COASTAL CARE SERVICES, INC.®

member quality redefined.

Provider Manual

WELCOME

Dear Network Provider:

Welcome to Coastal Care Services, Inc.'s Network of Providers. We are pleased to have you participate in our network and we look forward to our partnership in coordinating and delivering quality home care services.

Coastal Care Services, Inc. is an independent home care management company that contracts primarily on a capitated basis with several local and national managed care organizations operating in Florida. Coastal is dedicated to coordinating a full range of home care services via its network of quality providers throughout the State of Florida. Working as a team, our services continue to meet and exceed our patients' and clients' expectations. **We are a viable solution for growing entities looking to simplify its members' access to ancillary services in the home**.

This manual is designed to provide you with a reference tool and be a supplement to your Health Services Provider Agreement. Please refer to it as much as possible. If you should have any questions please do not hesitate to contact our offices.

Once again Welcome and Thank You for joining the Network.

Carlos Ramirez
President

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Important Contact Information

Phone/Fax/Mai

Department	Contact Information
Provider Relations Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone:1-855-481-0505 Fax:1-855-481-0606
Credentialing Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
Member Services/Customer Service Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
Utilization Management Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
DME Intake Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
Home Health Intake Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
Pharmacy Intake Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
Claims Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
Grievance & Appeals Department	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone: 1-855-481-0505 Fax: 1-855-481-0606
Compliance Officer	7875 NW 12 Street, Suite 200 Miami, FL 33126 Phone:1-855-481-0202 Fax: 1-855-481-0606

Coastal Care Services, Inc. Website

www.ccsi.care

Coastal's website allows Providers to access a rich source of information. On the homepage, Providers can access the "Information for Providers" page and download the most current versions of the following:

- Provider Manual
- Provider Training Tool/FAQs
- Credentialing Applications
  - Durable Medical Equipment
  - Home Health
  - Pharmacy
- Provider Forms
  - Referral Request Form
  - Recommendation & Status Report
  - Claims Appeal Form
  - Notice of Medicare Non-Coverage

HOURS OF OPERATION

Standard Business Hours of Operation: 8:30am to 5:30pm

Available 24 hours a day, 7 days a week.

AFTER HOURS

Telephones are forwarded after hours to our Answering Service. Coastal will have on-call personnel after regular business hours, weekends and holidays in order to coordinate services 24 hours a day, 7 days a week. The Answering Service contacts the on-call Coastal Case Coordinator who will then contact the ordering physician and processed the orders according to the above referenced guidelines.

The **Home Health Referral Information Worksheet** will be utilized to coordinate care after hours. A printed authorization will be faxed to network provider on next business day.

BUSINESS GOALS AND GUIDING PRINCIPLES

Coastal is committed to coordinating quality comprehensive home services to improve patient outcomes. We effectively tailor programs to meet different reimbursement methodologies with guaranteed cost effectiveness. Our network of providers strive to prevent further illness and promote better health practices. We have vast experience in efficiently and effectively coordinating the delivery of home care and coordinate a full range of home services. Coastal also recognizes that a goal of home health is to teach and train the patient and/or caregiver and all network providers must work hard towards this goal.

Mission

We are a customer focused home care services management company dedicated to coordinating high quality home care services, to rehabilitate and restore the health of our patients.

Our Vision

To become the leading national home care Management Company.

Our Values and Guiding Principles

Ethics and integrity are at the heart of our approach to improving patient outcomes, with a firm belief in coordinating quality care.

Code of Ethics and Business Standards

Ethics and integrity are at the heart of our approach to improving patient outcomes, with a firm belief in coordinating quality care. Coastal has excelled in coordinating and providing a full range of home care services through the hard work and dedication of its employees and its network of providers throughout the State of Florida. As a team, our services continue to meet and exceed our patients' and clients' expectations. Our employees and network providers are committed to working hard to establish and maintain our reputation and commitment to patients, payors and clients.

Cultural Competency

Coastal has a cultural competency plan as part of the UM program to improve our Member's outcomes and quality of care and to reduce racial and ethnic health care. Our providers are prohibited from discriminating against different types of patients based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, source of payment, or health status. We will educate our employees, members, and providers on the importance of communication in a preferred language and respect for cultural health beliefs.

Services for Translation and the Hearing Impaired

All Coastal Members whose primary language is not English are entitled to receive interpreter services through Coastal at no cost to the member by calling Customer Service at 1-855-481-0404 For the hearing impaired, TTD/TTY is 711.

Member Eligibility

Coastal receives periodic member eligibility information from the health plans we are contracted with. Our IT department works closely with these health plans to make sure we have the most accurate and up to date eligibility information. A member's eligibility can still change at any time. Coastal places the responsibility for eligibility verification on the provider rendering services.

Providers may confirm current eligibility through the following process:

- Contact Coastal's Intake Department at 1-855-481-0505, Option 2
- Online verification through our website coming soon.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification eligibility is never a guarantee of coverage or payment.

COASTAL AND ITS NETWORK PROVIDERS WILL:

- Conduct our business in strict compliance with applicable laws, rules and regulations
- Work hard to coordinate and provide timely and only the highest quality care and services
- Strive to strengthen the collaborative association between Coastal and network providers
- Always be honest, forthright and accountable in all dealings with others for instance; patients, physicians, clients, coworkers and each other
- Not discriminate on the basis of race, color, religion, sex, age, national origin, disability, communicable disease, physical or mental condition or any other legally protected status and always provide considerate care that respects patients' personal values and beliefs
- Be receptive to guidance and counseling services to help improve work performance
- Attend staff development seminars and in-service training programs to keep current in the latest developments in our field of specialization including an understanding and knowledge of National Patient Safety Goals and The Joint Commission or other applicable standards
- Accept only those assignments that are within the network provider's scope and specialization and communicate to Coastal on a timely basis if the services cannot be rendered within the expected/required timeframe.
- Keep confidential any client and/or company information entrusted
- Actively strive to improve standards of care and to control healthcare costs
- Not knowingly misrepresent our services
- Ensure the safety of those clients entrusted to our care, and will immediately report any worsening in the patient's condition, and any incident of patient abuse or suspected abuse according to law
- Safeguard the property of the company used in the performance of their duties
- Not engage in any conduct detrimental to the best interest of patients, physicians, clients, coworkers and the network providers
- Promote a positive working environment and good public relations
- Be good citizens and supportive of local communities and activities
- Practice the highest level of ethical behavior and professionalism in our day to day activities

CREDENTIALING/RECREDENTIALING PROCEDURES

All licensed entities who participate with Coastal are credentialed and re-credentialed in accordance with our standards and requirements for acceptance. The purpose of credentialing is to ensure and promote the delivery of quality health services and equipment/supplies through the selection, and continued monitoring, of qualified practitioners. Coastal reserves the right to accept into or reject providers into network.

During the credentialing process a site visit of potential providers will be conducted if the organization is not accredited. The site visit may be waived for Medicare/Medicaid licensed home health agencies whose last AHCA survey had no deficiencies.

Any changes and updates to the provider profile that was supplied on the original application must be communicated to Coastal's Network Manager in writing. This notice should contain both the old and the new information. Examples of changes that should be reported include:

- Copies of licenses and certificates upon renewal
- Change is Service Area and or scope of services
- New address
- New telephone numbers and/or fax numbers
- Additional locations
- New ownership and or Tax Identification # changes
- New tax identification number
- Change in liability coverage, company or limits
- Change is service area (counties)
- Change in accreditation status
- Change in participation with government programs
- Change in Licensure

This list is not meant to be all inclusive. Providers should refer to their Agreement regarding proper notices and established time frames.

It is important that all written notices be as clear and precise as possible. This will ensure accuracy and allow for changes to be processed in a timely manner. Please send all written notices to:

Network Manager
7875 NW 12 Street, Suite 200
Miami, FL 33126
Or Via Fax: 305-418-9378

Another convenient way to notify Coastal of changes is through our web site, www.ccsi.care. Your changes will then be forwarded to the Network Management and Credentialing Departments. We will contact you to verify accuracy and confirm changes.

Re-credentialing is performed every 3 years. During the 3 year term providers are expected and required to submit copies of documents (licenses, certificates) upon renewal. You will be contacted prior to any documents expiring. These documents should be faxed to the Credentialing Department at 786-454-9989.

Providers who do not submit expired documentation on a timely basis will be suspended and patients will be transitioned accordingly.

CHANGES IN PROVIDER INFORMATION

Prior notice to Coastal is required for any changes in the information below and according to the terms of your contract:

- 1099 Mailing Address
- Physical or Billing Address
- Tax ID Number (W-9 form Required)
- Group Name or affiliation
- Telephone/Fax Numbers
- E-mail address

MEDICAID MEMBERS CONTINUATION OF CARE

For all new members, for the first sixty (60) days of enrollment, Coastal will accept any authorization from another plan for care or services the member is receiving.

Coastal encourages all Non-Participating providers to contact the Provider Relations department and join our Network.

CASE COORDINATION / AUTHORIZATION PROCESS

Coastal will review all orders and select the most appropriate network provider and issue authorizations in order for services to be rendered to patients of Managed Care Organizations contracted with Coastal. All services, regardless of payor or cost, require the review, assignment and prior authorization process. The authorization process ensures patients are active to receive services, the patient is eligible for a defined benefit/item, the services are reasonable for treatment of illness or injury, and meets all other applicable medical criteria and statutory and regulatory requirements. The following depicts the authorization process.

CCS Intake Flow

Order Received via Electronic Fax

Electronic Fax is Logged
Plan Eligibility Verified and Prescription is reviewed for Completeness
CCS Data Management System Reviewed and
Patient File Created

Patient Eligible?

No

Ordering Physician or Health Plan Notification Provided

Yes

Order Provided to Department Case Coordinator

Home Medical Equipment

Home Health Care

Infused and Non-Infused Therapies

Diabetic and Other Supplies

Coordinator Will Review Benefits And Medical Necessity and Refer Any Questions/ Issues Accordingly (Health Plan, Case Manager, Director). Coordinator Will Contact Network Providers To Coordinate Services, Coordinate Faxing of Information and Confirm Receipt of Fax by Network Provider and Staffing of Service. Case Coordinator Will Also Contact Discharging Facilities to Confirm Staffing and Patient to Advise Them of CCS's Role and Provider That Will Directly Provide the Services.

Services Are Provided By Network Providers and Claims forwarded to CCS for Processing

Customer Service Call Back Program Conducts Surveys to Ensure Satisfaction

Case Managers Utilize Interdisciplinary Process to Manage Patient Care and Review and Coordinate Requests for Additional Services based on physicians orders.

Weekly Rounds Conducted With Agencies (when necessary) to Address The Clinical Challenges and Progress of Patients With Certain Chronic Conditions or Participating in Health Plan's Case Management Program

Documentation Filed Accordingly

Our Case Management Monitoring Promotes The Delivery of Health Care and Services in an Effective Cost Efficient Manner. This is a Process Whereby We Evaluate the Adequacy and Appropriateness of The Delivery of Home Care Services and Ongoing Services

Referral Work Flow

Once the provider has accepted the patient for service, an authorization is issued and **Referral Authorization Form** is printed and forwarded via fax along with doctor's order and pertinent patient information. The **Referral Authorization Form** contains; Patient Information, Ordering Provider Information, Clinical Information along with authorized Date Ranges and Procedure Codes for the services being authorized. The Authorization also contains comments that include important patient information. The Authorization # is important as it is used for tracking, reporting and billing purposes. The same authorization number remains in effect until the patient is discharged. Network providers are to contact Coastal for any additional information that may be needed prior to the start of care.

The **Referral Authorization Form** will also identify the patient's Health Plan and line of business such as Medicare, Medicaid or Commercial. This is important for home health care providers since government regulations vary according to the patient coverage; for example, if a Medicare patient is to receive home health care services, an OASIS needs to be completed and transmitted and the **"Notice of Medicare Non-Coverage"** must be provided prior to discharge or discontinuation of services.

Coastal will contact discharging facilities or patients prior to the start of care/services and may mail a letter to patients to advise them of the services that were coordinated and servicing provider name. In addition, Coastal conducts surveys after the start of care and periodically while the patient is receiving services to ensure patient satisfaction.

Providers must notify Coastal immediately if services are unable to be provided for any reason. For example, a patient may not be home or medications may not have arrived and care cannot start as requested/scheduled.

Pharmacy

Coastal's contractual arrangements with the Health Plans vary in this area as most Health Plans manage many self injectables through their pharmacy benefit.

Pharmacy authorizations will also be accompanied by the ordering physician's orders. Authorizations will only be provided for the month in which they are requested and will include the total number of doses to complete the treatment or the amount of doses contained within the month. If the patient is to continue with the treatment, the provider will request an authorization extension from Coastal each month. If the provider has obtained a new or revised order from the physician, this information must also be submitted to Coastal. It is the responsibility of the provider to request the authorization at least 5 days prior to the expiration of the existing authorization to ensure continuity of care and reimbursement. Providers are required to include both the HCPCS Codes and corresponding NDC codes when submitting bills.

Home Health Care

New Patients

Home health care authorizations will typically include an evaluation or assessment of the home situation, patient and caregiver education and follow-up visits which will be authorized according to the patient's diagnosis and physician's orders. This is done to ensure that patients are homebound, and meet both medical necessity and home health criteria. Providers must send the completed **"Recommendation & Status Report"** via fax to Coastal Case Management Department upon completion. The submitted recommendation and accompanying documentation / signed doctor's orders will then be reviewed and a determination will be made by the Case Manager. Please note that all requests for extensions or additional visits **must** be supported by documentation. Coastal will in most circumstances contact the patient and/or physician to confirm services.

As patients are scheduled to be discharged from service, providers must send a **"Notice of Medicare Non-Coverage"** to all Medicare patients 2 days prior to expected date of discharge. The Notice of Medicare Non-Coverage can be found in the Appendix Section of this Manual. Authorizations are again reviewed and closed. Patient documentation is filed and stored in accordance with applicable federal and state laws and regulations.

We use an interdisciplinary team approach to care, with strong interaction with our network providers, patients and physicians. Every Monday, all home health care providers must forward a list of recently discharged patients to Coastal for census review along with copies of all **"Notice of Medicare Non-Coverage"** forms issued the previous week.

Home Medical Equipment & Supplies

Coastal coordinates all services and the same process as above is followed. HME authorizations will be accompanied by the ordering physician's orders, and must meet medical necessity and criteria. Brand specific items or supplies are not considered covered by most insurers however they may be reimbursed at the appropriate allowable amount for the HCPCS Code. Reimbursement will not be brand specific.

Initial HME authorizations for rental equipment are usually provided with a time frame of 30 days (PAP 60days) After 30 days the patient is contacted to ensure continued need and use of equipment. If this is confirmed, the authorization will be updated accordingly usually for an additional 60 days. This process will repeat until the patient is discharged from service or equipment reaches rental cap agreement. Network providers may request renewal of the authorization with their system's active patient list which **MUST** be in a file format that could be modified (ex: Excel) and include the patient name, id#,

current auth #, description of equipment, HCPC and **START OF CARE**. It is the provider's responsibility to submit to Coastal a monthly list of all active patients whose authorizations will expire during that month by the 5th day of each month. Network will be responsible for verifying eligibility and continued use of equipment and will provide reauthorization no later then the last day of the month.

Network providers must track the rental cap timeframe as payments will not be made once reached. The authorization will indicate if the equipment is a purchase or rental. Small ticket items (canes, walkers, commodes, nebulizers) are usually handled as a purchase unless otherwise determined and indicated.

As a reference, **The DMEPOS Supplier Standards** can be found in the Appendix. Coastal is solely responsible for paying network providers for services coordinated and authorized for our eligible managed care patients.

PATIENT RIGHTS AND RESPONSIBILITIES

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients, You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he does not speak English.
- A patient has the right to know what rules and regulations apply to his conduct.
- A patient has the right to be given by his health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that shall deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his rights, as stated in Florida, through the grievance procedure of the health care provider or health care facility which served him and to the appropriate state licensing agency.

- A patient is responsible for providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health.
- A patient is responsible for reporting unexpected changes in his condition to his health care provider.
- A patient is responsible for reporting to his health care provider whether he comprehends a contemplated course of action and what is expected of him.

A patient is responsible for following the treatment plan recommended by his health care provider.

- A patient is responsible for keeping an appointment and, when unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his actions if he refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

In addition when utilizing home medical equipment patients must understand that:

- Rental equipment must be used with reasonable care, not altered or modified, and returned in good condition (normal wear expected).
- **COASTAL AND NETWORK PROVIDERS ARE NOT RESPONSIBLE FOR ACCIDENTS OR INJURIES CAUSED DIRECTLY OR INDIRECTLY BY THE USE OF RENTAL EQUIPMENT.**

Patients receiving services must:

- Promptly report to provider any malfunction or defects in rental equipment so that repair/replacement can be arranged.
- Provide access to all rental equipment for repair/replacement, maintenance and/or pick-up.
- Use the equipment for the sole purpose indicated and in compliance with the physician's orders.
- Keep the equipment in their possession and at the address to which it was delivered unless otherwise authorized by provider.
- Notify provider of any hospitalizations or change in health insurance, address, telephone number, physician, or when the medical need for rental equipment no longer exists.
- Agree to accept all financial responsibility for all services.

SERVICE OBJECTIVES

Coastal shall coordinate all necessary Covered Services to patients through its network of Providers, in accordance with Coastal's contractual arrangement with the patient's Health Plan, the scope of Providers' licensure and applicable certification and the prevailing standards of care in the community in which services will be provided.

Coastal is "Dedicated to Coordinating Superior Comprehensive Home Care Services" in a timely manner. Our goals include:

- Staffing and coordinating services on all cases the same day orders are received
- Delivery of services by our network providers, unless otherwise specified:
  - Routine Services - within 24 hours
  - Urgent Service – same day
  - Stat Services – within 4 hours
- On call service available 24 hours a day, 7 days per week
- Patients and family members are thoroughly advised of after hours, weekend and holiday phone numbers as well as Emergency Procedures by the Network Provider
- Patients and family members are thoroughly trained on care instructions by the Network Provider. If respiratory equipment is being used, patients are properly trained on its use and care.

Please refer to the Service Standards Appendix of your provider agreement.

Patient Records

Coastal and Network Providers shall create and maintain patient records for each patient receiving service. Patient records shall be maintained in a legible, comprehensive, and in chronological order in accordance with community standards. Patient records must be treated as confidential in accordance with Florida law, and providers shall comply with applicable state and federal laws regarding patient records and confidentiality. In addition, patient records must be available to both Coastal and the Health Plan in order to support business activities. These activities include, but are not limited to, accreditation activities, utilization review, risk management, peer review studies, customer service inquires, grievance and appeals, quality improvement initiatives and claims audits.

Security and Confidentiality of Patient Information

Coastal and Network Providers must comply with all applicable state and federal laws including, without limitation, the federal Health Insurance Portability and Accountability Act of 1996 and the related regulations, regarding the security and confidentiality of information concerning patient identifiable information.

Risk Management Process

The purpose of the Risk Management Program is to promote health, safety, quality of service, prevent loss and liability exposure and protect resources. Our Risk Management Program provides us with a framework for identifying risks, weighing various risks and making decisions about which risks deserve immediate attention. We define risk as anything that threatens our ability *to coordinate and ensure high quality home care services are rendered by network providers, to rehabilitate and restore the health of our patients.*

An **Unusual Occurrence Form** has been included in the Appendix Section of this Manual. This form is used as the network's internal reporting system. We require the reporting of unexpected occurrences while patients are receiving services coordinated by Coastal and are under the care of our Network Providers. These occurrences are not limited to sentinel events or those events involving death or serious physical or psychological injury or risk there of but rather all unusual issues or adverse occurrences, injury or alleged injury or incidents involving quality of care, patient complaints, formal/information grievances or potential professional liability. A fall at home would not need to be reported unless it occurred while the patient was receiving services such as physical therapy. The development of decubitis while receiving home care, should be reported. These issues will be investigated and action taken accordingly. The Unusual Occurrence Form is considered peer review and protected from discovery as long as it is not copied or made public in any other way. The originals should be mailed to:

Coastal Care Services, Inc.
Attn: Risk Management
7875 NW 12 Street, Suite 200
Miami, FL 33126

CLAIMS PROCESS

Coastal will send physician orders/referrals and a print out of our authorization to network providers authorized to provide health services. The authorization process and the claims process are closely linked. Appropriate authorization number must be submitted on claims. A claim submitted without an authorization number may be rejected.

Compensation for services is subject to patient's eligibility with the Health Plan at the time that the service is rendered. Authorizations are not a guarantee of payment, payment is subject to patient eligibility. Although eligibility is verified by Coastal prior to issuing an authorization or reauthorization, we encourage providers to also verify eligibility should an authorization extend from one month to another. Verifying eligibility is a joint responsibility. Also, a variation or increase in Health Services requires a new authorization request and updates to the authorization issued. Claims adjudicate based on HCPCs/CPT codes and units authorized.

Submission of accurate claims information in a timely manner is an essential part of the network provider's role in delivering care, tracking clinical activity and maintaining fiscal stability. Network providers must submit complete CMS 1500 billing forms with the necessary information which includes Nursing Notes for Home Health Care Providers. As appropriate include the most recent ICD* version diagnosis codes identified to the highest level of specificity and codes for procedures, medicines, services or supplies with modifiers if indicated (e.g., HCPCS, CPT-4, NDC). Please note that pharmacy claims must include both NDC codes and respective HCPCS codes. Providers are requested to submit claims within 30 days of providing services as Coastal must also comply with the timely submission of data to each Health Plan. Claims will be denied for untimely filing according to applicable statutory and regulatory requirements.

Providers are encouraged to submit claims on a timely basis due to strict utilization management reporting requirements which Coastal has with its Managed Care Organizations. Coastal will acknowledge receipt of claims within 15 days of receipt. Each Monday, a **Claims Inventory Report** is faxed to providers who have submitted claims two weeks prior. For instance, on November 17, 2014, the report will include claims received for the week of November 3rd to November 7th. A sample of this report can be found in the Appendix Section of this Manual. This is a tool to assist providers in the billing and collections process.

**Coastal will be accepting ICD-9 Codes until ICD version 10 is mandated (October 1, 2015). All providers should take all necessary steps to ensure they are ICD10 compliant prior to this date. Coastal will be able to accept test files from providers starting 8/15/2015. Please contact the claims department for further testing instructions.*

To expedite the correct processing of claims the appropriate information should be included on the claims form, in addition to the Coastal authorization number and skilled services notes for all home health care, if applicable. All claims must be submitted to:

Paper Claims must be mailed to:

Coastal Care Services, Inc.

Attn: Claims Department
7875 NW 12 Street, Suite 200
Miami, FL 33126

Electronic Claims can be submitted through:

Emdeon

1-877-363-3666

Monitoring of Claims Activities

Special features have been and continue to be incorporated into the Claims Payment System to ensure the correct processing of claims. These features or "edits" include but are not limited to the review of claims that:

- Have not been authorized
- Have been previously paid
- Have been provided to persons who were ineligible for services
- Have been billed at a higher level than what is validated in the notes or was authorized

Coastal reserves the right to request supporting documentation from Network Providers

Claims Issues

It is our policy to pay claims correctly. When a payment error is detected or reported the claim must be adjusted accordingly for correct calculation of underpayment or recovery of overpayment.

The **Network Provider Claim Research Request** form should be utilized by providers to request a review of any potential payment issue. This form is located in the Appendix Section of this manual and you can also request for it to be sent electronically. The **Network Provider Claim Research Request** form should be mailed to:

Coastal Care Services, Inc.
Attn: Network Manager
7875 NW 12 Street, Suite 200
Miami, FL 33126

Upon notification of a possible error, the claim will be reviewed and if adjustment is required, the claims will be reprocessed. An explanation will be documented on research request form.

Claims Appeals

Please note that if your claim was denied in whole or part, you have the right to request a review. To initiate a review, you must file a written appeal of the denied claim within 90 days after receipt of this remittance.

A claims appeal is a request for reconsideration of a denied claim or for an additional payment on a previously paid claim or resubmission. Its CCS' policy to respond to all claims appeals within 10 days of receipt and a subsequent letter with the decision will be sent within 60 days of the receipt of the appeal. An appeals form must be sent for each claim and all necessary legible documentation should be submitted with each appeal to allow CCS to do a thorough review of the case (appeal forms can be downloaded from our website).

If a claim was denied and requires a correction, you MUST submit a corrected claim. Please submit the corrected claim identifying the corrections to the address below.

Website:	www.ccsi.care
Please mail claims to:	Coastal Care Services, Inc. 7875 NW 12 St, Suite 200 Miami, FL 33126
Claims Customer Service:	855-481-0505
Appeals:	Claims Manager Attn: Claims Appeals Coastal Care Services, Inc. 7875 NW 12 St, Suite 200 Miami, FL 33126
Corrected Claims:	Claims Manager Attn: Corrected Claims Coastal Care Services, Inc. 7875 NW 12 St, Suite 200 Miami, FL 33126

Note: Please remember that according to your provider agreement you are not allowed to bill the member for any monies beyond their co-pay or co-insurance on claims for covered services.

Balance Billing

Patients cannot be billed for the difference between the provider's normal billed charge and the contractual negotiated rate, or any fee reduction imposed on the provider due to non-compliance with contractual requirements. This does not include collection of applicable copayments, deductibles or coinsurance.

Non Covered Services

Network providers should not represent to any patient that any non-covered service is a covered service or that such non-covered service should or will be paid by their insurance company. However, nothing prohibits network providers from seeking payment from a patient for non-covered services. Network providers may render a non-covered service to patients only if the following conditions are met: **(a)** insurance company advises the patient in writing and in advance that the service is a non-covered service; **(b)** insurance company advises the patient in writing that it will not pay for the service; and **(c)** the patient consents to the service and agrees in writing to be responsible for payment.

Coastal again emphasizes that although eligibility is verified upon issuing an authorization, providers must also verify eligibility and clearly communicate to patients in writing that they will be financially responsible for copayments, deductibles and other charges that may be associated with termination or change in insurance coverage.

PROVIDER COMPLAINTS

Coastal's appeal rights provide it's Providers the opportunity to express dissatisfaction about Claim determinations as well as about any other administrative complaints they may have.

Coastal does not deny services. If you have a complaint or do not agree with the determination regarding denial of services, please follow the member's health plan appeal policies.

Complaints: Coastal's Network Director is designated to receive and process provider complaints. Complaints may be received by:

- Phone by calling 1-855-481-0505 Ext.109
- Email to ProviderRelations@ccsi.care
- By mail or in person at: 7875 NW 12 Street, Suite 200, Miami, FL 33126

Grievance: The Grievance process provides the provider the opportunity to express dissatisfaction about a Coastal service/administration issue. A complaint is not considered formal until is written and signed by the provider. All grievances must be submitted within 60 days from the date of incident or event.

- Formal Grievances should be submitted to the attention of the Network Director:
  - Email to ProviderRelations@ccsi.care
  - By mail or in person at: 7875 NW 12 Street, Suite 200, Miami, FL 33126

Appeal: Appeal rights provide the provider the opportunity to appeal a claim determination. The member may not be billed for any services rendered. Below are the appeal timeframes:

- Appeals must be filed within 365 calendar days from the date of service for a claim adverse decision.
- Claim Appeals form can be downloaded from our website at www.ccsi.care under the “Information for Providers” tab.

Once we receive a formal grievance or appeal, Coastal will:

- Submit a grievance/appeal acknowledgement letter within five (5) working days from the receipt of the document.
- A resolution will be communicated to the provider in writing within a sixty (60) day period from the receipt of the document. The letter will include information of filing a level II appeal , should the provider not be satisfied with the decision.

SUPPORT SERVICES

Our Support Services include:

- Availability 24 hours a day 7 days a week
- Customer Service
- Utilization Management
- Information Management

As the network management company, we are responsible for coordinating and ensuring that services are available **24 hours a day, 7 days a week**. Our qualified personnel are ready to respond to emergencies, answer questions, troubleshoot and process urgent orders. **Customer Service** is our Top Priority. Providing quality customer service is the responsibility of all our employees and network providers. Our surveying methods and follow-up programs ensure that protocols are working to deliver quality services. We recognize Managed Care Organization challenges in discharge planning and fully understand that many times same day discharge planning occurs.

Our **utilization monitoring in conjunction with our managed health care partners** promotes the coordination and delivery of health care and services in an effective cost

efficient manner. Our continuous monitoring of utilization establishes a process whereby we evaluate the adequacy and appropriateness of the delivery of health care and services. The focus of this process is to maximize the utilization of our combined resources. Our program requires network providers to cooperate with prior authorization requirements and by initiating requests for extensions of authorization. Appropriate medical information must be provided to Coastal in order for our personnel to complete the reviews. All Network Providers are expected to cooperate in the review process.

Coastal Care Services, Inc., also has a track record for timely encounter data submission of services provided. It is therefore very important that claims are submitted on a timely basis.

Our **Information Management Department** works closely with the different departments within the organization to produce valuable managerial reports. These reports are utilized by our management team to monitor progress and provide feedback to different Managed Care Organizations and our Network Providers. Our software allows flexibility in the customizing of reports for management and our customers.

INTERDISCIPLINARY TEAM APPROACH

One of the unique aspects of home care is the nature of the collaborative team effort. There are many health care professionals and paraprofessionals who may provide services for patients in the home setting. The composition of the team varies according to responsibilities for caring for the patient. Team members might include physicians, physical, occupational and speech therapists, nurses and social workers, pharmacists as well as the home medical equipment provider's support staff. The most important members of the home care team are the patient and his/her family or friend and caregiver. We utilize an interdisciplinary team approach to care, with strong interaction with network providers. Network Providers are responsible for communicating with ordering physicians and submitting progress reports to Coastal.

Coastal Care Services, Inc. works closely with the team in a cohesive effort that not only looks out for the patient's well being but also for the Payer's interest, ensuring that benefits and processes are followed. A true partnership is what Coastal strives for, and what differentiates us from others. Our management teams' broad experience in healthcare, specifically in managed care, along with our commitment to customer satisfaction helps us achieve our common goals of improving patient outcomes while upholding/enforcing benefits.

QUALITY IMPROVEMENT PROGRAM

Coastal Care Services, Inc. is committed to coordinating the highest quality of services and products possible. To that end, we continuously strive to meet all standards

established by The Joint Commission for network management, and consequently expect our providers to share in this commitment. Therefore, in addition to the basic credentialing requirements that all providers must meet, and in addition to contractual terms agreed to, all providers will be expected to participate in quality initiatives. This participation will not only strengthen the collaborative association between Coastal and our providers, but will also benefit ALL parties involved: patients, Coastal and providers. All Joint Commission accredited providers will already be familiar with the ever-evolving expectations of the The Joint Commission experience. Those providers not yet accredited by The Joint Commission, or accredited by some other body will benefit by their adherence to, and participation in initiatives.

Coastal will monitor the following as part of our oversight function on behalf of the Managed Care Organizations with whom we contract:

- National Patient Safety Goals: As part of our Continuous Quality Improvement efforts, and in order to comply with The Joint Commission standards, we provide all of our providers with The Joint Commission's National Patient Safety Goals information and strongly urge that they implement the necessary processes to comply with these, as applicable. This information may be found in the Appendix Section of this manual

We will make every effort to keep all of our providers updated as these are expanded and/or modified. All providers that are THE JOINT COMMISSION accredited will already be aware of these and should have the necessary processes in place.

- Timely Delivery of Services
- Patient Satisfaction Surveys
- Health Plan/MCO QI Inquiries
- Patient Records Auditing
- Periodic Site Visits, along with review of QI/PI programs, and pertinent Policies and Procedures
- Credentialing and re-credentialing Process

UTILIZATION MONITORING ACTIVITIES

Coastal Care Services, Inc. believes that successful partnering is based on establishing rigorous standards to ensure that Network Providers provide the highest quality care, and simultaneously work collaboratively to optimize cost effectiveness and containment. Consequently, we expect our providers to share in this commitment by actively participating and joining our efforts to assure that the utilization of resources is optimized, without ever compromising quality of care. Therefore, in addition to the basic credentialing requirements that all providers must meet, and in addition to contractual terms agreed to, all providers will be expected to participate in Coastal's Utilization Management/Monitoring Programs. This interdisciplinary participation will not only strengthen the collaborative association between Coastal and our providers, but will also benefit ALL parties involved: patients,Coastal and providers.

Included in our Utilization Monitoring Activities are the following criteria and/or indicators according to discipline:

Home Health Services

- Timeliness of admission and delivery of services, along with appropriate documentation for authorization of continued/extended services
- Timeliness of Notification of Inability to Deliver Services, regardless of reason, to Coastal as well as to the ordering physician
- Timeliness of Discharge from services when patient has reached maximum potential, or requires alternate setting of care, with timely notification of discharge to Coastal.
- On-going complex patient review with Coastal's clinical and case management staff; this includes both chronic patients as well as patients that might benefit from receiving additional services either at home or in a different setting of care
- Weekly submission of active patient lists
- Track and trend visits per admission (patient) by diagnosis and type of service.

Home Medical Equipment

- Adherence to appropriate criteria and guidelines applicable to the patient's corresponding line of business (Medicare, Medicaid), or group contract benefits
- Timeliness of service delivery
- Timeliness of Notification of Inability to Deliver Services, regardless of reason, to Coastal as well as to the ordering physician
- Timeliness and appropriateness of discharge

Pharmacy Services

- Adherence to appropriate criteria and guidelines applicable to the patient's corresponding line of business (Medicare, Medicaid), or group contract benefits
- Timeliness of service delivery
- Timeliness of Notification of Inability to Deliver Services, regardless of reason, to Coastal as well as to the ordering physician
- Timeliness and appropriateness of discharge

INFORMATION ON FRAUD AND ABUSE

Coastal has policies and procedures towards the prevention, detection, reduction, correction and reporting of healthcare fraud and abuse in compliance with all state and federal program integrity requirements.

Coastal's Compliance Officer oversees all the activities of our Compliance Program and reports any possible violations to the proper agencies. If you suspect a violation or a Coastal member tells you of a possible violation please contact our Compliance Officer/Fraud Hotline at 1-855-481-0202, via fax to 855-481-0606, or email to Compliance@ccsi.care. For direct reporting of suspected fraud or abuse, please use one of the following avenues below:

- Agency for Health Care Administration Hotline: 1-888-419-3456 OR
- Florida Attorney General's Office: 1-866-966-7226 OR
- The Florida Medicaid Program Integrity Office – 1-850-412-4600 OR
- Complaint Form: https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx

Coastal instructs and expects all the employees, associates and providers to comply with all applicable laws and regulations and has procedures to report violations and suspected violations on the part of any employees, associates, persons or entities providing care or services to our members.

Examples of violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft, or members' fraud with medications.

Coastal is obligated to report any suspected cases of healthcare fraud or abuse to the regulatory agencies. We may also consider reporting the conduct to other government authorities such as the Office of Attorney General, Office of Inspector General or the Department of Justice. In addition, the Agency for Health Care Administration (AHCA), Office of the Inspector General (OIG), Office of Attorney General, Bureau of Medicaid Program Integrity audits and investigates providers suspected of overbilling or defrauding the Florida Medicaid Program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the Medicaid Fraud Control Unit. Program Integrity may also originate an investigation due to a complaint being filed.

Federal regulations require mandatory Compliance and Fraud and Abuse training to be completed by First Tier, Downstream and Related Entities (FDRs) as well as their employees, within ninety (90) days of hire/contracting and annually thereafter.

Records of the training must be maintained for a period of ten (10) years with copies available to Coastal's Compliance Officer. These records must include the following as Coastal,Health Plans, AHCA, CMS or agents of AHCA or CMS may request such records to verify that training occurred:

1. Materials used for classroom training; Date(s) training was provided
2. Methods of training provided or online training modules
3. Training sign-in logs or employee attestations, or electronic certifications from the employees completing the training.

As stated above, it is your responsibility and part of your contractual obligation to comply with all federal and state healthcare program requirements for your continued participation with Coastal. You must maintain record of completion.

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It is important that you review certain federal regulations:

1. The False Claims Act

Coastal has prepared its compliance programs so that its policies and procedures are consistent with the Federal Civil False Claims Act, which prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. The Act also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents, When submitting claims data you must certify that the claims data is true and accurate to the best of your knowledge and belief. In addition, parties have a continuing obligation to disclose to the government any new information indicating the falsity of the original statement.

2. The Anti-Kickback Statute

Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other Federal health care programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other Federal health care programs and subject to civil monetary penalties. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Coastal has policies and procedures employed to ensure that illegal remuneration is not permitted and shall specify follow-up procedures if they uncover unlawful remuneration schemes.

3. The Health Insurance Portability and Accountability Act (HIPAA)

HIPAA was enacted, among other things, for the purpose of improving the efficiency and effectiveness of health information systems through the establishment of standards and requirements for the electronic transmission of certain health information. As a result, there are standards for certain electronic transactions, minimum security requirements, and minimum privacy protections for individually identifiable health information that is held by covered entities (i.e., protected health information); national

identifiers under HIPAA for providers, plans and employers. Covered entities include health plans, health care clearinghouses and certain health care providers (namely those that conduct covered transactions). The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulations. The Centers for Medicare and Medicare Services (CMS) is the Departmental component responsible for implementing and enforcing the other HIPAA regulations.

HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule
We anticipate that you may have questions about whether the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule permits you to disclose your patients' (our members') medical information to us for these activities without written authorization from your patients.
Section 164.506(c)(4) of the Privacy Rule explicitly permits you to make this type of disclosure to Coastal without a written authorization.
Additionally, the Office of Civil Rights (the federal agency tasked with enforcing the Privacy Rule) has also made this point clear. It wrote in its December 3, 2002, Guidance on the Privacy Rule that: "A covered entity may disclose protected health information to another covered entity for certain health care operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the information and the protected health information pertains to the relationship, and the disclosure is for a quality-related health care operations activity."

How to Report Fraud or Abuse
Suspected fraud and/or abuse may be reported by phone and online. To report suspected fraud and/or abuse in Florida Medicaid, call the **Consumer Complaint Hotline toll-free at 1-888-419-3456**, or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:
https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

Reward Program
If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (**toll-free 1-866-966-7226 or 850-412-3990**). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case. (Florida statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Coastal Care Services, Inc. Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer:

Privacy Officer

7875 NW 12 Street, Suite 200

Miami, FL 33126

Tel: 855-481-0202

Fax: 855-481-0606

www.ccsi.care

WHAT DOES A NOTICE OF PRIVACY PRACTICES TELL YOU

The Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by, calling the office and requesting that a revised copy be sent to you in the mail. Our Notice of Privacy is also available on our website, www.ccsi.care.

OUR SERVICES AND PLEDGE REGARDING YOUR HEALTH INFORMATION WHICH IS PRIVATE

Coastal Care Services, Inc., is able to coordinate superior comprehensive home services by coordinating home medical equipment, nursing, rehabilitation, respiratory, social services, and pharmacy (infusion and injectables) services through its extensive network of providers. Our complete, coordinated care combines experienced professionals and quality products.
We understand that information we collect about you and your health is personal. We are committed to protecting your health information and following all laws regarding the use of your health information.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

Your protected health information is usually sent to us by your physician, physician's office staff or others outside of our office that are involved in your care and treatment, for the purpose of providing services to you. In turn we utilize this information to coordinate the delivery of care, receive payment for the services provided and to support the operations of Coastal Care Services, Inc.

The following are examples of the types of uses and disclosures of your protected health care information that Coastal Care Services, Inc. is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage services in the home such as medical equipment, nursing, pharmacy, pharmacy supplies. This includes the coordination or management of your health care with a third party. We would disclose your protected health information, as necessary, to our network of providers that include home medical equipment companies, home care agencies and pharmacies who will be providing services to you. We may also disclose protected health information to physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information. Our network of providers assigned to render services to you are responsible for safeguarding your privacy as required by law.

Payment: Your protected health information will be used, as needed, to obtain payment for services provided to you. In addition, we may be required to report services provided to you, to your health plan, for utilization purposes. This may include certain activities that your health insurance plan may undertake before it approves or pays for the services provided such as; making a determination of eligibility or coverage for insurance benefits, reviewing services for medical necessity, and undertaking utilization review activities. For example, obtaining approval for

certain medications or equipment may require that your relevant protected health information be disclosed to the health plan to obtain approval for services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of the organization. These activities include, but are not limited to, accreditation, quality assessment, utilization review, employee reviews, training, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

We may use or disclose your protected health information, as necessary, to contact you to schedule services and determine quality of care.

We will share your protected health information with third party "business associates" that perform various activities. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, we may send you information about products or services that we believe may be beneficial to you. **You may contact our Privacy Officer to request that these materials not be sent to you.**

We may use or disclose your demographic information in order to contact you for fundraising or wellness activities supported by our office. If you do not want to **receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.** In addition, our office may post or share with others outside of Coastal Care Services, Inc., thank you letters/cards and other holiday cards received from patients in lobby bulletin boards or other general areas.

WHAT IF MY INFORMATION NEEDS TO GO SOMEWHERE ELSE

Other uses and disclosures of your protected health information will be made only with your written Authorization, unless otherwise permitted or required by law as described below. You may revoke this Authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the Authorization.

COULD MY HEALTH INFORMATION BE RELEASED WITHOUT MY PERMISSION

We may use and disclose your protected health information to others involved in your health care**.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also tell your family or friends your condition as directed by you. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status or location. We may also use or disclose your protected health information in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object:

We may use or disclose your protected health information in the following situations without your Authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and to a public health authority that is permitted by law to collect or receive the information. These activities generally include the following: prevent or control disease, injury or disability, to notify people of recalls of products they may be using, notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, to report abuse or neglect or domestic violence.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These include audits, investigations and licensures. These activities are necessary for government agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises, and (6) medical emergency when it is likely that a crime has occurred.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.
Required Uses and Disclosures**: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.**

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to inspect and copy your protected health information. Usually this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Under Federal law, however, you may not inspect or copy information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Coastal Care Services, Inc. is not required to agree to your restriction request, especially if it believes it is not in your best interest. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. To request restrictions, please make request in writing to our Privacy Officer. Please indicate what information you want to limit, whether you want to limit use or disclosure or both and to whom you want the limits to apply, for examples, disclosures to your spouse.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer indicating how or where you wish to be contacted.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information if you feel that medical information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we maintain the information. An amendment request must be made in writing and submitted to the privacy officer. In addition, you must provide a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request, the information was not created by us, is not part of information kept by us, is not part of information which you would be permitted to inspect and copy or information is accurate and complete. You have the right to file a complaint in writing and we will prepare a written response to your complaint. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. You have the right to receive specific information regarding these disclosures that occurred after **April 14, 2003**. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

QUESTIONS OR COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against you for filing a complaint.
You may contact our **Privacy Officer at 855-481-0202** for further information about the complaint process. **This notice was published and becomes effective on April 14, 2003**

BUSINESS CONTINUATION PLAN

The purpose of a Business Continuation Plan is to minimize the impact caused by events that could disrupt Coastal's business and its ability to coordinate services. Coastal has established preventive controls, contingency resources, and procedures administered by a formal internal management team to ensure the continuance of business operations.

Objectives

Since avoiding all disasters is impossible, the ability to recover from minor and major disruptions is a prerequisite for business continuity. Our plan focuses upon the worst-case disruption that could impact Coastal and/or our network providers. The objectives of the plan include, but are not restricted to:

- Reducing the critical impact that a disruptive occurrence can have on Coastal, our network providers and the patients for which Coastal is responsible
- Permitting timely response to the loss of resources
- Enabling the transition of critical functions to an alternate facility and or provider
- Providing access for communicating information
- Ensuring recovery of all business systems
- Providing for time-phased restoration of all business resources and services

Coastal recognizes that protection of our assets and our ability to coordinate and provide uninterrupted services, through network providers, is a major responsibility that we have to our clients/payors and patients.

We also recognize the importance of establishing methods that allow submission of referrals/orders that will be processed so that patients will receive ancillary home services in a timely manner in the event of a disaster at our offices in South Florida or at any one of our network provider locations. In the event of a disaster at Coastal, network providers may be called upon to render care without a written authorization until the recovery of business systems. Services provided will be honored and payment appropriately processed by Coastal.

The continuation of critical business activities in the event of disruption is the focus of our Business Continuation Plan. The plan provides for backup and replacement of information and equipment, but cannot replace the life of an employee. It is our goal to protect life, information and equipment, in that order.

Scope of Plan

Coastal's Business Continuation Plan is based on the following:

Coastal is responsible for:

- Notifying Managed Care Organizations and our Network Providers of an emergency situation which could affect our ability to coordinate services

- Rerouting affected telephone and fax numbers to their preplanned destination
- Maintaining backup copies of support software in a secure offsite storage facility
- Supporting communications access for contingency services
- Restoring customer information and support systems with system backups stored off-site
- Resuming support of defined critical services as soon as reasonably possible and generally within 12-24 hours of incident, at alternate location if necessary

Coastal further acknowledges that a worst-case scenario could result in complete facility destruction. Offsite storage and alternate locations should be unaffected by the disaster since distance and accessibility were considered in selection.

Network providers are responsible for the following:

- Advising all patients of their disaster procedures at the start of care
- Submitting any revisions to their Emergency Disaster Recovery Plan to Coastal on a timely basis
- Testing their Recovery Plan and contingency systems
- Notifying Coastal of any emergency situation as well as upon being able to resume services

EMERGENCY PROCEDURES

Coastal has a mailbox within the existing voice mail system that network providers and employees can call to receive updates on the status of the facility and the estimated outage duration.

Emergency Voice Mail#: 305-270-4785

All Network Providers should advise Coastal at 855-481-0505 or gruiz@ccsi.care where notification of the activation of our Business Continuation Plan should be sent.

APPENDIX

- Recommendation and Status Report
- Referral Form
- Claims Appeals Form
- The Joint Commission National Patient Safety Goals

Recommendation & Status Report

Home Health Agency:______________________________ **Date:** ______________ **S.O.C:** _________

Patient's Last Name:

First Name:

D.O.B: Policy#: Tel #:

Primary Diagnosis:				.		
Secondary Diagnosis:				.		
Addt'l Diagnosis:				.		

History of Present Illness: ____

Homebound, Describe Reason: ____

Teaching and training of patient/caregiver/ friend/ family: ☐ Possible ☐ Not Possible

Home Environment: ☐ Lives Alone ☐ Debilitated ☐ Frail Elderly Caregiver ☐ Other: ____________________

Wound Care:

Type	Location	Dimensions	Drainage	Stage	Improving
		L_______cm x W_______cm x D ______cm			
		L_______cm x W_______cm x D ______cm			
		L_______cm x W_______cm x D ______cm			

(Agencies must submit a status report on all wound care cases on a weekly basis)

Has a physician been notified of Plan of Care: ☐ Yes ☐ No Next Physician Appt: __________________

Medications being administered by Nurse: ☐ Yes ☐ No Indicate Medication: ____________________

AGENCY RECOMMENDATIONS/REQUEST

Discipline	# Visits	From	To	Specify Reason for Follow-up -Visit/Plan of Care/ Frequency

Provider Signature: __________________________ Date: ______________

Comments:

Recommendation and Status Report Form must be submitted for review before the current authorization expires if recommendation is for services to be continued

Referral Form

Please fax this form along with Signed orders and required information to
Fax# **305-418-9378 or 1-855-481-0606**

Patient Information

Policy Number:	Last Name:	First Name:
Health Plan:	Date of Birth:	Phone Number:
Service address:		

Ordering physician:	NPI:	Phone: Fax:
Sender's Name and Number:	Facility:	Discharge Date:

Diagnosis- ICD-9 (ICD-10 after 10/1/14)

Services Requested

Home Health Orders

☐ **Nurse Evaluation** -for home or wound care needs & treatment ______________________________

Wound care treatment plan & Location: ______________________________

____

☐ **Physical Therapy Evaluation** & Treatment

☐ **Home infusion/** medication(All first doses need to be given at the facility or PCP office)
Administration -Medication, dosage, route & frequency/ duration: ______________________________

____

☐ **Other:**

Durable Medical Equipment and Supplies (Please describe)

______________________________ Height: ________

Weight: ________

☐ **Oxygen Therapy:**

- O2 Saturation Level on Room Air ________%
- Date O2 Sat was taken: ______________
- Taken @ rest or with ambulation: ______________
- If taken with ambulation- resting O2 Sat: ________%
- Bled into CPAP/BIPAP______________

Script needs to have dx, settings (liters per minute, route of administration, continuous or nocturnal) AND oxygen saturation on room air.

☐ **CPAP Therapy:** _____Initial

☐ **BIPAP Therapy:** ______ Extension of existing rental

Date of SOC ______________

- Settings ______________
- Baseline AHI ______________

For PAP Rental extension please provide PAP Compliance Report.
For Initial PAP Rental please attach baseline sleep study report.
For Bipap therapy, please provide two (2) pressure settings.

******Attach all history & physical, discharge plans, any surgical reports, treatment and medication list******

CCSI 2015

PROVIDER CLAIM APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant Coastal to re-evaluate its original decision.

- An appeal request must include claim numbers and supporting documentation (e.g. complete copy of the medical records and claim form).
- Review of a claim does not guarantee a change in payment disposition.
- An acknowledgement letter will be sent to you within ten (10) calendar days upon receipt of the Appeal Form.

Provider Information:

Provider Name: ____

Provider NPI #:____

Claim Information:

Member Name: ___________________________ Claim Number(s):_______________________

Member Group & ID #:_____________________ Date(s) of Service: _____________________

Reason for Appeal:

☐ Timely Filing – Claims submitted beyond 180 days from DOS or 12 months from disallowed date

☐ Pricing – Incorrect payment or application of benefits

☐ Eligibility – Payment issued for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility

☐ Medical Policy – Appeal a denial for failure to obtain prior authorization (Supporting documentation required).

☐ Other – Provide a detailed description

Description of Claim Appeal:

____

____

Supplemental Documentation Attached:

☐ Remittance Advice ☐ Refund ☐ Medical Records ☐ Other (e.g.Timely filing Documentation)

Contact Information:

Requester:___________________ Phone #:___________________ Date:_____________

Mail completed form and attachments to:

Coastal Care Services, Inc.

Attention: Provider Claim Appeals

7875 NW 12 Street, Suite 200

Miami, FL 33126

Home Medical Equipment/Supplies (HME) – Protocols and Service Standards

The Provider must comply with the following protocols and service standards:

- Provider will accept all case referrals for services within their licensure, scope of practice and geographic service area. When unable to provide the service, Provider will notify the Network within half an hour of receipt of referral.
- Provider will notify network if unable to complete the scheduled delivery.
- Products of equal quality will be provided to all patients.
- Provider must assure that all patient information is treated as confidential.
- Services must be provided pursuant to the Patient's Benefits and the terms and limitations of the referral/authorization issued by the Network.
- Provider will deliver, install, provide regular maintenance and repair, and remove equipment within 24 hours of Network authorization/notification, unless otherwise specified.
- Service Response Time:
    a. Routine service – within 24 hours.
    b. Urgent service – within 4 hours.
    c. On call service for patients 24 hours a day, 7 days per week.
    d. Return patient's call within 15 minutes – after hours.
    e. Discharge orders will be completed within 4 hours of receipt, unless otherwise specified.
    f. Respond to emergency calls for repair of life-sustaining equipment as soon as possible but no later than one (1) hour from the time the Provider receives the call, subject to limitations due to acts of God. The equipment shall be repaired or replaced as soon as possible but no later than two (2) hours from the time the Provider receives the call.
- Provider requires registered licensed personnel to provide follow-up services associated with such equipment to patients, as authorized by the Network:
    a. C-pap and Bi-pap
    b. Air compressors
    c. Suction machines
    d. Apnea monitors
    e. Oxygen systems
- Provider may use UPS, next day service for delivery of certain equipment and supplies if patient resides in a rural area or does not require set-up assistance. Provider is responsible for providing detailed written instructions and telephone support.
- Patients and family members are educated and oriented on the care and use of the equipment. Education shall include training in

emergency procedures in the event of equipment malfunction.

- Patients and family members are properly educated and oriented on the care and use of respiratory equipment by properly trained licensed personnel, when applicable. Registered Respiratory Therapists and or Respiratory Technicians will also provide follow-up service associated with equipment, when applicable.
- Patients and family members are in-serviced on after-hours phone numbers and availability.
- All patient calls regarding additional services/supplies are to be referred to the Network.
- Provider will obtain valid prescriptions/CMNs for equipment and follow Medicare & Medicaid guidelines for medical necessity.
- Medical necessity documentation must be kept in patient's record as must documents reflecting proof of delivery.
- Provider will maintain accurate records in a manner that is readily retrievable.
- Provider will maintain records for a period of ten (10) years or as required by changes in the law.
- Provider will use standard forms and protocols to communicate patients' status information to referring physician and the Network at no extra charge to patient, referring physician or the Network.
- Patient and physician complaints are registered by category and type, with specific corrective action plans. Action plans will also be submitted for any identified patterns.
- Provider will have available, if applicable, accreditation results or any other accreditation certification accepted by the Network/Carrier, Medicare surveys and any other documents referenced in this Agreement, subject to rules and regulations governing patient confidentiality.
- Provider requires registered Respiratory Therapists and/or Respiratory Technicians to provide follow-up services associated with such equipment to members, as authorized by Network: (a) Volume Ventilators, (b) C-Pap, (c) Air Compressors, (d) Suction Machines, (e) Apnea Monitors and (f) Oxygen Systems.

  Have registered respiratory therapists and/or respiratory technicians trained in the operation of gaseous, liquid and oxygen concentrator systems perform respiratory equipment set-ups. In addition, registered respiratory therapists and/or respiratory technicians shall follow up with the member, in accordance with accreditation standards, if applicable. The method of member follow up shall include telephone and/or visits depending on the member's condition and type of equipment being utilized.
- Provider will notify Network of any patients discharged from service, with reason.
- Provider will submit to Network a monthly list of all active patients whose authorizations will expire during that month by the 5th day of

each month. Network will be responsible for verifying eligibility and continued use of equipment and will provide reauthorizations no later than the last day of the month.

- Network will not be responsible for additional request of services not submitted within the established time frame above.
- Provider will submit monthly active patient lists and reports on volume of services, distribution and trend by HCPCS code, start of service, average cost/patient, , non-admits and customer service activity in the format specified by the Network.
- Provider will grant Network full access to patient records.
- Network/Carrier may conduct performance/compliance reviews, with reasonable notice.
- There is dedicated training staff.
- There is documentation of initial and ongoing training programs including policies and procedures for all staff patients. Education shall include training in emergency procedures in the event of equipment malfunction.
- There is a documented QI program identifying (through data) opportunities of real time, measured improvement in areas of core competencies.
- There are demonstrated ties between QI findings and staff orientation, training, policies and procedures.
- Incident rates will not exceed acceptable standards.
- Timely reporting of unusual occurrence/incidents to the Network.
- 100% of all claims submitted shall contain accurate and all information necessary to process the claim as defined in Payment Appendix.