TAR and Non-Benefit: Introduction to List

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‹‹*The Treatment Authorization Request* (TAR) and Non-Benefit lists that follow this section contain Health Insurance Portability and Accountability Act (HIPAA)-compliant Current Procedural Terminology (CPT®) procedure codes, including Proprietary Laboratory Analyses (PLA) procedure codes, and Healthcare Common Procedure Coding System (HCPCS) procedure codes, along with applicable benefit restrictions. Refer to the *HCPCS Introduction* section in this provider manual for an explanation of HCPCS.

Not all HIPAA-compliant CPT, PLA or HCPCS procedure codes may be listed in the ensuing *TAR and Non-Benefit* lists. If Medi-Cal providers are uncertain about whether a specific procedure code is a Medi-Cal covered benefit, are uncertain about any authorization requirements or suspect that this list contains an error, they should contact the Telephone Service Center (TSC) at 1-800-541-5555.

Note: Refer to American Medical Association or Centers for Medicare & Medicaid Services publications for complete descriptions of the listed CPT, PLA and HCPCS procedure codes.››

Non-Benefit

‹‹Medi-Cal has not activated all CPT Category I, PLA or HCPCS procedure codes associated with various covered Medi-Cal benefits and services. In these instances, the CPT Category I PLA or HCPCS procedure codes are classified as “non-benefit” for Medi-Cal and in deny status for the general Medi-Cal population. However, Medi-Cal may provide reimbursement for a CPT Category I, PLA or HCPCS procedure code with an approved TAR if medical necessity is established. Billing codes in non-benefit status should be evaluated and coverage decided on a case-by-case basis for individual Medi-Cal members based upon medical necessity.

Medi-Cal currently does not reimburse most CPT Category II or Category III procedure codes and does not publish a list of such procedure codes If a provider believes that billing for a CPT Category II or Category III procedure code is medically necessary, they must submit a TAR prior to claim submission.››

Requires TAR, Primary Surgeon/Provider

‹‹“Requires TAR, Primary Surgeon/Provider” indicates procedure codes requiring a TAR for the Primary Surgeon or provider whether performed on an inpatient or outpatient basis. Anesthesiologists and Assistant Surgeons do not need a TAR for procedure codes indicating benefit restrictions as “Requires TAR, Primary Surgeon/Provider.”››

Non-Benefit, Assistant Surgeon

‹‹Medi-Cal will not reimburse Assistant Surgeon services for procedure codes displayed as "Assistant Surgeon services not payable." Do not bill the Assistant Surgeon modifier for such codes.››

Inpatient Hospitalization Stay: Authorization Reminder

Authorization for an inpatient hospital stay may be required, even if the procedure being performed does not require a TAR. Refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in the *Inpatient Services* provider manual.

Authorization may be requested by either the physician performing the procedure or the hospital providing the inpatient stay.

Biomarker and Pharmacogenetic Testing

Medi-Cal covers medically necessary biomarker and pharmacogenomic testing, as described in the *Proprietary Laboratory Analyses* and *Pathology: Molecular Pathology* sections of the Provider Manual. ‹‹However, Medi-Cal may not cover all CPT and HCPCS codes associated with particular biomarker or pharmacogenomic tests.›› In these cases, the particular biomarker or pharmacogenomic test may nevertheless be covered with an approved TAR if medical necessity is established.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.