



PA TAR REQUIREMENTS

Effective 09/01/2010

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

- A. **Hospitalization**
 1. The hospital must notify PA 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 PA 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.

◆ <u>Acupuncturist*</u>	◆ <u>Physical Therapy</u>
◆ <u>Chiropractor**</u>	◆ <u>Speech Therapy</u>
◆ <u>Faith Healer*</u>	◆ <u>Occupational Therapy</u>
◆ <u>Nutrition Services*</u>	◆ <u>Home Infusion Therapy</u> (<i>Nursing Component Only</i>)
◆ <u>Podiatry Services**</u>	◆ <u>Home Health Care</u>

*Not covered benefits

** Chiropractic and Podiatry services have limited coverage

I. **Hospice Care**

- J. **Hyperbaric Oxygen Pressurization**
- K. **Non-Emergency Medical Transportation**
- L. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services
- M. **Phototherapy** for dermatological condition
- N. **Dental Anesthesia**
- O. **CCS/GHPP** - Authorization for services related to eligible condition(s) must be requested from CCS or GHPP office(s).
- P. **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 from 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
 - ◆ **Incontinence Supplies**
 - Incontinence supplies if monthly cumulative cost for all related supplies exceeds \$125.00
AND any unlisted or miscellaneous code
 - Washes and creams for members with incontinence will only be authorized if the physician justifies medical necessity
 - ◆ **Nutritional Supplements**



Partnership Advantage Outpatient Surgical Procedures - CPTs Requiring TAR

Attachment II

Partnership Advantage (HMO SNP)

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, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE

**Partnership HealthPlan of California - Outpatient Surgical Procedures
- CPTs Requiring TAR (Continued)**

Attachment B

CPT CODE	DESCRIPTION
43771	LAPAROSCOPY, SURG, REVISION OF ADJUST GASTRIC BAND
43772	LAPAROSCOPY, SURGICAL, REMOVAL OF ADJUSTABLE GASTRIC BAND
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 ADVANTAGE (HMO)
Pain Management CPTs Requiring TAR**

CPT CODE	DESCRIPTION
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, lumbar (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
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
64490 - PA	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491 - PA	Second level (List separately in addition to code for primary procedure)
64492 - PA	Third level (List separately in addition to code for primary procedure)
64493 - PA	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT, lumbar or sacral; single level
64494 - PA	Second level (List separately in addition to code for primary procedure)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Pain Management CPTs Requiring TAR (continued)

CPT CODE	DESCRIPTION
64495 - PA	Third level (List separately in addition to code for primary procedure)
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

Partnership *Advantage* Members ONLY- CPT Codes 64470 - 64476 have been deleted and replaced by 64490 - 64495 effective 01/01/ 2010