICE | SEQUENCE NUMBER | PI

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

360 Campus Lane, Suite 100
Fairfield, CA 94534
(707) 863-4133 or (800) 863-4144
(707) 863-4118 FAX

TREATMENT AUTHORIZATION REQUEST (TAR) EXTENSION FORM

ADMIT NUMBER (ORIGINAL AUTHORIZATION NUMBER) | ADMIT DATE MM DD YY | AUTH EXP. MM DD YY | EMER ADMIT | VERBAL CONTROL

PATIENT ID NO. | SEX | DATE OF BIRTH MM DD YY | AGE

PROVIDER NUMBER*

*If you do NOT have a PHC HK Provider Number, please contact the Provider Relations Department at 707-863-4100.

PROVIDER PHONE NO. ( )

PATIENT NAME | OTHER COV

PROVIDER NAME

NUMBER OF DAYS REQUESTED | TYPE OF DAYS | RETRO ACTIVE | MM DD YY | ADMITTING ICD9-CM

PROVIDER STREET / MAILING ADDRESS

ADMITTING DIAGNOSIS DESCRIPTION

PROVIDER CITY, STATE AND ZIP CODE

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

CURRENT DIAGNOSIS | CURRENT ICD9-CM CODE

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

-
-
-
-

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

LIST THE PROCEDURES THAT WIL REQUIRE AN EXTENSION OF THIS HOSPITAL STAY. INCLUDE DATES WHEN POSSIBLE.

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

SIGNATURE OF PROVIDER | DATE / /

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN.

SIGNATURE OR RESPONSIBLE PHYSICIAN

X / /

VALIDATING INFORMATION AND EXPLANATION

CHART REVIEWS

REVIEW COMMENTS INDICATOR

FOR PHC USE ONLY

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

X DEFERRED | X APPROVED AS MODIFIED | M M D D Y Y

DAYS D D | ACUTE | ACUTE ADMIN | SUB ADMIN VENT | SUB ADMIN N-VENT

DAYS OF THE HOSPITALIZATION ARE DENIED (SEE COMMENTS)

M M D D	M M D D	M M D D	DATES OF DAYS DENIED
M M D D	M M D D	M M D D	
M M D D	M M D D	M M D D	
M M D D	1 2 3 4 5 6		

PARTNERSHIP HEALTHPLAN OF CA CONSULTANT

BY

DATE M M D D Y Y

TAR CONTROL NUMBER

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

360 Campus Lane, Suite 100
Fairfield, CA 94534
(707) 863-4133 or (800) 863-4144
(707) 863-4118 FAX

TREATMENT AUTHORIZATION REQUEST (TAR) EXTENSION FORM

ADMIT NUMBER (ORIGINAL AUTHORIZATION NUMBER)

ADMIT DATE MM DD YY

AUTH EXP. MM DD YY

EMER ADMIT

VERBAL CONTROL

PATIENT ID NO.

SEX

DATE OF BIRTH MM DD YY

AGE

PROVIDER NUMBER*

*If you do NOT have a PHC HK Provider Number, please contact the Provider Relations Department at 707-863-4100.

PROVIDER PHONE NO. ( )

PATIENT NAME

OTHER COV

PROVIDER NAME

NUMBER OF DAYS REQUESTED

TYPE OF DAYS

RETRO ACTIVE MM DD YY

ADMITTING ICD9-CM

PROVIDER STREET / MAILING ADDRESS

ADMITTING DIAGNOSIS DESCRIPTION

PROVIDER CITY, STATE AND ZIP CODE

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

CURRENT DIAGNOSIS

CURRENT ICD9-CM CODE

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

-
-
-
-

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

LIST THE PROCEDURES THAT WIL REQUIRE AN EXTENSION OF THIS HOSPITAL STAY. INCLUDE DATES WHEN POSSIBLE.

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

SIGNATURE OF PROVIDER

/ /
DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN.

SIGNATURE OR RESPONSIBLE PHYSICIAN

X / /

VALIDATING INFORMATION AND EXPLANATION

CHART REVIEWS

REVIEW COMMENTS INDICATOR

FOR PHC USE ONLY

X DENIED

X DEFERRED

X APPROVED AS REQUESTED

X APPROVED AS MODIFIED

FROM
M M D D Y Y
M M D D Y Y

DAYS D D

ACUTE

ACUTE ADMIN

SUB ADMIN VENT

SUB ADMIN N-VENT

DAYS OF THE HOSPITALIZATION ARE DENIED (SEE COMMENTS)

M M D D	M M D D	M M D D
M M D D	M M D D	M M D D
M M D D	M M D D	M M D D
M M D D	1 2 3 4 5 6	

DATES OF DAYS DENIED

PARTNERSHIP HEALTHPLAN OF CA CONSULTANT

BY

DATE M M D D Y Y

TAR CONTROL NUMBER

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY