



Standardized Coded Commercial and Medicare Advantage DOFR

Recommended Guidelines: Release 1.2

1. This Division of Financial Responsibility (DOFR) applies to services that are included in member-purchased benefits, which are medically necessary and/or authorized per plan's medical policy, and meet physician referral requirements.* The HMO Provider Manual will provide additional detail useful to the provider. The manual does not however, supersede the contractual agreement between the provider and the health plan. If a conflict were to arise the contract takes precedent.

*Physician referral not applicable for emergency and/or urgent care, or maternity services; also, certain specialties (e.g., OB/GYN) do not require Medical Group Referral/Authorization in order to be utilized.

2. Health plans will rely on current practices for assigning risk at claim header level versus claim line level.
3. 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 (diagnosis and revenue codes only provided if a determinant factor in assigning risk).
 - a. DOFR coding will solely rely on elements on UB04 and 1500 claim forms, including procedure codes, diagnosis codes, place of service codes, type of bill codes, and revenue codes.
 - b. Procedure codes within the DOFR may include Current Procedural Terminology (CPT®), HCPCS and ICD9 codes. CPT copyright 2011 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association (AMA). Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
 - c. The coding on the DOFR is provided to illustrate unambiguous definitions for services. This DOFR does not attempt to represent all possible coding combinations for a given service. This DOFR is not intended to give guidance on how to bill or code for services.
 - d. DOFR service subcategories are provided only to the extent necessary to identify a shift in risk.
4. DOFR identifiers are limited to information available on the claim at hand (no claim history or other documentation required).
5. Release 1.2 of the DOFR uses 2011 versions of code sets. Updates to code sets will be made on a regularly scheduled basis through a DOFR maintenance process by IHA. ICD-10 mapping will be done by IHA.

6. The DOFR document 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. Legacy claim systems may require plans to revise the DOFR accordingly. For transparency, it is recommended that contracting organizations clearly highlight any customization of the DOFR.
7. Contracting organizations are expected to revise the DOFR appropriately to fit a specific capitation/risk arrangement.
 - a. Some agreements may not include all the delineated categories, and/or use a subset and/or additional categories not identified here. For example, a contracting organization may roll-up subcategory rows if risk is not assigned, or add a row for a risk "carve-out" (for example, some plans may carve bariatric surgery out from other surgery services).
 - b. Some overlapping codes appear in more than one category. 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
 - c. Some agreements may not split out certain categories by location of service or split-billing; a contracting organization may consolidate or add financial responsibility columns as needed
8. Risk assigned under the DOFR will follow Health and Safety Code requirements, including requirements for childhood immunizations and injectable medications
9. The following injectable medication categories are regulated under Health and Safety Code 1375.8 and referred to in the "Injections: Injections Subject to HSC1375.8" category in the DOFR (except for Chemo and adjunctive injectable medications, which are referred to in the Chemotherapy category):
 - a. Chemo and adjunctive
 - b. Hemophilia drugs
 - c. Transplant related immunosuppressives
 - d. Adult Immunizations
 - e. Self-Administered Injections
 - f. All other drugs, not specified above with a per dose cost of \$250 or more

Non-regulated injectable medications are generally covered under an inpatient stay or via an outpatient pharmacy benefit.

10. Radiology CPT® codes are classified as diagnostic or therapeutic, with the exception of a few codes that may be used with either type of service (see Code Type "Both" on Radiology tab). For these codes, additional claim information is required to determine whether the service provided was diagnostic or therapeutic; each plan to define the information required to classify these services.