

GOVERNMENT RESPONSE TO REQUESTS FOR INFORMATION (RFI's)

RFI #1 – The Price/Cost Schedule: (Section B.2) seems to reflect a misunderstanding of how IONM is performed and billed. For each contract period (base + two option years), there are 18 procedures listed, along with an estimated quantity for each. The first of these (0001 – Intraoperative Neuromonitoring Services) shows an estimated quantity of 900 hours. This clearly is intended to reflect the hourly charge for continuous monitoring during a surgical procedure, after appropriate baseline tests are setup and initial baseline recordings obtained. The remainder of the descriptions is per unit, rather than per hour, charges, and in each case, the estimated quantity is 50. This presumably reflects an anticipated 50 cases during the first 6-month period, which is roughly in line with historical data for this hospital. However, dividing 900 hours/case by 50 cases yields an estimated 18 hours per case, which is off by a factor of 3 or 4, since cases typically last from 4 to 8 hours. Using this figure would thus result in a gross overestimation of the likely cost to the Government for these services. Also, per CMS regulations, ongoing monitoring is now billed in 15-minute increments, rather than rounding to the nearest hour, so simply changing the unit to 15-minute periods rather than an hour would make this a much more reasonable estimate of the monitoring time for 50 cases. Please verify either the hours per 50 cases or the increment of 15 minutes versus an hour.

ANSWER: Increments of 15 minutes.

RFI #2 – Still in the Price/Cost Schedule (B.2), the next 13 items (0002 – 0014) are a list of base codes that are also used in billing for IONM. These represent the actual tests that are performed, which vary depending on the needs of each case, and are billed as one-time charges. The ongoing monitoring (hourly) charges discussed above begin only after the initial baseline recordings represented in items 0002 – 0014 are obtained, typically one to two hours after the patient enters the room, and just prior to the surgical incision. The way they are listed in the schedule seems to ask for a unit price for each study, multiplied by the estimated quantity of 50 cases during the initial 6-month period, and then summed to obtain a total estimated cost for the first 6 months. However, not all of these studies would be done in every case, and some are mutually exclusive. For example, items 0003 – 0006 represent the base codes for EMG recordings in 1, 2, 3, and 4 limbs respectively. Only one of these (most commonly two limbs) could possibly be used in any given case. Again, filling out the entire matrix as presented in the solicitation would result in a gross overestimation of the costs to the VA. Please verify if the abovementioned cost analysis is what is required, given the overestimation considerations.

ANSWER: Pricing shall be based on the applicable baseline CPT code plus hourly rate of monitoring (billed in 15 minute increments).

RFI #3 – Notably missing from the list discussed in point #2 above is the test for transcranially elicited motor evoked potentials (CPT code 95939), which is one of the most valuable

monitoring modalities and thus a one of the most commonly used baseline tests. Please verify inclusion of this baseline and monitoring modality.

ANSWER: RFI #3 CPT Code 95939 is included as accepted CPT code.

RFI #4 – Still in Section B.2, the next 10 items (0015 – 0024) describe not monitoring procedures, but specific types of surgery in which neuromonitoring is typically performed (for example, anterior cervical discectomy, lumbar fusion, or cerebral aneurysm). The choice of specific tests to be performed during IONM would obviously depend on the specific surgery being monitored, but there is no IONM pricing for the surgical procedures themselves since this is the province of the surgeon, not the IONM provider. Please verify which method of pricing to use, either by the modality used in each surgery or by the surgical case. Pricing by surgical case would be an estimate based on required modalities per national guidelines and benchmarked time versus pricing per actual modality implementation.

ANSWER: Pricing shall be based on the applicable baseline CPT code plus hourly rate of monitoring (billed in 15 minute increments).

RFI #5 – Finally, the price/cost schedule for each year in Section B.2 concludes (items 0025 – 0028) with a list of surgery-specific monitoring procedures (cranial nerve monitoring for skull base tumors; motor, sensory, and speech mapping for brain tumors; electrocorticography; and peripheral nerve monitoring for peripheral nerve tumor). This list is not specific and duplicates some of the previous items. For example, take item 0025, cranial nerve monitoring for skull base tumors. It is not specified whether sensory, motor, or both types of nerve are to be monitored (this would depend on the specific location of the tumor and the patient's pre-existing deficits) or whether the monitoring is to be unilateral or bilateral. The specific tests are those listed earlier: item 1002 for auditory (sensory) evoked potentials, item 1010 for visual (sensory) evoked potentials, and items 1007 and 1008 for EMG from (motor) cranial nerve supplied muscles, either unilateral or bilateral. Again, not all of these would be used in a given case, and 1007 and 1008 are mutually exclusive, as monitoring is either unilateral or bilateral, but cannot be both. Please verify which method of pricing to use, either by the modality used in each surgery or by the surgical case. Pricing by surgical case would be an estimate based on required modalities per national guidelines and benchmarked time versus pricing per actual modality implementation.

ANSWER: Pricing shall be based on the applicable baseline CPT code plus hourly rate of monitoring (billed in 15 minute increments).

RFI #6 – The price/cost schedule for the option years 1 and 2 contains the same issues regarding overlap, duplication, etc., that are discussed above for the first year. However, despite the change from 50 to 120 units of each, which presumably reflects a full year rather than 6 months, with a

slight increase in cases/month, the total units of hourly monitoring is still listed as 900 rather than rising to reflect the greater number of cases. At 900 hours total for 120 cases, this translates to 7.5 hours per case, a more realistic number but which might still be overestimated. Please verify that 900 hours for 120 cases is accurate.

ANSWER: Confirmed. 900 hours at 120 cases per year reflects a more accurate estimation.

RFI #7 – The qualifications listed in Section 2.1 (pp 13-14) appear to be an incomplete listing of the appropriate qualifications for performing intraoperative neuromonitoring, and as written, would specifically exclude the current contractor from applying under this re-solicitation. The Education section requires either a Master's or Doctorate degree in Audiology, or a degree in Medicine (MD) or Osteopathy (DO). Historically and continuing to the present day, one of the most common educational backgrounds is a Doctorate (PhD) in a relevant life science, such as Biology, Physiology, or Neuroscience. This includes the current contractor, which is headed by Charles Yingling, PhD, who is internationally recognized as one of the founding practitioners in this field and who founded the Neuromonitoring Service at UCSF in 1984, where he was Professor of Neurological Surgery until 2002. Please confirm that individuals with an appropriate PhD degree are eligible to apply.

ANSWER: Confirmed. Individuals with an appropriate PhD degree are eligible to apply. Appropriate changes are reflected in the revised PWS (Ref: Amendment A00001).

RFI #8 - Under the Certification heading in Section 2.1, the following credentials are listed (only abbreviations included here for the sake of brevity): DABNM, ABPN, ABCN, ABEM, and CCC-A ASHA. This list excludes the Certification in Neurophysiologic Intraoperative Monitoring (CNIM), which is administered by the American Board of Registration of Electroneurodiagnostic Technologists (ABRET), and which is currently the most commonly held credential for individuals actually performing intraoperative neuromonitoring. Dr. Yingling holds both the CNIM and DABNM certifications, and all other personnel of the current contractor hold the CNIM credential. Please confirm that personnel holding the CNIM credential are eligible to perform intraoperative neuromonitoring under this contract, with proper supervision by an individual holding at least one of the five professional credentials listed above.

ANSWER: Confirmed. Personnel holding the CNIM credential are eligible to perform intraoperative Neuromonitoring under this contract, with proper supervision by an individual holding at least one of the five professional credentials listed above. Appropriate changes are reflected in the revised PWS (Ref: Amendment A00001).

RFI #9 – Under the Licensure heading in Section 2.1, the contractor is required to possess a current, valid, unrestricted license to practice either medicine or audiology in the State of

California. In fact, there is currently no licensure specific to intraoperative neuromonitoring available in California, or indeed in any of the 50 states. As discussed above in RFI #7, many of the past and current practitioners are individuals with PhD degrees who have no licensure available to them at this time. Again, this requirement would specifically exclude the current contractor from applying under this re-solicitation. Please confirm that the lack of licensure for those who are not audiologists or physicians does not exclude contractors headed by properly qualified and certified PhDs (including the current contractor) from applying under this re-solicitation.

ANSWER: Confirmed. Lack of licensure for offerors who are not audiologists or physicians shall not exclude contractors who are otherwise qualified and certified PhDs. Appropriate changes to qualifications are reflected in the revised PWS (Ref: Amendment A00001).

RFI #10 – How many surgical cases required IOM last year?

ANSWER: Approximately 64 cases were required in FY 13.

Proposal RFI #11 – Can you provide us with a breakdown of the types of cases, i.e. orthopedic spine vs. neurosurgical

ANSWER: No.

RFI #12 - How many technologists (contractors) are needed in the OR per day?

ANSWER: Approximately one (1) technologist may be needed per day.

RFI #13 – Who is the present provider (incumbent)?

ANSWER: Golden Gate Neuromonitoring

Proposal RFI #14 – Are they accustomed to real time remote monitoring?

ANSWER: No

Proposal RFI #15 – Can a PC (professional component) be billed to the VA?

ANSWER: No.

Proposal RFI #16 – What is the present structure for billing IOM services, i.e., per hour, single fee per case?

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ANSWER: Flat fee per CPT code per case.