

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

*Provider Training Tool &
Quick Reference Guide*

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I. Coastal Introduction

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

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

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

II. Services

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

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

III. Obtaining Authorization

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

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

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

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

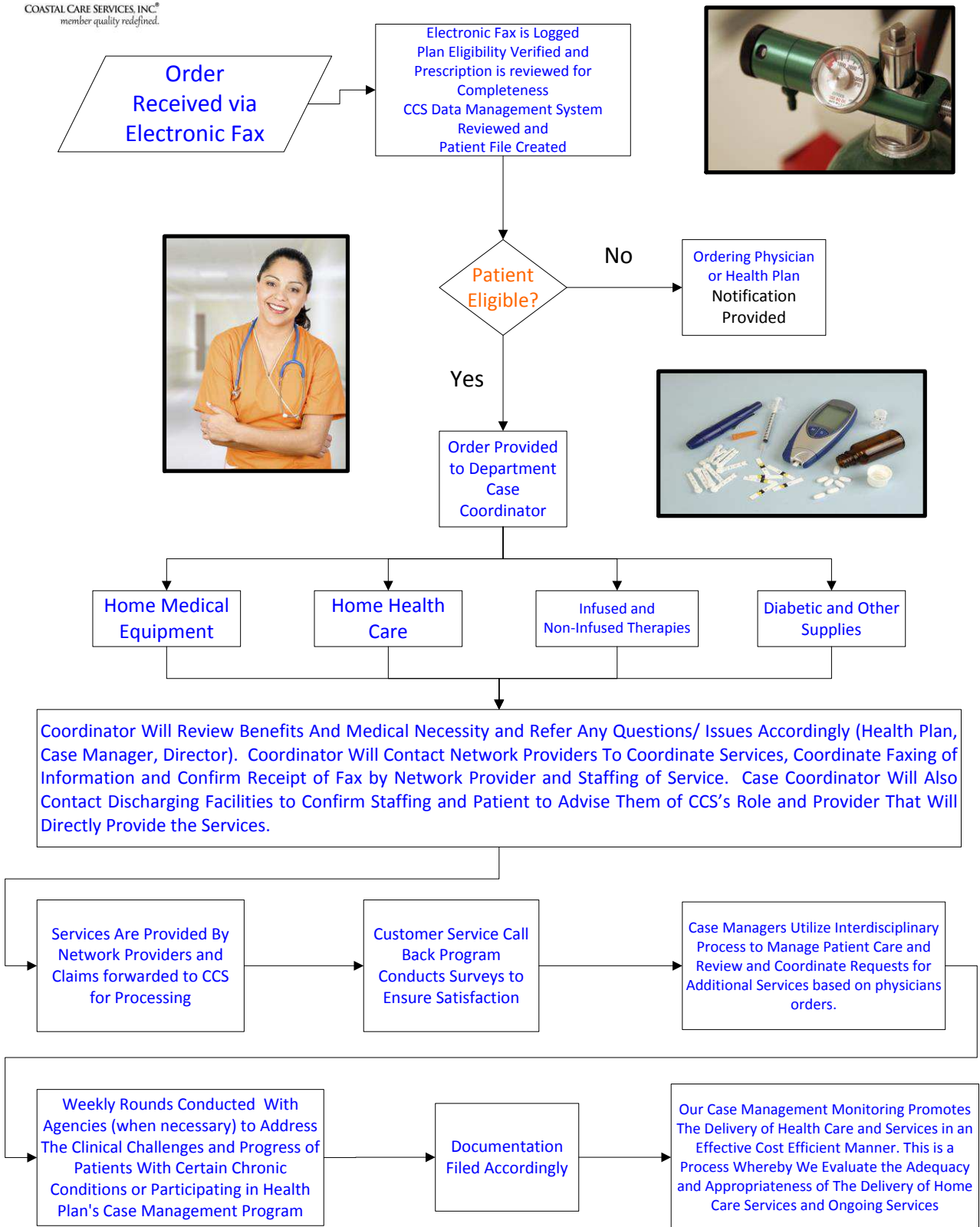
The Referral Authorization Form contains: Patient Information, Ordering Provider Information, Clinical Information, Special Comments along with Date Ranges and CPT/HCPC Codes for the precise services being authorized. The authorization number remains in effect until the patient is discharged. **See attached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

Participating Providers must notify Coastal immediately if services are unable to be provided for any reason. For example, a patient may not be home or medications may not have arrived and care cannot start as requested.

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



CCS Intake Flow





REFERRAL AUTHORIZATION FORM

Referral Status: 2

Urgency: 24

Authorization #: 1

<u>PATIENT INFORMATION</u>		
Patient Name: 3	PCP Name: 10	
DOB: 4	PCP ID: 11	
Patient ID: 5	PCP Phone: 12	
Home Phone: 7		
Address: 6		
Primary Carrier: 8	Primary Healthplan: 9	
<u>ORDERING PROVIDER</u>		
Name: 14-16	Phone:	Fax:

<u>REFERRED TO PROVIDER</u>		
Name: 25	Specialty: 25	
Address:	Phone:	Fax:
<u>CLINICAL DATA</u>		
Primary DX: 17-18	HT:	WT:
Secondary Diagnosis:	Secondary Diagnosis:	

SPECIAL INSTRUCTIONS: 19

CCSI Coordinator/Manager: 20

<u>SERVICES REQUESTED</u> 20-23					
Service Status	Effective From	Effective Thru	Procedure	Description	# of Units

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

Referral Authorization Form – field definition

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

IV. Request for Additional Services

Home Health/Infusion

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

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

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

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

Home Medical Equipment & Supplies

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

Initial Home Medical Equipment authorizations for rental equipment are usually provided with a time frame of thirty (30) days. Participating Providers must track the rental cap timeframe as payment will not be made once reached. Coastal authorization will indicate if the equipment is a purchase or rental. Small ticket items (canes, walkers, commodes & Nebulizers) are usually handled as a purchase unless otherwise determined and indicated.

Home Medical Equipment authorizations will be accompanied by the ordering physician's orders and must meet medical necessity & criteria. Brand specific items or supplies are not considered covered by most insurers however they may be reimbursed at the appropriate allowable amount for the HCPCS Code. Reimbursement will not be brand specific.

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

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

Clinical Recommendation & Status Report – field definition

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

V. Claim Submission

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

Coastal has the following guidelines:

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



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> HCA <input type="checkbox"/> PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (DAD/DaD) CHAMPVA <input type="checkbox"/> (Member Or)	GROUP HEALTH PLAN <input type="checkbox"/> (GHP) FECA BENEFIT <input type="checkbox"/> (FBL) (Other)	1a. INSURED'S ID NUMBER (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY SEX: M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				9. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>			
11. INSURED'S POLICY GROUP OR FECA NUMBER				12. INSURED'S DATE OF BIRTH MM DD YY SEX: M <input type="checkbox"/> F <input type="checkbox"/>		13. OTHER CLAIM ID (Designated by NUCC)			
14. INSURANCE PLAN NAME OR PROGRAM NAME				15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 10, and 11.		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE & AUTHORITY I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: _____ DATE: _____			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ITA 17b. SPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to ICD-9 to service (no ICD-9) (I)		22. RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER				24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. ICD-9-CM D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS ON UNIT H. PRIORITY I. QUAL. J. RENDERING PROVIDER ID, #		25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. plans, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Reserved for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: _____ DATE: _____				32. SERVICE FACILITY LOCATION INFORMATION NPI # _____		33. BILLING PROVIDER INFO & PH # () NPI # _____			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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

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

Remittance Advice

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

Prompt Payment

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

Claim Mailing Address

Participating Providers should mail CMS 1500 Claim Forms to:

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

Electronic Claim Submission

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

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

Reminders:

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

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

VI. Transition *(when applicable)*

Coastal's contract effective date:

New DME orders beginning:

New Home Health & Home Infusion orders beginning

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

VII. Coastal Contact Information

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