



COASTAL CARE SERVICES, INC.<sup>®</sup>  
*member quality redefined.*

## *Provider Manual*

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**How to apply for participation**

If you are interested in applying for participation with Coastal Care Services, please visit <http://www.ccsi.care/providers/> or call a Provider Relations representative at 1-855-481-0505, ext. 8903.

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# INTRODUCTION

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. Coastal is dedicated to coordinating a full range of home care services via its network of quality providers throughout. 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.

# Overview

## **BUSINESS GOALS AND GUIDING PRINCIPLES**

Coastal is committed to coordinating quality comprehensive home services to improve patient outcomes. Our network of providers strives to prevent further illness and promote better health practices. We have vast experience in efficiently and effectively coordinating the delivery of home care and coordinating a full range of home services. Coastal also recognizes the goal of home health, to teach and train the patient and/or caregiver and all network providers to work hard towards this goal.

## **MISSION**

To provide exceptional transition of care to the home, foster member independence in their homes, improve health outcomes, reduce medical and administration costs and prevent unnecessary readmission.

## **Code of Ethics and Business Standards**

Ethics and integrity are at the heart of our approach to improving patient outcomes, while coordinating quality care. Coastal has expertise 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. 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.

## Important Contact Information

### Phone/Fax/Mail

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](http://www.ccsi.care)

Coastal's website allows Providers to access a source of information. It is a complement of online provider resources. The website portal features online provider prior authorization requests, claims status, claims resubmission, claims disputes and demographic changes. You may also submit demographic changes via email to [providerrelations@ccsi.care](mailto:providerrelations@ccsi.care). In addition, the website has other resources and materials to help you work with us, including provider forms, electronic remittance advice and electronic funds transfer information, and updates. Visit our website at [www.ccsi.care](http://www.ccsi.care).

## **HOURS OF OPERATION**

Standard Business Hours of Operation: 8:30am to 5:00pm

Available 24 hours a day, 7 days a week.

## **AFTER HOURS**

Coastal has 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 then contacts the ordering physician and process the orders according to guidelines.

## **Cultural Competency**

Cultural competency refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of individuals, and protects and preserves the dignity of each. Coastal promotes cultural competency. We provide training opportunities to staff, helping them learn ways to interact effectively with members. Staff cultural competency is monitored as part of Coastal's Quality Improvement process.

Coastal has a comprehensive written Cultural Competency Plan (CCP) describing our program to ensure that services are provided in a culturally competent manner. The CCP is updated yearly. You can call and request a copy at no cost to you by calling 1-855-481-0505 ext. 8903.

## **Services for Translation and the Hearing Impaired**

All members whose primary language is not English or Spanish are entitled to receive interpreter services through Coastal at no cost to the member by calling Customer Service at 1-855-481-0505. 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 confirm 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
- Online verification through our website portal (coming soon).

Verification is 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.

## **CONTINUITY OF CARE**

Coastal observes a 60-day continuity of care waiver for all MMA services. No services will be denied for absence of authorization in circumstances where care was in place prior to the transition date. For all new members, for the first sixty (60) days of enrollment, Coastal accepts any authorization from another plan for care or services the member is receiving.

The continuity of care waiver applies to both participating and nonparticipating providers. The service is continued until we assess the member and reauthorize and/or transfer him or her to a participating provider. Once we assess the member, the new authorization is to be observed and drive future claims payment.

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



## **COASTAL'S ROLE & RESPONSIBILITIES:**

- Conduct our business in strict compliance with applicable laws, rules and regulations
- Work hard to coordinate and provide timely and 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, sexual orientation, 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. 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 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

## **PROVIDER'S ROLE & RESPONSIBILITIES :**

- Submit all required claims information
- Verifying member eligibility before rendering services
- Obtain prior authorization from Coastal prior to rendering services
- Communicate to Coastal on a timely basis if the services cannot be rendered within the expected/required timeframe
- Provide 24 hours a day, 7 day a week coverage and maintain regular hours of operation that are clearly defined and communicated to members
- Provide services ethically and legally in a culturally competent manner and meet the unique needs of members with special health care requirements
- Participate in the systems established by Coastal that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
- Participate and cooperate with Coastal in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs established by Coastal
- Participate in and cooperate with Coastal's complaint and grievance processes and procedures; Coastal notifies provider of any member grievance brought against the provider
- Not balance bill members
- Continue care in progress during and after termination of contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider or in accordance with applicable state and federal laws and regulations
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Support, cooperate and comply with the Coastal QI Plan initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
- Inform Coastal if a member refuses services for any reason

# **PATIENT RIGHTS AND RESPONSIBILITIES**

## **Summary of Patient's Bill of Rights and Responsibilities**

State law requires that providers recognize the rights of members while they are receiving medical care and that members respect the health care provider's right to expect certain behavior on the part of members. Members may request a copy of the full text of this law from their health care provider. The following is a summary of the member's rights and responsibilities.

### **Patients' Rights**

Patients have the right to:

- Be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy
- A prompt and reasonable response to questions and requests
- Know who is providing medical services and who is responsible for his care
- Know what patient support services are available, including whether an interpreter is available if they do not speak English
- Know what rules and regulations apply to his conduct
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their conditions and ability to understand; members are given the opportunity to be involved in decisions involving their health care, except when such participation is contraindicated (not recommended) for medical reasons
- Participate in decisions regarding their health care, including the right to refuse treatment
- Be given health care services in line with federal and state regulations
- Be given, upon request, full information and necessary advice of available financial help for their care
- Receive, upon request, before treatment, a reasonable estimate of charges for medical 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.
- Receive a copy of a reasonably clear and easy-to-understand itemized bill and, upon request, to have the charges explained
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- To treatment for any emergency medical condition that shall deteriorate from failure to provide treatment
- To know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research

- To express grievances regarding any violation of his rights, as stated in State law, through the grievance procedure of the health care provider or health care facility which served him and to the appropriate state licensing agency
- Be free from any form of restraint (control) or seclusion used as coercion (force), discipline, convenience or retaliation (revenge)
- Ask for and get a copy of their medical records and ask that those records be updated or corrected

### **Patients' Responsibilities**

Patients have the responsibility to:

- Provide their health care provider, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications (including over the counter products), dietary supplements, any allergies or sensitivities, and other matters relating to his health
- Report unexpected changes in their condition to their health care provider
- Report to their health care provider whether they comprehend a contemplated course of action and what is expected of them
- Follow the treatment plan recommended by the health care provider
- Keep appointments and, when unable to do so for any reason, notifying the health care provider or health care facility
- Understanding their actions if they refuse treatment or do not follow the health care provider's instructions
- Inform their providers about any living wills, medical powers of attorney or other directives that could change their care.
- A patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible
- Make sure the needs of their health care are met as quickly as possible
- Follow health care facility rules and regulations about member care and conduct
- Behave in a way that is respectful of all health care providers and staff, as well as of other members

**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.*

# **CREDENTIALING/RE-CREDENTIALING 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 is to 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 in 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 in accreditation status
- Change in participation with government programs
- Change in Licensure
- Change of ownership

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 are as clear and precise as possible. This ensures 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: 855-481-0606  
Or Via Email: [ProviderRelations@ccsi.care](mailto:ProviderRelations@ccsi.care)

Another convenient way to notify Coastal of changes is through our web portal via [www.ccsi.care](http://www.ccsi.care). Your changes are then forwarded to the Network Management and Credentialing Departments. You may also submit demographic changes via email to [providerrelations@ccsi.care](mailto:providerrelations@ccsi.care). Our Network Department then 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 are to be e-mailed to the Credentialing Department to [ProviderRelations@ccsi.care](mailto:ProviderRelations@ccsi.care).

Providers who do not submit expired documentation on a timely basis are suspended and patients are 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:

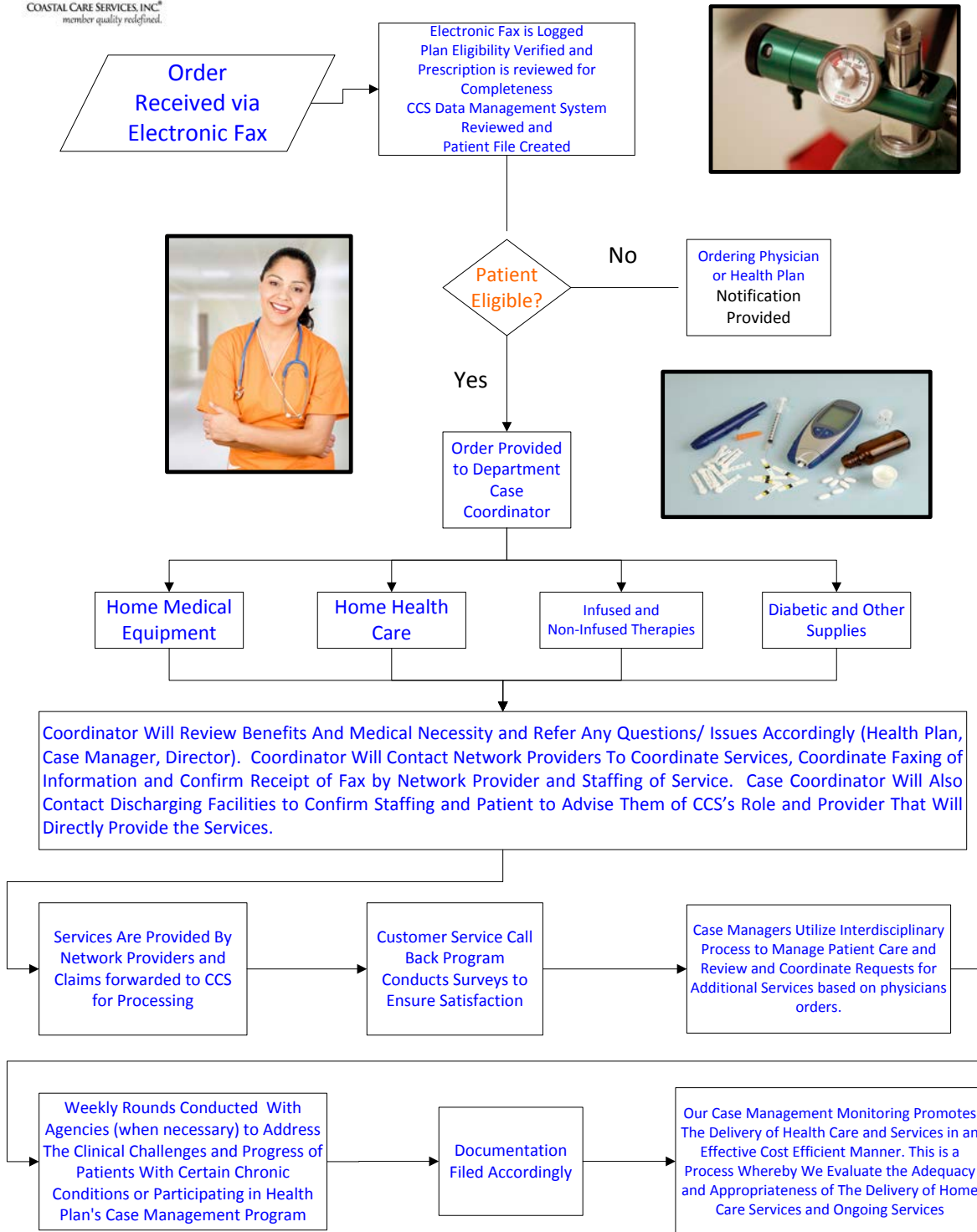
- 1099 Mailing Address
- Physical or Billing Address
- Tax ID Number (W-9 form Required)
- Group Name or affiliation
- Telephone/Fax Numbers
- E-mail address

## **CASE COORDINATION / AUTHORIZATION PROCESS**

Coastal reviews all orders and selects the most appropriate network provider and issues 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





## 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** 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 contacts 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 are also to be accompanied by the ordering physician's orders. Authorizations are only provided for the month in which they are requested and 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 requests 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 typically include an evaluation or assessment of the home situation, patient and caregiver education and follow-up visits, which is then authorized according to the patient's diagnosis and physician's orders. These steps are taken 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 are then reviewed and a determination is made by Coastal's Case Manager. Please note that all requests for extensions or additional visits **must** be supported by documentation. Coastal, in most circumstances contacts 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 covered services and the same process as above is followed. HME authorizations are to 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. Reimbursements are not 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 is updated accordingly usually for an additional 60 days. This process repeats 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 5<sup>th</sup> day of each month. Network providers are responsible for verifying eligibility and continued use of equipment and provide reauthorization no later than the last day of the month.

Network providers must track the rental cap timeframe as payments will not be made once reached. The authorization indicates 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.

## **Noncompliant Members**

Coastal recognizes that providers may need help in managing noncompliant members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment, and/or scheduling appointments/deliveries, please contact our Customer Service department at 1-855-481-0505.

## **Background Checks**

Providers must complete a Level 2 criminal history background screening to determine whether there are any employees who meet the definition of "direct service provider" have disqualifying offenses as provided for in s. 430.0402 F.S. as created and s. 435.04, F.S. Any employee meeting the definition of a "direct service provider" who has a disqualifying offense is prohibited from providing services to patients as set forth in s. 430.0402, F.S.

## **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 State 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.

Providers are required to have a designated person in charge of medical records. This person's responsibilities include, but are not limited to:

1. The confidentiality, security and physical safety of records
2. The timely retrieval of individual records upon request
3. The unique identification of each patient's record
4. The supervision of the collection, processing, maintenance, storage and appropriate access to the usage of records
5. The maintenance of a predetermined, organized and secured record format

The following requirements must also be met regarding the patient's medical records:

1. **Security** — Providers must maintain a written policy and are required to ensure that medical records are safeguarded against loss, tampering, alteration, destruction, or unauthorized use or inadvertent use.
2. **Storage** — Providers must maintain a system for the proper collection, processing, maintenance, storage, retrieval and distribution of patient's records. Also, the records must be easily accessible to personnel in the provider's office and readily available to authorized personnel any time the organization is open.
3. **Release of information** — Written procedures are required for releasing information and obtaining consent for treatment.

## **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 Process is to promote health, safety, quality of service, prevent loss and liability exposure and protect resources. Our Risk Management process 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 decubitus 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 sends 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/ UB-04 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 are 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 acknowledges 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, 2016, the report includes claims received for the week of November 3<sup>rd</sup> to November 7<sup>th</sup>. 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.

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 are to be submitted through in one of the following format:

*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:*

**Change Healthcare**

**(formerly 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 is reviewed and if adjustment is required, the claim is reprocessed. An explanation is 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 the timeframe listed on your remittance advice.

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 Coastal's 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 Coastal to do a thorough review of the case (appeal forms can be downloaded from our website).

If a claim is 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](http://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 its Providers the opportunity to express dissatisfaction about Claim determinations as well as 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 Manager is designated to receive and process provider complaints. Complaints may be received by:

- Phone by calling 1-855-481-0505 Ext.8903
- Email to [ProviderRelations@ccsi.care](mailto: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](mailto: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](http://www.ccsi.care) under the “Providers” tab.

Once we receive a formal grievance or appeal, Coastal:

- Submits a grievance/appeal acknowledgement letter within five (5) working days from the receipt of the document.
- A resolution is communicated to the provider in writing within a sixty (60) day period from the receipt of the document. The letter includes 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.

## **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. We continuously strive to meet all standards established by The Joint Commission for network management, and consequently providers are to

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

Coastal monitors 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

Coastal makes 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 are expected to participate in Coastal's Utilization Management/Monitoring Programs. This interdisciplinary participation not only strengthens the collaborative association between Coastal and our providers, but also benefits 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, WASTE, 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](mailto: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](https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx)

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

Many types of fraud, waste and abuse are identified, including the following:

## **Provider Fraud, Waste and Abuse:**

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Up coding

Providers can help prevent fraud, waste and abuse by ensuring that the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

## **Member Fraud, Waste and Abuse:**

- Benefit sharing
- Collusion
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation and/or misrepresentation
- Subrogation and/or third-party liability fraud

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.

It is important that you review and understand the following federal regulations:

### **1. The False Claims Act**

Coastal's compliance programs 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’s policies and procedures employed ensure that illegal remuneration is not permitted and shall specify follow-up procedures if they uncover unlawful remuneration schemes.

### **3. HIPAA**

The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Coastal strives to ensure that both Coastal and our contracted providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers must have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations.

We recognize our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose and ask that our providers do the same when contacting Coastal. Please note, the privacy regulations allow the transfer or sharing of member information, which may be requested by Coastal to conduct business and make decisions about care, such as a member’s medical record, to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Coastal, verify that the receiving fax number is correct, notify the appropriate staff at Coastal and verify that the fax was appropriately received.

Email (unless encrypted) should not be used to transfer files containing member information to Coastal (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual or department at Coastal.

Coastal’s voicemail system is secure and password-protected. When leaving messages for our associates, only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting Coastal, please be prepared to verify the provider’s name, address and tax identification number, or national provider identifier.

### **How to Report Fraud or Abuse**

Suspected fraud and/or abuse may be reported by phone and/or 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](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.

## **MISROUTED PROTECTED HEALTH INFORMATION**

Providers are required to review all member information received from Coastal to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about members that a provider is not treating. PHI can be misrouted to providers by mail, fax, email or electronic remittance advice. Providers are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers permitted to misuse or re-disclose misrouted PHI. If providers cannot destroy or safeguard misrouted PHI, please call our Provider Relations Department at 1-855-481-0505 ext. 8903 for help.

# **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's established preventive controls, contingency resources, and procedures administered by a formal internal management team 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 receives 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 are 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](mailto:gruiz@ccsi.care) where notification of the activation of our Business Continuation Plan should be sent.

## **APPENDIX**

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

**NOTICE OF PRIVACY PRACTICES  
COASTAL CARE SERVICES, INC.**

Privacy Officer  
7875 NW 12<sup>th</sup> Street Suite 200  
Doral, FL 33126  
Phone: 1-855-481-0202  
Fax: 1-855-481-0606  
E-mail: [compliance@ccsi.care](mailto:compliance@ccsi.care)

**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.**

**WHAT A NOTICE OF PRIVACY PRACTICES TELLS 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" 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 do not use or share your PHI without written authorization except as stated in this document.

**YOUR RIGHTS**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

**Inspect and copy your protected health information.** Typically, this includes medical and billing records. To inspect and copy medical information that may be used to make decision 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.

**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.

**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.

**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.

**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.

**Obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice electronically.

**Be notified and informed regarding a breach of unsecured protected health information.** This means that we must notify you without unreasonable delay and in no case no later than 60 days, following the discovery of a breach in your protected health information. We must provide you in written form by first-class mail, or alternatively, by e-mail if you have agreed to receive such notices electronically. The notification must include, to the extent possible, a brief description of the breach, a description of the types of information that were involved in the breach, the steps you should take to protect yourself from potential harm, a brief description of what we are doing to investigate the breach, mitigate the harm and prevent further breaches, as well as our contact information.

**To choose someone to act for you.** This means that if you have given someone medical power of attorney or if someone is your legal guardian, that person can

exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

You may file a complaint if you feel we have violated your rights by notifying our Privacy Officer at 1-855-481-0202 or by using the information on page 1.

If you believe your privacy rights have been violated by us, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

We will not retaliate against you for filing a complaint.

## **YOUR CHOICES**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situation described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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 and the dates that you received services, in order to contact you for fundraising 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 thank you cards and other holiday cards received from patients in lobby bulletin boards or other general areas.

## **OUR USES AND DISCLOSURES**

### **We typically use or share your health information in the following ways:**

Your protected health information is typically 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 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 the delivery of durable medical equipment and supplies, and home health services. This may include the coordination or management of your health care with a third party. For example, we would disclose your protected health



information, as necessary, to suppliers who may be called upon to assist us with providing service 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.

**Payment:** Your protected health information will be used, as needed, to obtain payment for services provided to you. 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 a hospital bed may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital bed.

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

We will share your protected health information with third party “business associates” that perform various activities for example, billing and health care providers. 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.

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.

## **WILL MY HEALTH INFORMATION BE RELEASED WITHOUT MY PERMISSION**

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 – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**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, if you are unable to agree or object, such as in an emergency or when you fail to object when asked. 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.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation.

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local 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 purposes 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 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 and 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.

## OUR RESPONSIBILITIES

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.

We are required to abide by the terms of this Notice of Privacy Practices.

We will inform you promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and provide you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of This Notice**

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 or on our web site.

This notice became effective on May 1<sup>st</sup>, 2015

Recommendation & Status Report



COASTAL CARE SERVICES, INC.<sup>®</sup>  
member quality redefined.

Home Health Agency: \_\_\_\_\_ Date: \_\_\_\_\_ S.O.C: \_\_\_\_\_

Patient's Last Name:

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First Name:

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D.O.B:

Policy#:

Tel#:

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<b>Primary Diagnosis:</b>					
<b>Secondary Diagnosis:</b>					
<b>Add'l Diagnosis:</b>					

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)

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## Services Requested

### Home Health Orders

<input type="checkbox"/> <b>Nurse Evaluation</b> -for home or wound care needs & treatment _____ Wound care treatment plan & Location: _____ _____
<input type="checkbox"/> <b>Physical Therapy Evaluation &amp; Treatment</b>
<input type="checkbox"/> <b>Home infusion/ medication</b> (All first doses need to be given at the facility or PCP office) Administration -Medication, dosage, route & frequency/ duration: _____ _____
<input type="checkbox"/> <b>Other:</b>

### Durable Medical Equipment and Supplies (Please describe)

_____ Height: _____ _____ Weight: _____	
<input type="checkbox"/> <b>Oxygen Therapy:</b> <ul style="list-style-type: none"> <li>O2 Saturation Level on Room Air _____%</li> <li>Date O2 Sat was taken: _____</li> <li>Taken @ rest or with ambulation: _____</li> <li>If taken with ambulation- resting O2 Sat: _____%</li> <li>Bled into CPAP/BIPAP _____</li> </ul> <i>Script needs to have dx, settings (liters per minute, route of administration, continuous or nocturnal) AND oxygen saturation on room air.</i>	<input type="checkbox"/> <b>CPAP Therapy:</b> _____Initial <input type="checkbox"/> <b>BIPAP Therapy:</b> _____ Extension of existing rental Date of SOC _____ <ul style="list-style-type: none"> <li>Settings _____</li> <li>Baseline AHI _____</li> </ul> <i>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.</i>

\*\*\*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.

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### 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 5<sup>th</sup> 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 the Provider Agreement.