COMSTAR

PROVIDING AMBULANCE BILLING & COLLECTION SERVICES SINCE 1984

CLEVELAND COUNTY, NORTH CAROLINA

REQUEST FOR PROPOSAL
EMERGENCY MEDICAL SERVICES
BILLING AND COLLECTION
BID NO. EMS001-2014

MAY 16, 2014
12:00 PM
ORIGINAL

Submitted by:
Jeff Tassi, Director of Business Development
Comstar, Inc.
8 Turcotte Memorial Drive, Rowley, MA 01969
(800) 488-4351
jtassi@comstarbilling.com

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LETTER OF TRANSMITTAL
(Section 6.0 of Cleveland County RFP)

Corporate: 8 Turcotte Memorial Drive, Rowley, MA 01969
Local: 705 Planters Row, Wilmington, NC 28405
Ph: 800-488-4351 Fx: 978-948-8480

LETTER OF TRANSMITTAL

The proposal submitted to Cleveland County, NC, for Request for Proposal, Bid No. EMS001-2014, Cleveland County Emergency Medical Services System, by

Comstar
705 Planters Row
Wilmington, NC 28405

is valid for One Thousand Ninety Five Days (1,095) calendar days from the deadline for the submission of proposals, but may be extended by mutual agreement of both parties.

We certify that that all the information contained in Comstar's proposal is accurate.

Comstar has read the Request for Proposals and fully understands its intent and contents. We certify that we have adequate insurance, financial resources, equipment, facilities and experienced staff to fulfill the specified requirements. In addition, Comstar verifies that it can meet all specifications and conditions stated within, and have attached the following documentation and evidence as specified in the RFP Specifications.

Comstar is a privately-owned corporation, whose only business is providing ambulance billing service to primarily government (city, town, county, and volunteer) ambulance services. We have been successfully been providing theses services since 1984,and as stated throughout our proposal document, have the necessary people, processes, and technology in place to successfully meet and exceed all the demands of the County's ambulance billing needs.

Comstar has legal council, representation and a billing operations office in Wilmington, NC.

Our resources are 100% dedicated to ambulance/emergency medical services billing and do not perform any other type of medical billing services, and all of our clients' work is performed on Comstar premises (by our over 60 employees) and nothing is ever outsourced, ever. Our employees currently serve over 210 government ambulance services.

Our success is based on 30 years of ambulance billing experience. As you review our proposal document, I think that you will understand that Comstar is not simply a billing company; we are a billing partner for our clients. Each of our clients have different needs, processes, and procedures, and we are able successfully work with all of them. Not only can Comstar change as your needs change, but we can also offer suggestions based on current industry standards as well as our years of experience, to identify areas of opportunity, so that you may fully maximize your ambulance revenues. We can demonstrate, with objective evidence, our success at supporting all our clients EMS data collection, billing & collection and reporting needs. We act as our clients advisor, service provider and partner, doing whatever it takes to get the job done, done well, done in a compliant manner.

On behalf of the entire Comstar team, we are excited and appreciate the opportunity to submit this qualified bid to Cleveland County, North Carolina.

Questions concerning Comstar's proposal may be submitted to either of the following individuals, although Richard L. Martin has the sole authority to negotiate and execute contracts in the name and on behalf of Comstar:

Richard L. Martin
Owner & CEO
(978) 771-6482
Rick.Martin@comstarbilling.com

Jeffrey L. Tassi
Director of Business Development
(978) 356-3344
jtassi@comstarbilling.com

Name: Richard L. Martin
Title: Owner & CEO
Company: Comstar

EXPERTISE/EXPERIENCE/QUALIFICATION STATEMENT
(Section 7.0 of Cleveland County RFP)

7.1 Provide a brief statement describing the Offeror's background, history, resources and/or track record.

Comstar was founded in Massachusetts in 1984 and is a privately-owned corporation, whose only business is providing ambulance billing service to County, town, county, and volunteer ambulance services. All of our clients' work is performed on Comstar premises and nothing is ever outsourced, ever. Our employees currently serve over 210 ambulance services.

Throughout our years in business, we have followed a strategic plan of slow steady client growth while expanding our scope of service and developing a very effective process supported by a top flight management team with well trained employees. To date, this strategy has yielded success for both Comstar and our clients. Comstar's 55 permanent full time employees provide our services across seven different states and growing. We utilize best in class hardware, software, organizational training and continuous improvement techniques to routinely meet the challenge faced by all municipalities, do more, do it better, maintain or reduce costs. Additionally, we have added trained paramedics with ambulance service management experience to our team. This allows us to be an even stronger partner to our clients.

Our flexibility and customization of approaches allows us to work with clients of all different sizes, and needs, and locations. Whether you transport 500 patients per year or 50,000, Comstar is the company for you to maximize your revenue recovery, at some of the most competitive service fees on the market. We are a full service firm, with the support of nationally know EMS and Medicare reimbursement attorneys, Werfel & Werfel, P.L.L.C. Comstar is a closely held, private, financially stable company. Our financial stability is evidenced by our 30 years of being in business Comstar's length and time in business and wide client base should act as proof of its ability to provide the services requested by the Cleveland County. In addition, our annual SOC I (Formerly SAS 70) Independent Auditors Report, which is included in this document, will detail that we have the financial stability and controls in place to successfully handle your contract.

Comstar's longevity offers evidence of permanency and reliability. Our reputation can also be evidenced by any of our over 200 clients, as well as our references which are included in this document. Comstar's length and time in business and wide client base should act as proof of its ability to provide the services requested by the Cleveland County.

Our experience not only involves the billing of medical claims, but we have a positive history of meeting with our clients whenever they see fit, reviewing their billing procedures, offering input and suggestions and creating lasting business relationships, which produce successful results. We have a history of exceeding our promises to our clients, which in turn has created loyalty

In addition, we are able to adapt to changes within the industry to always offer you the most robust package of services. Many of your requirements ask about our processes. However, as you will learn, our processes are customizable, so we may meet your exact needs. So, our processes will be tailored and customized to your County as opposed to a one size fits all approach.

Comstar provides total support for your ambulance billing and collection needs. Our experienced staff's efforts on your behalf begin with a comprehensive setup & training process. We provide you total support for the establishment and on going maintenance of your provider numbers with Medicare, Medicaid and other insurance carriers. We will train you on the billing and collection processes we use on your behalf and provide you comprehensive reporting to allow you to monitor and manage the services we are performing on your behalf. Our staff is totally accessible to you and your patients, providing prompt and courtesy service and support at all times.

As you will read in the following pages, Comstar has the necessary experience, expertise, professionalism and resources to successfully meet and exceed all the expectations of the Cleveland County as they relate to Ambulance Transport Billing and Collections.

7.2 Provide an organizational chart of proposed team or staff for this project.

Comstar has the proper people, operational controls and experience in place to meet and exceed all of the demands of this RFP and of Cleveland County EMS.

Our experience and expertise is solely dedicated to billing and collections for town, city, county and volunteer ambulance services. And, as you will read in our business plan, Comstar works in a work cell environment to ensure that your account receives full coverage at all times.

Please see Comstar's Organizational Chart on the next page to see the experienced teams in place to mange your account.

BUSINESS PLAN
(Section 8.0 of Cleveland County RFP)

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

The previous section discussed Comstar's Key Employees who are responsible for the overall success and management of your account. But, on a day-to day basis, Comstar operates out of a work-cell structure environment, where many different people have responsibility for your account as opposed to just one. Each client is assigned a main account manager known as a lead Account Specialist. Your Account Specialist will oversee, or be the "quarterback" working your account. Your Account Specialist is part of a small team with a Team Leader, with team leader and team members provide extended client and patient support while providing an internal structure that allows for maximum process control, quality control and communication.

This format allows many employees to be working on your account at once, as opposed for a small handful of people being responsible for your account from start to finish. As previously mentioned, you are assigned a primary Account Specialist; we have a series of teams to assist in efficiently managing your account. These work cells consist of the following departments:

1. **Pre Billing**
2. **Run Entry and Coding**
3. **Payment Application**
4. **Insurance Follow-up/Denial Processing**
5. **Account Specialists**
6. **Provider Relations**
7. **Client Accounting**
8. **Information technology**

Each Team and all Comstar employees are managed and performance measured based on the timeliness, accuracy and efficiency achieved in the execution of the billing and collection process steps authorized by the client.

Comstar's work-cell structure has been efficient and successful for its entire client base, and would allow for efficiency and maximum productivity for Cleveland County as well. Plus, with the assigned Account Specialist, the County will always have one main contact to verse the account and develop a relationship with.

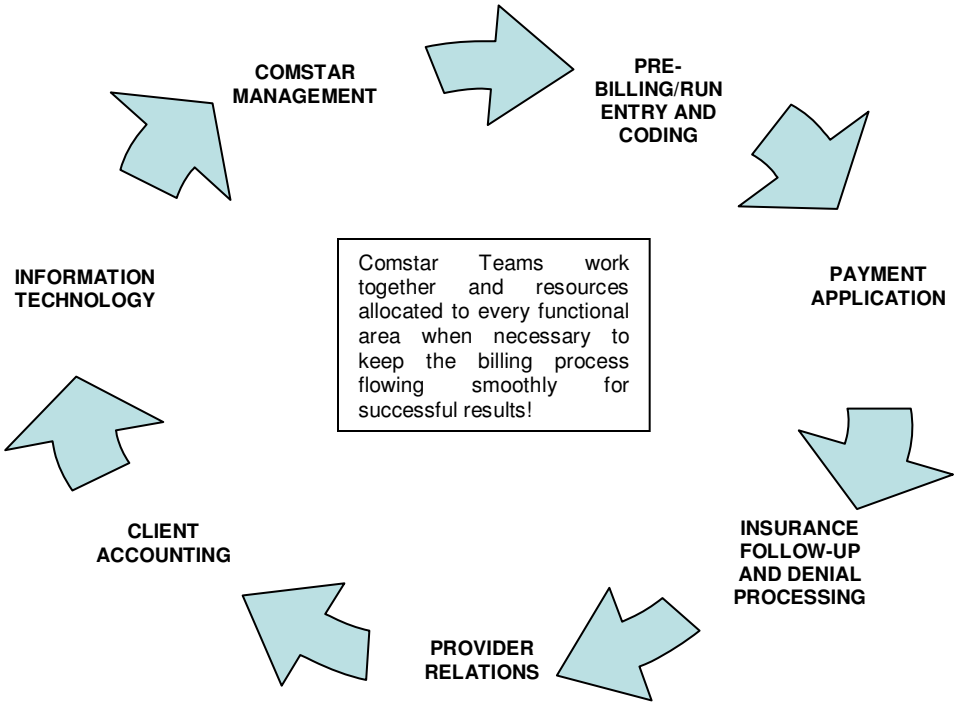
Because there are many hands working on your account through these work cells, it is an easy transition to make internal adjustments if a staff member terminates employment, and allows for full coverage and seamless transition during times of FMLA, utilization of earned vacation time, injury, illness, etc.

8.2 Describe your firm's Project Management capabilities.

Comstar has extensive Project Management capabilities and experience. In managing our business, Comstar manages a critical chain management approach to project management, which allows us the flexibility to move and allocate resources internally and quickly switch between tasks and task chains to keep the project on schedule.

As stated in the previous response, Comstar has a work-cell environment, and every client is assigned a lead Account Specialist. We process about 250,000 ambulance claims every year, but we don't control the frequency of when those PCR's are ready to come to Comstar. Therefore, our employees are all cross trained in multiple functional areas of the business. We have the ability, capability and experience to move employees around when necessary, to keep the business flowing smoothly.

We have resources and times assigned to each task (run entry and coding, pre-billing, payment application, etc.) Some tasks are going to take more or less time than allocated for a variety of reasons, including workflow, employee vacation, etc. Each Team Leader will recognize when their particular tasks will take more or less time, and Comstar's General Manager (Project Manager) will allocate employees accordingly, so that each functional team will be able to meet its goals. The process of Ambulance Billing is ongoing, and Comstar has the people and controls in place to mange this efficiently for Cleveland County as well as all of our clients.



8.3 Describe your firm's Customer Service process and provide samples of firm's communications and statements.

Our employees are the main resource which makes Comstar tick. Many of our employees have multiple years of experience with Comstar. Comstar takes much pride in investing in its employees, because great employees are the most important element in a successful business. Our employees are carefully recruited, screened, and properly trained. We value our employees and go through great lengths to offer comprehensive in-house training. Our employees are not only trained at the beginning of their employment, but it is an ongoing process to keep educated and up to date on changes going on within the industry.

Topics of in-house training include, but are not limited too: proper run entry and coding, electronic claim filing, HIPAA compliance, Medicare regulations, sexual harassment, etc.

Customer Service is not only a top priority at Comstar, it is a core value in which the Company operates and all employees strive for on a daily basis. Part of Comstar's long term strategic plan is to sustain a continuous and healthy growth rate while maintaining and improving the quality of service provided to our existing customer base.

A key element to our success in achieving this objective is Comstar's in-house education, training and quality assurance program. This program, which is ongoing, supports and sustains current staff members, and allows us the ability to hire and develop new staff in an efficient and timely manner. Employees are not only trained in different aspects of compliance and billing, but it also enables them professional development and growth within the organization.

Comstar is a participant in the National Academy of Ambulance Coders (NAAC). Through this program, Comstar employees take online classes to become Certified Ambulance Coders. This is an important aspect to pour internal training program. Each employee who takes the National Academy of Ambulance Coders class will receive training, and become better educated in the aspects of ambulance billing. It is a specific class geared specifically toward ambulance billing since medical billing itself covers a wide range and is not geared toward any specialty. All new employees are receive training through NAAC to receive their Certified Ambulance Coding Certificate as part of Comstar initial training as well.

Obviously, phone skills and etiquette are important parts of our training program as well, as A very important aspect of Comstar' administrative procedures are the handling of phone calls. Comstar has state of the art telephone call center hardware and software. The phones are staffed with our billing specialists. We do not use automated attendants or rely on voice mail, as a primary method to answer phone.

When calling Comstar during business hours (8am to 9pm M-F), our clients and their patients will always be greeted by not just a live voice but a billing specialist trained to assist the client or patient directly or route the call to someone who can. Calls may be monitored and recorded for quality control purposes. Our extended hours allow patients to call and have concerns addressed outside of "normal business hours." All patient inquires will be responded to within 24 hours.

Comstar has the necessary people and processes to give full coverage to your account on a daily basis.

Please see APPENDIX 2 for samples of Patient correspondence Letters and Statements (which may be customized by the County).

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

On the software side, Comstar utilizes a state of the art, robust and feature rich billing system developed and supported by a nationally recognized industry leader in EMS data processing systems, ZOLL Data Systems. Their software, RescueNet Billing and Dispatch, operates on a Microsoft SQL database in tandem with the powerful Crystal Report Writer. Together, these tools allow Comstar's in-house IT department to support all client needs for customization of forms, reports and billing process steps.

The RescueNet Billing system is compatible and can successfully integrate with any NEMSIS compliant electronic patient care reporting platform, including emsCharts, as the County is currently utilizing. This is evidenced by the fact that we are receiving electronic patient care data from over 85% of our municipal EMS clients, including many clients utilizing emsCharts for electronic patient care reporting.

Specifically, we are using RescueNet Billing version 4.4 Service Pack 5. However, we will soon be in the process of upgrading to RescueNet Billing version 4.5.

When our software needs to be updated, or required programming changes are made, that work is always done on the weekend and outside of normal business hours, so testing can be performed, and no client work is interrupted. We have used this software for over 10 years, and have to update almost annually, and have done so smoothly and seamlessly each time.

Please see APPENDIX 3 for a ZOLL RescueNet Brochure, describing our billing software in more detail.

8.5 Provide a detailed plan of your firm's proposed approach.

Comstar's overall plan is to maximize revenues for the Cleveland County. The overall project strategy discussed here will be a basic overall plan of action, which notes how we will meet and exceed your EMS medical billing needs, and can be changed and customized based on your desires. Some of this information is repetitive in other parts of our proposal but it addresses all of your scope of services in a paragraph format.

As far as a time frame is concerned, EMS Billing and Collections is a circular, ongoing process. The timeframes discussed will be set-up timeframes, but the process itself is ongoing throughout the life on the contract.

Upon contract award, a start date will have to be established. Per your RFP that date would be July 1, 2014, to which Comstar understands and agrees to.

As soon as possible after contract award, it is advised to have an initial set-up meeting. A solid understanding of the ambulance billing process by Cleveland County officials is a key element to a smooth implementation and transition. Prior to this meeting Comstar will forward the County a list of documents and items required by Medicare, needed for new account set-up.

At this meeting we still discuss with you some of the different options available to meet your billing and collection needs. We will gather information from you in order to process your provider enrollment paperwork with Medicare, Medicaid, and Blue Cross. Also we will discuss your specification on how invoices should look, and what special language they should contain. In addition, we will set a calendar for any and all future training sessions (which may be updated at any time) required by the Cleveland County .

With a change from internal billing to have a billing agent perform these services the County must notify Medicare, Medicaid, Blue Cross, etc. However, Comstar has a Provider Relations Team ready to prepare all the complicated paperwork involved in notifying these providers. Shortly after the initial set-up meeting, Comstar will then prepare all of the necessary provider change documents for Medicare, Medicaid, and Blue Cross. After completing the applications, Comstar will forward to the County for proper signature, and walk you through the forms if necessary. Upon receipt with signatures, Comstar will forward to the proper agencies for processing.

Comstar will assist you, by tracking paperwork and applications filed with Medicare and other agencies on behalf of the County, so you may have an idea of where things are in the process. However, we are unable to speed up Medicare's and other insurance payers internal processes.

We strive to allow our client to get as knowledgeable as possible of the various aspects of ambulance billing so that our client will have a thorough understanding of scope of our services and opportunities and options available to them when outsourcing their ambulance billing and collection requirements.

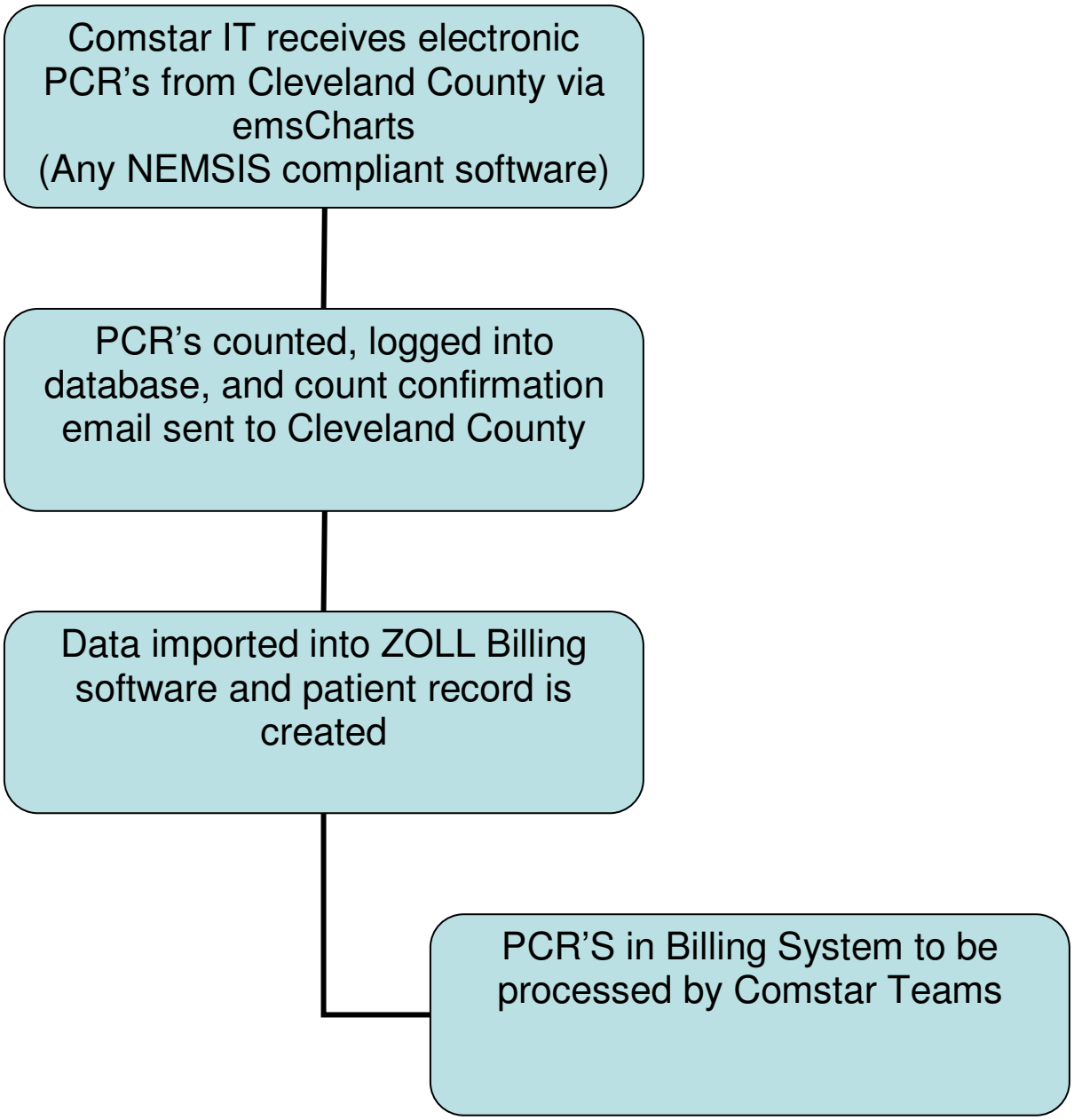
Once the start date arrives, the Cleveland County will simply start transmitting ePCR's to Comstar via emsCharts, via your schedules. Comstar is a business partner of emsCharts, and is very familiar with the electronic export of records via emsCharts, as we have many current clients utilizing the product.

As with most of our clients who are utilizing and emsCharts product, Comstar will (on a decided timeframe), obtain your ePCR's directly from emsCharts, once your administrators take a few steps to let us know that the PCR has gone through internal QA/QC and is ready to be billed. When your trips are at your decided minimum QA level, we will know they are ready for billing and import into our system. Comstar will completely explain these steps to you and walk you through the process during account set-up as well.

Then, on a daily basis (or 2-3 times a week) basis, an authorized Comstar employee will log into the emsCharts product to download PCR data. Data is extracted that matches specific criteria for billing and imported into Comstar's billing system to be worked prior to billing. After each download, a confirmation notification email will be sent to your specified contact(s) with the quantity and dates of service.

As stated, Comstar is a billing partner of emsCharts, so there is not much different Cleveland County crew members would have to do in creating trips in emsCharts than they are doing now, in order for Comstar to handle your billing needs.

Please review the following flowchart detailing the ePCR process:


Comstar IT receives electronic PCR's from Cleveland County via emsCharts
(Any NEMSIS compliant software)
PCR's counted, logged into database, and count confirmation email sent to Cleveland County
Data imported into ZOLL Billing software and patient record is created
PCR'S in Billing System to be processed by Comstar Teams

As described in 8.4 of this section, Comstar operates in a work-cell structure. This format allows many employees to be working on your account at once, as opposed for a small handful of people being responsible for your account from start to finish. This assures that all of accounts are monitored to assure maximum productivity. Included are a series of checks and balances to make sure that everything is being done correctly, and any mistakes that are made are caught before they go out the door. In addition, our full time Quality Control supervisor continually monitors all aspects of our data entry and claims submissions.

Because there are many hands working on your account through these work cells, it is an easy transition to make internal adjustments if a staff member terminates employment. If your Account Specialist terminates employment, another member of that team would take over the account as lead MBS. The County would be notified via phone, as well as in introduction meeting would be scheduled if desired. Although most of our Account Specialists have a long length of tenure, The County would face no service interruption for any internal staff changes.

All of the transports received by the Cleveland County will be done electronically, and entered into our system, where they are checked by our run entry and coding team to make sure that all necessary information was transmitted, enter any insurance information that was received from the admitting hospital, and review the report for completeness. Your crew members do not currently obtain any insurance information, and Comstar has always worked diligently to obtain patient insurance information through the following Pre-billing Steps and Procedures:

- **Patient insurance and demographic information retrieved from area hospitals – Comstar will work with you to establish relationships at area hospitals**

- **Insurance verification and eligibility checks through various web programs and searches**

- **Address verification of every patient address via the USPS and other applicable tools and databases**

Comstar has many resources available in order to obtain patient insurance information. Comstar will perform many web-based insurance searches (Medicare, Medicaid, Zirmed, etc), to find a patient's specific coverage.

As far as managing your account on a daily basis, Comstar has internal schedules (both manual and automated within our billing software) that log and track the receipt of transport information from clients, payments from patients or their insurance carriers and processing of other information received that is pertinent to a patient transport.

These schedules have specific time frames for processing based on the receipt date of the information to ensure that all items are processed in a timely manner.

Comstar files claims to the appropriate parties, whether it be insurance companies or individual patients. We will submit claims to all insurance companies as well, whether it be health, auto, workmen's' compensation, etc. Additionally, claims are filed electronically, which decreases payment time and eliminates all keying errors, and subsequent rejections, on the part of the insurance carrier.

However, in dealing with insurance companies, claims may not always be paid and may be denied. Comstar always follows-up on all denied claims. Comstar employs a specific work cell (Insurance Follow-up Team) staffed with billing specialists trained in the resolution of denied claims. The first step is to code the claim with a denial reason. The information is then used for internal QA purposes and statistical analysis to detect denial trends.

As part of the setup of your accounts, Comstar will program its billing software with the billing rates for Cleveland County, and the allowed payments for the insurance carriers (Medicare, Medicaid and any others) with whom you have a contractual relationship. When a transport is entered into the system, the charges for each billable item are assigned.

Each charge represents an accounting transaction. If the transport is assigned a payer (such as Medicare) with whom you have a contractual relationship, our billing software will automatically generate and post a "contractual allowance" transaction. New charges and any corresponding contractual allowances are reported (in summary and detail) separately.

Our processing steps and forms are customizable to ensure proper administration of your billing policies, including the County's current policy of submitting unpaid bills for reimbursement under the NC Debt Setoff program, and/or forwarding to the County's Collection Agency

A very important aspect of Comstar' administrative procedures are the handling of phone calls:

- **State of the art telephone call center hardware and software**
- **Phones are staffed by billing specialists from 8:00 AM through 9:00 PM**
- **Callers are always greeted by live, trained billing specialist**
- **No use of automated attendants or outsourced call centers**

Also, Comstar has a tiered process in which to handle patient questions:

●Comstar Team members successfully handle patient concerns during initial call 93% of time

●Escalation to a manager for difficult questions 7% of time

●All complaints are reported to President and GM for tracking and follow-up as necessary

●Note: Complaints about EMS services provided are immediately forwarded to our client contact

Clients and their patients can communicate with Comstar in several different ways. Return envelopes are included in all correspondence sent to patients. Comstar includes its toll free phone number (800-488-4351) and website address (www.comstarbilling.com) on all correspondence. Our website has a page which allows patients to input and send insurance information and/or questions to Comstar via the internet.

Payments received by Comstar are always in the Cleveland County's name, as we have no negotiating rights to your funds. We direct payers to make payments to the "Cleveland County." We have the ability to work with you and your bank and lockbox services, so that all payments are submitted to you, with Comstar having access to the online lockbox payments and remittances for proper processing.

Patients will also have the ability to pay their bills or co-pays with a credit card via Comstar's secure website. Payments via credit card are posted to a trust account and then dispersed to you. There is no additional fee to the patient or the County to pay via credit card. In addition credit card payments can only be made via the web, so Comstar employees are not taking sensitive financial information. Additionally, there are no additional fees for either the patient or the County for credit card usage, as that is a standard part of our service offerings.

Comstar's policy is to immediately notify our clients of any overpayment where a refund needs to be issued. The notification will include the patient's name, patient's address, date of service, incident number, insurance provider, amount to be refunded, name and address of individual/company receiving a refund, and reason overpayment occurred, as well as the supporting documentation and evidence of the overpayment.

The Cleveland County will also be notified of any retractions. Often, large payers such as Medicare, Blue Cross, etc., will make an overpayment. When Comstar realizes this overpayment, the payer is notified to make a retraction on their next payment. Comstar's reporting package will notify the Cleveland County of all retractions that took place, and that all patient accounts are properly credited.

On a monthly basis, Comstar will provide the Cleveland County with a full accounting reconciliation of account activity. Our reporting structure is based on our internal controls and record keeping that is consistent within Generally Accepted Accounting Principles. Section 5 of this proposal on page 25 discusses our reporting capabilities in more detail.

Comstar is more than just a billing company; we are a billing partner for our clients. Part of that partnership involves consulting and the sharing of knowledge with you, so that you may make the bets decisions for your service.

We offer many consulting and training services to our clients as part of our robust, inclusive service offerings.

We are able and willing to meet with you at regular interviews to discuss the health of your account, as well as offer input and suggestions. Additionally, we can provide a written progress report as well, detailing the overall status of your account, as well as identifying any deficiencies as well as solutions.

We are working diligently to stay on top of and inform our clients of any and all changes that may affect them due to the Affordable Care Act. Being a Massachusetts company, we are very familiar with some of the aspects of the ACA, since MA instituted a similar healthcare law in 2006.

Comstar had the right technology infrastructure to properly meet all the demands of your RFP, and operates a Tier III data center, and has data recovery and contingent operations plans in place in the event of a disaster.

Comstar maintains all records for at least (7) years according to HIPAA regulations and an agreed upon retention plan.

So, Comstar has the policies and procedures in place to successfully perform the emergency medical services billing and collection functions for your community. In addition, we have the flexibility and customizations to meet all current and future changing needs of the Cleveland County.

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

As you will read through our bid document, Comstar is not simply a billing company; we are a billing partner for our clients. We offer many consulting and training services to our clients as part of our robust, inclusive service offerings.

We are able and willing to meet with you at regular interviews to discuss the health of your account, as well as offer input and suggestions. Additionally, we can provide a written progress report as well, detailing the overall status of your account, as well as identifying any deficiencies as well as solutions.

Specifically for crew members, Comstar offers a run-report writing class. The purpose of this class is to help our clients keep their crew up to date on all certifications and Continuing Education, as well as be kept aware of Medicare/Medicaid regulations when it comes to drafting the PCR, created with the help of the EMS specific law firms of Page, Wolfberg & Wirth, and Werfel & Werfel, P.L.L.C. Although the course does touch so much on the clinical side of your PCR's, it is more based upon the legal, compliance, and reimbursement side, so we may help you fully maximize your ambulance billing revenues. Additionally, this training could be offered multiple times for your multiple services and crews.

Additionally, Comstar will provide with access to billing and collection data via a VPN and our RescueNet Reporting. This access would require a specific log-in by Cleveland County personnel, to only have access to your data. Through log-in, Cleveland County would be able to track trip information, payment data, etc. Comstar would provide any and all necessary training on how to utilize and access this system. It would be the responsibility of Cleveland County to decide which of your employees would have access to this data.

We are able and willing to meet with you at regular interviews to discuss the health of your account, as well as offer input and suggestions. Additionally, we can provide a written progress report as well, detailing the overall status of your account, as well as identifying any deficiencies as well as solutions.

We are working diligently to stay on top of and inform our clients of any and all changes that may affect them due to the Affordable Care Act. Being a Massachusetts company, we are very familiar with some of the aspects of the ACA, since MA instituted a similar healthcare law in 2006.

Training and Consulting is an integral part of building a solid relationship with all of our clients, and we will provide any and all necessary training necessary to Cleveland County, as it relates to ambulance billing and collections. This is an inclusive part of our service offering and there would be no additional cost to the County.

8.7 Identify potential risks associated with the execution of this contract and how your firm proposes mitigating those risks.

Having performed Ambulance Billing Services for 30 years, and constantly transitioning new clients to Comstar, we do not foresee potential risks with the execution of a contract. However, in order to mitigate any unforeseen risks, Comstar has a proven Implementation and Transition Plan as will be discussed under point 8.9 of this section. Our Transition Plan along with open and constant communication has been our method to have all aspects of contract execution flow smoothly.

Additionally, Comstar has on retainer, the EMS law form of Werfel & Werfel, P.L.L.C., to assist us in aspects of our operation including Medicare compliance and risk management.

8.8 Describe the Firm's Disaster Recovery Plan.

Comstar operates a Tier III data center, and has data recovery and contingent operations plans in place in the event of a disaster. Our well-trained, in-house, IT staff administers a state-of-the-art Information Technology Systems. Key components of our infrastructure include: HP Blade servers utilizing VMware technology for optimum server utilization and redundancy, Citrix Presentation Server, EMC's CLARiiON CX3 Networked Storage System for data storage and redundancy and a comprehensive local and off-site, secure back-up of all computer data.

Comstar maintains a four-tiered back-up strategy. Nightly, all server data is backed up to a NAS device which then writes the data to an ADIC FastStor tape back-up device. From there, data is securely transmitted to a locked-down computer facility. Bi-weekly, the back-up tapes are removed off-site for secured storage. All of our staff and equipment also have the support and oversight of our outside IT consultant, Focus Technologies. Focus provides Comstar comprehensive managed IT services that monitor our computer systems for performance and predictive failures. Their efforts ensure 100% uptime for our IT infrastructure, which is a critical element to the timeliness, quality and consistency of the service Comstar provides to its clients.

Comstar's IT infrastructure is all based upon up-to-date Hewlett-Packard Servers running across a TCP/IP network utilizing Extreme gigabit switches. All server and networked hardware are secured in a room that is temperature controlled for optimum performance. An APC Symmetra provides a consistent and steady power to the systems. Additionally, we are fully equipped with a back-up generator for Comstar to be operational in the event of power failure. Access to the server room is restricted. Access to the servers' operating systems and data is restricted through Windows 2003 Server user control.

Please see APPENDIX 4 for Comstar's Back-Up Disaster Recovery Plan.

8.9 Describe your recommended Transition Plan with respect to the Scope of Services.

Comstar understands that moving your billing operations to new vendor can be challenging, and there can be many questions and uncertainties. The best way to ensure a smooth transition is twofold. First is a detailed plan of action with complete understanding of both sides. By having a plan, we will both know what to expect along the way and when it's to be expected. Sometimes the plan can be amended and edited during the process, but an implementation plan is the backbone to a successful relationship.

The second part of overcoming challenges is open communication. Comstar prides itself on open and clear communication with all of its clients from the day a contract is awarded throughout the entire life of the contract. By keeping our clients aware of any and all issues as they arise, we can let them know how they are overcome, and offer less surprises to you. Also, as you will read throughout our document, issues often arise when dealing with Medicare, Medicaid, etc. Our goal is to constantly keep you informed of what is going on, and how we are monitoring each and every situation. So, Comstar has the proper policies in place to not only lessen the chance of difficulties but to overcome them as well.

Please see APPENDIX 5 for a detailed Implementation and Transition Plan of Action.

8.10 Describe any legal protests your firm has lodged pursuant to the notification of award with respect to an EMS Billing and Collections contract. Detail the Project (name of County) the date of the legal challenge, reason for the protest and final outcome of the challenge.

None.

BILLING PROCESS
(Section 9.0 of Cleveland County RFP)

9.1 Document your firm's billing process for each of the various payer groups.

Comstar files claims to the appropriate parties, whether it be insurance companies or individual patients. We will submit claims to all insurance companies as well: health, auto, workmen's' compensation, etc.

All claims are filed electronically, which decreases payment time and eliminates all keying errors, and subsequent rejections, on the part of the insurance carrier.

As far as electronic filing is concerned, Medicare approves Comstar for electronic claim submission in the National Standard format. We submit claims directly to Medicare, Blue Cross, and certain Medicaid plans. For all other commercial (healthcare) payers, Comstar manages electronic claims submission through Zirmed, www.zirmed.com .

Here is an overview of Zirmed's service:

- **Claims Tracking to eliminate lost claims; you'll receive a report that indicates when your claims are received, delivered and accepted by payers**
- **Rejection Analysis to categorize rejected claims by reason — in plain English — and to let you research, edit and resubmit claims quickly**
- **Real-Time Submission to immediately return claims that the system is unable to validate during initial edits**
- **An Extensive System of Edits to ensure clean claims are delivered to payers the first time**

Although Comstar will submit claims electronically in all cases when allowed by the carrier, there are some instances, where claims need to be filed on paper, such as certain auto and workmen's compensation claims. When a patient is found to be uninsured or underinsured will be billed directly.

This is the general process we use for submitting claims to various payer groups; however, it may vary slightly depending on the specific payer.

9.2 Describe your firm's process for limiting denied claims.

Comstar's policy is to follow-up on all denied claims, to find out why the denial occurred, or why an insurance company has not paid within a timely manner. Comstar employs a specific work cell (Insurance Follow-Up Team) staffed with billing specialists trained in the resolution of denied claims. The first step is to code the claim with a denial reason. The information is then used for internal QA purposes and statistical analysis to detect denial trends. We use these statistics to identify opportunities for internal improvement and to support appeals or address issues that may be the results of errors by the insurance carrier who initially denied the claim. Each major carrier (Medicare, Medicaid, and Blue Cross) has a team assigned to it which follows up on any denials, underpayments or unpaid claims. All claims are electronically submitted to these major carriers. For hundreds of other insurance carriers, Comstar submits claims electronically and manages their progress to payment via the use of Zirmed, a national medical claims clearinghouse. The use of electronic claims ensures rapid transmission, receipt of confirmation and efficient claims management.

Additionally, Comstar's denial rate with Medicare is less than 3%.

9.3 Describe in detail the process your firm uses to obtain demographic and insurance information for patients, when such information is missing or incomplete.

In order to submit to insurance companies, Comstar must first obtain the proper insurance. Our Pre-Billing Team first scrubs all claims for insurance information, before any claims are submitted. We have many resources available in order to obtain patient insurance information.

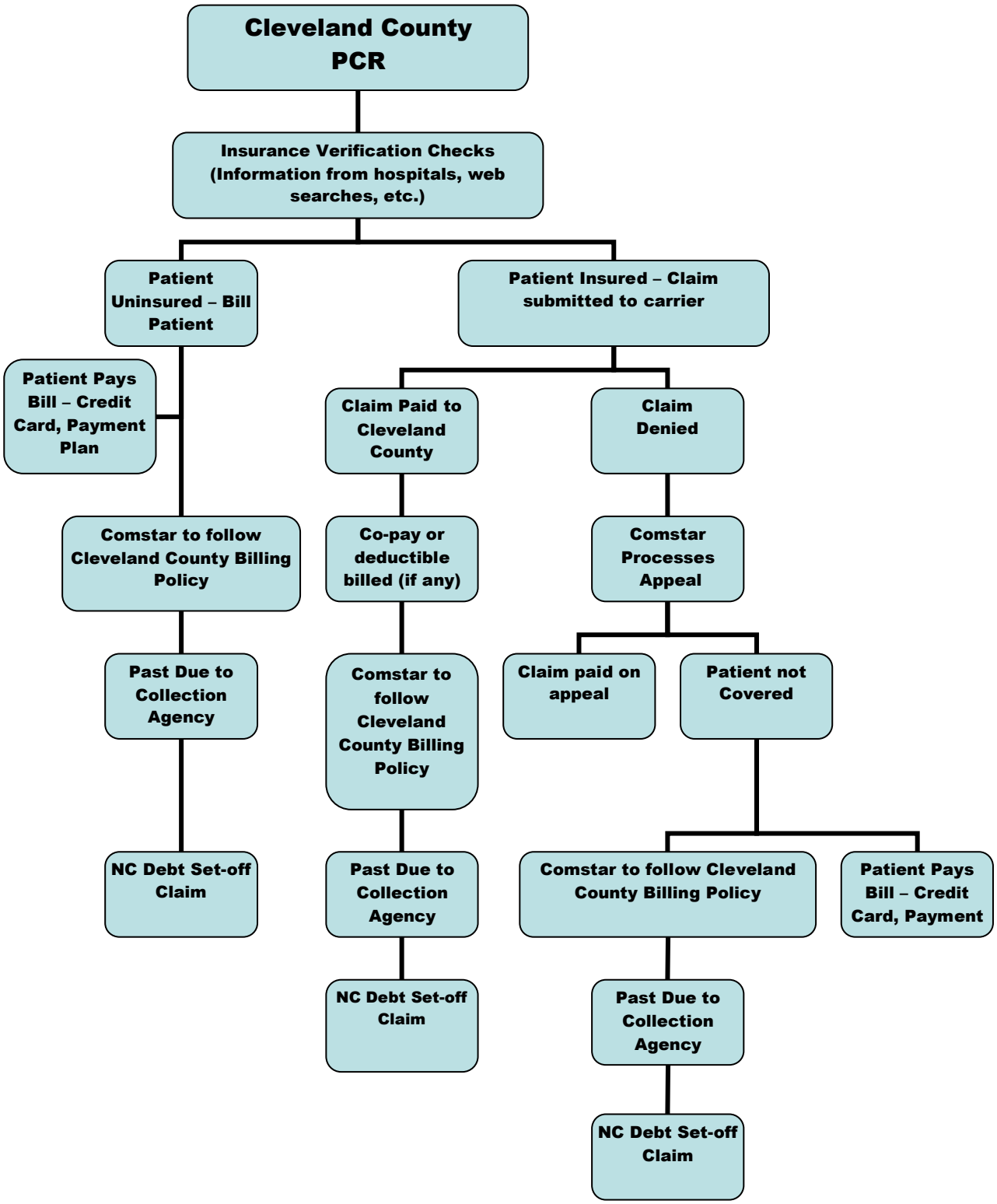
Comstar will perform many web-based insurance searches (Medicare, Medicaid, Blue Cross, etc), to find a patient's specific coverage, and eligibility. By querying the primary payers directly, it greatly speeds up the process by providing up to date accurate information.

Additionally, we will work with you and your admitting hospitals to set up an interface to electronically receive patient demographic and insurance information. It is understood that the hospital sheets are attached to your emsCharts, but we will work with the hospitals to obtain the proper information when the hospital sheets supplied are inaccurate or incomplete.

By obtaining the correct insurance information, the first time, that enhances the quick reimbursement process for our clients.

The following flowchart details Comstar's overall billing process which can be customized by Cleveland County:

BILLING PROCESS FLOWCHART



REPORTING
(Section 10.0 of Cleveland County RFP)

10.1 Provide in detail your reporting capability.

On a monthly basis, Comstar provides each of our clients with a full accounting reconciliation of account activity. Our reporting structure is based on our internal controls and record keeping that is consistent within Generally Accepted Accounting Principles.

Comstar has robust account reconciliation report package, as well an in-depth virtually limitless report writing capability. In addition to the forms and reports called for in this RFP, Comstar has the capability to provide custom forms and reports upon client request. Comstar uses an SQL database and Crystal Report Writer. This allows us to develop infinite variations of forms and custom reports linking any data we enter into our system on our clients' behalf. If the forms or reports shown herein do not meet your exact needs, with specific feedback from you, we can modify the forms to meet your exact need. We can create ad-hoc or as needed reports typically within a few hours of your request. Our IT team tirelessly works to meet the unique reporting needs of all our clients.

If you desire, we can produce other statistics on a variety of parameters including number of patients transported, use of Oxygen, ALS, medical vs. trauma, etc. In addition we can, if requested, enter runs where patients were not transported. By entering this information we can include in your statistics how many patients refused service, etc.

Many clients also call us for statistics not needed routinely. These might include "How many patients in motor vehicle accidents last year required ALS services?" We can usually have these statistics within a few hours.

Our Crystal Report writing program has practically limitless report writing capabilities. We can turn any information you give us on a PCR into a report for the Town.

Reporting is typically an ongoing changing process. We understand that your reporting needs may change from time to time based on your various needs. If a new report is required, simply notify your Comstar Representative, and we would be happy to create that new report for you either as a one-time report, or as a standard weekly or monthly report. Our reporting is very flexible to meet your changing needs.

10.2 Provide sample reports.

Please see APPENDIX 6 for a Sample Monthly Report Reconciliation Report Package. (All HIPAA related information is intentionally redacted IN ALL REPORTS). Additionally, please note that these are simply samples, and reports can be customized and tailored to your exact needs.

HIPAA COMPLIANCE PROGRAM
(Section 13.0 of Cleveland County RFP)

13.1 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 within the proposal. In addition, Red Flag plans should be included in your proposal.

Comstar has a comprehensive HIPAA compliance program in place.

Prior to the April 14, 2004 deadline, All employees received HIPAA compliance training which included instruction by our Training and Education Director, viewing of a HIPAA compliance video prepared by the EMS law firm of Page, Wolfberg and Wirth and a written test. Thereafter, new hires receive the same training as part of the orientation to the company. Employees will be required to attend a HIPAA "refresher" session annually. Topical issues and examples have been directed to be part of the weekly team meeting for all Comstar team members.

Comstar operates a secure facility. Entrance is attained by card key access for employees and with employee escort for visitors. Confidential client information and patients protected health information are stored in our secure facility for the duration of the required record retention period. When the record retention period expires, these records are shredded. Other arrangements, such as returning the records to the client, can be made upon request.

Comstar will provide your service a signed Business Associate Agreement (HIPAA required) for your use or use an agreement developed by your service. Comstar maintains active relationships with an EMS law firm (Page, Wolfberg & Wirth) and the American Ambulance Association, to provide our clients a ready resource for HIPAA guidance and information.

Comstar understands that your patients' PHI is very important and simply does not distribute medical records. Very often we will get requests from Attorneys and others requesting run reports. As previously stated, Comstar will not distribute that information; we will direct the requests to a designated County Official for distribution. The medical records belong to the County, and Comstar uses them for billing purposes only. At times patients will request run reports as well, in which Comstar has the same policy of directing them to the County.

When copies of bills are requested by a patient, they are given to the patient, free of charge, upon confirmation of who the patient is. If an Attorney is to request the bill, Comstar has policies in place to make sure the attorney is actually representing the patient, before we will distribute that information. This is typically done through a Certified Bill Request process where a signed patient release must be received before any information is given to an attorney, or other third party.

As stated throughout this document, Comstar utilizes the Zoll Data Systems RescueNet Billing Software, which is a HIPAA compliant billing system. In fact, the developer has delivered excellent support with system updates in response to Medicare's publication of its "Final Rule" for the new national fee schedule and HIPAA compliance.

In addition, Comstar utilizes several methods to prevent unauthorized access of patient information. All outgoing and incoming email and internet access is restricted to authorized, HIPAA trained individuals. Any data transfers are done with one more of the following protocols: secure FTP, VPN, peer-to-peer, encrypted data files or recognized websites utilizing HTTPS connectivity. Access to our internal network is severely limited and allowed only via VPN and secured with a Cisco ASA 5505.

Comstar offers NPP (Notice of Privacy Practices) Mailing Service, as part of our service offerings, which has been designed to satisfy your services HIPAA obligation to provide a copy of your Notice of Privacy Practices to each patient transported. This notice need only be sent once no matter how many transports a patient receives.

Comstar has incorporated this mailing function into its Ambulance Billing and Accounts Receivable Software System. After a trip report is entered into our system on your behalf, the system will automatically generate a NPP Letter that will be promptly mailed to the patient. The system logs the 1st event of the mailing and uses this stored data to ensure that only one mailing goes to each patient transported, even if that patient is transported again. Letters will be printed weekly for all patient trips entered during that week. Clients will be provided a monthly transaction report listing the patients/runs for which a mailing was done. Patients who have been transported by your service and mailed a letter by Comstar in a prior period will not receive another letter nor appear on future monthly transaction reports. A history report will be provided upon request to support any audit or verification requirements.

Please see APPENDIX 7 for a copy of Comstar's Compliance Plan.
Please see APPENDIX 8 for Comstar's "Red Flag" policies.

CERTIFICATE OF INSURANCE
(Section 14.0 of Cleveland County RFP)

14.1 Provide a Certificate of Insurance based on requirements as specified in 31.0.

Comstar has the necessary insurance requirements as specified in 31.0

The following page is Comstar's Certificate of Insurance detailing the coverage we have in place. Upon being selected as the winning bidder, Comstar would add Cleveland County to our updated policy as an additional insured.

It is also important to note that Comstar does carry Third-Party Employee Dishonesty Coverage in the amount of $500,000. The Third Party Coverage protects our clients from loss in the case of Comstar employee dishonesty. If a company does not carry this coverage, then only the company is covered against loss, and not the company's clients. We want our clients to know that they are protected in the event of loss (even though none of our clients have suffered loss to due Comstar's employees in over 30 years of business).

Comstar certifies, that it can and has the ability to meet all of the County's insurance requirements.

COMSINC-01 LIN

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 11/18/2013

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Lin Schwarz	
Elliot Whittier Insurance Services, LLC 75 Sylvan Street Suite B202 Danvers, MA 01923	PHONE (A/C, No, Ext): (978) 977-4884	FAX (A/C, No): (978) 977-0850
	E-MAIL ADDRESS: lschwarz@elliotwhittier.com	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Comstar, Inc. c/o Richard Martin 7 Wildwood Road Danvers, MA 01923	INSURER A : Peerless Insurance Co	24198
	INSURER B : Excelsior Insurance Co	11045
	INSURER C : Executive Risk Indemnity/Chubb	
	INSURER D : United States Liability Co.	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR X Employee Benefits X Liability $1,000,000 GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			BOP8819556	11/22/2013	11/22/2014	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 300,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
B	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS X SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			BA8811857	11/22/2013	11/22/2014	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			CU8813657	11/22/2013	11/22/2014	EACH OCCURRENCE AGGREGATE	$ 2,000,000 $ 2,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WC5002524	11/22/2013	11/22/2014	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
C	Errors & Omissions			8171-3437-13	5/1/2013	5/1/2014	Each Claim/Agg	2,000,000
D	EPLI thru USLI			EPL2007407D	11/19/2012	11/19/2015	Each Claim/Agg	500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

D. Third Party Employee Dishonesty coverage of $500,000 provided by The Hartford effective July 21, 2013 to July 21, 2014 Policy Number 08BDDGH2966

Operations: Medical Billing

CERTIFICATE HOLDER

EVIDENCE OF COVERAGE

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

PRICING PROPOSAL
(Section 15.0 of Cleveland County RFP)

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

Comstar has proposed a percentage based fee structure for all billing and collection services requested in the County's RFP. Please see Comstar's detailed pricing structure on the following pages.

15.2 Respondent must also detail in 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.

Comstar understands that its pricing structure includes and alternative ePCR system and/or partial hardware refresh. Therefore, our pricing includes the annual cost of "refresh" items, as per your APPNDIX H from the County's RFP. It is Comstar's understanding, that the winning bidding company, will be billed, by the County, on an annually basis for approximately 1/5 of the total amount in APPENDIX H ($197,000), and our pricing represents that.

Additionally, Comstar has offered an alternative ePCR option to your current emsCharts. We have proposed an ePCR solution via ZOLL RescueNet TabletPCR, that the County has the option to utilize as an option to emsCharts, and is also inclusive of our pricing structure.

Comstar's Service fee for services:

5.5% (FIVE AND ONE HALF PERCENT)
Of net funds collected

Our fee is inclusive of all the services and statements made within this proposal. A recap of our services includes, but not necessarily limited to the following billing and collection services:

Billing Services:

- All set-up costs.
- Web-Based Insurance eligibility Checks.
- Address scrubbing to verify correct address information.
- Attempt to attain insurance info from the receiving hospital.
- Attempt to contact patient via phone to attain insurance information
- Submission and follow-up of all claims to insurances.
- 1st direct bill/insurance questionnaire to patients.
- 1st Balance billing patients where appropriate.
- Posting and depositing all payments.
- Account Reconciliation.
- All reports and statistical data.
- Lock Box Service.
- Outgoing postage and supplies.
- Use of 800-telephone number.
- $500,000 Dishonesty Bond.
- $2,000,000 Errors and Omissions Bond.
- Customization of processes.
- Data transfer from your emsCharts system.

Collection Services:

- 2nd direct bill to patient
- 3rd direct bill to patient
- 4th direct bill / Collection Letter
- Reporting to Experian Credit Reporting Bureau.
- Data transmission to Collection Agency
- NC Debt Set-Off

Additional Inclusive Services:

- Access to opinions of EMS Attorney.
- Credit-Card payments
- Custom made reports and forms.
- Training and Consulting.
- Notice of Privacy Practices Mailing

Comstar's fee is also inclusive of an ePCR option and a partial hardware refresh as detailed on your APPENDIX H, which is also listed on the following page. Comstar understands that its fee to the County includes 1/5 of the total amount of the County's APPENDIX H on an annual basis.

CLEVELAND COUNTY EMS
PCR PROGRAM COSTS - FIVE YEAR PLAN

Description	Cost/ea	Needed	Monthly	Total Cost	
PC- Laptop Panasonic Toughbooks	$ 4,700.00	15		$ 70,500.00	Replace 3 per year
Sequel Server	$ 15,000.00	1	1	$ 15,000.00	
Sequel Server Cross-over OSSI (Times)	$ 25,000.00	1	1	$ 25,000.00	
OSSI Maintenance	$ 1,500.00	5	Years	$ 7,500.00	Per year $1500
PCR software monthly	$ 850.00	1	60	$ 51,000.00	
Wireless cards	$ 40.00	12	60	$ 28,800.00	Per month $480.00
	5 Year Cost			**$ 197,800.00**	

APPENDIX H

COMSTAR HOSTED ZOLL ePCR Solutions

As an option to your current emsCharts ePCR product, we are proud to offer a solution of fully hosted ePCR options from ZOLL Data systems, and their RescueNet TabletPCR product. Comstar and ZOLL Medical have enjoyed a business partnership relationship together for many years. With the RescueNet ePCR solution, you are able to simplify data collection, improve access to information, and enhance operational efficiency. In addition, RescueNet ePCR Suite is NEMSIS-compliant at the Gold Level. Through this option, Comstar will provide the client with the use of a specified amount of licenses of the powerful ZOLL RescueNet ePCR software, as well as provide training, hosting and support.

What does this mean for you? In simple terms, it means that all Cleveland County would need are ruggedized laptop computers (i.e. ToughBook), which you already have, and which Comstar will be providing "refresh" for and an internet connection, and Comstar would take care of the rest. There is no additional software or hardware purchase you would need to make.

RescueNet TabletPCR Mobile Computers

The following list identifies the mobile computer devices that have been used during testing of RescueNet ePCR Suite 5.4. All other mobile computer hardware devices you may choose to evaluate/use in your organization should meet the minimum requirements detailed in the table below.

ZOLL Tested Mobile Devices

- Panasonic Toughbook CF-30
- Panasonic Toughbook CF-19

General Device Requirements Hardware	
Processors	1.2Ghz or higher
Memory	1 GB RAM
Hard drives	2 GB free space
Internet Connectivity	Ethernet or Wireless
Software	
Operating system	Microsoft Windows XP Professional Microsoft Windows XP Professional Tablet PC Microsoft Windows 7 Professional (32-bit & 64-bit versions) Microsoft Windows 8 Professional (32-bit and 64-bit versions) (all above with latest Microsoft Windows service packs installed)
.NET Framework	Version 4.0
Other	Adobe Acrobat Reader

Your computer network needs to be a minimum of 100 Mbps. Internet connection speed needs to be a minimum 128kbps.

The following pages will describe in detail Comstar's hosting service, which includes training and implementation, as well as the ZOLL RescueNet software itself.

As stated, Comstar is a Business Partner of ZOLL medical and is proud to offer RescueNet ePCR solutions to Cleveland County. Since this is a hosted service, so the software to be described will reside on Comstar's server and the County's laptops and desktops.

Comstar long used ZOLL's RescueNet Billing system and has now leveraged that knowledge and relationship to host ZOLL's ePCR solution, TabletPCR. Utilizing a hosting service for your ePCR needs means that we keep the software running, supported and up-to-date.

Running a modern, function rich, ePCR system requires solid servers and storage with near 100% uptime. Having your ePCR solution hosted by Comstar means that you get the benefit of high-end, up-to-date server hardware without having the capital expenditure, and more importantly without the maintenance. By utilizing blade servers and a highly rated, high capacity EMC Clariion storage array, we can ensure that the product you use will be available at all times. In addition, Comstar utilizes VMware's virtualization software for our servers. This enables us to maintain server uptime and quick disaster recovery schemes with little or no impact on your user experience.

Comstar's IT Team has many years of experience providing software support internally. That experience is now provided to you and ZOLL's TabletPCR product. In addition, our long standing relationship with ZOLL provides our IT Team with direct support on any TabletPCR problem that they cannot resolve.

This multi level support is mirrored in the support for our servers and network. Focus Technologies, an IT maintenance and support company, works with our IT Team to monitor and maintain our IT infrastructure. Our work with them keeps our servers up-to-date and our uptime near 100%.

Comstar utilizes a multi-tiered, triple redundant system for maintaining all data storage. On daily and weekly schedules, all data stored at Comstar is backed-up to tape, local mass storage, and moved off-site. In the case of a major disaster at the Comstar offices, potential data loss is minimized. In addition, with our redundant systems, blade servers, and VMware environment, we will be backing up and running with minimal downtime.

Comstar maintains the responsibility of troubleshooting problems with the RescueNet PCR software, and providing EMS agency data updates. On our side internally, we will maintain the uptime of our servers, data history and integrity, as well as internet connectivity.

As far as RescueNet usage is concerned, Comstar is offering a solution to be up and running 24 hours a day, 7 days a week. Additionally we have 24/7 support for any issues that may arise.

The RescueNet ePCR suite is a complete electronic patient care reporting system that combines the proven, easy-to-use TabletPCR product with a web-based PCR editor and advanced document routing for better QA/QI. It's designed to capture and allow access to all pre-hospital patient, clinical and system information on tablet PC's and mobile computers. The RescueNet ePCR Suite simplifies data input and improves access to information. The solution offers an easy-to –use touch screen user interface, advance reporting of all data captured and a web-based solution for reviewing and editing patient care reports.

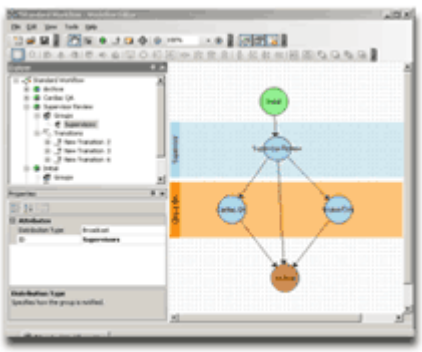
RescueNet Tablet PCR is the most effective field data solution for record accuracy, data integration and advanced analysis. Highlights of the product include: prevention of incomplete patient care reports, improvement of medic efficacy, reduction of risk in the events of litigation or audits, and ensure protocol is followed consistently.

As with any software, the longevity of a solution typically leads to stability and reliability. With many years of experience with ePCR solutions, hosted by Comstar, a company you know and trust, RescueNet ePCR offers a solution that meets and exceeds all of your electronic reporting needs.

The RescueNet interface was designed with simplicity and the ease of use in mind. So, when creating the interface, ZOLL performed focus groups to test the interface certain criteria in mind, such as, the ability to use with little or no training, to alleviate long learning curves and customer frustrations. ZOLL then took the results from these focus groups to create an optimal, simplified experience for its users.

Therefore, RescueNet has an easy-to use, user friendly software application. Additionally, the application's versatile design is for touch-screen (stylus or finger) and keyboard input, to meet the different need of your crew members' preferences.

Quick Log



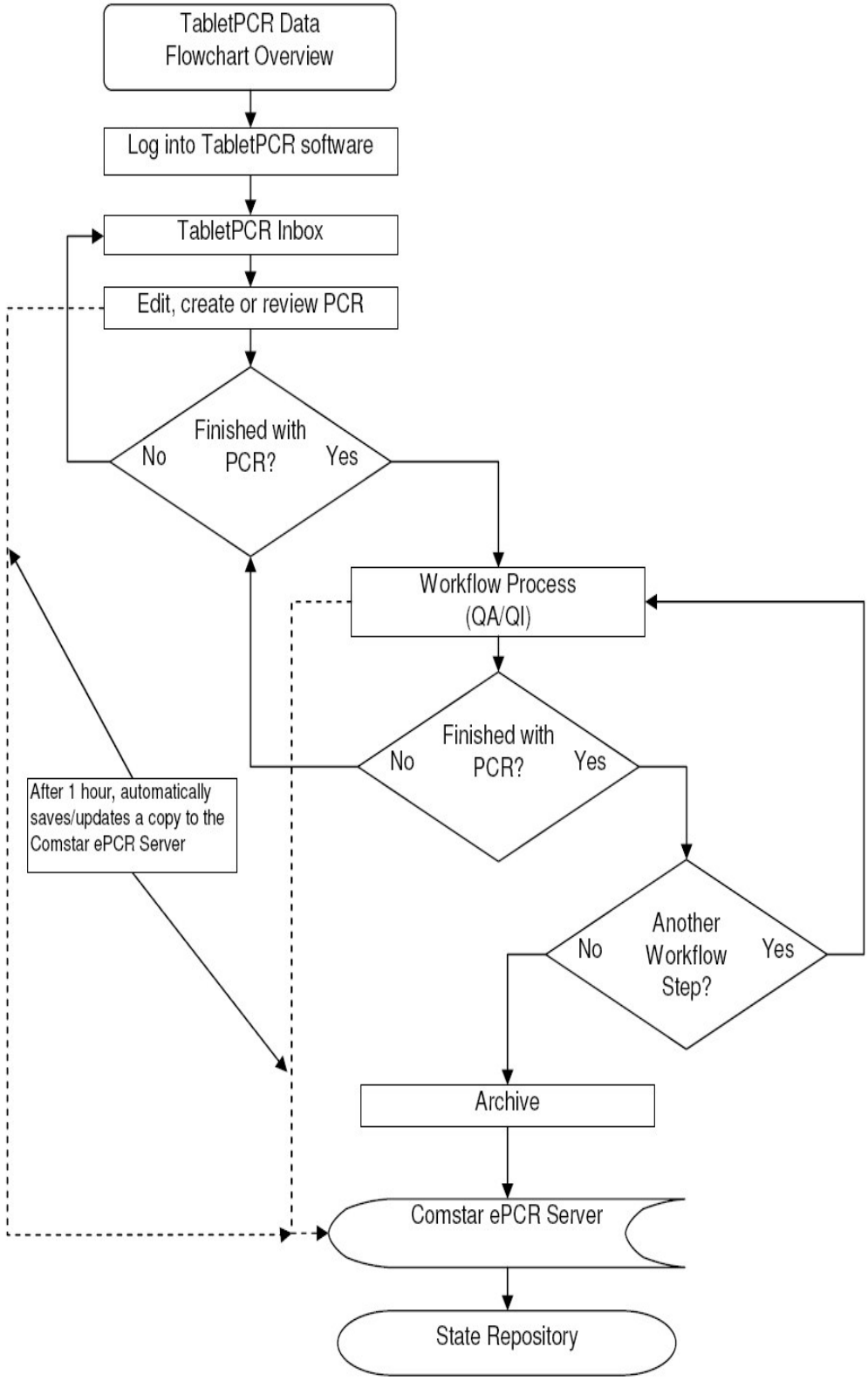
Workflow

The RescueNet software has all of the minimum fields as required by the County, and the interface is designed to flow logically left –to-right by tapping on rectangular buttons (along the top of screen), and top-to-bottom, to expand screen categories by tapping on the oval buttons (on the left-hand side). Additionally, this allows the user to basically get anywhere within the application in just two clicks. This will help avoid the frustration of being buried in an application and not knowing where to go or where you came from. The two-click system is both logical and intuitive. The buttons are also color-coded, to indicate which screens have data, and which still need to be completed. The touch screen application also has a Quick Log interface, which allows for time stamping of common procedures. Patient and crew member signatures are electronically captured on the tablet, with different signature options available for refusal of treatment, refusal of transport, treat and release, etc. Additionally, the software contains a medical dictionary and spell-check feature to make sure that treatments are entered correctly.

Upon completion of an ePCR by a crew member, the document is saved on the machine locally for later editing if necessary. Additionally, after an hour of connectivity, a copy is sent and saved to the Comstar server for security. A crew member may make edits on the PCR up until the point when he/she hit the “Save to Server” button, when the PCR is now sent off for QA/QC. The internal QA/QC process will be decided by the County and created by Comstar to map out the process. Additionally, when a PCR is completed, through our eFAX service, a copy is electronically faxed to the admitting hospital, so they crew member does not have to leave a hard copy. (Please not that the eFAX service is dependent on the hospitals ability to receive faxed documents).

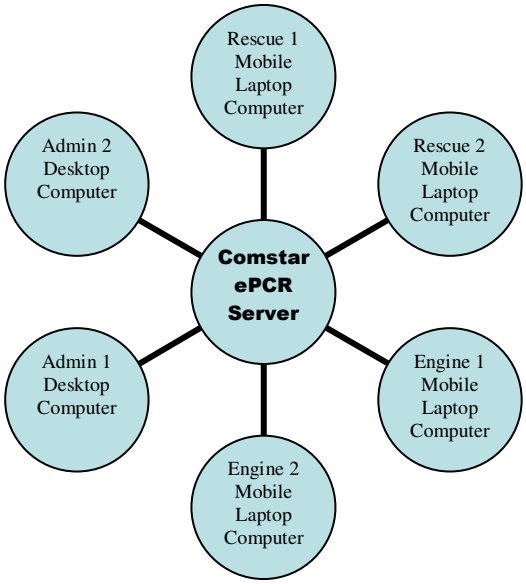
Internally, Cleveland County will QC the PCRS electronically, just as they would if they were on paper. When All QA/QC steps are completed, the reports will then simply be sent to Comstar by the click of a button. Once they are received by Comstar, we will begin the billing process. There is nothing else you would need to do.

Please see the following page with a detailed flowchart document describing the ePCR journey.


TabletPCR Data
Flowchart Overview
Log into TabletPCR software
TabletPCR Inbox
Edit, create or review PCR
Finished with
PCR?
No
Yes
Workflow Process
(QA/QI)
Finished with
PCR?
No
Yes
After 1 hour, automatically
saves/updates a copy to the
Comstar ePCR Server
Another
Workflow
Step?
No
Yes
Archive
Comstar ePCR Server
State Repository

An integral component of the PCR workflow module is the QA/QI component. The ePCR flowchart provides for automatic routing of PCR's as well as the manual routing for corrections. It can also support "route and return" to ensure that after a PCR is reviewed, it is returned to the creator. PCR QA/QI and editing can take place on any workstation that the software is loaded upon.

As the flow of information has been discussed, it's also important to realize that your hardware can exchange data through Comstar's server. So while the mobile laptop for Rescue 1 can not transfer data directly to the mobile laptop for Rescue 2, the information is shared on Comstar's server. So a crew member can start a report on Rescue 1 laptop, save it, and then complete it on Rescue 2 laptop. RescueNet ePCR supports laptops, tablets, and desktop computing systems, providing flexible input and display options. Basically all Cleveland County employees would need to have is a live internet connection to facilitate the transfer of data from Comstar's server to your hardware. The diagram below should show how the information is shared from your hardware.



So, you can easily access your data through all your designated hardware, through connection to our server where your information is hosted. And, even though all your data is hosted on Comstar's servers, it always remains the property of Cleveland County and will be returned and/or provided to the County upon request. All electronic data is governed by the same HIPAA rules and regulations as paper data, and we will keep your information secure under the Business Associate Agreement that Cleveland County and Comstar would have in place. Additionally, as per regulations, your information will be kept electronically for a period of seven years.

Not only does RescueNet ePCR allow you to quickly and efficiently capture all important data when creating the patient care report, but it allows you to extract that data in multiple different report forms. RescueNet reporting provides administrative personnel with a multitude of reports on many aspects of the ambulance operation. Standard sample reports are in the following categories: Administration reports, treatments and impressions reports, Medic skills reports, Statistics reports, Performance reports, and more. And, as you will read in the training section, Comstar will teach you how to access, run and create these reports. If there is a report that the County requires, that is not available, Comstar will create that particular report for you.

Training Plan

As mentioned, the RescueNet ePCR product is easy to use, and has a short learning curve; however, Training is an integral part of our deployment process to ensure that you have the proper tools to fully understand and feel confident and comfortable with the application.

Our training is based on the ZOLL model of a "Train the Trainer" instruction for your managers.

This training session take place on your premises, so it is important to have a proper training room with network connectivity. Also helpful is computer for access to the administration application (for reporting training), as well as on overhead multimedia projector and whiteboard. A proper training classroom helps facilitate proper training.

Our Train-the Trainer session is typically a six-hour training session. We feel that it is paramount that all the personnel, after receiving the initial training, take time to explore and acclimate themselves to the ZOLL ePCR system. We recommend that secondary to our initial deployment and training, the administrator(s) become as comfortable as possible before educating the rest of your team (s). The goal of the Train-the Trainer, is to have a few "experts" on the application that can then roll it out to the other crew members within your timeframes. The training includes all basic functionality of the field end user and day to day operational use such as, logging in, setting a crew and everything you will need to know to complete save, and send a PCR.

Additionally, the Train the Trainer session includes many aspects including QA/QI, tracking, daily checks, and system maintenance, and upgrades.

Quality Assurance/Quality Improvement is, and has been, an integral part of EMS for quite some time. It is conducted on two levels- operationally and clinically. Operational QA/QI deals with hard data. Making sure that the PCR was completed properly i.e., The PCR has all of the required demographics, run and incident numbers, outcomes etc. etc. This phase of QA/QI is very pertinent to the billing aspect as it helps to speed up the billing process. The Clinical aspect of QA/QI governs the clinical side of the PCR. This process ensures that state and local protocols are met, allows for the administration to see areas of weakness as well as areas of strength, which can then be relayed to the field providers. This continuum helps to enhance the overall care that the public you serve depends on. Our system is set up so all calls are required to go through this process at least from an operational standpoint. However, we at Comstar Billing feel very strongly that both facets of the QA/QI process should be performed.

It is Comstar Billing's position that a system of 'checks and balances' is in place on the clients end. We would like to see a tracking/log system in place where an administrator would be able to cross reference virtual ePCR's with a hard copy i.e. checking your online banking statement with the register of your check book. An administrator should make a walkthrough daily. His/her primary objective would be to check each mobile tablet unit, and make sure all calls are flowing.

We would like to see each individual mobile tablet unit powered down at least once daily. It would also be wise to either block access or limit the field provider's access to the internet, although the mobile unit will need connectivity to send ePCR's and receive updates.

From time to time the system will be upgraded, whether it is the latest versions of the software or to remain compliant with NEMSIS and State of Rhode Island standards, when applicable. Before these upgrades occur Comstar Billing will send out an e-mail notification containing the changes and/or upgrades. Once received by the County, it will rest on the administrators' shoulders to roll out the new changes to the staff. It is our position that a continuing education process for the ePCR should be established.

As far as the Administration or report writing training is concerned, this is typically done remotely through a Go to Assist Meeting session, and many of our clients would like that to take place after the "Go Live" date, so that the training can involve real data that has been obtained.

A specific detailed and transition plan can be discussed and created if the County decides this would be a beneficial ePCR option for them.

COMSTAR APPENDIX

1. Scope of Services Point by Point Responses
2. Sample Patient Correspondence Statements
3. ZOLL RescueNet Billing Software Brochure
4. Comstar Back-Up and Disaster Recovery Plan
5. Sample Transition and Implementation Plan
6. Sample Monthly Reconciliation Report Package
7. Comstar Compliance Plan
8. Comstar Red Flag Plan
9. Comstar 2013 SOC I Independent Audit Report

SCOPE OF SERVICES
(Section 2.0 of Cleveland County RFP)

In addition to putting together a proposal based on the criteria required by the County, Comstar has offered a point by point response to each of the County's Scope of Services as an Appendix. Each scope of Service criterion is listed with Comstar's response following on **BOLD.**

Please note that some of this information may seem repetitive, and our proposal discusses the scope of services in more detail, this may make for easier reading and quick reference in a point by point format.

2.1 Provide Emergency Medical Services (EMS) billing services. County will award one contract to a firm to provide all services necessary to receive and process patient billing and NC Debt Set-off collection. The term of the contract resulting from this solicitation shall be for a period not to exceed three (3) years.
Understood and Agreed.
Comstar fully understands the scope of this RFP for Emergency Medical Billing Services and the specific terms contained within.

2.2 The term of the contract resulting from this solicitation shall be for an initial period of one (1) year with 2 optional one year extensions.
Understood and Agreed.

2.3 Create and maintain interface capability to receive electronic run tickets from the existing emsCharts system, check for discrepancies to ensure all run tickets have been received, and verify that required trip and patient information is included.
Understood and Agreed.
Comstar is a business partner of emsCharts, and is fully compatible to receive electronic information via emsCharts, as we have many clients currently utilizing the emsCharts product. Upon receipt of your electronic data, Comstar provides the County with a confirmation email noting how many runs were received and the dates of service, so the County can confirm, to ensure that no trips were missed.

2.4 Contractor must be prepared to furnish, at some point during the term off the contract, either an electronic patient care reporting software system (ePCR) should the county decide to replace its existing system, and/or a complete hardware "refresh" including mobile computing hardware and all attendant hardware peripherals. (See appendix for 5 yr plan).

Understood and Agreed.

Comstar understands the County's requirements for software and hardware to be provided (financially) by the awarded vendor as part of this project. We have provided our understanding and detailed pricing in our pricing section on page 34 of our response document.

2.5 Provide all labor, materials, and technology necessary to obtain missing information from all available sources prior to issuing insurance claims or direct patient billing.

Understood and Agreed.

Comstar's fee structure is all inclusive, and includes eligibility checks, hospital inquires, and skip tracing methods in order to exhaust all resources to obtain a patients correct insurance information, prior to claims being sent. Our goal is to obtain the proper patient insurance coverage and submit a claim for the County to maximize its revenues.

2.6 Electronically file insurance claims and mail direct patient billing upon verification of run ticket information no later than 25 days after receipt of run ticket.

Understood and Agreed.

All claims are filed electronically (when allowed by the payer). However, it is Comstar internal policy to have all claims billed within three (3) business days of receipt, in order to speed up cash flow, and not to run into timely filing deadline issues.

2.7 Provide follow-up billing upon receipt of "new" information received concerning a patient. This includes, but is not limited to, additional insurance information, change of address, or change of responsible party.

Understood and Agreed.

Comstar will always update patient records when new information is received, and file new claims and bills accordingly.

2.8 Electronically receive data files from County's lockbox and/or other sources (i.e. Medicare or insurance companies) to update patient accounts. Use the County's lockbox system (when available) for viewing lockbox receipts including check copies and enclosed correspondence. Hard copies of these items will not be provided, but may be printed from the online system.
Understood and Agreed.
Comstar will work with you and your lockbox service. We understand that it will be our responsibility to obtain copies of receipts and remittances from the lockbox's online system, for proper posting to patient accounts. Comstar is managing processes similar to this for other clients.

2.9 Update patient accounts upon receipt of information.
Understood and Agreed.
Patient records are always updated as soon as any new information is received.

2.10 First invoice should be sent no later than 30 days from dispatch date. Second invoice to be sent at 60 days from dispatch date. A third invoice to be sent no later than 90 days from the dispatch date. This third invoice should include a delinquent letter along with debt setoff garnishment notice (certified mail).
Understood and Agreed.
Comstar will abide by the billing process as described above and established by the County. Our processes are customizable to your exact wishes. Additionally we agree to send a delinquent letter with debt set-off garnishment notice via certified mail as per North Carolina law.

2.11 Bills with no payment activity at 120 days will be forwarded to County agency in XML format. If a payment plan has been established with the patient that exceeds 120 days for non-insurance bills, and is being met, the account will not be turned over to the collection agency.
Understood and Agreed.
Comstar will forward all accounts with no activity after 120 days to the County collection Agency in XML format. We further understand that patients making timely payments on payment plans are not to be sent to collections.

2.12 Provide 24/7 online access to information including notes and hard copy reports required by County, including but not limited to:

- Run tickets received/billed
- Payments received
- Outstanding balances
- Adjustments and refunds
- Aging of open accounts
- Accounts forwarded to County agency
- Status of all accounts

Understood and Agreed.

Comstar will provide with access to billing and collection data via a VPN and our RescueNet Reporting. This access would require a specific log-in by Cleveland County personnel, to only have access to your data. Through log-in, Cleveland County would be able to track trip information, payment data, etc. Comstar would provide any and all necessary training on how to utilize and access this system. It would be the responsibility of Cleveland County to decide which of your employees would have access to this data.

2.13 Provide regular updates and on-going training to County on changes to billing requirements based on industry standards or requirements of applicable health care laws and regulations.

Understood and Agreed.

Training and Consulting is an integral part of building a solid relationship with all of our clients, and we will provide any and all necessary training necessary to Cleveland County, as it relates to ambulance billing and collections. This is an inclusive part of our service offering and there would be no additional cost to the County.

Please see page 19 of our proposal document for more detailed information on our training offerings.

2.14 Provide County with Contractor's 'Red Flag" plan and all updates throughout the term of the contract.

Understood and Agreed.

Please see APPENDIX 8 for Comstar "Red Flag" Plan.

2.15 Comply with all HIPAA rules and regulations.

Understood and Agreed.

Comstar is HIPAA compliant, and more detailed information on how we manage compliance can be found in Tab Section 8, page 30 of our proposal document.

Federal Tax ID #
0123456789

CLEVELAND COUNTY EMS

C/O COMSTAR AMBULANCE BILLING SERVICE
8 TURCOTTE MEMORIAL DRIVE, ROWLEY, MA 01969
(800) 488-4351

PATIENT NAME: SMITH, JOHN

RUN NUMBER: 09 -26184
DATE OF CALL: 02/10/2014
PATIENT SSN: XXX-XX-3210

JOHN SMITH
100 ELM STREET

SHELBY, NC 28151

FROM: RESIDENCE
TO: Kings Mountain Hospital

PRIMARY PAYOR: Bill Patient

SECONDARY PAYOR: TUFTS HEALTH PLAN

DESCRIPTION	CHECK #	QUANTITY	UNIT PRICE	PMT DATE	AMOUNT
BLS Emergency Base Rate		1	575.00		575.00
Mileage		5	22.30		111.50

PLEASE PAY THIS AMOUNT $686.50

This bill is your responsibility. Please remit payment.

We are not associated with the hospital. If you have insurance to cover these charges, please see our website, call us or complete the back and return in the enclosed envelope. As a courtesy, we offer to direct bill insurance companies for you, but ultimately the financial responsibility belongs to the patient. Thank you.
To view our NOTICE OF PRIVACY PRACTICES, please visit our website: WWW.COMSTARBILLING.COM.

DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT. THANK YOU.

PATIENT NAME: SMITH, JOHN

RUN NUMBER: 09 -26184

INCIDENT DATE 02/10/2014

CURRENT DATE: 2/13/14

AMOUNT ENCLOSED: $

REMIT TO:

CLEVELAND COUNTY
c/o Comstar, Inc.
8 TURCOTTE MEMORIAL DRIVE
ROWLEY, MA 01969

Please make check payable to:
CLEVELAND COUNTY

Federal Tax ID #
0123456789

CLEVELAND COUNTY EMS

C/O COMSTAR AMBULANCE BILLING SERVICE
8 TURCOTTE MEMORIAL DRIVE, ROWLEY, MA 01969
(800) 488-4351

PATIENT NAME: SMITH, JOHN

RUN NUMBER: 13 -26184
DATE OF CALL: 02/10/2014
PATIENT SSN: XXX-XX-3210

JOHN SMITH
100 ELM STREET

SHELBY, NC 28151

FROM: RESIDENCE
TO: KINGS MOUNTAIN Hospital

PRIMARY PAYOR: Bill Patient

SECONDARY PAYOR: AETNA HEALTH PLAN

DESCRIPTION	CHECK #	QUANTITY	UNIT PRICE	PMT DATE	AMOUNT
BLS Emergency Base Rate		1	575.00		575.00
Mileage		5	22.30		111.50

PLEASE PAY THIS AMOUNT $686.50

This account is now over 30 days past due. This bill is your responsibility. Please remit payment.

We are not associated with the hospital. If you have insurance to cover these charges, please see our website, call us or complete the back and return in the enclosed envelope. As a courtesy, we offer to direct bill insurance companies for you, but ultimately the financial responsibility belongs to the patient. Thank you.
To view our NOTICE OF PRIVACY PRACTICES, please visit our website: WWW.COMSTARBILLING.COM.

DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT. THANK YOU.

PATIENT NAME: SMITH, JOHN

RUN NUMBER: 13 _26184

INCIDENT DATE 02/10/2014

CURRENT DATE: 03/10/14

AMOUNT ENCLOSED: $

REMIT TO:

CLEVELAND COUNTY
c/o Comstar, Inc.
8 TURCOTTE MEMORIAL DRIVE
ROWLEY, MA 01969

Please make check payable to:
CLEVELAND COUNTY

Federal Tax ID #
0123456789

CLEVELAND COUNTY EMS

C/O COMSTAR AMBULANCE BILLING SERVICE
8 TURCOTTE MEMORIAL DRIVE, ROWLEY, MA 01969
(800) 488-4351

PATIENT NAME: SMITH, JOHN

RUN NUMBER: 13 -26184
DATE OF CALL: 02/10/2014
PATIENT SSN: XXX-XX-3210

JOHN SMITH
100 ELM STREET

SHELBY, NC 28151

FROM: RESIDENCE
TO: KINGS MOUNTAIN Hospital

PRIMARY PAYOR: Bill Patient

SECONDARY PAYOR: AETNA HEALTH PLAN

DESCRIPTION	CHECK #	QUANTITY	UNIT PRICE	PMT DATE	AMOUNT
BLS Emergency Base Rate		1	575.00		575.00
Mileage		5	22.30		111.50

PLEASE PAY THIS AMOUNT $686.50

This account is now over 60 days past due. This bill is your responsibility. Please remit payment.

We are not associated with the hospital. If you have insurance to cover these charges, please see our website, call us or complete the back and return in the enclosed envelope. As a courtesy, we offer to direct bill insurance companies for you, but ultimately the financial responsibility belongs to the patient. Thank you.
To view our NOTICE OF PRIVACY PRACTICES, please visit our website: WWW.COMSTARBILLING.COM.

DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT. THANK YOU.

PATIENT NAME: SMITH, JOHN

RUN NUMBER: 13 -26184

INCIDENT DATE 02/10/2014

CURRENT DATE: 04/10/14

AMOUNT ENCLOSED: $

REMIT TO:

CLEVELAND COUNTY
c/o Comstar, Inc.
8 TURCOTTE MEMORIAL DRIVE
ROWLEY, MA 01969

Please make check payable to:
CLEVELAND COUNTY

Creditor:
CLEVELAND COUNTY
C/O COMSTAR.
(800) 488-4351
8:00am to 9:00pm EST

Customer:
SMITH, JOHN

COLLECTION NOTICE

Origin
RESIDENCE
100 ELM ST
SHELBY, NC 28151

Destination
KINGS MOUNTAIN HOSPITAL

Billed To:
JOHN SMITH
100 ELM ST
SHELBY, NC 28151

Amount Overdue: $686.50

Run Number 26184
Date of Service 02/10/2014

Dear JOHN SMITH,

Because your account for ambulance services provided by Cleveland County EMS remains unpaid, and is 90 DAYS PAST DUE, collection of this debt has been assigned to Comstar, Inc. Your creditor has requested us to report this account to a credit bureau in their name.

If you wish to make payment now, send your check in the enclosed envelope. Please call if you have any questions or wish to arrange monthly payments.

If we do not receive your payment or your written dispute of the validity of this debt or any portion thereof within 30 days of receipt of this letter, we will continue with what we consider to be the most effective means of collecting your debt.

Thirty days from the receipt of this letter, unless you have notified us in writing that you dispute the validity of this debt or any portion thereof, we may file a report with Experian Credit Bureau. Please be advised that Experian Credit information is available to lenders throughout the United States. A debt on file will affect your ability to get credit and may jeopardize credit you have now. A claim will be filed with the State of North Carolina as per the North Carolina Setoff Debt Collection Act. Please see the attached letter.

We are attempting to collect a debt or gain information to collect a debt. Any information we obtain will be used only for that purpose.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, we will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice, we will obtain verification of the debt or will obtain copy of a judgment and mail you a copy of such judgment or verification. If you request this office in writing within 30 days after receiving this notice, we will provide you with the name and address of the original creditor, if different from the current creditor.

Sincerely,

If payment of this bill creates a financial hardship, please call us at (800) 488-4351 to make arrangements.

REMIT TO:

CLEVELAND COUNTY
C/O COMSTAR, INC
8 TURCOTTE MEMORIAL DRIVE
ROWLEY, MA 01969

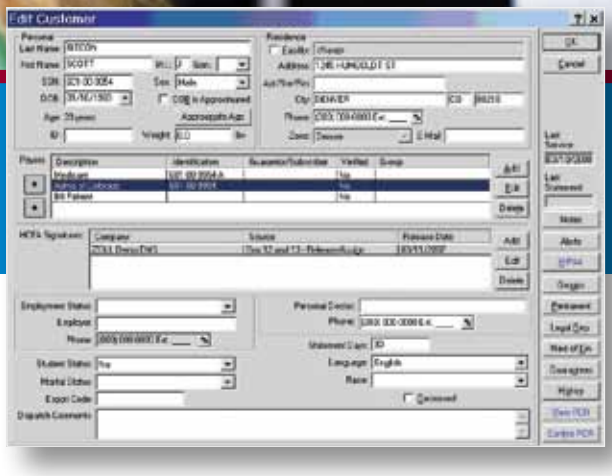
CURRENT DATE: 05/10/2014

SMITH, JOHN
Run Number 26184 DOS: 02/10/2014

1, Make check payable to:
CLEVELAND COUNTY
2, Note the run number on payment
3, Return this letter and fold this letter so that the address to your left is visible in the return envelope window.

RescueNet Billing

ZOLL®



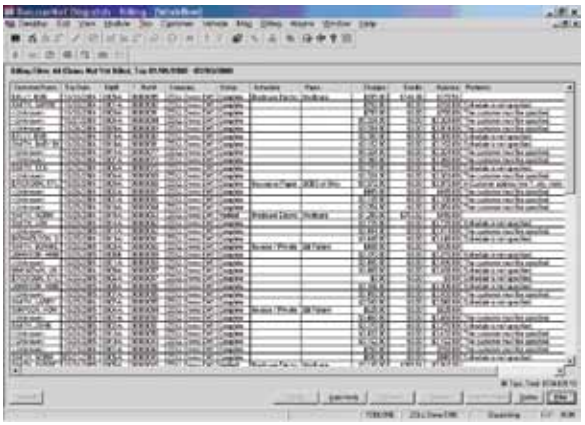
Next-Generation Automated Billing and Collections

RescueNet®

RescueNet® Billing automates the billing process so you can get paid on time. Its intuitive features help your billers organize their workday and avoid mistakes that can lead to denials. Keep claims from slipping through the cracks, speed up collections, and generate powerful business analysis and productivity reports. RescueNet Billing monitors claims for errors and reduces receivable turnaround times to help you maximize your cash flow. It shares a common database with RescueNet Dispatch and ePCR, so the information collected by your call takers, dispatchers, and field staff is immediately available to your billers. This eliminates time consuming and error-prone duplicate data entry. RescueNet Billing provides managers with a high-level view of the department's workload. The most widely used Windows®-based EMS billing system enables you to slash your receivables, improve cash flow, reduce staff hours, and easily stay Medicare-, Medicaid-, and HIPAA-compliant.

Work Smarter with Intelligent Workflow

The foundation of efficiency is based on the ability to identify what work needs to be done and to prioritize that work. To build successfully on that foundation, you need to easily access the details of that work and the account data that underlies those details. RescueNet Billing's workflow feature spots the problem areas of your A/R and gives your billers simple, one-step access to information. Workflow makes it easy to find, organize and prioritize your billing and collections efforts.



In-depth filter definition to define workflow/billing filters

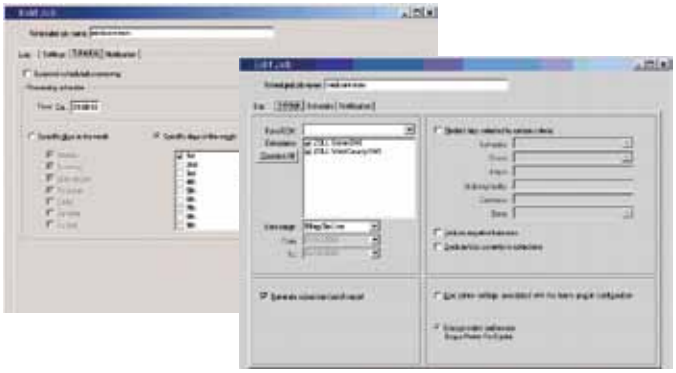
On-screen interactive operations reports:
As changes are made to trips, workflow immediately reflects those changes.

RescueNet Billing Today:
A summary of important Workflow filters to help prioritize and organize claims to be worked by individual billers.

Automated Billing and Electronic Submissions

The faster you can get a claim correctly billed and submitted, the sooner the cash will be in the bank. RescueNet Billing makes it easy for you to get your claims submitted as quickly as possible by automating the billing process. The process of billing trips and generating electronic claims, and/or printing paper claims, is simple with RescueNet Billing.

RescueNet Billing Schedules:
Automate your billing cycles and let the system ensure timely invoices/claims go out to customers and insurance payors.

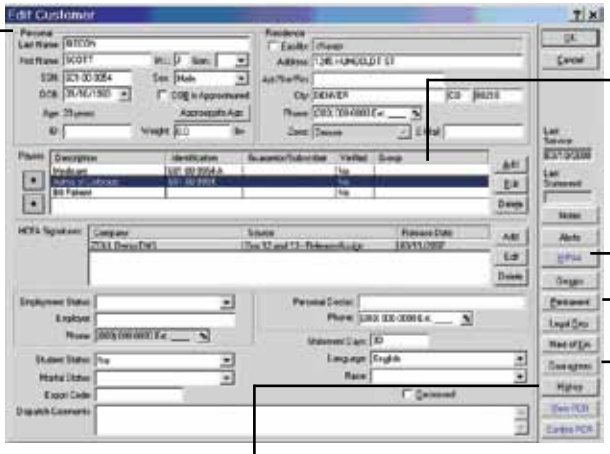


RescueNet Scheduled Batch Processing:
Configure jobs to generate paper and electronic claim batches automatically at any time during the night or day.

Claims are re-verified during the batch processing to ensure accuracy and completion, reducing the possibility of denials.

Easily Manage Critical Patient Information

Customer information is all stored in one location



Sort customer payors in the most appropriate billing order

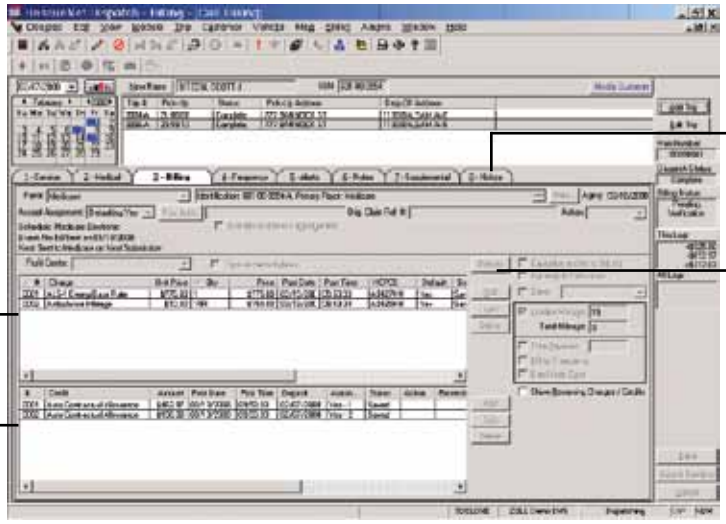
Log all HIPAA documentation received from customers

Track the changes made to customer information and who did the changes

Capture permanent address, legal rep and next of kin information to facilitate collection efforts

Fast, Well-Organized Data Entry

Easy user interface for reviewing and entering trip information



History log of all actions done to trip

Automated entry of charges and contractual allowances for primary payor

Add denials directly to each trip

Add payments directly to each trip

Attach files/important records to the trip

RescueNet Billing Modules – Get more out of your technology investment

RescueNet Billing includes several modules provided to streamline the cost recovery process. This saves your department time and money associated with administrative services and allows you to focus on life-saving operations.

Electronic Claims Module

RescueNet Billing Electronic Claims Modules (ECMs) allow for the creation of files for electronic submission to carriers for billing. Standard ECMs are available for different carriers and custom ECMs can be developed as needed. The development and testing of ECMs requires extensive time and resources. RescueNet Billing comes with four ECMs: Medicare for one state, Railroad Medicare, Medicaid for one state, and one of the following Clearinghouse ECMs: WebMD, THIN (Texas), ET&T, Gateway EDI, ZirMed, and NHS.

RescueNet Code Review with Billing

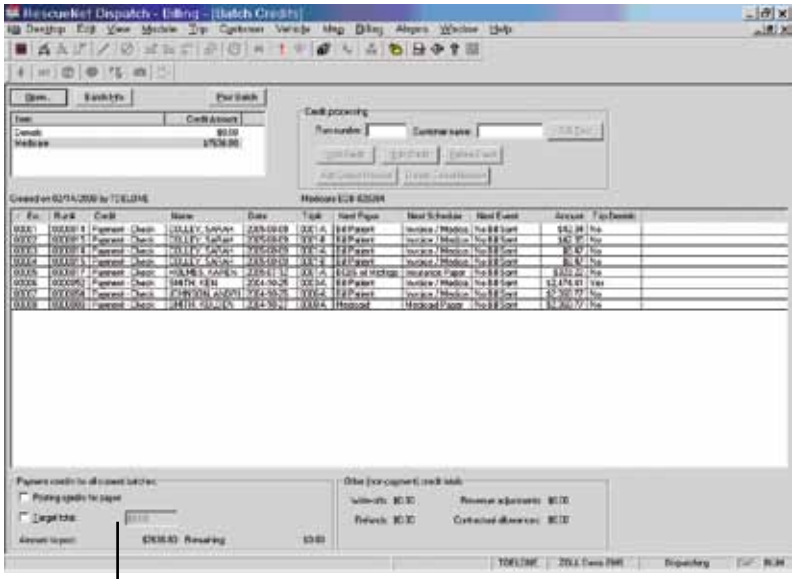
When you use RescueNet Code Review with RescueNet Billing, you can view ECGs with easy access to this record if you're required to print and forward it to an insurance company for additional evidence as to the patient's condition and course of treatment when medical necessity is in question. Also your billing office staff can quickly access the record later if a legal matter requires this documentation to be produced for evidence.

Paper Forms

Standard Paper Forms are available for different carriers and custom forms can be developed as needed. A set of standard forms come with RescueNet Billing including a patient invoice, a facility invoice, a collection letter, HCFA 1500, etc. and all state-specific forms for one state.

Automated Electronic Remittance and Batch Credit Processing

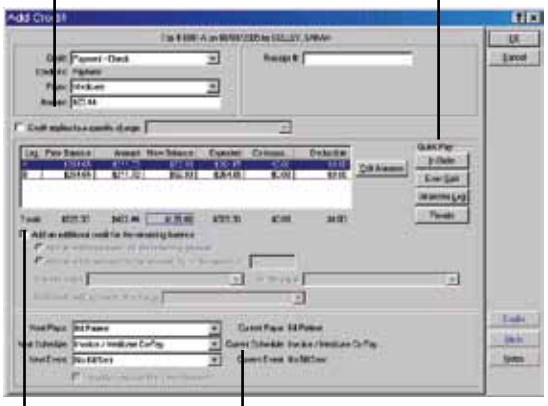
Processing payments has never been easier. A biller can select whether to add a payment or denial directly into each trip. Or they can process an EOB using the batch credits module to quickly add all credits and denial in one step without having to open each individual trip.



Assign Target Total to batch for easy reconciliation

System can automatically calculate appropriate expected amounts

Distribute payments over multiple legs of a trip



Enter secondary credits (i.e. adjustments and write-offs) as payments are entered

Automatically selects the next payor and appropriate schedule for each trip

Capture co-insurance and deductible amounts for electronic filing of secondary claims

The Flexible Auto-Fill option makes it simple to handle tasks such as writing off small balances and posting facility payments

DANTOM ECM

DANTOM Systems, Inc. develops collection letters, invoices and statements, and provides high-speed laser printing and mailing services. If you're using DANTOM Systems for any of these services, you can use the RescueNet Billing DANTOM Electronic Claims Module (ECM) to easily generate an electronic data file that contains all of the information DANTOM needs to process your invoices or collection letters. Then you can simply upload the data file to DANTOM Systems for processing. The DANTOM ECM also enables you to receive updated address information from DANTOM if you subscribe to that service. This module lets you reduce FTE's, and/or clerical staff, allocated to the printing, collating, and mailing of patient invoices and collection letters. Because many EMS organizations and billing services send multiple invoices and notices to a patient while trying to collect on a bill, there is an exponentially higher number of claims that are processed for patient billing. Plus you can reduce overhead costs for printing supplies.

Medifax Utility

Medifax-EDI, Inc. is a company that, in addition to providing other services, sends eligibility requests to carriers nationwide on behalf of healthcare providers. If you're working with Medifax, you can use the RescueNet Billing Medifax Utility to easily generate an electronic data file that contains eligibility requests you need Medifax to process. Then you can simply upload the data file returned from Medifax using the data transmission software provided by them.

Scanned Documents Applications (Image Viewer and Auto-Attach for Scanning)

These applications enable you to attach scanned documents to your trip records either automatically by attaching files to trips based on file name, or manually by keying in the run number to a viewed image. One great way to use this application is to attach scanned copies of the patient care report to the trip so it's handy for billing. This solution can help you realize your dream of the paperless office. Use the integrated scanning interface to scan and link either a single document or a batch of documents quickly and efficiently. Attach copies of run reports, physician certification statements, EOB's and more to the claims you bill from RescueNet Billing. Don't waste time going back and forth to the file room to retrieve important documents you need each day. Instead you can view and print them directly from your RescueNet Billing workstation as needed. Secure file storage as mandated by HIPAA can be expensive for some organizations with limited office space. As a result, it's more cost effective to store documents offsite. Offsite storage requires another mechanism for staff in the billing office to access records required for billing, working denials and follow-up collections. Scanning is the perfect solution since each of the relevant documents are ready and available to the system users as they work the claim for viewing and printing. Prioritize your billing and collections efforts.

Even if storage is not an issue, the process of searching for, copying, and filing supporting documents in a billing office requires time and is a redundant task that can increase staffing costs. The scanning solution requires that each document only be filed once by scanning it into the system, then the permanent filing of a printed copy. Any subsequent need for that document is easily met by accessing it via RescueNet Billing for viewing or printing.

With the Scanned Document Application you can:

- Efficiently attach scanned images that have been scanned in with a batch of documents.
- Attach a single document to a single trip record or to multiple trip records.
- Attach a single document to multiple trip records with the same incident number in one easy step.
- Include a comment with any attachment.

Acceptable file types:

- Adobe® Portable Document Format (PDF) files with a .pdf file extension.
- Joint Photographic Experts Group (JPEG) image files with a .jpg file extension.
- Graphics Interchange Format (GIF) image files with a .gif file extension.
- Tagged Image File Format (TIFF) image files with a .tif file extension.

Membership Module

This module enables you to create and maintain your membership program, including tracking and reporting membership fees, printing renewal invoices and membership cards. It can track head-of-household and dependents, create new customers in RescueNet Billing, and update existing customers when necessary. Members are indicated in RescueNet Billing so your billing staff can appropriately handle accounts.

Questionnaire

The RescueNet questionnaire enables users to define a series of questions and answers or statements and choices. This feature is designed to allow the capture of additional information in a logical format.

A typical use for the questionnaire is qualification for transportation. Both questions and responses can be logged to the history of a call. Call type and priority can be set based on questionnaire responses.

Security

Security is used to control access to the RescueNet system, allowing for great flexibility in defining user access. Security can be used on two levels, system-wide and user-specific, or a combination of both.

Security allows for predefined configurations for users that can be saved and titled (e.g. dispatchers, call takers, and billers) and alleviates the need to define a security configuration for each user every time.

QA/QI

The RescueNet QA/QI module enables the capture of procedures and interventions, medications administered, and vital signs and Glasgow Coma scores for patients on an individual trip. Users can define their procedures and medications, and select them from pick lists. This module also captures associated crew members, amounts and times, and the success of procedures and medications.

Professional Reports

When reporting on your billing operations and accounts receivable is the highest priority, arm yourself with RescueNet Professional Reports. The Professional Reports package provides over 100 professional reports for RescueNet that assist you with quickly reporting on the status of your business at every stage of the billing process. With RescueNet Billing and Professional reports you can quickly report on all sales and receivables activity over a period of time to analyze and monitor trends in your accounts receivable. Evaluate claim aging based on billing schedules and events to improve internal process and follow-up efforts in your billing office. Monitor user productivity by department and function with various user activity reports. Stay ahead of insurance eligibility verification in pre-billing by reporting on expiring verification of patient insurances. These are just a few examples of the many reporting options available in the Professional Reports package for RescueNet Billing.

Proven Solutions

RescueNet Billing is a component of the RescueNet Suite of integrated data management solutions for fire and EMS that are designed to reduce duplication of processes, simplify data sharing, and increase efficiency and data accuracy in order to achieve performance excellence. Our suite of solutions also helps improve patient care, enhances quality of service, and maximizes profitability.

www.zoll.com

US Sales 800 474 4489 | US Fax 303 801 0001 | US Direct Dial +1 303 801 0000
Asia/Pacific +61 2 9420 8733 | Europe 06571-145-7220

Managed Disaster Recovery
Prepared For: Rick Martin
Comstar Billing Services

Focus Technology Solutions, Inc.
Bill Smeltzer
93 Ledge Road
Seabrook, NH 03874
Phone: 617-938-6214
Fax: 603-766-0060
bsmeltzer@focustsi.com
Prepared by: FocusOn Managed Services

Summary

This document provides Comstar with a complete understanding of the backup and disaster recovery methodology Focus Technology Solutions Inc. provided via FocusOn Managed Services.

Description of Services

Two tier backup media solution:

Focus will use a combination of backup-to-disk and backup to tape to ensure Comstar Billing Services' critical data is stored on physically separate backup devices, as well as physically disparate backup media. This method mitigates the risk associated with a single technology entrusted to protect mission critical data. The following provides a basic flow of physical backup device and media rotation.

- All initial server based backups will be directed to disk. The disks are centrally stored and located on a NAS device which is located on the Comstar premises. The NAS device is included with the FocusOn Managed Services agreement.
- Once the Bi-Monthly full data backups have completed to disk, a secondary backup will take place. All full backup data stored on the NAS device will be backed up a second time to tape based media. The tape library will be provided by the FocusOn Managed Services agreement and will also be located onsite.
- As part of the FocusOn Managed Services agreement, during the bi-monthly onsite scheduled visits, a Focus Systems Engineer will be responsible for rotating tape media offsite. The existing tape library cartridge will store three Full Bi-Weekly backups to provide six weeks of backup protection. Two cartridges will be provided as part of the FMS agreement. Upon return to Comstar during the second scheduled visit of the month, the cartridges will be rotated; ensuring critical data is physically removed from site providing adequate offsite DR data storage.

Media Rotation:

Focus will use Bi-Monthly full data backups in combination with Differential data backups. This rotation scheme provides the optimal combination of recoverability and backup window reduction.

- A full backup of the entire server infrastructure will be performed on the 1st and 15th of each month
- Differential backups will be performed on the 2nd thru the 14th, as well as the 16th thru the 31st.

Any media removed from the Comstar facilities is immediately transported to the Focus Network Operations Center where it is stored in a secure location.

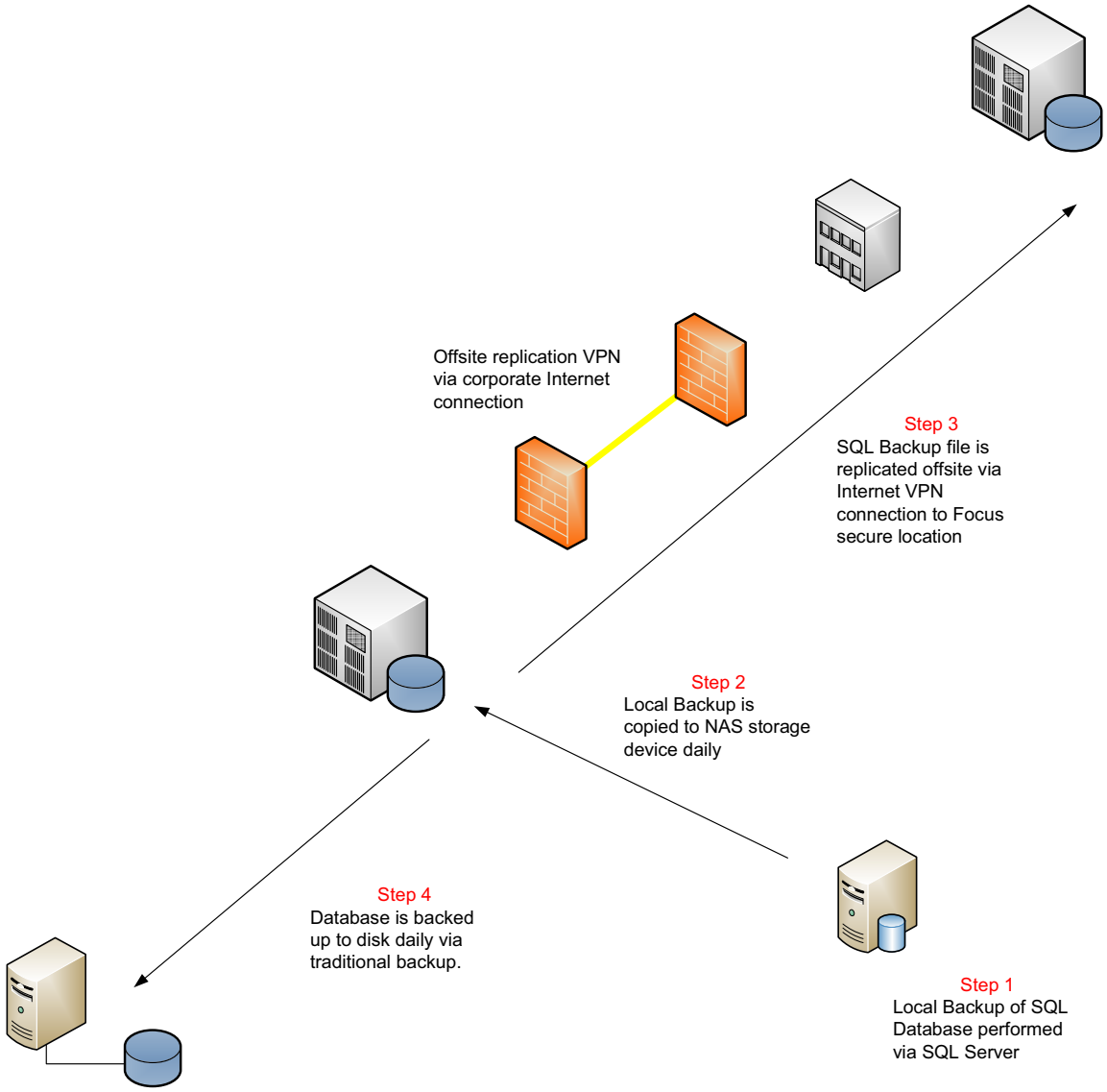
Offsite Data Replication:

As part of the comprehensive Disaster Recovery plan, Focus will execute daily SQL database offsite replications to our secure co-location facility. Offsite replication of the SQL database will mitigate critical data exposure in the event of a site disaster. The offsite replication will be achieved via the corporate internet connection and will traverse the internet via Secure VPN tunnel, ensuring data integrity and security. The offsite storage device is physically secured at a World Class AT&T co-location. The offsite replication cycle will provide a full database replication daily.

The resultant sets of backup data are as follows:

- Daily local backup to disk media
- Daily offsite replication of full SQL database
- Bi-Monthly offsite rotation of full tape media backup sets

The following diagram outlines the SQL database backup and replication steps:



IMPLEMENTATION PLAN

- Introduction Meeting(s).
- Setup Meeting(s).
- Provider Forms Paperwork.
- Training.

COMSTAR

PROJECT TIMELINE

- AMBULANCE BILLING AND COLLECTIONS IS A CIRCULAR ON-GOING PROCESS
- COMSTAR CAN CONTROL INTERNAL PROCESSES AND TIMELINES
- OUTSIDE AGENCIES (MEDICARE, MEDICAID) HAVE THEIR OWN TIMELINES

COMSTAR

PROJECT TIMELINE

Ambulance Billing Implementation Gant Chart		Week 1	Week 2	Week 3	week 4	Month 2	Month 3	Month 4
Task	Done BY							
Billing Service								
Billing Contract Award	Client							
Setup Meeting with Client	Client & Comstar							
Internal Setup of Client Account	Comstar							
Preparation of Provider Enrollment Docs	Comstar							
Review, signoff and submission of Provider Enrollment Docs	Client							
Medicare review, approval and assignemen of Provider Number	CMS			process tracked by Comstar ---------->				
Sample Forms to Client For Review	Comstar							
						1st day of Month 2		
Non Medicare Billing Starts	Comstar							
Medicare Billing Starts Retroactive to Enrollment Doc Submission Date	Comstar							Day 1 of Month 4 - Worst Case

COMSTAR

PROJECT TIMELINE
WEEK 1

- COMSTAR/CLEVELAND COUNTY SET-UP MEETING
  - START DATE DETERMINED FOR COMSTAR TO RECEIVE BILLABLE RUNS
  - DISCUSSION OF CLEVELAND COUNTY BILLING PROCESS
  - CLIENT ACCOUNT SET-UP DOCUMENTS AND INFORMATION

- INTERNAL COMSTAR SET-UP MEETING
- COMSTAR PREPARATION OF PROVIDER ENROLLMENT DOCUMENTS

COMSTAR

PROJECT TIMELINE
WEEK 2

- INTERNAL SET-UP ONGOING
- CLEVELAND COUNTY TO RECEIVE, REVIEW AND SIGN PROVIDER ENROLLMENT DOCUMENTATION
- PROVIDER ENROLLMENT DOCUMENTS FORWARDED TO PROPER PARTIES BY COMSTAR

COMSTAR

PROJECT TIMELINE
WEEK 3

- INTERNAL SET-UP ONGOING
- COMSTAR TRACKING PROVIDER ENROLLMENT APPLICATIONS AND PROCESS
- SAMPLE BILLING FORMS SENT TO CLEVELAND COUNTY FOR REVIEW AND ACCEPTANCE
- SAMPLE DATA FILES SENT VIA EMSCHARTS FOR TESTING

COMSTAR

PROJECT TIMELINE
WEEK 4

- INTERNAL SET-UP ONGOING
- OPERATIONS INTRODUCTION CALL
- CONFIRMATION WITH CLEVELAND COUNTY THAT COMSTAR IS READY TO “GO LIVE”

COMSTAR

START DATE

- CLEVELAND COUNTY TO BEGIN ELECTRONIC SUBMISSION OF BILLABLE PCR'S TO COMSTAR

- NON MEDICARE BILLING STARTS

COMSTAR

MEDICARE BILLING

- TO BEGIN RETROACTIVELY FROM START DATE, AS SOON AS MEDICARE APPROVES ENROLLMENT APPLICATION
- TYPICALLY ABOUT 90-120 DAYS FROM RECEIPT OF PAPERWORK

  (Usually between months 3-4 from when contract is awarded)

COMSTAR

TRANSITION

- Simple.
- Seamless.
- Comstar will prepare all necessary paperwork.

COMSTAR

WHY COMSTAR

- Experience.
- Expertise.
- Increased Collections.
- Customizable Billing and Collection Policies.
- Proven Track Record.

COMSTAR

COMSTAR

Ambulance Billing Service

SAMPLE REPORTS

(These are samples of actual reports issued by Comstar. All PHI is intentionally omitted for HIPAA purposes. Please note, that they are not complete reports, but just a sample of each report to demonstrate what reports will look like. Also; the sample reports are not intended to tie out or reconcile to the summary report. They are intended to illustrate the form and content of the reports. Rest assured actual detail reports will tie to the penny with the numbers on their corresponding summary page. The actual AR aging at the end of each month will tie to the penny with the calculated ending balance on the reconciliation summary.

COMSTAR
Ambulance Billing Service

MONTHLY RECONCILIATION REPORT PACKAGE

The intent of this report package is to provide the client and traditional accounting reconciliation of all transactions processed for the reporting period. The following is an actual client report package. Client and patient identifying information has been removed to ensure the confidentiality of their information.

Reports Description:

Reconciliation Summary Report
This is a management report which provides month and year to date total for all transaction categories. This report also serves as the reconciliation tool for accounting purposes. The **Beginning Balance** for each month is also the **Ending Balance** from the prior month. Both represent the total amount owed to the client by its patients at that point in time. **Gross Commitments** are the new charges posted and billed during the month on behalf of your service. **Contractual Allowances** are the differences between your billing rates and reimbursement rates called for in contracts your service has signed with certain payers (Medicare, Medicaid…….) **Net Commitment**s are the Gross Commitments less the Contractual Allowances. **Total Payments Received by Comstar** is the sum of all checks sent to Comstar, always payable to your service, which were posted to your patient accounts during the month. **Payments Received by Client** is typically electronic funds transfers made directly to the clients bank account by payers such as Medicare and Medicaid. We account for these separately to facility the reconciliation of your bank account on a monthly basis. **Retractions** are amounts a payer withholds due to a prior over payment. **Net Payments Applied** is the sum of Payments Received by Comstar and the Client less retractions. On a monthly basis, Comstar's fee is calculated and billed to you based on this figure. **Write-Offs** are patient account balances that you have directed us to write-off.

Transaction Detail Reports
For all of the transaction types listed above, you will receive a detailed report by transport date of service. Each transaction listed on these reports shows your incident number so that you have a complete audit trail back to the source document of our bill activity, your incident report.

Aging Detail Report
This report lists each patient that owes your service money at the close of the reporting period. The total on this report ties to the Ending Balance in the Reconciliation Summary Report for a given month.

Request For Write-Off Report
When we have exhausted all authorized billing and collection steps, a patient account will be put on hold and placed on this report for your review and disposition decision.

Main Street USA

Ambulance Billing Account Reconciliation Report

FY 2013

Prepared By: Comstar, Inc

4/2/2013

Month Ended:	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	YTD
Beginning Balance	**$249,120.91**	**$272,669.66**	**$254,455.73**	**$264,264.75**	**$264,868.40**	**$260,878.95**	**$304,228.38**	**$399,747.68**	**$367,699.31**	**$360,057.26**	**$360,057.26**	**$360,057.26**	**$249,120.91**
Gross Commitments	$178,979.18	$168,939.73	$155,884.99	$155,417.58	$159,044.90	$179,434.31	$242,066.38	$222,070.09	$207,069.09				$1,668,906.25
Contractual Allowances	$35,279.52	$34,608.87	$33,951.11	$34,889.81	$36,718.05	$42,486.12	$68,290.74	$73,061.75	$70,069.77				$429,355.74
Net Commitments	**$143,699.66**	**$134,330.86**	**$121,933.88**	**$120,527.77**	**$122,326.85**	**$136,948.19**	**$173,775.64**	**$149,008.34**	**$136,999.32**	**$0.00**	**$0.00**	**$0.00**	**$1,239,550.51**
Payments Recvd By Comstar	$48,280.42	$64,046.75	$50,864.21	$63,538.50	$49,267.45	$35,095.38	$34,470.93	$60,141.48	$68,324.02				$474,029.14
Payments Rcvd By Client	$71,870.49	$86,718.07	$61,679.98	$57,877.44	$77,048.85	$57,798.30	$42,408.79	$122,249.37	$77,153.62				$654,804.91
Retraction		$8.79	$419.33	$1,491.82	$0.00	$242.13	$420.85	$1,334.14	$1,639.50				$5,556.56
Net PMT Applied	**$120,150.91**	**$150,756.03**	**$112,124.86**	**$119,924.12**	**$126,316.30**	**$92,651.55**	**$76,458.87**	**$181,056.71**	**$143,838.14**	**$0.00**	**$0.00**	**$0.00**	**$1,123,277.49**
Previous PMT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00				$0.00
Write-Offs	$0.00	$1,788.76	$0.00	$0.00	$0.00	$947.21	$1,797.47	$0.00	$474.72				$5,008.16
FFR Pmt	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$328.51				$328.51
Ending Balance	**$272,669.66**	**$254,455.73**	**$264,264.75**	**$264,868.40**	**$260,878.95**	**$304,228.38**	**$399,747.68**	**$367,699.31**	**$360,057.26**	**$360,057.26**	**$360,057.26**	**$360,057.26**	**$360,057.26**

Commitments Report For: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA

Incident Date	Incident #	Run #	Charge Description	Qty	PPU	Total
07/30/12	13-0636	245468	MAIN STREET USA Mileage	4.0	$8.78	$35.12
			MAIN STREET USA BLS Base Rate	1.0	$457.16	$457.16
					Total Charges	$492.28
07/30/12	13-0637	245469	MAIN STREET USA Mileage	6.0	$8.78	$52.68
			MAIN STREET USA BLS Base Rate	1.0	$457.16	$457.16
					Total Charges	$509.84
07/30/12	13-0640	245470	MAIN STREET USA Mileage	1.5	$8.78	$13.17
			MAIN STREET USA BLS Base Rate	1.0	$457.16	$457.16
					Total Charges	$470.33
07/30/12	13-0639	245471	MAIN STREET USA ALS1 Base Rate	1.0	$542.88	$542.88
			MAIN STREET USA Mileage	3.0	$8.78	$26.34
					Total Charges	$569.22
07/30/12	13-0635	245472	MAIN STREET USA BLS Base Rate	1.0	$457.16	$457.16
			MAIN STREET USA BLS Base Rate	-1.0	$457.16	-$457.16
			MAIN STREET USA ALS1 Base Rate	1.0	$542.88	$542.88
			MAIN STREET USA Mileage	0.5	$8.78	$4.39
					Total Charges	$547.27
07/30/12	13-0634	245473	MAIN STREET USA ALS1 Base Rate	1.0	$542.88	$542.88
			MAIN STREET USA Mileage	11.0	$8.78	$96.58
					Total Charges	$639.46
07/30/12	13-0633	245485	MAIN STREET USA ALS1 Base Rate	1.0	$542.88	$542.88
			MAIN STREET USA Mileage	0.0	$8.78	$0.00
			MAIN STREET USA Mileage	0.0	$8.78	$0.00
			MAIN STREET USA Mileage	1.0	$8.78	$8.78
					Total Charges	$551.66
07/30/12	13.0632	245486	MAIN STREET USA Mileage	0.0	$8.78	$0.00
			MAIN STREET USA Mileage	0.0	$8.78	$0.00
			MAIN STREET USA Mileage	2.5	$8.78	$21.95
			MAIN STREET USA BLS Base Rate	1.0	$457.16	$457.16
					Total Charges	$479.11
07/30/12	13-0631	245487	MAIN STREET USA Mileage	5.0	$8.78	$43.90
			MAIN STREET USA BLS Base Rate	1.0	$457.16	$457.16
					Total Charges	$501.06
07/30/12	13-0630	245488	MAIN STREET USA BLS Base Rate	1.0	$457.16	$457.16
			MAIN STREET USA Mileage	2.0	$8.78	$17.56
					Total Charges	$474.72

Commitments Report For: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA

Incident Date	Incident #	Run #	Charge Description	Qty	PPU	Total
03/24/13	201313-4761	50068	MAIN STREET USA BLS Base Rate	1.0	$547.82	$547.82
				Total Charges		$719.48
03/24/13	201313-4756	50071	MAIN STREET USA ALS1 Base Rate	1.0	$650.52	$650.52
			MAIN STREET USA Mileage	6.5	$28.61	$185.97
				Total Charges		$836.49
03/24/13	201313-4760	50072	MAIN STREET USA Mileage	4.0	$28.61	$114.44
			MAIN STREET USA BLS Base Rate	1.0	$547.82	$547.82
				Total Charges		$662.26
03/24/13	201313-4758	50073	MAIN STREET USA Mileage	1.0	$28.61	$28.61
			MAIN STREET USA Mileage	-1.0	$28.61	-$28.61
			MAIN STREET USA Mileage	0.5	$28.61	$14.31
			MAIN STREET USA BLS Base Rate	1.0	$547.82	$547.82
				Total Charges		$562.13
03/25/13	201313-4765	50069	MAIN STREET USA ALS1 Base Rate	1.0	$650.52	$650.52
			MAIN STREET USA Mileage	1.0	$28.61	$28.61
				Total Charges		$679.13

Total Trips **332**

Total Charges **$ 207,069.09**

Allowances Report for: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS AMBULANCE FUND PAYMENT OR CONT. ALLOW - BLUE CROSS OR CONT. ALLOW - CONTRACT OR CONT. ALLOW - MANUAL OR CONT. ALLOW - MEDICAID OR CONT. A...

CONT. ALLOW - CONTRACT

Incident Date	Incident #	Run #	Dollars
12/14/12	201213-3042	231442	$238.44
12/17/12	201213-3087	245502	$226.74
12/23/12	201213-3184	233893	$268.16
12/24/12	201213-3191	233836	$226.74
01/20/13	FL-201313-3667	9303	$388.59
02/21/13	201313-4326	28996	$337.23
02/22/13	201313-4337	28998	$395.63
02/27/13	201313-4422	32467	$395.63
02/27/13	201313-4433	33389	$337.23
03/02/13	201313-4490	35784	$414.27
03/09/13	201313-4571	39462	$465.63
03/09/13	201313-4569	39464	$446.99
03/11/13	201313-4598	41556	$414.27
03/14/13	201313-4624	43274	$472.67
03/15/13	201313-4639	45512	$414.27
03/18/13	201313-4675	47793	$362.91
		SUBTOTAL	**$ 5,805.40**

CONT. ALLOW - MANUAL

05/26/12	12-5388	87688	$76.56
05/31/12	FL12-5469	92355	$46.60
06/03/12	FL12-5504	92382	$74.45
06/29/12	12-1913	113946	$93.77
08/08/12	201213-0821	138065	$14.89
08/09/12	201213-0848	138059	$87.44
08/19/12	FL201213-1065	148356	$15.00
09/19/12	FL201213-1600	165762	$77.26
09/21/12	FL201213-1625	168085	$75.85
09/21/12	FL201213-1624	168088	$232.59
10/26/12	2012132190	193517	$102.45
10/27/12	2012132207	193500	$164.56
10/31/12	2012132315	195352	$87.44
11/07/12	201213-2422	210229	$74.45
11/10/12	201213-2468	202634	$74.45
11/16/12	201213-2571	210224	$88.15
11/18/12	201213-2610	210198	$9.98
11/18/12	201213-2612	210202	$95.45
11/24/12	201213-2692	216671	$285.24
12/03/12	201213-2829	219171	$110.95
12/07/12	201213-2906	220670	$117.36
12/21/12	201213-3138	233871	$73.74

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS AMBULANCE FUND PAYMENT OR CONT. ALLOW - BLUE CROSS OR CONT. ALLOW - CONTRACT OR CONT. ALLOW - MANUAL OR CONT. ALLOW - MEDICAID OR CONT. A...

Incident Date	Incident #	Run #	Dollars
12/25/12	201213-3216	233860	$285.72
12/28/12	201213-3269	238378	$88.85
01/07/13	201313-3441	752	-$147.84
01/23/13	FL-201313-3706	10135	$78.59
01/27/13	201313-3794	11399	-$31.62
01/29/13	201313-3825	13990	$439.93
02/09/13	201313-4022	23197	$81.43
		SUBTOTAL	**$ 2,873.69**

CONT. ALLOW - MEDICAID

07/30/12	13-0639	245471	$279.86
07/30/12	13-0630	245488	$232.59
09/27/12	FL201213-1739	172230	-$226.74
11/29/12	201213-2760	216623	-$268.16
12/17/12	201213-3087	231402	-$226.74
12/31/12	201213-3324	238357	$403.06
01/08/13	201313-3471	2367	-$549.71
01/16/13	201313-3608	6863	-$472.67
01/16/13	201313-3601	6865	-$524.03
01/18/13	FL-201313-3644	9318	-$472.67
01/20/13	FL-201313-3667	9303	-$388.59
01/29/13	201313-3835	13991	-$421.31
02/05/13	201313-3937	19514	$395.63
02/14/13	201313-4234	30069	$421.31
02/22/13	201313-4351	30057	$337.23
02/22/13	201313-4346	30060	$337.23
02/25/13	201313-4394	31741	$395.63
02/26/13	201313-4403	31739	$414.27
02/26/13	201313-4406	32472	$446.99
02/27/13	201313-4429	33390	$362.91
02/28/13	201313-4448	33395	$395.63
02/28/13	201313-4437	33396	$388.59
03/01/13	201313-4458	35806	$395.63
03/01/13	201313-4460	35811	$439.95
03/01/13	201313-4466	35818	$472.67
03/03/13	201313-4491	35791	$337.23
03/04/13	201313-4510	37564	$395.63
03/06/13	201313-4533	39469	$446.99
03/09/13	201313-4572	39465	$395.63
03/09/13	201313-4575	40470	$446.99
03/10/13	201313-4589	39453	$337.23
03/13/13	201313-4620	43268	$439.95
03/15/13	201313-4643	44433	$414.27

Allowances Report for: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS AMBULANCE FUND PAYMENT OR CONT. ALLOW - BLUE CROSS OR CONT. ALLOW - CONTRACT OR CONT. ALLOW - MANUAL OR CONT. ALLOW - MEDICAID OR CONT. A...

Incident Date	Incident #	Run #	Dollars
01/26/13	201313-3773	11390	-$35.44
01/26/13	201313-3771	11391	$234.88
01/27/13	201313-3790	11400	-$96.43
02/05/13	201313-3935	19515	$74.12
02/15/13	201313-4246	25820	$348.12
02/20/13	201313-4308	28063	$136.26
02/20/13	201313-4311	28065	$101.28
03/01/13	201313-4468	35819	$36.97
03/01/13	201313-4464	35821	$147.00
03/02/13	201313-4484	35814	$147.00
		SUBTOTAL	**$ 1,848.38**

FFR ALLOWANCE

02/06/12	FL12-3678	31314	-$26.81
		SUBTOTAL	**-$ 26.81**

FFR FEE

02/06/12	FL12-3678	31314	$164.24
		SUBTOTAL	**$ 164.24**

INTEREST PAYMENT

01/30/13	201313-3849	14519	-$0.25
		SUBTOTAL	**-$ 0.25**

GRAND TOTAL	**$ 70,069.77**

Ambulance Payment Summary for: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS PAYMENT - CHECK OR PAYMENT - EFT OR PAYMENT-CASH OR PAYMENT-CREDIT CARD OR PMT-RCVD BY CLIENT OR PMT-WITHHELD BY STATE

Incident Date	Incident#	Run#	PMT Method	Amount	Payment By	Final
01/31/12	FL12-3602	31305	PAYMENT - CHECK	$73.04	UNITED HEALTH CARE (ALL	NO
01/31/12	FL12-3602	31305	PAYMENT - CHECK	-$73.04	UNITED HEALTH CARE (ALL	NO
01/31/12	FL12-3602	31305	PAYMENT - CHECK	$239.29	UNITED HEALTH CARE (ALL	NO
03/06/12	FL12-4084	38761	PAYMENT - CHECK	$509.84	COMMERCE INS CO - ALL CLAIMS	YES
05/01/12	FL12-4968	70611	PAYMENT - CHECK	$578.00	TUFTS HEALTH PLAN	NO
05/01/12	FL12-4968	70611	PAYMENT - CHECK	-$578.00	TUFTS HEALTH PLAN	NO
05/14/12	12-5159	76089	PAYMENT - CHECK	$88.15	UNITED HEALTH CARE (ALL	YES
05/28/12	12-5416	87699	PAYMENT - CHECK	$175.59	UNITED HEALTH CARE (ALL	YES
05/28/12	12-5416	87699	PAYMENT - CHECK	-$175.59	UNITED HEALTH CARE (ALL	YES
05/28/12	12-5416	87699	PAYMENT - CHECK	$87.44	UNITED HEALTH CARE (ALL	YES
06/13/12	FL12-5689	100620	PAYMENT - CHECK	$578.00	PLYMOUTH ROCK - BOSTON	YES
06/14/12	12-5701	100615	PAYMENT - CHECK	$551.66	Bill Patient	YES
07/05/12	FL13-0081	116590	PAYMENT - CHECK	$100.80	AARP - GA	YES
07/07/12	FL13-0124	116631	PAYMENT - CHECK	$81.48	AETNA US HEALTHCARE (EL	YES
07/10/12	13-0189	117503	PAYMENT - CHECK	$200.00	Bill Patient	NO
07/30/12	13-0640	245470	PAYMENT - EFT	$8.44	MEDICARE-MA	NO
07/30/12	13-0640	245470	PAYMENT - EFT	$284.72	MEDICARE-MA	NO
07/30/12	13-0635	245472	PAYMENT - EFT	$346.94	MEDICARE-MA	NO
07/30/12	13-0635	245472	PAYMENT - EFT	$2.82	MEDICARE-MA	NO
07/30/12	13-0634	245473	PAYMENT - EFT	$61.86	MEDICARE-MA	NO
07/30/12	13-0634	245473	PAYMENT - EFT	$346.94	MEDICARE-MA	NO
07/30/12	13-0633	245485	PAYMENT - EFT	$5.62	MEDICARE-MA	NO
07/30/12	13-0633	245485	PAYMENT - EFT	$346.94	MEDICARE-MA	NO
07/30/12	13.0632	245486	PAYMENT - EFT	$14.06	MEDICARE-MA	NO
07/30/12	13.0632	245486	PAYMENT - EFT	$292.17	MEDICARE-MA	NO
07/31/12	13-0658	245215	PAYMENT - EFT	$8.44	MEDICARE-MA	YES
07/31/12	13-0658	245215	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-0650	245217	PAYMENT - EFT	$5.62	MEDICARE-MA	YES
07/31/12	13-0650	245217	PAYMENT - EFT	$292.17	MEDICARE-MA	YES
07/31/12	13-0654	245218	PAYMENT - EFT	$25.31	MEDICARE-MA	YES
07/31/12	13-0654	245218	PAYMENT - EFT	$292.17	MEDICARE-MA	YES
07/31/12	13-0652	245219	PAYMENT - EFT	$19.69	MEDICARE-MA	YES
07/31/12	13-0652	245219	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-0651	245220	PAYMENT - EFT	$25.31	MEDICARE-MA	YES
07/31/12	13-0651	245220	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-648	245221	PAYMENT - EFT	$16.87	MEDICARE-MA	YES
07/31/12	13-648	245221	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-0647	245222	PAYMENT - EFT	$22.50	MEDICARE-MA	YES
07/31/12	13-0647	245222	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-0649	245249	PAYMENT - EFT	$5.62	MEDICARE-MA	YES
07/31/12	13-0649	245249	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-0663	245254	PAYMENT - EFT	$11.25	MEDICARE-MA	YES
07/31/12	13-0663	245254	PAYMENT - EFT	$502.16	MEDICARE-MA	YES
07/31/12	13-662	245255	PAYMENT - EFT	$33.74	MEDICARE-MA	YES
07/31/12	13-662	245255	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-0061	245256	PAYMENT - EFT	$5.62	MEDICARE-MA	YES

Ambulance Payment Summary for: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS PAYMENT - CHECK OR PAYMENT - EFT OR PAYMENT-CASH OR PAYMENT-CREDIT CARD OR PMT-RCVD BY CLIENT OR PMT-WITHHELD BY STATE

Incident Date	Incident#	Run#	PMT Method	Amount	Payment By	Final
07/31/12	13-0061	245256	PAYMENT - EFT	$292.17	MEDICARE-MA	YES
07/31/12	13-0659	245214	PAYMENT - EFT	$11.25	MEDICARE-MA	YES
07/31/12	13-0659	245214	PAYMENT - EFT	$346.94	MEDICARE-MA	YES
07/31/12	13-662	245255	PAYMENT - CHECK	$95.18	BC/BS OF MASSACHUSETTS	YES
07/31/12	13-0061	245256	PAYMENT - CHECK	$74.45	BC/BS OF MASSACHUSETTS	YES
07/31/12	13-0650	245217	PAYMENT - CHECK	$74.45	BC/BS OF MASSACHUSETTS	YES
07/31/12	13-0663	245254	PAYMENT - CHECK	$128.35	BC/BS OF MASSACHUSETTS	YES
07/31/12	13-0652	245219	PAYMENT - CHECK	$91.66	TRICARE	YES
07/31/12	13-0649	245249	PAYMENT - CHECK	$88.15	MASS MEDEX	YES
07/31/12	13-0643	245250	PAYMENT - CHECK	$551.66	BC/BS OF MASSACHUSETTS	YES
07/31/12	13-0660	245257	PAYMENT - CHECK	$551.66	BC/BS OF MASSACHUSETTS	YES
08/02/12	201213-0686	133624	PAYMENT - CHECK	$100.00	Bill Patient	YES
08/14/12	FL201213-0963	148407	PAYMENT-CREDIT CARD	$474.72	Bill Patient	YES
09/10/12	201213-1440	158885	PAYMENT - CHECK	$81.48	MASS MEDEX	YES
09/16/12	FL201213-1539	244099	PAYMENT - CHECK	$560.44	LIFEWISE	YES
09/17/12	FL201213-1558	168087	PAYMENT - CHECK	$289.36	AMTRUST NORTH AMERICA - GA	NO
09/21/12	FL201213-1624	168088	PAYMENT - CHECK	$242.13	AICC/CCMSI	YES
09/27/12	FL201213-1739	243222	PAYMENT - CHECK	$239.20	BMC HEALTHNET PLAN	YES
10/06/12	201213-1876	181253	PAYMENT - CHECK	$155.35	BMI BENEFITS	YES
10/07/12	201213-1892	181244	PAYMENT - CHECK	$100.00	Bill Patient	NO
10/14/12	201213-2019	186249	PAYMENT - CHECK	$460.44	BC/BS OF MASSACHUSETTS	NO
10/14/12	FL201213-2008	183661	PAYMENT - CHECK	$92.36	BANKERS LIFE (Do not change	YES
10/15/12	201213-2034	183646	PAYMENT-CREDIT CARD	$109.20	Bill Patient	YES
10/22/12	201213-2124	190447	PAYMENT - CHECK	$99.39	Bill Patient	YES
10/26/12	2012132190	193517	PAYMENT - CHECK	$407.39	HOPEHEALTH INC.	YES
10/26/12	201213-2195	193534	PAYMENT - EFT	$286.43	MEDICAID-MA	YES
10/27/12	2012132207	193500	PAYMENT - EFT	$431.00	TRICARE	YES
10/27/12	2012132208	193499	PAYMENT - CHECK	$89.55	UNITED HEALTH CARE (ALL	YES
11/01/12	2012132333	196602	PAYMENT - CHECK	$90.96	Bill Patient	YES
11/02/12	2012132344	199465	PAYMENT - EFT	$242.13	MEDICAID-MA	YES
11/03/12	2012132380	199451	PAYMENT - CHECK	$551.66	KEY BENEFITS ADMINISTRATORS	YES
11/05/12	201213-2389	233882	PAYMENT - CHECK	$74.45	Bill Patient	YES
11/06/12	2012132402	199456	PAYMENT - CHECK	$73.74	UNITED HEALTH CARE (ALL	YES
11/07/12	2012132424	202661	PAYMENT - CHECK	$80.77	Bill Patient	YES
11/07/12	201213-2411	202651	PAYMENT - CHECK	$247.99	BMC HEALTHNET PLAN	YES
11/08/12	201213-2438	202659	PAYMENT - CHECK	$50.00	Bill Patient	YES
11/09/12	2012132467	202642	PAYMENT - CHECK	$543.90	HARVARD PILGRIM	NO
11/13/12	201213-2532	207673	PAYMENT - CHECK	$465.94	KEY BENEFITS ADMINISTRATORS	YES
11/14/12	201213-2539	207665	PAYMENT - CHECK	$551.66	KEY BENEFITS ADMINISTRATORS	YES

Ambulance Payment Summary for: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS PAYMENT - CHECK OR PAYMENT - EFT OR PAYMENT-CASH OR PAYMENT-CREDIT CARD OR PMT-RCVD BY CLIENT OR PMT-WITHHELD BY STATE

Incident Date	Incident#	Run#	PMT Method	Amount	Payment By	Final
03/01/13	201313-4459	35820	PAYMENT - EFT	$11.34	MEDICARE-MA	YES
03/01/13	201313-4459	35820	PAYMENT - EFT	$294.50	MEDICARE-MA	YES
03/01/13	201313-4464	35821	PAYMENT - EFT	$232.13	MEDICARE-MA	NO
03/01/13	201313-4464	35821	PAYMENT - EFT	$11.34	MEDICARE-MA	NO
03/02/13	201313-4486	35782	PAYMENT - EFT	$11.34	MEDICARE-MA	NO
03/02/13	201313-4486	35782	PAYMENT - EFT	$294.50	MEDICARE-MA	NO
03/02/13	201313-4489	35785	PAYMENT - EFT	$8.51	MEDICARE-MA	YES
03/02/13	201313-4489	35785	PAYMENT - EFT	$294.50	MEDICARE-MA	YES
03/02/13	201313-4476	35789	PAYMENT - EFT	$31.20	MEDICARE-MA	NO
03/02/13	201313-4476	35789	PAYMENT - EFT	$349.73	MEDICARE-MA	NO
03/02/13	201313-4482	35812	PAYMENT - EFT	$11.34	MEDICARE-MA	YES
03/02/13	201313-4482	35812	PAYMENT - EFT	$294.50	MEDICARE-MA	YES
03/02/13	201313-4473	35813	PAYMENT - EFT	$5.67	MEDICARE-MA	YES
03/02/13	201313-4473	35813	PAYMENT - EFT	$294.50	MEDICARE-MA	YES
03/02/13	201313-4484	35814	PAYMENT - EFT	$5.67	MEDICARE-MA	NO
03/02/13	201313-4484	35814	PAYMENT - EFT	$176.90	MEDICARE-MA	NO
03/03/13	201313-4495	35793	PAYMENT - EFT	$5.67	MEDICARE-MA	NO
03/03/13	201313-4495	35793	PAYMENT - EFT	$294.50	MEDICARE-MA	NO
03/03/13	201313-4492	35796	PAYMENT - EFT	$8.51	MEDICARE-MA	NO
03/03/13	201313-4492	35796	PAYMENT - EFT	$294.50	MEDICARE-MA	NO
03/03/13	201313-4501	35797	PAYMENT - EFT	$5.67	MEDICARE-MA	YES
03/03/13	201313-4501	35797	PAYMENT - EFT	$294.50	MEDICARE-MA	YES
03/03/13	201313-4493	35798	PAYMENT - EFT	$5.67	MEDICARE-MA	NO
03/03/13	201313-4493	35798	PAYMENT - EFT	$294.50	MEDICARE-MA	NO
03/03/13	201313-4500	37562	PAYMENT - EFT	$8.51	MEDICARE-MA	YES
03/03/13	201313-4500	37562	PAYMENT - EFT	$349.73	MEDICARE-MA	YES
03/04/13	201313-4509	37559	PAYMENT - EFT	$62.39	MEDICARE-MA	NO
03/04/13	201313-4509	37559	PAYMENT - EFT	$343.02	MEDICARE-MA	NO
03/04/13	201313-4508	37560	PAYMENT - EFT	$8.51	MEDICARE-MA	NO
03/04/13	201313-4508	37560	PAYMENT - EFT	$349.73	MEDICARE-MA	NO

Total Payments **$145,477.64**

Summary of Payments Received After Patient was Sent to FFR

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS FFR PAYMENT - NO FEE

MAIN STREET USA

Trip Date	Incident#	Run#	Patient City & State	PMT Method	Amount	Payment By	Post Date
2012-02-06	FL12-3678	31314	MAIN STREET USA,	FFR PAYMENT - NO FEE	$328.51	FFR - FIRST	2013-03-17

Company Total: **Total Payments** **$328.51**

Report Total: **Total Payments** **$328.51**

Retraction / Reimbursement Report for: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS REIMBURSEMENT OR RETRACTION

RETRACTION

Incident Date	Incident #	Run #	Dollars
05/01/12	FL12-4968	70611	-$578.00
05/27/12	12-5391	87708	-$483.50
07/24/12	FL13-0514	125728	-$578.00
		SUBTOTAL	**-$ 1,639.50**
		GRAND TOTAL	**-$ 1,639.50**

COMSTAR ★

Monthly Deposit / Payment Summary Reconciliation

Prepared For: TOWN OF MAIN ST USA

Date: 4/2/2013

For the Period: 2/25/2013-3/31/2013

Total Deposits - Payments Received By Comstar	$68,324.02
Reconciling Items:	
Electronic Funds Tranfers Received By Client	$77,153.62
Subtotal	$145,477.64
Reimbursement/Retraction	-$1,639.50
Net Payment Applied	**$143,838.14**

EFT - electronic funds transfers- Medicare, Medicaid, VA payments, etc.

Foreign check- payment applied using the exchange rate provided by client bank

Payment received by client- payments clients have received and deposited, forwarding remittance to Comstar for posting.

Payment withheld by state-payments intercepted by government for outstanding balances owed by client.

Prior/Post billing- payments received for prior/post billing that are deposited on clients behalf.

Reimbursement- monies for previous payments returned by client

Returned checks- checks that have been returned and payment reversed.

Write Off Report for: MAIN STREET USA

Post Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Credits IS WO / ANTHEM PATIENT-NO RESP OR WO/DECEASED-NO RESP. ESTATE OR WO/INCORRECT INFO-CLIENT-MGT OR WO/INSUFFICIENT INFO-CLIENT OR WO/LATE RESP...

WRITE-OFF / CLIENT REQUEST

Incident Date	Incident #	Run #	Dollars
02/21/12	FL12-3892	36086	$474.72
			$ 474.72

GRAND TOTAL **$ 474.72**

Aging by Incident with FFR Separation: MAIN STREET USA

Company IS MAIN STREET USA; AND Status IS Assigned OR Billed OR Complete OR NetTransit New Call OR NetTransit New Will Call OR NetTransit Review OR NetTransit Will Call OR Not Billed OR On Hold OR Open OR ProQA Hold OR Verified OR W...

At Comstar

Incident Date	Incident #	Run #	Current	31-60	61-90	91-120	Over 120	Total
01/12/12	FL12-3307	31581	0.00	0.00	0.00	0.00	77.12	77.12
01/14/12	FL12-3335	31526	0.00	0.00	0.00	0.00	417.23	417.23
01/14/12	FL12-3344	31571	0.00	0.00	0.00	0.00	369.43	369.43
01/14/12	FL12-3340	31645	0.00	0.00	0.00	0.00	501.06	501.06
01/15/12	FL12-3353	31641	0.00	0.00	0.00	0.00	501.06	501.06
01/25/12	FL12-3529	31577	0.00	0.00	0.00	0.00	292.29	292.29
01/30/12	FL12-3599	31303	0.00	0.00	0.00	0.00	551.66	551.66
01/30/12	FL12-3600	31306	0.00	0.00	0.00	0.00	551.66	551.66
01/30/12	FL12-3599	31606	0.00	0.00	0.00	0.00	509.84	509.84
01/31/12	FL12-3602	31305	0.00	0.00	0.00	0.00	-148.19	-148.19
02/07/12	FL12-3707	31616	0.00	0.00	0.00	0.00	492.28	492.28
02/09/12	FL12-3792	31410	0.00	0.00	0.00	0.00	74.45	74.45
02/10/12	FL12-3742	31537	0.00	0.00	0.00	0.00	483.50	483.50
02/12/12	FL12-3780	31574	0.00	0.00	0.00	0.00	569.22	569.22
02/22/12	FL12-3885	36072	0.00	0.00	0.00	0.00	126.24	126.24
02/25/12	FL12-3957	36113	0.00	0.00	0.00	0.00	474.72	474.72
02/25/12	FL12-3950	36160	0.00	0.00	0.00	0.00	245.06	245.06
03/03/12	FL12-4048	36638	0.00	0.00	0.00	0.00	560.44	560.44
03/07/12	FL12-4089	38743	0.00	0.00	0.00	0.00	465.94	465.94
03/14/12	12-4191	75440	0.00	0.00	0.00	0.00	474.72	474.72
03/17/12	FL12-4238	44792	0.00	0.00	0.00	0.00	465.94	465.94
03/17/12	FL12-4238	44802	0.00	0.00	0.00	0.00	465.94	465.94
03/26/12	FL12-4376	50128	0.00	0.00	0.00	0.00	465.94	465.94
03/26/12	FL12-4347	50135	0.00	0.00	0.00	0.00	578.00	578.00
03/26/12	FL12-4377	50155	0.00	0.00	0.00	0.00	465.94	465.94
03/26/12	FL12-4383	50156	0.00	0.00	0.00	0.00	253.85	253.85
04/01/12	FL12-4471	51972	0.00	0.00	0.00	0.00	-324.86	-324.86
04/03/12	FL12-4494	54174	0.00	0.00	0.00	0.00	101.66	101.66
04/03/12	FL12-4498	54184	0.00	0.00	0.00	0.00	518.62	518.62
04/07/12	FL12-4579	55820	0.00	0.00	0.00	0.00	-95.44	-95.44
04/08/12	FL12-4606	55822	0.00	0.00	0.00	0.00	-100.00	-100.00
04/09/12	FL12-4618	56878	0.00	0.00	0.00	0.00	75.15	75.15
04/23/12	FL12-4860	66063	0.00	0.00	0.00	0.00	474.72	474.72

Aging by Incident with FFR Separation: MAIN STREET USA

Company IS MAIN STREET USA; AND Status IS Assigned OR Billed OR Complete OR NetTransit New Call OR NetTransit New Will Call OR NetTransit Review OR NetTransit Will Call OR Not Billed OR On Hold OR Open OR ProQA Hold OR Verified OR W...

At Comstar

Incident Date	Incident #	Run #		Current	31-60	61-90	91-120	Over 120	Total
			Totals At Comstar	**94,512.42**	**65,876.82**	**37,946.73**	**21,920.50**	**107,512.24**	**327,768.71**

Aging by Incident with FFR Separation: MAIN STREET USA

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At FFR

Incident Date	Incident #	Run #		Current	31-60	61-90	91-120	Over 120	Total
06/12/12	FL12-5665	100686		0.00	0.00	0.00	0.00	483.50	483.50
06/16/12	FL12-5748	100641		0.00	0.00	0.00	0.00	569.22	569.22
06/18/12	FL12-5779	101468		0.00	0.00	0.00	0.00	465.94	465.94
06/20/12	FL12-5815	105261		0.00	0.00	0.00	0.00	474.72	474.72
06/22/12	FL12-5844	105245		0.00	0.00	0.00	0.00	501.06	501.06
06/24/12	FL12-5885	105252		0.00	0.00	0.00	0.00	465.94	465.94
06/25/12	12-5909	106037		0.00	0.00	0.00	0.00	560.44	560.44
06/30/12	12-6002	113915		0.00	0.00	0.00	0.00	578.00	578.00
			Totals At FFR	**0.00**	**0.00**	**0.00**	**0.00**	**32,288.55**	**32,288.55**

Aging by Incident with FFR Separation: MAIN STREET USA

Company IS MAIN STREET USA; AND Status IS Assigned OR Billed OR Complete OR NetTransit New Call OR NetTransit New Will Call OR NetTransit Review OR NetTransit Will Call OR Not Billed OR On Hold OR Open OR ProQA Hold OR Verified OR W...

At FFR

Incident Date	Incident #	Run #		Current	31-60	61-90	91-120	Over 120	Total
			At Comstar	**94,512.42**	**65,876.82**	**37,946.73**	**21,920.50**	**107,512.24**	**327,768.71**
			At FFR	**0.00**	**0.00**	**0.00**	**0.00**	**32,288.55**	**32,288.55**
			Combined Comstar and FFR Totals	**94,512.42**	**65,876.82**	**37,946.73**	**21,920.50**	**139,800.79**	**360,057.26**

MAIN STREET USA

Request for Disposition Report / FFR Authorization

Last Event Date IS BETWEEN 02/25/2013 AND 03/31/2013; AND Company IS MAIN STREET USA; AND Status IS Billed OR Complete OR Verified; AND Schedule IS WRITE-OFF REQUEST

We were unable to collect from the patients below for the reasons listed. We will hold these accounts which will continue to appear on your aging report until we receive a response from you. For each account, please indicate your disposition decision by putting a check in the appropriate box.

Incident Date	Incident #	Run #			Dollars
01/14/12	FL12-3340	31645	**Reason >**	NO RESPONSE FROM PATIENT	$501.06
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
01/30/12	FL12-3600	31306	**Reason >**	BAD ADDRESS	$551.66
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
01/30/12	FL12-3599	31606	**Reason >**	NO RESPONSE FROM PATIENT	$509.84
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
02/12/12	FL12-3780	31574	**Reason >**	NO RESPONSE FROM PATIENT	$569.22
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
02/25/12	FL12-3950	36160	**Reason >**	ALL STEPS EXHAUSTED-MGT	$245.06
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
03/14/12	12-4191	75440	**Reason >**	ALL STEPS EXHAUSTED-MGT	$474.72
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
03/26/12	FL12-4347	50135	**Reason >**	BAD ADDRESS	$578.00
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
03/26/12	FL12-4377	50155	**Reason >**	NO RESPONSE FROM PATIENT	$465.94
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
04/03/12	FL12-4498	54184	**Reason >**	NO RESPONSE FROM PATIENT	$518.62
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
04/23/12	FL12-4850	66064	**Reason >**	NO RESPONSE FROM PATIENT	$551.66
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
05/02/12	FL12-4992	73213	**Reason >**	NO RESPONSE FROM PATIENT	$569.22
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					
05/04/12	FL12-5013	75432	**Reason >**	BAD ADDRESS	$509.84
[ ] Write-Off [ ] Report to Experian [ ] Transfer to FFR Collection Agency [ ] Other :					

Incident Date	Incident #	Run #			Dollars
11/28/12	201213-2755	216619	**Reason >**	HOMELESS / INDIGENT NO ADDRESS	$483.50
[ ] Write-Off	**[ ] Report to Experian**	**[ ] Transfer to FFR Collection Agency**	**[ ] Other :**		
12/10/12	201213-2966	223237	**Reason >**	BAD ADDRESS	$474.72
[ ] Write-Off	**[ ] Report to Experian**	**[ ] Transfer to FFR Collection Agency**	**[ ] Other :**		
12/29/12	201213-3288	240273	**Reason >**	BAD ADDRESS	$551.66
[ ] Write-Off	**[ ] Report to Experian**	**[ ] Transfer to FFR Collection Agency**	**[ ] Other :**		
12/30/12	201213-3307	238398	**Reason >**	OUT OF STATE WELFARE	$200.00
[ ] Write-Off	**[ ] Report to Experian**	**[ ] Transfer to FFR Collection Agency**	**[ ] Other :**		
01/10/13	201313-3505	2980	**Reason >**	BAD ADDRESS	$633.65
[ ] Write-Off	**[ ] Report to Experian**	**[ ] Transfer to FFR Collection Agency**	**[ ] Other :**		
02/02/13	201313-3877	17246	**Reason >**	BAD ADDRESS	$793.57
[ ] Write-Off	**[ ] Report to Experian**	**[ ] Transfer to FFR Collection Agency**	**[ ] Other :**		

GRAND TOTAL **$ 47,935.70**

INITIALS _____

COMSTAR
Ambulance Billing Service

OTHER REPORTS

As part of our service to you, Comstar can provide additional reports upon request. The following are a few examples. Comstar will also provide custom reports prepared to your specifications upon request. These reports provided on an ad-hoc basis or included as part of your monthly report package at your discretion.

ACTIVITY TRACKING REPORT
BY PAYOR GROUPS

Company IS TOWN OF MAIN STREET; AND Trip Date IS BETWEEN 01/01/2012 AND 06/30/2012

TOWN OF MAIN STREET

	Total Transports	Total Charges	Total Allowable	Total Collected	Percent Collected
Blue Cross	**149**	**$80,012.08**	**$74,782.80**	**$72,041.39**	**96.33%**
Medicaid	**106**	**$53,856.10**	**$27,395.01**	**$25,408.16**	**92.75%**
Medicaid HMO	**91**	**$48,510.97**	**$24,494.26**	**$24,201.97**	**98.81%**
Medicare	**1,004**	**$528,419.03**	**$400,550.95**	**$399,354.42**	**99.70%**
Medicare HMO	**13**	**$6,990.26**	**$5,582.61**	**$5,581.91**	**99.99%**
Other Insurance	**182**	**$95,390.21**	**$89,027.02**	**$76,321.44**	**85.73%**
Totals >	**1,545**	**$813,178.65**	**$621,832.65**	**$602,909.29**	**96.96%**

	Total Transports	Total Charges	Total Allowable	Total Collected	Percent Collected
Patient-No Insurance	**103**	**$52,460.36**	**$52,005.63**	**$12,461.80**	**23.96%**
Totals >	**103**	**$52,460.36**	**$52,005.63**	**$12,461.80**	**23.96%**

Grand Totals >	**1,648**	**$865,639.01**	**$673,838.28**	**$615,371.09**	**91.32%**

COMSTAR

Ambulance Billing & Collection Service

Monthly Statistics For: Town of Main St USA

For the Month Ended: 3/31/2013

	# of Trips	% of Total
Transports:		
Residents (01234)	68	73%
Non-Residents	25	27%
Total	93	100%
Level of Service:		
ALS1	67	72%
ALS2	0	0%
BLS	26	28%
Total	93	100%
Hospitals Used:		
Other	0	0%
Charlton Memorial	77	83%
Hasboro	0	0%
Morton	0	0%
Rhode Island	1	1%
St. Ann's	15	16%
Total	93	100%
Services Used:		
Airway	0	0%
Cardiac Monitor	56	60%
Defibrillation	0	0%
I.V. Therapy	59	63%
Imobilization	8	9%
MAST	0	0%
Oxygen	65	70%
Total	188	

COMSTAR AMBULANCE BILLING SERVICE

COMPLIANCE PROGRAM MANUAL

COMSTAR AMBULANCE BILLING SERVICE
CORPORATE RESOLUTION ADOPTING COMPLIANCE PROGRAM

Comstar is committed to providing services and conducting its business in full compliance with the law. In some circumstances, the interpretation and application of the law is highly technical, and common concepts of right and wrong often provide inadequate guidance. Thus, volunteers, employees, and agents who believe that they are conducting themselves properly may, in fact, be violating applicable laws. Violations of the law by volunteers, employees and agents, even unwitting violations, can subject Comstar to the risk of lawsuits, government investigations, fines, penalties and embarrassment.

Comstar can meet its compliance commitment only through the efforts of our highly skilled and dedicated ambulance and support staff. It is they who must earn the trust and respect of patients and others by continuing to conduct their daily affairs with honesty, integrity, and in compliance with the letter and spirit of all applicable laws. Although honesty and integrity are individual attributes, and each individual ultimately is responsible for his or her own conduct, Comstar is committed to maintaining a working environment that promotes these ideals and permits our volunteers, employees and agents to demonstrate the highest ethical standards in performing their daily tasks.

In order to avoid violations of law, the Board believes that Comstar should implement a formal Compliance Program concerning Comstar's operations. The Board's action in directing management to proceed in the development and implementation of a Corporate Compliance Program should not be interpreted as concern that present management systems are inadequate. Rather, development and implementation of a Compliance Program is one important element in Comstar's continuing effort to improve quality and performance. The Board also recognizes that federal agencies responsible for enforcement of Medicare, Medicaid, and other federal health program laws and regulations applicable to health care providers recently have encouraged the development and implementation of Corporate Compliance Programs by health care providers.

WHEREFORE, BE IT RESOLVED ON THIS DATE

1. Management of Comstar is directed to dedicate the necessary resources toward development of an effective Corporate Compliance Program ("the Program") designed to prevent and detect violations of federal or state law in the conduct of Comstar's operations by volunteers, employees and agents.

2. The Program will meet or exceed the elements of an effective compliance program, specifically the OIG's Compliance Program Guidance for Ambulance Suppliers, which require an ambulance organization to:

   a. Establish compliance standards and procedures reasonably capable of reducing the prospect of wrongful conduct;

   b. Appoint specific, high-level individual(s) with overall responsibility to oversee compliance with such standards and procedures;

   c. Exercise due care not to delegate substantial discretionary authority to individuals with a propensity to engage in unlawful activities;

   d. Take steps to communicate effectively the compliance standards and procedures to all volunteers, employees and agents by, for example, mandatory training sessions or the dissemination of publications;

   e. Take reasonable steps to achieve compliance by, for example, utilizing monitoring and auditing systems, and by publicizing a reporting system whereby volunteers, employees and agents can report perceived wrongful conduct by others within the organization without fear or retribution;

   f. Consistently enforce its standards through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals for failure to detect non-compliance; and

   g. Take responsible steps to respond appropriately to non-compliance after detection and to prevent recurrence, which may require modifications to the compliance program.

3. The development and implementation of specific standards, educating and training volunteers and employees with respect to those specific standards, and reviewing and possibly enhancing internal controls and monitoring systems will be time-consuming. Accordingly, management is directed to proceed in phases, if necessary, but management should make steady progress toward the creation and implementation of specific standards and systems relating to all material areas of Comstar's operations where there are compliance obligations. Management shall provide periodic progress reports to the Board.

SIGNED:

President and CEO

Treasurer

Secretary

Date: 9/2/11

COMSTAR AMBULANCE BILLING SERVICE
COMPLIANCE PROGRAM MANUAL

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6. Policy on Complaint and Concern Reporting
7. Policy on Confidentiality of Patient Information
8. Policy on Credit Balances/Overpayments
9. Policy on "Golden Rule" of Billing
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11. Policy on Disseminating Changes

COMSTAR AMBULANCE BILLING
POLICY STATEMENT ON COMPLIANCE

We are committed to providing ambulance billing services and conducting our business practices with the highest level of skill, integrity, honesty, and compassion, and in compliance with the laws and regulations that govern our operations. In order to achieve this commitment, we have periodically adopted policies and procedures that are intended to guide our actions and protect against unlawful activity. Our Code of Conduct has been specifically designed to provide the necessary guidance that will allow each of us to perform our jobs with the highest level of integrity, and thereby avoid even the appearance of unlawful behavior.

However, we all must make personal commitments to adhere to these guiding principles and to comply with our policies, procedures and regulatory requirements, including the Comstar Code of Conduct. If you have questions or concerns about what is appropriate conduct, or if you become aware of any situation that may jeopardize the ethical integrity of our organization, we ask that you please refer to the Code of Conduct, or promptly contact our Compliance Officer or a member of the Compliance Committee. However, if you feel that your concern has not been addressed to your satisfaction, or if you would prefer to remain anonymous, you can submit an inquiry to our email address as follows: info@comstarbilling.com

Comstar depends on everyone to carry out its values and achieve its mission of responding to the health care needs of our patients. We must all commit ourselves to conducting business ethically and in accordance with applicable laws, rules and regulations.

COMSTAR AMBULANCE BILLING SERVICE
CODE OF CONDUCT

I. PURPOSE

Comstar Ambulance Billing Service continually strives to provide high quality billing services to our clients and to maintain high standards of integrity. It is our philosophy that we provide all of our services in full compliance with all laws and regulations. This requires the highest standard of conduct from all of our staff members. This philosophy of total compliance is the foundation of all that we do, and consistent with that philosophy, Comstar Ambulance Billing Service has approved and adopted this Code of Conduct.

II. POLICY

A. STATEMENT OF COMMITMENT

Comstar Ambulance Billing Service has been, and continues to be, committed to conducting our activities in full compliance with all federal, state and local laws. Our reputation for quality service and excellent care has been achieved by the personal integrity, good judgment and common sense of our staff members. Staff members are expected to demonstrate appropriate ethical behavior when conducting activities with patients and their families, fellow staff members, suppliers, vendors, consultants and those with whom we do business. We commit to provide each staff member the policies, procedures and guidelines to be aware of his/her responsibility in ensuring compliance with this Code of Conduct.

B. PURPOSE OF THE COMPLIANCE PLAN

The Compliance Plan provides the approach to guide our conduct in all that we do. It is intended to provide overall guidance for us in providing billing services in a legal, ethical, and appropriate manner; however, it does not supersede the more specific policies of Comstar Ambulance Billing Service. The Compliance Plan is a supplement to the standards of conduct as presented in general staff member policies and procedures, such as in our personnel handbook, where applicable. Each staff member and all supervisory and administrative personnel should read and understand the Code, and subscribe to its standards and procedures.

This Code of Conduct does not address every aspect of Comstar's activities and the applicable legal issues they may entail. Because of changes in Comstar's structure and operations or changes in regulatory requirements, the document is inherently subject to change.

Each staff member, supervisor, and manager should participate in an initial training program explaining the Code. New staff members should receive compliance training during new staff member orientation. Annually, each staff member may receive a minimum of one hour of compliance training. Upon completion of each training session or orientation, staff members should be required to sign a statement of participation and attendance.

Each staff member is expected to be familiar with the applicable laws and regulations that govern the matters set forth in the Code of Conduct as it pertains to his or her duties. That familiarity should be part of every staff member's job performance and a regular part of that staff member's review.

C. STANDARD OF COMPLIANCE WITH LAWS

1. Comstar personnel, including, where applicable, managers, staff members, agents, consultants and other representatives, should conduct their activities in compliance with applicable laws, rules and regulations. If there is reasonable doubt as to the appropriateness of an activity, staff members should seek advice within the Comstar chain of command. Staff members may also contact the Comstar Compliance Officer at any time if they have questions about the appropriateness of any particular action or course of conduct.

2. Policies and procedures regarding certain laws and regulations important to the provision of health care services are a part of the Compliance Plan.

a) Patient Rights

Comstar is dedicated to protecting patients' personal privacy and confidentiality of information consistent with Comstar's mission, applicable laws (including HIPAA, where applicable) and quality standards.

b) Disclosure

Comstar and its agents will deal honestly and fairly with patients, community members, vendors, competitors, mutual aid companies, payors and other outside contractors. Communication and disclosure information should be clear, accurate and sufficiently complete.

Financial and operational reports should be prepared in accordance with applicable rules and regulations and prepared within Comstar's normal system of accountability.

c) Patient Billing

Comstar will deal honestly with all payors (e.g., self-pay, insurance companies, HMOs, Medicare, Medicaid, etc.). Claims submitted to Medicare and other governmental and private payors should be complete and accurately reflect the services rendered. Comstar should submit claims for services that are supported by the necessary documentation, while maintaining prompt and proper billing practices.

Billing issues should be resolved according to applicable laws, regulations, organizational policies and, where applicable, payor contracts. Questions regarding patient billing should be resolved expeditiously. If staff members are unsure of the proper response to a question or inquiry, the staff member should contact the Compliance Officer or other responsible person in the organizational chain of command.

d) Integrity of Workforce

We recognize that the personal integrity, good judgment and common sense of our staff members is responsible for our reputation of quality service. To maintain that reputation, prior to entering into a relationship with Comstar, all staff members, contractors, vendors and others will be subject to a reasonable and prudent background investigation, including a reference check.

Applicants (career and/or volunteer, as applicable) will be asked to disclose any criminal convictions, (as defined by 42 U.S.C. 1320a-7(i) and state law) or any action taken by the government to exclude the individual from participation in federal health care programs. Individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in federal health care programs (as defined in 42 U.S.C. 1320a-7b(f)) may not be considered for employment or a volunteer position with Comstar. Additionally, applicants may be required to divulge their driving record, particularly if their work involves the operation of Comstar vehicles.

e) Conflict of Interest

Staff members are to conduct themselves in a manner that encourages and preserves the trust of those we serve. Staff members should not have financial relationships with parties with which Comstar does business. Prompt disclosure of conflicts of interest should be made to Comstar administration. Violations should be handled in accordance with applicable Comstar disciplinary procedures.

f) Confidentiality

No member of the organization should use confidential or proprietary information for his or her own personal gain or for the benefit of another person or entity, while associated with Comstar or at any time thereafter.

Information concerning a patient is confidential. Comstar personnel should not obtain or divulge details of a patient's condition without a specific professional reason, except as required by law. Violations should be handled in accordance with Comstar disciplinary policies, and/or our HIPAA compliance plan, where applicable.

All new personnel, prior to performing any substantial duties with Comstar that involve patient interaction or information, shall undergo the mandatory privacy training as required under the HIPAA Privacy Regulations (where Comstar is a "business associate" in accordance with HIPAA).

g) Compliance with Federal, State and Local Laws and Regulations

Comstar will take all actions necessary to ensure compliance with all applicable federal, state and/or local laws and regulations, as well as with the public policies they represent.

h) Anti-Kickback Laws

Comstar will take all actions necessary to ensure compliance with Federal and State anti-kickback laws regarding the acceptance or payment of any remuneration for the inducement of referrals of services or the generation of other business, and shall comply with all applicable regulations regarding self-referrals and kickbacks. Staff members should not give or receive kickbacks, rebates or anything of value to a vendor, patient, physician or other health care provider in exchange for a referral for services or the generation of other business.

i) Business Arrangements With Physicians or other Referral Sources

Comstar will take all actions necessary to ensure compliance with federal and state laws regarding self-referral and business arrangements. Business arrangements with any referral sources should be set forth in a written contract and should be in accordance with applicable federal and state laws. Payments by Comstar to any referral source should be equal to the fair market value of the services rendered or items being purchased by Comstar and should not be based on the volume of transports or the value of referrals generated by the referral source.

j) Environment

Comstar strives to manage and operate in ways to ensure there is minimal risk to patients, staff members, visitors and the community environment within the confines of Comstar. Every staff member should comply with the safety, hazardous waste and other environmental care policies established by Comstar.

k) Comstar Transactions

Comstar transactions should be completed at fair market value and should not result in a direct or indirect monetary benefit to a staff member. Comstar assets should not be used for the benefit of private individuals or staff members.

l) Anti-Competitive Practices

Comstar will take all actions necessary to ensure compliance with federal, state and/or local laws and regulations that prohibit price-fixing and other anti-competitive practices. This includes compliance with all laws and regulations related to the procurement of billing services for a municipality or other government entity.

m) Gifts to Government Representatives

Staff members should not provide gifts or pay for meals, refreshments travel or lodging expenses for government or public agency representatives, with the intent to influence an official action or decision in an illegal, unethical or unlawful manner.

n) Government Investigation

Comstar has established prescribed procedures and guidelines to ensure an appropriate response to government inquiries. Information disclosed without proper authorization jeopardizes the rights of our patients. We also do not want to hinder in any way a legitimate government investigation. If federal or state law enforcement officials request information from a Comstar staff member, the staff member should direct the federal or state law official to contact the Comstar Compliance Officer. The Comstar Compliance Officer should then communicate with the staff member to ensure that the appropriate documents are provided.

Whenever there is any indication that a government investigation may be underway, under no circumstances will any records or documents that could have a bearing on that investigation be destroyed or altered in any way. Any question about disposition of documents or records should be directed to the Compliance Officer.

o) Individual Judgment

Staff members are often faced with making critical decisions based on activities in the workplace. Remember to always respect others and use good judgment and common sense. If anything within this Code of Conduct goes against your own good judgment, you are encouraged to discuss it with the Compliance Officer or other member of Comstar management.

III. IMPLEMENTATION OF THE CODE

A. COMPLIANCE COMMITTEE/COMPLIANCE OFFICER

Comstar may appoint a Compliance Committee. The Compliance Committee, where applicable, is responsible for working with the appropriate personnel to ensure that the Code and related policies and procedures govern the business activities of Comstar.

The Compliance Officer's responsibilities are to develop, implement and maintain the plan, oversee the staff member education, investigate issues in a confidential manner, and report periodically to the Board of Directors or other governing body of the organization.

Designation of a Compliance Committee or Compliance Officer does not lessen each staff member's responsibility to comply with the Code and related policies and procedures.

B. REPORTING OF VIOLATIONS

It is important to first attempt to resolve issues within the area of responsibility in which they arise. If the staff member knows of a violation or possible violation of the Code or related policies and procedures, it is the staff member's responsibility to report that information immediately to the staff member's Supervisor (if applicable) or Compliance Officer.

Ultimately, potential violations should be brought to the attention of an appropriate Administrator or Manager within the organization. The Administrator or Manager, in turn, should report potential violations to the Compliance Officer. If the staff member cannot report a possible violation to their Supervisor or Administrator, the staff member may report such violations anonymously to the confidential email address established under the compliance program. Information on making confidential email reports shall be disseminated to all personnel. Reported violations should be logged, assigned a tracking number and investigated by the Compliance Officer.

In reporting violations to the Compliance Officer, if staff members wish to remain anonymous, they may do so by either not disclosing identifying information or by requesting that their confidentiality be protected. The Compliance Officer should make an effort not to identify an individual making an anonymous report, unless it is subsequently determined that the person engaged in improper conduct. Reasonable efforts shall be expended to assure confidentiality of anonymity requests; however, there may be a point where the individual's identity may become known in connection with the investigation or may have to be revealed if governmental authorities become involved.

C. DISCIPLINARY ACTIONS

Failure to comply with the standards established by the Code may have severe consequences. Appropriate discipline for violations of the Code, up to and including suspension or termination, may be imposed. Personnel will be subject to disciplinary action if they authorize or participate directly or indirectly in actions that constitute a violation of the law, the Code or related policies and procedures.

D. NO RETALIATION FOR GOOD FAITH REPORTING OF VIOLATIONS

The success of any compliance policy, including this Code, depends on the prompt and accurate reporting of violations and suspected violations without fear of retaliation. Comstar's policy, as well as both federal and state law, does not condone retaliation against a staff member for reporting, in good faith, an actual or suspected violation of the law. Reports should remain confidential except when the nature of the complaint requires disclosure and then should be disclosed only to the extent necessary or advisable to resolve the complaint.

E. MONITORING OF COMPLIANCE EFFORTS

An integral component of the Compliance Code and Compliance Plan is the continual monitoring, auditing and evaluation of Comstar's compliance efforts. An initial audit of compliance should be conducted to determine the areas in which area-specific compliance programs should be focused. Thereafter, audits may be authorized by the Compliance Committee or Compliance Officer in response to reports received through the compliance reporting system or through other means. In addition, overall compliance efforts should be reviewed on an annual basis.

IV. QUESTIONS REGARDING THE CODE

Comstar wants to provide timely guidance to its staff members with respect to the Code. If staff members have a question concerning the Code or related policies or feel the need to seek guidance with respect to a particular issue, staff members should consult their supervisor, administrator or manager, or the Compliance Officer.

V. ACKNOWLEDGMENT

All employees, volunteers, vendors, contractors, consultants and others with a business relationship to Comstar shall complete the following acknowledgment:

COMPLIANCE CODE OF CONDUCT

EMPLOYEE ACKNOWLEDGEMENT

I acknowledge that I have received the Comstar Code of Conduct, that I have read it, and that I will comply with its terms, to the extent applicable and relevant to my duties or responsibilities, throughout my employment or association with the organization. I understand that the Code represents mandatory organization policies and that violation will result in termination of my employment/membership/business relationship with Comstar.

Name (print): _____

Signature: _____ Date: _____

COMSTAR AMBULANCE BILLING
POLICY ON STAFF MEMBER RIGHTS AND OBLIGATIONS
IN A GOVERNMENT INVESTIGATION

Background

Government attorneys, agents, and investigators frequently conduct investigations and inquiries in order to monitor compliance with government regulations and laws. As a result, Comstar staff members or personnel may be contacted by a government attorney or agent in the course of an investigation. This does not mean that any laws have been violated; it could simply be part of a routine inquiry. You may be contacted either at work or away from work during off hours. You may be visited at home, at work or at some other location.

You have certain rights and obligations of which you should be aware in the event that you are contacted by an agent or attorney during the course of an investigation. Please be aware of the following:

While you are free to talk with government investigators, you are under no obligation to do so.

You have a right to decline to be interviewed by a government attorney or investigator.

Government agents or investigators cannot require you to be interviewed or make a statement.

Unless you give them permission, government agents or investigators cannot enter your home without a search warrant. Unless you give them permission, they cannot take any documents, papers or other items without either a search warrant or a valid subpoena (which may be called a "subpoena duces tecum").

Just as you are free to decline to speak with an investigator or agent, you also have a right to choose to speak with a government investigator or agent. If you choose to be interviewed or make a statement, we expect you to respond to questions truthfully.

Regardless of whether you refuse to be interviewed or agree to be interviewed, please immediately report all contacts by government agents or investigators to the management or administration of Comstar. Please provide the date and time of the contact and the name and agency of the investigator.

If contacted by a government agent or investigator, you have the right to meet with an attorney. You also have the right to have an attorney present during an interview. Comstar may provide an attorney to meet with any current or former employee, volunteer, contractor or agent who is contacted during the course of an investigation, and may provide an attorney to accompany any employee during any interview or discussion with any government agent or investigator. If an attorney is requested, the attorney will be able to inform you of the nature of the investigation and your rights in connection with the investigation. If you desire to request that Comstar provide an attorney for you, please contact the appropriate member of the company's management team.

Policies

In accordance with the above rights and obligations, Comstar has established the following policies and procedures:

1. If contacted by an agent or investigator, whether in person or by telephone, at home, at work, etc., inform the agent or investigator that you wish to have an attorney present for any interviews or statements if that is in fact your wish.

2. Inform the agent or investigator to contact Comstar management for the purpose of scheduling the interview at a mutually convenient time when legal counsel can be present.

3. If a government agent or investigator asks for copies of any Comstar documents, including call records, patient care reports, computer disks, hard drives, printouts, faxes, medical necessity forms, etc., inform the agent or investigator to contact Comstar management as indicated above. Do not give out any documents or materials in the absence of a search warrant or other legal papers that require an immediate response.

4. In the event that the agent or investigator has a search warrant or other such legal document, they are permitted to enter and inspect the premises described in the warrant and obtain all documents or other evidence within the scope of the subpoena or search warrant. If the agents or investigators have a search warrant and/or subpoena:

a. DO NOT interfere or prevent them from performing their duties or lawfully executing the warrant.

b. IMMEDIATELY contact Comstar management.

c. DO NOT make any statements to the investigators while they are executing the warrant.

d. DO monitor the agent or investigator while he or she is performing the search or executing the warrant.

e. DO take notes as to the areas searched and documents or other evidence seized by the agents or investigators during the course of their visit.

f. DO NOT destroy or dispose of any documents or records in any form that may have any relationship to a government investigation without the express authorization of the Compliance Officer or management representative responsible for records.

f. Ask to make copies of the documents being seized. You may not have a right to copy documents being taken in response to a warrant, but make a request of the investigator or agent to permit you to do this. If they refuse, allow them to continue to do their work uninterrupted.

COMSTAR AMBULANCE BILLING
RECORD RETENTION SCHEDULE

IMPORTANT: Never destroy or dispose of any records or documents that could be relevant to a pending government investigation of any type. Contact the Compliance Officer if you have any questions as to whether a record should be retained or destroyed.

Type of Record	Retention Period
Patient Care Reports (adults)	7 years after date of service
Patient Care Reports (minors)	7 years
Billing Records (claims, remittance advice forms, EOBs, etc.)	7 years
Physician Certification Statements and Supporting Medical Necessity Documentation	7 years
Privacy-Related Documents (Notice of Privacy Practices, Patient Accounting forms, Privacy Complaints, etc.)	7 years
Employment related records that document decisions on hiring, selection, promotion, demotion, or discipline	7 years
Payroll records	7 years

COMSTAR AMBULANCE BILLING SERVICE
BACKGROUND SCREENING POLICY

Background

In accordance with the Comstar Code of Conduct, it is the policy of Comstar to verify the backgrounds of its personnel (employees and volunteers, where applicable) and vendors, contractors, consultants, management, officers and others with which Comstar has a business relationship. Comstar will generally not employ, accept into membership or otherwise enter into a business relationship with an individual or entity who is excluded from participation in state or federal health care programs and/or who has been convicted of any health care program-related offense.

Procedures

With respect to prospective staff members, Comstar will perform the following background checks prior to offering membership/employment:

- OIG List of Excluded Individuals/Entities (www.exclusions.oig.hhs.gov/search.html)

- Reference Checks (i.e., references supplied by applicant)

With respect to prospective vendors, contractors, etc., Comstar will perform the following background checks prior to initiating the business relationship:

- OIG List of Excluded Individuals/Entities (www.exclusions.oig.hhs.gov/search.html)

- Reference Checks (i.e., references supplied by prospective business partners)

In the event that the background check reveals findings or issues of concern regarding the prospective applicant or business partner, the following procedures shall apply:

- Comstar shall contact the agency that issued the report and confirm the identity of the applicant/prospective business partner as well as the facts underlying the report.
- The applicant/prospective business partner shall be presented with the findings and asked for a written response
- In the event that the questionable history is confirmed, Comstar shall not enter into a relationship with the prospective applicant/business partner

COMSTAR AMBULANCE BILLING
POLICY ON COMPLAINT AND CONCERN REPORTING

Background

Comstar is committed to a workplace environment that encourages good faith reporting of any issues of concern to staff members. Particularly, as part of our ongoing compliance initiatives, Comstar staff are encouraged to report concerns regarding policies, procedures or general practices of any aspect of service operations.

Any specific concerns regarding any perceived impropriety or improper conduct of a Comstar staff member should be reported to a supervisor or manager when it involves typical operational or personnel issues. Usually, this reporting should be done following the "chain of command" and a report should first be made to your immediate supervisor.

However, if the concern involves issues for which the reporting staff member would prefer to remain anonymous, if possible, or if the individual does not feel comfortable about reporting the issue to the immediate supervisor, then the report can be made directly to the Compliance Officer.

Procedure

Types of Issues to Report

Any issue that involves a concern about impropriety should be reported. Some examples of issues to report include:

- Observed falsification of records, including patient care reports or billing records;
- Conduct in violation of the Comstar Code of Conduct;
- Theft of equipment, drugs or supplies;
- Misuse of equipment or supplies;
- Suspicious activity on the premises or in or around service vehicles;
- Conduct in violation of the policy against harassment;
- Any conduct that could be seen as violating the principles of the Comstar Compliance Plan.

When to Report

Concerns should be brought to management's attention as soon as possible after the incident or behavior that results in perceived improper conduct occurs.

How to Report

Ordinarily, concerns should be brought to the attention of your immediate supervisor. If you feel the concern could be related to legal compliance issues, you should consider reporting the concern to the Compliance Officer.

Reports may be made in writing, but it is not required that concerns be placed in writing to be treated seriously. Any concern that could affect the organization's compliance with the law will be investigated, even if it is not put in writing.

Where to Report

Reports should be made in person at the Comstar Office located at 8 Turcotte Memorial Drive, Rowley, Ma., in writing to the same address or by telephone to the Comstar Compliance Officer at 978-771-6482.

Anonymous reporting is encouraged in any situation where the individual making the report is concerned about his/her identity being established. To provide an avenue for anonymous reporting, Comstar has identified the following procedure to make an anonymous report of a compliance concern:

Email to info@comstarbilling.com

No Retaliation for Good Faith Reports

Comstar encourages the good faith reporting of compliance concerns. Comstar will not retaliate or take any adverse action against any staff member who in good faith makes a report of a compliance concern.

Any questions about whether a concern should be reported or any questions about this procedure should be directed to the Compliance Officer.

COMSTAR AMBULANCE BILLING
COMPLIANCE COMPLAINT/CONCERN REPORTING FORM

Please return completed forms to the Compliance Officer.

Attach additional sheets if you need more space to describe the incident

1. Control # _____ (Comstar use only)

2. Date: _____ Time: _____

3. Name (optional) _____

4. Individuals involved:

_____
_____
_____

5. Provide a detailed description of the suspected non-compliant conduct (including specific concern, why you think it is a problem, dates, duration and locations)

_____
_____
_____
_____
_____
_____
_____

6. Are there others with knowledge of the problem? Yes __ No___
Who? _____
_____
_____

7. Have you reported this concern to anyone else? Yes____No____If yes, when?

_____

To whom? _____(Optional)

8. Provide specifics of the discussion with that person.

9. Please identify any documents pertaining to the issue (describe them and indicate where they are located).

10. How did you discover the problem?

11. Are you willing to meet with the Comstar Compliance Officer?

Yes __ No____

12. Additional Information:

COMSTAR AMBULANCE BILLING
POLICY ON CONFIDENTIALITY OF PATIENT INFORMATION

Background

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. Comstar prohibits the release of any patient information to anyone outside the organization unless required for purposes of treatment, payment, or health care operations, and discussions of patient information within the organization should be limited wherever possible.

Acceptable uses of PHI within the organization include, but are not limited to, exchange of patient information needed for the treatment of the patient, billing, and other essential health care operations (such as peer review, internal audits, and quality assurance activities). There is no restriction on sharing any patient information with coworkers and other health care providers or emergency responders who are participating in the treatment of the patient, or if the discussion is needed to adequately locate and/or treat the patient.

Procedures

Staff members will comply with all confidentiality policies and procedures set in place by Comstar at all times.

If a staff member knowingly or inadvertently breaches the patient confidentiality policies and procedures, the staff member should notify his or her supervisor or the Privacy Officer of Comstar immediately.

Any breach of patient confidentiality may result in suspension or termination of employment or association with Comstar.

Upon termination of employment or association for any reason, or at any time upon request, staff members must return any and all patient confidential information in their possession.

COMSTAR AMBULANCE BILLING
POLICY ON CREDIT BALANCES/OVERPAYMENTS

Background

Credit balances generally occur when reimbursement for services provided to a patient exceeds the charges billed. When we receive a duplicate payment from the Medicaid or Medicare program, receive payment from another payer after Medicaid or Medicare reimbursement has been received, or receive excess payment from a patient or other financially responsible party, an overpayment exists and should be paid back to the insurer or the patient as applicable.

Credit balances may also occur from errors in calculating contractual allowances, errors in calculating coinsurance and other accounting errors.

The law requires that we promptly identify any credit balances and, when applicable, make a refund payment to the Medicare or Medicaid programs as soon as possible. As an example of the significance of this responsibility on our part, Title 42 of the Code of Federal Regulations Part 489.20 (h) states that if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare, the provider must "reimburse Medicare any overpaid amount within 60 days."

The purpose of this policy is to ensure that we reduce the time between the discovery of a credit balance and actual repayment to Medicare or other payor.

Procedures

1. When an account goes into a "credit" status (i.e., overpayments have been received, the payment received exceeds the charges or amount due, including the effect of mandatory assignment, when applicable) it should appear on a monthly credit balance report generated by the billing manager.

2. The billing manager will review the monthly account statements, particularly the credit balances to verify the validity of the statements, reconciling the account statements with the individual remittance advice for each account.

3. Adjustments to the accounts should promptly be made to the payor or patient, as applicable. When Medicare is the recipient of the overpayment, refunds shall be done in accordance with the procedure identified by the Carrier and utilizing the appropriate overpayment form.

4. There shall be periodic reviews of the monthly account statements and a small sample of credit balance accounts shall be reviewed to ensure that: 1) the credit balances are properly identified, and 2) there is verification that any overpayments due were promptly refunded.

COMSTAR AMBULANCE BILLING
POLICY ON "GOLDEN RULE" OF BILLING

It is Comstar's policy that every client account is billed completely, accurately and in accordance with state and federal rules and regulations. Some of the information necessary to accomplish that goal is detailed in our CLIENT INFORMATION SHEET. There is a sheet prepared and kept current for each of our clients. It is available for viewing by all billing staff. It is accessed by opening the Company Web Page and selecting Client Information.

It is the duty and responsibility of each billing staff member to open the appropriate Client Information Sheet before processing any claims, read the instructions contained there and then follow those instructions.

COMSTAR AMBULANCE BILLING SERVICE
POLICY ON AMENDMENT OF PATIENT CARE REPORTS

Background

Patient Care Reports (PCRs) or "tripsheets" create a legal record of an ambulance call. This policy outlines the role and responsibility of each billing staff member. Additionally, this policy allows Comstar to fulfill its legal obligation to ensure the integrity of its operations and the confidentiality of patient information and ensure that it is in compliance with all state and federal regulations.

It is legally permissible for billing staff members to amend PCRs for reasons of completeness, correction, and clarity, and in compliance with the procedures outlined below. Comstar does not endorse nor will it tolerate any staff member who embellishes or falsifies medical necessity, mileage, services rendered, supplies used or any other information for the purpose of obtaining or enhancing reimbursement.

Proper reasons for modifying a patient care report may include correcting erroneous information, such as the patient's name, address, insurance numbers, or patient care-related information.

Procedures:

- Comstar billing staff members are allowed to amend the following demographic information without the need for written confirmation from the person or entity supplying the information:
  PATIENT NAME
  PATIENT ADDRESS
  DATE OF BIRTH
  SOCIAL SECURITY #
  PHONE #
  INSURANCE INFORMATION

- Any and all other amendments to the trip sheet require written notice from Comstar's client. The Comstar Addendum is the preferred form; however, fax or mail clearly stating the information to be amended and containing a client signature is also acceptable. The written request must be attached to the trip sheet.

- All amended PHI (Protected Health Information) will be maintained and disseminated as required by the HIPAA Privacy Rule and in accordance with Comstar's HIPAA compliance policies.

COMSTAR AMBULANCE BILLING
POLICY ON DISSEMINATING CHANGES IN CMS REGULATIONS

Comstar is committed to remaining current with regard to changes in carrier regulations that affect how we produce and process claims for our clients. To meet that goal, it is Comstar's policy that a staff member will review all mail received from CMS to identify any changes that affect ambulance billing. Upon identifying any changes, the staff member is charged with the responsibility of notifying all billing staff by written memo outlining the change. Billing staff is then encouraged to discuss any questions with the Training Manager. Billing staff is supplied with a Regulation Change Folder and are expected to add the written memo to the folder for future reference.

Comstar's policy further includes a monthly evaluation of the CMS website by the Compliance Officer or his designee to identify any changes that are posted there. Notification of the change will proceed in the manner identified above.

SECTION 2

COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

COMSTAR'S DESIGNATED OFFICIALS

RESPONSIBILITIES OF COMPLIANCE OFFICER

RESPONSIBILITIES OF COMPLIANCE COMMITTEE

COMSTAR AMBULANCE BILLING SERVICE

DESIGNATED COMPLIANCE OFFICIALS

COMPLIANCE OFFICER: Richard Martin
CONTACT INFORMATION: Comstar Inc.,
8 Turcotte Memorial Drive,
Rowley, MA or
978-771-6482

COMPLIANCE COMMITTEE:
Richard Martin
Robert Martin
Lissette Breen
CONTACT INFORMATION: Comstar Inc.
8 Turcotte Memorial Drive,
Rowley, MA or
978-948-7352

2. Designation of the Compliance Officer and Other Oversight Responsibilities

Specific individual(s) with high-level authority within Comstar have been assigned overall responsibility to oversee compliance with such standards and procedures. Comstar has designated a Compliance Officer and other appropriate bodies (e.g., a Compliance Committee) charged with the responsibility for operating and monitoring the organization's compliance program. Comstar will use due care not to delegate substantial authority to individuals who may have the propensity to engage in illegal activities.

a. Compliance Officer

Comstar has appointed a Compliance Officer, who is responsible for overseeing implementation of this Plan, making recommendations to Comstar regarding changes to Comstar to enhance compliance, updating the Compliance Plan and serving as liaison to those served by Comstar to ensure that the Comstar Plan conforms with those of vendors, suppliers, and third party agents. The Compliance Officer has the following specific responsibilities:

- Develop compliance policies and standards;
- Oversee/monitor implementation of compliance activities;
- Report on a regular basis to Comstar management on implementation progress;
- Assist in developing methods for reducing the company's vulnerability to fraud, abuse, and waste;
- Periodically revise the Plan to reflect changes in practice, or in the laws and policies of government and private payor health plans;
- Develop, coordinate, and/or conduct educational activities and other methods of communication that focus on elements of the Plan and the specific risk areas identified in the Plan, e.g., training for billing staff members regarding coding, appropriate documentation and medical necessity of transports;

- Ensure that all staff members have read the Code of Conduct and sign a statement acknowledging their understanding of its requirements;

- Seek to assist provider clients in ensuring that all relevant staff members and management are knowledgeable about and comply with relevant federal and state standards;

- Work with individuals responsible for personnel decisions to ensure that appropriate credentials and references are checked for all staff members;

- Conduct or assist in the conducting of appropriate internal compliance reviews and audits;

- Develop policies that encourage reporting of suspected fraud and other improprieties without fear of retaliation;

- Independently investigate compliance problems and bring them to the attention of the Comstar management staff for appropriate response and disciplinary action if necessary; and

- Carry out corrective actions.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities including, but not limited to, patient records, billing records, contracts, and records relating to marketing of the service, as well as the company's arrangements with other clients, including ambulance services, independent contractors, vendors, agents, etc.

It should be clearly understood that the Compliance Officer is not responsible for the organization's actual compliance with applicable laws, rules and regulations or for transacting business in conformity with the law. Rather, the Compliance Officer is responsible for ensuring that the organization has in place, at all times, an effective Compliance Program, and that the applicable policies, procedures and practices are sufficient for purposes of communicating, monitoring and enforcing Comstar's ongoing commitment to compliance.

b. Compliance Committee

Comstar shall appoint a Compliance Committee that will have overall responsibility for oversight of compliance activities. This committee will review reports on Comstar's compliance activities and will assist the Compliance Officer in the operation of the Plan.
Other responsibilities of the Compliance Committee shall be to:

- Keep up to date on current issues and trends in the ambulance industry as well as regulatory activities of the federal government that may affect Comstar in its compliance initiatives;

- Review company policies to ensure that they are up to date and reflect the latest national industry standards and recommend to Comstar management revisions to existing policies and new policies that may be necessary in light of industry-wide changes in compliance standards;

- Review specific trends and issues identified by the Compliance Officer and other staff members and work with the Compliance Officer and others to spearhead necessary change in the overall compliance program; and

- Serve as the "watchdog" group on all corporate compliance issues and provide guidance to management on a regular basis to evaluate operational and administrative changes in procedures that could impact on the overall compliance program.

Due to the potential seriousness of compliance issues that may be violations of the law and the negative consequences a violation may have on Comstar, both the Compliance Officer and the Compliance Committee will have direct access to the chief executive or governing body. The Compliance Officer will also have the authority to deal directly with operational managers on any compliance issue and will have an "open door" to all staff members of Comstar with respect to any compliance concerns that any individual in the organization may wish to report or discuss.

SECTION 3

EDUCATION AND TRAINING

Our Program

Training Record Form

Compliance Training Post-Test

3. Development of Education and Training Programs

Comstar will take all necessary steps to communicate effectively its standards and procedures to all staff members and other agents, e.g., by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required of them to avoid compliance issues. Our training content will be tailored appropriately and will be delivered in a way that will maximize the likelihood that the information will be understood by all staff members.

a. Overview of Compliance Training Programs

Comstar believes that continuing education for its staff members and agents promotes professional excellence and regulatory compliance. Coding proficiencies require that billing staff enroll in continuing education where necessary.

In addition to professional training, the Compliance Officer will ensure that Comstar employees are afforded regular training and educational programs about regulatory compliance issues. Likewise, Comstar billing personnel are required to participate in such programs and to educate themselves regarding compliance issues as a condition of working in the claims submission field and failure to do so may result in disciplinary action, including termination. Compliance training should be face-to-face, and may include lectures, videos and interactive sessions. It may be conducted by Comstar personnel, outside trainers and lecturers, or a combination of both.

Staff members participating in training will complete a post-compliance training test to verify comprehension of the material presented.

b. Core Content of Our Compliance Training Program

Compliance-related education programs should, at a minimum, include:

- An overview of federal and state fraud and abuse laws and regulations, coding requirements, documentation requirements, and market practices that reflect current legal and program standards.

- How the Plan operates and the significance of this Plan; and

- The role of each Comstar staff member and agent in adhering to this Plan.

Training will be geared to level of responsibility and job function. Training for billing personnel should focus on coding and billing practices, and compilation of all necessary documentation to verify the legitimacy of the level of service submitted for reimbursement. Specific appropriate training topics should include, among other things:

- Government and private payor reimbursement principles and policies;

- General prohibitions on false claims, self-referrals, and the payment or receipt of remuneration (i.e., anything of value) to induce referrals;

- Proper confirmation of patient condition or interpretation of documentation submitted by the patient care staff;

- Proper completion of all documentation and the importance of not altering patient care reports after they have been submitted unless for routine demographic and other minor corrections that would be appropriate for billing staff to complete (e.g., adding a social security number that was missing, correcting an incorrect address, etc.); and

- Duty to report any billing concerns, improper procedures or any possible misconduct.

c. Compliance Officer's Role in Training

The Compliance Officer shall be responsible for coordinating these training activities. Comstar staff members will be required to have a minimum number of educational hours per year, as an appropriate part of their organizational responsibilities.

The Compliance Officer also is responsible for maintaining a library of regulatory compliance-related information and training manuals. This should include coding references, Carrier newsletters, Medicare manuals, federal regulations, CMS interpretations, and other relevant resource materials. This material will be maintained by the Compliance Officer. The Compliance Officer is also responsible for regularly disseminating new compliance information to Comstar staff members and agents.

The Compliance Officer is required to thoroughly document all educational activities. Appropriate documentation includes a record of dates, time, attendance, and agenda for all professional and compliance training sessions in which staff members participate. It also includes development of measurement tools (test or quiz) to verify comprehension of the compliance material by the training participants. Copies of materials disseminated at training sessions should also be maintained to the extent feasible.

COMSTAR AMBULANCE BILLING
COMPLIANCE TRAINING RECORD FORM

Topic: "Compliance Program Training"

Date of Training: _____

Time Training Began: _____

Time Training Ended: _____

IMPORTANT! SIGN IN AND VERIFICATION REQUIRED*

By my signature below, I verify that I have attended the training session described above and that I will adhere to the Comstar Code of Conduct, Policy Statement on Compliance, and all related policies and procedures, a copy of which I received as part of the training materials for this session:

Date	Name (Please Print)	Job Title	Signature Verification of Attendance

* Attach a copy of the program handouts and materials and keep this log sheet on file with the organization's compliance documentation.

COMSTAR AMBULANCE BILLING SERVICE
COMPLIANCE PROGRAM TRAINING POST-TEST

1) You should generally not include personal opinions in any patient care documentation. Identify which is NOT a personal opinion and would be an appropriate objective statement to include in a PCR (patient care report):

   a) "The patient is drunk."
   b) "The patient is so thin, she must have AIDS"
   c) "Just by looking at him, you could tell he was lying about his chest pain"
   d) "The patient describes his chest pain as a crushing-type pain"

2) Appropriate patient care documentation should include:

   a) A description of the patient upon arrival of the ambulance
   b) A description of the patient during treatment
   c) A description of the patient upon delivery to the hospital
   d) All of the above

3) For most ambulance trips to be fully covered under Medicare (including the miles the patient was on board the ambulance), the patient should be transported to the closest "appropriate facility". An appropriate facility is one that:

   a) is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved.
   b) is one where the patient's physician has privileges, regardless of its location.
   c) is a more distant hospital that is requested by the patient because he does not like the closer hospital that has the same services available
   d) Both a and b

4) In order to bill Medicare for an "emergency response" we must be able to document that:

   a) The call came in through 9-1-1 or the equivalent means and the ambulance crew took immediate steps to respond
   b) Red lights or sirens were used to get to the scene
   c) Both (a) and (b)
   d) None of the above

5) When is a Physician Certification Statement (PCS) required for a Medicare patient?

   a) For all scheduled and unscheduled non-emergency transports of Medicare patients when the patient is in a facility and under the direct care of a physician
   b) Emergency Transports
   c) For non-emergency, unscheduled transports of patients residing at their home and not under a physician's care.
   d) For non-emergency, unscheduled transports of patients residing in facilities where they are <u>not</u> under the direct care of a physician. (e.g: Assisted Living Center, Personal Care Home, etc.)

6) Medicare will only reimburse claims for ambulance service that are reasonable and medically necessary. The most common reason Medicare denies payments for ambulance service is:

   a) Failure to establish the medical necessity that the patient actually needed an ambulance
   b) Failure to document that lights and sirens were used while responding
   c) Both A and B
   d) None of the above

7) For inter-facility transports, proper documentation must include the specific reason why the patient is being transported. An appropriate statement that would support a claim for Medicare reimbursement would be:

   a) "The patient requested transport to a hospital across the city, bypassing other appropriate facilities because her physician is at that hospital"
   b) "The physician requested that we take the patient to this hospital to treat his patients because he can never find parking at the hospital down the block"

c) "Nurses state that an upgrade in care to the destination hospital with specialized services that are not available at the sending hospital is necessary to properly treat the patient's condition"
d) None of the above

8) For ambulance services that are covered by Medicare, documentation that should be obtained from the patient (if possible) includes:

a) A completed Signature Authorization Form signed by the patient that authorizes release of medical information & assignment of benefits
b) Insurance and patient information including name, date, SS #, primary and secondary insurance, group number, responsible party, etc.
c) Hospital or facility insurance records that includes the face sheet, patient's medical records and a list of procedures or tests performed
d) All of the above

9) If you have a concern about an operational practice or other policy or procedure that you suspect may violate our Compliance Plan or Code of Conduct, you should:

a) Ignore the problem unless it happens again
b) Immediately report the problem to the media
c) Immediately report the problem to your immediate supervisor or the Compliance Officer
d) All of the above

10) Changes to the patient care report are required on certain occasions. Late entries to a record that has already been completed and turned in are permitted if:

a) They are obviously additions or corrections that are noted and dated as such and not made to "blend in" with the original record.
b) You have the wrong address of the patient's residence
c) You make sure the amended copy is also given to the hospital if there is a correction in patient information.
d) All of the above are acceptable

11) The primary responsibility for refunding any amounts that have been improperly billed rests with:

a) The physician who ordered the ambulance transport
b) The RN who signed the PCS form
c) The Discharge Planner
d) The ambulance service that provided the transport

12) Advance Beneficiary Notices (ABNs) advising the patient that all or a portion of the ambulance service may not be covered by Medicare should be given:

a) For all emergency patients
b) For all non-emergency patients
c) For non-emergency patients when you don't think that the transport would meet Medicare medical necessity requirements
d) None of the above

13) If an ABN is given to the patient to sign, it should be given and explained to the patient:

a) After the transport is completed
b) Before the transport begins
c) After the transport is completed, and before the claim is submitted to Medicare
d) None of the above

14) Payments from Medicare for ambulance service rendered to a patient will only be made when the service provided is:

a) Reasonable and necessary
b) Emotionally satisfying to the patient
c) Requested by the patient
d) Ordered by the patient's doctor

SECTION 4

INTERNAL MONITORING AND REVIEW

4. Development of Internal Monitoring and Reviews

Comstar will take reasonable steps to achieve compliance with its standards by using monitoring and review systems reasonably designed to prevent and detect potentially criminal conduct by its staff members and other agents. This includes developing and using appropriate monitoring methods to detect and identify problems, and to help reduce the future likelihood of problems. Claims and system reviews are common internal monitoring methods that will be employed. Another key element of Comstar's Plan is our reporting system that staff members and others can use to report compliance issues and suspected criminal conduct by others within the organization without fear of retribution.

a. Coding and Billing Decisions

It is Comstar's policy that all claims submitted for reimbursement shall be accurate and based upon information provided by dispatch information and the patient's physician.

In order to ensure that this policy is implemented appropriately, Comstar has established the following procedures for the review and application of all existing criteria for determining levels of service, procedure codes, and other regularly used claims methods. The Compliance Officer shall be responsible for assuring that regular reviews and updates of these policies take place and any changes are communicated to the appropriate personnel.

It is essential that all services that are provided by Comstar are submitted for reimbursement using the proper service level and procedure codes, and the proper diagnosis/condition codes as appropriate. The Compliance Officer shall take necessary steps to review the standards and criteria which the billing staff uses to make coding decisions and to assure that those standards and criteria are accurate. The Compliance Officer shall assure that Comstar has a procedure for the prompt and accurate answering of all of its staff member questions regarding coding decisions. Thereafter, reviews of coding procedures shall be repeated periodically by the Compliance Officer.

b. Illegal Remuneration and Prohibited Referrals

Comstar's reputation for quality service is due to the professional and ethical conduct of its staff members and other agents. All staff members should conduct themselves with personal integrity, good judgment and common sense. No staff member shall make, offer to make, solicit, receive any payment, or provide any other thing of value to another person with the understanding or intention that such payment is to be used for an unlawful or improper purpose. This includes bribes, kickbacks, or payoffs, in cash or in kind, to garner favorable decisions, obtain client referrals, discounts from vendors, etc.

c. Billing and Claims Submission

Comstar requires its billing staff to comply with all billing and claims submission requirements promulgated by federal, state, and other payors. For instance, Comstar must adhere to the following principles:

- Proper and timely documentation of all services provided to patients must be maintained to ensure that only accurate and properly documented services are billed;

- Under no circumstances may claims be submitted for services not provided or for a level of service that exceeds the level of service actually provided;

- Patient care reports, dispatch records, physician certification statements, medical and nursing notes, and other documentation used as a basis for a claim submission should be appropriately organized and in a legible form so they can be audited and reviewed;

- Levels of service, patient condition and procedures reported on claims for reimbursement should be based on the patient care report and other legitimate supporting documentation;

- The documentation necessary for accurate assignment of levels of service, procedures performed, and patient condition should be available to the billing staff; and

- The compensation for billing staff should not provide any financial incentive to improperly "upcode" claims (e.g., bill a BLS-Emergency

- improperly "upcode" claims (e.g., bill a BLS-Emergency call as an ALS 2-Emergency when there was no paramedic on the crew), or to exaggerate the level of service actually provided to the patient.

Among other things, Comstar desires to follow the billing and coding rules issued by the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agency, and the local Medicare carrier. Comstar recognizes its greatest role in this effort is in the accurate submission of bills for rendered services. To ensure compliance in this area, Comstar regularly monitors and audits the coding decisions of its billing staff and takes corrective action as necessary.

- While proper documentation is the responsibility of the ambulance transport supplier, the billing staff should be aware of proper documentation requirements and should encourage other health care providers to document their services appropriately.

d. Assessment of the Claims Submission Process

i. Information and Documentation on the Patient Care Report

The documentation in the Patient Care Report (PCR) must provide evidence that the patient's medical condition required ambulance transportation and that no other means of transportation were appropriate for the patient. The PCR should include enough information to allow the billing staff to determine the appropriate level of service to bill, and to whom the claim should be submitted.

Documentation on the PCR should provide a clear answer to the question: Why did the patient require ambulance transportation at this particular time? Patient care reports should be reviewed prior to bill submission to ensure that the trip is only billed for services that are considered covered services.

iii. Coding of the Claim

Comstar staff should be extremely careful to bill at the appropriate level for services actually provided. The federal government has prosecuted a number of ambulance cases involving "upcoding," where claims are billed at a higher level than what was justified by the services actually performed. Compliance activities will focus on ensuring that the likelihood of inadvertent or intentional upcoding is minimized.

iv. Copayment Collection Procedures

Comstar will follow all regulations and payor policies with respect to collection of copayment amounts from Medicare and other patients. Regular follow up procedures will be used to ensure that a patient's coinsurance is properly billed and that "waiver" of any copayments is approved only in limited circumstances, such as in bona fide financial hardship cases, or in the case of an actuarially sound subscription or membership program.

v. Subsequent Payor Reimbursement

Comstar will ensure that all payments received subsequent to initial receipt of reimbursement are proper. These payments will be properly credited to the patient account and any overpayments will be promptly refunded to the payor.

e. Integrity of Electronic or Computer Billing Systems

Comstar will establish procedures for maintaining the integrity of its electronic or computer billing/data collection and storage systems. This will include procedures for regularly backing-up data (either by diskette, restricted system or tape) to ensure the accuracy of all data collected in connection with submission of claims and reporting of overpayments. At all times, Comstar will have a complete and accurate "audit trail" to track all incoming and outgoing claims information.

Additionally, Comstar will develop a system to prevent the contamination of data by outside parties. This system will include regularly scheduled virus checks. Finally, Comstar will ensure that electronic data are protected against unauthorized access or disclosure. In order to ensure compliance in this area, Comstar staff must adhere to our security policies regarding patient information and use of electronic equipment. Comstar regularly monitors the system for integrity and takes corrective action as necessary.

f. Auditing and Monitoring

Comstar is committed to ensuring that this Plan is properly implemented through a system of periodic monitoring and auditing. The principal concern for Comstar includes the coding, documentation, and medical necessity determination activities of its billing staff.

While the Compliance Officer will be ultimately responsible for coordinating formal audits, the audits themselves may be performed by internal or external auditors with expertise in federal and state health care statutes, regulations and policies. The routine audits will be conducted by staff members of Comstar. Comstar may also have audits by billing claims auditors independent of Comstar.

The purpose of the routine audits is to detect potential errors in coding, documentation and medical appropriateness. The regular audits should be conducted to detect possible billing errors or fraud. The Compliance Officer shall be responsible for investigating incidents of systemic errors or reports of noncompliance. If indicated, the results of the audit process must be communicated to and discussed with legal counsel to determine whether corrective action is required.

i. Who Should Conduct Audits and Reviews

The claim reviews will be conducted by individuals with experience in coding and billing and familiar with the different payors' coverage and reimbursement requirements for ambulance services. The reviewers will be independent and objective in their approach. Claim reviewers who analyze claims that they themselves prepared or supervised often lack sufficient independence to accurately evaluate the claims submissions process and the accuracy of individual claims. The appearance of a lack of independence may hinder the effectiveness of a claim review.

The review/audit methodology may consist of various techniques, such as:

- Testing billing and coding staff on their knowledge of reimbursement and coverage criteria, e.g., presenting hypothetical scenarios of situations experienced in daily practice and assess responses;

- Unannounced mock surveys, audits and internal reviews;

- Examination of complaint logs;

- Checking personnel records to determine whether any individuals who have been reprimanded for compliance issues in the past are among those currently engaged in improper or potentially improper conduct;

- Interviews with personnel involved in management, operations, coding, claim development and submission and other related activities;

- Questionnaires developed to solicit impressions of a broad cross-section of the Comstar staff; and

- Reviews of written materials and documentation prepared by the different divisions of Comstar.

The reviewer(s) should:

- Possess the qualifications and experience necessary to adequately identify potential compliance issues;

- Be objective and independent of line management;

- Have access to existing audit and health care resources, relevant personnel and all relevant areas of operation;

- Present written evaluative reports on compliance activities to the Comstar Compliance Committee on a regular basis, but not less than annually; and

- Specifically identify areas where corrective actions are needed.

ii. The Baseline Review

Comstar will conduct audits/reviews of new and current staff members' coding and documentation skills until it is determined that they are proficient in their accuracy. This baseline review would apply to all Comstar staff. The focus will be documentation on the PCR and the coding and submission of claims for payment.

The Compliance Officer will monitor this audit process on a regular basis. Comstar will conduct a baseline audit of its claims submission process that appropriately represents the universe of claims it submits, shortly after the adoption of the Comstar Compliance Plan.

iii. Prebilling Reviews

Comstar will audit/review claims on a prebilling basis to identify errors before claims are submitted. If there is insufficient documentation to support the claim, the claim should not be submitted for payment until it is determined by a responsible person within Comstar that accurate, appropriate and adequate documentation exists to support the claim. Through the prebilling review, Comstar will review the medical necessity of all claims before they are submitted to the local carrier. If, as a result of the prebilling claim review process, a pattern of claim submission or coding errors is identified, Comstar will develop a responsive action plan, which would include a plan to ensure that overpayments are identified and repaid.

iv. Periodic Review of Claims Denials

Comstar will conduct periodic "spot-check" audits at regular intervals to ensure ongoing coding accuracy, medical appropriateness and compliance with any new rule or regulation implemented since the previous audit. The periodic audits should focus on problems discovered in the baseline audit and previous audits.

Comstar will review their claims denials periodically to determine if denial patterns exist. If a pattern of claims denials is detected, the pattern will be evaluated to determine the cause and appropriate course of action. Staff education regarding proper documentation, coding, or medical necessity may be appropriate. If Comstar believes its payor is not adequately explaining the basis for its denials, Comstar will seek clarification in writing.

The manner in which the periodic audits will be conducted is comparable to that described for the baseline audit. Significant variations should be investigated to determine the cause. If there is a legitimate explanation and no systemic error, the Compliance Officer may not need to take any corrective action. If the deviation is due to improper procedures, misunderstanding of rules, potential fraud, or systemic problems, then prompt corrective action should be taken.

The Compliance Officer or auditors should also review whether the requirements of the compliance program are being followed. For instance, the review should determine whether the program standards have been adequately disseminated, whether appropriate training and education programs have been conducted, and whether the disciplinary process is working properly. The reviewers should also determine whether appropriate records are being kept and that other documentation requirements are being satisfied. Where it is determined that the Plan is not being followed, corrective action should be taken.

v. System Reviews and Safeguards

Comstar will conduct a risk analysis to evaluate internal and external factors that affect Comstar's operations from a compliance perspective. This risk analysis may include a review of internal systems and management issues, as well as the federal health care program requirements that govern Comstar's operations. This evaluation will form the basis for the creation and adoption of written policies and procedures to ensure compliance. The evaluation process may be simple and straightforward or it may be fairly complex and involved. For example, an evaluation of whether Comstar's existing written policies and procedures accurately reflect current federal health care program requirements is straightforward. However, an evaluation of whether Comstar's actual practices conform to its policies and procedures may be more complex and require several analytical evaluations to determine whether system weaknesses are present.

The evaluation process will provide a "snapshot" of Comstar's strengths and weaknesses and assist management in recognizing areas of potential risk. This system review will be conducted initially upon implementation of the compliance program and periodically as the governing body or the Compliance Officer may suggest. The review will provide a "risk analysis" to evaluate a variety of practices and factors and may be completed by legal counsel knowledgeable in ambulance industry compliance issues, or outside consultants. The risk analysis will include a review of Comstar's policies and procedures, employee training and education, employee knowledge and understanding, claims submission process, coding and billing, accounts receivable management, documentation practices, management structure, employee turnover, contractual arrangements, changes in reimbursement policies, and payor expectations.

g. Disclosure of Review Results

i. Internal Disclosure

The Compliance Officer will ensure that the findings of reviews/audits are reported to the management of Comstar, and in particular, the Compliance Committee. There are many occasions where there are no violations discovered, but there may be trends or areas for improvement that should be addressed internally. In these situations, there may be no need to report any findings externally to the Medicare carrier, other payors, or government agencies. This includes isolated overpayments involving individual beneficiaries where the overpayment has been corrected by repayment to the carrier.

Review results should be kept confidential, accessible only by those with a need to know. The fact of the review should be documented in writing on an appropriate Self Audit Form, but particular details of the review may not necessarily be documented in writing.

ii. External Disclosure

If regular patterns of errors, significant overpayments are uncovered, or violations of the law are discovered, thus necessitating corrective action, the advice of legal counsel must be sought. Legal counsel will advise on matters of attorney/client privilege, disclosure, and whether Comstar has any affirmative duties to report the violations and/or make restitution to health care payors. In some cases, legal counsel may recommend procedures for notifying the carrier or in implementing the OIG's Self Disclosure Protocol.

h. Overpayments

"Overpayments" are Medicare funds that Comstar has received in excess of amounts due and payable to Comstar under the Medicare statute and regulations. In addition, it is a debt owed to the U.S. Government by Comstar. Overpayments occur for a variety of reasons that may include among other things: a claim paid in error by the carrier, inadvertent miscoding of a claim, mistake in submitting mileage, or a later determination that a claim for ambulance service was not medically necessary or was not to a destination covered by Medicare.

As an agent for the federal government, Medicare carriers must attempt to recover overpayments through timely and aggressive efforts. These efforts include demands for repayment, offsets of benefits and establishment of repayment schedules.

Comstar will regularly review claims that have been paid by Medicare to verify that the amounts paid were proper and that no overpayment exists. When an overpayment does exist, Comstar will take all reasonable steps to promptly refund the full overpayment amount to the Medicare carrier, with an explanation as to why the overpayment may have occurred. In no case will Comstar keep reimbursement that has improperly been paid to it by Medicare or any other federal health care program. The Compliance Officer will periodically review the overpayment process to ensure that overpayments are refunded and that trends or repetitive overpayments are corrected.

The Medicare program is also the "secondary payor" with respect to items and services furnished to Medicare patients for whom it is reasonably expected that payment will be made under: (a) the patient's automobile policy or plan, (b) another person's automobile policy or plan, (c) the patient's workers' compensation policy or plan, or (d) a group health policy or plan in which the patient is enrolled, unless such group health policy or plan has less than 20 employees with employment status for 20 or more calendar weeks of the current or preceding year.

Payment will be made by the Medicare program for items and services with respect to which it is the secondary payor. However, all necessary steps must be taken to ensure that repayment is made to the Medicare program within 60 days from the date Comstar receives payment or notice that payment will be made for the items and services billed to the Medicare program, or as soon as reasonably possible thereafter.

SECTION 5

SYSTEM TO RESPOND TO MISCONDUCT AND DISCIPLINARY STANDARDS

5. Responding Appropriately to Detected Misconduct

If an offense has been detected, Comstar will take all reasonable steps to respond appropriately to the offense and to prevent further similar offenses. This includes appropriate legal consultation, when necessary, and proper reporting of the misconduct to appropriate authorities. Any suspected misconduct may make it necessary to modify our compliance program to determine any weaknesses and to correct those weaknesses. The goal at all times is to further prevent and detect potential violations of law, or the established reimbursement regulations and policies set forth by the federal government or payors of health care services.

a. Government Investigations

If any Comstar staff member is contacted concerning an investigation (e.g., telephone interview, subpoena, personal visit) by a governmental agency regarding Comstar business, they are required to notify the Compliance Officer immediately. While it is Comstar's policy to cooperate with governmental agencies, Comstar's legal rights must be protected. In the case where a governmental agent visits an Comstar staff member, the agent should be asked to contact the Compliance Officer to arrange an interview. The Compliance Officer, in turn, will notify legal counsel to discuss the matter. See Comstar's Policy on Staff Member Rights and Obligations in Government Investigation.

b. Reporting Intentional Wrong-Doing To Authorities

It shall be Comstar's policy to carefully evaluate all allegations of wrongdoing to determine: (a) if the allegation appears to be well founded, and (b) whether the allegation warrants reporting to enforcement authorities. When billing errors have been reported and payments returned, unless there is evidence of a pattern of wrongdoing, or an attempt to conceal wrongdoing, no further reporting to enforcement authorities is ordinarily required.

The Compliance Officer shall consult with any outside experts deemed necessary in order to comply with this policy. Unless immediate reporting is required to prevent personal injury, property damage, bodily harm or damage to the environment, or is otherwise mandated by law, the Compliance Officer will consult in advance with Comstar Management before reporting suspected violations of the law to third parties.

If, after a thorough internal investigation, Comstar decides to make a report to the authorities, it will assure that the report is made under the direction of Comstar legal counsel and to the appropriate governmental authorities; and that the report is both timely and thorough.

Enforcing Disciplinary Standards

Comstar has developed policies and procedures to ensure that there are appropriate disciplinary mechanisms and standards applied in a fair and consistent manner. These policies and standards address situations in which staff members, vendors, or contractors violate, whether intentionally or negligently, internal compliance policies, applicable statutes, regulations, or other Federal health care program requirements.

The standards will be consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, corrective counseling and if necessary, discipline of individuals responsible for the failure to detect an offense. Adequate discipline of individuals responsible for an offense is a necessary component of enforcement. However, the form of correction or discipline provided will be case specific and may be based on a variety of factors, including severity of the offense, previous incidents involving the individual, and the individual's commitment to a positive change in behavior.

a. Compliance as an Element of Performance Evaluation

Staff members who fail to comply with the rules and procedures set forth in this plan or the laws and regulations governing Comstar's operations will be subject to disciplinary action. Adherence to compliance requirements will be a factor in staff member evaluations and will affect a staff member's continued relationship with Comstar.

b. Disciplinary Procedures

Comstar will not tolerate illegal or unethical conduct of any sort, business or personal, by its staff members. Comstar is prepared to take disciplinary action against individuals who violate the requirements of this Plan or otherwise engage in unethical or unlawful activities. Comstar will publish and distribute to all staff members its disciplinary policies and procedures. The sanctions available under this Plan may include required remedial training, verbal and/or written reprimand, or, for serious infractions, suspension, expulsion or termination.

All aspects of corrective action or disciplinary action against staff members will be thoroughly and impartially investigated and documented.

Record Retention

Comstar maintains a uniform system for record creation, distribution, retention, storage, retrieval, and destruction of documents. The type of documents developed under this system include patient care records, billing, claims documentation, and other financial records, and all records necessary to protect the integrity of our compliance process and confirm the effectiveness of the program. This includes documentation regarding staff member training, modifications to the compliance program, results of any investigations conducted, self-disclosures to enforcement agencies, and results of the company's auditing and monitoring efforts. Under no circumstances may documents relating to a pending investigation, or an inquiry regarding a report of a possible billing error, or an incident of fraud or abuse, be destroyed without permission of the Compliance Officer and approval of legal counsel.

d. Relationship With Competitors / Vendors

Information about our operations, such as marketing, strategy, service pricing, finances, etc. is in many cases confidential. Comstar business should generally not be discussed with anyone outside the organization. Contracts and contract negotiations are conducted in accordance with the law. Business integrity is important in choosing Comstar business partners.

Comstar should be open and honest in their business relationships with other ambulance transport professionals, Comstar lawyers, accountants, consultants, and the Compliance Officer. Comstar encourages a free flow of information among these individuals. Furthermore, free flowing communication will reduce the potential for fraud, abuse or waste. The failure to deliver information that is known or thought to be necessary, or delivering information that is known or thought to be inaccurate, misleading, or incomplete, is unacceptable and disciplinary action may be taken in such cases.

The Compliance Officer is responsible for promoting communication between Comstar and any vendor or supplier with which Comstar conducts business. Comstar staff is encouraged to solicit the opinion of the Compliance Officer if they are uncertain about a compliance-related matter. They are expected to report billing errors or suspected incidents of health care related fraud and abuse. Communication and reporting may take place in person, by telephone, memoranda, or through electronic mail. The Compliance Officer shall use best efforts to keep all communications confidential whenever possible.

COMSTAR, INC.

POLICY/PROCEDURE FOR IDENTITY THEFT PREVENTION, DETECTION AND MITIGATION PROGRAM

I. Purpose and Overview.

A. The purpose of this Policy/Procedure ("Policy") is to assure that Comstar, Inc. ("The Billing Agent") maintains compliance with the requirements regarding the prevention, detection and mitigation of Identity Theft as set forth in the federal regulations known as the "Red Flag Rules."[1]

1. "Identity Theft" means a fraud committed or attempted using the identifying information of another person without authority. This includes "Medical Identity Theft," i.e., Identity Theft committed for the purpose of obtaining medical services, such as the use of another person's insurance card or number. Although Medical Identity Theft may occur without the knowledge of the individual whose medical identity is stolen, in some cases the use of an individual's medical identity may occur with the knowledge and complicity of that individual.

B. This Policy sets forth the steps The Billing Agent will take in implementing a program for detecting, preventing and mitigating Identity Theft (the "Program") in connection with Covered Accounts, as required by the Red Flag Rules. "Covered Account" means:

1. An account that The Billing Agent offers or maintains, primarily for personal, family, or household purposes, that involves or is designed to permit multiple payments or transactions; and

2. Any other account that The Billing Agent offers or maintains for which there is a reasonably foreseeable risk to individuals or to the safety and soundness of The Billing Agent from identity theft, including financial, operational, compliance, reputation or litigation risks.

C. Section II of this Policy describes the risk assessment The Billing Agent shall conduct at the inception of the Program and annually thereafter. Section III sets forth the "Red Flags" (i.e., warning signs) that may alert The Billing Agent personnel to the possible existence of Identity Theft in the course of The Billing Agent's day to day operations. Section IV sets forth the procedures The Billing Agent will follow in attempting to detect those Red Flags. Section V sets forth the procedures The Billing Agent will follow in responding appropriately to Red

[1] See 16 C.F.R. § 681.2, as supplemented by the Interagency Guidelines on Identity Theft Detection, Prevention and Mitigation set forth in Appendix A of 16 C.F.R. Part 681 ("Guidelines") and the Supplement thereto.

Flags that are detected, in order to prevent and mitigate Identity Theft. Section VI sets forth the procedures The Billing Agent will take in responding to a claim by an individual that he has been a victim of Identity Theft. Section VII describes how The Billing Agent will administer the Program. Section VIII describes the annual updating of the Program.

D. Questions regarding this Policy or the Program shall be directed to the Program Compliance Officer designated pursuant to Section VII.

II. Risk Assessment

A. Upon initial implementation of the Program, and annually thereafter as a part of the annual update described in Section VIII of this Policy, The Billing Agent shall determine whether it maintains Covered Accounts. As part of that determination, The Billing Agent shall conduct a risk assessment to determine whether it offers or maintains Covered Accounts that carry a reasonably foreseeable risk of identity theft, including financial, operational, compliance, reputation or litigation risks. The risk assessment shall take into consideration:

1. The methods The Billing Agent provides to open its accounts;

2. The methods it provides to access its accounts; and

3. Its previous experiences with identity theft.

III. Identification of Red Flags

A. A "Red Flag" is a pattern, practice or specific activity that indicates the possible existence of Identity Theft. In other words, a Red Flag is a warning sign regarding the possibility of Identity Theft.

B. In identifying Red Flags relevant to its operations, The Billing Agent has:

1. Reviewed the examples of Red Flags found in the Red Flag Rules (see the Supplement to the Guidelines);

2. Considered the factors specified in Section II.A above; and

3. Incorporated Red Flags from sources such as changes in identity theft risks of which The Billing Agent becomes aware and applicable regulatory guidance.

C. Based on the process specified in the Section III.B above, The Billing Agent has identified the following situations as Red Flags that should alert The Billing Agent personnel to the possibility of Identity Theft:

1. A patient submits a driver's license, insurance card or other identifying information that appears to be altered or forged;

2. The photograph on a driver's license or other government-issued photo I.D. submitted by a patient does not resemble the patient;

3. Information on one form of identification submitted by a patient is inconsistent with information on another form of identification, or with information already in The Billing Agent's records or information obtained from other sources such as a consumer credit data base;

4. A patient has an insurance member number but no insurance card;

5. The Social Security Number ("SSN") or other identifying information furnished by a patient is the same as identifying information in The Billing Agent's records furnished by another patient;

6. The SSN furnished by a patient has not been issued, is listed on the Social Security's Administration's Death Master File, or is otherwise invalid. The following numbers are always invalid:

   a. the first 3 digits are in the 800, 900 or 000 range, or in the 700 range above 772, or are 666;

   b. the fourth and fifth digits are 00; or

   c. the last four digits are 0000;

7. The address given by a patient does not exist or is a post office box, or is the same address given by an unusually large number of other patients;

8. The phone number given by the patient is invalid or is associated with a pager or an answering service, or is the same telephone number submitted by an unusually large number of other patients;

9. The patient refuses to provide identifying information or documents;

10. Personal identifying information given by a patient is not consistent with personal identifying information in The Billing Agent's records, or with information provided by another source such as an insurance company or consumer credit database;

11. A patient's signature does not match the signature on file in The Billing Agent's records;

12. A patient contacts The Billing Agent and indicates that he or she has received an invoice, explanation of benefits or other document reflecting a transport that the patient claims was never received;

13. Mail correspondence is returned to The Billing Agent despite continued activity associated with that mailing address;

14. The Billing Agent receives a warning, alert or notification from a credit reporting agency, law enforcement or other credible source regarding a patient or a patient's insurance information;

15. The Billing Agent has suffered a security breach, loss of unprotected data or unauthorized access to patient information;

16. An insurer denies coverage due to a lifetime benefit limit being reached or due to an excessive volume of services;

17. A discrepancy exists between medical or demographic information obtained by The Billing Agent from the patient and the information found in health facility records;

18. Attempts to access an account by persons who cannot provide authenticating information;

D. The Billing Agent shall update the foregoing list of Red Flags as part of its annual update of the Program.

E. All The Billing Agent personnel have an affirmative obligation to be vigilant for any evidence of a Red Flag and to notify their immediate supervisor, or the Program Compliance Officer, to report the Red Flag.

IV. Procedures for Identifying Red Flags

The Billing Agent personnel will follow the following procedures in order to detect the Red Flags indicated above, which indicate the possibility of Identity Theft.

A. The process of confirming a patient's identity should never delay the delivery of urgently or emergently needed medical care. When a patient's condition permits collection of demographic information and documentation, medical transport crews shall request, in addition to an insurance card, a driver's license or other form of government issued photographic personal identification. If the patient lacks such photographic identification, medical transport personnel shall:

1. Request other form of identification, such as a credit card; and/or

2. Ask a family member or other person at the scene who knows the patient to verify the patient's identity.

B. Billing personnel, in the course of creating and processing claims, and verifying patient information, shall be alert for the existence of any of the Red Flags listed in Section III above.

C. Before providing information regarding an account, or making any change to an address or other information associated with an account, the requester shall be required to provide the social security number, full name, date of birth and

address of the patient. If the requester makes the request in person, a driver's license or other government issued photographic identification shall be requested.

D. In the event medical transport personnel or billing personnel encounter a Red Flag, the existence of the Red Flag shall be brought to the prompt attention of the individual's supervisor or the Program Compliance Officer so that it can be investigated and addressed, as appropriate, in accordance with the procedures set forth in Section V below.

V. Responding to Red Flags

A. When a Red Flag is detected, The Billing Agent personnel shall investigate the situation, as necessary, to determine whether there is a material risk that Identity Theft has occurred or whether there is a benign explanation for the Red Flag. The investigation shall be documented in accordance with The Billing Agent's incident reporting policy. If it appears that Identity Theft has not occurred, The Billing Agent may determine that no further action is necessary.

B. The Billing Agent's response shall be commensurate with the degree of risk posed by the Red Flag. In determining an appropriate response, The Billing Agent shall consider aggravating factors that may heighten the risk of Identity Theft, such as a data security incident that results in unauthorized access to a patient's account records, or notice that a patient has provided information related to a The Billing Agent account to someone fraudulently claiming to represent The Billing Agent or to a fraudulent website.

C. If it appears that Identity Theft has occurred, the following steps should be considered and taken, as appropriate:

1. Except in cases where there appears to be obvious complicity by the individual whose identity was used, promptly notify the victim of Identity Theft, by certified mail, using the Identity Theft Patient Notice Letter developed by The Billing Agent. Notification may also be provided by telephone, to be followed by a mailed letter;

2. Place an Identity Theft Alert on all patient care reports ("PCRs") and financial accounts that may have inaccurate information as a result of the Identity Theft;

3. Discontinue billing on the account and/or close the account;

4. Reopen the account with appropriate modifications, including a new account number;

5. If a claim has been submitted to an insurance carrier or government program ("Payor") in the name of the patient whose identity has been stolen, notify the Payor, withdraw the claim and refund any charges previously collected from the Payor and/or the patient;

6. If the account has been referred to collection agencies or attorneys, instruct the collection agency or attorneys to cease collection activity;

7. Notify law enforcement and cooperate in any investigation by law enforcement;

8. Request that law enforcement notify any health facility to which the patient using the false identity has been transported regarding the Identity Theft;

9. If an adverse report has been made to a consumer credit reporting agency regarding a patient whose identity has been stolen, notify the agency that the account was not the responsibility of the individual;

10. Correct the medical record of any patient of The Billing Agent whose identity was stolen, with the assistance of the patient as needed;

11. If the circumstances indicate that there is no action that would prevent or mitigate the Identity Theft, no action need be taken.

VI. Investigation of Report by a Patient of Identity Theft

A. If an individual claims to have been a victim of Identity Theft (e.g., the individual claims to have received a bill for a transport he did not receive), The Billing Agent [*or its billing service*] shall investigate the claim. Authentication of the claim shall require a copy of a Police Report and either:

1. The Identity Theft affidavit developed by the FTC, including supporting documentation; or

2. An identification theft affidavit recognized under state law

B. The Billing Agent personnel shall review the foregoing documentation and any other information provided by the individual and shall make a determination as to whether the report of Identity Theft is credible.

C. The individual who filed the report shall be informed in writing of The Billing Agent's conclusion as to whether The Billing Agent finds the report credible.

D. If, following investigation, it appears that the individual has been a victim of Identity Theft; The Billing Agent will take the appropriate actions as indicated in Section V of this Policy.

E. If, following investigation, it appears the report of Identity Theft was not credible, the individual shall be notified and The Billing Agent may continue billing on the account, upon approval of the Program Compliance Officer. The account shall not be billed without such approval.

VII. Administration of the Program

A. The Program, and all material changes thereto, shall be approved by The Billing Agent's [*board of directors/ an appropriate committee thereof/other*[2]]. (the "Oversight Body"). *[NOTE; If The Billing Agent does not have a board of directors or other governing body, the Program may be approved by an individual at the level of senior management*.]

B. A designated employee at the level of senior management shall be designated by the Oversight Body as the Program Compliance Officer and shall be responsible for the oversight, development and implementation of the Program.

C. The Billing Agent shall train staff, as needed, to effectively implement the Program. The following categories of personnel shall be trained in the implementation of the Program:

1. All medical transport personnel;

2. All billing office personnel;

3. All management personnel;

4. [*Other*].

D. Initial training shall occur no later than May 1, 2009 for all current personnel. Newly hired personnel shall be trained in the implementation of the Program as part of their standard compliance and HIPAA training. "Refresher" training shall be included in the annual compliance and HIPAA training given to The Billing Agent personnel, and may be given to specific employees from time to time on an "as needed" basis.

E. The Billing Agent shall exercise appropriate and effective oversight of all arrangements involving a service The Billing Agent whose duties include opening, monitoring or processing patient accounts, or performing other activities which place them in a position to prevent, detect or mitigate Identity Theft ("Service The Billing Agents"). Each Service The Billing Agent shall be required to execute an amendment or addendum to its service agreement or business associate agreement which requires it to:

1. Implement a written Identity Theft Program that meets the requirements of the "Red Flags Rule";

2. Provide a copy of such Program to The Billing Agent no later than May 1, 2009;

[2] NOTE; If The Billing Agent does not have a board of directors or other governing body, the Program may be approved by an individual at the level of senior management.

3. Provide copies of all material changes to such Program on an annual basis; and

4. Either report all Red Flags which it encounters to The Billing Agent, or take appropriate steps to prevent or mitigate Identity Theft itself.

F. The Program Compliance Officer shall report to the Oversight Body [*or to a designated employee at the level of senior management*], on an annual basis, on compliance with the Program. The report shall address material matters related to the Program and evaluate issues such as:

1. The effectiveness of the Program in addressing the risk of Identity Theft;

2. Service The Billing Agent arrangements;

3. Significant incidents involving Identity Theft and The Billing Agent's response;

4. Recommendations for material changes to the Program.

VIII. Annual Update of the Program

The Program will be reviewed, revised and updated on an annual basis. In performing such update, The Billing Agent shall consider:

A. The Billing Agent's experiences with Identity Theft over the period since the last revision of the Program;

B. Changes in methods of Identity Theft, or in methods to detect, prevent and mitigate Identity Theft;

C. Changes in The Billing Agent's technology and operations, including any new electronic health record or financial software programs implemented by The Billing Agent; and

D. Changes in business arrangements of The Billing Agent, including but not limited to changes in its relationships with Service The Billing Agents.

COMSTAR, INC.

AMBULANCE BILLING SERVICE
ROWLEY, MASSACHUSETTS

SERVICE ORGANIZATION CONTROLS REPORT
ON CONTROLS PLACED IN OPERATION

As of July 31, 2013

COMSTAR, INC.

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As of July 31, 2013

JOHNSON O'CONNOR FERON & CARUCCI LLP
CERTIFIED PUBLIC ACCOUNTANTS

I. INDEPENDENT SERVICE AUDITORS' REPORT

Comstar, Inc.
Rowley, Massachusetts

Scope

We have examined Comstar, Inc.'s (Comstar) description of its Ambulance Billing Services system for processing user entities' transactions as of July 31, 2013, and the suitability of the design of controls to achieve the related control objectives stated in the description. The description indicates that certain complementary user entity controls must be suitably designed and implemented at user entities for related controls at the service organization to be considered suitably designed to achieve the related control objectives. We have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

Comstar uses a computer service organization, Focus, to perform certain computer administration functions including network administration and backup. The description in Section III includes only the controls and related control objectives of Comstar and excludes the control objectives and related controls of Focus. Our examination did not extend to controls of Focus.

Service Organization's Responsibilities

In section II of this report, Comstar has provided an assertion about the fairness of the presentation of the description and suitability of the design of the controls to achieve the related control objectives stated in the description. Comstar is responsible for preparing the description and for its assertion, including the completeness, accuracy, and method of presentation of the description and the assertion, providing the services covered by the description, specifying the control objectives and stating them in the description, identifying the risks that threaten the achievement of the control objectives, selecting the criteria, and designing, implementing, and documenting controls to achieve the related control objectives stated in the description.

Service Auditor's Responsibilities

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design of the controls to achieve the related control objectives stated in the description, based on our examination. We conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform our examination to obtain reasonable assurance, in all material respects, about whether the description is fairly presented and the controls were suitably designed to achieve the related control objectives stated in the description as of July 31, 2013.

An examination of a description of a service organization's system and the suitability of the design of the service organization's controls to achieve the related control objectives stated in the description involves performing procedures to obtain evidence about the fairness of the presentation of the description of the system and the suitability of the design of the controls to achieve the related control objectives stated in the description. Our procedures included assessing the risks that the description is not fairly presented and that the controls were not suitably designed to achieve the related control objectives stated in the description. An examination engagement of this type also includes evaluating the overall presentation of the description and the suitability of the control objectives stated therein, and the suitability of the criteria specified by the service organization and described in section II of this report.

We did not perform any procedures regarding the operating effectiveness of the controls stated in the description and, accordingly, do not express an opinion thereon.

We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

Inherent Limitations

Because of their nature, controls at a service organization may not prevent, or detect and correct, all errors or omissions in processing or reporting transactions. The projection to the future of any evaluation of the fairness of the presentation of the description, or any conclusions about the suitability of the design of the controls to achieve the related control objectives is subject to the risk that controls at a service organization may become ineffective or fail.

Opinion

In our opinion, in all material respects, based on the criteria described in Comstar's assertion in section II of this report,

a. the description fairly presents the Ambulance Billing Services system that was designed and implemented as of July 31, 2013, and

b. the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the control objectives would be achieved if the controls operated effectively as of July 31, 2013, and user entities applied the complimentary user entity controls contemplated in the design of Comstar's controls as of July 31, 2013.

Restricted Use

This report is intended solely for the information and use of Comstar, user entities of Comstar's Ambulance Billing Services system as of July 31, 2013, and the independent auditors of such user entities, who have a sufficient understanding to consider it, along with other information including information about controls implemented by user entities themselves, when obtaining an understanding of user entities information and communication systems relevant to financial reporting. This report is not intended to be and should not be used by anyone other than these specified parties.

Johnson O'Connor Feron & Carucci LLP

Wakefield, Massachusetts
September 19, 2013

II. COMSTAR INC.'S ASSERTION

We have prepared the description of Comstar's Ambulance Billing Services system for user entities of the system as of July 31, 2013, and their user auditors who have a sufficient understanding to consider it, along with other information, including information about controls implemented by user entities of the system themselves, when obtaining an understanding of user entities' information and communication systems relevant to financial reporting. We confirm, to the best of our knowledge and belief, that:

A. The description fairly presents the Ambulance Billing Services system made available to user entities of the system as of July 31, 2013, for processing their transactions. Comstar uses a computer service organization, Focus, to perform certain computer administration functions including network administration and backup. The description in section Ill of this report includes only the control objectives and related controls of Comstar and excludes control objectives and related controls of Focus. The criteria we used in making this assertion were that the description:

    1. Presents how the system made available to user entities of the system was designed and implemented to process relevant transactions, including:

        - The classes of transactions processed.

        - The procedures, within both automated and manual systems, by which those transactions are initiated, authorized, recorded, processed, corrected as necessary, and transferred to the reports presented to user entities of the system.

        - The related accounting records, supporting information, and specific accounts that are used to initiate, authorize, record, process, and report transactions; this includes the correction of incorrect information and how information is transferred to the reports presented to user entities of the system.

        - How the system captures and addresses significant events and conditions, other than transactions.

        - The process used to prepare reports or other information provided to user entities of the system.

        - Specified control objectives and controls designed to achieve those objectives.

        - Other aspects of our control environment, risk assessment process, information and communication systems (including the related business processes), control activities, and monitoring controls that are relevant to processing and reporting transactions of user entities of the system.

    2. Does not omit or distort information relevant to the scope of the Ambulance Billing Services system, while acknowledging that the description is prepared to meet the common needs of a broad range of user entities of the system and the independent auditors of those user entities, and may not, therefore, include every aspect of the Ambulance Billing Services system that each individual user entity of the system and its auditor may consider important in its own particular environment.

B. The controls related to the control objectives stated in the description were suitably designed as of July 31, 2013, to achieve those control objectives. The criteria we used in making this assertion were that:

1. The risks that threaten the achievement of the control objectives stated in the description have been identified by Comstar; and

2. The controls identified in the description would, if operating as described, provide reasonable assurance that those risks would not prevent the control objectives stated in the description from being achieved.

III. DESCRIPTION OF COMSTAR, INC.'S SYSTEM

Overview of Operations

Company Background

Comstar, Inc. (Comstar or the Company) is a Massachusetts corporation that processes medical claims, sends bills and provides collection and ambulance services. The Company has been in business since 1984. Comstar's objectives are to maximize revenues to ambulance services for services provided while taking into consideration patients without insurance and/or fixed/low incomes. The Company realizes that clients often have differing needs when it comes to ambulance billing. Comstar has the ability to "customize" processing to meet the exact wishes and needs of its clients.

Description of Services Provided

Billing and Revenue Recovery

Comstar receives information from clients about ambulance runs, records and codes that information and invoices the appropriate payees, including the patient, parents of a minor, insurance companies or third-party payers. Comstar tracks the receivable and records payments and ensures that write-offs and refunds are tracked and recorded for a complete financial compilation of each transaction that pertains to an account.

Reporting

Comstar's ambulance billing services include a comprehensive set of reports that allow clients to view information in the specific date ranges requested. Clients can look at run activity, payment activity, write-offs, memos, balances, statistics and receivables at any time for any date range with various sorting options.

Scope of Report

The scope of this description includes ambulance billing services provided by Comstar to its clients. These services include receiving ambulance run information from clients, entering and coding the runs in ZOLL Data Management's RescueNet system (RescueNet), invoicing appropriate payers, collecting and recording receipts on behalf of clients, tracking receivables, processing write-offs and refunds, and reporting to clients.

Comstar uses a computer service organization, Focus, to perform certain computer administration functions, including network administration and backup. This description includes only the control objectives and related controls of Comstar and excludes control objectives and related controls of Focus.

Relevant Aspects of the Control Environment, Risk Assessment Process, Information and Communication, and Monitoring Controls

Control Environment

The control environment reflects the overall attitude and awareness of management and personnel concerning the importance of controls and the emphasis given to controls in the Company's policies and procedures and actions. The organizational structure, separation of job responsibilities by work cell/team and business functions and documentation of policies and procedures are the methods used to define and implement operational controls. Importance is placed on maintaining sound internal controls and the integrity and ethical values of all the Company's personnel. Organizational values and behavioral standards are communicated to all personnel through policy statements.

Information and Communication

Management Processes

The business is controlled and policies are set through management processes that include periodic meetings of the Management Team. There is a standing weekly management meeting that includes the president and chief executive officer (CEO), director of human resources (HR), director of operations, director of business development, all billing managers, team lead staff and senior billers. These meetings are held to discuss and prioritize current issues and provide ongoing focus and direction towards Company goals.

Communication

Comstar has implemented various methods of communication to ensure that employees understand their roles and responsibilities. These include open communication channels, published policies and procedures, written job descriptions and annual reviews discussing performance and expectations. All information is under revision control, stored in SharePoint, accessible to all staff on their computer desktops in a read-only format.

Organizational Structure

The Company's organizational structure provides the overall framework for planning, directing and controlling operations. Personnel and business functions are separated into teams and subteams according to job responsibilities/process flow that lends itself to comparative performance measurement and quality assurance over time. The structure provides defined responsibilities and defined lines of authority for reporting and communication.

Risk Assessment Process

To identify the potential impact of changes to the operating effectiveness of the existing controls and environment, Comstar has a risk management process in place that consists of the following elements:

- Identifying sources of potential risk, such as competitors, technology, new services and regulatory changes
- Monitoring the effects of changes within the Company, such as rapid growth, new or innovated information systems and new personnel
- Developing and implementing initiatives to mitigate potential sources of risk

- Constantly monitored strategic plan with prioritized tasks and requirements tracking

- Comprehensive third-party compliance assessments

Monitoring Controls

Management is responsible for directing and controlling operations and for establishing, communicating and monitoring control policies and procedures. Importance is placed on maintaining sound internal controls and the integrity and ethical values of all Comstar personnel.

Organizational values and behavioral standards are communicated to all personnel through policy statements and management leadership. In addition, Comstar's management reviews and approves all process and procedure documentation. Management has a proactive philosophy and a hands-on operating style that emphasizes the responsibility and ownership of work projects and areas by individuals.

Description of Related Controls and Control Objectives

Computer Operations

Physical Access

Entrance into the building is restricted by an electronic key fob. Physical access to the data center is restricted via lock and key. Authorized key holders include the IT Manager, Training Manager and the CEO. The CEO maintains possession of additional keys and distributes them to appropriate employees needing access based on his discretion. The Company uses a sub-service provider, Focus Technology Inc. (Focus) to provide certain information technology-related administrative and processing functions. In the event that Focus requires access to the server room, a key will be provided to them from one of the authorized key holders. Access to the data center is monitored via external cameras.

Physical Protection

The data center is equipped with appropriate environmental controls, such as air conditioning, uninterruptible power supply (UPS), fire suppression, temperature monitoring and a water detection mechanism. Back-up fans are on hand, if necessary. A back-up generator was also installed to power the Server Room, one heating unit and walkway floor lighting for safety precautions, if necessary.

System Access

Access Requests/Changes/Terminations

Access for existing and new hires is initiated by the employee's manager by completing a New Hire Setup/IT Project Form. The form must be approved by the system owner and is then submitted to IT for processing. IT staff will create the user account and assign the appropriate access rights based on the roles and responsibilities of the new employee. Completed forms are stored onsite in a filing cabinet in the CEO's office. Changes to existing user access are documented in email or a New Hire Setup/IT Project Form similar to the new-hire process. Remote access is restricted to authorized personnel and must be approved by the CEO.

In the event of an employee termination, the Employee Termination/IT Project Form must be completed by the employee's manager. Client Accounting will approve the removal of access and the CEO will review the form to ensure completeness and that proper approvals are documented. The IT department

deactivates the employee's access to all systems immediately upon the employee's departure from the Company. If email needs to be forwarded to another individual, the network password is changed. In the event of an emergency termination, an email is immediately sent, notifying management throughout the organization.

Passwords

Active Directory account passwords must be six characters in length, expire every 60 days, retain a password history of two and must be complex. Access to RescueNet is authenticated via Active Directory.

User Accounts

User accounts are issued at the network level through Active Directory. Users are provided with unique accounts. Generic accounts are allowed only for system-related accounts.

There are thirteen security profiles: Denials, Run Entry Coding (REC), Portfolio, Payment Application, Client Accounting, Printers, Supervisors (Lead MBS), System Administrator, Manager, REC Plus, Portfolio Plus, RNB Admin, and Reporting Only. Batch Processor is a nonuser account required for the system to create electronic loads to put clients on hold.

System administrator access to the network and RescueNet is restricted to IT personnel and Focus. Access to change RescueNet master files is restricted to system administrators.

User Access Reviews

On an annual basis, a detailed review of each user's access rights for the network and RescueNet is performed by their manager during the performance appraisal process.

System Development and Change Management

Change Management Process

Changes to the network and RescueNet software are documented in IT Project Forms and must be initially approved by a manager. These changes include:

- Client requested change
- Nonstandard major change
- Script change
- Upgrades

Additional approval is required by the client contact for customer requested changes. Client-requested, nonstandard major and script changes are performed by a member of the IT department in a nonproduction environment. Upgrades are performed by Focus and ZOLL Data Management, both third-party managed service providers. Testing is then performed by the Quality Assurance group (QA) and documented in the IT Project Form. A final review is also performed by an independent member of the IT group. The CEO then provides final approval for all changes before they are deployed to the production environment. Only members of Comstar's IT group can migrate changes into production.

Operational Controls

Run Receiving

New Client Setup

New client accounts are set up by the Information Technology (IT) Team per the new client information sheet agreed upon with each client. A new client questionnaire is completed by the client and returned to Comstar with each new contract. The questionnaire provides Comstar with the essential detailed information necessary to set up processing procedures, parameters and allowances in the RescueNet system for each new client. The IT Team completes an IT Project Form to document client setup or changes to existing client master files. Changes are reviewed and approved by a Portfolio Team Manager via the IT Project Form before any changes are made by IT. All batches processed for new clients undergo a 100 percent quality control review by the Training Manager to ensure that each new client is provided accurate and complete information.

Manual Ambulance Run Logging

Run detail documentation submitted manually through the mail is received and batched by client in the mailroom. The batch of runs is manually logged into the Run Receiving database. Data fields recorded for each batch in the Run Receiving database include the date received, date range of the runs in the batch, number of runs in each batch, date assigned for coding and the Comstar employee to whom the coding is assigned. Batches for each client are assigned to a coding employee for processing and unprocessed batches are tracked daily by the REC Supervisor through the Active Runs in Queue Report. Aged or incomplete batches are identified, researched and followed up to ensure consistent timely progress on all aged items.

Electronic Ambulance Run Logging

Runs received or retrieved electronically by the IT Team are logged and tracked using the same information as the manual process noted above. Batches for each client are assigned to a coding employee for processing. Unprocessed batches are tracked daily through the Active Runs in Queue Report. Aged or incomplete batches are identified, researched and followed up to ensure consistent timely progress on all aged items.

Electronic Run Receiving

Over 85 percent of the claims processed at Comstar are received electronically. There are four electronic methods of receiving incident reports: email, SFTP (secure FTP), TEMSIS/NEMSIS and MEMRS/SIRENS/MATRIS. The most common method used is email. Clients send run data in a zipped file to the Comstar IT Team for processing. These emails can be either encrypted or unencrypted. SFTP is available to clients whose IP address is pre-registered with Comstar via a username and password. The last method is where Comstar IT would retrieve run data files from the client via TEMSIS/NEMSI and MEMRS/SIRENS/MATRIS. Currently, clients in Maine, Massachusetts, New Hampshire and Vermont are using this method.

Daily import emails containing client name, batch number, number of runs and date range are sent to the Client Accounting Team. A Comstar import confirmation email containing the date, date of service range and quantity of incident reports downloaded is emailed to the client when Comstar downloads data files from a client.

Load Failure Reviews

On a daily basis, electronic files are moved to the "importdata" folder by the IT Team to be processed. Once the files are loaded, the files go into one of two folders: failure or success. IT communicates load failures to the Portfolio Team to work with the client to resolve. Once the issue is resolved, Comstar imports a new file for reprocessing.

Monthly Commitment Reports

Comstar generates Commitment Reports for each client that summarize the run dates, incident numbers, patient name, a description of the charges and an amount for the charges for all runs received during the month. The reports are provided to each client to review and agree to the client's internal records of runs processed to ensure accuracy and completeness. In the event that variations are identified and reported by a client, the Coding Team reworks the run as needed.

Run Entry Coding

Training of Billing Specialist Employees

All new Billing Specialist employees undergo an extensive training program. The program is designed to adequately train and monitor both the quality and quantity of the employees' work. As a result of the training, the employee will be able to perform all aspects of work within the work cell for all clients and all complexities of the different runs and communities. The employee will also be trained in all current regulations, HIPAA requirements and company policy and procedures.

The training program is broken down into modules, which vary on time completion. The online class is broken down into 6 classes with multiple modules for each class. After the completion of each individual class module, the employee is required to successfully pass a quiz. At the completion of the entire online class, the employee is required to successfully pass a one hundred question test.

For the final phase of training, the employee is put into the production environment for hands on training. This is the most extensive part of the training that encompasses months of hands on work. The focus of this part of the training is to concentrate on the complexities of each community serviced and the types of runs the biller will be required to work with. The complexities are divided into tiers 1 - 4, with tier 1 being the simplest and tier 4 being the most complex. Benchmarks for quantity and quality have been established for the timeline during the training. Once each tier training is complete, the employee must be able to meet production quotas.

Upon completion of the overall training program, all batches coded by each new employee will receive ongoing quality reviews by the Training Manager. These reviews continue until the employee's error rate is less than ten percent. In addition to completing the training program, the employee will also become a Certified Ambulance Coder by attending a week long online course sponsored by the National Academy of Ambulance Coding (NAAC).

Coding Quality Reviews

Quality reviews are performed at least monthly by the Training Manager. A haphazard sample selection of batches is reviewed for each employee to ensure that error rates are less than 10 percent. If error rates exceed 10 percent for the batches selected, the sample is expanded to further identify any trends and confirm the rate of error. The Training Manager follows up on error rates exceeding 10 percent to ensure each employee understands the errors made and how to best address remediation. If the quality review discovers an employee with error rates exceeding 20 percent, the employee is placed on probation, during

which time 100 percent of their batches will be reviewed until error rates of less than 10 percent are consistently achieved.

Monitoring Active Runs in Queue

Run batches for each client are tracked daily through review of the Active Runs in Queue report. The report details the client name, the date range of the runs received in queue, number of runs in queue, the number of runs for which coding is complete, the coding employee the batch is assigned to and the date the batch was assigned. The Training Manager reviews the report to ensure consistent progress is maintained for all batches. Aged batches that have not been completed are researched and resolved to ensure timely coding of batches received.

Annual Independent Review

Comstar receives an annual independent review from an Emergency Medical Services (EMS) attorney. The EMS attorney's report is divided into two sections; section one discusses general comments for billing, coding, coverage and industry best practices; section two is a detailed review of a sample of claims processed. A report is provided to Comstar summarizing any findings noted during the review and any recommendations for improving billing, coding and coverage practices.

Run Entry Coding Segregation of Duties

Access to enter ambulance runs in the RescueNet system is restricted to essential personnel. The Run Entry Coding Team is responsible for entering all ambulance trips and coding them appropriately. Appropriate Supervisors or Managers are also granted logical access to run entry coding. See Logical Access section for further discussion of proper access and segregation of duties.

Aging Summary by Schedule Reports

The Portfolio Team monitors aged items through the Aging Summary by Schedule report. This report is run daily and includes aging for all open incidents recorded in the RescueNet system. Each client is assigned to a specific member of the Portfolio Team who manages the account and monitors ongoing operations related to the client. The Portfolio Team is responsible for initiating and overseeing the follow up procedures for aged receivables, denied claims, partially paid claims, aged claims with no response, payment retractions, offsets, reimbursements and collection activities. Each member of the Portfolio Team summarizes their daily actions taken on aged items in a Portfolio Team Assignment page in SharePoint. The Billing Manager monitors the progress made on aged items through review of the activities in SharePoint.

Invoicing and Claim Submission Processing

Invoice and Claim Generation

Upon completion of the run entry coding process each run is placed in a No Bill Sent status. To initiate the claim submission process, the Invoicing Team queries the RescueNet system for runs with a No Bill Sent status and begins the invoice printing process and generates electronic claims. Each printed invoice is then reviewed by a Manager before being sent to the appropriate payer. Most insurance companies accept an electronic version of the invoice known as electronic claims (e-claims) instead of paper invoices.

The Invoicing Team monitors a printer error report throughout the invoice printing process to ensure all invoices are physically printed. Invoices not printed due to printer errors are reprinted as necessary. After

invoices are printed, the system updates the run status from a No Bill Sent status to a Bill Sent status, posting the invoice.

Allowance Setup and Maintenance

Allowance agreements and fee schedules between each client and payer (Medicaid, insurance carrier, etc.) are provided to Comstar with each new contract. The IT Team completes an IT Project Form to document the setup of parameters for each client and loads them into the appropriate client master file in RescueNet. The Portfolio Team reviews each setup. All subsequent changes to allowances and fee schedules requested by payers and/or clients are reviewed and approved by a Portfolio Team Manager via the IT Project Form before being placed into production.

Completeness of Invoice Processing

The Invoicing Team follows an invoice print checklist to ensure invoices are printed each day for all payee types. The number of runs and a batch number for each batch of invoices are recorded on the print schedule as each payee type is invoiced. This checklist is used to ensure that all runs available for invoicing per RescueNet are actually invoiced. Through adherence to the daily print schedule, the Invoicing Team ensures that invoices have been printed for all runs with a status of No Bill Sent at the time of printing.

Monitoring of Aged Batches Not Invoiced

The Invoicing Team monitors the Aging Summary report to identify aged runs with a No Bill Sent status. These are runs that have been coded but not yet invoiced due to an issue, such as coding questions arising from the quality review process. The report lists all payee types for each client and the number of days the run has aged. Aged runs that have not been billed are identified, researched and resolved as necessary. The Aging Summary report is reviewed weekly by the Invoicing Team and a Manager.

Payment Receipt Processing

Payment Application

All checks, remittance advices and lockbox reports are received in the mailroom, sorted and batched by client. Batched receipts are filed in a secured filing cabinet until retrieved by the Payment Application Team for processing. The Payment Application Team applies payments received to open invoices based on the check, remittance advice or lockbox report. Payments are applied against a unique run number corresponding to the original coded run. Each Payment Application Team member totals the batch of payments entered in the system and agrees it to the sum of the batch check totals processed to ensure accurate and complete recording.

Payment Application Checklist

A daily checklist is utilized to ensure receipts are processed for each client based on frequencies determined by the individual clients. The checklist indicates which client's receipts are to be processed on each given day, the Payment Application Team member assigned to process the payments received and the date all receipts have been applied. The checklist is maintained by the Payment Application Team Supervisor and monitored to ensure timely application of receipts.

Payment Application Quality Review

Quality reviews are performed monthly by a Payment Application Team Supervisor. A haphazard sample selection of payments is reviewed for each employee to ensure error rates are less than 3 percent. If error

rates exceed 3 percent for the applications selected, the sample is expanded to further identify any trends and confirm the rate of error. Employees exceeding the 3 percent error rate are monitored by the Supervisor to ensure error rates return to less than 3 percent.

Cash Receipts Deposits

Receipts are forwarded to the client or deposited directly in the client's bank account or the trust account managed by Comstar, based on the frequency determined by each individual client. Funds deposited to the trust account are subsequently remitted to the client.

Safeguarding of Checks Received

Checks are bundled and stored in a locked filing cabinet until deposits are made, or forwarded to the client. The filing cabinet is restricted to members of the Payment Application Team and appropriate members of management.

Payment Processing Segregation of Duties

Access to apply payments in the RescueNet system is restricted to essential personnel. The Payment Application Team, Denials Team and the Portfolio Team require access to apply payments against open invoices as part of their daily job responsibilities. Appropriate Supervisors or Managers are also granted logical access to apply payments. See Logical Access section for further discussion of proper access and segregation of duties.

Monitoring of Aged Accounts

Aging Detail Reports

Aging Detail reports are provided to each client with the monthly client reporting package. The reports detail the incident number, incident date, patient name, age of the incident and the total aged amount outstanding. The reports can be used by each client to monitor aged open items and the results of collection activities.

Denial Management

Denied claims are monitored by the Insurance Follow-Up Manager for all insurance carriers. The Insurance Follow-Up Manager tracks the number of new denied claims added, completed and outstanding for each business day. Denied claims are assigned to members of the Denial Team who determine the appropriate appeals action needed and initiate the appeal. The Denial Team monitors the status of open appeals to track the disposition or necessary follow up procedures.

Processing of Credits due to Payment Errors and Overpayments

In the event of a payee overpayment or payment error, the Portfolio Team is notified by the payee as to the amount and underlying reason for the error. Overpayments and payment errors may be corrected through a payment retraction (EFT processed by payer), offset (to another payment) or payment reimbursement (check). The Portfolio Team approves and initiates the retraction, offset or payment authorization form based on discussions with the payee and provides the form to the Payment Application Team for entry into the RescueNet system. The Portfolio Team monitors the aging of unapplied credits through review of the Reimbursements or Retractions Pending report that is part of the daily Aging Summary by Schedule report. Clients receive a Retraction/Reimbursement Summary as part of the monthly client reporting package.

Management Monitoring of Production

Management monitors operational activities through the Daily Production and Activity Tracking Report. The report summarizes operational metrics, efficiency metrics, accuracy percentages and aging of all open items in the RescueNet system. The results of the monthly quality control efforts, as well as all items currently on hold, undergoing appeal and the number of runs and claims processed each business day, are summarized in the report. The report is generated by the Billing Manager and distributed to all team managers and the CEO.

Aged Items Disposition

Request for Disposition Reports are sent to clients monthly for review of unresolved aged receivables. The request lists the details of each incident, the date and the total amount outstanding. Clients indicate through a checkmark, if they would like to write-off the receivable, send the account to a collection agency, report the claim to a credit bureau or request other specific actions. The Request for Disposition Report is returned to Comstar who executes the indicated action. Selected clients have authorized Comstar, through contractual parameters, to take predetermined action on their behalf without a completed Request for Disposition Reports.

Write-Off Processing Logical Access

Access to write-off aged receivables in the RescueNet system is restricted to appropriate personnel. The Payment Application Team, Denials Team and the Portfolio Team require access to write-off the balances of aged receivables as part of their daily responsibilities. Appropriate Supervisors or Managers are also granted logical access to process write-offs.

Client Reporting

Monthly Client Reports

Comprehensive reporting packages are sent to each client on a monthly basis. The package includes the following reports and summaries (monthly reporting package content may vary):

- Ambulance Billing Account Reconciliation Report
    - A report that summarizes gross commitments, contractual allowances, payments received by Comstar and by the client, retractions, total value of write-offs processed for the month and the ending account balance

- Monthly Statistics Report
    - An analysis of multiple metrics summarizing the different hospitals used, the treatment types, average number of runs for each day of the week, average time range for runs, patient age range and gender

- Detailed Activity Report
    - A detailed list of all activity recorded for the month including run activity, commitments, a payment summary, incident aging detail and requests for write-off of aged receivables

- Commitments Report
    - A summary of runs received during the month including the run dates, incident numbers, patient name, a description of each charge and the total amount for all charges received during the month

- Retraction/Reimbursement Summary
    - A summary list of retractions, offsets or reimbursements recorded during the month, the corresponding incident and the amount (Clients monitor the summary for reasonableness of the transactions processed.)

- Allowances Report
    - A summary of payee allowances for each coded charge on a run (The summary lists the gross charge, the maximum allowance for the charge and the net amount billed.)

- Payment Summary
    - A summary listing all payments received against each incident, the amount and type of payment

- Aging Detail
    - A report detailing all aged incidents recorded in the RescueNet system (The report includes the incident number, incident date, patient name, age of the incident and the total aged amount outstanding.)

- Request for Disposition Report
    - A list of unresolved aged receivables listing the details of each incident, the date and the total amount outstanding (Clients indicate their preferred action for each receivable and return the request to Comstar.)

- Write-off Report
    - A list of all write-offs processed during the month, the reason for each, the incident the write-off was applied to and the total amount

- Deposit Summary
    - A summary of payment deposits on the client's bank account

- Bank Account Reconciliation (for applicable clients)
    - Comstar prepares the bank reconciliation and provides a summary of the reconciliation, the corresponding bank statement, a payment summary and identifies any reconciling items requiring follow up and resolution by the client.

- Client Billing Rate Report
    - A report detailing rate changes and the effective dates of those changes (Comstar sends this to the clients as needed when fees or rates are changed.)

- Comstar Invoice
    - A description of the services rendered by Comstar for the month and the applicable amount due

<u>Bank Reconciliations</u>

Comstar prepares bank reconciliations for selected clients. Bank reconciliations are prepared by the Client Accounting Team and reviewed by the Client Accounting Manager. A summary of the reconciliation, the corresponding bank statement, a payment summary and reconciling items requiring client follow up are provided to the client with each monthly reporting package. The trust account is reconciled on a monthly basis by a third party accounting firm and reviewed by the CEO.

Check Processing

Occasionally there is a need to reimburse a payer for an overpayment. In these cases, selected clients allow Comstar to prepare manual checks on their behalf. All manual checks are prepared by the Client Accounting Team and supported by the appropriate documentation justifying the expenditure. Unsigned checks and related support are provided to the client with the reporting package for client-signature. The client reviews the expenditure support and then signs and mails the check to the appropriate party.

Safeguarding of Checks

All client check books are stored in a locked filing cabinet accessible to members of the Client Accounting Team and necessary Supervisors or Managers.

User Controls Considerations

Comstar's processing of transactions and the controls over the processing were designed with the assumption that certain controls would be placed in operation at user organizations. This section describes additional controls that should be in operation at user organizations to complement the controls at Comstar. User auditors should consider whether the following controls have been placed in operation at user organizations:

- User has controls to deliver accurate, timely and complete run reports to Comstar that facilitate accurate coding.

- User has controls in place with ambulance providers to ensure compliance with Medicare regulations for CMS rule 42 C.F.R §424.36.

- User has controls in place to ensure proper licensure and certification of ambulance service providers and crew members.

- User has controls to reconcile internal records with the Comstar provided Monthly Commitments Report to ensure accuracy and completeness of coded trip information.

- User has controls to reconcile bank account balances to their internal accounting system records.

- User has controls in place to establish an appropriate billing and collection policy, and deliver the policy, or subsequent changes, to Comstar in a timely manner.

- User has controls in place to provide Comstar with accurate and complete allowance parameters and fee schedules and to perform timely review of periodic updates to fees and allowances processed by Comstar as needed.

- User has controls in place to monitor aging activity and calculate appropriate reserves for uncollectable accounts.

- User has controls in place to review and authorize write-off of aged receivable balances.

- User has controls in place to review retractions, offsets and reimbursements for reasonableness.

- User has controls in place to reconcile the Comstar monthly reporting packages to user-recorded financial information.

- Selected users have controls in place to review bank reconciliations prepared by Comstar for accuracy and completeness.

- Selected users have controls in place to review and sign checks prepared by Comstar.

- Users have controls in place to provide accurate information for client setup and to authorize client requested changes to RescueNet setup.

- Users have controls in place to validate data files sent to Comstar and confirm Comstar's acknowledgement of receipt.

Control Objective 1:	COMSTAR Control Activity
Controls provide reasonable assurance that physical access to computer equipment and storage media is restricted to properly authorized individuals.	• Entrance to the building is restricted by electronic key fob. • Access to the building is monitored by external cameras. • Access to the data center is restricted via a locked door. • The CEO maintains custody of the data center keys and distributes them to the appropriate employees needing access to the data center based on his discretion.

Control Objective 2:	COMSTAR Control Activity
Controls provide reasonable assurance of physical protection of data processed within the data center.	• Environmental controls have been implemented including temperature and humidity monitoring, UPS, generator, fire suppression, water detection, and backup generator.

Control Objective 3:	COMSTAR Control Activity
Controls provide reasonable assurance that logical access to system resources (for example, programs, data, tables and parameters) is restricted to properly authorized individuals.	• New hire access requests are initiated by the employee's manager by completing a New Hire Setup/IT Project Form. The form must be approved by the system owner. • Changes to existing access requests are initiated by the employee's manager by completing a New Hire Setup/IT Project Form. The form must be approved by the system owner. • Network and RescueNet access terminations are documented in an Employee Termination/IT Project Form approved by Client Accounting and reviewed by the President and CEO. Individuals are removed from the system timely. • Strong passwords for the network and RescueNet are defined; password expiration is 60 days, minimum length is six characters, password reuse of two and complexity is enabled. • Generic or shared accounts are not permitted when accessing production systems. • Administrative access is restricted to authorized personnel. • Access to change RescueNet master files is restricted to system administrators. • User access reviews are performed annually during the annual performance appraisals.

Control Objective 4:	COMSTAR Control Activity
Controls provide reasonable assurance that changes to critical systems are tested, approved and documented.	• Network and RescueNet system changes are documented in an IT project form and approved by a manager. Additional approval is required by the client contact for customer related changes. • A separate nonproduction RescueNet environment exits for testing changes. • Network and RescueNet system changes are tested by Quality Assurance group. • System changes made to the production environment are reviewed by another member of the IT team prior to release into production. • Network and RescueNet system changes are approved by the CEO prior to deployment into production.

Control Objective 5:	COMSTAR Control Activity
Controls provide reasonable assurance that ambulance trips are recorded in a timely and complete manner.	• Manual run batches are logged into a tracking database and reported on the Active Runs in Queue Report. Unprocessed batches are tracked daily through the Active Runs in Queue Report. Aged or incomplete batches are identified, researched and followed up to ensure consistent timely progress on all aged items. • Electronic run batches are logged into a tracking database and reported on the Active Runs in Queue Report. Unprocessed batches are tracked daily through the Active Runs in Queue Report. Aged or incomplete batches are identified, researched and followed up to ensure consistent timely progress on all aged items. • The daily processing of electronic run data files is monitored to ensure processing is successful. • Electronic run data import failures are reviewed and resolved. • A Comstar import confirmation email containing the date, date of service range and quantity of incident reports downloaded is emailed to the client when Comstar downloads data files from a client. • New clients are set up in the RescueNet system based on parameters outlined in the new client information sheet. All new client setup entries and changes to existing client master files are documented on an IT Project Form and approved by the Portfolio Team manager prior to entry. • Monthly Commitments Reports are sent to clients summarizing all runs received for the period. • All batches processed for new clients undergo a 100 percent quality control review by the Training Manager to ensure that each new client is provided accurate and complete information.

Control Objective 6:	COMSTAR Control Activity
Controls provide reasonable assurance of the accuracy, timeliness and validity of coding.	• All new coding team members complete a training program with the Training Manager. Upon completion of the training program, all batches coded by new employees are monitored until acceptable batch entry error rates of less than 10 percent are achieved. • Managers perform quality control reviews for all coding team members at least once per month from a haphazard selection of runs from one day during the month. If error rates exceed 10 percent, the Training Manager performs expanded quality control procedures and escalates remediation measures as needed with each coding employee. • Managers monitor the Active Runs In Queue Reports daily to evaluate the continued progress of batch processing and ensure aged batches are researched and coded in a timely manner. • Comstar receives an annual independent operational review from an EMS Attorney. The review encompasses billing and coding accuracies, efficiencies, industry best practices and a detailed review of a sample of claims. A detailed report of the independent review is provided to Comstar to document the results. • The ability to code trips is restricted to appropriate personnel and segregated from conflicting duties. • All aged items are monitored daily though the Aging Summary by Schedule Report. The Portfolio Team monitors the status of individual aged items to identify denied claims, partially paid claims and aged claims with no response. Follow up procedures are initiated by the Portfolio Team per client parameters and monitored by the Billing Manager for timely completion.

Control Objective 7:	COMSTAR Control Activity
Controls provide reasonable assurance of the accuracy, completeness and timeliness of invoice processing.	• Invoices are generated on a daily basis for all completed runs. Invoices are reviewed for completeness by a Manager and sent to the appropriate billable parties. • Setup and changes to the allowances and fee schedules are documented and approved through the IT change management process prior to being changed in RescueNet. All setups and changes to allowances and fee schedules requested by payers and/or clients are reviewed and approved by a Portfolio Team Manager via the IT Project Form before being placed into production. • An invoice print checklist by payer is followed daily to help ensure that invoices are printed and posted for all runs which have been flagged in RescueNet to indicate coding is complete and which have been placed in the print queue. • The Invoicing Team monitors the status of unprinted bills through review of the Printer Error Report. (Should also address electronic claims) • After invoices are printed, the system updates the run status from a No Bill Sent status to a Bill Sent status, posting the invoice. • The Invoicing Team monitors the Aging Summary Report to identify aged runs with a No Bill Sent status. Aged runs that have not been billed are identified, researched and resolved as necessary. The Aging Summary Report is reviewed weekly by the Invoicing Team and a Manager. • Access to change RescueNet master files is restricted to system administrators.

Control Objective 8:	COMSTAR Control Activity
Controls provide reasonable assurance of the accuracy, timeliness and completeness of payment receipt processing.	• The Payment Application Team applies individual payment receipts. The total of payments entered in the RescueNet system is agreed to the sum of the check totals processed to ensure accurate and complete recording of receipts. • A standard daily checklist is followed to ensure that receipts are processed for each client in accordance with the frequency agreed to with each individual client. The checklist is monitored by a Supervisor in the Payment Application Team to ensure timely application of receipts. • A Payment Application Supervisor performs quality control reviews for all Payment Application Team members once per month from a haphazard selection of payment applications from one day during the month. If error rates exceed 3 percent, the Supervisor performs expanded quality control procedures and escalates remediation measures as needed. • The Payment Application team ensures receipts are remitted to each client or deposited in the client's bank account according to the requirements of each client's individual statements of work. • Checks are physically safeguarded until deposited or remitted to each client. • The ability to process payment receipts is restricted to appropriate personnel and segregated from conflicting duties.

Control Objective 9:	COMSTAR Control Activity
Controls provide reasonable assurance over identification and monitoring of aged accounts, account adjustments (reimbursements, retractions, offsets, etc.) and collection activities and that write-offs are authorized.	• Aging Detail Reports are sent to clients monthly for monitoring. The reports detail the incident number, incident date, patient name, age of the incident and the total aged amount outstanding. • The Insurance Follow Up Team monitors denied insurance claims, determines the appropriate appeals actions needed, and monitors the disposition of appealed claims. The Billing Manager utilizes a spreadsheet to track the number of new denied claims added, completed and outstanding each day. • The Portfolio Team monitors the aging of unapplied credits due to a retraction, reimbursement or offset, through daily review of the Reimbursement or Retractions Pending Report. • Comstar Management monitors operational activities through the Daily Production and Activity Tracking Reports and prioritizes follow-up procedures as needed. • Disposition of aged items is authorized through client approval of a Request for Write-Off Report (replace with Request for Disposition Report) or as detailed per individual client statements of work. • The ability to write off aged receivables is restricted to appropriate personnel and segregated from conflicting

Control Objective 10:	COMSTAR Control Activity
Controls provide reasonable assurance of the accuracy, timeliness and completeness of check issuance, reconciliation of bank accounts and reporting of account activity.	• Reporting packages are sent to clients on a monthly basis. Key transactional, monitoring and operational summaries are included in the reporting package for analysis and reconciliation to internal client records. • Bank reconciliations for selected clients are prepared by the Client Accounting Team, reviewed by the Client Accounting Manager and delivered with the monthly reporting packages for client review. • Manual checks are prepared for selected clients by the Client Accounting Team and delivered with appropriate supporting documentation in the monthly reporting package. The client reviews, signs and mails the checks to the appropriate party. • Client check stock is safeguarded and maintained by appropriate Comstar personnel. • Monthly bank reconciliations for the trustee account is prepared by an independent third-party service provider and reviewed by management.