

DOFR QUESTIONS / COMMENTS and RESPONSE LOG

Updated: 1/23/12

Release 1.0

No.	Comment/Question	Response
GENERAL		
A1	The idea is that if a service is specific to us, we can add that line item when working with the health plan, example - Burn Care as I didn't see that.....otherwise it looks really great...	Yes; the Coded DOFR may be modified by adding service rows (it is recommended that modifications be clearly explained between contracting parties). Workgroup did not add burn care category as there are 100's of diagnoses related to burn unit care, making this category very difficult to break out.
A2	can we get a copy of the slide deck?	Slides are available at http://www.iha.org/dofr.html
A3	"Who authorizes" does not belong on the DOFR (e-mailed response to a comment made during Webinar #1)	N/A
A4	I have been looking forward to this type of DOFR for years . . . This will be a tremendous assistance to many people.	N/A
A5	This is a noble effort and I continue to be impressed by the type of projects IHA has taken on - the level of cooperation between health plans is unprecedented and, while I understand this can be painful, it really sets us apart from the rest of the country. Really terrific team work and I hope I can participate, as it relates to further discussion on the diagnostic portion of the DOFR.	N/A
A6	How is this product priced?	The AMA charges a licensing fee for each download. For the time being, IHA plans to fund licensing costs for all downloads. This approach may be modified for future releases.
A7	thank you, this is a wonderful tool!	N/A
A8	This looks like a great too, but do you think health plans will buy into using this tool? I know they were in the work group, but I suspect plans may balk at a standardized DOFR.	The Coded DOFR is a customizable tool to be utilized between contracting parties in their negotiations. It is not prescriptive, but does reflect the best thinking and suggestions of industry representatives. It is recognized that plans and providers have system limitations (see DOFR Guidelines 6 and 7). Plans and providers have expressed support of the Coded DOFR as a tool to clarify definitions, support process improvement and automation, and address historical issues and challenges between contracting parties.
A9	Are you planning to apply this to Govt. Programs?	This will be considered for a future release.
A10	Is this DOFR grid available for Healthplans to down load?	The Coded DOFR is available at http://www.iha.org/dofr.html
A11	How do you handle case rates?	As noted in the DOFR End User Agreement, "IHA does not assign or recommend use of fee schedules, relative values, conversion factors, related components, contracting and/or designation of risk." Coded DOFR users may opt to customize the coded DOFR (for example, by adding a Case Rate column).

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A12	You need some backers from the contracting departments in the health plans. If they understand that this won't force them into too much technical work, they won't resist it.	Plans have expressed support of the Coded DOFR as a tool to clarify problem areas, support process improvement, and address issues and challenges among contracting parties.
A13	The industry has a collaboration group www.ICE4health.com that might help or tackle an authorization tool.	The scope of DOFR Release 1.1 is purposefully limited to developing and coding the DOFR service rows. Authorization responsibility will typically be designated within the delegation agreement; however, Coded DOFR users may opt to customize the coded DOFR (for example, by adding an Authorization column).
A14	Will the DOFR be updated to include Medi-Cal codes?	IHA will announce the scope of our DOFR 2.0 release after Workgroup and IHA management review.
A15	Are all comments accepted? For example, additional categories, additional codes, etc to specify further?	The DOFR workgroup will review and respond to all comments via the IHA DOFR website. Based on their review, the DOFR workgroup will make recommendations to IHA re: changes to the Coded DOFR.
A16	What is the buy-in from the health plans, IPAs, hospitals etc? Do you feel all parties will implement the standardized DOFR?	The Coded DOFR is a customizable tool to be utilized between contracting parties in their negotiations. It is not prescriptive, but does reflect the best thinking and suggestions of industry representatives. It is recognized that plans and providers have system limitations (see DOFR Guidelines 6 and 7). Plans and providers have expressed support of the Coded DOFR as a tool to clarify definitions, support process improvement and automation, and address historical issues and challenges between contracting parties.
A17	In our discussions with the plans, how should we refer to this DOFR, what should we call it?	The DOFR Workgroup recommends referring to the DOFR as the "Coded DOFR" or, more specifically, the "Coded DOFR - Commercial and Medicare Advantage."
A18	Have you considered adding a scope of authorization Section as well? Establishing not only who is financially responsible but who is expected to authorize the service.	Yes, the DOFR Workgroup considered adding supplemental information. However, the scope of DOFR Release 1.1 is purposefully limited to developing and coding the DOFR service rows. Authorization responsibility will typically be designated within the delegation agreement; however, Coded DOFR users may opt to customize the coded DOFR (for example, by adding an Authorization column).
A19	For our purposes we would need the code lists to include medi-cal codes for most of our dofrs in the system and the attached is for Commercial/Senior only	Scope expansion to be considered for subsequent DOFR releases.
A20	FYI, you may have received this information already, but various plans may do regular updates (e.g., injectables may have quarterly coding reviews/updates), so some plans do not want this as an exhibit in the contract so that amendments don't have to be done every time there is a change. Just an FYI.	N/A
A21	All the plans are represented on your committee. Does that mean all the plans have bought into this type of structure and are ready to implement it?	Plans participating in the Workgroup have signed off on the structure. Implementation is subject to plan specific timelines and protocols.
A22	Do you have implementation tools built that you can share such as a project schedule created in Microsoft Project?	No.

No.	Comment/Question	Response
A23	Will there be the availability to have a historical record as changes are implemented to coding? As DOFR's are frequently in question, frequently identification when a change was implemented gets called into question.	Yes, IHA will maintain a cumulative change log to accompany each new release.
A24	Given the relatively short time remaining for comment what are the procedures contemplated for additional input and modification?	Potential End Users are encouraged to submit specific suggestions via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.
A25	How will this DOFR address the issue we as hospital have with Health plan not wanting to share info with us currently. The reason they give us that they cannot share proprietary information between medical grp and plan	The contract between the plan and medical group, just like the contract between the plan and hospital/your company is unique. In the past, plans did not have all the code details, and did not have a seperate document to share. This Coded DOFR is a tool that allows the detailed range of codes to be shared. This should help facilitate communication, so we encourage you to keep trying after implementation.
A26	How will you determine from the DOFR when updates have been made?	IHA will maintain a change log for each successive release. The change log will be cumulative to all releases.
A27	I would think that not having any doctors (let alone no doctors on the provider side) would compromise the end product. Just my two cents. I'll mention it to CAPG and see if they have any ideas of 1-2 individuals who could join the workgroup.	IHA is discussing this issue internally
A28	Well done and glad it has come this far.	N/A
A29	I did not take note of a "catch all" to assign those services that were not listed or are new services.	As noted in Guideline 7, contracting organizations are expected to revise the Coded DOFR appropriately to fit a specific capitation/risk arrangement; a contracting organization may consolidate or add service categories as needed.
A30	<p>The current structure of the DOFR (all DOFR's) is inherently flawed. DOFR should be set up from the procedure code to responsibility, with the ability to sort by any heading. Also, The DOFR should link the procedure code to diagnosis codes and place of service, the elements used to determine financial responsibility, to determine financial responsibility.</p> <p>Procedure codes should not be repeated but defined to determine the various possible financial responsibility.</p> <p>*This would allow the DOFR to be used to answer questions, which are usually driven by a particular service.</p> <p>*Easy validation that all services have been addressed in the DOFR</p>	<p>Please consider joining the next phase of work. The downloadable DOFR format can be sorted, filtered, or loaded into a tool that meets your unique needs. As noted in the Guidelines, the Coded DOFR is unable to replicate detailed claims system programming and remain manageable, therefore some areas of complexity/ambiguity may need to be addressed outside the DOFR. Some overlapping codes appear in more than one category; that is why they are noted with an asterisk. The intention of the committee was to allow flexibility since one contract may have the code in category A while another contract has it in category B. The completeness of each standard category is important; also, at times duplication is necessary as risk may be assigned differently in some instances (e.g., a physician visit for mental health or chemical dependency). Since duplication creates ambiguity; when modifying the DOFR to fit a specific capitation/risk arrangement, contracting organizations are expected to appropriately remove duplicate codes, reducing such ambiguity where possible.</p>

No.	Comment/Question	Response
DUPLICATE CODES		
B1	A simple outline of the various codes in question with concise descriptions as to what areas or categories in which the codes may appear would be sufficient. These codes are generally the ones most susceptible to misinterpretation and conflict in terms of assignment of risk. By indicating those potential problem codes and categories, the contracting parties may be able to address the risk assignment during negotiation and alleviate later conflict, which is a core objective of the standardized DOFR and something by which the overall success of this effort will be gauged.	IHA to take this under consideration, however, a list would be helpful. Please submit specific suggestions regarding vague areas to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.
B2	I think it makes sense to leave the final determination to the end user but it would be helpful to identify where a duplicate code exists and under what category to find the overlap so they can be easily identified and edited out of the final document.	Duplicate codes are identified (*). Link duplicate codes to define overlap is only feasible via a data conversion. This suggestion will be considered as part of any database conversion.
B3	It isn't so much that there are duplicate codes, but that a single procedure code can have different financial responsibility based on the various criteria used. All criteria used to determine financial responsibility should be included in the DOFR.	As noted in the Guidelines, in order to keep this document manageable, service and coding detail is provided only to the extent necessary to capture differences in assignment of risk. Potential End Users are encouraged to submit specific suggestions regarding financial responsibility criteria via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.
DATABASE FORMAT		
C1	can you sort by code? I couldn't figure it out. Excel is a good format though. I suspect this work will greatly eliminate ambiguities between parties.	In the Release 1.1 Coded DOFR, codes can not be sorted (except for the codes on the supplemental tabs). However, the Excel Filter function (found in the Excel Data menu) can be used to filter for specific codes.
C2	Add functionality so that DOFR can be searched by descriptors or codes	In the Release 1.1 Coded DOFR, codes can not be sorted (except for the codes on the supplemental tabs). However, the Excel Filter function (found in the Excel Data menu) can be used to filter for specific codes. The Excel Find function (found in the Excel Edit menu) can be used to search for specific words or terms.
C3	There needs to be additional options in the Financial Responsibility columns to accommodate various risk categories: ie: Health Plan, IPA, Hospital, Specialist Group.	The financial responsibility section of the DOFR will be completed by the contracting parties to indicate which entity (e.g., Health Plan, IPA, Hospital, Specialist Group) is responsible for each service sub-category by location of service. See the blue circle and blue font on the DOFR Example tab for an illustration of this.
C4	No additional suggestions or comments, as the format that is in Release 1.0 appears sufficient to identify the various codes and categories without significant issues.	N/A
C5	Structuring the DOFR to be code driven addresses this issues. Please see #2 (in Duplicate Coding section).	As noted in the Guidelines, the Coded DOFR is unable to replicate detailed claims system programming and remain manageable.
C6	The excel format is a bit difficult to read. If you find that many people do not like the Excel format. How easy and how quickly could would IHA change to a system that would be more easily read.	IHA is considering a database conversion.
SUPPLEMENTAL CODING		

No.	Comment/Question	Response
D1	Place of service is very important for responsibility. For example, emergency room claims and all related services are usually health plan responsibility. The place of service on a claim is enough to make the whole claim a health plan responsibility.	Place of service is generally addressed in the financial responsibility matrix columns; however, in some cases place of service is addressed in a service category (for example, emergency services are addressed in the Emergency Room service category).
D2	Any thoughts about adding a column for the actual place of service codes. (11,22,12, etc)?	The DOFR workgroup is considering whether to add supplemental coding information to the standard DOFR (e.g., UB-04 type of bill codes and 1500 Place of Service Codes). These codes would not be a determinant factor in assigning financial responsibility; the codes would be provided as supplemental information only to assist providers in their billing process, using typical code examples (not representative of all possible codes that might be utilized by a provider to submit a bill).
D3	Place of Service codes are an integral part of any DOFR, and, therefore, inclusion of such codes with the template is highly recommended. For instance, an outpatient surgical procedure may be performed either as a hospital outpatient service(POS 22) or at an ambulatory surgical center (POS 24), and the assignment of risk for each of these separate locations may differ. By identifying the possible Place of Service locations on the template, contracting entities can more clearly specify where the financial risk lies for each and prevent potential conflict at time of claim adjudication. Again, the greater clarity that may be achieved through Place of Service codes serves the core objectives of the standardized DOFR, and this extra effort here on the front end will help to increase the probability of successful adoption of this template.	Please see D2 above.
D4	I feel this tool is intended to be used to assign responsibility only. Adding other codes that are not a determinant factor could only create confusion. Also it would add a additional burden for up keep when the other codes are updated or altered.	Many on the workgroup share this opinion.
D5	Place of service codes ARE a factor in determining financial responsibility for some services. The DOFR should include all elements used to determine financial responsibility.	Potential End Users are encouraged to submit specific suggestions regarding financial responsibility criteria via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.

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D6	<p>How come place of service and/or bill types are not used. I find that using the TOB or POS easily helps in identifying the risk and/or type of service.</p> <p>For example, Affinity does not hold risk for in-patient facility charges, if the claim TOB is 111 (hospital, inpatient) then our claims system is configured to deny it as plan risk.</p>	<p>Place of service is generally addressed in the financial responsibility matrix columns; however, in some cases place of service is addressed in a service category (for example, emergency services are addressed in the Emergency Room service category). The DOFR workgroup is considering whether to add supplemental coding information to the standard DOFR (e.g., UB-04 type of bill codes and 1500 Place of Service Codes). These codes would not be a determinant factor in assigning financial responsibility; the codes would be provided as supplemental information only to assist providers in their billing process, using typical code examples (not representative of all possible codes that might be utilized by a provider to submit a bill).</p>
D7	<p>Coding determinants should be expanded to use other UB04/1500 form variables such as place of service codes and type of bill codes in order provide further specificity and minimize duplicate/overlapping procedure codes.</p>	<p>Place of service is generally addressed in the financial responsibility matrix columns; however, in some cases place of service is addressed in a service category (for example, emergency services are addressed in the Emergency Room service category). Potential End Users are encouraged to submit specific suggestions regarding additional coding determinants via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.</p>
GUIDELINES		
E1	<p>Revise Guideline #9 to address more than injectables, such as infused chemo and/or injectables delivered by IM, SubQ or Intravenous</p>	<p>Coding for the injectable category is to be determined; Guideline 9 will also be reviewed at that time.</p>
E2	<p>The fifth point of the Guidelines states that Release 1.0 of the DOFR uses 2011 code sets and that updates will be made on a regular basis. Does IHA intend to notate when and where changes have been made? Specifically, when a CPT or HCPC code gets replaced, will there be a reference indicating when the old code was deleted and the new code was added? Because DOFRs are notorious for remaining in question years after being agreed upon by the parties, references frequently are required to indicate when a code was added or changed. This occurs particularly when the HCPCS codes (drug, temporary codes, etc.) are updated throughout the year and during the annual CPT code updates. CMA recommends that IHA adopt such a referencing and notation practice to aid significantly in alleviating future conflicts between parties.</p>	<p>Yes, IHA will maintain a rigorous change log.</p>
FINANCIAL RESPONSIBILITY MATRIX		
F1	<p>Can the DOFR be used to assign actuarial values?</p>	<p>As noted in the DOFR End User Agreement, "IHA does not assign or recommend use of fee schedules, relative values, conversion factors, related components, contracting and/or designation of risk." End Users of the Coded DOFR may choose to use the DOFR information (at their own risk) as a resource for actuarial or other analysis.</p>
F2	<p>Responsibility is often dependent on place of service. Examp: Emergency encounters and all related codes may be responsibility of the health plan. How do you handle that?</p>	<p>Place of service is generally addressed in the financial responsibility matrix columns; however, emergency services are addressed in the Emergency Room service category.</p>

No.	Comment/Question	Response
F3	Customization between contracting parties will work for manual reference, but if integration or loading into existing claims systems and automation are desired, some "flexible use" columns may be very useful to minimize what existing claims systems have to adapt.	As noted in Guideline 7, contracting organizations are expected to revise the Coded DOFR appropriately to fit a specific capitation/risk arrangement; a contracting organization may consolidate or add financial responsibility columns as needed.
F4	Your tool is a good first step. Please consider adding a couple of undefined columns for "user use." Such "flexible use" columns may be very useful to allow experimentation with unforeseen possibilities and also for experiments in claim processing automation to take place very early. A sub-group trying this out might quickly develop some standardized use for these columns that would allow others to keep the same format they have already downloaded and follow on in starting up automation, themselves.	As noted in Guideline 7, contracting organizations are expected to revise Coded the DOFR appropriately to fit a specific capitation/risk arrangement; a contracting organization may consolidate or add financial responsibility columns as needed. Potential End Users are encouraged to submit specific suggestions regarding columns via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.
F5	The terminology for Hospital vs. Non-Hospital should be changed to Facility vs. Non-Facility to account for free-standing facilities, such as ASC, Dialysis Centers, etc.	This change has been made in Release 1.1
F6	I suggest you revisit the core structure to create a document that would add value to the users rather than trying to corrected an inherently flawed structure.	Please consider joining the next phase of workgroup activities. Potential End Users are encouraged to submit specific suggestions via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.
F7	I suggest the addition of a column for "Healthplan" risk. For example we have several existing DOFRs where the healthplan is responsible for: out of area emergency services, formulary pharmaceuticals, mental health services, or transplants	The financial responsibility section of the DOFR will be completed by the contracting parties to indicate which entity (e.g., Health Plan, IPA, Hospital, Specialist Group) is responsible for each service sub-category by location of service. See the blue circle and blue font on the DOFR Example tab for an illustration of this.
CATEGORIES/SUBCATEGORIES		
G1	Consider further break-out between diagnostic and non-diagnostic categories	Potential End Users are encouraged to submit specific suggestions regarding further break-out of the DOFR categories via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.
G2	Genomic Health has two tests called Oncotype Dx (breast and colon). Breast is billed under S3854 and is considered part of the diagnostic risk under the DOFR. ODX is ordered on cancer patients to determine benefit from chemotherapy. Use of ODX leads to a significant reduction in chemotherapy as most women tested receive a low recurrence score. My point is, the risk for the test should be tied to the party with the risk for the chemotherapy - often it is not.	The DOFR Workgroup will consider adding a Genetic Testing category in a future release.

No.	Comment/Question	Response
G3	<p>A complex area is making sure financial incentives are aligned. It seems like the medical group gets "played" by the health plan for these expensive new technologies. It isn't fair to lump them all under diagnostics, especially if they do not have the risk for chemotherapy. In our case, a \$4000 test may be the cost of the group, while the \$20K+ in savings in avoided chemo is absorbed by the plan. In the interest of transparency, the diagnostics risk should be fleshed out to include approved technologies and specific expectations of coverage by the plans. Maybe there should be a specific section that outlines what is usually found in these misc. "bucket" codes. There should be a link between the common chemo treatments and the related diagnostic tests. They can be grouped together or have some type of asterisk that allows the specifics to be laid out. I have got to assume there are other technologies that get stuck in the middle like this.</p>	<p>The DOFR Workgroup will consider this issue at a later date.</p>
G4	<p>Our CPT Code, S3854, is often carved in or out of the DOFR. The plans often kick the claim back to the group, who kick it right back to the plan! This can go on for many months and often ends up with a laboratory, like Genomic Health, not getting paid. IPA's get angry because they can't believe they have to pay for an expensive test like Oncotype Dx. What's worse, is often the financial incentives aren't aligned. For example, an IPA may be responsible for diagnostic testing but has carved out chemotherapy risk. Our test is ordered on breast cancer patients to determine need for chemo. The majority of the time, based on the recurrence score, the patient does not need chemotherapy – better for the patient, cost savings in avoided treatment. So you might have a smaller IPA who has to pay for ODX (\$4175 list) but the chemo savings is realized by the health plan! My opinion is the risk and savings should go together. It appears that your project may help smooth this out, that would be a terrific achievement Cindy!</p>	<p>N/A</p>
G5	<p>On the webinar, there was feedback that case rates are not part of the scope of your work. It may be possible to use your format with one additional column for case rates. That would be a column for a limit on the number of times a particular service may be repeated (replicated) and still be covered under the case rate. Office visits and injections would be examples.</p>	<p>As noted in the DOFR End User Agreement, "IHA does not assign or recommend use of fee schedules, relative values, conversion factors, related components, contracting and/or designation of risk." Coded DOFR users may opt to customize the coded DOFR (for example, by adding a Case Rate column).</p>

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G6	Have you considered the complex radiology subcategory to radiology and the genetic testing subcategory to laboratory services	Workgroup determined that the complex radiology category is a benefit administration issue. The Workgroup will consider the genetic testing category and whether to address benefit administration issues within the DOFR at a later date.
G7	We use the DOFR categories also to administer our copays collection. Plans differ as to how they define these service categories for benefits and copays. Is this topic on your administrative simplification agenda?	The DOFR Workgroup will consider whether to address benefit administration issues within the DOFR at a later date.
G8	MRI's should be split out from other radiology	Workgroup determined that the complex radiology category is a benefit administration issue. The Workgroup will consider whether to address benefit administration issues within the DOFR at a later date.
G9	Several diagnostic categories are split into very specific buckets where it might be easier to combine diagnostic testing (but cardiac catheterization should remain separate)	The DOFR workgroup will consider the recommendation to combine diagnostic testing at a later date.
G10	On the webinar, there was feedback that case rates are not part of the scope of your work. It may be possible to use your format with one additional column for case rates. That would be a column for a limit on the number of times a particular service may be repeated (replicated) and still be covered under the case rate. Office visits and injections would be examples.	As noted in the DOFR End User Agreement, "IHA does not assign or recommend use of fee schedules, relative values, conversion factors, related components, contracting and/or designation of risk." Coded DOFR users may opt to customize the coded DOFR (for example, by adding a Case Rate column).
G11	<p>All services should be linked to the applicable diagnoses.</p> <p>* Physician services (E&M codes) related to infertility can have different responsibility.</p> <p>* Avastin can be used as chemotherapy or for macular degeneration, which change the financial responsibility based on how it is used. (J9035 is listed as a chemo or adjunctive drug, which it can be but it may also be non-chemo based on diagnosis.)</p> <p>* Lupron can be used for infertility or to treat a different medical condition, which can change the financial responsibility or even if it is a covered service.</p> <p>Services should be linked to place of service (DOFR creep.)</p> <p>Some common, current areas aren't listed, e.g., infertility, complex radiology, wound care, pain management, hospice services in patient's home.</p> <p>Lists of codes are incomplete, e.g., Emergency Room professional services codes should include, or at least reference, ancillary, e.g. radiology, and specialty, e.g., surgery, services.</p>	The DOFR Workgroup will consider these issues at a later date.

No.	Comment/Question	Response
G12	<p>Below I have listed some service categories that we have in existing DOFRs that I did not note in Release 1. I apologize if I overlooked them.</p> <ol style="list-style-type: none"> 1) Long Term Care 2) Out of Area ER 3) Pain Management (non anesthetic services) 4) Transfusion (blood was listed but was the service?) 5) Wound Care <p>Below I have listed some services that fall into other, already listed, categories. I have singled them out because we have found them to be contentious and worthy of individual listings:</p> <ol style="list-style-type: none"> 1) Aspirations (is it diagnostic or surgical?) 2) Cataract surgery (Is it part vision coverage?) 3) Doppler Studies (Nuc Med? Radiology? Cardiology/Stress?) 4) Insulin (take home? pharmacy? carve out?) 	<p>The DOFR Workgroup will consider these issues at a later date.</p>
G13	<p>Any thoughts on genetic testing carve outs?</p>	<p>The DOFR Workgroup will consider these issues at a later date.</p>
G14	<p>Is there any place on the DOFR that addresses radiation therapy and Aids specific codes?</p>	<p>Radiation therapy is addressed in the subcategory Radiology (excluding Nuclear Medicine) - Therapeutic (see also Guideline 10 and the Radiology Codes supplemental tab). As AIDs is a diagnosis, versus a unique treatment modality, it is not addressed separately within the DOFR.</p>
G15	<p>CHW and CHW Medical Foundation staff reviewed the DOFR and found it very thorough and complete. We would like to see the following services added as line items:</p> <p>AFP Test ECMO Burn Care Gamma Knife</p> <p>These are areas that can be gray on a DOFR based on our experience.</p>	<p>The DOFR Workgroup will consider these issues at a later date.</p>
CODING DETAIL		
H1	<p>Provide coding detail for DME</p>	<p>DME coding was added in Release 1.1</p>
H2	<p>Medi-Cal local procedure codes (X & Z) codes need to be used in the DOFR codification</p>	<p>The current version of the Coded DOFR, Release 1.1, covers commercial HMO/POS enrollees, as well as Medicare Advantage enrollees; therefore Medi-Cal codes are not used. IHA will announce the scope of our DOFR 2.0 release after Workgroup and IHA management review.</p>
H3	<p>It would be worth the effort to code DME, Orthotics, Prosthetics; I have already identified working groups of codes</p>	<p>These codes were added to Release 1.1.</p>
H4	<p>If the assigned category for a code comes into question in the future, will IHA be able to provide clarification on what category it may fall in?</p>	<p>Yes; End Users are encouraged to submit specific questions via the IHA DOFR Maintenance process or directly to Cindy Ernst, IHA Director, cernst@iha.org or 510-208-1743.</p>

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H5	I could not find S3854 on this worksheet.	The DOFR Workgroup will consider adding a Genetic Testing category in a future release.
H6	<p>Another concern is the misc code, 84999. We use this code with Medicare for breast and for all payers for colon.</p> <p>Msc codes present a challenge under a DOFR because they are often included in the capitated risk of the reference lab. There are many different items that can be thrown under this code, the contents of this category should be spelled out specifically.</p>	CPT Code 84999 is in the Laboratory service category on the Coded DOFR. Contracting organizations may wish to define use of miscellaneous codes outside the DOFR (per Guideline 6, some areas of complexity/ambiguity may need to be addressed outside the DOFR) or by modifying the DOFR (per Guideline 7, contracting organizations are expected to revise the DOFR appropriately to fit a specific capitation/risk arrangement).
H7	<p>Clearly define Injectable Risk (home, self, office, hospital, home care)</p> <p>Clearly define out of area (This is a big one. I have actually had an insurance rep tell me that OOA was defined as 30 miles is the crow flies)</p> <p>ID split risk services (ie, Vision isrefraction and radiology)</p> <p>Define risk for cochlear implants outside audiology</p> <p>Clearly define DME risk (different if from home care?)</p> <p>Define chemo / blood products risk</p> <p>Supplies isdefine what is reimbursable</p> <p>Define associated supplies, labs etc with Dialysis, infusion, chemotherapy, nuclear medicine</p> <p>Add section for home care pharmacy</p>	The DOFR Workgroup will consider these issues at a later date.
H8	Codes should be linked to a comparative value scale, e.g., Medicare to facilitate financial impact of the DOFR and potential changes.	As noted in the DOFR End User Agreement, "IHA does not assign or recommend use of fee schedules, relative values, conversion factors, related components, contracting and/or designation of risk."
H9	Also are their codes that specifically address Allied Health Specific codes, such as Genetic counseling not done by a physician? For example, Genetic Counselor 99211-4 and Genetic Counselor 96150-5? These can only be billed by a non-MD Genetic Counselor. Ancillary providers are the only legal entities able to bill for certain procedure codes and be reimbursed for the services provided.	99211 is found in the Physician Visit and Chemical Dependency categories, and 96150 is in the Health Education category. As noted in Guideline 7, contracting organizations are expected to revise Coded the DOFR appropriately to fit a specific capitation/risk arrangement; a contracting organization may consolidate or add service categories or financial responsibility columns as needed.
H10	Is there a list of suggested Oncology Rx Codes?	<p>There are several oncology drug categories (with codes) on the DOFR:</p> <p>Chemotherapy: Adjunctive Drug</p> <p>Chemotherapy: Antineoplastic Drug</p> <p>Chemotherapy: Administration and Supplies</p>

No.	Comment/Question	Response
H11	the current dofr shows the Scodes as Home Health, however there are injectable supplies, infusion supplies are usually tied to the risk they are associated with. Were these categorized as home health because that is usually the place of service?	This question will be reviewed by the DOFR Workgroup at a later date.
H12	1) Under Endoscopic Studies section, I did not see CPT code 45378-Diagnostic Colonoscopy. Was this considered surgical , thus purposely omitted from this section?	45378 is found in the Endoscopic Studies: Diagnostic service category.
H13	Under the Radiology (Excluding Nuclear Medicine) section, I noticed the Surgical Revenue code 369 was excluded. We have some radiology charges mapped to the Surgical revenue code 369. Would it be possible to add a Radiology (excluding Nuclear Medicine) "Other/Surgical " section? Or perhaps, you intend for users to address the surgical CPTs individually by plan? Thank you for this DOFR template. This is a great start.	As noted in Guideline 7, contracting organizations are expected to revise Coded the DOFR appropriately to fit a specific capitation/risk arrangement; a contracting organization may consolidate or add service categories as needed.