



COASTAL CARE SERVICES, INC.[®]
member quality redefined.

Provider Billing Manual

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OVERVIEW

Coastal Care Services, Inc. (Coastal), recognizes that our providers want to receive payment in a timely manner. The focus of Coastal's Claims Department is to process claims in a timely manner. Coastal is contractually required to capture specific data regarding services rendered. Providers must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. In general, Coastal follows CMS (Centers for Medicare & Medicaid Services) billing requirements, but for additional questions regarding billing requirements, please contact our claims department at claims@ccsi.care.

It is important providers ensure Coastal has accurate billing information. The following information must be updated with the Provider Relations department as accurate:

- Provider Name – Name changes will require an updated W-9 Form
- National Provider Identifier (NPI)
- Tax Identification Number (TIN) – any changes will require an updated W-9 Form
- Taxonomy Code
- Physical location address
- Billing Name and Address
- Medicare and/or Medicaid Identification Numbers

Changes to billing information must be made in writing via the Provider Relations department. Changes will not be accepted when sent via a claim form.

Coastal's contacts with each of its Health Plan partners differ from plan to plan. For a detail of which plans Coastal works with and what services are covered by Coastal for each plan, please see **Appendix I – Health Plan Partners**.

CLAIMS SUBMISSION REQUIREMENTS

Claims for services covered by Coastal must be submitted by the provider who performed the service or by the provider's authorized billing vendor. All claims filed are subject to verification procedures. These include but are not limited to the following:

- All required fields are completed on the current industry standard CMS 1500 (HCFA), CMS 1450 (UB-04) paper claim forms or EDI electronic formats for Professional and/or Institutional claims.
 - The only services that are required to be billed on a CMS 1450 (UB-04) or Institutional EDI format are for Medicare Home Health services. These claims MUST follow the current Medicare Home Health Billing Requirements. You may access the Medicare

Home Health Billing Code Sheet at the link below: [Home Health Medicare Billing Codes Sheet \(Home Health & Hospice\) \(cgsmedicare.com\)](https://www.cgsmedicare.com/Sheet/HomeHealthHospice)

- All Diagnosis, Procedure, Modifier, Place of Service, Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service being billed.
- All Diagnosis, Procedure, Modifier, and Place of Service codes are valid for the provider type/specialty being billed.
- All Diagnosis, Procedure, and Revenue Codes are valid of the age and/or sex for the date of service being billed.
- All Diagnosis Codes are to the highest number of digits available (4th or 5th digit).
- Principle Diagnosis billed reflects an allowed Principle Diagnosis as defined in the current volume of ICD-10 for the date of service being billed.
 - For HCFA (CMS 1500) claim form, the criteria looks at all procedure codes billed and the diagnosis codes they are pointing to. If a procedure code points to the diagnosis as primary and that code is not valid as a primary diagnosis code, that claim line will be denied.
- Member Identification number is located in Box 1A of the paper HCFA CMS 150 form and Loop ID 2010 BA segment NM109 of the 837P.
- National Drug Code (NDC) is billed in the appropriate files on all claim forms as required by the State for pricing drugs. **See Appendix III – Instructions for Submitting Pharmacy Claims.**
- Member is eligible to services under one of Coastal’s current health plan contracts for the date of service being billed. See Appendix I – Health Plan Partners, for additional information on Coastal’s covered services.
- Appropriate authorizations were obtained for the services being billed.
 - Out of Network Providers require authorization for all services.
- Medicare coverage or other third party coverage has been clearly identified and appropriate COB information has been included with the claim submission. Please refer to “Coordination of Benefits” section for additional information on submitting COB claims to Coastal.

Rejections VS Denials

Rejections

Rejections are defined as an unclean claim that contains invalid or missing data elements that are required for acceptance of the claim into the claim processing system. A list of common upfront rejections can be found listed in **Appendix IV – Common causes for upfront rejections.**

Rejections will never enter the claims system, so there is no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim is submitted electronically.

Denials

A denial is a claim that has passed all minimum edits and is entered in the claim system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that

includes the denial reason. A list of common denials can be found in **Appendix V- Common Causes of Claim Denials**.

ELECTRONIC CLAIM SUBMISSION

Coastal strongly encourages our providers to submit claims electronically through Electronic Data Interchange (EDI). The advantages of submitting an electronic claim versus a paper claim include:

- Faster, more expedient payment of your claims
- An electronic receipt acknowledging your claim (through Change Healthcare)
- Improved claims tracking
- Improved claims status reporting
- Improved turnaround time for timely reimbursement
- Elimination of paper and waste
- Improved cost effectiveness

All EDI files submitted to Coastal must be in the ANSI ASC X12N format, version 5010A or its successor. Providers should work with their existing clearinghouse, or Coastal's clearinghouse, to establish EDI with Coastal. Below is Coastal's Clearinghouse information:

Change Healthcare

Coastal Payer ID# 47394

Telephone: 1-877-363-3666

To initiate the electronic claims submission process or to get more information, contact Change Healthcare.

Electronic Claim General Information

All EDI claims must be forwarded to Change Healthcare. This can be done via a direct submission to Change Healthcare or through another EDI clearinghouse using Coastal's Payer ID.

Change Healthcare will validate all EDI claims received against their proprietary specifications and Coastal specific requirements. Claims not meeting these requirements are rejected and sent back to the sender via a Clearinghouse error report. These claims are not forwarded to Coastal. If you need assistance in resolving submission issues, please contact your clearinghouse for assistance. Accepted claims are then forwarded to Coastal and the Clearinghouse will send acceptance reports to the sender.

Claims forwarded to Coastal by the Clearinghouse are validated against provider and member eligibility records. Claims that do not meet requirements are rejected by Coastal and sent back to the clearinghouse. The clearinghouse will in turn forward these rejections to the sender.

Electronic Claim Exclusions

The following claims are excluded from the EDI submission option and must be filed on paper:

1. Coordination of Benefit (COB) Claims. Coastal does not receive cross-over claim information. Therefore, providers must submit all COB claims on paper with the primary EOB attached.
2. Claims that require Manual Pricing - Please see **Appendix II – Manually/Specially Priced Codes** for additional information.

PAPER CLAIM SUBMISSION

Coastal only accepts CMS 1500 and CMS 1450 (UB-04) forms. All other claim forms will be rejected and returned to the provider. Providers who choose to submit paper claim forms must purchase the appropriate claim forms from the supplier of their choice. It is preferred all paper claim forms are typed and in the original red and white version to ensure clean acceptance and processing.

Paper Claims must be mailed to:
Coastal Care Services, Inc.
Attn: Claims Department
5000 SW 75th Avenue, Suite 300A
Miami, FL 33155

ONLINE CLAIM SUBMISSION

Participating providers who choose not to submit claims via EDI or paper can submit claims directly to us via our secure provider portal at <https://web.ccsi.care>

You must request access to our secure site by registering for a user name and password.

For new users needing to Register for Portal Access, please send email with the request to ProviderRelations@ccsi.care

The email should include the following information for individuals needing access:

- Name
- Email address
- What kind of access is needed (Claims, Authorization, or both)

An email with the individual’s USER Id and Temporary password will be sent to the email provided.

For any support needed with regards to the Portal, please send email to the email address listed below with a brief description of your question.

Support Email: IT.Support@ccsi.care

TIMELY CLAIMS SUBMISSION

Coastal applies time filing requirements as follows:

1. Claims are considered received on the date the claims are received by Coastal.
2. Unless otherwise stated in the Provider Agreement, participating providers must submit claims (initial and corrected) within six months (180 calendar days) from the date of service.
3. Non-contracted providers must mail or electronically transfer (submit) the claim within twelve (12) months of the date of service.
4. COB claims, provider must submit claims within 90 days from the primary payers EOB date.
 - a. Medicare cross-over claims must be submitted within 12 months from the Medicare EOB date.
5. Provider Complaints/Claim Disputes must be received within 90 days of the remittance advice.
6. Overpayment Disputes must be received within 40 days of the Overpayment Notice.

Claims not received within the specified limits may be denied for payment.

The following items can be accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating that a claim was submitted timely and accepted by Coastal.
- Catastrophic event that substantially interferes with normal business operations of provider or damage of destruction of the provider’s business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Coastal.

CORRECTED AND VOIDED CLAIMS

Corrected Claims are considered new claims for processing purposes. Corrected claims must be sent within 180 days of the date of service 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 claims 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.

PROMPT PAYMENT

Please refer to your agreement and/refer to Florida Statute 641.3155.

Coastal will reimburse providers for Medicare deductibles and co-insurance payments for Medicare dually eligible members in accordance with Rule 59G-1.052.

Adjusted claims, requests for reconsideration and disputed claims will be finalized to a paid or denied within 30 calendar days of receipt.

PROVIDER COMPLAINT

If your claim was denied in whole or part, you have the right to request a review. To initiate a review, you must file a provider complaint regarding the denied claim within 90 days of the date of the original notification of payment or denial was issued. 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 (timely 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 complaint 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.
5000 SW 75th Ave, Suite 300A
Miami, FL 33155

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

Claims Disputes: Coastal Care Services Inc.
Attn: Claims Disputes
5000 SW 75th Ave, Suite 300A
Miami, FL 33155

APPENDIX

- I. HEALTH PLAN PARTNERS
- II. MANUALLY/SPECIALY PRICED CODES
- III. INSTRUCTIONS FOR SUBMITTING PHARMACY CLAIMS
- IV. COMMON CAUSES OF UPFRONT REJECTIONS
- V. COMMON CAUSES OF CLAIM DENIALS
- VI. INSTRUCTIONS FOR SUBMITTING SUPPLEMENTAL INFORMATION
- VII. COMMON EOP DENIAL CODES

APPENDIX I: 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 Defibrillator
- Miscellaneous 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 include 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 II: MANUALLY/SPECIALY PRICED CODES

In an effort to simplify the billing and claims payment process for services requiring manual pricing, Coastal has put procedures in place that will allow providers to bill electronically without the need to submit any additional supporting documentation. Providers can still bill via our portal or submit paper claims, but they will not need to submit on paper with supporting documentation as long as all of the following requirements are met:

1. Provider has obtained prior authorization for services.
2. Provider has a mutually agreed upon rate for services being billed for which an allowable does not exist. These rates would be detailed in the payment appendix of the provider agreement with Coastal.
3. For Miscellaneous codes (i.e. E1399, A9900, etc.) or codes that do not have an allowable assigned to them, the authorization will show the mutually agreed reimbursement rate for each code next to the Description of the item. See example below:

4/27/2020	5/4/2020	5/5/2020	E1399	DME ITEM 1234 AGREED PRICE \$10.00 PER UNIT	1.0
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- a. All required documentation that will be needed to manually price items, will be collected from the provider at the time of authorization. This will include, but is not limited to, the following:
 - i. Invoices showing description and MSRP amounts
 - ii. Quotes
 - iii. Medical Documentation

When submitting claims for these services, the following processes **MUST** be followed to avoid a claims rejection or denial:

- All miscellaneous codes require a description. Please see Appendix VII- Instructions for submitting supplemental information.
- If multiple miscellaneous codes are being billed for the same date of service, they **MUST** all go on one claim in order to avoid a duplicate claim denial.
 - If a claim is received with the same procedure code and the same date of service, even if the billed amounts and descriptions are different, this will cause the claim to deny as a duplicate claim.
 - The provider will have to submit a corrected claim for the previously billed claim to include all codes or send a corrected claim for the duplicate claim denial with a "59" Modifier = Distinct Procedural Service.

NOTE: If authorization is not obtained, provider must submit claims requiring manual pricing on paper with all required invoices attached.

APPENDIX III: INSTRUCTIONS FOR SUBMITTING PHARMACY CLAIMS

CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units.

When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.

For Electronic submissions, this is highly recommended and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410

837P		
Data Element	Loop	Segment/Element
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03
Quantity	2410	CTP04

Paper claims will use Field 24 A shaded claim line

Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size.

If you are given an NDC that is less than 11 digits, add the missing digits as follows:

- For a 4-4-2 digit number, add a 0 to the beginning
- For a 5-3-2 digit number, add a 0 as the sixth digit
- For a 5-4-1 digit number, add a 0 as the tenth digit.

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

- F2 - International Unit
- GR -Gram

- ML - Milliliter
- UN – Unit

Home Infusion Providers billing per diem procedure codes, should use the following modifiers on the per diem procedure codes when billing for multiple infusion therapies:

- **Modifier SH:** Denotes second concurrently administered infusion therapy. Services submitted with this modifier will be allowed at 50% of the eligible amount.
- **Modifier SJ:** Denotes third concurrently administered infusion therapy. Services submitted with this modifier will not be reimbursed.

APPENDIX IV: COMMON CAUSES OF UPFRONT REJECTIONS

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or handwritten information is not legible, not aligned correctly.
- Member Demographics are missing: Name, ID Number, DOB
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing
- Date of Service is not prior to the received date of the claim (future date of service)
- Date of Service or Date Span is missing from required fields
- Type of Bill is invalid
- Diagnosis Code is missing, invalid, or incomplete
- Service Line Detail is missing
- Date of Service is prior to member's effective date
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14)
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17)
- Occurrence Code/Date is missing or invalid
- Revenue Code is missing or invalid
- CPT/Procedure Code is missing or invalid
- Incorrect Form Type used
- Claim Signature and date on Block 31 of paper claim is missing

APPENDIX V: COMMON CAUSES OF CLAIM DENIALS

- **Diagnosis Code** is missing the 4th or 5th digit
- **Procedure** or **Modifier Codes** entered are invalid or missing
- **Explanation of Benefits (EOB)** from the primary insurer is missing or incomplete
- **Third Party Liability (TPL)** information is missing or incomplete
- Member ID is invalid
- Place of Service Code is invalid
- Provider TIN and NPI does not match
- Revenue and/or HIPPS Code is invalid
- **Dates of Service** span do not match the listed days/units
- Tax Identification Number (TIN) is invalid
- **NDC Code** missing for drug codes
- Multiple Home Health Services provided on same date of service are billed on multiple claim lines.
- DME HCPC codes are missing required modifier.

APPENDIX VI: INSTRUCTIONS FOR SUBMITTING SUPPLEMENTAL INFORMATION

CMS-1500 Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (8/05) form field 24A-G:

- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs

The following qualifiers are to be used when reporting these services:

ZZ Narrative description of unspecified/miscellaneous/unlisted codes

N4 National Drug Codes (NDC)

The following qualifiers are to be used when reporting NDC units:

F2 International Unit

GR Gram

ML Milliliter

UN Unit

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

APPENDIX VII: BILLING REMINDERS

Claim Signature – Paper Claims

- Block 31 must contain a signature for paper claims. The signature in Block 31 must match the NPI billed in Block 24J of the claim form.
- “Signature on File” is not accepted
- Signatures must be: hand written, a stamp, or computer generated

Diagnosis Codes

- Must code to the highest number of available digits

Multiple-Page Claims

- Do NOT total each page of the claim – the last page of the claim should contain the total
- CMS 1500 Form – Block 28 of the last page contains the total
- UB-04 Form – Line 23, Block 47 contains the total
- Pages leading up to the last page of a multiple-page claim should contain the word “continued” or “cont.”
- Totaling each page will result in separate claims that may reimburse incorrectly or cause erroneous duplicate claim denials.

Claim Line Limits – including claims entered online via the provider portal

- CMS 1500 claims have a limit of 50 lines per claim
- UB -04 claims have a limit of 100 lines per claim

Miscellaneous Codes

- Miscellaneous codes must be billed with a description
- When billing multiple miscellaneous codes for the same date of service, they must ALL be billed on one claim

Home Health Claims

- Home Health claims for Medicare members must be billed on a UB-04 or Institutional claim and must be billed with a valid HIPPS code.
- Home health services for Medicaid members require EVV verification. The following health plans use HHAX as their EVV vendor. Claims for these plans, should be billed via the HHAX platform and not billed to Coastal directly:
 - Molina Healthcare
- Private Duty Claims must follow the requirements below:
 - Claims must be submitted within 60 days of the date of service
 - One unit = 1 hour of service

- Do not bill in 15 minute increments
- Units must be rounded up or down as appropriate
- Units cannot exceed 24 hours per day
- Do NOT bill in shifts.
 - Only 1 claim line for each HCPC code can be billed per day
 - For example, if 2 LPNS provided services on the same day, then the services must be billed on one claim line totaling the hours for both nurses.
 - Billing S9123 (RN) and S9124 (LPN) on separate claim lines for the same date of service is acceptable.