COASTAL CARE SERVICES, INC.®

member quality redefined.

Provider Training Tool &

Quick Reference Guide

Table of Contents

I. Coastal Introduction

Coastal is a care management company whose executive team has over 100 years combined experience in the Ancillary Management Health Care Space.

We have designed a managed care solution that will deliver Ancillary Home Care Services to Commercial, Medicare and Medicaid insureds throughout the State of Florida, by bringing together the delivery of Durable Medical Equipment, Home Health (skilled nursing, OT, PT and Speech therapies), and Home IV, via our statewide network of reputable community based providers. Developing a collaborative model of care that support our health plan partners provide a viable solution that simplify access to ancillary services through "Single Point of Entry".

In collaboration with providers, Coastal works effectively and efficiently to deliver quality Ancillary Home Care services to members, aiding patients to foster independence in their homes and improving outcomes, all while reducing and controlling medical and administrative costs.

II. Services

New order request(s) for Durable Medical Equipment, Medical Supplies, Home Health Care, Home Infusion and Diabetic Supplies are the responsibility of Coastal Care Services, Inc. on a statewide basis as.

- Providers may contact Coastal 24 hours a day/7 days a week by calling 855-481-0505
- Physician orders may by submitted by facsimile at 855-481-0606
- Hospital Discharge Planners may also submit request via ECIN.

III. Obtaining Authorization

The referral authorization process is an important component of Coastal's Clinical Intake Program. The referral authorization process must be used by all participating Home Health, Home Infusion, and Durable Medical Equipment providers to assure that the member receives the maximum benefit and that claim(s) are considered for benefits in a timely manner and processed correctly.

Coastal will review all orders and select the most appropriate participating provider and issue authorization in order for the service(s) to be rendered to patient. All services require clinical review, assignment and prior authorization. Coastal's referral authorization process confirms member eligibility, member benefits, the services are

reasonable for treatment of illness or injury, and meets all applicable medical, health plan and regulatory criteria.

Once a Coastal Participating Provider has accepted a patient for service, an authorization is issued and an Coastal Referral Authorization Form is sent to the provider outlying the specific service/item being approved. The Referral Authorization Form is accompanied by the doctor's order and pertinent patient information including any member financial responsibility.

The Referral Authorization Form contains: Patient Information, Ordering Provider Information, Clinical Information, Special Comments along with Date Ranges and CPT/HCPC Codes for the precise services being authorized. The authorization number remains in effect until the patient is discharged. **See attached sample Referral Authorization Form.**

Participating 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.

The authorization process and the claim processing are closely linked. Claims are considered for benefits based on CPT and HCPC Codes and units authorized. Submission of accurate claims information in a timely manner is an essential part of Participating Provider's role. Appropriate authorization number must be submitted on all claims. A claim submitted without an authorization number may be rejected and/or denied.

COASTAL CARE SERVICES, INC®
member quality redefined.

CCS Intake Flow

Order Received via Electronic Fax

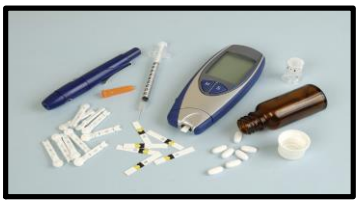
Electronic Fax is Logged
Plan Eligibility Verified and
Prescription is reviewed for Completeness
CCS Data Management System Reviewed and
Patient File Created

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

COASTAL CARE SERVICES, INC.®
member quality redefined.

REFERRAL AUTHORIZATION FORM

Referral Status: 2 Urgency: 24 Authorization #: 1

PATIENT INFORMATION

Patient Name: 3
DOB: 4
Patient ID: 5
Home Phone: 7
Address: 6
Primary Carrier: 8

PCP Name: 10
PCP ID: 11
PCP Phone: 12
Primary Healtplan: 9

ORDERING PROVIDER 14-16

Name: Phone: Fax:

REFERRED TO PROVIDER

Name: Specialty: 25

Address: Phone: Fax:

CLINICAL DATA 17-18

Primary DX: HT: WT:
Secondary Diagnosis: Secondary Diagnosis:

SPECIAL INSTRUCTIONS: 19

CCSI Coordinator/Manager: 20

SERVICES REQUESTED 20-23

Service Status	Effective From	Effective Thru	Procedure	Description	# of Units

This Referral Authorization Form is NOT a guarantee of payment. Reimbursement is subject to patient's eligibility with the Health Plan at the time the service is rendered.

CCSI: 6/24/2015

Referral Authorization Form – field definition

1. Coastal Authorization Number (applicable authorization number must be submitted on all claims)
2. Referral Status (i.e.: approval amended, approved, denied, entered, information) requested, non Admit, Under Review
3. Name of Patient (Last, Middle, First)
4. Date of Birth
5. Patient ID - Health Plan assigned identification number
6. Patient Address
7. Patient Home Phone No.
8. Insurance Plan Name
9. Insurance Plan Benefit Specification (i.e.: Commercial, Medicare and Medicaid)
10. Patient's Primary Care Physician Name
11. Primary Care Physician ID
12. Primary Care Physician Phone No.
13. Name of Doctor Requesting Services or Equipment
14. Doctor's Phone No.
15. Doctor's Fax No.
16. Primary Diagnosis
17. Secondary diagnosis
18. Notes or Special Instructions for Service or Equipment Provider (i.e.: Member Co-payment/responsibility, Reference Number & etc.)
19. Coastal Representative authorizing the services.
20. Authorized Date of Service Start Date (One Month Time Span)
21. Authorized Date of Service End Date (One Month Time Span)
22. CPT Code and/or HCPC Code of authorized Service or Equipment with Description
23. Approved No. of Visits for precise CPT Cade, HCPC Code or No. of Equipment
24. Delivery Instruction - Route, Within 24 hours; Stat, Within 4 Hours; Urgent, Same Day
25. Company Providing Services/Equipment

IV. Request for Additional Services

Home Health/Infusion

The referral re-authorization process is an important component of Coastal's Clinical Intake Program. The Clinical Recommendation & Status Report Form must be used by all participating Home Health and Home Infusion providers to assure that the member receives on-going services beyond Coastal's initial referral authorization.

After the member has been treated by a participating provider, their findings, diagnosis and recommendations should be sent to Coastal Intake Department using the attached Clinical Recommendation & Status Report Form along with signed doctor's orders.

After the member has been seen by a participating provider and the provider desires to request additional covered medical services, the Clinical Recommendation & Status Report Form will be used to evaluate and process requests for on-going treatment/services along with signed doctor's orders. Failure to provide the Clinical Recommendation & Status Report Form could result in your patient's requested covered medical services being delayed and/or claims payment denied.

Coastal's Intake Department will review the Clinical Recommendation & Status Report Form for medically necessity and/or benefits coverage and extend existing Referral Authorization. The extension of medically necessary treatment/services will be authorized according to specific CPT Code(s), HCPC code(s), units and date ranges. The initial referral authorization number will remain in effect until the patient is discharged.

Home Medical Equipment & Supplies

All participating Durable Medical Equipment and Medical Supply providers are required to request re-authorization by the 5th day of each month of existing authorization to assure that the member receives on-going services beyond Coastal's initial referral authorization and ensure continuity of care and reimbursement.

Initial Home Medical Equipment authorizations for rental equipment are usually provided with a time frame of thirty (30) days. Participating Providers must track the rental cap timeframe as payment will not be made once reached. Coastal 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.

Home Medical Equipment authorizations will be accompanied by the ordering physician's orders and must meet medical necessity & 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.

Network Providers may request renewal of the authorization with their system's active patient list which must include: 1) patient name; 2) health plan Id#; 3) current authorization #; 4) description of equipment; 5) HCPC Code and 6) Start of Care.

Failure to obtain timely re-authorizations could result in your patient's requested covered medical services being delayed and/or claims payment denied.

Recommendation & Status Report

COASTAL CARE SERVICES, INC.®
member quality redefined.

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.

Clinical Recommendation & Status Report – field definition

1. Agency providing home care services
2. Date requested
3. Start of care date
4. Patient last name
5. Patient first name
6. Patient Date of Birth
7. Policy #
8. Patient Telephone Number
9. Primary diagnosis and ICD code
10. Secondary diagnosis and ICD code
11. Additional diagnosis
12. History of present illness
13. Homebound Description (Reason and way the patient is homebound)
14. Teach and Train
15. Home Environment
16. Wound Care Description
17. Homebound Description (Reason and way the patient is homebound)
18. Can the family or friends be trained?
19. Has physician been notified of Plan of Care?
20. Date of next physician appointment
21. Are medications being administered by Nurse?
22. Type of medication(s)
23. Type of discipline requested by agency
24. Number of visits requested by agency
25. Date from requested by agency
26. Date to requested by agency
27. Type of discipline approved by Coastal (i.e.: High Tech Nursing, RN, LPN, OT, PT, SP & etc.)
28. Description for on-going services/Plan of Care

V. Claim Submission

The Agreement between Coastal and participating providers indicate that all claims should be submitted on a CMS1500 Health Insurance Claim Form. For fee-for-service medical services, a CMS1500 Clams Form is to be submitted either by a paper claim or electronic claims submission.

Coastal has the following guidelines:

- An original form is required with any submission
- For timely filing, claims must be received no later than one hundred and eighty (180) days after the date of services were rendered per your Agreement. Claims received thereafter will be denied for late submission.
- Provider can collect only applicable co-payment(s), co-insurance and deductible(s) from members at the time medical services are rendered.
- Provider agrees to accept contractual reimbursement from Coastal as payment in full and will not bill member for any covered medical services.
- Coastal will pay based on your contractual agreement.
- Complete all applicable boxes on the claim form and each covered service must be itemized on a separate line to expedite payment of your claims.
- For payment to made directly to the provider, the following items are required
- Patient's original signature, or "Signature on File" or "Assignment on File" stamped or typed and dated.
- Provider must maintain on file a valid written Assignment of Benefits from the member. This will serve as evidence that the provider is entitled to all payments for billed covered services.
- All documentation or information related to COB, Third Party Liability, etc. should be attached to the CMS1500 Claim Form for prompt adjudication of claim.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

For claims to be paid promptly, a properly completed claim must be submitted by paper or electronically. Providers must use a CMS 1500 Claims Form. Providers should reframe from submitting hand-written CMS 1500 Claim Forms. The following mandatory information is required on the CMS 1500 Claim Form:

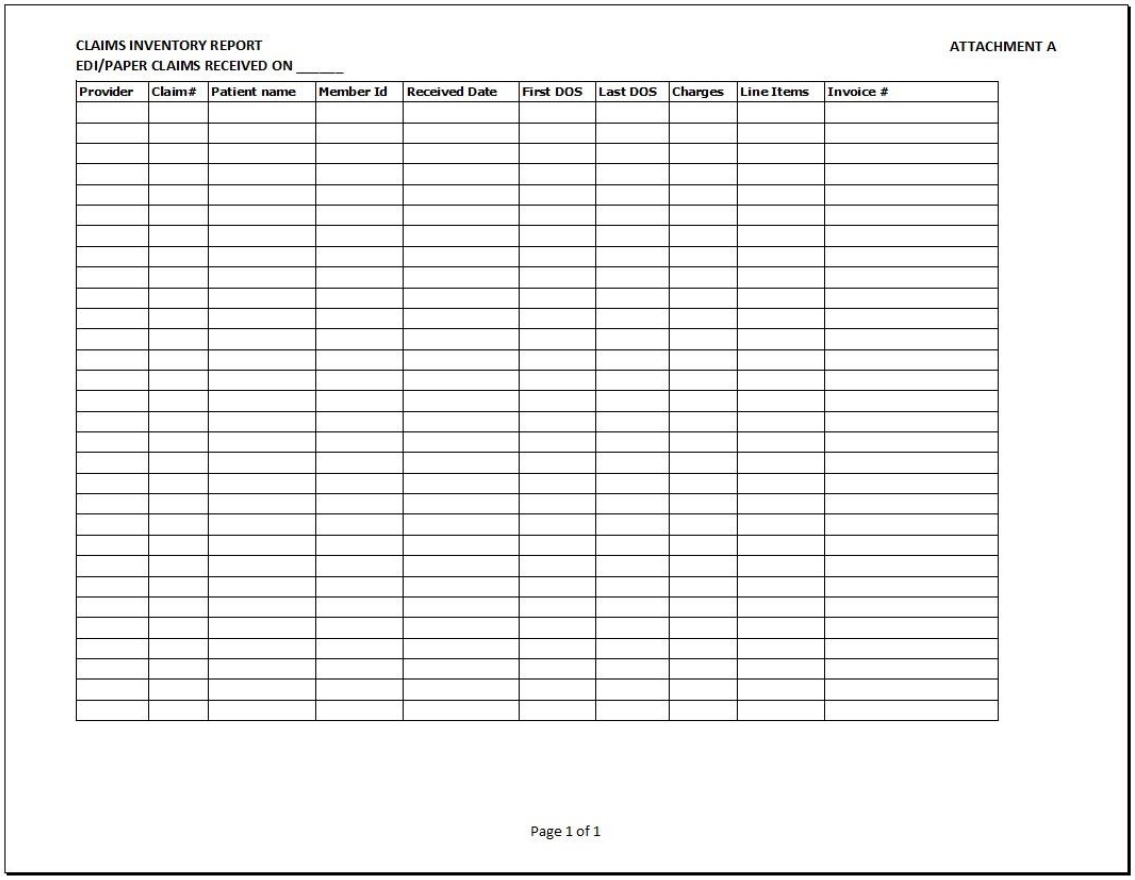
Box 1	Coverage Category
Box 1a	Insured's I.D. Number
Box 2	Patient name (Last Name, First Name, Middle Initial)
Box 3	Patient's birth date and sex
Box 4	Insured's name (Last Name, First Name, Middle Initial)
Box 5	Patient's address
Box 10	Is patient's condition related to
Box 12	Patient's or authorized person's signature or signature on file and date
Box 13	Insured's or authorized person's signature or signature on file
Box 14	Date of current illness, injury or pregnancy
Box 17	Name of referring physician
Box 17A	I.D. number of referring physician
Box 21	Diagnosis or nature of illness or injury, ICD-9 diagnosis codes at the highest level of specialty. Multiple codes should be used submitted as necessary to identify all components of complex diagnosis as well as co-existing conditions.
Box 23	Coastal referral authorization numbers (The authorization process and claim processing are closely linked. Please use correct referral authorization number when submitting a claim)
Box 24A	Date(s) of service
Box 24B	Place of service
Box 24C	Type of service
Box 24D	CPT/HCPCS and modifier (please provide nursing visit notes when services have been authorized)
Box 24E	Diagnosis code (designate as 1, 2, 3 and/or 4 from Box 21)
Box 24F	Charges
Box 24G	Days or units
Box 24k	UPIN of the rendering provider
Box 25	Provider's Federal Tax ID (Social Security number or EIN)
Box 26	Patient's Account No.
Box 27	Accept assignment
Box 28	Total billed charges
Box 29	Amount Paid
Box 30	Balance Due
Box 31	Signature of the rendering provider or supplier
Box 32	State and Zip code of where services were rendered
Box 33	Provider or supplier's billing name and address

Acknowledging Claims Received

Coastal will provide acknowledgement of receipt of claims within 15 days after receipt of the claim via Coastal's Claims Inventory Report. The Claims Inventory Report will be sent to each participating provider from whom claims have been received two (2) weeks prior. The Claims Inventory Report will be printed by participating provider and include the following fields:

- Date claims was received
- Patient's insurance group
- Insured's name
- Patient I.D. number
- Dependant information (if applicable)
- Incurred Date
- Claim Number
- Charged/Billed amount

<u>Participating Providers are encouraged to review the Claims Inventory Report carefully.</u>
Please see below sample Claims Inventory Report



CLAIMS INVENTORY REPORT

ATTACHMENT A

EDI/PAPER CLAIMS RECEIVED ON _____

Provider	Claim#	Patient name	Member Id	Received Date	First DOS	Last DOS	Charges	Line Items	Invoice #

Page 1 of 1

Remittance Advice

The Coastal claims processing policies, procedures and guidelines are set in accordance with applicable Florida & Medicare/Medicaid statutory requirement for timely payment of claims. All fee-for-services reimbursement will be sent to participating provider with a remittance advice.

Prompt Payment

Coastal claims processing policies, procedures and guidelines follow the current applicable Florida & Medicare/Medicaid requirements. A clean claim is processed promptly within statutory guidelines.

Claim Mailing Address

Participating Providers should mail CMS 1500 Claim Forms to:

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

Electronic Claim Submission

In addition to submitting paper claim(s), participating providers may also submit claims electronically to Coastal. To submit claims electronically, please take the following steps:

- Register with Emdeon (Coastal's Clearinghouse)
- Payer ID# 47394
- To register, please phone 877.363.3666
- Select sales when prompted
- Once registered, Emdeon will provide support on submitting claims electronically

Reminders:

- For timely filing, claims must be received no later than one hundred and eighty (180) days after the date of services were rendered per your Agreement. Claims received thereafter will be denied for late submission.
- Provider can collect only applicable co-payment(s), co-insurance and deductible(s) from members at the time medical services are rendered.
- Provider agrees to accept contractual reimbursement from Coastal as payment in full and will not bill member for any covered medical services.
- Coastal will pay based on your contractual agreement.
- For payment to made directly to the provider, the following items are required

- Patient's original signature, or "Signature on File" or "Assignment on File" stamped or typed and dated.
- Provider must maintain on file a valid written Assignment of Benefits from the member. This will serve as evidence that the provider is entitled to all payments for billed covered services.
- All documentation or information related to COB, Third Party Liability, etc. should be attached to the CMS 1500 Claim Form for prompt adjudication of claim.

VI. Transition *(when applicable)*

Coastal's contract effective date:

New DME orders beginning:

New Home Health & Home Infusion orders beginning

Health Plan Name is holding weekly conference calls with Coastal to identify and coordinate those member and provider concerns

VII. Coastal Contact Information

Coastal Care Services, Inc.
7875 NW 12 Street, Suite 200
Miami, FL 33126
855-481-0505 (main number)
855-481-0606 (facsimile)