**RFP 474-22 – Coding Outsourcing**

**Vendor Questions received as of February 13, 2023**

1. What are your productivity expectations for coders by chart type (e.g., “minimum number of charts per 8-hour shift)? For our outpatient clinics, we have set the following standards:

* SinglePath Clinics – 6 encounters per hour (minimum)
* NonSinglePath Clinics & Edits – 10 encounters/edits per hour (minimum)

1. Can you provide annual encounter volumes by specialty? At this time, outpatient volumes range from 45,000-50,000 per month. The following are annual estimates:

* Cardiology – 21,000
* Dermatology – 16,000
* Digestive/Gastrointestinal – 9,700
* Primary Care – 100,000
* Specialty Clinics (multidisciplinary) – 120,000
* Neurology – 26,000
* Ophthalmology – 22,000
* Pediatrics – 76,000
* Surgery – 25,000
* OBGYN/Women’s & Newborn – 56,000
* Ancillary (audiology, rehab, etc.) – 18,000
* Inpatient Advanced Practice Provider E&M Coding – 35,000

1. Can you provide annual encounter volumes by Outpatient Clinic, Ancillary Service, E&M, and Coding Edits? Volumes are listed above; at this time, ¼ of all outpatient clinics are on SinglePath, which would require technical and professional coding to be done simultaneously. For coding edits, this ranges from 8-12,000 edits on a monthly basis.
2. Is there a technical and professional coding requirement in scope? Yes, at this time, our outpatient clinics are converting to SinglePath coding, which allow the professional and technical components to be coded simultaneously.
3. Please define your “quality standards as defined in the organization’s quality guidelines” that our coders are expected to meet: We hold a 85% minimum quality expectation; however, we do strive to have coders in the 90-95% quality range.
4. What additional performance metrics are important to UNMH?  Quality and productivity are the highest metrics of value to UNMH; in addition, timely turnaround time and ongoing coder education is critical. Of mention, reporting and proper communication between UNMH and vendor will be significant in order to keep
5. What is your expected go-live date and desired length of contract? At this time, no go-live date has been given. For such a large operation, this will take a length of time to properly transition from our organization to the vendor. It is possible to start transition this year; though, all areas may take time to transition to vendor. If vendor is selected, go-live date and contract length would be determined at that time.
6. Please provide coding denials by reason code for last 6 or 12 months Coding denials have centered on missing and/or invalid modifier usage, medical necessity (sometimes this is a coder issue for not coding appropriately; other times, this is a physician documentation issue), and bundling.
7. What is the volume by outpatient clinic specialty, what is the volume by facility services, please include all possible patient types.  Please reference #2 with volumes; of mention, SinglePath is rolling out at this time – but still only roughly ¼ of volumes. SinglePath has been employed throughout our primary care areas, and has started to expand into other specialty areas, such as pediatrics, sleep medicine, and several specialty areas.
8. Broken out by types (hospital and pro fee separated)
9. Is the 100% case audit requirement expected to be complete post implementation, or only when bringing on new coders. The 100% review is more for initial onboarding of coders; if vendor has a different protocol, UNMH will review and determine if vendor’s onboarding protocol is acceptable. After onboarding, vendor would need to continue quality audits on coding staff on a routine, consistent basis.
10. What percent of the coding volume have edits worked by coding.  Please reference #2, which has average coding edit volumes.
11. What is the ETA on Single Pathway for coding? We have transitioned roughly a quarter of our outpatient clinics to SinglePath as of current date; we have a workgroup that continues to plan future clinic conversions. At this time, we are working closely to tentatively complete all transitions by 2024, though this may be adjusted.
12. Can you clarify the stance on offshoring of services? Miscellaneous section indicates only domestic coders, but the next paragraph contains language about employed coders based internationally. Are offshore coders allowed? Does it matter if the offshore coders are employed or subcontracted? At this time, we would like all coding to be performed by domestic coders. We are not interested in offshore coders for our account.
13. Is it required to provide a cost per chart AND per hour? Will a cost per chart suffice? We’d like to see both costs; however, if vendor only wants to submit based on one criteria (either per chart vs. per hour), this is acceptable to the organization as well.
14. From Page 10: Can you please provide a breakdown of the 750,000 services for each specialty/patient type and include what is coded for each (i.e. Diagnosis, E&M, CPTs or what combination thereof? Volumes have been referenced in #2; with that said, of this volume, three-quarters is considered “nonSinglePath,” whereby coders are responsible for capturing diagnosis code(s) for the encounter; of the remaining SinglePath encounters, coders are responsible for capturing diagnosis code(s) for both the facility and technical component, while providing the E&M leveling for the professional fee code (alongside any additional procedural code(s)), while the coder would abstract for any additional technical, procedural code(s) as well.
15. Pages 11-12: Is there a bill hold timeframe for the physicians and clinical staff to complete their documentation? At this time, we hold all encounters until timely deadline or 90 days (whichever comes sooner). Our organization is moving ahead with setting up an electronic medical record access turnoff for our physicians if documentation is deficient; however, this is still in progress and not finalized as of yet.
16. Page 12: under “Management/Performance Measures”, it is stated that “Coder shall code a minimum number of charts per 8 hour shift as defined in the organization’s guidelines”. May we get the productivity expectations of UNM per chart type? Please see #1.
17. Page 10: can you provide the average volume of coding and billing edits expected for a given period (i.e. per day/week/month)? Please see #2 for volumes.
18. Page 10 & 11: What is the expected turnaround time for edits? Our organization’s expectation is to have all claims issued by day 5 from date of service; as such, coders (both those coding and/or resolving edits) would be aiming to have the coding/edit resolution completed by day 4. If the encounter is missing documentation, this expectation cannot be obtained; this expectation is based on documentation being present for coding to take place.
19. How many total providers are there? Can you provide the breakdown by specialty/patient type? Please reference #2 for total volumes; at this time, we have roughly 1600 providers throughout our organization (physicians, advanced practice providers, etc.). The following is a breakdown by specialty of all providers, irrespective of patient type. Please note: Patient type is difficult as we have many physicians that practice on an outpatient and inpatient basis; so this breakdown cannot be given at this time.

* Anesthesiology/Critical Care – 105
* Surgery - 160
* Dental – 6
* Dermatology – 10
* Emergency Medicine – 172
* Family & Community Medicine – 111
* Internal Medicine – 350
* Neurology & Neurosurgery – 83
* Obstetrics & Gynecology - 78
* Ophthalmology – 17
* Orthopedics & Rehab – 50
* Pediatrics – 172
* Radiology – 69
* Psychiatry - 123
* Other - 85

1. Are the coders expected to contact providers with changes in E&M’s & CPT? Not at this time. The departments review their own reporting for E&M leveling; if changes are noticed, vendor and/or internal department may be contacted to audit and/or comment on differences.
2. Assuming all regulatory and security information is provided and acceptable, are there any restrictions on international coders working from home? Please see #13
3. Page 14, Cost Fee: is there a preferred fee model or structure (per hour, per chart, monthly subscription, etc)? Our organization is open to viewing all fee model/structures that vendor will submit for – We prefer more choices to get a full picture of all costs and making a final decision based on options provided.
4. Is a vendor/third party currently performing this work? At this time, our organization is utilizing supplemental contract coding at this time; a full outsourcing of our coding operation is new for our organization.
5. Will selected vendor be able to use their own workflow/technology to perform coding tasks and enter back into the desired system(s) either manually or through electronic interfaces? At this time, our organization utilizes established systems: 3M Coding for coding software and Soarian Financials and IDX for billing systems. The vendor would be held to working in these systems and the coding would be expected to go through the 3M coding system; as there are pre-existing interfaces between the electronic medical record, coding and billing systems.
6. Is education required as part of these services? If so, can you please define your expectations regarding education frequency, audience, output, and length of sessions. It is an expectation that vendor’s coders are completing their annual CEUs for their respective credentials; as well as taking and/or receiving ongoing continuing education (monthly and/or quarterly basis).
7. Is this coding function currently outsourced? If so, what are a few key areas that you are seeking improvement? For example, reduce coder turnover, increasing productivity and/or quality, improving communication, improved reporting capabilities, etc. Please reference #24.
8. If this function is NOT currently outsourced, what are the top 4-5 areas that UNMH wants to improve? Our goal is to have an efficient coding operation with a steady coding workforce. Due to the pandemic, coder turnover has been high – with an option to outsource, we’re hoping to be able to keep staffing steady for the organization. Staffing is our number one consideration for outsourcing at this time.
9. On average what are your coding productivity KPI expectations by clinic type? Please reference #1
10. What are your average volumes in the following categories: Please reference #2 for volumes.
    1. Outpatient Clinic Encounters
    2. Ancillary Service Encounters
    3. Evaluation & Management Encounters
    4. Resolution of Coding Edits (Correct Coding Initiatives, Medical Necessity, Medically Unlikely edits)
11. RFP suggested that all coders must be issued company computers. Most coders have their own systems and dial into a VPN or Cloud Based Network at hospital. Is company issued computers a mandatory request? If vendor utilizes VPN and/or cloud network functionality, this may be allowable. If there are any security considerations and/or concerns on our part, UNMH IT Security will engage with vendor to determine current setup and viability of system access.
12. How is UNMHSCs EMR accessed? At this time, our current contract vendors utilize Citrix as their contact point to access our EMR, along with our coding and billing systems.
13. Is a VPN client required on the coder systems? Please reference #31; I’m not certain of all specifics of system security.
14. Is a certificate on the coder system needed? Please reference #31; I’m not certain of all specifics of system security.
15. Does UNMHSC manage access to the VPN and EMR? UNMH will manage system access to all systems needed on our side: EMR and coding/billing systems.
16. Will any other software need to be installed on the coder systems to access the EMR? No; at this time, Citrix has been our access point for all system access.
17. Will any data be stored on the coder systems? No – We do not want any PHI and/or other data stored on individual systems. Our Citrix connection is also a generic access account only; as such, coders will be unable to save any data to the virtual desktop.
18. Are you able to provide a breakdown of the 750,000 accounts (for example, how many of them are ancillary and what is the breakdown of the Profee Specialties? Please reference #2.
19. Profee: what are the specialties to be coded? Is this E/M and ICD10 or procedure/surgeries as well? Please reference #2 & #15 for detail.
20. Ancillary Services: are coders responsible for assigning radiology codes? At this time, radiology coding is handled by a separate coding group and is not necessarily within scope for this RFP. With that said, at times, as needed, our group will occasionally assist with resolving radiology CCI and MN edits; this is on an overflow basis only and amounts to roughly 45 edits a month (some months less; some months higher, but this is the average).
21. Are you able to provide internal productivity standards for your professional and ancillary coders? Please reference #1
22. What are your productivity standards for each category? Please reference #1
23. Will coders be working edits and denials as well? Edit resolution would be a part of this RFP scope; in terms of denials, this would most likely transition to the vendor after coding services are in place by vendor.
24. What is your accuracy rate? Please reference #5
25. What are the volumes per quarter/year? Please reference #2 for volumes.
26. Will you accept offshore coding? Please reference #13