PARTNERSHIP HEALTHPLAN of CALIFORNIA

PHC TAR REQUIREMENTS

Attachment A - MCUP3041
Attachment A - MCUP3049
Attachment B - MCUG3007

(TAR to be submitted by the provider performing the service) **Revised 05/08/2019**

A. **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.
1. Acupuncturist *(see policy MCUG3002 Acupuncture Service Guidelines)*
2. Chiropractor *(see policy MCUG3010 Chiropractor Services)*
3. Physical Therapy *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*
4. Speech Therapy *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*
5. Occupational Therapy *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*
6. Home Infusion Therapy *(Nursing Component Only) (see policy MCUG3011 Criteria for Home Health Services)*
7. Home Health Care *(see policy MCUG3011 Criteria for Home Health Services)*

B. **Dental Anesthesia** *(see policy MPUP3048 Dental Services (including Dental Anesthesia)*

C. **Diagnostic Studies**
1. CT Scans (Except 76497)
2. MRI (Except 76494, 76380, 76506)
3. Cardiac MRI - 75561 only (effective 08/01/2017)
4. MRA
5. PET scan *(see policy MPUP3116 Positron Emission Tomography Scans (PET) for Diagnosis and/or Treatment of Cancer)*
6. Transcranial Doppler
7. Sleep Studies / Polysomnography *(see policy MCUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*

D. **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 on the PHC formulary.
PLEASE REFER TO PHC FORMULARY

E. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services (*see policy MCCP2022 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services)*

F. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MCUP3136 Fecal Microbiota Transplant)*

G. **Gender Dysphoria** – A TAR is required for all procedures related to gender dysphoria. *(see policy MCUP3125 Gender Dysphoria/ Surgical Treatment)*

H. **Genetic Testing** – A TAR is required for certain genetic testing as outlined in Attachment A of policy *MCUP3131 Genetic Screening and Diagnostics*

I. **Hysterectomy** – *(see policy MCUP3135 Hysterectomy Review Policy)*

J. **Hospice Care (Inpatient Only)** *(see policy MCUP3020 Hospice Service Guidelines*)

K. **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 prior to the admission.

L. **Hyperbaric Oxygen Pressurization**

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M. **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.) *See policy MCUG3051 Coordination of Services for Members Requiring Long Term Care.*

N. **Non-Emergency Medical Transportation** [*see policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)*]

O. **Outpatient Hemo / Peritoneal Dialysis** *(see policy MCUP3027 Members with Limited Benefits)*
(Note: initial authorization will be limited to 90 days and a lifetime TAR will be granted only after submission of Medicare determination.)

P. **Outpatient Surgical Procedures** – see **CPTs Requiring TAR** list (page 4)

Q. **Pain Management** – see **CPTs Requiring TAR** list (page 7) and policy *MCUP3049 Pain Management Specialty Services*

R. **Phototherapy** for dermatological condition *(see policy MPUG3061 Scope of Primary Care Dermatology and Indications for Referral Guidelines)*

S. **Pulmonary Rehabilitation** *(see policy MCUP3111 Pulmonary Rehabilitation)*

T. **Supplies / Equipment**

1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item *(see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines)*
2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (see policy MCUG3032 O*rthotic and Prosthetic Appliances Guidelines).* ***Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Ostomy Supplies – If **monthly** cumulative cost for all related supplies exceeds $150
4. Hearing Aid – All purchases, rentals or repairs exceeding $50 /item (Batteries are non-covered except for some CCS / EPSDT cases, in which case a TAR is required (*see policy MCUG3019 Hearing Aid Guidelines*).
5. Cochlear Implant Replacement Supplies: (*see policy MCUG3019 Hearing Aid Guidelines*).
   a. L8615 Headset/headpiece for use with cochlear implant device, replacement
   b. L8616 Microphone for use with cochlear implant device, replacement
   c. L8617 Transmitting coil for use with cochlear implant device, replacement
   d. L8618 Transmitter cable for use with cochlear implant or auditory osseointegrated device, replacement
   e. L8619 Cochlear implant external speech processor and controller, integrated system, replacement
   f. L8627 Cochlear implant; external speech processor, component, replacement
   g. L8628 Cochlear implant; external controller component, replacement
   h. L8629 Transmitting coil and cable, integrated, for use with cochlear implant device, replacement
6. Oxygen and related supplies *(see policy MCUP3013 DME Authorization*)
7. Diabetic Supplies are to be provided by Pharmacies ONLY
8. Nebulizers – When the billed price including tax is $100 or more (*see policy MPUG3031 Nebulizer Guidelines)*
9. Medical Supplies – ***If dispensed by PHARMACY, please refer to formulary***

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10. DME –*(see policy MCUP3013 DME Authorization*) ***If dispensed by PHARMACY, please refer to formulary***
    a. 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)
    b. No TAR is required for CPAP supplies for a CPAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).
    c. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as "Hospital Beds" or "Bathroom Equipment," are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)
    d. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)
    e. Purchase of any wheelchairs for Medi-Medi members
    f. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. (*see policy MCUP3013 DME Authorization*)
11. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Incontinence supplies if monthly cumulative cost for all related supplies exceeds $125.00
    b. Washes and creams for members with incontinence will only be authorized if the physician justifies medical necessity
12. Nutritional Supplements (Submit TAR to Pharmacy) *(see policy MCUP3052 Medical Nutrition Services*)
13. **ANY UNLISTED OR MISCELLANEOUS CODE**

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Outpatient Surgical Procedures - CPTs Requiring TAR

CPT Code	Description
10040	Acne Surgery
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower Or Upper Eyelid
15845	Skin And Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy For Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	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
28291, 28292, 28899	Correction Of Bunion
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30520	Reconstruct Of Nose
30520	Repair Nasal Septum
32999	Chest Surgery Procedure
36299	Vessel Injection Procedure
37700	Ligation And Division Of Long Saphenous Vein At Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins From Saphenofemoral Junction To Knee Or Below
37735	Ligation And Division And Complete Stripping Of Long Or Short Saphenous Veins With Radical Excision Of Ulcer And Skin Graft And/or Interruption Of Communicating Veins Of Lower Leg, With Excision Of Deep Fascia
37760	Ligation Of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation Of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions

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Outpatient Surgical Procedures - CPTs Requiring TAR (Continued)

CPT Code	Description
37766	More Than 20 Incisions
37780	Ligation And Division Of Short Saphenous Vein At Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC 's
36512	Therapeutic Apheresis Of RBCs
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
43771	Laparoscopy, Surgical, 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
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass
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
43999	Stomach Surgery Procedure
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy (per pg. 1 see *MCUP3135 Hysterectomy Review Policy*)
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)

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Outpatient Surgical Procedures - CPTs Requiring TAR (Continued)

CPT Code	Description
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61885, 61886, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62290 thru 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63658, 63661-63664, 63685, 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
72285	Cervical and Thoracic Discography
72295	Lumbar discography

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Pain Management CPTs Requiring TAR

CPT CODE	DESCRIPTION
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
22511, 22515	Percutaneous vertebroplasty and percutaneous vertebral augmentation
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
62360 thru 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63658, 63661-63664, 63685, 63688	Insertion, revision or removal of spinal neurostimulator
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); 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	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491	Second level (List separately in addition to code for primary procedure)
64492	Third level (List separately in addition to code for primary procedure
64493	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	Second level (List separately in addition to code for primary procedure)
64495	Third level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve. cervical or thoracic, single level
64634	Cervical or thoracic, each additional level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve. single level lumbar or sacral
64636	Lumbar or sacral, each additional level