

**STATE OF FLORIDA
DEPARTMENT OF FINANCIAL SERVICES**

**REQUEST FOR INFORMATION
DFS RM RFI 12/13-04**

**MEDICAL SERVICES BILL REVIEW AND REPRICING, UTILIZATION REVIEW, AND
HOSPITAL INPATIENT PRE-ADMISSION CERTIFICATION WITH CONCURRENT REVIEW**

1. PURPOSE

The Department of Financial Services (“Department”) is issuing this Request for Information (“RFI”) to solicit information regarding the provision of medical services bill review and re-pricing, utilization review services, and hospital inpatient pre-admission certification with concurrent review services for its workers’ compensation program. (The use of “MBR Services” in this RFI shall refer collectively to all of the aforementioned services.) The Department’s workers’ compensation program, which is administered by its Division of Risk Management (Division), is in need of such services in order to reduce costs of workers’ compensation medical services.

The Department will review responses received from this RFI to identify vendors interested in contracting with the Department for services described herein. An RFI is not a method of procurement, and this RFI will not result in the award of a contract. However, the Department intends to utilize the information gathered from vendors through the RFI process to develop a scope of services, which may be incorporated into a contract using a statutorily approved method of procurement.

2. INTRODUCTION

The MBR services described in this RFI must meet current and future requirements of the Florida Administrative Code (F.A.C.) governing the provision of medical services, billing of such services, electronic filing of medical bills with DWC, and all other applicable administrative rules.

Required services include review and re-pricing of bills according to the reimbursement manual guidelines referenced in Rule 69L-7, F.A.C., including the Health Care Provider Reimbursement Manual (HCPRM), the Florida Workers’ Compensation Reimbursement Manual for Hospitals, the Florida Workers’ Compensation Reimbursement Manual for Ambulatory Surgical Centers, and also includes review of bills for contractually priced medical services. In addition, the Department administers claims for the Department of Military Affairs, National Guard. These bills may also need review and re-pricing for Department reimbursement, but are not subject to the same administrative requirements of the Department’s Division of Workers’ Compensation (DWC). The MBR services described

herein do not include bill review for pharmaceutical prescription or physician-dispensed pharmaceutical services.

The Department requires review and re-pricing of medical bills, including the following types of bills, as referenced in <http://www.myfloridacfo.com/wc/forms.html>:

- Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 08/05) for use by health care providers;
- Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Equipment & Supplies Form), Rev. 3/1/09;
- Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2006);
- Form DFS-F5-DWC-90-B (Completion Instructions for Form DFS-F5-DWC-90 for use by hospitals), Rev. 1/1/09; Form DFS-F5-DWC-90-C (Completion Instructions for Form DFS-F5-DWC-90 for use by Ambulatory Surgical Centers), New 1/1/09; Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006-DWC-90-D (Completion Instructions for Form DFS-F5-DWC-90 for use by Home Health Agencies), New 1/1/09; DFS-F5-DWC-90-E (Completion Instructions for Form DFS-F5-DWC-90 for use by Nursing Home Facilities), New 1/1/09; and
- Any other medical bills subject to Rule 69-7.602, Florida Administrative Code (F.A.C.).

The Department currently has two contracts with separate contractors under which both medical case management and bill review services are being provided within the same contract. The Department's long term goal is to consolidate all of the medical case management services into one contract, and all of the bill review services into another contract. A MBR service provider should have the ability to provide all of the MBR services described herein.

3. ANTICIPATED SERVICES

The Department is interested in contracting with a single entity to provide an array of MBR services that meets or exceeds the specifications and requirements outlined below. The services to be provided by a MBR service provider should include at least the following components:

A. Receipt of Medical Services Bills

- 1) Coordination with the Department and its medical services contractors for the submission of medical service bills on a daily basis.
- 2) Utilization of a system to track receipt dates and maintain a bill status log.
- 3) Rejection of medical service bills that are not payable under the Department's associated medical services contract, and return the bill to the submitting party.

B. Automated Re-pricing of Medical Services Bills

- 1) Automated review and re-pricing of medical bills assigned by the Department to meet a performance standard of 95% of bills processed within 72 hours of receipt.
- 2) Utilization of a data processing system that allows for correct extraction and input of all available and necessary data elements from paper medical bills so that the tasks specified herein can be completed.
- 3) Access to a database of prevailing charges for like or similar services in the specific geographic area from which the medical bill originated. (This would apply to assigned medical bills with procedure codes/items which do not have a maximum reimbursement allowance established in the HCPRM, such as those listed as "By Report", Category III CPT codes, HCPCS Level II codes, or procedures with a descriptive modifier.)
- 4) Verification of form completion as set forth in Rule 69L-7.602, F.A.C. (and referenced in Section 2, INTRODUCTION of this RFI); Rejection of any incomplete or inaccurate bills, and return to the provider with an Explanation of Medical Benefit (EOMB) letter specifying the reason for rejection. Submission of a copy of the EOMB letter to the Department; Maintenance of a log of all bills returned to provider with EOMB identifying required correction for processing.
- 5) Re-pricing of assigned medical bills to ensure compliance with the provisions of the Florida Workers' Compensation Law; (Reimbursement Manuals, pursuant to Rule 69L-7 F.A.C., any other applicable DWC rules or Florida Statutes on the basis of the date of accident of the claim for which the medical bill is submitted and the date of service as depicted on the medical bill).
- 6) Re-pricing of medical bills to be reimbursed under each of the Department's medical case management (MCM) contracts by correctly applying any reduced rates (discounts) that apply to each contract; and
- 7) Re-pricing of medical bills according to any specially negotiated pricing arrangements provided by adjuster or case manager, or any other post-MCA (Managed Care Arrangement) agreements or National Guard provisions, according to Department specifications, including compliance with any revisions and additions to such rules or statutes that become effective.

C. Transmission of payment records

- 1) Electronic filing of medical service vendors compatible in format and identical in content to the Department's vendor file on its Risk Management Information System (RMIS) to the extent necessary to facilitate processing of

re-priced medical bills for payment by it without any data conversion requirements imposed on it. Updating and maintaining vendor file within 24 hours of receipt of updated information from the Department.

- 2) Receipt of daily electronic vendor file activity records from the Department and processing of such records to update the vendor file.
- 3) Submission of electronic payable records to the Department on a weekly basis in a format specified by the Department.
- 4) Weekly transfer of all documentation relevant to medical bills processed the prior week, to the Check Processing Unit within the Department.
- 5) Establishment of an electronic communication process to facilitate transfer of the actual pay date of medical bills from the Department to the MBR service provider's system for electronic filing with DWC.
- 6) Electronic filing with DWC all DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90 forms required in conjunction with the medical bill paying process, in compliance with Rule 69L-7.602, F.A.C.
- 7) Timely and accurate monitoring of the DWC Centralized Performance System (CPS) to evaluate fines and penalties assessed to the Division and respond via the website with corrected data and explanations.
- 8) Timely payment of all fines and penalties resulting from non-compliance with Rule 69L-7.602, F.A.C., upon notification by the Department.
- 9) Evidence to support the total number of rejections identified by DWC per monthly submission, the reasons for the rejections, and the length of time required to resolve and successfully file with DWC.
- 10) Transmission of electronic document images to and from the Department in a format as directed by the Department.

D. Utilization Management and Review

- 1) Receipt of an "initial" payment history file, consisting of data collected from the medical bill review/re-pricing processes conducted previously, for integration into the MBR service provider's database.
- 2) Maintenance of payment history information for all bills processed for the Department in order to:
 - a. Prevent duplicate payment;
 - b. Identify possible utilization issues;

- c. Produce a printed medical payment history which depicts all processing activity conducted by the MBR service provider for a given vendor, claimant, or other criteria as specified by the Department; and
 - d. Maintain data relevant to all medical bills processed.
- 3) Automated identification of first line utilization review issues during the initial re-pricing process, including but not limited to: potential over- or under-utilization, improper billing practices, "unbundling" of services, causality, compensability, appropriateness of services and quality of care issues.
- 4) Assistance to the Department and its medical case management service vendors with the implementation and coordination of the utilization review plan as required by Chapter 440.13, Florida Statutes and the Department's internal utilization review policy and procedure, any revisions of the plan, and the provision of necessary reports at no additional cost to the Department. Services may include the following:
 - a. Provider education letters when billing or utilization issues are identified; and
 - b. Access to specialty peer network for medical consultation, as per Rule 69L-7.020, F.A.C., to assist with the evaluation of the medical necessity, appropriateness, and efficiency of workers' compensation medical benefits, and prospective, concurrent, retrospective and medical record review.

E. Hospital Pre-admission Certification and Concurrent Review

- 1) Notification of the program, in writing, to the Admissions and Business Offices of all hospitals licensed under Chapter 395.002, F.S. in the service area, and any other facilities identified by the Department or its medical case management vendor(s).
- 2) Establishment of a toll-free number to be used by the Department, facility or treating physician for contact purposes.
- 3) Pre-certification of the length of stay using established national criteria and the publications adopted by reference in Rule 69L-7.501, F.A.C., upon notification of a request for admission for treatment. Admissions will be evaluated and determinations made according to requirements in DWC hospital manual. These reviews will be conducted by Registered Nurses experienced in utilization management and precertification.
- 4) Pre-certification authorization to the Department and its medical case management vendor(s) if applicable, to include at least the following:
 - a. date of request for pre-certification;
 - b. date certification is obtained;
 - c. name and title of person pre-certifying;

- d. number of days requested;
 - e. number of days certified;
 - f. diagnosis and treating physician;
 - g. primary procedure;
 - h. pertinent additional information obtained at the time of certification; and
 - i. target date for follow-up.
- 5) Establishment of a date, prior to anticipated discharge, to contact the treating physician to determine if discharge will occur as planned or sooner and notification of such to the Department. (The MBR service provider should initiate concurrent review on the final certified day.)
 - 6) Certification of additional days of treatment when medical circumstances indicate the need for an extension. Provide written confirmation to all parties.
 - 7) Access to a tiered review process that includes peer review and recommendations by specialists and an appeals process for reviewing non-certified admissions and/or non-certified continued stays.
 - 8) Utilization of a hospital bill review process that includes verification of precertification information and authorization.

F. Reporting

- 1) Quarterly reporting of pre-certifications and continued stay authorizations, and summary ICD 9 (and ICD10, when implemented) diagnosis procedure category, total admissions, total days stayed, average length of stay and either statewide or national average length of stay for workers' compensation, number of cases appealed, number not certified, and total cost avoided, and complaints/appeals registered by any facility, provider, or claims staff member.
- 2) Quarterly reporting of peer review and medical specialist utilization, including referring party, brief case summary and recommendations
- 3) Monthly bill review reporting to include at least the following: monthly bill performance summary, totals processed, review processing times, reconsiderations, refunds, exceptions, DWC disputes, summary of DWC CPS monthly performance, and savings to the Department for MBR services.
- 4) Monthly/quarterly reporting to demonstrate the MBR service provider's performance monitoring and performance improvement efforts.

4. RFI RESPONSE SUBMISSION REQUIREMENTS

This RFI and any response to it are public records under Chapter 119, Florida Statutes. Vendors who provide responses to this RFI must indicate which portions, if any, of the information provided are trade secret by marking each page upon which such information

appears as “trade secret pursuant to Section 812.081, Florida Statutes.” Vendors must indicate which portions, if any, of the information being provided are trade secrets, by marking each page upon which such information appears within its Response. Information specifically identified as a trade secret under Section 812.081, Florida Statutes, will be kept confidential to the extent provided by law. If the Agency receives a public records request for information that has been identified by the Respondent as a trade secret, the Agency will notify the Respondent of such request.

Vendors responding to this RFI are asked to be thorough, but concise when providing responses. The total response to this RFI should be limited in length to no more than fifty (50) pages, typed in Arial 11 pt. font, or equivalent using 1 inch margins.

Interested vendors shall submit their response electronically to the contract person listed below. The software used to produce the electronic files must be Microsoft Word 97 and/or Excel 97 or newer.

Vendors shall also submit an electronic redacted copy of the response suitable for release to the public. Any confidential or trade secret information covered under Section 812.081, Florida Statutes, should be either redacted or completely removed. The redacted response shall be marked as “redacted” and contain a transmittal letter authorizing release of the redacted version of the response in the event the Department receives a public records request.

Responses to this RFI shall be submitted via email no later than **August 16, 2012, 5:00 PM, Eastern Time**. Responses shall be submitted to:

Florida Department of Financial Services
Attn: Shannon Segers, Division of Risk Management
Email: Shannon.Segers@myfloridacfo.com

The RFI response should include the following information which should be sectioned as indicated below for ease of reference by Department review staff.

Section A: Vendor Information – The vendor’s current name, primary business address, and the name, telephone number(s) and email address(es) of the contact person for the vendor. **(The vendor should include a list of all names under which it has operated during the last five years.)**

Section B: Vendor Experience – A description of the vendor’s business and its experience as it relates to the services outlined in this RFI. This description should include a narrative explaining any past or present experience in which the vendor has engaged in providing automated medical bill review services according to Rule 69-L, F.A.C. The vendor should include a description of its experience with providing utilization management services.

Section C: Service Approach – A description of the vendor’s ability to provide the MBR services described herein, including:

1. Service Transition - The vendor’s approach to transition and assumption of business processes from another MBR service provider.
2. Fraud Detection - The vendors’ scope of fraud detection and internal control measures.
3. Reporting – The vendor’s reporting capabilities, including relevant report sample(s).
4. Utilization Management – The vendor’s current utilization management process.
5. Information Systems – The vendor’s current information systems capabilities.
6. Medical Bill Review – The vendor’s current method(s) for conducting medical bill review services, and how it offers advantages or improvements over existing, known technologies or methods of medical review services.
7. Information Security – The vendors’ procedures for ensuring claimant confidentiality and information technology security.
8. Disaster Recovery – The vendor’s disaster recovery plan, including confidential data retrieval, and ability to resume services with minimal disruption.
9. Invoicing – The vendor’s invoicing methodology for medical bill review, utilization review, and hospital pre-certification services.
10. IRS Reporting – The vendor’s current process for ensuring compliance with Federal regulations for IRS reporting.

Section D: Staffing – A description of the vendor’s ability to provide adequate staff and staffing levels to complete the MBR services described herein, including:

1. The vendor’s current organizational chart.
2. The estimated number of staff the vendor would assign to provide the services described herein, including identification of any known key staff to which the vendor would assign to a contract for such services.
3. Resumes and responsibilities, by position of any identified key staff.

4. The vendor's criteria, or plan for hiring and retaining additional staff, if needed, to provide services described herein.

Section E: Quality Assurance and Monitoring - A description of the vendor's quality assurance system, including how the vendor would monitor the appropriateness and effectiveness of the services described herein.

Section F: Innovative Concepts - Identification of any additional services or standards proposed by the vendor which exceed the Department's minimum requirements for the services as described herein.

Section G: Cost - An estimate of the overall cost to provide the services described herein over a three-year period, including an additional three year renewal period. If innovative concepts are proposed, separate estimated costs for those services or standards should be provided. **Respondents to this RFI hereby understand and agree that the estimate is not a cost proposal. The Department reserves the right to utilize the cost information received for budgeting and planning needs.**

5. QUESTIONS

Questions concerning this RFI may be submitted, in writing via email to the contact person listed above. All responses to questions received will be made, in writing, directly to the sender.

6. VENDOR COSTS

Vendors are responsible for all costs associated with preparing a response to this RFI. The state of Florida Department of Financial Services will not be responsible for any vendor costs associated with preparing this information.