TAR Completion for Vision Care

Page updated: August 2020

Authorization is required for medically necessary contact lenses and contact lens evaluations, low vision aids, and non-Prison Industry Authority covered items. Providers must request authorization on a *50-3 Treatment Authorization Request* (TAR) form from the Department of Health Care Services (DHCS) Vision Services Branch (VSB).

Since Medi-Cal is always the payer of last resort, providers must obtain a denial from Other Health Coverage (OHC) for vision services that require authorization before submitting a request to the VSB. Providers must submit documentation that OHC has been billed with the authorization request. Insurance denials are still required to justify retroactive authorization as appropriate.

Note: Authorizations for eye appliances will continue to be deferred for recipients enrolled in a Medi-Cal Managed Care Plan and for Medicare recipients with the diagnosis of aphakia.

Obtaining Authorization

To request authorization for the following TAR required procedures, providers should complete and submit the *50-3 TAR* form as instructed on the following pages.

TAR Required Procedures

The following HCPCS/CPT® codes require authorization and must be submitted on a *50-3 TAR* form:

‹‹**Required Codes for *50-3 TAR* Form**››

HCPCS Code	Description
S0500	Disposable contact lens, per lens
S0512	Daily wear specialty contact lens, per lens
S0514	Color contact lens, per lens
S0516	Safety eyeglass frames
V2025	Deluxe frame
V2199	Not otherwise classified; single vision lens
V2299	Specialty bifocal
V2399	Specialty trifocal
V2499	Variable sphericity lens, other type
V2500	Contact lens, PMMA, spherical, per lens
V2501	Contact lens, PMMA, toric or prism ballast, per lens
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric or prism ballast, per lens
V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens
V2521	Contact lens, hydrophilic, toric or prism ballast, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens
V2531	Contact lens, scleral, gas permeable, per lens
V2600 *	Hand held low vision aids and other nonspectacle mounted aids
V2610 *	Single lens spectacle mounted low vision aids
V2615 *	Telescope and other compound lens system
V2623	Prosthetic eye, plastic, custom
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell

‹‹**Required Codes for *50-3 TAR* Form (continued)**››

HCPCS Code	Description
V2628	Fabrication and fitting of ocular conformer
V2629	Prosthetic eye, other type
V2702	Deluxe lens feature
V2750	Antireflective coating, per lens
V2760	Scratch resistant coating, per lens
V2761	Mirror coating, any type, solid, gradient or equal, any lens material, per lens
V2762	Polarization, any lens material, per lens
V2781	Progressive lens, per lens
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excluding polycarbonate, per lens
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens
V2784	Lens, polycarbonate or equal, any index, per lens
V2799	Vision item or service, miscellaneous
92071	Fitting of contact lens for treatment of ocular surface disease
92072	Fitting of contact lens for management of keratonconus, initial fitting
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes

Modifiers

All authorization requests for TAR-required vision procedures must include a correct modifier. Refer to the *Modifiers Used With Vision Care Procedure Codes* section in this manual for a list of procedure codes and their corresponding required modifiers.

Note: When billing, the procedure/modifier combination(s) on the claim must match the approved TAR or the claim will be denied.

Authorization Procedures

The following steps are required when requesting authorization for eye appliances and vision care services.

Approvals

Upon DHCS VSB's completion of the authorization review process, an *Adjudication Response* (AR) will be sent to the submitting provider with the status of the requested services. The AR lists the status of all service lines submitted on the TAR.

For additional information about ARs, providers may refer to "TAR Status on Adjudication Response (AR)" in the *TAR Overview* section of the Part 1 manual.

The AR will be faxed (if a valid fax number is included on the form) or mailed. All TARs are assigned a TAR Control Number (TCN) and Pricing Indicator (PI), found on the AR.

Eye Appliance Items With No Price on File

All eye appliance items with no price on file are manually priced based on invoice or catalog page. Providers have a choice of whether the pricing is done at the time of TAR adjudication or at the time of claim processing.

In order to have pricing done at the time of TAR adjudication, the provider must include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at the DHCS VSB will determine the price and assign a Pricing Indicator (PI) of 3. When this is done, the claim can be submitted without the invoice or catalog page. Providers must enter the 10-digit TCN followed by the PI of 3 (eleventh digit) in the *Prior Authorization Number* field (Box 23) of the *CMS-1500* claim form.

In order to have pricing done at the time of claim processing, the provider does not have to include a copy of the invoice or catalog page with the TAR. If the TAR is approved, the Medi-Cal consultant at DHCS VSB will assign a PI of 0. When this is done, the claim must be submitted with the invoice or catalogue page. Providers must enter the 10-digit TCN followed by the PI of 0 (eleventh digit) in the *Prior Authorization Number* field (Box 23) of the *CMS-1500* claim form.

Note: Authorization of "By Report" procedure codes is only a determination that the appliance and associated services are medically necessary. Determination of reimbursement fees in each case will be made by Medi-Cal. If a TAR is approved, a claim associated with that TAR that fails to meet other Medi-Cal billing requirements may be denied.

Deferrals

If the service is deferred, submitting providers will receive an AR with the reason for the deferral in the *Comments* section.

If additional information is required, providers must submit the AR with the additional requested information to the DHCS VSB.

Denials

If the service is denied, submitting providers will receive an AR with the reason for the denial.

Denied TARs being appealed should follow the "First Level Appeal of Authorization Request" information on a following page.

Retroactive Authorization

If a claim has been denied because the provider did not obtain authorization, retroactive authorization can be requested through the DHCS VSB by submitting a *50-3 TAR* form for approval.

Note: For authorization of requests with a date of service prior to the date of TAR submission, indicate the Date of Service in the *Medical Justification* area.

Delayed Billing

If the authorization process causes a delay in submitting claims, providers can request an extension of the usual six-month billing limit by entering the appropriate code in the *EMG* field (Box 24C). For more information about billing limit exceptions, refer to the *CMS-1500 Submission and Timeliness Instructions* section in this manual.

Where to Submit TARs

The *50-3 TAR* form and associated documentation may be mailed or faxed to:

Department of Health Care Services
Vision Services Branch
MS 4600
P.O. Box 997413
Sacramento, CA 95899-7413
Fax Number: (916) 440-5640

First Level Appeal of Authorization Requests

First level appeals of authorization-request decisions must be submitted to the DHCS VSB that made the original decision. Providers may appeal denied or modified authorization requests by submitting the following documentation within 60 calendar days from the date of the original decision by the DHCS VSB:

- A copy of the original denied or modified *Adjudication Response*
- A letter stating why denial or modification should be overturned (state that the documentation included is for a “First Level Appeal”)
- Documentation to support overturning the original denial or modification
- A new, completed *50-3 TAR* form

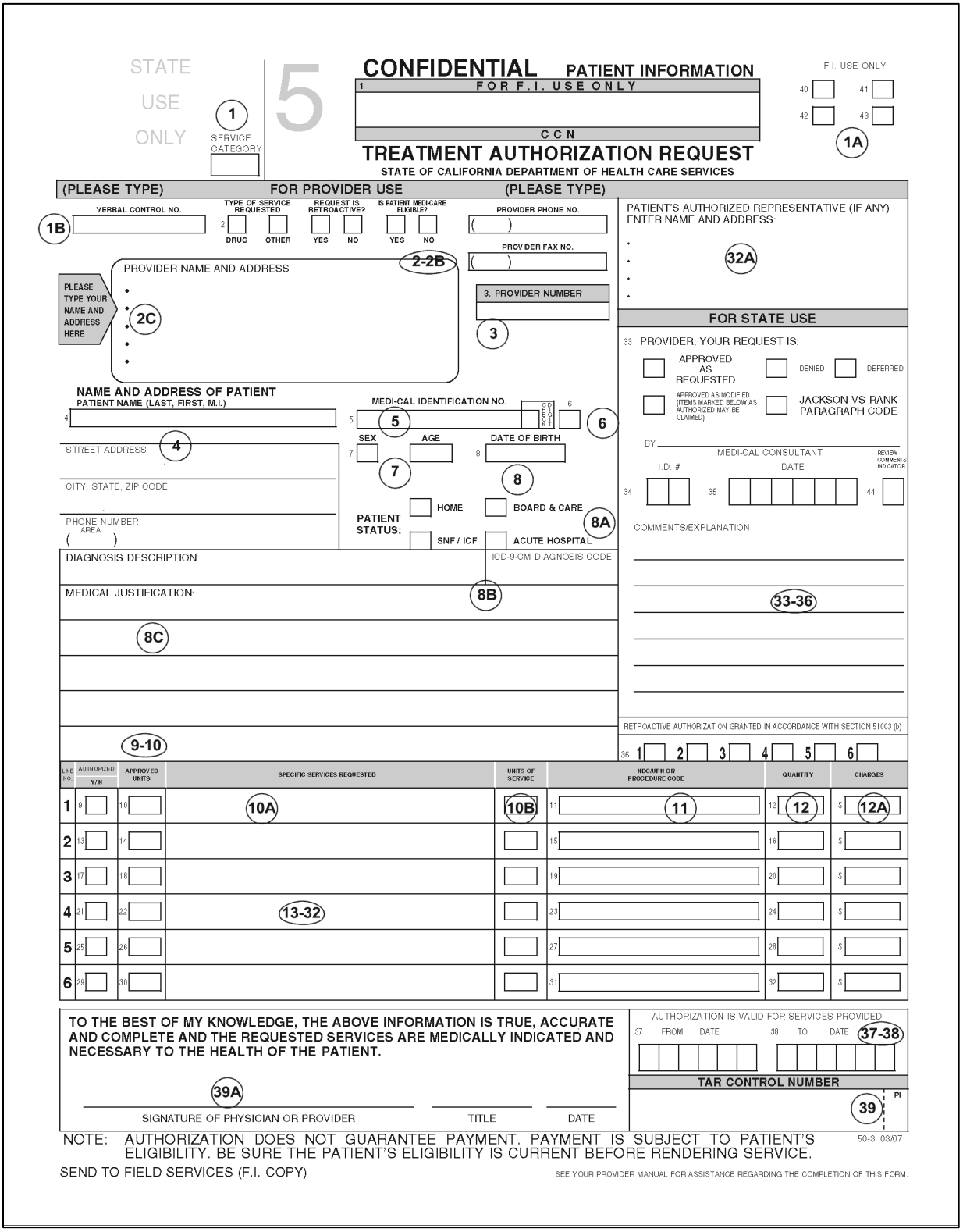
Second Level Appeal of Authorization Requests

Second level authorization-request appeals must be submitted within 30 calendar days from the date of first level appeal denial or modification to DHCS VSB.

Submit the following documentation with second level appeals:

- Copy of denied/modified *Adjudication Response*
- Copy of first level appeal response letter
- Letter stating why the first level appeal denial or modification should be overturned (state that the documentation included is for a “Second-Level Appeal”)
- Documents supporting overturning of the first level appeal denial or modification

50-3 Treatment Authorization Request (TAR) Form



STATE USE ONLY

1 SERVICE CATEGORY

5

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43 1A

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

1B VERBAL CONTROL NO.

2 TYPE OF SERVICE REQUESTED: DRUG OTHER

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MEDI-CARE ELIGIBLE? YES NO

PROVIDER PHONE NO. ( )

PROVIDER FAX NO. ( )

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

PROVIDER NAME AND ADDRESS 2-2B

PLEASE TYPE YOUR NAME AND ADDRESS HERE 2C

3. PROVIDER NUMBER 3

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

APPROVED AS REQUESTED DENIED DEFERRED

APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) JACKSON VS RANK PARAGRAPH CODE

BY MEDI-CAL CONSULTANT I.D. # DATE REVIEW COMMENTS INDICATOR

34 35 44

COMMENTS/EXPLANATION 33-36

NAME AND ADDRESS OF PATIENT

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

MEDI-CAL IDENTIFICATION NO. 5 6

STREET ADDRESS 4

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ( )

SEX 7 AGE DATE OF BIRTH 8

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

DIAGNOSIS DESCRIPTION: ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION: 8B

8C

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36 1 2 3 4 5 6

9-10

LINE NO.	AUTHORIZED Y/N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9	10	10A	10B	11	12	$ 12A
2	13	14			15	16	$
3	17	18			19	20	$
4	21	22	13-32		23	24	$
5	25	26			27	28	$
6	29	30			31	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 38 TO DATE 37-38

TAR CONTROL NUMBER 39 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.

50-3 03/07

SEND TO FIELD SERVICES (F.I. COPY)

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

Explanation of Form Items

The following item numbers and descriptions correspond to the *50-3 Treatment Authorization Request* (TAR) form on a previous page in this section.

‹‹**Explanation of Forms Table**››

Item	Description
1	**State Use Only**. Leave blank
1A	**F.I. Use Only**. Leave blank
1B	**Verbal Control Number**. Enter a fax number to receive an AR for this TAR by fax. An AR will be mailed if the fax number is invalid or the AR is unable to be faxed via normal processing.
2	**Type of Service Requested/Retroactive/ Medicare Eligible Status**. Mark appropriate box. If the request is retroactive, indicate the date of service in the *Medical Justification* area.
2A	**Provider Phone No**. Enter the telephone/fax number with area code of the requesting provider.
2B	**Provider Fax Number**. Enter provider fax number, including area code.
2C	**Provider Name and Address**. Enter the provider name, address and nine-digit ZIP code. **Note:** The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.
3	**Provider Number**. Enter the provider's National Provider Identifier (NPI) in this area.
4	**Patient Name, Address, Phone Number**. Enter recipient information in this space.
5	**Medi-Cal Identification No**. When entering the recipient's identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. The county code and aid code must be entered just above the recipient *Medi-Cal Identification No*. box. Do not enter any characters (dashes, hyphens, special characters) in the remaining blank positions of the *Medi-Cal Identification No*. box or in the *Check Digit* box.
6	**Pending**. Not required

‹‹**Explanation of Forms Table (continued)**››

Item	Description
7	**Sex and Age**. Use the capital "M" for male, or "F" for female. Enter age of the recipient in the *Age* box.
8	**Date of Birth**. Enter the recipient's date of birth in a six-digit format. 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 (Optional).** Mark appropriate box.
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 code book. **Note:** This form has not been updated to reflect an ICD-10-CM field label name.
8C	**Medical Justification**. Provide sufficient medical justification for the consultant to determine whether the service is medically justified. If one of the following special handling descriptors is required due to claim limitations, enter it in this field: • Exceeded billing dollar amount • Exceeded billing frequency limit • Use is for non-standard diagnosis If necessary, attach additional information. **Note:** For authorization of services with a date of service prior to the date of TAR submission, enter the Date of Service here.
9	**Authorized Yes/No**. Leave blank.
10	**Approved Units.** Leave blank.
10A	**Specific Services Requested.** Indicate the name of the procedure, item or service. If HCPCS codes V2600,V2610, V2615 or V2799 are submitted, a detailed description of the item must be provided here.
10B	**Units of Service.** Indicate the units of service requested. Please note that the number of units requested may differ from approved units.
11	**NDC/UPC or Procedure Code.** Enter the anticipated code (five-character HCPCS, five-digit CPT [followed by the two-digit modifier]).

‹‹**Explanation of Forms Table (continued)**››

Item	Description
12	**Quantity**. This is not required. The Units of Service field is adequate.
12A	**Charges**. Indicate the dollar amount of your usual and customary charge for the service(s) requested.
13 thru 32	**Additional Lines 2 Through 6**. Additional TAR lines.
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 personal affairs.
33 thru 36	**For State Use**. Leave blank.
37 & 38	**Authorization is Valid for Services Provided – From Date/To Date**. Leave blank.
39	**TAR Control Number.** Leave blank. Consultant will assign a TAR Control Number (TCN) and Pricing Indicator (PI) on "Approved as Requested," "Approved as Modified," "Denied" or "Deferred" TARs, and return the information to providers on an Adjudication Response (AR).
39A	**Signature of Physician or Provider.** Form must be signed by the optometrist, physician or authorized representative.

‹‹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.
*	Special Handling Descriptors – Low vision aids (HCPCS codes V2600, V2610 and V2615) do not require a TAR when the billed amount is less than $100.00. For low vision aids with billed amounts of $100.00 and greater, authorization requests must include one of the following special handling descriptors in the *Medical Justification* field of the *50-3 TAR* form: • Exceeded billing dollar amount • Exceeded billing frequency limit • Usage is for non-standard diagnosis