University of New Mexico Hospitals
Request for Proposals

Addendum 5 dated 10-5-20

Project number RFP P427-20
Medical Coders and Auditors

Due date for proposals is October 13, 2020, 2:00PM MST

Due Date for all inquiries is 10-5-20, 2:00PM MST

The time and date proposals are due shall be strictly observed.

ADDENDUM 5 RFP P427-20 Medical Coders and Auditors

1. Is there any visibility into the supplemental anticipated FTE need outside of 1 or more? More than 1 FTE will be needed.

2. Would be helpful if there was some FTE need forecasting between the inpatient coder and outpatient coder need Currently, we utilize 30 outpatient contract coders, and roughly 6 inpatient contract coders for a reference point.

3. Is the Coding Auditor need included in the 1 or more FTE or will there be a separate FTE need outlined for this? Separate FTE need.

4. Is the scope of the coding Auditor to audit both the physicians and coders? The scope is to ensure accuracy coding – if opportunities are found for coders, physicians or even CDI, those would be advantageous to be a part of the auditing process.

5. Is there any Inpatient Auditing Program in place such as SMART and if so, would that be part of the scope of experience needed from the Auditor? No present auditing program.

6. Please clarify what UNM is looking for on the question:
7. List all vendor demographics including: Please provide a summary of the vendor's organization/company.
8. Employee Credentials For the contract coders, please state credential requirements (if any)
9. Does UNMH analyze coding volumes, e.g. expected monthly charts by type? Please share any information on patterns that allow you to make predictions as to volume, specialty, type, etc. Historically, contract coding services have covered 35-50% of total encounter volumes at UNM Health System. HIM management does track on a monthly basis volumes by specialty and type – however, prior to reaching out to contract coding, HIM management ensures there is a need. A full scope of what is needed would always be shared with vendor – though, contract coding services have been supplemental, it has been a long-term basis.
10. Is it correct that outsourced coders will have full remote access to UNMH's systems? (Cerner EMR and 3M?)Yes, both systems
11. Is UNMH able to anticipate the expected intervals when assistance is needed for the HIM department? (Frequency and expected length.) Yes – please note as stated in (a), we have utilized contract coding services on a long-term basis. UNMH has went through volumes and productivity to calculate the need for additional support. If vendor is selected, full scope and detailed volumes would be given to vendor to review.
12. Please clarify the requirements of 2.2.2 Proposal Content and Organization, *Section C.2.a. Scope of Work Requirements (1.B.i through 1.B.iv)* and *b. Facility Support*.

13. Pg. 5 Section 1.9.2 – Verification of work. This type of work is done remotely and cannot be verified at a central location, how would you perform this verification visit at an employee's home office? UNMH will be able to review coded and productivity reports to verify work is completed and performed by contractor. Report access can be given to vendor as well.
14. Coding Augmentation Services: In the past 12 months what was the average FTE usage of augmentation staff per month? Historically, contract coding services codes 35-50% of all annual encounter volumes across the spectrum (inpatient, observation, same day surgery, physician services, and hospital outpatient clinic visits).
15. Coding Augmentation Services: Do you have established productivity standards per patient type? Yes
16. Coding Augmentation Services: If so, please share per patient type.
    - Inpatient: 13 charts per day; roughly 260 charts on a monthly basis
    - Observations: 18 charts per day; roughly 360 charts on a monthly basis
    - Same Day Surgeries: 30 charts per day; roughly 600 charts on a monthly basis
    - Outpatient Clinic Visits/Physician Billing: Split: If coder is coding diagnosis codes only for an outpatient encounter, standard is 75 charts per day (roughly 1500 encounters on a monthly basis). If coder is coding diagnosis codes and CPT procedural codes (such as E&M and other procedures); standard is 45 per day, roughly 900 charts on a monthly basis.

16. Coding Augmentation Services: Cerner is the EMR. Is it the same for all locations? Yes
17. Coding Augmentation Services: What is the abstract system (revenue cycle platform)? Coding is performed in 3M; however, our billing system is Soarian.
18. Coding Augmentation Services: Claim Edit Resolution – What percentage of encounters goes to a claim edit work queue? Approximately 70% - however, coders will see edits directly in 3M as well.
19. Inpatient Audits: How many inpatient discharges are to be reviewed monthly? In terms of audits, we'd like to complete 300 inpatients audits on a rotational basis (roughly every 3 months)
20. Inpatient Audits: If selection is made per coder, how many inpatient coders? How many records per coder? n/a
21. Inpatient Audits: Will the review be under MS-DRGs and/or APR-DRGs? MS-DRGs
22. Inpatient Audits: Will the record selection be random or targeted based on high-risk and complex targets? Targeted audit based on different parameters (mortality, focus-DRGs, etc.)
23. Outpatient Audits: What service types are to be included – All (observations, same day surgeries, emergency department, and outpatient clinic visits)
24. Outpatient Audits: How many encounters of each service type are to be reviewed monthly? In terms of audits, we'd like to complete 300 OP audits on a rotational basis (roughly every 3 months)
25. Outpatient Audits: If selection is made per coder, how many outpatient coders? How many records per coder? n/a
26. Outpatient Audits: Will the review for EDs and observation encounters include validation of injection and infusion services? Yes
27. Outpatient Audits: Will any of the outpatient encounters include validation of ICD-10-PCS codes? No
28. Outpatient Audits: For any observation encounters, will validation of units/hours be included in the review? No

29. Outpatient Audits: Will any codes outside of the surgical section of CPT (often chargemaster assigned) be included in the review? What areas? No – unless an edit develops between charges and codes that coder selected.
30. Does the scope include professional fee audits? Uncertain at this time, though likely.
31. Professional Fee Audits: What specialties will be included? All
32. Professional Fee Audits: What volumes per specialty would be included? Same as noted above – 300 encounters on a rotational basis (perhaps every 3-4 months)
33. Professional Fee Audits: How many providers? n/a – It'll be a random assortment based on volume
34. Professional Fee Audits: Who is assigning the diagnosis, CPT, and E/M codes? Coders, providers, a mixture? Mixture
35. Professional Fee Audits: Will mid-level providers be included in the reviews (validation of incident-to needed)? Yes
36. Professional Fee Audits: How often do you wish to include a group coders' education session based on the audit results? UNMH employs internal educators – Vendor would only need to complete audits and internal educators would be responsible for educational sessions. This would be the primary educational method.
37. Professional Fee Audits: How often do you wish to include a provider education session based on the audit results? Same as above.
38. Volumes: Please provide a breakdown of the number of monthly audits by modality (Inpatient, Outpatient, Professional, E&M, etc.) As noted above, we would have audits of 300 encounters on a monthly rotational basis amongst the various modalities.
39. Is provider education in scope? Noted above – we do have internal educators that will assist with educational needs.
40. Has the incumbent vendor been offered or is expected to bid again for these services? Yes What negative issues have you had with the incumbent vendor that you wish to improve upon, if any? With a new management team and a long-standing RFP, UNMH HIM felt strongly that it was critical that a new RFP process be re-enacted to ensure a full re-evaluation of all vendor options was explored in the best interests of UNMH.
41. What type of hospital inpatient cases will be audited (e.g. MS-DRG cases, short stays, LOS outliers, etc.)? Already noted above
42. What type of hospital outpatient cases will be audited? (e.g. observation cases, ED visits, outpatient/ambulatory surgery, etc.) Already noted above
43. Will coding audits be concurrent (pre-bill) or retrospective? Retrospective
44. Can you provide any information on your expectations of the coding audit deliverables? All expectations and scope will be explored with chosen vendor. All UNMH policies/procedures will be given to vendor as well. UNMH is expecting audit to be conducted in a fair/impartial manner and tied to timely deadlines. UNMH is interested in any reporting that vendor will provide on each audit – specifically to a full summary of audit and any opportunities seen from the audit.
45. Will the education be provided virtually or on-site? On-site – Noted above that we use internal educators
46. What is the anticipated volume or percentage of audits to be performed for facility and professional fee billing? Already noted above
47. Do you want education developed and delivered specifically based on audit results? Yes – though we do use internal educators

48. How often will AHIMA approved continuing education sessions be requested? Offering AHIMA CEUs is always desirable, though, it is expected that UNMH internal educators will probably offer education. UNMH is interested in CEU sessions that vendor might offer.
49. What is the timeline for delivery of written analysis/corrective feedback from the start of the audit? On a weekly basis as audits are completed, they are returned to UNMH and a rebuttal period enacted… Roughly 30 days from each audit, a full written analysis is provided to UNMH.
50. If the providers assign Pro-Fee codes, do coders review the code assignment? Yes
51. Is there an established acceptable error rate or expectancy? No – UNMH would like to evaluate based on industry standards.
52. Are the results of the audits tied to physician compensation? No
53. Please provide a list of key statistics for both IP and OP Within RFP, volumes were given for organization.
54. Would provider education take place onsite or via web- based? As noted above, education will most likely occur with internal educators. However, vendor is welcome to provide details of their educational offerings and modalities.
55. Can you provide your rationale for conducting an RFP for your coding & auditing at this time? Noted above
56. .Do you report PCS codes for outpatient encounters? No
57. .Do you report CPT codes for inpatient encounters? No
58. Who is the incumbent? No comment as incumbent is included on current RFP process.
59. Is KLAS rating important in your decision process? Although not driving force, KLAS rating is important.
60. Will all the records will be accessible through the same EMR Yes
61. Does the organization have a clinical documentation improvement program? Yes, for inpatient encounters only at this time.
62. Does the Professional Services auditing include meeting with the providers to share audit results? As noted above, internal educators will likely provide education to physicians.
63. Please list the systems coders/auditors will need to access to perform these services? Vendor will be given access to EMR and 3M coding system.
64. What is the timeline for delivery to detailed reports from the start of the engagement? Noted above – but roughly 30 days from conclusion of audit.
65. Will UNM provide established coding policies and protocols prior to the start of the engagement? Yes
66. Must education be delivered on-site or can it be delivered via Web-Ex? Noted above – internal educators will most likely conduct education – though vendor is welcome to provide their educational platform and services for UNMH's review.
67. What key challenges or concerns are you experiencing today that you are seeking to improve? Auditing and being able to see trends and opportunities is always a struggle – as such, UNMH has determined to start hosting additional audits to help improve coding accuracy for the organization, as well as, be able to see trends for coding and physician education.

68. What are UNMH auditor hourly productivity guidelines per patient type? UNMH has only started incorporating auditors internally – based on historical trends, auditor productivity guidelines have varied between the various chart types. UNMH will evaluate vendors on their internal productivity guidelines for their auditors.

69. What are UNMH quality standards per organizational quality guidelines? 95% - industry standard
Is University requesting full time audit staff? Can you provide details related to the auditor scope of work? It would be full-time audit staff – completing monthly audits rotating between inpatient and outpatient service lines.
What is the onsite requirement driving the need for travel? For contract staff, there should be no need for travel to our facility.

70. SDS Coding Questions:
Do the coders do any injection and infusion coding? No, not for SDS. OBS and ED coders do perform infusion coding.
Any anesthesia coding? No

71. IVR
UNMH has an advanced interventional radiology program for inpatient and outpatient, what are the top 10 procedures performed? In no particular order: AV fistulograms, radiofrequency ablations, angiography, angioplasty/stenting, brachytherapy, variety of embolizations, thrombectomies, but also fairly common procedures: paracentesis, CV line placement/removals, g-tube placement/removals, biopsies, etc. comprise a substantial portion of completed procedures.

72. GI
With state-of-the-art facility for digestive care, are there any new technologies or advanced surgeries being performed?
What is the standard volume today for inpatient/outpatient GI procedures? For 2020, the volume was roughly 380 a month; however, this is skewed by COVID, which has limited the amount of procedures performed during part of this year. In 2019, numbers were roughly approximately 660-700 on a monthly basis.

73. Cardiac
With new department for cardiac cath, are there any new technologies or advanced surgeries being performed? Not necessarily – Department has been increasing Watchman device implementation.
What is the standard volume today for inpatient/outpatient Cardiac procedures? Approximately 60 procedures performed monthly.

74. ED
Do the coders code injection and infusion or through EHR system? Coders code infusions/injections.
Are EM levels assigned by coder for both facility and profee or through EHR ED system? E&M levels ae assigned by the coder on the facility and professional fee side. For the purposes of this RFP, this is only for the facility side (pro-fee coding is performed via a separate entity).
Are ED procedures assigned by coder or review charges? By Coder
Are appropriate modifiers assigned by coders? Yes

75. Outpatient Clinics—Hospital
Noting assignment of EM codes, will coders be coding procedures and modifiers or reviewing system charges? This will vary - but could encompass both coding and reviewing system charges.

76. Profee Coding- Physician Clinics

Will coders be billing for inpatient services separately for physicians? No – this is handled by a separate entity.

77. Will there be physician/split billing? Yes, there are some instances of split/billing. If so, what physician groups and how many physician/practioners? This varies depending on different areas. If split-billing is required to code for a certain area, UNMH will provide all specific details to vendor, along with coding processes, procedures and workflow requirements.

Any physician's practicing their own billing process with coders "validating" prior to billing. If so, how many physicians and what specialty? At this time, physicians are marking their charges on a charge sheet (coders will review selected codes for accuracy); however, the organization is striving to move forward with coding taking over 100% of the coding process

78. Can UNMH please clarify the preferred format for RFP responses? Section 2.2.2 "Proposal Content and Organization" and Exhibit B "Evaluation Criteria" don't seem to match up, and both state "Proposals should be labeled and tabbed according to the numbering shown below". Which format is correct? In addendum 3

79. Can UNMH please clarify the preferred format for cost/fee? Page 13 differs from Exhibit K. Which format is preferred for the pricing piece? In addendum 3.

80. Under Management/Performance Measures on page 12, it is stated that the coder and auditor shall code or review in the case of the auditor a minimum number of charts per 8 hour shift as defined in the organization's productivity guidelines. What are UNMH's hourly productivity standards per record type?

Productivity will vary depending on chart type: 13 charts/per day (INPATIENT); 18 charts/per day (OBSERVATION); 30 charts/per day (SAME DAY SURGERIES); and for outpatient clinic visits – 75 charts/per day (if coding diagnosis code(s) only) or 45 (if coding diagnosis codes, alongside procedural and E&M leveling).

81. What are the quality standards/accuracy rate requirements for UNMH? 95% (industry standard)

82. Page 10 states that all outpatient coders must possess either a CPC or CCS-P. If an outpatient facility coder has CCS only does that fill this requirement? UNMH management reserves the right to be flexible with staff credentials, depending on the need of the organization and the contractor's experience.

83. On page 11 Under Management/Performance Measures it states coder and auditor shall code or review in the case of the auditor a minimum number of charts per 8 hour shift as defined in the organization's productivity guidelines. Can you provide us productivity numbers for coding and auditing for your facility? Based on industry standards, auditing can vary – though 2 charts per hour is standard. Due to the complexity of some inpatient charts at UNMH, there may be times when this standard may need to be expanded.

84. Page 9 states that CCS certification is required for inpatient coders. Is this required for our staff that are RHIT/RHIT credentialed? Defer to answer under #5

85. Will University of New Mexico provide facility established coding policies and protocols prior to the start of the engagement? Yes

86. What is UNMHS' primary EMR? Cerner PowerChart

87. Does UNMHS have more than one EMR? No

88. What is the average onboarding time to gain access to systems? This will vary between 2-4 weeks.

89. Will CDI be involved? On the inpatient side, UNMH has an internal CDI team that concurrently reviews and queries on charts. CDIs will also perform a final review of all reviewed charts to ensure agreement with final DRG.

90. Will the auditors be responsible for developing education and delivering specifically based on audit results or will this be handled inhouse? UNMH has internal educators that can provide internal education based on audit results.

General Questions:

1. Anticipated award date? Tentatively 11/1/20
2. Will provider/profee coding and auditing be included in the scope of work? Yes
3. Anticipated review frequency (annual, semi-annual, quarterly)? We would like monthly audits.
4. Anticipated number of vendors to be awarded? Undetermined – depends on outcome of RFP and vendor selections.
5. Is there an incumbent vendor? Yes

Acute/Facility Reviews:

1. Number of coders on staff? Approximately 45 internal coders
2. Anticipated volume of records per review? Anywhere from 150-300 records on a monthly basis rotating through the different service areas (inpatient, same day surgery/OBS, ED, and hospital outpatient/physician services).
3. What service areas will be included (Inpatient, ASC, Observation, etc.…)? All
   a. Will there be any focus areas? This will vary as UNMH consults with our Quality Department.
4. Will UNMH select the sample for review? Or HIA? UNMH
5. Will there be a need for UB validation? No
6. Will there be a need for POO validation? I'm not aware of POO.

Inpatient:

1. Will POA indicators need to be validated for all diagnosis codes or just HAC's? All
2. Will any inpatient APR-DRG's require validation? Yes – a random or focus DRG audit will be created.

Outpatient:

1. Is PCS code validation required? If so, what patient types? No – not at all

2. Will Injection and Infusion validation be required for any outpatient types? Yes, ED, Observations, Infusion Clinic.
3. Will interventional services be included in the sample? Yes If so, will supervision and interpretation codes need to be validated? No
4. Will facility E/M codes need to be validated? Yes
5. Will EAPG validation be required No

Profee/Provider Reviews (if applicable):

1. Number of employed providers on staff? 1000+
2. Anticipated volume of encounters per review? Same as noted above
3. Are codes being assigned by provider, coder, or combination? Combination and depends on area.
   a. Who assigns the diagnoses codes? Coders
   b. Who assigns the E/M codes? Depends on area – coders or physicians
   c. Who assigns the CPT codes? Depends on area – coders or physicians
4. Which specialties will be included (cardio, ortho, family practice, etc.)? All
   a. Will there be any focus areas? Undermined at this time.
5. Will UNMH select the sample for review? Or HIA? UNMH
6. Are there midlevel providers? Yes
   a. Are they credentialed to bill? Yes
   b. Do any payors not credential midlevel's? Not that I'm aware of.
7. Proceduralists? n/a
8. Practice in Hospital and Clinic? Yes
9. Are there any residents and/or students? Yes
   a. List of supervising providers? If vendor is selected, all specifics will be given to vendor on clinical staffing model.
10. Who is the MAC? Novitas
11. Guidelines (95, 97, both)? Both
12. Will the 1500 be available? If needed
13. Provider-based billing? I'm unsure of the meaning of this question.
14. Any provider specific guidelines? Yes – all internal guidelines will be given to vendor.

Coding Services:

1. Are there any current coding issues that UNMH is experiencing? Nothing unique to other facilities.
2. RFP leans toward coding support. Are you asking for coding audit pricing as well? Yes
3. For profee coding, can you confirm 100% case types and daily volumes will be coded by selected vendor? Historically, contract coding services cover 35-50% of all encounter volumes on an annual basis.

4. Will coding be on an "as needed/per diem basis"? Historically, contract coding services have been used on a long-term basis. If as needed/per diem is needed, UNMH will specify with vendor.
5. Does UNMH require weekend work? Outside of the Monday through Friday workweek? No
6. Does UNMH have established productivity standard for profee and facility coding? Yes
7. For Profee (if applicable), E/M and surgical CPT? Yes
8. Are there any mid-level providers? If so, are they credentialed to bill? Yes to both
9. Will the coders be assigning all codes? Or validating provider assigned codes? Both? Both
10. For ED coding, are the coders responsible for picking up facility and/or profee E&M levels? Picking up facility levels only.
11. For Observation and ED records, will either require Injections and Infusions code assignment be required? Yes – both OBS and ED
12. For interventional services, will supervision and interpretation code assignment be required? No
13. Is there a current backlog of coding work associated? In some areas, but based on RFP timing, this may or may not be present once RFP is completed/vendors selected.
14. Are there any residents or students? Both
15. Any provider specific guidelines? Yes – all internal guidelines will be given to vendor.
16. Who will abstract the accounts? HIM Operations/HIM Techs

1. How many Coders are contemplated for performing the services? Historically, we have a contract team of roughly 40 coders.

2. Will coders credentialed by AAPC be accepted along with AHIMA certified coders? Yes

3. Will the coding and audit services be awarded to a single coding vendor? Undermined, this will depend on RFP and vendor offerings.

4. Will the Offerer coding managers run production reports for outsourced coding team members? UNMH can run reports, or provide access to vendor for their own reporting.

5. What are the annual volumes for each outpatient specialty listed in the RFP or contemplated by UNMH? Historically, contract coding services provide coding for 35-50% of all encounter volumes at UNMH annually.

6. Are there presently any coding backlogs in inpatient and/or outpatient coding? There is a slightly OP backlog; however, it may or may not be present by the time of the RFP awarded to a vendor.

7. Are all UNMH clinics and physicians working in Cerner? Yes

8. Will professional and technical coding for inpatient and emergency department coding be performed through Cerner? Yes – However, inpatient professional coding is not part of this

RFP.

9. Will the Offerer be required to code any infusion or injection services within the emergency department? Yes

10. For emergency department coding, will there be any facility E/M coded? Yes

11. Do physicians currently code encounters as they see patients? For some outpatient clinic visits, physicians mark a charge ticket with their services and leveling – coder would be responsible for coding the diagnosis code(s) and reviewing physician's marked items.

12. What are the annual volumes broken down by patient service to be outsourced for inpatient services? For example: Inpatient, observation, emergency department, diagnostics, ancillary and series accounts. Historically, contract coding services provide coding for 35-50% of all encounter volumes (across the board – IP, OBS, ED, outpatient, etc.) at UNMH annually.