

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
BID No. 2014-03
Workers Comp and Out-of-State A/R Services
March 14, 2014

ADDENDUM NO. 1

Questions / Answers

1. Does the 40-page limit apply only to items required by Exhibit A or does it also include required Attachments 1 through 7, which total 31 pages?
A: The page limit is only for the information required in Exhibit A.
2. The Services Expectations specify that the successful bidder will maintain 3 on-site representatives “at all times” to manage various tasks. Is this intended to mean the successful bidder must have 3 representatives on-site 24 hours a day, 7 days a week? Or can the bidder determine on-site staffing based on volume, with the expectation that during daytime business hours there will be 3 staff on-site?
A: The contract will require that there be 3 onsite representatives that work M-F 7:00am – 3:30PM or 8AM - 4:30PM. The best coverage would be to have at least one person on each of these shifts. The office is closed on all legal holidays. The expectation is to have this staff on site regardless of volume. This has been the standard under our current contract and there has never been an issue with not having enough volume for 3 staff members on a full time basis.
3. Please clarify “accounts forwarded for legal action on behalf of the hospital must be processed separately from other client accounts”?
A: UMC accounts cannot be mixed in with any other company, hospital or organization for which the successful bidder does business. UMC accounts must be referred for legal actions separately.
4. Item 3 Is this 15 days from discharge or assignment? Is UMC intending to bill some of these accounts?
A: Fifteen days from date of placement. At times when a patient has out of state Medicaid secondary to Medicare, the MAC will automatically forward the claim to the Medicaid carrier and a payment is initiated to UMC without any action on the provider’s part.
5. Is the Out of State Medicaid billing for all states including Border States?
A: Yes
6. Are there any contractual, formal, informal agreements with WC payers that we should be aware of?
A: Yes, several work comp carriers have negotiated rates UMC. These will be provided. All other work comp carriers reimburse according to Nevada DIIR rates.
7. How does UMC handle WC accounts involving UMC employees? Would those be handled by the vendor or returned to the facility for internal management?
A: They are handled in the same manner as all other work comp claims. No special handling.
8. What are the estimated monthly Worker’s Compensation referrals by number of accounts and total charges?
A: The average number of referrals per month for worker’s compensation is 696 accounts with average total charges of \$2,772,276.13 based on 2013 historical account data.
9. What are the estimated monthly Out of State Medicaid referrals by number of accounts and total charges?
A: The average number of referrals per month for out of state Medicaid is 207 accounts with average total charges of \$3,202,004.53 based on 2013 historical account data.
10. Will there be a backlog of referrals for Worker’s Compensation? If so, how many account with that total charges?

A: This will need to be determined as the current vendor may elect to keep the accounts already referred and run them out. If not, any outstanding accounts would be transferred and the date of referral updated to reflect when it is placed with the current agency.

11. Will there be a backlog of referrals for Out of State Medicaid? If so, how many account with that total charges?

A: Same as above.

12. Will Vendor be allowed to utilize an electronic notes transfer of comments to UMCSN's system?

A: This has not yet been established with the new McKesson STAR system.

13. Will all referrals be accomplished electronically?

A: Yes via FTP transfer.

14. Will Worker's Compensation accounts be billed from UMCSN's billing system or Alegis' billing system?

A: They initial claim is released from the UMC billing application and printed. These are provided to the vendor for submission to the appropriate work comp carrier.

15. Will Out of State accounts be billed from UMCSN's billing system or Alegis' billing system?

A: Same as above

16. Will accounts continue to be referred at Day 1?

A: Yes

17. Are bidders required to bid separately on aged A/R greater than 181 days?

A: See Section IV of the Bid

18. Will a pre-bid conference be held with respect to this RFP? If so, when and where?

A: No

19. May we include a cover letter/executive summary with our response? If yes, are there any formatting requirements?

A: You may but it will count towards the page limit mentioned in Exhibit A. There are no format requirements.

20. What type of employment documentation do you refer to on the last line of page 20?

A: UMC Human Resources requires specific documentation for all persons working onsite. This includes background check, TB testing, right to work in US, etc.

21. How many hard copies of the final bid response do you require? Would you like an electronic copy sent as well?

A: Please send two (2) hardcopies and one (1) electronic file on a CD. No thumb drives.

22. Page 8, Number 15. In discussing subcontractors, our attorneys at Aspirion help with the legal trials and mediation for certain patients to ensure the State Board is aware there is an outstanding bill for our facility to ensure this does get paid accordingly, and must comply with HIPAA regulations per the attorney/patient confidentiality agreement. Would this interfere with Aspirion's bid?

A: No

23. Page 19, Number 35. Termination for Convenience. My question is that if UMC elects to terminate the contract, would we still continue to process the accounts we currently have been working before the termination date until payment? Or, would we completely halt all processing completely? Would there be a clause in our contract with UMC stating our services will be provided for a certain "locked in" amount?

A: The notice of termination would explain the situation and how each party should handle the work already assigned. There will be no "locked in" amounts.

24. Page 20, Service Expectations: This states that if a payment is received within fifteen days, the payment is perceived to be as a result of UMC's efforts and no fee will be paid. However; after coding and billing has been done, most government (OWCP/Longshore) fee schedule abiding companies pay within fourteen days. These companies use electronic funds transfers (EFT), so the payment is issued directly to the bank's account, without having to wait for the check to be issued to the provider and then received to deposit. Also, employers may request the bill and pay the hospital within the fifteen day timeframe. Would certain circumstances be rendered an exception in this expectation in order for Aspirion to be reimbursed properly? Also, please have them clarify if they mean fifteen days from the discharge date, or fifteen days from when the bill is ready to be submitted and free of coding errors. There is a difference in these two time frames. With that being discussed,

is UMC would please define the efforts of UMC that would be perceived if payment is received. Would UMC originally process the claim, and Aspirion would receive this after a certain allotted time? Or, would the perceived efforts be the registration department speaking with a patient or employer? Would Aspirion have these workers compensation claims once the patient is discharged as a claim for us to work starting day one, or would we receive the claim after UMC's efforts to recover payment are exhausted?

A: Claims are not transferred until the coding and billing is completed. However, the C4 process required by the state begins on registration and is a joint effort between the vendor and UMC to ensure no fines are imposed. See answer to question # 4

25. Have any addendums been issued?

A: This will be the first one.

26. How can I obtain any addendums that are issued?

A: Addendums will be sent directly to vendors who submitted a Confirmation Form. Addendums will also be posted on the Clark County website. <http://www.clarkcountynv.gov/depts/finance/purchasing/Pages/listings.aspx>

27. If awarded bid will we have time to apply for business license and Limited Vendor before contract is executed?

A: There would be some time before the agreement is executed however, I would suggest getting the forms ready to help speed up the process.

28. Have you outsourced this service in the past and if so, can you please provide recovery results?

A: Unable to provide this information from current vendor.

29. What billing system is currently being used?

A: McKesson STAR

30. Will Parallon have full electronic remote system access to obtain the following:

- a. Demographics –
- b. Payments
- c. Medical records, EOB's etc.

A: only onsite staff has direct access to UMC's demographics, payments, medical record etc. There is not remote access to this information except on a limited basis.

31. Will the accounts include: IP/OP and ED

- a. If yes, what is the anticipated monthly volume of accounts broken out by IP/OP/ED

A: Accounts will include all accounts assigned to a worker's compensation or out of state Medicaid insurance plan. (Information based on 2013 account activity)

Workers Compensation:

Inpatient: Average 15 accounts per month with average gross charges of 1,864,246.51

Emergency: Average 126 accounts per month with average gross charges of 415,689.89

Outpatient: Average of 555 accounts per month with average gross charges of 432,339.73

Total: Average 696 accounts for 2,772,276.13

Out of State Medicaid

Inpatient: Average of 38 accounts per month with average gross charges of 2,524,906.43

Emergency: Average of 137 accounts per month with average gross charges of 302,466.69

Outpatient: Average of 32 accounts per month with average gross charges of 371,631.41

Total: Average 207 accounts per month with average gross charges of 3,202,004.53

Note: Outpatient accounts include observations services

32. What were total Workers' Compensation charges for 2013 broken out by IP/OP/ED; are these gross or net charges?

A:

Inpatient: Average 15 accounts per month with average gross charges of 1,864,246.51

Emergency: Average 126 accounts per month with average gross charges of 415,689.89

Outpatient: Average of 555 accounts per month with average gross charges of 432,339.73

Total: Average 696 accounts for 2,772,276.13

33. What were total collections for Workers' Compensation in 2013 broken out by IP/OP/ED

A: Collections are based on the Nevada DIIR published rates or by contracted directly with UMC.

34. How often will accounts be placed?

A: Daily

35. Are your expectations that the selected vendor does the initial billing, or will you do the billing and then assign accounts; if you do the billing, at what age will accounts be placed?

A: Initial billing yes, placed as soon as the claim is produced and passes edits.

36. Will client send daily/weekly payment reports?

A: Weekly

37. If a payment is received by the vendor, will they be allowed to post and then forward to you?

A: No, all EOB/Remittance Advice and payments come back to UMC and are posted by UMC staff. The system identifies payments for the carriers placed with the vendor and a reconciliation report is provided weekly. If a payment is received by the vendor it is expected that it will be provided to UMC within 48 hours of receipt.

38. Historically, the need for onsite personnel is determined by client volume, amount of remote access, and how much of the process can be automated as opposed to manual. Are you flexible with number of on-site staff?

A: No

39. How many hard copies of the RFP would you like provided?

A: See question 21.

40. Will Parallon be granted remote access for Medical records, UB04's and reimbursements from Medicaid?

A: No see question 30 above

41. Will Parallon be provided a list of states where the facility is approved for the filing of claims as a provider and those that require TOG to file to obtain provider status?

A: Yes, unable to answer second question as TOG is not an abbreviation we currently use.

42. Personal information is required to obtain provider status for Medicaid in certain states. Are there any states that UMC has refused to provide this information? If so, which states?

A: Yes, Connecticut and Massachusetts are the only two states in which we have been unable to become a provider with due to them requiring the Social Security numbers for our board of directors.

43. Number of claims and related hospital reimbursement by state in order to determine volume levels.

A: Unable to provide the number of claims by state due to having one insurance plan for Out Of State Medicaid that is updated for each account with the correct state information.

44. Have you outsourced this service in the past and if so, can you please provide recovery results, by state?

A: Yes we have outsourced this. Vendor recovery rates not for publication.

Changes / Clarifications

BIDs are still due on March 27, 2014 at 2:00:00PM.

BID opening will be held in Conference Room H at 3:00PM.

Issue by

Should you have any questions, please contact me at (702) 207-8846 or via email at robert.maher@umcsn.com.

Issued by:

Rob Maher
Sr. Contract Management Analyst
UMC

Acknowledgement

*****All Proposals submitted shall include a signed copy of this addendum acknowledging receipt and understanding. Addendums shall not count towards the page limitation.***

Signature: _____

Title: _____

Company Name: _____

Date Received: _____