RFP Bid No. EMS001-2014
Emergency Medical Services Billing and Collections
May 16, 2014 at 12:00pm

Cleveland County EMS System
Attention: Kim Ogle
311 E. Marion Street
Shelby, NC 28151
(704) 484-4840
May 16, 2014

Cleveland County Finance/Purchasing
Attn: Kim Ogle
311 E. Marion Street
Shelby, NC 28151

Dear Ms. Ogle and the Cleveland County EMS System Evaluation Committee:

Please accept this proposal in response to the Cleveland County EMS System's Request for Proposal for Emergency Medical Services Billing and Collection (Bid No. EMS001-2014). We appreciate the opportunity to respond to your needs. The proposal contents may be incorporated, in whole, into a written contract. We are familiar with, understand and will comply with all of the provisions set forth in the RFP and Addenda. Our pricing is inclusive and will remain firm throughout the contract, for a period of 1,095 days.

Intermedix has more than 35 years of experience in EMS billing. We now serve more than 300 clients across the country, including many of the largest agencies in the United States, including Chicago, Los Angeles, Philadelphia, Miami-Dade County, New Orleans, Hawaii, Boston, San Francisco, Sacramento, Washington D.C., Jacksonville, Denver, Lee County (Florida) and El Paso. Although we are proud to serve these easily recognized cities, the majority of our business is 5-10 k transports, similar to Cleveland County EMS. We have a local office in Raleigh, NC and are committed to serving our clients in the State with specific knowledge about your payers.

Intermedix serves many clients in North Carolina, including Cumberland County EMS with ambulance billing, 11 hospital emergency departments with billing and coding, 17 physician practices with practice management services and provision of our emergency incident command software, WebEOC for 35 clients in the State.

Through our above experience, we process more than three million EMS patient encounters annually, and collect more than $1 billion for our EMS clients every year. We have significant experience in handling mid-sized accounts with 23 clients ranging from 5,000 to 10,000 annual transports and we will apply this knowledge and experience to produce the best possible results for the County.
The following individuals are authorized to make representation for and legally bind our company:

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<tr>
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Intermedix is ready to exceed your expectations. Please reach out to Nicole Hill, Business Development Executive by phone at (678) 680-4974 or via email at Nicole.Hill@intermedix.com if you should need further information or to schedule a time for oral presentations. Thank you for your consideration.

Respectfully submitted,

Brad Williams,
Chief Accounting Officer
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EXECUTIVE SUMMARY

Intermedix offers the leadership necessary to partner with Cleveland County EMS to predict and adapt to the rapidly changing emergency health care landscape. We invest heavily in data analytics, offering powerful capabilities to gain insight into your patient care data, demographic data and financial data. Our risk management capabilities protect you from government regulatory enforcement and provide resilience in the event of a crisis. Finally, we offer a solution that provides responsive and compassionate patient services to protect your reputation with your community.

The County has identified four areas for evaluation:

- **Adequate technical and financial resources for the performance of the contract.** Intermedix is very profitable with a strong balance sheet, excellent cash flow and the strong backing of credible financial sponsors.
- **Necessary experience, organization and technical skill in the field of billing and collection for EMS transport services.** Our depth of resources will be detailed, demonstrating talent and experience in every facet of ambulance billing. Our culture of corporate integrity and ethics will be evident from the commitment we make to compliance and information security through people, policies, processes and technology.
- **Have a satisfactory record of performance in developing and implementing similar billing and collection programs.** Our proposal will outline an experience-based approach to implementing and managing revenue cycle operations for the County’s emergency medical transport claims. We will define specific proprietary methodologies that demonstrate our thought leadership, innovation, advanced technology and business process design.
- **Ability to satisfy insurance requirements.** Our team has reviewed the County’s insurance requirements and will meet them throughout the contract.

And three general minimal criteria:

- **Contractor must have a hosted solution with enabled remote access to current claims and financial data.** The proposed Intermedix billing system is offered as a Software as a Service and ensures that the authorized County representatives will have 24/7 access to its data and patient records. The County will have remote access to current claims and financial data through our hosted billing solution.
- **Contractor must own the billing software with which they process claims.** Intermedix has owned our proprietary billing system for more than 35 years.
- **Contractor must have a data center that meets a minimum “Tier 3” requirement.** Our data centers are state of the art, HIPAA HITECH certified for Tier 3 security.

Intermedix is a national leader in the EMS industry with local support and expertise. This summary illustrates how we make this possible and what is unique about Intermedix.
BILLING EXPERTISE

- Our proprietary billing platform, efficient workflow and industry leading professionals have produced hundreds of success stories in which we have increased collections and exceeded projections.
- We match every patient account to a database with more than 30 million patient records to find missing insurance information and improve your collections.
- We have a direct interface for several existing clients from your current emsCharts ePCR solution to our billing platform. One such integration is for Cape Fear Valley Health System / Cumberland County EMS in North Carolina. Through this interface and our analytics platform, we can combine clinical and financial data to optimize reimbursement and clinical outcomes.

PATIENT FOCUS

- We act as an extension of our clients with professional and compassionate care with each patient interaction.
- We use state-of-the art technology at our Patient Contact Center that guarantees efficient call processing, availability of translation services and accurate reporting, including call recording capabilities.

NATIONAL LEADERSHIP

- We have several operations facilities and data storage locations across the country to ensure business continuity in the event of a catastrophe.
- We have an elite Compliance department, including a dedicated EMS compliance officer with more than 40 years of experience, a chief compliance officer and general counsel.
- We are an active software company with hundreds of developers and a team dedicated to our proprietary billing technology.
- We have representation in Washington, D.C. and recognized industry governing bodies, giving our clients a legislative voice and the opportunity to learn about new developments directly from the source to stay informed of the changes ahead.

INTERMEDIX PARTNERSHIP

In addition to optimizing your revenue through our proprietary technology and services, we are positioned to help you adapt to a changing health care environment with additional business services and technology solutions. We are more than just a billing company - we are your partner.
Intermedix has the qualifications and experience necessary to serve as a trusted partner to Cleveland County EMS, as evidenced by:

- **Clear market leadership in ambulance billing**
- **Excellence in leadership and compliance**
- **Experienced key staff to serve the Cleveland County EMS System**
COMPANY OVERVIEW

Intermedix has been a leader in health care business services for more than 35 years. Today, with approximately 2,000 employees, Intermedix annually processes more than 15 million patient encounters, collects more than $3 billion in revenue for clients and connects more than 95% of the United States population through its emergency preparedness and response technologies.

EMS MARKET LEADERSHIP

Intermedix is a leading provider of EMS revenue cycle management services and serves 47% of the nation’s largest cities by population.

MARKET SHARE OF TOP 50 CITIES*

*cities who choose to outsource billing

GLOBAL PRESENCE

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ORGANIZATIONAL CULTURE

We are guided by these core values:

**INNOVATION** To create new sources of value for our clients we must quickly transform new technologies and ideas into solutions that exceed expectations and improve our effectiveness.

**QUALITY** We build trust and loyalty with our clients by committing to the highest standard of excellence, which leads to outstanding results for all.

**TEAMWORK** Each individual contributes as a member of the team with flexibility, mutual trust and cooperation, accomplishing more than an individual can alone.

**COMPLIANCE** We place compliance at the heart of all we do, and our integrity drives us to ‘do the right thing’ for our clients.

These values result in a culture of continuous improvement, and our organizational structure enables an efficient and compliant decision making process.
NORTH CAROLINA EXPERIENCE

PAYER KNOWLEDGE

Intermedix has experience with all North Carolina payers including Palmetto GBA (Medicare), NC Medicaid, BCBS of NC, UHC and VA.

HOSPITAL INTEGRATIONS

- We have a number of established hospital connections in North Carolina, some with electronic connections and others with fax connections.
- Our dedicated integrations team will work with other hospitals in your area during the implementation process to ensure that connections are in place.

CLIENT EXPERIENCE

Intermedix serves clients of all sizes across North Carolina, from small-town agencies and hospitals to large cities. We serve clients with a variety of solutions, including:

- EMS and Fire Revenue Cycle Management: 2 Clients
- Incident Management Technology: 42 Clients
- Emergency Department Revenue Cycle Management: 11 Clients
- Physician Practice Management: 17 Clients
Intermedix is uniquely positioned to serve as a trusted partner to Cleveland County EMS, as evidenced by:

- Implementation approach and timeline
- Billing system capacity and integration experience
- Business continuity and disaster recovery capabilities
- Patient call center technology
IMPLEMENTATION

Intermedix has extensive experience successfully onboarding clients. Our proven implementation process centers around the following principles:

CLIENT FOCUS  We establish a comprehensive client profile and use it throughout the implementation process to ensure your business needs are met.

PROACTIVITY  We establish communication channels early and remain actively engaged in the relationship to ensure we are exceeding your expectations.

EXPERTISE  We have a dedicated implementation team with experience deploying revenue cycle management programs to clients throughout the country.

QUALITY  We perform ongoing testing and quality assurance checks throughout the process to ensure each component of the plan is working on the date we go live.

PROJECT MANAGEMENT APPROACH

Intermedix utilizes a robust, scalable Project Management methodology based on the Project Management Institute’s (PMI) Project Management Body of Knowledge (PMBOK). Intermedix adjusts its project activities and resource allocation to meet the needs of each individual client. This methodology is flexible and scalable in nature and allows for complete customization of each project to fit the specific needs of our individual clients. In our decades of experience, we have found that approximately 80% of the individual activities are standardized while 20% are customized activities dependent on the variables introduced by the individual project and client. This allows the team to complete a comprehensive and accurate project plan soon after project kickoff. Once complete, the project plan provides a clear and concise, step by step road map of the activities that will need to be completed in order to meet the project’s milestones and overall objectives. The project plan is reinforced by a comprehensive communication and stakeholder engagement strategy which includes regular project checkpoints, strong feedback loops and clear concise project snapshots.
ROLES & RESPONSIBILITIES

Intermedix Responsibilities

- Project management
- Quality assurance
- Weekly status report meetings
- Coordination of all vendor activities
- Facilitation of the issue resolution process
- Purchase of necessary hardware and software (if applicable)
- Preparation and update of the detailed implementation plan
- Management of project scope
- Operational knowledge and recommendations

Client Responsibilities

- Access to necessary information, reports and personnel
- Designation of functional, technical and support resources as part of the project team
- Assisting with the identification and documentation of technical requirements
- Participation in the design of processes, workflows, and configurations
- Timely acceptance of deliverables
- Assistance with the design of quality assurance testing and training plans
- Completion of required paperwork to allow for set up and transfer to Intermedix

IMPLEMENTATION TIMELINE

Implementation begins with contract award and typically commences thirty days later with project go-live.

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Intermedix has an organizational capacity significant enough to consistently meet the needs of the largest emergency medical service providers across the country.

**2,000 EMPLOYEES**

- Management & Administration
- Training & Quality Assurance
- Client Services
- Coding
- Data Gathering
- Accounts Receivable
- Payment Posting
- Collections
- Call Center
- Mail Room, Records & Scanning
- Credit Balances & Other

**25 OFFICES & 10 EMS OPERATIONS CENTERS**

**EMS OPERATIONS TECHNOLOGY & SUPPORT**

- Support Center
- Product Management
- Product Development
- Business Intelligence
- Infrastructure

**SYSTEM CAPACITY**

- **3 MILLION** EMS transports
- **All patients checked against 30 MILLION** records daily
- More than **60,000** active users

Intermedix has over 550 people focused on EMS business and technology services.
PATIENT EXPERIENCE

AN EXTENSION OF YOU

At Intermedix, we see ourselves as an extension of the clients we serve. Your patients should be focusing on their health, not worrying about their bills. Patient satisfaction is at the heart of what we do and in our opinion, the best experience is the one with the least amount of patient touch points prior to resolution of the account. Towards that goal, we have adopted the following processes to streamline the patient experience:

- Automatically check every patient record against our internal database of more than 30 million patient encounters to identify missing information.
- Automatically search for missing insurance and demographic information through external eligibility sources and demographic data providers.
- Proactively initiate outbound phone calls to gather information that is still missing after these automated searches are run.
- Send patient mail with multiple options for response, including calling our contact center, utilizing the online patient portal or sending response by mail.

Of all patient records processed by Intermedix, 61% of accounts are resolved without direct patient interaction.

STREAMLINED RESOLUTION

Phone Calls

Our professionally-staffed patient contact center works toward the goal of resolving patient inquiries during the initial contact, and has invested in leading technology to assist in streamlining this process.

Patients can:
- Connect with the most appropriate and experienced patient account representative upon initial contact.
- Communicate with patient account representatives in more than 200 languages.
- Utilize self-service features, such as balance check.

Clients can:
- Receive detailed statistics and reports to validate that patients are receiving optimal service.

Intermedix can:
- Use real-time dashboard capabilities to identify surges in call volume and reallocate resources.

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ONLINE CONVENIENCE

Patient Portal

Patients have the option of engaging with us online through our secure online patient portal. From the patient portal, your patients can:

- Make a payment
- Print a statement
- Update demographic information
- Update insurance information

Did you know? Clients who offer online payment average $80 per uninsured account*
*compared to $18 for clients who do not offer online payment

CUSTOMIZED PROCESSING

Physical Mail

Patient invoices include an itemized invoice for the services provided. All of the details surrounding the patient record are on the face of the invoice and the back has space for updates, changes or corrections.

Patients can communicate with us through the mail to:

- Provide demographic or insurance updates on the back of the invoice
- Make a payment by returning the payment coupon with a check, cashier’s check, bank check or other valid method
- Make a payment by sending in the payment coupon with credit card information completed on the back

Intermedix has a secure mail room that processes inbound mail on a daily basis and quickly converts paper correspondence into an electronic format using our image enabled workflow tool.

- Backlogs are immediately apparent and quickly worked
- Accounts can be worked anytime, anywhere as necessary
- Throughput is monitored to ensure productivity
BUSINESS PLAN

1. Describe in detail how your firm is structured to ensure timely delivery of required services/products.

Intermedix supports health care providers with technology-enabled solutions that span the full spectrum of patient care, including business management services and emergency preparedness and response technologies.

**Leadership and Management Teams**: Our leadership and management teams are the best in the industry. They understand the needs of our clients, the regulations in our industry and what it takes to create a compliant organization with a culture of innovation and continuous improvement.

**Compliance**: Compliance is our first priority in EMS billing. We have invested in a first class team, thorough quality assurance processes and in-depth training of every employee in our organization both upon hire and annually. Our compliance team is critical to our mission of providing compliant services and technology to our clients.

**Operations and Technology**: Our operational processes and technologies have been developed by experts in the industry over many years, and we are constantly evaluating and improving upon them by implementing new ideas from our clients, employees, and industry experts. This is supported by our organizational culture of innovation and continuous improvement. The following diagram illustrates our organizational process to improve our mission and manage decisions.

![Organizational Process Diagram]

2. Describe your firm’s Project Management capabilities.

Please see the Transition Plan at the beginning of this section for a description of our project management and transition methodology. Additionally, Appendix B contains a detailed New Client Startup Process. This is a proven methodology that has consistently resulted in smooth transitions for our municipal clients and year over year financial improvement.
3. Describe your firm’s Customer Service process and provide sample of firm’s communications and statements.

We are focused on providing a comfortable and low-stress interaction with your patients when they contact us with inquiries about their ambulance bill. Our Patient Contact Center capabilities and other ways we seek to serve your patients with efficient and timely service is demonstrated in the Patient Experience detail at the beginning of this section.

Please see Appendix C for sample patient statements.

4. Describe the billing software you are using, who owns it, who supports it, and describe the process by which required programming changes are made.

Our proprietary billing system is a SaaS product that supports more than 300 clients and 3 million transports. To ensure the highest level of security for our clients, we have developed a web-based distributed architecture that provides scalability, high availability, manageability, and vendor neutrality. To support the secure environment required to do our business, we have established standards that govern our system, our facilities and our employees.

Intermedix is in compliance with SSAE-16, HIPAA and HITECH, and is working towards HITRUST compliance, as described earlier in this section.

Our system security and backup procedures are described in the Business Resilience overview at the beginning of this section.

5. Provide a detailed plan of your firm’s proposed approach (including major tasks and subtasks).

Our commitment to building long and successful relationships with our clients has led us to implement a model to support both the contract schedule as well as the day-to-day services required for EMS billing services. If awarded the contract by the County, Intermedix is prepared to begin this process immediately with the full support of our Operations staff. We have provided a summary of events in the Transition Plan above and a detailed outline of the new client startup process and a sample implementation plan in Appendix D.

6. Describe training that will be provided for County staff by the contractor.

Training is included in the fixed percentage rate and is delivered in the following methods:

EMS BILLING TRAINING

We provide training on Intermedix billing system set-up, procedures for navigating and using the system, and how to receive customer support as part of the implementation process. Initial training is focused around ensuring that you are able to easily view account activity on a real-time basis. Training will occur at the location of your choice.

EMS CREW DOCUMENTATION TRAINING

We customarily provide training for field personnel on the essential elements of clinical, patient demographic, and insurance information that helps maximize reimbursements when properly collected. In fact, our training department has recently completed a new nine-step training program to accommodate various client nuances. The nine training modules allow agencies to only use the modules that are applicable to their department.
Billing Process

Intermedix has a detailed understanding of the scope of this RFP and has the ability to accomplish the tasks described, as evidenced by:

- Financial results for clients
- Billing technology and processes
- Leveraging data to maximize revenue
EMS REVENUE CYCLE MANAGEMENT

The Intermedix EMS billing process is technologically advanced, customer-centric and supported by industry best practices. Throughout our history of more than 35 years of billing for ambulance transports, we have developed a proprietary technology platform that supports an industry-leading process that is proven to optimize revenue for our clients.

Our process encompasses the following phases:

- **Patient Research.** During this phase, we import ePCR patient data and gather demographic and insurance information for billing.
- **Billing.** Next, we submit claims to third-party payers and invoice patients.
- **Payer Response.** When a response is received, we post and reconcile payments and support follow-up with payers and patients.
- **Account Resolution.** Finally, we process refunds, set up payment arrangements and identify accounts for write-off, debt setoff, garnishment, or advanced collections.

Throughout the billing process, Intermedix focuses on supporting you with a dedicated compliance program and proactive, experienced client service representatives. Dashboards and reports make both clinical and financial data available to you at any point in the revenue cycle.

PATIENT RESEARCH

We use a combination of advanced technology and experienced representatives to efficiently prepare claims for submission. Claims with accurate information can move to the billing process as quickly as possible.

The Patient Research phase includes:

- PCR capture
- Coding
- Medicare signature receipt and verification
- Eligibility verification
- Patient outbound phone calls
PCR CAPTURE

We collaborate with most PCR vendors and can capture electronic records through an automated import from your emsCharts software. Upon receipt, the transport is given a unique patient account number that corresponds with the client’s internal account number.

We import both electronic and paper PCRs into our proprietary front-end coding software with a monitoring program that regularly checks a secured website for new transports.

CODING

Our coding application automatically performs data quality and integrity checks on incoming data. When the system finds inconsistencies, it alerts our coders. In compliance with proprietary rules-based algorithms, a coder cannot save the claim until the issues are addressed. For example, we verify that demographic data contains elements such as patient address, social security number and date of birth.

We code the trip based on dispatch, assessment, narrative and treatment data. The initial coding is done through our automated systems. After that, a coder manually reviews every account for accuracy and completeness. The coder verifies that insurance information is consistent with payer specific requirements. The coder also reviews the account for medical necessity documentation using our proprietary contraindication codes, signature capture and other information supporting the submission of a complete and accurate claim.

We use the Medicare Level of Service Coding Guidelines unless they conflict with a local ordinance.

Coding every trip at the highest, compliant level of service for the care provided ensures that your organization is able to recover the cost of providing the service while remaining compliant with all of the rules and statutes that govern ambulance billing.

Intermedix is aware of all ICD-10 requirements, testing schedules and implementation deadlines. We are working closely with Medicare, State Medicaid programs, commercial insurance companies, clearinghouses and other trade partners to ensure a successful transition to the new coding format. Our coding team managers regularly attend ICD-10 training classes. We are also building training materials and will make them available to our entire team of coders prior to the ICD-10 requirements implementation date.
MEDICAL NECESSITY REVIEW AND SIGNATURE REVIEW

The Intermedix billing system automatically performs data quality and integrity checks on incoming patient records. Intermedix will run all patient records received through our automated platform as an added layer of compliance verification prior to invoicing. For example, we will verify that demographic data contains elements such as patient address, social security number and date of birth. This automated platform is a proprietary system that uses algorithms and key data points to suggest medical necessity and diagnosis codes and uses the Medicare Level of Service Coding Guidelines unless in conflict with a local ordinance. We also review the account for medical necessity documentation using our proprietary contraindication codes and review required patient and crew credentials.

If we identify a discrepancy based on element of medical necessity, we will send the patient record for internal review. In compliance with our proprietary algorithms, the reviewer must resolve the issue before continuing to the next patient record. If the discrepancy is valid, we will send the patient record to a research request queue inside the billing system. From there, the reviewer has a variety of options to respond to the issue with next steps and can forward it back to the appropriate parties for resolution. This process allows for back and forth dialogue on patient records within the system, ensuring that the process is logged in the patient record.

MEDICARE SIGNATURE RECEIPT AND VERIFICATION

It is important to capture a valid signature and prevent filing Medicare claims without it. The Office of Inspector General (OIG) has been involved in a number of cases that have resulted in EMS agencies being held to a Corporate Integrity Agreement based on previously poor practices. However, Intermedix policies and procedures have kept all of our clients in compliance.

To successfully document signatures, we implement a number of solutions:

- We link accounts without a valid signature to accounts for the same patient where we have a lifetime signature on file, or where there is an indication that the patient is deceased.
- We link Patient Unable to Sign (PUTS) and Representative Unable to Sign (RUTS) accounts to electronic medical records for the same incident that we have received from the hospitals.
- We run accounts against the SSA's “deceased” file to identify deceased patients.
- We send letters to patients with specifically targeted language asking for a signature.
- We work with hospitals to obtain a proxy signature per the Medicare regulation exception which allows certain other signatures to satisfy the signature rule.
ELIGIBILITY VERIFICATION

We execute a series of insurance eligibility transactions to help retrieve appropriate insurance information. To ensure the information is complete, we interface with external sources such as Medicare HIPAA Eligibility Transaction System (HETS), Medicaid, Emdeon and ZirMed. Our Hospital Liaison Program supplements this data by focusing on connecting with your receiving facilities to gather demographic and insurance information from their on-site registration staff to augment the data in our database.

For additional demographic and insurance information, we search our proprietary database that contains more than 30 million active patient records. If the patient demographic information is not found during the initial search of our databases, we utilize an external demographic data provider to perform skip tracing.

All data updates are completed with quantitatively-defined metrics and our data gathering specialists review all records.

PATIENT OUTBOUND PHONE CALLS

When insurance information is still missing after the eligibility verification stage, Patient Account Representatives (PARs) contact the patient. We use Predictive-Dialer Technology to call patients with a valid phone number and then automatically transfer connected calls to a PAR. If the patient is uninsured, the PAR requests payment at that time or attempts to initiate a payment plan for the patient. These call campaigns are customizable based on account attributes, patient demographics, number of attempts, days and times to call and many other attributes.
BILLING

We use a combination of automated technology and billing specialist monitoring to ensure clean claims. The depth of our company makes it possible to communicate electronically with a large number of payers. Our customizable patient billing rules ensure a patient-centric billing process.

The Billing phase includes:

- Primary payer billing
- Patient invoicing

Notable EMS Billing Statistics

- Average clean claim rate: **94%**
- First invoice payment rate: **80%**
- Claims submitted electronically: **100%**
  *(to payers who accept electronic submission)*

PRIMARY PAYER BILLING

Prior to submission, we automatically review claims against our proprietary rules-based engine. Claims not passing the review are placed into a work queue and processed by team members. Our clearinghouse provides a second level of review for electronic claims. Inconsistencies caught by our clearinghouse are also reviewed by a billing specialist and updated in the Intermedix system.

Claims to Medicare, Medicaid and most commercial payers are transmitted electronically. We print and mail paper claims if electronic delivery is not available or when the payer requires hard copies of PCRs or explanation of benefits.

PATIENT BILLING

Intermedix does extra work behind the scenes to ensure that we have gathered accurate patient contact information. We identify accounts with invalid addresses and automatically apply our skip tracing process to find updated mailing address from our external demographic data provider, previous transports and hospital files.

Intermedix has a flexible patient mail application that ensures clear and specific communication:

- We include account charge, payment and insurance information on invoices.
- We supply virtually unlimited patient statement wording variations.
- We automatically generate mail from the billing system.
- We allow authorized users to access and print statements on demand.
We offer a wide range of default letter templates for the most common situations; however, specialized wording can be created from a combination of more than 15 account attributes so that the patient fully understands actions taken on the account. Whether it is a first invoice or a payment plan reminder, each letter is tailored to specific patient needs, accommodating for such situations as absence of insurance, liability coverage and remaining balance.

PAYER RESPONSE

We support a number of methods to receive payments and our system auto-posts payments upon receipt of documentation. We also have advanced processes in place to deal with denials, aged accounts receivable associated with no payer response, and self-pay accounts. Our clients receive monthly account reconciliation reports, as well as advanced reporting and auditing services.

The Payer Response phase includes:

- Payment posting
- Denial management
- Supplemental claims filing
- Patient response
- Reconciliation

Notable EMS Billing Statistics

- Remits received electronically: **100%**
- Online payment success Rate: **$80 per uninsured account**
  *(compared to $18 for clients who do not offer online payment)*
- Primary claims filed: **55,000 per week**
- Monthly inbound calls: **55,600**
- Calls handled by self service: **5,261**
- Abandonment rate: **2%**
- Average speed to answer: **17 seconds**
- Median speed to answer: **6 seconds**
PAYMENT POSTING

Upon receipt of payment documentation, our Payment Posters post payments to the account within one business day. We provide the tools necessary to receive payments through several methods, including electronic fund transfers (EFTs), checks and credit cards. We receive electronic payment from Medicare, Medicaid and most commercial payers and our Electronic Remittance Advice (ERA) Browser allows the Payment Poster to access and verify these responses.

When we receive hardcopy EOB documents instead of ERAs, a Payment Poster manually applies the payment with our web-based system. Credit card information received through the contact center or patient correspondence is processed by a Payment Poster online through Virtual Merchant.

We review every data element for accuracy and completeness before committing transactions to our database. We maintain an audit trail with the User ID to ensure the best quality assurance processes. If payments are received without identifying information, they appear in our Check Reconciliation Queue for follow-up. We research the payment with both the client and the entity that provided the payment, then post to the proper payment account.

SUPPLEMENTAL PAYER CLAIM FILING

Claims that contain supplemental payer information are submitted according to the established procedures after the initial payment is received. When dealing with Medicare crossover claims:

- We send claims to the supplemental insurer automatically.
- We automatically file a claim with the corresponding EOBs to the secondary payer on file if a secondary payment is not received in a predefined number of days.
- We automatically handle exceptions and adjust the remaining balance when Medicaid does not cover the remaining 20% responsibility.
- We file a claim with the supplemental insurer immediately upon receipt of Medicare’s Electronic Remittance Advice when we have supplemental insurance (MediGap) on file, but Medicare has not crossed over the information to the payer. We file Medicare secondary claims electronically with all required information.

DENIAL MANAGEMENT

Our goal is to file a clean claim the first time; however, denials do occur. In case of a denial, we initiate a series of actions specific to the denial reason. For example:

- If a claim is denied due to a policy number issue, we check a number of insurance eligibility sources and may contact the patient to obtain the correct insurance information.
- If a claim is denied for medical necessity reasons, we review the PCR to verify the original medical necessity determination.
We are committed to timely and accurate processing to improve cash flow, and address many denials automatically upon receipt. We are continuously expanding the payer and denial code combinations that can be handled automatically. Denials that are not processed automatically are addressed by Accounts Receivable resources through our Manual Denial Management Queue. We engage in a number of activities to resolve accounts such as researching accounts, verifying electronic claim status, accessing payer websites and making payer phone calls. Once the problem has been identified, we update accounts and re-file claims when appropriate. The queue allows sorting by payer, so that our representatives can quickly resolve multiple claim issues for a single payer at the same time.

We use denial reports by payer and denial type to identify trends, implement training and process improvements and, in some cases, take action against the payer. Our Compliance and Audit Departments are continuously engaged in performing reviews and analysis of payment and denial trending so that we can take appropriate action on behalf of our clients. With hundreds of clients doing millions of transports annually, we have a distinct voice among even the largest insurers such as BCBS, Aetna, Cigna and government insurers.

When no response is received from a payer, we automatically follow up on claims. Our Claim Status Monitoring tool allows us to follow up on claims for which we have not received a response in the expected timeframe. The monitor recognizes the claim filing date and searches for a response from the payer, sending the account to a work queue when a payer response has not been received within the defined timeframe.

**PATIENT RESPONSE**

We offer a number of methods for the patient or patient representative to respond to requests for insurance or payment. For example, they can contact us by mail, through a dedicated customer service toll-free phone line or on our secure patient website. We recommend that clients use an online payment solution to significantly increase collections.

Our professionally staffed Patient Contact Center is focused solely on interacting with EMS transport patients. Our representatives handle both insurance and self-pay arrangements. Patients can use a client-specific, toll-free number to access the Contact Center, which takes calls between 8:00 a.m. and 8:00 p.m. Eastern Time. After hours calls are received by a messaging system and voicemail is returned the next day. The Contact Center uses the latest telephony technology, including skills-based routing by call type and language preferences.

We have a number of bilingual Contact Center representatives for foreign language calls with fluency in many languages including Burmese, Cantonese, Creole, Dutch, Filipino/Tagalog, French, Guarati, Hindi, Korean, Mandarin, Russian, Spanish, and Vietnamese. Translation services are also available—PARs can dial in the vendor for a live conference with a translator for one of the 150 supported languages.
ACCOUNT RESOLUTION

Intermedix has processes in place to support each of the situations below:

- Appeals
- Aged Accounts Receivable
- Refunds
- Adjustments and Write-Offs
- Third Party Debt Collections
- Data Entry, Record Retention and Auditing

APPEALS

Intermedix offers several important advantages surrounding appeals:

- We review each payment received from a third party to ensure accurate reimbursement.
- We identify problematic patterns and proactively involve our EMS Compliance Officer to work directly with the carrier to get them resolved.

When invoices are short-paid:

- We flag the account for exception processing, which triggers an appeal to the carrier for payment.
- We send a letter requesting that the payer pay the full usual and customary rate.

When we receive no payment:

- We immediately appeal any timely filing denials with proof showing when we received the insurance information and filed the claim.
- We submit a new claim with the proof of eligibility from the Medicaid Web portal for patients who receive retroactive Medicaid coverage.

RECONCILIATION

We provide detailed month-end reports that include all payments, write-offs and adjustments. We reconcile with the date of transport, monthly bank deposits, credit card payments and the month-end total. Checks and balances occur at numerous levels throughout the payment posting process to ensure that all money posted balances at the end of each day. Daily “batch” reporting is reviewed to verify the total amount of money posted each day.
AGED ACCOUNTS RECEIVABLE

We have developed monitoring tools that allow us to follow-up on claims that have not been paid in the expected timeframe. Our staff is assigned to these work queues to avoid cases where claims are submitted without a payer response. Accurate data mining of denials is the most critical element of our denial management process. This “Claims Status Monitor” queue monitors activity on accounts with a primary insurance invoice, an open status, and a balance that is not equal to zero. It recognizes the primary insurance process date and searches for a response from the payer.

REFUNDS

When a credit balance occurs, Payment Posters provide the payment record to a Refund Processor for follow-up. The Refund Processor then researches the claim, gathering supporting documentation from our billing system, which may include the EOB and copies of the original check from the payer. After the credit balance is confirmed as a legitimate overpayment or duplicate payment, the Refund Processor completes the necessary refund request documentation.

ADJUSTMENTS AND WRITE-OFFS

We work with clients to define and implement adjustments and write-offs. Typically, a core set of reasons for adjustments and write-offs is used, but we can implement additional reasons that better fit clients’ reporting operations.

THIRD-PARTY DEBT COLLECTIONS AND SETOFF PROGRAM

After exhausting all efforts—including applying payments, adjustments and write-offs—accounts with open balances may become eligible for advanced collections. If the client chooses to pursue advanced collections, we will send the patient an invoice warning them that the account will potentially be sent to collections if left unpaid. Then, after a final review to ensure no recent account activity, we provide the client’s designated collections agency with the necessary data to perform collection services. If the account is deemed a candidate for debt set off, we will begin the debt set off process by providing the required patient data files electronically to the County, provide patients with compliant notifications of impending debt set off and giving them adequate time to clear the debt. If the responsible party has not cleared the debt through either payment in full or establishing a payment schedule arrangement, we will proceed with filing the debt with the Debt Setoff Program. We will also provide reporting on accounts and recovery amounts in debt set off status and maintain records that will support possible disputed action.

DATA ENTRY, RECORD RETENTION AND AUDITING

We link any hardcopy documentation received to the appropriate account by first tagging it with a barcode and then updating the information to the account. All documents are available to clients with the appropriate permissions online.

Intermedix maintains all billing information for the required time (typically seven years), either in the original electronic format, or via a scanned copy created from all paper-based payment records. We routinely provide audit support for our clients relative to meeting State and local reporting requirements.
LEVERAGING DATA

Intermedix’s reach across the health care continuum results in significant benefits for our clients.

**EMERGENCY MEDICAL SERVICES**
- 3 MILLION Annual EMS Transports

**PHYSICIAN SERVICES**
- Anesthesiology
- Emergency Medicine
- Family Practice
- Internal Medicine
- OB/GYN
- Orthopedics
- Pediatrics
- Urgent Care

**HOSPITAL INTEGRATIONS**
- 145 Hospital Integrations
- Covering 400 Facilities

**30 MILLION**
- Patient Records (and growing every day!)

**12 MILLION**
- Annual Physician Encounters

**BENEFITS**
- Financial Results
- Predictive Modeling, Analytics & Reporting
- Client & Patient Satisfaction

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BILLING PROCESS

1. Document your firm’s billing processes for each of the various payer groups.

Today, we provide EMS billing services to more than 300 government-based EMS providers (in addition, we provide the same services to a number of hospital-based services and a handful of private providers). As a result, our knowledge of State regulations, payers, etc., as well as the relationships we have established in the EMS industry is extensive. Specific benefits of this deep knowledge include:

- Being informed on what agencies across the country are doing as a matter of policy, selection and experience with electronic patient care reporting solutions, computer aided dispatch (CAD) systems, transport volume trends, payer mix shifts, etc., as well as a strong understanding of local political, economic, and demographic issues.
- Systems and process that ensure compliance with state requirements for Medicaid coding and third party billing service EMS provider invoicing.
- Having a robust proprietary database of patient information, that includes surrounding agencies, against which the County’s self-pay accounts are checked for insurance and demographic information on a nightly basis.
- Successful defense of clients at a Medicare Fair Hearing related to overpayment recovery. As a result, over $1.4 million was repaid to EMS services by Medicare.
- Successful representation of clients via arbitration with commercial HMO’s that have been short paying EMS transports.

Intermedix is exclusively focused on the emergency services industry. A detailed description of our billing operations process is included at the beginning of this section.

2. Describe your firm’s processes for limiting denied claims.

While a more detailed description of our billing process, which is highly focused on eliminating denials whenever possible, is included in the beginning of this section - Intermedix offers several important solutions for managing appeals:

- We review each payment received from a third party to ensure accurate reimbursement.
- We identify problematic patterns and proactively involve our EMS Compliance Officer to work directly with the carrier to get them resolved.

When invoices are short-paid:

- We note the account for exception processing, which triggers an appeal to the carrier for payment.
- We send a letter to the payer requesting payment of the full usual and customary rate.

When we receive no payment:

- We immediately appeal timely filing denials with proof showing when we received the insurance information and filed the claim.
- We record a list of insurance claims for which no payment or acceptable response is received from the insurer after the legal time limit.
3. Document in detail the process your firm uses to obtain demographic and insurance information for patients, when such information is missing or incomplete.

We place intense operational efforts on our front-end processes with the primary goal of obtaining patient demographic and insurance information wherever it exists. Our billing methodology uses a combination of technology, personnel and processes designed to locate patient information from receiving facilities, insurance databases, transport records, skip tracing resources, and patient phone calls.

To the degree that we capture valid information, we are able to bill the patient’s insurance without ever having to contact the patient, thus achieving optimal customer service for the obvious reason that we do not have to bother your patient for information.

PATIENT DATABASE

We have developed a master database application within our proprietary billing system for internal eligibility sweeps. Our database runs each account against EVERY EMS patient in our database, ALL hospital data, ALL prior patient linkage, and ALL patient information maintained by our physician services division database – more than 30 million records nationwide.

It also contains the patient information we receive directly from hospital connections that have been established through our Hospital Liaison program. This proprietary linkage database is a clear differentiator that only Intermedix has to offer, the result of which is improved collections and/or cash flow timing.

SKIP-TRACING AND ELIGIBILITY

Each patient account is sent through a series of eligibility transactions to retrieve all appropriate insurance information. The most frequently used resources are Medicare (HETS), Medicaid, and cascading insurance eligibility clearinghouses like Emdeon and ZirMed. Many times we are not only missing insurance information but patient demographics are incomplete as well. If the patient demographic information is not found during the initial search of our databases, we utilize Accurint to perform skip tracing. Eligibility and skip tracing activities are completed with a quantitatively defined confidence that the data returned belongs to the patient in our system, and reviewed by our billing specialists.
Reporting

Intermedix has a detailed understanding of the reporting needs of Cleveland County EMS and has the ability to provide the reports described, as evidenced by:

- **Dashboards, reports and data analytics**
Intermedix offers customizable dashboards that support interactivity for ad hoc data exploration. You can select data from any report and pair it with one of many visualization options in a layout tailored to your organization.

**100% Customizable Dashboard**

More Than 1,000 Available Data Elements

**Self Service Reporting**

* Access To Pre-Built Reports
* Drag-and-drop Report Creation

Expert Report Building Service

Report Scheduling

Available Formats: PDF | Excel | CSV | XML
Intermedix works with every client to develop a customized reporting package that communicates the metrics most important for creating transparency for operational efficiency and quality. We assemble this package from our suite of pre-built reports as well as custom reports tailored to specific client needs. The sample package below illustrates the range of data we believe to be most important.

**END OF MONTH FINANCIAL DATA**

**MTD & YTD Reports**
- Charge Activity
- Receipts
- Adjustments & Write-Offs
- AR aging
- Executive Summary

**MEDIC STATISTICS**

**Data Capture by Medic & Trends**
- Demographics
- SSN
- Insurance
- Denials
- Receipts

**KEY PERFORMANCE INDICATORS**

**Data Trends**
- Charges
- Receipts
- Level of Service
- Gross/Net Collection Percentage
- Medical Necessity
- Medic Data Capture

**PREDICTIVE MODELING**

- Flu Forecasting
- Seasonal
- 2 Weeks Out
- Validated vs. CDC Data
- Propensity to Pay
- Targeted Collections
- Benchmarking
- Resource Positioning
- Route Organization

**DATA ANALYTICS**

- Operational Metrics
- Provider Metrics
- Metric Driven Alerting
- Community Paramedicine
  - Community Health Dashboard
  - High Risk Patient Identification
  - Plan Enrollment Candidates
- Patient Outcomes
- Geospatial High Utilization Mapping
- Market Analysis

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REPORTING

1. Describe in detail your reporting capability.

The Intermedix billing system is equipped with Business Objects reports powered by SAP. With this, the County will be able to define any number of reports for automated delivery on a scheduled basis or on the fly.

Our web-based Intermedix Business Intelligence System (IBIS) reporting tool provides you with real-time access to your EMS billing data for scheduled and adhoc reporting 24 hours a day, seven days a week, and 365 days a year. This level of robust reporting enhances the timeliness, flexibility, and specificity of the reports you will be able to access from the Intermedix billing system.

2. Provide sample reports.

The data analytics and reporting description at the beginning of this section illustrates many examples of the types of reports the County can generate and lists many of the most common reports accessed by our clients.
CLIENT EXPERIENCE

The nation’s largest emergency medical service providers trust Intermedix as their revenue cycle management partner. We process more than 3 million transports for our clients and collect nearly $1 billion annually.

We serve 300+ clients across the U.S.

LARGE CLIENTS BY ANNUAL VOLUME
HIPAA Compliance Program

Intermedix has the qualifications and experience necessary to continue to serve as a trusted partner to Cleveland County Emergency Medical Services System, as evidenced by:

- **Compliance and quality control measures**
- **Excellence in leadership and compliance**
HISTORY OF INVESTMENT IN COMPLIANCE

The following timeline illustrates our long history of forward-thinking investments in our compliance program.

2003
Intermedix makes its first dedicated compliance hire, Joe McCloskey, who continues to focus solely on EMS compliance.
Intermedix establishes voluntary compliance program following OIG guidelines.

2004
Intermedix expands its compliance staff to include a certified audit team.

2012
Intermedix hires Chief Compliance Officer, Gregg Bloom.
Intermedix hires Certified Information Security Manager.

2013
Intermedix hires a Vice President of Information Security, additional information security and privacy staff and begins to standardize on the HITRUST Common Security Framework (CSF).

2014
Intermedix invests in additional tools to enhance the efficacy of its information security and privacy program.

HIPAA HITECH COMPLIANCE

The HITRUST CSF is becoming the de facto standard framework that is being used by most major healthcare providers and payers. 50% of all providers and 70% of all health plans with more than 500,000 members have standardized on HITRUST.

HITRUST ensures compliance with:

- HIPAA (Privacy and Security Rules)
- HITECH
- The Omnibus Rule
- PCI (Payment Card Industry) Data Security Standards
- State Information Security and Privacy controls

Intermedix ensures compliance through:

- **Internal Audits**
  We regularly perform audits to ensure that all the required controls are in place are effective.

- **Independent Third Party Audits**
  We bring in auditors to objectively assess our control structures on a regular basis.

**SSAE16 / SOC1 reports issued by auditors certify the existence and effectiveness of the controls around all major Intermedix systems.**
CHOOSE YOUR PARTNERS CAREFULLY!
Based on recent changes in health care regulations such as the Omnibus Rule, third parties who fail to comply with regulations could incur severe penalties for themselves and for their customers.

Did you know? 70% of all data breaches are caused by Business Associates. Business Associates are now held to the same standards as Covered Entities and are subject to direct liability for failure to comply.

Is your mission protected?
In the News: Cost of HIPAA Non-compliance
- Rural Metro Ambulance: $2.8M
- City of Dallas: $2.47M
- Blue Cross, Blue Shield of Tennessee: $1.5M fine; +$17M in cleanup efforts
- CVS Pharmacy: $2.3M
- CIGNET: $4.3M
- Triple S Salud (Blue Cross Blue Shield franchise out of Puerto Rico): $6.8M

INNOVATION AND CONTINUOUS IMPROVEMENT
Every day, our compliance team is monitoring new industry developments, communicating them to our clients, and proactively developing and rolling out strategies to ensure compliance and security for client information.

Aggressive Investment in Security and Privacy Program
Includes building a dedicated team, expanding our vulnerability management, data leakage protection, log collection and correlation, application security and third-party management programs.

Commitment to Client and Vendor HIPAA HITECH Compliance
Includes protection from the steep fines and high costs associated with non-compliance and a vendor management program, which ensures that our partners have the appropriate controls in place to protect client data.
QUALITY CONTROL

Automated System Controls
Our EMS billing system was built from the ground up with a focus on compliance. We have the following automatic controls in place to ensure that a human verifies accounts that could have compliance issues.

- Automatic routing of claims coded as “Not Medically Necessary” to a manual review queue
- Automatic routing of claims missing signatures to a manual review queue
- Automatic alerts on outliers of pre-configured metrics for hospital connections
- Daily email alerts about queues, volumes, process reports, etc

Coder Audits
Our supervisors conduct a monthly audit, scored on the following criteria.

A score of at least 95% is required.

- Assignment of appropriate level of service
- Determination of medical necessity
- Determination of emergency or non-emergency transport
- Assignment of appropriate signature acronym
- Assignment of appropriate HCPCS modifiers
- Assignment of appropriate ICD-9 codes, including E-codes
- Verification and entry of all appropriate charges

Implementation and ePCR Integration Controls
During implementation, the following quality assurance steps are completed to ensure information flowing from the ePCR to the Intermedix billing system is complete and accurate.

- Medical record mapping
- Facility mapping
- User acceptance testing
- CAD reconciliation
- Signature compliance
- Client documentation audits
- Charge verification (ongoing)
- Go-live testing & verification
- Documentation training (ongoing)
HIPAA COMPLIANCE PROGRAM

1. Contractor shall have a Department of Health and Human Services Office of the Inspector General (OIG) compliance program or policy in place. Please provide a copy with the proposal. In addition, Red Flag plans should be included in your proposal.

Compliance is our first priority in EMS billing. We have invested in a first class team, thorough quality assurance processes and in-depth training of every employee in our organization both upon hire and annually. Our compliance team is critical to our mission of providing compliant services and technology to our clients. A detailed description of our compliance team and the components of our program are included in the compliance overview at the beginning of this section.

Intermedix has developed a comprehensive internal Red Flag Identity Theft Prevention Program ("Red Flag Program") to help identify, detect, and respond appropriately to activities, patterns, and situations that signal the possibility of fraud or identity theft. This includes financial and medical identity theft ("Red Flags") in relation to the financial and medical "covered accounts" established and/or held for our clients. We continue to follow this best practice even though a ruling in late 2010 specifically excludes medical providers from falling under the Red Flag rules.

A confidential copy of our compliance program is included in Appendix F.
Certificate of Insurance

Copies of the necessary insurance policies are included in this section for your review.
CERTIFICATE OF INSURANCE

1. Provide a certificate of insurance based on requirements as specified in 31.0.

Intermedix offers to Cleveland County our $1 million crime policy which provides more protection than the bond mentioned in its RFP. Attached is our Crime Policy which we offer in lieu of this lower value bond. However if the County would like Intermedix to purchase the bond coverage in addition to our Crime Policy, we will be happy to do so and pass along the cost of the bond coverage in the form of a 1.00% increase to our fee.

Copies of the necessary insurance policies are included in this section for your review. After contract award, we will have the County named as an additional insured.
Pricing Proposal

Intermedix has provided pricing that reflects the benefits our technology, personnel and processes can bring to Cleveland County EMS.
PRICING PROPOSAL

1. Pricing for all billing and collection services requested in this RFP must be stated as a percentage of total collections.

Thank you for allowing Intermedix the opportunity to evaluate the Cleveland County financial data. We have described throughout our proposal the detailed descriptions of our people, our technology, our billing processes and the positive results we have driven for over 300 EMS billing clients utilizing our expertise. We have the ability to bring a great deal of value to Cleveland County through ongoing assessment of your revenue opportunity and implementation of methods to enhance results in partnership with your County management team.

In evaluating your data as provided during the RFP process, Intermedix focuses our attention in on four potential significant drivers of revenue improvement.

1. Level of service (LOS) mix
2. Charge mix
3. Collection percentage for each payer group
4. Transport fee schedule

While we anticipate slight variations in the areas of LOS mix, charge mix and the collection percentages by payer, our analysis did not uncover major opportunities from the data provided. However if the County is looking for ways to increase the revenue recovered via your EMS transports, the area that would provide the most immediate upside is in the fees being charged for the services provided. Intermedix has worked with hundreds of clients to bring fees up to a sustainable level that has yielded significant financial upside to the municipal budget. While we understand that the County has compared its fees with other regional municipal agencies and even increased fees to some extent as a result of your analysis, Intermedix is able to expand greatly on the topic and provide sound and measurable rationale in this area at any time during our relationship. On point, we ran some different scenarios in our financial model and anticipate more than a few hundred thousand more net dollars to the County if such a discussion and decision was of interest to Cleveland County leadership.

If during the term of our service relationship the County opts to move ahead with a meaningful fee increase, Intermedix will be open to discussing a lower fee for the billing services at that point. As pointed out throughout our proposal, Intermedix has been successful in increasing revenue results for our clients year after year, and we anticipate being able to do the same for Cleveland County, working closely with your leadership team to achieve the results we mutually establish as annual revenue goals.

<table>
<thead>
<tr>
<th>Year 1 - Billing &amp; Hardware</th>
<th>9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 &amp; 3 - Billing &amp; Hardware</td>
<td>6.85%</td>
</tr>
<tr>
<td>Years 1, 2, &amp; 3 – Billing Alone</td>
<td>5.15%</td>
</tr>
<tr>
<td>Year 1 – Hardware</td>
<td>3.85%</td>
</tr>
<tr>
<td>Year 2 &amp; 3 – Hardware</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
**Hardware Pricing:** In year one, Intermedix expects to cover the charges for an invoice (per Appendix H of the hardware pricing schedule) of $71,560. In year two and year three, Intermedix expects to receive and pay for the invoice per the appendix H of the hardware pricing schedule of $31,560. In summary, if selected as the vendor for the County, we will cover the full set of fees for the hardware/software in the three years that we will be awarded the contract per the details listed in Appendix H and according to the annual schedule of invoices to Intermedix, one invoice per year for each of the three years.

2. **Respondent must also detail its pricing and methodology for including, at some point during the term of the contract, an alternative ePCR system and/or complete or partial hardware "refresh". Include detailed transition plan including various transition options based on the timing of the ePCR software/ field hardware refresh including risks of each option and respondents recommended transition plan.**

Intermedix will provide a complete or partial hardware "refresh" for the County, as desired. Per our discussion with Mr. Lord, Intermedix will refresh three Toughbooks per year for the County. Intermedix sees no risk in the transition plan above as we are going to fully adhere to Appendix H of the RFP. Intermedix already has an existing interface with EMS Charts Software. Please see our letter of recommendation from them below.

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**emsCharts**

600 Mifflin Road, Suite 102
Pittsburgh, PA 15207
Phone: 866-647-6282
Fax: 412-461-3270
www.emscharts.com

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**To:** emsCharts customer  
**From:** Greg Howard, Director of Sales  
**Date:** 9/5/12  
**Re:** emsCharts billing export to ADPI/Intermedix

Dear emsCharts prospect,

emsCharts is proud to offer state of the art technology to our customers giving them the tools to be successful.

We pride ourselves on our business relationships to help streamline processes, reduce errors, and save our customers money through technology.

emsCharts has been working with Advanced Data Processing for a number of years automating the billing data delivery process. EMS agencies can choose at what QA level the NEMSIS XML file is delivered to the ADPI billing department. Although the ePCR and billing software are completely separate, there is a seamless integration to the end-user from chart completion to chart delivery.

This yields a highly efficient chart start time to billing delivery time.

Best Regards,

Greg Howard  
Director of Sales
APPENDICES

A  RESUMES
B  DETAILED NEW CLIENT START-UP PROCESS
C  SAMPLE PATIENT STATEMENTS
D  SAMPLE IMPLEMENTATION PLAN
E  DISASTER RECOVERY PLAN
F  COMPLIANCE PROGRAM
APPENDIX B: DETAILED NEW CLIENT STARTUP PROCESS
New Client Start Up

**Process Steps**

**Step 1**
Pre Executed Contract
- Contracting
- Review Contract from Business Development
- Provide Feedback and Edits as Needed to Bus Dev & Legal
- Bus Dev/Legal Provides Contract to Client
- Execute Contract "Welcome Email" sent from Bus Dev to Client

**Step 2**
3 to 5 Bus. Days
- Complete Project Planning
- CSM Updates Project Plan
- CSM Conducts Call with Bus Dev, Ops, Integration to Discuss Nuances
- CSM Places Intro Call to Client
- CSM Sends IMX Sep Up Packet to Client

**Step 3**
7 to 10 Bus. Days
- Compile & Complete Set Up Data
- Kick-Off Call with Client to Review/Complete Set Up Forms
- Receive Completed Forms and Validate Info and
- Submit All Forms/Applications to Internal Dept or Vendors to Begin Processing
- Receive Confirmation of Completed Department Profile and Verify

**Step 3.1**
10 to 15 Bus. Days
- TripTix Set Up
- Internal Call With TripTix Support and Schedule Call With Client
- Receive Completed TripTix Forms and Open JIRA Ticket, Order and Image Toughbooks
- Conduct Training
- Conducting Training

**Step 3.2**
20 to 25 Bus. Days
- ePCR Integration
- Internal Call With Integration Support and Schedule Call With Client
- Complete Mapping, UAT and Bug Fixes for Approval for UAT in Live Environment
- Testing Completed and Approved to Go Live

**Step 4**
5 to 10 Bus. Days
- Complete Client Set Up
- Begin Policy/Procedure and Document Packet; Schedule On-Site Meeting With Client
- Receive Completed Forms, Forward applicable Forms to Dept For Internal Processing; Place All Forms on Shared Drive and Send Email to all Managers
- Schedule and Conduct Call With Internal Stakeholders and Client to Review Status

**Step 5**
3 to 5 Bus. Days
- Complete Setup Validation
- Conduct On-Site Meeting With Client to Review Policy/Procedure & Document Packet
- Conduct On-Site Meeting With Client
- Conduct Internal Go Live Meeting With All Managers (Mandatory)
- Conduct Internal Go Live Meeting

**Step 6**
Post Go-Live
- Conduct Post Production Client Monitoring
- Receive Final Confirmation From Each Dept/Vendor That All Processes Are Ready to Go Live
- Schedule On-Site Processes
- Receive Completed Forms, Final Accommodations
- Continue to Review Forms/Applications to Internal Dept or Vendors to Begin Processing
- Receive Completed Forms, For Internal Processing; Place All Forms on Shared Drive and Send Email to all Managers
- Conduct Internal Go Live Meeting With All Managers (Mandatory)
- Conduct Internal Go Live Meeting
- Conduct Internal Go Live Meeting With All Managers
- Conduct Internal Go Live Meeting With All Managers

**First Week:** Verify Billing, IMX Processes and Documentation. Discuss Issues/Status With Client/Ops

**30 Days:** Conduct EOM Report Review With Client; Verify Invoicing; Continue Monitoring Billing, Processes, Documentation. Discuss Issues/Status With Client/Ops

**60 Days:** Continue to Monitor Billing, Processes, Documentation and Discuss Issues/Status With Client/Ops

**90 Days:** Review Billing, Processes, Documentation and Discuss Issues/Status With Client/Ops
Statement Date: 

Primary Insurance: Cigna Health Care  
Policy Number: 
Secondary Insurance: Aetna  

Statement of Account

Emergency Medical Services

Amount Due: 

**DETACH LOWER PORTIONS AND RETURN STUB WITH YOUR PAYMENT, THANK YOU**

<table>
<thead>
<tr>
<th>INCIDENT NO.</th>
<th>STATEMENT DATE</th>
<th>PAY THIS AMOUNT</th>
<th>ACCOUNT NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

Make checks payable to: 1st Response Medical Transport Corp.

To pay online, go to www.intermedix.com/billpay
In order to process your claim, please provide your insurance information below and mail the form to 1ST RESPONSE MEDICAL TRANSPORT CORP., 1105 Schrock Road Suite 610, Columbus OH 43229 or fax it to 614-987-2075. To pay online, go to www.intermedix.com/billpay

Do you have insurance? Yes ☐ No ☐ (If you do not have insurance, complete only the Patient Information section.)

<table>
<thead>
<tr>
<th>Patient Information (Required Information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s First Name</td>
</tr>
<tr>
<td>Patient’s Date of Birth (MM-DD-YYYY)</td>
</tr>
<tr>
<td>E-mail Address</td>
</tr>
</tbody>
</table>

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or any other government agency or insurance carrier responsible for payment any information needed for this related Medicare or other claim, now, in the future or in the past. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the service provider.

Signature __________________________ Date __________________________

<table>
<thead>
<tr>
<th>Medicare Information</th>
<th>Medicaid Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare ID (Include letters and numbers)</td>
<td>Railroad</td>
</tr>
<tr>
<td>Medicaid ID (Include letters and numbers)</td>
<td>State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Insurance Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder’s First Name</td>
</tr>
<tr>
<td>Insurance Company Name</td>
</tr>
<tr>
<td>Insurance Policy Number</td>
</tr>
<tr>
<td>Insurance Company Address</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Accident/Injury Insurance Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder’s First Name</td>
</tr>
<tr>
<td>Insurance Company Name</td>
</tr>
<tr>
<td>Insurance Policy Number</td>
</tr>
<tr>
<td>Insurance Company Address</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At-fault Party’s Accident/Injury Insurance Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder’s First Name</td>
</tr>
<tr>
<td>Insurance Company Name</td>
</tr>
<tr>
<td>Insurance Policy Number</td>
</tr>
<tr>
<td>Insurance Company Address</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

For office use only - Patient Account Number: ________
# Implementation Plan

## Phase 1: Project Initiation

<table>
<thead>
<tr>
<th>Contract Award: Day 1</th>
<th>30 days</th>
<th>• Pam Krop</th>
<th>• Introduce key Intermedix personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalize negotiations and sign contract</td>
<td></td>
<td>• SALES</td>
<td>• Identify CLIENT stakeholders and schedule kickoff meeting</td>
</tr>
<tr>
<td>Form project team</td>
<td>2 days</td>
<td>• Client Services</td>
<td>• Define CLIENT requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CLIENT stakeholders</td>
<td>• Review scope of work</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Establish a communication schedule</td>
</tr>
<tr>
<td>Conduct kickoff meeting</td>
<td>1 day</td>
<td>• Client Services</td>
<td>• Distribute forms to identified hospital stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CLIENT stakeholders</td>
<td>• Initiate one on one outreach to individual hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formalize hospital contact form</td>
<td>3 days</td>
<td>• Hospital liaison</td>
<td>• Formalize hospital information channels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integration team</td>
<td>• Establish automated data feeds where available</td>
</tr>
<tr>
<td>Initiate hospital outreach efforts</td>
<td>1 day</td>
<td>• Hospital liaison</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integration team</td>
<td></td>
</tr>
<tr>
<td>Establish hospital communications and integrations</td>
<td>Ongoing</td>
<td>• Hospital liaison</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integration team</td>
<td></td>
</tr>
<tr>
<td>Continue integration efforts through to completion</td>
<td>Ongoing</td>
<td>• Hospital liaison</td>
<td>• Continue efforts for all identified hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integration team</td>
<td></td>
</tr>
</tbody>
</table>
## Phase 2: Planning and Design

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Roles and Responsibilities</th>
<th>Steps and Additional Details</th>
</tr>
</thead>
</table>
| Solidify project scope | 3 days | Client Services, CLIENT stakeholders | • Review current system practices  
• Refine requirements  
• Identify system exceptions  
• Document deliverables |
| Finalize work plan (including current vendor service transition activities) | 2 days | Client Services, Client Services, CLIENT stakeholders | • Identify tasks, resources, dependencies and timeframes  
• Discuss overall strategy for service transition, identify risks and formulate plans to mitigate risks |
| Establish process flow | 5 days | Client Services, Intermedix team, CLIENT stakeholders | • Document interfaces, integrations, imports and exports  
• Collect and reconcile ePCR trip reports, face sheets and signature pages |
| Complete client intake forms | 10 days | Intermedix team, CLIENT stakeholders | • Obtain setup and usage information, including protocols, closed-call rules, personnel, units, medications, procedures and levels of service |
| Design business rules | 5 days | Intermedix team, CLIENT stakeholders | • Request client determination regarding departments, authorization levels and quality assurance procedures |
| Design reports and dashboards | 10 days | Intermedix team | • Map requirements to existing reports and design new custom reports and dashboards |
| Design customizations | 10 days | Client Services, Intermedix team | • Design solutions for customized technology processes |
### Design and initiate technology integrations

**5 days**
- Intermedix team
- Third party vendors

*Design integration points by identifying sources, data and protocols and contacting vendors as needed*

### Phase 3: Setup, Testing and Acceptance

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Responsible Parties</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build client installation</td>
<td>5 days</td>
<td>Joe Belfer, Intermedix team</td>
<td>Load CLIENT data and business rules into the Intermedix billing system</td>
</tr>
<tr>
<td>Build training products</td>
<td>5 days</td>
<td>Client Services</td>
<td>Create a custom training curriculum for CLIENT</td>
</tr>
<tr>
<td>Build reports and dashboards</td>
<td>10 days</td>
<td>Client Services, Intermedix team</td>
<td>Develop new custom reports and dashboards</td>
</tr>
<tr>
<td>Conduct system test</td>
<td>1 day</td>
<td>Joe Belfer, Intermedix team</td>
<td>Confirm that the system adheres to CLIENT business rules</td>
</tr>
<tr>
<td>Complete ePCR integration</td>
<td>15 days</td>
<td>Joe Belfer, Intermedix team</td>
<td>Establish and test data import mechanisms, Configure standard intervals for data import, Determine exception handling process</td>
</tr>
<tr>
<td>Establish operational infrastructure</td>
<td>5 days</td>
<td>Client Services, Intermedix purchasing</td>
<td>Identify, procure, setup and configure all operational infrastructure (e.g. lockbox, additional hardware and software)</td>
</tr>
<tr>
<td>Establish patient contact center and client services infrastructure</td>
<td>5 days</td>
<td>Client Services, Intermedix purchasing</td>
<td>Identify, procure, setup and configure all client services infrastructure (e.g. phone lines, custom phone numbers, etc.)</td>
</tr>
<tr>
<td>Review system configuration</td>
<td>1 day</td>
<td>Client Services, CLIENT stakeholders</td>
<td>Review customized workflows and business rules and address any areas of concern</td>
</tr>
<tr>
<td>Acceptance and signoff</td>
<td>1 day</td>
<td>Client Services, CLIENT stakeholders</td>
<td>Confirm acceptance from CLIENT stakeholders</td>
</tr>
</tbody>
</table>
### A/R Conversion

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine scope</td>
<td>5 days</td>
<td>Joe Belfer, Intermedix team</td>
</tr>
<tr>
<td>Finalize data definitions and conversion specifications</td>
<td>5 days</td>
<td>Joe Belfer, Intermedix team</td>
</tr>
<tr>
<td>Acquire data</td>
<td>5 days</td>
<td>Former vendor, Intermedix team</td>
</tr>
<tr>
<td>Perform data import</td>
<td>1 day</td>
<td>Joe Belfer, Intermedix team</td>
</tr>
</tbody>
</table>

- Work with all stakeholders to identify the scope of the AR conversion and data import
- Validate and verify all data import specifications
- Receive all data within scope of the AR conversion
- Validate and verify accuracy of data as compared to specifications
- Complete data import and AR conversion, including validation of import and data integrity

### Phase 4: Training

#### Intermedix Training

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff transition</td>
<td>1 day</td>
<td>Client Services</td>
</tr>
<tr>
<td>CLIENT compliance training</td>
<td>1 week</td>
<td>Joe McCloskey</td>
</tr>
<tr>
<td>CLIENT policy and procedure review</td>
<td>1 week</td>
<td>Client Services</td>
</tr>
</tbody>
</table>

- Transition assigned staff to CLIENT account
- Train Intermedix staff on CLIENT compliance program
- Train Intermedix staff on CLIENT patient invoicing policies and procedures

#### CLIENT Training

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify CLIENT trainees</td>
<td>1 day</td>
<td>CLIENT stakeholders</td>
</tr>
<tr>
<td>Develop training plan</td>
<td>1 day</td>
<td>Client Services</td>
</tr>
<tr>
<td>Schedule training</td>
<td>2 days</td>
<td>Client Services</td>
</tr>
</tbody>
</table>

- Identify individuals who require training on the Intermedix billing system
- Develop customized training plan based on the needs of the identified trainees
- Develop a detailed schedule accommodating trainees and trainers
## Phase 5: Go Live

**Full transition to Intermedix billing with ePCR data integration: Day 30**

## Phase 6: Transition and Project Close

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Responsible</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement Adjustments</td>
<td>10 days</td>
<td>Client Services</td>
<td>Review system configuration to identify and implement any necessary improvements and adjustments.</td>
</tr>
<tr>
<td>Schedule Review Meetings</td>
<td>1 day</td>
<td>CLIENT Stakeholders</td>
<td>Transition from project checkpoint meetings to revenue cycle meetings.</td>
</tr>
<tr>
<td>Conduct Retrospective</td>
<td>1 day</td>
<td>Client Services, Intermedix Team, CLIENT Stakeholders</td>
<td>Review the implementation process and define opportunities for both continued success as well as improvement in the relationship.</td>
</tr>
<tr>
<td>Close Project</td>
<td>1 day</td>
<td>Ken Cooke</td>
<td>Transition to steady state operations.</td>
</tr>
</tbody>
</table>