Question # 14  What is the current fee schedule?

Answer: The current fee schedule relates to hourly labor rates per employee and contains twenty-four (24) price lines. In contrast, the RFP requests an annual firm fixed price per completed and accepted cardiac surgery medical record and contains only three (3) price lines that will appear on the contract.

Question # 15  What is the total cost for the current and previous year?

Answer: The cost for each of the two contract years is approximately $125,000.

Question # 16  What are the minimum qualifications for the reviewing staff?

Answer: Personnel who review medical records must be experienced in medical record documentation and maintenance of medical records. Such personnel may include certified medical records reviewers, registered nurses certified in utilization review, or medical doctors.

Question # 17  Which firms are submitting questions for this RFP?

Answer: The names of the firms submitting questions are not known to the buyer and will not be revealed to the buyer.

Question # 18  RFP Section 5.12 - What licensing is required for this type of engagement?

Answer: There is no specific licensure required for this type of engagement, however, the contractor shall ensure all personnel performing work on this contract maintain appropriate certification or licensure required by the governing entity that oversees the profession of the personnel.

Question # 19  RFP Section 1.2.2 - Is "To establish a system..." a computerized solution, some manual data maintenance, or new computerized/manual that needs to be developed?

Answer: Here the "system" relates to a process or a sequence of events, not a computerized solution or manual.

Question # 20  RFP Section 3.2 - Are the "guidelines established by and available from DHSS" available on the web? If not, where are they?

Answer: Draft guidelines are attached as Exhibit 1. Final guidelines will be created with input from the contractor.
Question # 21

Is it necessary for the medical review to be conducted by New Jersey medical doctors?

Answer: No.

Question # 22

Does the onsite review with OHSCs and State Contract Manager have to be conducted for every patient record or just the overall finding per OHSC?

Answer: The medical reviews will be conducted on a sample of patient records (about 100 per hospital). Summary reports will also be provided for each hospital to the contractor. Each medical review finding will be reported back to the State in accordance with specifications agreed upon by the State Contract Manager and the contractor.

Question # 23

Do the audits need to be conducted one OHSC at a time or can the contractor conduct a few at a time?

Answer: The audits may be conducted in multiple hospitals simultaneously if the contractor has the means to do so. Most hospitals may prefer their audits to be completed within a day or two to minimize interference.

Question # 24

Have all eighteen (18) OHSCs been audited in the past?

Answer: No. Seventeen (17) of the current eighteen (18) have been audited in the past.

Question # 25

Please provide a brief description of the current process, systems, and protocol presently in place.

Answer: Please see Sections 3.1 to 3.3 of the RFP, which briefly summarize the current process. See also the guidelines that are attached.

Question # 26

RFP Section 3.3.a - Due to the need to comply with HIPAA regulations, e-mail that contains provider level or patient level data can not be sent via our e-mail system. Will the State consider a confidential fax as an alternative to this method of reporting?

Answer: The weekly update is a summary report and should not include patient level data. As a result, e-mail will be accepted. If the contractor prefers to send a confidential fax, that can be arranged.

Question # 27

RFP Section 3.3.e - Is it the expectation that all discrepancies will be satisfactorily resolved prior to the contractor leaving the facility?

Answer: No. The contractor, however, shall make a good faith effort to resolve the discrepancies while at the facility following a protocol to be provided.

Question # 28

RFP Section 3.3.f - Is the abstraction form the one that the OHSC signs on the last day of the audit giving it fifteen (15) working days to resolve the discrepancies with DHSS?

Answer: No. The abstraction form is the one that the contractor provides to DHSS documenting its audit findings. The facility then has fifteen (15) working days to resolve its discrepancies.
Question # 29  
RFP Section 3.3.h - If the answer to Question # 28 is "Yes", "h" states that the contractor shall submit all audit findings within two (2) weeks of the completion of the audit to the State Contract Manager. It seems this does not leave the facility a full fifteen (15) working days to respond to the discrepancies identified during the audit. Please clarify.

Answer: The answer to Question 28 is "No", and therefore this question does not require an answer.

Question # 30  
RFP Section 3.1.d - Please elaborate on any specific qualifications for the abstractors. Are they required to be nurses?

Answer: Abstractors are not required to be nurses. See further explanation under Question #16.

Question # 31  
RFP Section 3.3.d - In order to estimate staffing needs, please describe the intervals at which the samples will be distributed. Will the samples for the eighteen (18) OHSCs come at different times throughout the year?

Answer: The audit sample will be provided at the same time for all hospitals. The contractor can schedule itself in such a manner that it can complete the audits within the twelve (12) weeks specified in the RFP.

Question # 32  
RFP Section 3.3.i - What is the State's electronic format preference? In what electronic format are the current files?

Answer: No preference is set as yet. This will be established in consultation with the contractor. The format will be one of the standardized formats, such as Excel, dBase, Text, or Access. The Department maintains files in Excel, dBase, and SAS.

Question # 33  
RFP Section 3.4.a - If a Small Business Administration subcontractor is used to fulfill a portion of the medical review personnel requirement in addition to our staff, can the name of the agency be submitted in lieu of specific personnel?

Answer: The bidder should state how it will staff this contract. Names and backgrounds of key people, whether bidder employees or subcontractor employees, should be identified in accordance with Section 4.4.5 of the RFP.

Question # 34  
RFP Section 3.4.b - Is the "current list" to be submitted prior to or after contract award?

Answer: Although the list is required of the contractor, the Department of Health and Senior Services (DHSS) would like to obtain it at the time of bid submission and the list shall be updated throughout the contract term by the contractor.

Question # 35  
RFP Section 3.4.b - Does the term "other health care providers" include subcontracted physicians who also provide independent medical review for our company?

Answer: Yes. DHSS’s intent is to avoid any conflict of interest on the part of the reviewers.
Question # 36  RFP Section 5.22.3.d - Based on the potential size of the contract, will the State consider a lower limit on Professional Liability Insurance, such as $3,000,000?

Answer: Yes. RFP Section 5.22.3 shall be changed from $5,000,000 to $1,000,000.

Question # 37  RFP Section 3.3.d - Please explain in further detail the scope of onsite visits.

Answer: The reviewer makes all arrangements (most likely by phone) regarding the date(s) and time(s) planned to conduct the review. The OHSC will make all materials available for review on the set dates. Once at the site, the reviewer will assess provided materials to review and ask for additional materials if needed. The review is usually smooth and facilities are very cooperative in this process.

Question # 38  What is the class code for disposable exam gloves?

Answer: The State does not understand this question and therefore cannot provide an answer.

Question # 39  What was the amount of the last RFP winning bid?

Answer: Since the RFP and its price structure have been completely restructured, there is no comparison between the past contract and this one being procured. Nevertheless, as stated in Question #15, the annual cost of the program is approximately $125,000.

Question # 40  What time of the year will the audit take place?

Answer: The time of year that the audit takes place varies. Plenty of advance notice of an audit will be given to the contractor. In 2005 the audit for 2004 data commenced in October.

Question # 41  RFP Section 3.4. b - Our healthcare consulting firm's entire client list and the reasons for our relationships are considered confidential. May an abbreviated list of current clients be submitted?

Answer: The State requires this information to ensure that a vendor does not have conflicts of interest. No abbreviated list is acceptable.

Question # 42  RFP Section 4.4.5.3 - Detailed staff resumes are considered confidential until selected as contractor. May we provide brief biographies of key staff only during the RFP process?

Answer: It is important for the State to know the caliber of the personnel it is to engage. Brief biographies are not acceptable. Section 1.4.4 of the RFP relates to the Contents of Bid Proposal.

Question # 43  RFP Section 4.4.5.6 - May one contact name be submitted for each prior contact?

Answer: The State requests two (2) names and telephone numbers.
Question # 44
RFP Section 4.4.5.7 - Our financial statements are considered confidential. May they be provided when selected as contractor? What alternatives exist to satisfy this requirement?

Answer: It is important for the State to understand the bidder's financial capacity and capabilities to undertake and successfully complete the contract. The last two paragraphs of this Section specifically respond to the issue of confidentiality. If the bidder designates financial information as not subject to disclosure, and the State considers it confidential, the State will not release the financial statements to the public.

Question # 45
RFP Section 5.22.3 - Insurance in the amount of not less than $5,000,000 is prohibitive in cost to a small firm. Is insurance in the amount of $1,000,000 sufficient?

Answer: Yes. See Question #36 and its answer.
EXHIBIT 1

THE OPEN HEART SURGERY DATABASE
AUDIT REVIEW SIGNOFF FORM

TO BE COMPLETED BY THE AUDITOR:

Audited Medical Facility: ______________________________________
Year of Data Audited: __________________________
Medical Facility Contact Name: ______________________________________
Date Audit Completed: ___/___/______
                   MM / DD /YYYY
Name of Auditor: ______________________________   Title: _______________
Signature:   ______________________________   Date: _______________

TO BE COMPLETED BY THE MEDICAL FACILITY REPRESENTATIVE:

_____ I agree with all the findings of the auditor. I have enclosed the revised data file with this Signoff Form to reflect corrections on all errors identified by the auditor. I understand that the revised data is due to the Department of Health and Senior Services (DHSS) within 20 business days from the date the audit was completed.

_____ I disagree with all or some of the findings of the auditor. With this Signoff Form, the medical record review abstraction form for each case in disagreement, a buck slip that details the rationale for the disagreement and other documentation from the patient’s medical record are enclosed. I understand that the due date to submit all supporting documentation and the Signoff Form to the Department of Health and Senior Services is 20 business days from the completion of the date the audit was completed.

I understand that failure to respond to audit findings within 20 business days will constitute a violation of licensure requirements.

Medical Facility Representative:

Name:      __________________________________   Title: ________________
Signature: __________________________________   Date: ________________

Mailing Address to the Department of Health & Senior Services:

Open Heart Surgery Data Coordinator
Health Care Quality Assessment
NJ Department of Health and Senior Services
25 Scotch Road, Suite 10
Ewing, NJ 08628
1. The contractor will provide, on behalf of the Department of Health and Senior Services (DHSS) to the medical facilities, a listing of cases to be reviewed for the Year CABG report. The minimum sample to be reviewed will be 100 cases. DHSS will have provided a sample of 100 cases to the contractor. Additional cases have also been provided to cover any unavailable medical records. The sample will be drawn from the universe of coronary arterial bypass (CAB) procedures and other procedures that resulted in a fatality. The main criteria for case selection is based upon the observation by the Clinical Advisory Panel that a particular risk factor(s) is substantially higher than the statewide average for that risk factor at that particular institution. The associated statewide mortality for that risk factor must also be significant in order for the risk factor to be included in the sample.

For Example: Some risk factors have a high statewide mortality (e.g. renal disease, diabetes) a random sample will be drawn for each facility from those cases. In addition, if a facility reports substantially more of a risk factor(s) than the State average, additional samples will be drawn from those risk factors. If a facility has no risk factors over the State average, the balance of the cases drawn for that facility will be a simple random sample. Total of primary sample cases will be 100 with ten additional cases (secondary samples) to be added to cover contingencies.

2. In the event a medical record of a case to be reviewed cannot be located, replacement from the reserve pool (secondary sample) will be utilized. Missing cases will be subject to further investigation.

DHSS will supply the contractor with a file containing the audit sample data. The contractor will use this file to design a data abstraction program, which will be utilized to compare the reported data with the medical record.

DHSS will supply the contractor with standard definitions of medical terms that are consistent with the Society of Thoracic Surgeons National Cardiac Surgery Database.

The contractor will also review consent forms for planned cardiac surgery vs. actual surgery performed.

3. Discrepancies between the database and the medical record will be noted in the contractor’s abstraction program and identified in the medical record by the contractor in a DHSS approved format. The contractor will supply the medical facility with hard copy abstraction forms upon completion of the medical facility’s review. These abstraction forms will be express-mailed by the contractor to the medical facility on the first working day after audit completion. Within 15 working days of receipt of the abstraction form, the medical facility must satisfactorily resolve any discrepancies with DHSS.

4. The contractor will submit a data file of the abstraction forms and a summary report of each medical facility’s results to DHSS upon completion of the facility’s review. At the conclusion of the medical record review, the contractor will also provide to the DHSS an electronic summary report of all errors by risk factor by the medical facility.

5. During the course of a medical facility’s review, if the contractor identifies more than 50% over-coding of any risk factor in those cases sampled for that particular risk factor, the contractor will contact DHSS immediately. DHSS will contact the medical facility to initiate a re-coding of all cases with that risk factor. DHSS will supply the medical facility with a list of records to be re-coded, or the medical facility will need to provide to DHSS medical record documentation substantiating that risk factor.

For Example: Facility A has 20 cases of its 100 case review sample selected because renal failure is above the State average as described in Section 1 and eleven of those 20 cases could not be substantiated for renal disease by medical record review. The contractor will call DHSS. At this juncture, DHSS will
compile a list of all cases of renal disease in that facility. The medical facility will need to review all those cases and provide medical record documentation in support of the renal failure to DHSS for all those cases that have renal failure. In the absence of that documentation the risk factor should be removed (re-coded). The risk factors are as defined in the data collection booklet.

6. DHSS will supply the contractor with a sign-off form that is to be sent to the medical facilities one business day after the completion of the medical record review. This sign-off form attests as to whether the facility agrees or disagrees with the contractor’s findings. The form must be signed by the physician contact, the medical facility’s administrative designee, or the data manager earlier identified as the contact person. The form must be returned to DHSS within 15 working days after the close of the medical record audit. Any necessary medical record documentation must be submitted with the form.

7. If the medical facility does not agree with the contractor’s findings, the facility is required to submit to DHSS a rationale for the disagreement on a buck slip (one per case) with supporting medical record documentation attached. The facility should submit abstraction forms only for those cases that are being contested. DHSS, with the advice of its consultant and the Clinical Advisory Panel, will determine whether the documentation is acceptable.

8. If the facility disagrees with the contractor’s findings but is unable to provide supporting documentation, DHSS may assume that the variable was not present for that case. The contractor’s validation process may have three outcomes:

a) The database and the medical record agree for a particular risk factor.

b) A risk factor is reported in the database but is not documented in the medical record (risk factor is over coded).

c) A risk factor is not reported in the database but is documented in the medical record (risk factor is under coded).

9. If there is a significant amount of over-coding of a particular risk factor, DHSS will request that all cases with that risk factor be reviewed for re-coding. If any additional medical record review is required of the re-coded cases, such review may be done at the medical facility’s expense.

10. All database corrections identified through this medical record review must be corrected by the medical facility and submitted to DHSS within the 20 day time frame as noted on the sign-off form received by the facility from the contractor. If the findings are contested by the facility, the revised database must be submitted to DHSS within one week of the reconciliation of the disputed items.

11. DHSS will conduct a verification of the open heart surgery database against the UB-92 hospital discharge records and mortality records to ensure that all cases and deaths have been reported. In the event that a medical facility reports a significant amount of coronary artery bypass cases coded as CAB+OTHER in the open heart surgery database, DHSS may require an additional sample to be reviewed at the medical facility’s expense. All CAB+OTHER cases which resulted in a fatality will be reviewed and are part of the sample selected.
12. All information regarding this medical record review process is to be sent to:

Open Heart Surgery Data Coordinator
Health Care Quality Assessment
New Jersey Department of Health & Senior Services
25 Scotch Road, Suite 10
Ewing, N.J. 08628

Phone 609-530-7470
Fax 609-530-7478

Contractor Information:

(HERE)
**INSTRUCTIONS:** Complete one buck slip for each patient where you have disagreement with the contractor’s findings. Highlight all pertinent information in the attached documentation. One of these forms for each patient whose findings is being contested, is to be submitted to the Department of Health and Senior Services with the medical record review sign off form.

*Supporting documentation for any disagreement must be submitted with this form.*

MEDICAL FACILITY:_______________________________________________________

YEAR OF DATA AUDITED:___________

PATIENT FIRST NAME:_______________ PATIENT LAST NAME:_________________

MEDICAL RECORD NUMBER:   ____________________________

DATE OF SURGERY:   ____________________________

<table>
<thead>
<tr>
<th>DATA FIELD</th>
<th>RATIONALE FOR DISAGREEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Supporting documentation was unavailable at the time of review.</td>
</tr>
<tr>
<td>□</td>
<td>Supporting documentation is available in the medical chart.</td>
</tr>
<tr>
<td>□</td>
<td>Error was found and has been corrected.</td>
</tr>
<tr>
<td>□</td>
<td>Discrepancy between reports/progress notes.</td>
</tr>
<tr>
<td>□</td>
<td>Disagree for the following reason(s) see attachment:</td>
</tr>
</tbody>
</table>

If additional space per patient is required please copy this form as needed.