COASTAL CARE SERVICES, INC.®

member quality redefined.

Provider Training Tool

WellCare/StayWell Orientation

Coastal Overview

Coastal Care Services, Inc. (Coastal) is a healthcare solutions company that partners with Health Plans to provide their members with high quality, patient-centered, "high-touch" care through the delivery of home care services such as Durable Medical Equipment & Supplies, Home Health, Home Infusion, and post-acute transition of care.

With over 30 years' experience Coastal's executive team uses innovative solutions to create a flexible and collaborative model that successfully manages the unique needs of the members it services throughout the State of Florida, while providing our Health Plan clients with 100% transparency. Our approach is to deliver timely, effective care to our Health Plan members in a financially responsible, prudent manner while maximizing member satisfaction. Coastal's mission is to provide exceptional transition of care to the home, which fosters member independence in their homes, improves health outcomes, reduces medical and administration costs, and prevents unnecessary readmissions.

Coastal does not directly compete with its contracted providers as it does not own an interest in any DME, home health or home infusion providers. Therefore, Coastal's focus is on ensuring that the member receives the right care, at the right price, from the most qualified provider.

BUSINESS GOALS AND GUIDING PRINCIPLES

Coastal is committed to coordinating quality comprehensive home services to improve patient outcomes. Our network of providers strive to prevent further illness and promote better health practices. We have vast experience in efficiently and effectively coordinating the delivery of home care services.

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

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 expertise entaills 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 providers are committed to working hard to establish and maintain our reputation and commitment to patients, payors and clients.

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 to ensure 24 hours a day, 7 days a week availability.

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.

Covered Services & Regions

Effective 3/1/2018, Coastal will provide WellCare and Staywell members in certain regions throughout Florida with high quality, patient-centered care through the delivery of home care services including Durable Medical Equipment & Supplies and Home Health services through a "Single Point of Entry."

Service Scope – Services Coastal will provide include:

- Durable Medical Equiptment (DME) & Supplies
- Home Health Services

Service Area – Counties Coastal will provide services include:

- **StayWell (Medicaid)**
    - Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota

- Region 11: Miami-Dade and Monroe

- **WellCare (Medicare) & StayWell (Florida Healthy Kids)**
  - Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
  - Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
  - Region 10: Broward
  - Region 11: Miami-Dade and Monroe

Continuity of Care

FLORIDA MEDICAID MMA

Coastal observes a 60-day continuity of care period for all MMA Staywell Medicaid 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.

MEDICARE & FLORIDA HEALTHY KIDS

Coastal observes a 30-day continuity of care period for 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 thirty (30) days of enrollment, Coastal accepts any authorization from another plan for care or services the member is receiving.

The continuity of care period 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.

Utilization Management/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 health plans 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.

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

Please refer to the Service Standards Appendix of your provider agreement

OBTAINING AUTHORIZATIONS

The authorization process is an important component of Coastal's Intake Program. The referral authorization process is used to assure that the member receives the maximum benefit and that claim(s) are considered for benefits in a timely manner and processed correctly.

The following depicts the authorization process.

a. Coastal reviews all orders and selects the most appropriate provider and issue authorization in order for the service(s) to be rendered to patient. All services require clinical review, assignment and prior authorization. Coastal's referral authorization process confirms member eligibility, member benefits, the services are reasonable for treatment of illness or injury, and meets all applicable medical, health plan and regulatory criteria.
b. Authorizations may be requested via fax, phone, or online via the secure Provider Portal.
    i. Via Fax – 855-481-0606
    ii. Via Phone – 855-481-0505

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

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

d. Providers must notify Coastal immediately if services are unable to be provided for any reason.

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

LONG TERM CARE (LTC) MEMBERS

While Coastal does not cover LTC services, some services managed by Coastal are considered "mixed services." Mixed services are services that are covered under both the LTC and the MMA contacts. DME and home health services are both considered mixed services. For members who are eligible for both LTC and MMA, the LTC plan is primary. Services will be coordinated and payed by the LTC plan. Coastal will cover mixed services under the MMA plan only when then benefits under the LTC plan have been exhausted.

REFERRAL FORM

Referral Form

Please fax this form along with Signed orders and required information to
Fax# **786-446-9989 or 1-855-481-0606**

Patient Information

Policy Number:	Last Name:	First Name:
Health Plan:	Date of Birth:	Phone Number:
Service address:		
Ordering physician:	NPI:	Phone: Fax:
Sender's Name and Number:	Facility:	Discharge Date:

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

Services Requested

Home Health Orders

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

Wound care treatment plan & Location: _____

_____

☐ **Physical Therapy Evaluation** & Treatment

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

_____

☐ **Other:**

Durable Medical Equipment and Supplies (Please describe)

_____ Height: _____

Weight: _____

☐ **Oxygen Therapy:**

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

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

☐ **CPAP Therapy:** _____Initial

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

Date of SOC _____

- Settings _____
- Baseline AHI _____

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

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

CCSI 2015

AUTHORIZATION FORM

AUTHORIZATION NOTICE

Referral Status: **Urgency:** **Authorization #:**

PATIENT INFORMATION

Patient Name: PCP Name:
DOB: PCP ID:
Patient ID: PCP Phone:
Home Phone:
Address:
Primary Carrier: Primary Health Plan:

ORDERING PHYSICIAN

Name: Phone: Fax:

SERVICING PROVIDER

Name: Specialty:
Address: Phone: Fax:

CLINICAL DATA

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

SPECIAL INSTRUCTIONS:

CCSI Coordinator/Manager:

SERVICES REQUESTED

Coastal Care Services, Inc. has made the following decision after reviewing the information provided:

Service Status	Effective From	Effective Thru	Procedure	Description	# of Units	Next Review Date

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

To Medicare and Medicaid providers: You are not allowed to collect or bill for co-payments, coinsurance or deductibles for Medicare Parts A and B covered services, if the member you are treating is a dual-eligible member who is held harmless for such cost-sharing amounts by the State Medicaid plan. If the health plan and the state Medicaid agency are in an agreement for the health plan to assume the state's responsibility to pay cost-sharing amounts for dual-eligible members the state holds harmless, then you must accept Coastal's payment as payment in full. When no such agreement exists, you may bill the appropriate State source for such cost-sharing amount. You will have to be enrolled with the State agency prior to billing the State for cost sharing amounts. Therefore, if you do not accept Medicaid or are unable to bill the appropriate State source, you must accept Coastal's payment as payment in full. The Provider agrees to look solely to Coastal for payment of amounts due hereunder.

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REQUEST FOR ADDITIONAL SERVICES

A. Home Health

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

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

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

i. Recommendation Status Report

Recommendation & Status Report

COASTAL CARE SERVICES, INC.®
member quality redefined.

Home Health Agency:_____ **Date:** _____ **S.O.C:** _____

Patient's Last Name:

First Name:

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

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

History of Present Illness: _____

Homebound, Describe Reason: _____

Teaching and training of patient/caregiver/ friend/ family: ☐ Possible ☐ Not Possible
Home Environment: ☐ Lives Alone ☐ Debilitated ☐Frail Elderly Caregiver ☐ Other:_____

Wound Care:

Type	Location	Dimensions	Drainage	Stage	Improving
		L_____cm x W_____cm x D _____cm			
		L_____cm x W_____cm x D _____cm			
		L_____cm x W_____cm x D _____cm			

(Agencies must submit a status report on all wound care cases on a weekly basis)
Has a physician been notified of Plan of Care: ☐ Yes ☐ No Next Physician Appt: _____

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

AGENCY RECOMMENDATIONS/REQUEST

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

Provider Signature:_____ Date:_____

Comments:_____

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

B. Durable Medical Equipment & Supplies

All participating Durable Medical Equipment and Medical Supply providers are required to request re-authorization prior to the expiration of the existing authorization to assure that the member receives on-going services beyond Coastal's initial authorization and ensure continuity of care and reimbursement.

Providers must track the rental cap timeframe as payment will not be made once reached. Coastal authorization will indicate if the equipment is a purchase or rental. Small ticket items (canes, walkers, commodes & Nebulizers) are usually handled as a purchase unless otherwise determined and indicated.

DME authorizations will be accompanied by the ordering physician's orders and must meet medical necessity & criteria.

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

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

Claims Submission

As a contracted provider, it is important to understand how the claims process works to avoid delays in processing your claims. Providers are required to submit claims to Coastal with appropriate documentation following the appropriate State and CMS provider billing guidelines.

Claims may be submitted in one of the following formats:

- Electronic Claims Submission (EDI)
    - 837I Institutional Claims must be submitted for:
        - Medicare Home Health Claims
    - 837P Professional Claims must be submitted for:
        - Medicaid DME and Home Health Claims
        - Medicare DME Claims
        - Florida Healthy Kids DME and Home Health Claims

- Paper – CMS 1500 Form or UB-04 Form
    - UB-04 Form must be used for:
        - Medicare Home Health Claims
    - CMS 1500 Form must be used for:
        - Medicaid DME and Home Health Claims
        - Medicare DME Claims
        - Florida Healthy Kids DME and Home Health Claims
- Provider Portal – Coastal's Provider Portal offers a number of claims processing functionalities, including:
    - Available 24 hours a day, 7 days a week.
    - Ability to submit claims and attach documents
    - Check claims status

Coastal encourages providers to submit claims electronically via EDI. It is a less costly alternative to submitting paper claims and allows for a quicker claims processing timeframes.

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)
Payer ID# 47394
Telephone: 1-877-363-3666

REQUIRED ELEMENTS

The following guidelines must be adhered to for the processing of clean claims:

- Providers must submit claims within 6 Months of the date of service
- Members cannot be billed for services denied due to untimely claims submission
- Claims for dual eligible members must be submiited with the primary carrier's explanation of benefits.
- A valid NPI is required on all claim submissions. Providers must report any changes in their NPI to Coastal as soon as possible, not to exceed thirty (30) calendar days from the change.

    - For Florida Medicaid lines of business, a provider's NPI number is validated against AHCA's Provider Master List (PML). If an NPI number is not recognezed on the PML, the claim will deny for the services rendered.
- The following information must be included in every claim:
    - Member name, date of birth and Member ID number
    - Member's gender
    - Member's address
    - Date(s) of service
    - Valid International Classification of Diseases diagnosis and procedure codes
    - Valid revenue, CPT or HCPCS for services or items provided
    - Valid Diagnosis Pointers
    - Total billed charges for service provided
    - Place and type of service code
    - Days or units as applicable
    - Provider tax identification
    - National Provider Identifier (NPI)
    - Rendering Provider as applicable
    - Provider name and billing address
    - Place of service and type (for facilities)
    - Disclosure of any other health benefit plans
    - E-signature
    - Service Facility Location

CLEAN CLAIM

A clean claim means a claim received by Coastal for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Coastal.

NON-CLEAN CLAIM

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

CORRECTED CLAIMS

Corrected Claims are considered new Claims for processing purposes. Corrected claims must be sent following the below instructions to ensure the claims do not deny as duplicates:

- Paper Corrected Claims
  - Claims must clearly state "Corrected Claim."
- EDI Submissions
  - 837P – Professional Claims
    - In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
      - "1" – ORIGINAL (initial claim)
      - "7" – REPLACEMENT (replacement of prior claim)
      - "8" – VOID (void/cancel of prior claim)
    - In the 2300 Loop, the REF*F8 segment (claim information) must include the original reference number.
  - 837I – Institutional Claims
    - Bill type for UB clams are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1", "7", or "8" goes in the third digit for frequency.
    - In the 2300 Loop, the REF*F8 segment (claim information) must include the original reference number.

EXPLANATION OF PAYMENT

Explanation of Payment (EOP) is a statement Coastal sends to providers that delineates who claims were adjudicated. The EOP will include:

- General claim information – Patient Name & ID, Health plan information, claim number
- Claim summary – provides a general overview of costs related to the claim:
  - Amount billed
  - Discounts
  - Patient Financial Responsibilities
  - Net Paid Amount
  - Other Insurance Paid Amount
  - Payment Date
  - Payment check#/EFT tracking number
- Claim details – important information regarding the claim:
  - Date(s) of service

- Service Description
- Amount Billed
- Not Covered Amount
- Copay/co-insurance/deductible amounts
- Explanation of any claims that were denied and appeal information

ELECTRONIC CLAIM PAYMENT

Participating providers are encouraged to enroll for Electronic Funds Transfer (EFT). Providers will receive payment faster than through a paper check. There is no cost to the Provider for EFT enrollment. For additional information on enrolling for EFT payments, please contact our Provider Relations Department at providerrelations@ccsi.care.

CLAIM DISPUTES

Providers seeking a redetermination of a claim previously adjudicated must request such action directly to WellCare/Staywell.

The WellCare Claims Payment Policy Department has created a mailbox for provider issues related strictly to payment policy issues. Disputes for payment policy related issues (EOP Codes beginning with IHXXX, MKXXX or PDXXX) must be submitted to WellCare in writing within one year of the date of denial on the EOP. Please provide all relevant documentation, which may include medical records, in order to facilitate the review.

Mail all disputes related to payment policy issues to:

WellCare Health Plans, Inc. **Fax 1-877-277-1808**
Attn: Claims Payment Policy Disputes
P.O. Box 31426
Tampa, FL 33631-3426

PROVIDER APPEALS

Any provider wishing to file an appeal must do so directly through WellCare/Staywell. Providers may file an appeal on behalf of the member with his/her written consent. Providers may also seek an appeal through WellCare's Appeals Department within 90 calendar days of a claims denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16, and KYREC; however, this is not an

all-encompassing list of Appeals codes. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information like a summary of the appeal, relevant medical records and member-specific information.

Mail or fax medical appeals with supporting documentation to:

WellCare Health Plans, Inc. **Fax 1-866-201-0657**
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

Provider Relations

Developing and maintaining a statewide integrated delivery system of Ancillary Providers is one of our most important functions. With a panel of diverse ancillary provider locations, our Network Management Department understands the importance of developing and maintaining strong relationships with our contracting providers, while eliminating the barriers that people must overcome to access their health care services. It is the goal of the Network Management Team to be the most responsive department in the field by working closely with our providers to better identify obstacles and find new ways to improve the delivery of health care services.

Coastal is dedicated to education, training and ensuring that all participating providers have a platform to voice any concerns that they may have regarding services. Our Network Management Team acts as liaison between Coastal's various departments and the external provider to promote positive communication and facilitate the exchange of information, allowing Coastal to seek efficient resolutions to all provider inquiries. The following resources are available to all Coastal participating providers and outline key responsibilities suitable for their network participation:

- Provider Quick Reference Tool
- Provider Manual
- Provider Scorecards
- Dedicated Provider Relations Representative

Coastal's Provider Appeals and Grievances Process provides the following:

- Clear process with avenues to file an appeal or grievance
- Provider Appeals team will investigate the provider appeal/inquiry/complaint
- Root Causes are identified

- Health Plan notification as needed
- Provider Re-Education as needed by the Network Department

Please refer to "Provider Complaints" section for further detail on Appeals and Grievances.

CHANGES IN PROVIDER INFORMATION

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 or via Coastal's Provider Portal. The notice in writing 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
- 1099 Mailing Address
- Tax ID Number (W-9 form Required)
- Group Name or affiliation

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: 786-594-3028
Or Via Email: ProviderRelations@ccsi.care

RE-CREDENTIALING

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 by Coastal's Network Department prior to any documents expiring. These documents are to be e-mailed to the Credentialing Department to ProviderRelations@ccsi.care.

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

Grievances

Member grievances may be filed orally by calling WellCare/Staywell's Customer Service or submit to WellCare/Staywell by fax or email. Providers may also file a grievance on behalf of the member with his or her written consent.

Mail or fax member grievances to:

WellCare Health Plans, Inc. Fax: 1-866-388-1769
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

Abuse, Neglect, and Exploitation

Coastal's Abuse, Neglect and Exploitation policies, procedures and standards outline the prevention, detection, reduction, correction and reporting of healthcare abuse and neglect in compliance with all state and federal program integrity requirements.

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.

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/Abuse Hotline at 1-855-481-0202, via fax to 855-481-0606, or email to Compliance@ccsi.care. For direct reporting of Abuse, Neglect or Exploitation, please use one of the following avenues below:

- Florida Abuse Hotline: 1-800-962-2873 OR
- Complaint Form online:
  https://reportabuse.dcf.state.fl.us/Child/ChildForm.aspx
  https://reportabuse.dcf.state.fl.us/Adult/AdultForm.aspx

Many types of abuse, neglect, and exploitation are identified, including the following:

Member Abuse, Neglect, and Exploitation:

- Physical, sexual, neglect, psychological or financial abuse
- Caregiver misuse of welfare benefits
- Caregiver not meeting the needs of the member
- Intentional over and/ or under medicating

Tip: Providers can help identify abuse, neglect and exploitation through appropriate training for warning signs, patient evaluation, patient satisfaction survey, and caregiver evaluation,

Coastal requires Abuse, Neglect, and Exploitation training during the credentialing process and yearly thereafter. If you would like to request a copy of the manual, you can call and request a training and a copy of our Abuse, Neglect, and Exploitation training manual at no cost to you by calling 1-855-481-0505 ext. 8903.

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 and provides training opportunities to providers, helping them learn ways to interact effectively with members.

Coastal assures that its employees, providers are culturally diverse and competent to interact with our culturally diverse members. Coastal's Cultural Competency Plan (CCP) describes how providers, Coastal employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members and protects and preserves the dignity of

each. In addition, Coastal shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments.

Coastal continuously promotes cultural competency and provides training opportunities to providers, helping them learn ways to interact effectively with members.

Coastal requires CCP training during the Credentialing process and yearly thereafter. If you would like to request a copy of the CCP manual, you can call and request a training or copy of CCP training manual at not cost to you by calling 1-855-481-0505 ext. 8903.

Fraud, Waste and Abuse (FWA)

Coastal's FWA policies, procedures and standards outline the prevention, detection, reduction, correction and reporting of healthcare fraud and abuse in compliance with all state and federal program integrity requirements.

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.

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 786-594-3027, or email to Compliance@ccsi.care. For direct reporting of suspected fraud or abuse, pleaseuse 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

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

Tip: 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 guidelines.

Coastal requires FWA training during the credentialing process and yearly thereafter. If you would like to request a copy of the FWA manual, you can can call and request a copy at no cost to you by calling 1-855-481-0505 ext. 8903.

Business Continuation Plan

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

Coastal is responsible for:

- Notifying Managed Care Organizations and Providers of an emergency situation which could affect our ability to coordinate services
- Rerouting affected telephone and fax numbers to their preplanned destination
- 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

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

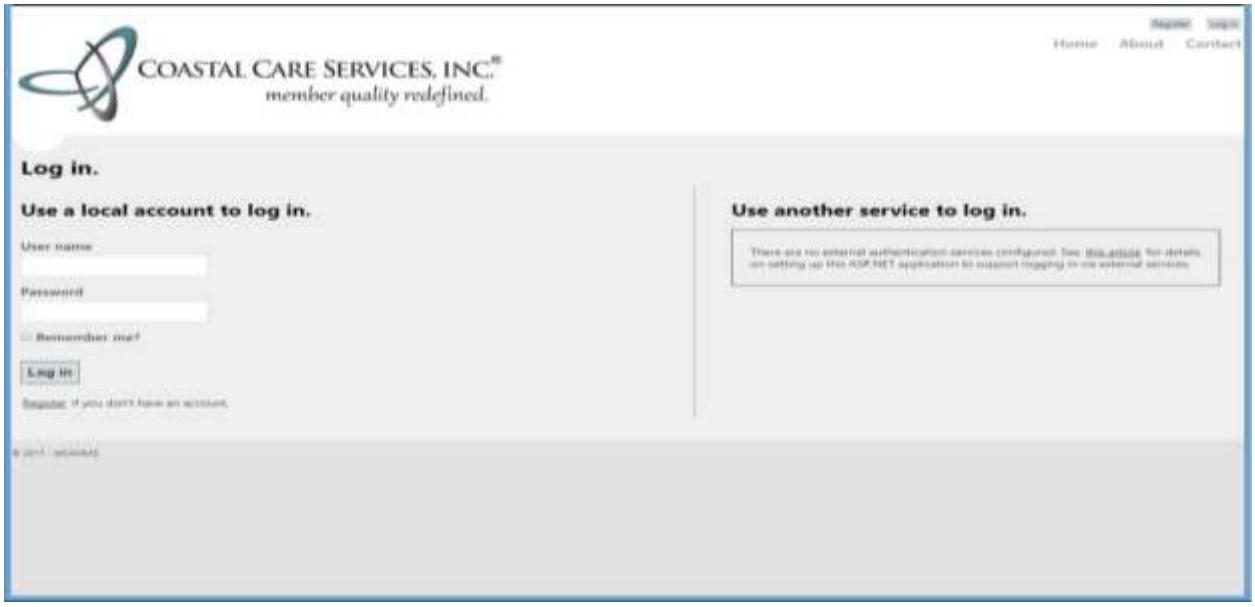
Web Portal

Coastal offers and welcomes all in-network providers to access our convenient Web Portal. The Web Portal is designed to allow providers to create their own personal account to update changes in Provider information, submit claims, check claims status.

PROVIDER ACCESS

A. Creating an Account

Once a Provider has been accepted into our network, Coastal's IT Department will send an email link to contact provided with Web Portal terms and policies along with instructions on creating an account. Once all terms and policies are agreed on Coastal's Web Portal, you will be directed to register for a new account. Screen below:



UTILIZATION MANAGEMENT

Authorizations may be requested via our Provider Portal by completing the Referral Form:

Referral Form

Please submit this form along with Signed orders and required information

Patient Information

Policy Number: Last Name: First Name:

Health Plan: Date of Birth: Phone Number:

Service address:

City: Zip:

Ordering physician: NPI: Phone Fax:

Sender's Name and Number: Facility: Discharge Date:

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

Services Requested

Home Health Orders

Nurse Evaluation –for home or wound care needs & treatment

Wound care treatment plan & Location:

Physical Therapy Evaluation & Treatment

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

Other:

Durable Medical Equipment and Supplies (Please describe):

Height: Weight:

Oxygen Therapy: CPAP Therapy:

O2 Saturation Level on Room Air: % BiPAP Therapy: Extension of existing rental

Date O2 Sat was taken: Date of SOC:

Taken @ rest or with ambulation: Settings:

If taken with ambulation, current O2 Sat: % Baseline AHI:

CLAIMS

A. Submitting Claims

COASTAL CARE SERVICES, INC.®

member quality redefined.

<< Return to main page

HEALTH INSURANCE CLAIM FORM

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

Claim No: Status: Pending

Type (Medicare,Medicaid,Other): Medicare

PATIENT'S NAME (Last,Fast,Mid) INSURED'S I.D. NUMBER

PATIENT'S ADDRESS INSURED'S NAME

CITY INSURED'S ADDRESS

STATE CITY

ZIP CODE STATE

TELEPHONE (Include Area Code) ZIP CODE

OTHER INSURED'S NAME TELEPHONE (Include Area Code)

PATIENT'S BIRTH DATE

Sex M

PATIENT RELATIONSHIP TO INSURED Self

EMPLOYMENT NO

AUTO ACCIDENT NO

OTHER ACCIDENT? NO

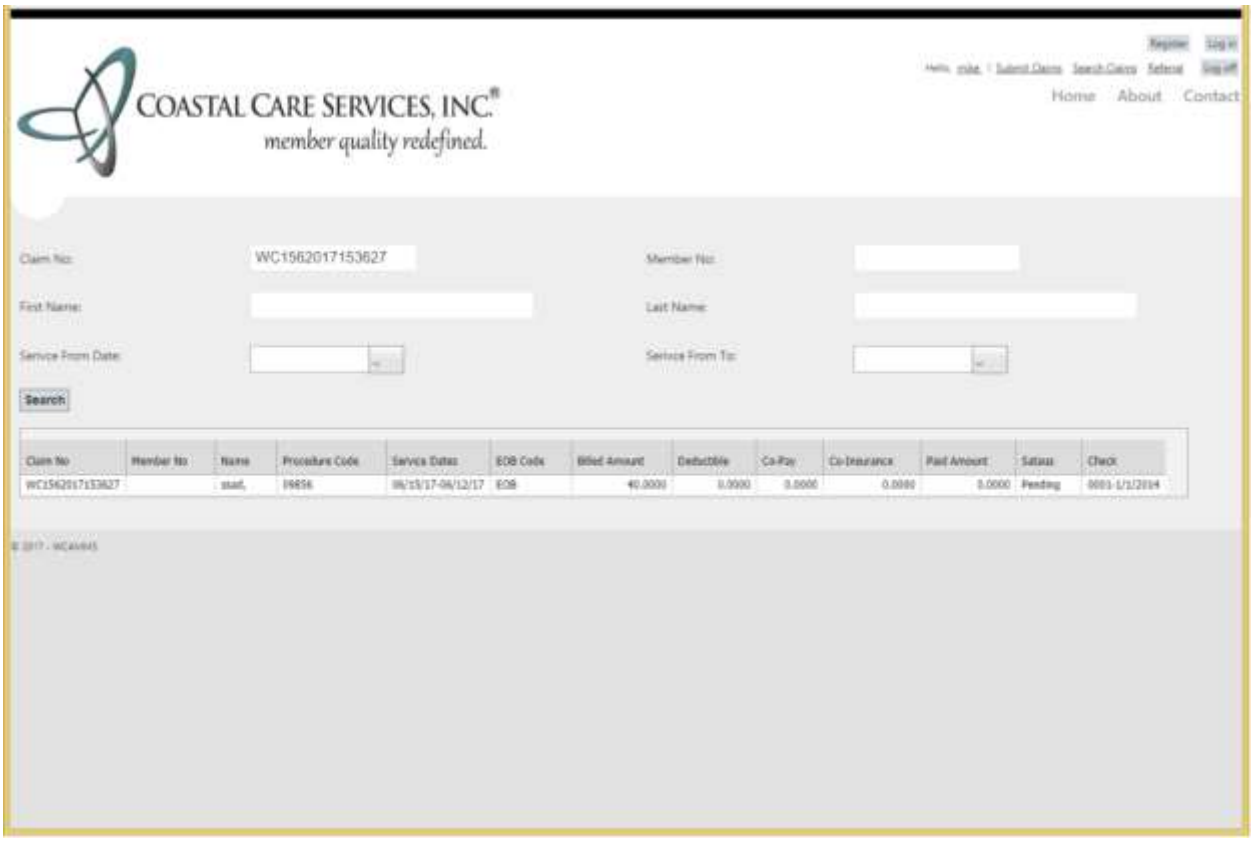
NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a

17b

PRIOR AUTHORIZATION NUMBER

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

B. Claim Status



General Contact Information

Phone/Fax/Email

Department	Contact Information
Provider Relations Department	Phone:1-786-879-8903 Fax:786-594-3028 Email: ProviderRelations@ccsi.care
Credentialing Department	Phone: 1-855-481-0505 ext. 8903 Fax:786-594-3028 Email: ProviderRelations@ccsi.care
Member Services/Customer Service Department	Phone: 1-855-481-0505 Fax: 1-855-481-0606
Utilization Management Department	Phone: 1-855-481-0505 Fax: 1-855-481-0606
DME Intake Department	Phone: 1-855-481-0505 Fax: 1-855-481-0606
Home Health Intake Department	Phone: 1-855-481-0505 Fax: 1-855-481-0606
Claims Department	Phone: 1-855-481-0505 Fax: 786-594-3029 Email: Claims@ccsi.care
Grievance & Appeals Department	Phone: 1-855-481-0505 Fax: 786-594-3028
Compliance Officer	Phone:1-855-481-0202 Fax: 786-594-3027 Email: gruiz@ccsi.care

Frequently Asked Questions

Listed below are Frequently Asked Questions (FAQs)

What impact, if any, will this have on providers?

This program does not eliminate any current providers from WellCare and StayWell's provider network. The program is designed to provide a uniform, outcome-based set of criteria for the provision of DME and home health services. Providers will be required to contact Coastal for precertification and claims payment.

Providers not currently in Coastal's network are encouraged to contact Coastal's Network Manager about participation.

Telephone – 833-204-4535
Email – ProviderRelations@ccsi.care

What services does this include?

The following services are included:

Home Health Services:

- Skilled Nursing
- Wound Care Program
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Social Worker
- Home Care Aide
- Patient Education & Training
- Medication Management

DME Services:

- Standard Wheelchairs
- Oxygen, CPAP
- Ambulatory Aides
- Hospital Beds
- Power Operated Vehicles

- Ostomy Supplies
- Wound Care Supplies
- Respiratory Devices

What services are not included?

The following services are not included in this program:

- Orthotics & Prosthetics
- Home Infusion
- Bone Growth Stimulators
- Speech Generating Devices
- Specialty Bed (i.e. Clinitron)
- Wound Vac Systems
- Implantable Devices
- Life Vest Defibrillator
- Transplant Related services
- Mental Home Health Services
- High Frequency Chest Wall Oscillation
- ESRD Related Services

What is Coastal's role in the authorization process?

WellCare/StayWell has delegated utilization management responsibilities for home health services and DME services to Coastal for delegated membership. Coastal's scope of responsibilities includes the management of the prior and concurrent authorization process for these services in accordance with the health plan's medical polices and clinical utilization management guidelines.

What is Coastal's role in the claims process?

WellCare/StayWell has delegated claims processing for home health services and DME services to Coastal for delegated membership. All claims for DME and home health services in the delegated service areas, should be submitted to Coastal for dates of service beginning 3/1/2018. Claims for dates of service prior to 3/1/2018, are to be submitted to WellCare/Staywell.

How is the servicing provider selected?

Coastal will contact the member and inquire if the member has previously received services. If so, with which provider, and inquire if the member has a preference for a specific provider. The provider which best meets the member's needs, contractual and regulatory requirements, is identified and contacted.

What documentation is required for submission on an initial authorization?

For an initial authorization, at a minimum, a signed MD order, clinical documentation, patient demographics and any additional notes.

Who will be reviewing my request?

Requests requiring medical necessity review will be reviewed by licensed personnel and professionals with experience in home health and DME services.

How do I check the status of an authorization?

Providers can check the status of an authorization via the Provider Portal or phone at 855-481-0505.

How will I find out about the decision?

Providers will receive a fax of the determination regardless if the request was submitted through the portal or not.

When a member has a change of condition or there is a hospital readmission, who should be contacted?

Please contact Coastal to notify us of the hospitalization or clinical complications.

Can I provide services prior to authorization?

If you provide services to a member prior to Coastal's authorization determination, please be advised that your authorization request may not be approved and your claim may not be paid.

What about members currently receiving services?

Any member, whose services will continue after 3/1/2018 will need a Coastal authorization. Coastal will begin issuing authorizations for these members beginning 2/15/2018. We will ensure providers have Coastal authorizations by 3/1/2018 so there is no gap in care and ensure a smooth transition.

What rates will be reimbursed for services?

Providers will be reimbursed according to their Coastal contract. For providers not currently in Coastal's network, Coastal will process claims according to their WellCare/StayWell contracts.

What if we do not want to join Coastal's Network?

We encourage you to join Coastal's network to continue providing services to our members. If you do decide not to join Coastal 's network, your organization will no longer receive authorizations for Home Health or DME services. Please continue to provide services to members throughout the Continuity of Care periods identified below:

- Staywell (MMA): 60 days after Coastal Care effective date
- Staywell Kids: 30 days after Coastal Care effective date
- Medicare: 60 days after Coastal Care effective date