COASTAL CARE SERVICES, INC.®

member quality redefined.

Provider Manual

Florida Medicaid & Health Kids

2026

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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. (Coastal). We are pleased to have you as a participating provider in our network and look forward to partnering with you to coordinate and deliver high-quality home care services to the members of our health plan partners.

Coastal is a leader in healthcare solutions, partnering with health plans to ensure members receive high-quality, patient-centered care through the coordination and management of home-based ancillary services. Our core service lines include Durable Medical Equipment and Supplies (DME), Home Health, and Home Infusion services. As a participating provider, you play a vital role in achieving our mission of delivering accessible, efficient, and exceptional care.

This Provider Manual serves as a comprehensive guide to our programs, policies, and operational procedures. To request a copy of this manual, please contact our Provider Relations Department at 855-481-0505 or email providerrelations@ccsi.care. A complimentary copy will be provided upon request.

Once again, welcome to the Coastal's network. We appreciate your commitment and look forward to a successful partnership.

Use of This Provider Manual

This Provider Manual is intended to serve as a reference guide and does not represent a complete statement of all policies and procedures. Coastal may issue additional policies or procedural updates through our website or provider portal that are not included in this manual.

This manual applies to participating Medicaid and Healthy Kids providers and outlines the policies and procedures governing the administration of Coastal's Medicaid and Healthy Kids plans. It supplements and forms part of the Provider Agreement between Coastal and the participating provider.

Policies and regulatory requirements may change periodically. As updates occur, revisions to this manual will be posted on our website. In the event of material changes, Coastal will make reasonable efforts to notify participating providers in advance via website postings, email or fax communications, and/or the provider portal.

An updated version of the Provider Manual will be made available annually to all contracted providers at www.ccsi.care.

This manual may include sample forms designed to assist providers in fulfilling their contractual obligations. Providers currently using equivalent forms that meet contractual and regulatory requirements may continue to use those forms without modification, unless explicitly informed otherwise.

Important Contact Information

Phone/Fax/Mail

Department	Contact Information
Provider Relations Department	Phone:1-855-481-0505 ext. 1904 Fax:1-855-481-0606 Email: ProviderRelations@ccsi.care
Credentialing Department	Phone: 1-855-481-0505 ext. 1903 Fax:1-855-481-0606 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 ext. 1906 Fax:1-855-481-0606 Email: Claims@ccsi.care
Provider Grievance & Appeals Department (Administrative appeals)	Phone: 1-855-481-0505 Fax:1-855-481-0606
Compliance Officer	Phone:1-855-481-0202 Email: compliance@ccsi.care

Hours of Operation

Standard Business Hours of Operation: **8:00am to 8:00pm**
Available 24 hours a day, 7 days a week.

After Hours

Coastal maintains on-call personnel outside of regular business hours, including weekends and holidays, to ensure continuous availability 24 hours a day, seven days a week.

Medicaid in Florida

Medicaid is a joint federal and state program that provides essential health coverage to eligible low-income individuals and families. The program is designed to improve access to healthcare services and promote better health outcomes for populations that may otherwise face barriers to care.

In 2011, the Florida Legislature established the Statewide Medicaid Managed Care (SMMC) program as a comprehensive, integrated managed care system encompassing all covered Medicaid services, including long-term care. The SMMC program is administered by the Florida Agency for Health Care Administration (AHCA), and the majority of Florida Medicaid recipients are enrolled in one of its managed care plans.

The SMMC program consists of three primary components:

1. Managed Medical Assistance (MMA): Provides primary and acute care services.
2. Long-Term Care (LTC): Delivers long-term services and supports to eligible recipients.
3. Dental Program: Ensures access to comprehensive dental services for Medicaid recipients.

Coastal operates as a Third-Party Administrator (TPA) and is committed to facilitating the delivery of high-quality healthcare services to Health Plan members. Coastal collaborates with multiple Medicaid Health Plans across the State of Florida that have been authorized by AHCA to provide Medicaid services.

Covered services administered by Coastal vary by Health Plan contract. For detailed information regarding covered services by Health Plan, please refer to Appendix A. Of the minimum required Medicaid benefits established by AHCA, below are the services Coastal may cover:

- Durable Medical Equipment and Medical Supplies: Rule 59G-4.070
- Home Health Services: Rule 59G-4.130
- Occupational Therapy Services: Rule 59G-4.318
- Personal Care Services: Rule 59G-4.215
- Physical Therapy Services: Rule 59G-4.320
- Private Duty Nursing Services: Rule 59G-4.261
- Provider Reimbursement Schedules and Billing Codes: Rule 59G-4.002
- Respiratory Therapy Services: Rule 59G-4.322
- Speech-Language Pathology Services: Rule 59G-4.324

Healthy Kids Program

Florida Healthy Kids is one of four programs under Florida KidCare children's health insurance program. Florida Healthy Kids provides access to health care for school age children 5-18 years of age that meet established eligibility guidelines such as citizenship, not be in a public institution, and income.

The Florida Healthy Kids Corporation is responsible for:

- Administering the Florida Healthy Kids program for children ages 5 through 18.
- Determining eligibility for the non-Medicaid parts of the Florida KidCare program.
- Collect monthly premiums.
- Managing the Florida KidCare customer service call center

Florida Healthy Kids Corporation holds the contract for the Plan which outlines policies, procedures, and programs to promote access to quality medical, behavioral, and therapeutic services for Florida Healthy Kids recipients. For additional information regarding the Florida Healthy Kids program visit, www.healthykids.org.

About Coastal Care Services, Inc (Coastal)

Coastal serves as a Third-Party Administrator (TPA) and a healthcare solutions leader dedicated to managing and coordinating high-quality, patient-centered care. Through strategic partnerships with Health Plans, Coastal delivers “high-touch” service by coordinating and managing home-based ancillary services, including Durable Medical Equipment (DME) and supplies, Home Health, Home Infusion, and post-acute transitions of care.

Coastal partners with multiple Health Plans across the State of Florida and supports a range of Medicaid and Florida Healthy Kids products, including:

- Managed Medical Assistance (MMA)
- Child Welfare Specialty Plan (CWSP)
- Serious Mental Illness Specialty Plan (SMI)
- Comprehensive (includes MMA and Long-Term Care Services)
- HIV/AIDS Specialty Plan (HIV)
- Children’s Medical Services (CMS)
- Florida Healthy Kids Title XIX (Medicaid)
- Florida Healthy Kids Tittle XXI (CHIP)

Organizational Principles

Coastal is committed to coordinating high-quality, comprehensive home-based services that improve patient outcomes. This commitment is achieved through collaborative partnerships with providers who deliver services to members and share Coastal’s mission of promoting healthier outcomes through effective, patient-centered care delivery.

Coastal adheres to the principle that services should be delivered at the least restrictive level of care appropriate to meet each member’s individual needs. Determinations of medical necessity are based on a thorough, individualized assessment to ensure optimal outcomes.

To support these objectives, Coastal operates in alignment with the following core principles:

- Establish and maintain strong local partnerships with providers to support accessible, community-based care.
- Promote open, consistent, and two-way communication
- Encourage collaboration
- Support innovation and continuous improvement
- Uphold the highest standards of ethical conduct
- Treat all individuals with respect, dignity, and compassion

Coastal recognizes that high-quality healthcare is most effectively delivered at the local level and that successful managed care relies on the provision of medically necessary services in the most appropriate setting. Accordingly, Coastal is committed to ensuring access to high-quality, culturally competent care through collaborative relationships with ancillary providers.

Coastal's programs, policies, and procedures are designed to:

- Promote quality, continuity, and appropriateness of care
- Ensure services are delivered in the most appropriate, least restrictive setting to achieve optimal outcomes
- Support member and provider satisfaction
- Ensure cost-effective administration of covered benefits

Coastal supports open communication between providers and members regarding all appropriate and medically necessary treatment options. Providers are not restricted or penalized for discussing treatment alternatives or advocating for the care that best meets the member's needs.

Coastal conducts all business activities in accordance with applicable federal and state laws and adheres to established standards of ethical business conduct. The organization is committed to safeguarding the privacy and confidentiality of member health information and maintains full compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as all applicable state privacy regulations.

In addition, Coastal complies with Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age, or disability. This includes protections against discrimination related to sex, including pregnancy, childbirth, and related medical conditions. Coastal ensures that all programs and services are administered in a nondiscriminatory manner consistent with these requirements.

Informational Tools for Providers

To keep our providers updated on new programs, requirements, and policies, Coastal utilizes a variety of communication tools:

- Communications sent via mail, email or fax
- New provider orientation

- Secure Provider Portal to manage claims and authorizations
- Web-based materials, provider manual and other provider resources, including policies and procedures on www.ccsi.care.
- Web-based trainings

Website

Providers can visit Coastal's website at www.ccsi.care to find information about policies, processes, trainings and quality programs. In addition, providers may:

- Access frequently used forms
- Access Provider Manual
- Access Practice Guidelines
- Access Provider Trainings
- Access Provider Alerts
- Access billing and claims Quick Reference Guides (QRGs)

Secure Provider Portal

Coastal allows providers and their office staff to register for the Secure Provider Portal by sending a request for access to ProviderRelations@ccsi.care. Email request should include full name, title, and email of the provider staff needing access to our portal.

On the secure site, providers can use tools that make obtaining and sharing information seamless. Through the secure site, providers can:

- Submit claims and check claim status
- Submit claim reconsiderations
- Resubmit claim adjustment and reconsideration for payments online
- Submit attachments for claims and resubmitted claims for payment reconsiderations and primary payer information for secondary payment
- Submit prior authorization requests

Cultural Competency

Coastal is committed to ensuring that all members receive care in a culturally and linguistically appropriate manner. Recognizing that respect for diversity positively impacts health outcomes, Coastal aligns its practices with the **Culturally and Linguistically Appropriate Services (CLAS) Standards** established by the Office of Minority Health (OMH) within the U.S. Department of Health and Human Services (HHS).

To effectively serve a diverse membership, Coastal employs staff who are proficient in languages commonly spoken by its members and who demonstrate an understanding of varied cultural backgrounds. In addition, interpreter services are made available to support communication between members, providers, and Coastal staff.

The Provider Network Team conducts an annual assessment of members' cultural, ethnic, racial, and linguistic needs by analyzing both internal and external data sources. This analysis includes comparing member demographics with provider network composition to ensure alignment and identify opportunities to enhance network diversity. Findings from this assessment are used to strengthen the network and improve access to culturally competent care.

All newly credentialed providers are invited to participate in orientation, which includes training on cultural competency and sensitivity to support the delivery of inclusive, patient-centered care.

Provider Support for Cultural and Linguistic Needs

Coastal Customer Service representatives are available to assist providers in coordinating language services for members. Available services include:

- Coordinating three-way calls with a qualified interpreter
- Communicating member-specific needs to the interpreter service vendor

Interpreter Services
Coastal provides telephonic interpreter services through a contracted vendor at no cost to members or participating providers. These services include both foreign language and sign language interpretation.

Providers may access interpreter services by contacting Customer Service at **1-855-481-0505**. For individuals who are hearing impaired, Telecommunications Relay Service (TTY/TDD) is available by dialing **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 via the FLMMIS portal

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

Continuity of Care for New Members

Coastal coordinates services for all newly enrolled members to ensure uninterrupted access to care. This process supports continuity for members with existing prior authorizations or those actively receiving treatment at the time of enrollment, including services previously authorized with non-participating providers.

The continuity-of-care (COC) period for new members is up to **120 days**, during which Coastal will honor existing treatment plans, as appropriate.

Continuity of Care Following Provider Termination

Providers who terminate their participation with Coastal are required to continue delivering medically necessary services to assigned members for a minimum of **60 days** following the effective date of termination, regardless of line of business.

Coastal allows members to continue receiving medically necessary services from providers who have been terminated without cause. During this period, Coastal will continue to reimburse claims for covered services for at least **60 days**, or until the member transitions to another participating provider, whichever occurs first.

In cases of provider termination, Coastal will issue the necessary prior authorizations to ensure continuity of care for affected members.

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, Rights & Responsibilities:

Contracted providers are responsible for providing and managing healthcare services for members as determined by medical necessity criteria. In addition, providers are responsible to:

- ***Notify Coastal in writing of any of these changes*:**
    - Changes in practice ownership, name, address, phone, national provider identifier (NPI) or federal tax identification numbers
    - Loss or suspension of the provider's license to practice
    - Bankruptcy or insolvency
    - Suspension, exclusion, debarment or other sanction from a state or federally funded health care programs
    - Indictment, arrest or conviction for a felony or any criminal charge related to the provider or its owners.
    - Material changes in cancellation or termination of liability insurance
    - The closing of services to new patients and vice versa
    - When terminating affiliation with Coastal
- ***Not bill or balance bill members*:** Providers have a responsibility not to bill or balance bill Medicaid recipients for covered services regardless of whether they believe the amount of money they have been or will be paid by Coastal is appropriate or sufficient.
- ***Participate in quality improvement programs*:** Providers are expected to actively collaborate with Coastal in quality improvement initiatives and participate in activities necessary to meet regulatory requirements and fulfill contractual obligations.
- ***Not discriminate*:** Providers have a responsibility to provide optimal care to members without regard to age, race, gender, religious background, national origin, disability, sexual orientation, source of payment, veteran status, claims experience, social status, health status or marital status.
- ***Supply members with complete and accurate information*:** Providers have a responsibility to give members complete and accurate information concerning a

diagnosis, treatment plan, or prognosis in terms they can understand (eliminating both language and cultural barriers) and without regard to plan coverage; to inform members of non-covered treatments or services and their cost prior to rendering them; and to advise members of their right to contact their health plan if they have concerns about a non-covered service or wish to file a grievance or appeal.

- ***Inform members about advance directives*:** Providers have a responsibility to inform members about their right to have an advance directive and provide written information on state law about members' rights to accept or refuse treatment and the provider's own policies regarding advance directives. Providers must document in the member's medical record any results of a discussion on advance directives and include a copy of the advance directive in the patient file if a member has or completes one.
- ***Maintain medical records*:** As a part of Coastal's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices. Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. The Member's medical record (hard copy or electronic) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Coastal's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.
- ***Submit claims*:** Providers have a responsibility to submit complete and accurate claims for their services that conform to Medicaid requirements within the time frames outlined in their contract and to provide Coastal with supporting documentation when required to support a claim accordance with state and federal regulations; and maintaining a current patient signature of consent. Medical records should be complete and legible and follow standard practices.
- ***Provide care*:** Providers have a responsibility to provide care within their scope of practice. Providers also should identify any member who requires translation, interpretation or sign language services and call Sunshine Health to arrange for such services.
- ***Maintain confidentiality:*** Providers have a responsibility to keep members' protected health information (PHI) strictly confidential in compliance with Health Insurance Portability and Accountability Act (HIPAA) standards and to provide necessary member PHI to Coastal, also in compliance with HIPAA standards, when required for payment, treatment, quality assurance, regulatory, data collection and reporting activities. Providers are responsible to contact Coastal's Compliance Officer when a HIPPA violation occurs.
- ***Participate in utilization management*:** Providers have a responsibility to conform to Coastal's referral and prior authorization policies and procedures as they relate to services provided and to cooperate with utilization management staff in providing the necessary documentation or medical information. Clinical documentation necessary to complete medical review and decision making is to be submitted to Coastal within 24 hours of request
- ***Provide continuity of care following provider termination*:** Providers who are terminating their affiliation with Coastal have a responsibility to provide medically necessary care for members at least 60 days following their termination date. Providers must adhere to the termination information included in the Agreement as well as the following terms:

- For providers wishing to terminate their agreement without cause, a 90-day prior written notice is required.
- Unless otherwise provided in the termination notice, the effective date of the termination will be on the last day of the month.
- For active members that require treatment past the termination effective date, provider may continue to service members for 60 days but not exceed six (6) months after the termination date.

- ***Report any adverse or critical incidents*****:** Providers are responsible for reporting to any critical or adverse incidents that negatively impact the health, safety or welfare of a member. Such incidents may include abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement or major medication errors.
- ***Report Abuse, Neglect or Exploitation*****:** Providers are responsible for immediately reporting knowledge or reasonable suspicion of abuse, neglect or exploitation of a child, aged person or disabled adult to the Florida Abuse Hotline via the statewide toll-free telephone number (1-800-962-2873 or TTY 711/1-800-955-8771) or via the online Reporter Portal. Providers are also responsible for ensuring that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation. Providers should refer victims of domestic violence to the National Domestic Violence Network Hotline at 1-800-799-7233 or to use the text and chat features at thehotline.org to seek information about local domestic violence programs and shelters in Florida.
- ***Participate in training***: Providers are responsible for participating in training as mandated by regulatory authorities and/or Coastal.
- ***Member Rights and Responsibilities:*** Providers are required comply with the Member Rights and Responsibilities as outlined in Member materials (such as Member Handbooks) distributed by each Health Plan that Coastal contracts with.
- ***Participation in Utilization Review and Care Management Programs:*** Providers are required to participate in and comply with Coastal's utilization review and Care Management programs, including all policies and procedures regarding prior authorizations. This includes the use of an electronic solution for the submission of documentation required for medical review and decision making. Providers will also cooperate with Coastal in audits to identify, confirm, and/or assess utilization levels of covered services.
- ***Access to Care Standards:*** Coastal is committed to providing timely access to care for all Members in a safe and healthy environment. Coastal will ensure Providers offer hours of operation no less than offered to commercial Members. Access standards have been developed to ensure that all health care services are provided in a timely manner.
- ***Delivery of Patient Care Information:*** Providers must comply with all State and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Coastal for use in conjunction with utilization review and management, grievances, peer review, Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Coastal and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction.
- ***Compliance:*** Providers must comply with all State and Federal Laws and regulations related to the care and management of Coastal Members.
- ***Confidentiality of Member Health Information and HIPAA Transactions:*** Coastal requires that its contracted Providers respect the privacy of Members and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

Additionally, Providers must comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations.

- ***Participation in Grievance and Appeals Programs:*** Providers are required to participate in Grievance Program and cooperate with Coastal in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member appeals, the Provider will participate by providing medical records or statement if needed.
- ***Participation in Credentialing***: Providers are required to participate in Coastal's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Coastal. This includes providing prompt responses to requests for information related to the credentialing or re-credentialing process.
    - Providers must notify Coastal no less than thirty (30) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the Provider's re-credentialing date.

Identifying and Reporting Abuse or Neglect

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child (including human trafficking), aged person, or disabled adult to the Florida Abuse Hotline. It is the provider's responsibility to ensure that they and their staff are aware and been trained that they are mandated to report abuse, neglect and exploitation.

Florida state law requires reporting by any person if they have "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse." Providers are to report any suspected child abuse or neglect immediately to children's services in the appropriate county. Reporting can be done anonymously. Providers are also to report any injuries from firearms and other weapons to law enforcement.

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 TTY 71 or 1-800-955-8771 OR
- Complaint Form online:
  https://reportabuse.dcf.state.fl.us/Child/ChildForm.aspx
  https://reportabuse.dcf.state.fl.us/Adult/AdultForm.aspx
- Report suspected abuse online at https://reportabuse.dcf.state.fl.us

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.

Identifying and Reporting Critical Events

Coastal requires its providers and direct service providers to report adverse or critical incidents to Coastal. Providers are required to report critical incidents immediately to ensure reporting of such critical incidents to AHCA within twenty- four (24) hours of the incident. Immediate notification of the incident can be reported by these methods:

- Calling 1-855-481-0505 (24/7)
- Sending fax to 1-855-481-0606
- Sending an email to QA@ccsi.care

Within 24 hours of the incident, an Incident Form must be submitted.

Critical incidents are events that negatively impact the health, safety or welfare of a member. Examples include:

- Death by suicide, homicide, abuse, neglect, or exploitation or otherwise unexpected
- Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or their preexisting physical condition
- Any condition resulting in transfer of the patient within or outside the facility to a unit providing a more acute level of care
- Suspected abuse, neglect or exploitation
- Any condition that results in limitation of neurological, physical or sensory functions which continues after discharge from the facility
- Medication errors
- Suicide attempts

Member Information and Marketing

Any written information or marketing materials directed to Members must be developed at a fourth-grade reading level and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Coastal prior to use. Please contact our Provider Relations Department for information and review of proposed materials.

Contracted Providers ***may not***:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Managed Care Plans or Coastal.
- Offer anything of value to induce recipients/enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in any Managed Care Plan.
- Accept compensation directly or indirectly from Managed Care Plans for marketing activities.
- Distribute marketing materials during delivery of services.
- Furnish to Managed Care Plans or Coastal lists of their Medicaid patients or the membership of any Managed Care Plan.

Contracted Providers ***may***:

- Provide the names of the Managed Care Plans with which they participate.
- Providers are permitted to make available and/or distribute Managed Care Plan marketing materials as long as the provider distributes or makes available marketing materials for all Managed Care Plans with which the provider participates.
- Providers may distribute printed information provided by the Managed Care Plans to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract. However, the Managed Care Plan shall ensure that:
    - Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information.
    - Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.
    - The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.

If a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates.

- Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
- To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
- Share information with patients from the Agency’s website or CMS’ website.
- Announce new or continuing affiliations with Managed Care Plans through general advertising (e.g., radio, television, websites).

- Make new affiliation announcements within the first thirty (30) calendar days of the new provider agreement.
- Make one announcement to patients of a new affiliation that names only the Managed Care Plans when such announcement is conveyed through direct mail, email, or phone.

Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.

Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.

Patient's Role & 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
- To refuse any treatment, except as otherwise provided by law.
- 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 receive information about Coastal, its services, its practitioners and providers and members' right and responsibilities.
- To make recommendations about Coastal's member rights and responsibilities policies
- To voice complaints or appeals about the organization or the care it provides
- 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)

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. The Credentialing Department is responsible for performing, tracking or monitoring all aspects of the credentialing and re-credentialing process under the purview of the Quality Management Department for providers joining or participating in the network. The credentialing process is designed to meet the State of Florida Requirements and NCQA Standards. In accordance with those standards, members will not be referred to a provider until the credentialing process has been completed.

Any provider meeting the definition of a "direct service provider" must complete a Level II criminal history background screening to determine whether the provider, or any employees or volunteers of the provider have disqualifying offenses as provided for in s. 430.0402 F.S. and s. 435.04, F.S. Direct service providers are persons eighteen (18) years of age or older who, pursuant to a program to provide services to the elderly or disabled, has direct, face-to-face contact with a client while providing services to the client and has access to the client's living areas, funds, personal property, or personal identification information as defined I s. 817.568, F.S. The term includes coordinators, managers, and supervisors of residential facilities and volunteers (see s. 430.0402(1)(b), F.S.)

Any provider, or any employees or volunteers of the provider who has a disqualifying offense is prohibited from contracting with Coastal.

Should your application be incomplete in any way, you will receive a request from Coastal to provide the needed information within a specified timeline.

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 Director
1200 NW 78th Avenue, Suite 100
Miami, FL 33126
Or Via Fax: 855-481-0606
Or Via Email: ProviderRelations@ccsi.care

Another convenient way to notify Coastal of changes is through our web portal via 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. 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.

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

You will receive a re-credentialing application approximately six (6) onths before your credentialing period is to expire. The format used is that of a “profile” and only information that may have changed since the last credentialing will be requested. We request that you verify the information and return it to us within the specified time frame. Failure to return the information will result in administrative termination from Coastal’s network as a non-compliant provider.

Information that is reviewed as part of the re-credentialing process includes:

- Verifying that our providers continue to meet the basic qualifications
- Information from reported quality performance issues, such as utilization data, member satisfaction surveys and customer service reports

Provider’s Right to Review

Providers have the right to review their credentials file at any time. The provider must notify the Credentialing Department in writing and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. The QI/Credentialing Director will be present. The Provider has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure. The only items in the file that may be copied are the application, the license and the DEA certificate. Providers may not copy documents that include pieces of information that are confidential in nature, such as the provider

credentialing checklist and the responses from monitoring organizations (i.e. NPDB, Department of Health/Medical Quality Assurance Commission).

Provider's Right to Notification and Correction of Erroneous Information

Coastal shall notify the provider immediately, in writing, in the event that Coastal receives information that conflicts with information given by the provider. Examples include, but are not limited to actions on a license; Medicare/Medicaid certification expirations. The notification shall detail the information in question.

The Provider must submit a written response to:

Coastal Care Services, Inc.
Attention: Credentialing Department
1200 NW 78th Avenue, Suite 100
Doral, FL 33126

This response must be sent by the provider within thirty (30) calendar days of receiving notification from Coastal. The notification shall detail the information in question. The provider must explain the discrepancy and may correct any erroneous information or provide any proof that may be available. If the provider does not respond within thirty (30) calendar days, application processing will be discontinued and network participation will be denied. Upon receipt of notification from the provider, Coastal will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the provider's file. The provider will be notified in writing that the correction has been made to the credentials file. If the primary source information remains inconsistent with providers' notification, the Credentialing Department will notify the provider. The provider may then provide proof of correction by the primary source body to Coastal's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

Providers Right to be informed of Application Status:

Providers have a right, upon request, to be informed of the status of their application. Providers applying for initial participation are sent a letter when their application is received by Coastal and are notified of their right to be informed of the status of their application in this letter. Providers are also notified of their right in the Provider Manual sent to them at the time of initial contracting. Providers can request to be informed of the status of their application by telephone, mail or email. Coastal will respond to the request within two (2) working days. Coastal may share with the provider the status of the application in the credentialing process. Coastal does not share with, or allow a provider to review references or recommendations, or other information that is peer-review protected.

Pursuant to section 1128 of the SSA, Coastal may not subcontract with an excluded provider/person. Coastal will terminate subcontracts immediately when Coastal becomes aware of such excluded provider/person or when Coastal receives notice from CMS or the Health Plan. Coastal certifies that neither it nor its providers are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Where Coastal is unable to certify any of the statements in this certification, Coastal will attach a written explanation to this Agreement.

Corrective Action, Fair Hearing Plan, and Reporting to the Florida Division of Medical Quality Assurance, Department of Health (Licensing Board) and the NPDB:

Providers have the procedural right to appeal in the event that PRC recommendations and actions result in filing a report to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB. The appeal right, Fair Hearing process, and the requirement to report to the Florida Division of Medical Quality Assurance, Department of Health and NPDB are described in Coastal's Fair Hearing Plan.

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

Provider Data Accuracy and Validation

It is important for Providers to ensure Coastal has accurate business information. Accurate information allows us to better support and serve our Provider Network and Health Plan partners. Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement. Invalid information can negatively impact Member access to care and member referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must notify Coastal in writing at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Change in Tax ID and/or NPI
- Any other information that may impact Member access to care

Please notify the Provider Relations department at: (855)481-0505 extension 8904 or via email at ProviderRelations@ccsi.care if your information needs to be updated or corrected.

Note: Some changes may impact credentialing. Providers are required to notify Coastal of changes to credentialing information in accordance with the requirements outlined in the Credentialing section of this Provider Manual.

Coastal is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-

back verification, etc. Providers are required to provide timely responses to such communications.

Utilization Management

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 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 Health Plan it contracts with, 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

Coastal only reimburses to services that are Medically Necessary. Coastal will use nationally recognized guidelines as well as other sources when making determinations, which include but are not limited to:

- InterQual
- Health Plan Clinical Coverage Guidelines
- Medical Necessity
- State Medicaid Contract
- State Provider Handbooks
- Medicaid and Medicare Guidelines

Medical criteria and guidelines are available to providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the UM Department.

Medical Necessity

Medical Necessity is defined as the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

UM Decision Making

Coastal, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

1. UM decision-making is based only on appropriateness of care and service and existence of coverage.
2. Coastal does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating providers or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.
3. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

Access to UM Staff

1. UM staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
2. Staff are available Monday through Friday between 8 a.m. and 8 p.m. Eastern time.
3. Staff can receive inbound communication regarding UM issues after normal business hours.
4. Staff is identified by first name/first initial of last name, title and organization name when initiating or returning calls regarding UM Issues.
5. TDD/TTY services are available by dialing 711.

OBTAINING AUTHORIZATIONS

Coastal requires Prior Authorizations for all services it manages. This includes authorizations for Medically Necessary services to Members under the age of 21 years when services are not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedules, or is not a covered service by the member's health plan; or if the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or fee schedules. Prior authorization requirements are designed to assure the medical necessity of service,

prevent unanticipated denials of coverage, ensure participating Providers are utilized and all services are provided at the appropriate level of care for the Member's needs.

A hard copy of the Referral Form is furnished to all participating providers upon credentialing and when revised, or upon request from a provider.

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 issues authorization in order for the service(s) to be rendered to the patient. All services require clinical review, assignment, and prior authorization. Coastal's referral authorization process confirms member eligibility, member benefits, that 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
    iii. Via Portal at web.ccsi.care
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 outlining 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.

e. 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.

The authorization process and the claim processing are closely linked. Claims are considered for payment based on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes and units authorized. Submission of accurate claims information in a timely manner is an essential part of the provider's role. The appropriate authorization number must be submitted on all claims. A claim submitted without an authorization number may be denied.

Providers are encouraged to use the Referral Form. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)

- Provider demographic information
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (Diagnosis Code and description)
- Clinical indications necessitating service or Referral
- Pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed

Pertinent data and information is required by the UM staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the authorization. Authorization is based on verification of Member eligibility and benefit coverage at the time of service. Claims payment is contingent on eligibility for date of service and appropriate coding and limitations.

Coastal will process any non-urgent requests within seven (7) working days after receiving adequate clinical information. Urgent requests will be processed within (48) hours. If a Referral has been previously approved, the provider may call Coastal directly to request an extension of services. Information generally required to support the decision-making process includes:

- Adequate patient history related to the requested services
- Physical examination that addresses the area of the request
- Relevant PCP and/or Specialist progress notes or consultations
- Any other relevant information or data specific to the request

Providers who request Prior Authorization approval for patient services may request to review the criteria used to make the final decision upon request by contacting the UM Department.

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

Home Infusion

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, if applicable.

REQUEST FOR ADDITIONAL SERVICES

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), HCPCS code(s), units and date ranges. The initial authorization number will remain in effect until the patient is discharged.

Home Medical Equipment & Supplies

All participating Durable Medical Equipment and Medical Supply providers are required to request re-authorization 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) HCPCS 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.

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.

Medical 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.

At a minimum, each medical record must be legible and maintained in detail with the following documentation:

- Identifying information of the member including name, Member identification number, date of birth, sex and legal guardianship (if applicable)
- Include all services provided; including nursing notes, delivery tickets, and proof of delivery.
- Dated and signed entries by the appropriate parties
- Name and profession of the provider rendering services
- Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services
- Information relating to the Member's use of tobacco products and alcohol/substance abuse
- Reflection of the primary language spoken by the member and any translation needs of the member
- Identification of member's need for communication assistance in the delivery of health care services
- Notes on any communications with the members or caregivers
- Copies of any Notice of Non-Coverage forms provided to members, if applicable.
- Documentation of Referral Services
- Entries dated and signed by appropriate party

Medical Record Retention

Medical records must be maintained for a period not less than ten (10) years from the close of the Provider Services Agreement, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Coastal if the Provider Services Agreement is continuous.

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
1200 NW 78th Avenue, Suite 100
Doral, FL 33126

Claims Submission

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. Claims must include the most recent ICD10 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.

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.

Coastal will return claims when billing information does not match the information in our files. Claims missing the below requirements will be returned, and a notice sent to the provider. Such claims are not considered "Clean" and therefore cannot be entered into the system.

Required Claims Information:

- Provider Name
- Member Demographics
- Provider National Provider Identifier (NPI)
- Referring Provider NPI
- Date of Service
- Place of Service (CMS 1500 forms only)
- Procedure Code
- Physical location address
- Billing name and address
- Tax Identification Number

We recommend that providers notify Coastal in advance of changes pertaining to billing information. Please submit this information on a W-9 form.

Providers must submit all claims within 180 days of the date of service, unless Coastal created the error. The filing limit may be extended for newborn claims and where the eligibility has been retroactively received by the Health Plan, up to a maximum of 365 days. For secondary claims, Coastal must receive the claim within 90 days of the final determination of the primary payer.

All requests for reconsideration or adjustment to paid claims must be received within 45 calendar days from the date the notification of payment or denial is received.

To expedite the correct processing of claims the appropriate information should be included on the claims form, in addition to the Coastal authorization number.

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).
    - 837P Professional claims.
- Paper – CMS 1500 Form.

- 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 quicker claims processing timeframes.

Paper Claims must be mailed to:
Coastal Care Services, Inc.
Attn: Claims Department
1200 NW 78th Avenue, Suite 100
Doral, FL 33126
Electronic Claims can be submitted through:
Change Healthcare
Payer ID# 47394
Telephone: 1-877-363-3666

REQUIRED ELEMENTS

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

- Participating providers must submit claims within 180 days of the date of service.
- Non-participating providers must submit claims within 365 days from the date of service.
- For third-party liability or coordination of benefits (COB) claims, the time filing limit is 6 months from the primary insurance explanation of benefits (EOB), or 12 months from date of service (DOS) for secondary claim submission, whichever is greater.
- For Medicare COB claims the time filing limit is 36 months from the DOS or 12 months from the Medicare EOB, whichever is greater. Medicare crossover claims shall not deny solely based on the date span between DOS and the date a clean claim was received, unless this period exceeds 3 years.
- 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 recognized 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 of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Disclosure of any other known health benefit plans.
- E-signature.
- Service facility location.

CLEAN CLAIM

A clean claim is a claim received by Coastal for adjudication in a nationally accepted format in compliance with standard coding guidelines 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.

COORDINATION OF BENEFITS (COB) & THIRD PARTY LIABILITIES (TPL)

Third party liability refers to any other health insurance plan or program that is or may be liable to pay all or part of the health care expenses of the member.

Medicaid is always the payer of last resort and providers shall make every effort to determine the legal liability of third parties to pay for services furnished. If third party liability can be established, providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Coastal for secondary claims processing. Providers must submit secondary claims with attachments, including the primary EOB, and any other pertinent required documents.

If payment is rendered prior to establishing third party liability, an overpayment notification letter will be sent to the provider requesting a refund including third party liability information required for billing.

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.

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Common Billing Errors

In order to avoid rejected claims, please remember the following:

- Always bill the primary diagnosis code in the first field.
- Use SPECIFIC CPT4 or HCPCS codes.
- Avoid the use of non-specific.
- Use the most current CPT4/HCPCS codes.
- Use the 4th or 5th digit when required for all ICD-10 codes.
- Ensure the member's information is complete and accurate
- Ensure all provider information (Tax ID, NPI, Billing address, etc.) is accurate and matches the information in our system.
- Submit the National Drug Code (NDC) in the appropriate fields for all pharmacy claims.

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."
    - Complete box 22 (Resubmission Code) with one of the following qualifier codes:
        - "7" to notify us of a corrected or replacement claim
        - "8" to notify us you are voiding a previously submitted claim.
        - Enter Coastal's "original" claim number as the Original Ref. No. if available.
- 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:
    - "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 "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 how 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) and Electronic Remittance Advice (ERA). Providers will receive payment faster than through a paper check. There is no cost to the Provider for EFT enrollment. Providers emrp;;ed om EFT payments will auto maticlaly receive ERAs as well.

Coastal uses a vendor to facilitate the HIPAA compliant EFT and ERA delivery processes. We have partnered with ECHO Health, Inc. (ECHO), for payment and 835 processing. On the ECHO platrform you have the ability to receive your payments via EFT/Automated Clearing House (ACH), a physical check, or a virtual card.

Please note that by default,if you do not have a payment preference specified on the ECHO platform, your payments will be issued as a virtual card. This method may include a fee tat is established between you and your merchant agreement and is not charged by Coastal or ECHO. You may opt out of this payment option and request payment be reissued at any time by following the instructions on your Explanation of Payment (EOP) or by contacting ECHO Customer Service at 888-834-3511 or edi@echohealthinc.com. Once a payment preference has been selected, all future payments will be sent in your preferred payment method.

Coastal's EFT provider is Change Healthcare/ECHO Helath Inc. To register for EFT, provider will need the following:

- Last Coastal Check*
- Name of the bank institution
- Bank routing number
- Bank account number
- Provider NPI
- Provider Tax ID
- Provider billing address (pay to address)
- Voided Check

*Providers must have received at least one paper check prior to enrolling for EFT. The paper check will include instructions on how to enroll throuch ECHO Health Inc.

For additional information on enrolling for EFT payments, please contact our Provider Relations Department at providerrelations@ccsi.care.

Claim Disputes

If your claim was denied in whole or part, you have the right to request a review. Providers are allowed 90 days from the date of final determination of the primary payer to file a complaint for claims issues. Coastal will accept complaints in either written or oral format. This involves a dispute where the provider disagrees with the amount of a payment or a non-payment of a claim due to administrative reasons (time filing, pricing, eligibility, contractual rates, etc). This is not based on medical necessity or clinical criteria. Administrative complaints are reviewed by a Coastal associate who was not involved in the initial decision.

A Claims Dispute form must be sent for each claim, and all necessary legible documentation should be submitted with each complaint to allow Coastal to do a thorough review of the case complaint forms can be downloaded from our website).

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

Website: www.ccsi.care

Please mail claims to: Coastal Care Services Inc.
1200 NW 78th Avenue, Suite 100
Doral, FL 33126

Claims Customer Service: 1-855-481-0505
Claims Fax: 1-855-481-0606

Corrected claims:
Claims Manager
Attn: Corrected Claims
Coastal Care Services Inc.
1200 NW 78th Avenue, Suite 100
Doral, FL 33126

Claims Disputes:
Coastal Care Services Inc.
Attn: Claims Reconsideration
1200 NW 78th Avenue, Suite 100
Doral, FL 33126

Note: Please remember that according to your provider agreement, you are not allowed to bill the member on claims for covered services.

Providers are notified (in writing) within three (3) business days of receipt of a complaint that the complaint has been received and the expected date of resolution. Coastal resolves claim related complaints within 30 days of receipt.

Providers are notified why a complaint is unresolved after 15 days of receipt and provide written notice of the status to the provider every 15 days thereafter.

Written notice of the disposition and the basis of the resolution is sent to providers within three (3) business days of resolution.

Coastal maintains a record of all complaints within the provider complaint system. Complaints are reported to the agency within thirty (30) calendar days after the end of the reporting month. Complaint reporting details the nature of the complaint, timeline of the complaint, as well as the resolution.

Coastal utilizes the Agency's contracted dispute resolution vendor, as described in s. 408.7057, F.S., for managing, addressing, and resolving provider complaints related to claims issues. The process will be in compliance with s. 641.3155, F.S. Coastal will comply with all terms and conditions set forth in any orders and instructions issued by the Agency or its designee as a result of the claim dispute resolution process.

All forms can be downloaded from the Coastal website at http://www.ccsi.care/providers/

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.

Co-payment Provision

If Co-payments are waived as an expanded benefit, Providers must not charge Members co-payments for Covered Services. If co-payments are not waived, the amount paid to Providers by Coastal will be the contracted amount, less any applicable co-payments. Members under the age of 21 and pregnant women are not required to pay co-payments.

Electronic Visit Verification (EVV)

In accordance with CMS regulations, the delivery of all home helaht services to Medicaid members must be electronically verified.

Below is a list of which EVV platform each MCO uses:

- Sunshine Health – HHAx
- Molina Healh plan of Florida – HHAx
- Community Care Plan – CCSI

Providers must maintain a minimum of an 85% compliance rate.

All manually submitted visits will be denied. However, some exceptions apply.

A provider is allowed to appeal any claim under certain circumstances. For claims denied due to visit not being electronically verified. The only allowed exceptions will be the following:

- Natural disaster or system outage
- Caregiver was filling in for regularly scheduled caregiver as was not able to use EVV platform
- Provider is not loaded in the EVV platform
- Continuity of Care
- Authorization was not entered in the EVV platform timely
- Providers who have reported EVV barriers

Nursing notes/attendant logs must be provided for all services that are not electronically verified.

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 Services

Providers may contact the appropriate departments at Coastal by referencing the "Important Contact Information" section on page 5 of this manual. Provider Relations representatives are available to assist Providers with their requests.

Provider Relations representatives will conduct initial and ongoing training in order to ensure compliance with program standards and contractual obligations. Provider trainings may be accomplished by provider orientations, emails, faxes, letters, on-site trainings, webinars or other means.
Initial orientation of providers will be performed within 30 days of placing a newly contracted provider in active status. During the orientation the following topics will be discussed:

- Coastal Health Plan partners
- Covered Services by Coastal
- Rights and Responsibilities
- Member Care and Quality
- Authorizations
- Coastal's Compliance Program
- Billing and Payment
- Electronic Visit Verification (EVV), for Home Health Providers only
- Appeals and Grievances
- Continuity of Care

Ongoing training will be provided as deemed necessary and meet the requirements outlined by Coastal or the State Medicaid contract in order to ensure compliance with program standards.

Provider Relations representatives are available to provide training on an ad hoc basis when requested by a Provider.

Provider Administrative Overview

This section is an overview of guidelines for which all Medicaid and Healthy Kids participating providers are accountable. Participating providers must, in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
- Agree to cooperate with Coastal in its efforts to monitor compliance with approved AHCA and Florida Healthy Kids Corporation (FHKC) rules and regulations, and assist in

complying with corrective action plans necessary to comply with such rules and regulations.
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to members as required by State and Federal laws.
- Provide Covered Services in a manner consistent with Professional recognized standards [42 C.F.R § 422.504(a)(3)(iii).]
- Maintain the confidentiality of Member information and records
- Allow Coastal to use Provider performance data for quality improvement activities
- Respond promptly to Coastal requests for medical records in order to comply with regulatory requirements
- Maintain accurate medical records
- Not discriminate in any manner between Coastal members and non-Coastal members
- Ensure that the hours of operation offered is no less than those offered to commercial members or comparable Medicaid Fee-For Service recipients.
- Not deny, limit or condition the furnishing or treatment to any member in the basis of any factor that is related to health status, including but limited to:
    - Medical condition, including mental and physical illness
    - Claims experience
    - Medical History
    - Genetic information
    - Evidence of insurability

Provider Complaints

Coastal's Provider Complaints Process permits providers to dispute Coastal's policies, procedures, or any administrative function, including proposed actions, and claims/billing disputes. Coastal is committed to the timely resolution of all provider complaints.

Disagreements regarding claims is considered a Claims Dispute. Please see section on "Claims Dispute" for further information.

Coastal does not deny services. If you have a complaint or do not agree with the determination regarding denial of services/authorizations, please follow the member's health plan appeal policies. Please refer to the individual plan's Provider Training Tool found at www.ccsi.care/providers.

Provider Complaints Not Related to Claims

Providers have forty-five (45) days to file a written complaint that is not related to claims. An acknowledgment letter will be mailed within three (3) business days of receipt of the complaint. Thereafter a written notice of the status of your request will be mailed every fifteen (15) days until the case is resolved. Providers will be notified of Coastal's decision in writing within thirty (30) days of receipt and provided written notice of the disposition and basis of the resolution within three (3) business days of the resolution.

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
- Fax by sending to 1-855-481-0606
- Email to ProviderRelations@ccsi.care
- By mail or in person at: 1200 NW 78th Avenue, Suite 100, Doral, FL 33126

Member Complaints, Grievances and Appeals

Members and Member's personal representatives have the right to file a complaint, grievance, and appeal through a formal process. Coastal is currently not delegated for Member Services. Please refer to the Member's Health Plan for instructions on the Grievance and Appeals Process.

Providers can also contact the Provider Relations department for further information or contact Coastal Customer Service Department for a warm transfer to the member's Health Plan.

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 **IT 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

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable Coastal to carry out its commitment to ongoing improvement of the services it provides to health plans and its members. The QIP assists Coastal to achieve these goals through an evolving program that is responsive to the changing needs of Coastal's clients and members, and the standards required by regulatory and accrediting bodies. The identified goals are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Quality Improvement Program Goals

- Design and maintain programs that improve the service outcomes
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, Member satisfaction and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health services provided to Members.
- Through ongoing and systematic monitoring, interventions and evaluation improve Coastal's structure, process, and outcomes.
- Using feedback from stakeholders, improve reporting methods to make information available, relevant and timely.

- Facilitate organizational efforts to achieve and maintain regulatory compliance and to continually review practices to ensure compliance with standards and contractual requirements.
- Identify and track adverse or critical incidents and review and analyze adverse or critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues.

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 786-594-3027, or email to Compliance@ccsi.care. For direct reporting of suspected fraud or abuse, please use one of the following avenues below:

- Agency for Health Care Administration Hotline: 1-888-419-3456 OR
- Florida Attorney General's Office: 1-866-966-7226 OR
- The Florida Medicaid Program Integrity Office – 1-850-412-4600

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:

- **Deficit Reduction Act**

The Deficit Reduction Act of 2005 (DRA), effective January 1st, 2007, requires all entities that receive $5 million or more in annual Medicaid payments to establish written policies that provide detailed information about the federal False Claims Act; the administrative remedies for false claims and statements; applicable state laws that provide civil or criminal penalties for making false claims and statements; the whistleblower protections afforded under such laws, and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

- **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.

- **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.

- **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

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 where notification of the activation of our Business Continuation Plan should be sent.

Appendix

A. Health Plan Partners
B. Notice of Privacy Practice

APPENDIX A: HEALTH PLAN PARTNERS

Coastal is contracted with several health plans throughout Florida, but our contracts differ from plan to plan. We have provided a breakdown on each of these contracts below. Please ensure that only claims for services specifically listed for each plan below is billed to Coastal in order to avoid claims rejections, payment denials and/or delays.

Any services or Lines of Businesses listed below as "Exclusions" should **NOT** be billed to Coastal, but sent to the health plan directly.

WellCare Health Plan

- **Effective Date of Contact** – 1/1/2024
- **Home Health Service Area:**
    - Region F: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
    - Region G: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
    - Region H: Broward
    - Region I: Miami-Dade and Monroe
- **DME Service Area:**
    - State of Florida - Statewide
- **Lines of Business:**
    - Medicare
        - Exclusions to Medicare include the following:
            - PPO Members
- **Scope of Services**:
    - Durable Medical Equipment & Supplies
        - Exclusions include the following:
            - Breast Pumps
            - Orthotics & Prosthetics (L-Codes)
            - Diabetic Supplies
            - Diabeti Shoes
            - ESRD Related Services
            - Transplant related services
            - Bone Growth Stimulators
            - Neuromuscular Stimulators
            - Implantable Devices
            - Custom Equipment
            - Complex Rehab Equipment
            - Specialty Beds
            - Speech Generating Devices

- Wound Vac Systems
- High Frequency Chest Wall Oscillation
- Life Vest Defibrilator
- Miscellanous Codes (i.e. E1399, A9900)

- Home Health Services
  - Exclusions include:
    - Private Duty Nursing
    - Personal Care Services
    - All Services covered via LTC
    - Outpatient Therapy Services (regardless of place of service)

Molina Healthcare of Florida

- **Effective Date of Contact** – 7/1/2019
- **Service Area:**
  - State of Florida - Statewide

- **Lines of Business:**
  - Medicaid
    - Exclusions inlude the following:
      - Long-Term Care Membership
  - Marketplace

- **Scope of Services**:
  - Durable Medical Equipment & Supplies
    - Exclusions include the following:
      - Orthotics & Prosthetics (L-Codes)
      - ESRD Related Services
      - Transplant related services
      - Implantable Devices
      - Cranial Helmets
      - Diabetic Shoes
  - Home Health Services
    - Exclusions include:
      - Outpatient Therapy Services (regardless of place of service)
  - Home Infusion Services

Community Care Plan

- **Effective Date of Contact** – 1/1/2020
- **Service Area:**
  - State of Florida - Statewide

- **Lines of Business:**
    - Medicaid
    - Florida Healthy Kids

- **Scope of Services**:
    - Durable Medical Equipment & Supplies
        - Exclusions include the following:
            - Orthotics & Prosthetics (L-Codes)
            - ESRD Related Services
            - Transplant related services
            - Implantable Devices
            - Cranial Helmets
            - Diabetic Shoes
    - Home Health Services
        - Exclusions include:
            - Outpatient Therapy Services (regardless of place of service)
    - Home Infusion Services

Sunshine Health

NOTE: Coastal is **NOT** delegated for claims processing for Sunshine Health. Please do **NOT** submit claims to Coastal. All claims must be billed to Sunshine directly.
Effective Date of Contact – 10/1/2021

- **Service Area:**
- Statewide **Lines of Business:**
    - Medicaid
    - Children's Medical Services
- **Scope of Services**:
    - Durable Medical Equipment & Supplies
    - Home Health Services
        - Exclusions include:
            - Outpatient Therapy Services (regardless of place of service)
            - Private Duty Nursing
            - CMS Home Health

Appendix B

NOTICE OF PRIVACY PRACTICES

COASTAL CARE SERVICES, INC.

Privacy Officer
1200 NW 78th Avenue Suite 100
Doral, FL 33126
Phone: 1-855-481-0202
Fax: 1-786-594-3027
E-mail: 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/.

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**.

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.

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 1st, 2015