

WINDSOR STERLING



Provider Manual

WindsorSterling
7100 Commerce Way, Suite 285
Brentwood, TN 37027
888-839-9052

No person, on the grounds of race, color, national origin, sex, religion, age or disability, shall be treated differently or denied the benefits of any program or service provided by WINDSOR.

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An overview of the format, style, structure, and usage of the WindsorSterling Provider Manual

This manual was developed for the benefit of all health care providers and facilities participating in WindsorSterling. The manual was designed to include information and materials to simplify the relationship between health care providers and the insurance company. Detailed information about each of the WindsorSterling plans allows providers to become familiar with our company and the products we market. Contact information and various request forms have been included to facilitate communication. Claims requirements and other instructional documentation have been included to simplify business transactions.

➤ **How to Use This Provider Manual**

The relationship between the health care provider and the health plan is complex with mutual expectations. Health care providers expect to provide services to plan members of the insurance company and to be reimbursed for those services based on a set of standards or rules that are the same for all members of the same plan type. The health insurance company requires its participating providers to follow these during the course of providing healthcare services to members and billing for services. The contract between the provider and the insurance company for each plan type addresses some of the basic rules of this relationship, but mostly in general terms. This reference material was developed as a guide to explain the standards and rules that define this relationship.

➤ **Provider Manual Format**

This Provider Manual is accessible on our Website www.windsorhealthplan.com. Providers who wish to receive a hardcopy of the Provider Manual should contact their Network Services Representative to request one.

➤ **Printing This Guide**

While the Provider Manual has been optimized for viewing on a computer, the guide can still be printed and used as a hard-copy desk reference. To print this document, select **File** from the menu at the top of the screen, and then select **Print...** from the menu that drops down. You may print the Provider Manual as many times as needed.

Provider Manual Updates

➤ Updates, Changes, Modifications, Corrections, and Deletions

WindsorSterling may periodically update the information contained in the Provider Manual using various methods: via newsletter or other correspondence. These updates contain the most current information related to WindsorSterling policies and address its relationship with its participating providers. The information contained in these updates supersedes all other information or communications on the same subject issued on any date prior to the effective date listed on the update release. Each participating provider is responsible for obtaining copies of and maintaining a record of these releases. Furthermore, each participating provider is responsible for understanding and following the provisions of each update. Contact your Network Services Representative with any questions.

➤ Sample Provider Manual Update

The following is a sample copy of a Provider Manual Update notification. Each update document will specify which of the sections is being updated, and which chapter or section of the provider manual to which the update applies. Furthermore, each update document includes an overview of the subject, title, and key topics of each update.

Attention WindsorSterling Providers:

Subject: Sample Update
Title: Provider Manual Updates
Topic(s): Example of update to provider manuals; Sample updated page to Provider Manual information
Guide: WindsorSterling Provider Manual
Applies to Chapter(s): Chapter 1 – Overview of the Provider Manual Affects:
All WindsorSterling Plan Participants
Text:

An overview of WindsorSterling, the role of WindsorSterling as administrator of the Medicare Advantage plan, and the role of the Provider as Plan participant

WindsorSterling is a Medicare Advantage and Prescription Drug Plan (MAPD). WindsorSterling is contracted with the Centers for Medicare & Medicaid Services (CMS) to provide healthcare services to Medicare beneficiaries in place of traditional Medicare. WindsorSterling is a Medicare Advantage Plan, *not a Medicare supplement*.

WindsorSterling provides members with all Medicare-covered services as well as additional services such as preventive and wellness care, including annual physical exams. WindsorSterling uses predetermined copayments to allow members to accurately budget their healthcare costs. Plan design is intended to encourage the Medicare population to appropriately utilize healthcare services for all healthcare needs.

WindsorSterling, not Medicare, will be the payer for any health services rendered to a WindsorSterling member. If a member presents with both a WindsorSterling and a Medicare card, you should file with WindsorSterling, not Medicare. See Claims Processing Chapter for specific claims submission requirements.

➤ **WindsorSterling and CMS**

The Centers for Medicare & Medicaid Services (CMS) is responsible for the administration of the traditional Medicare program and has regulatory oversight of the Medicare Advantage HMO programs. As a Medicare Advantage Organization, WindsorSterling is responsible for compliance with certain regulations set forth by CMS, including reporting requirements specific to the Medicare population. Provider compliance responsibilities are annotated throughout this guide.

WindsorSterling has contracted with CMS to provide Medicare beneficiaries with health services in a managed care delivery system. CMS pays WindsorSterling a set amount of money on a monthly basis to coordinate and provide for the healthcare needs of each Medicare beneficiary enrolled in WindsorSterling. CMS prohibits WindsorSterling, first tier & downstream entities from employing or contracting with individuals excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act.

WindsorSterling

Department Descriptions

➤ Marketing and Sales

Sales

The WindsorSterling sales process is customized to the Medicare population and handled by a dedicated unit supporting WindsorSterling. The process includes the following individual marketing efforts:

- Direct Marketing
- Community-based marketing presentations
- One-on-one sessions with potential members

Traditional Marketing

National Medicare Marketing Guidelines allow providers to display marketing brochures for a Medicare Advantage organization, such as WindsorSterling, but prohibit providers from distributing or accepting enrollment applications. Providers must adhere to CMS marketing provisions. The Policy and Procedure outlining the CMS marketing provisions is available upon request. If a beneficiary has questions about becoming a WindsorSterling member or is a current member with benefit questions, please refer him/her to WindsorSterling Customer Services at (888) 858-8551.

➤ Administrative Operations

Eligibility/Enrollment

Enrollment of members into WindsorSterling plans is handled by a dedicated unit supporting WindsorSterling. Some of the functions of this department include:

- Processing enrollment applications
- Ensuring the WindsorSterling enrollment process is consistent with CMS guidelines
- Processing plan changes and disenrollment
- Billing monthly member premium

Customer Service

The WindsorSterling Customer Service department is dedicated to addressing the needs of and resolving issues for its members. Functions of this department include:

- Answering questions about members' coverage and benefits
- Corresponding with members on issues related to quality of care or services
- Handling changes in member information
- Providing claims status information for members
- Informing members of appeals rights

Grievance and Appeals

The WindsorSterling Grievance and Appeals department is dedicated to handling appeals and grievances in accordance with Federal regulations. Functions of this department include:

- Distinguishing between appeals and grievances
- Maintaining an appeals process to address adverse initial determinations (Organization Determinations and Coverage Determinations) and adhering to strict processing timeframes for both standard and expedited appeals
- Timely processing of all appeal requests filed by the member or on behalf of the member
- Timely processing of all non-contracted provider appeals for payment filed with a properly executed Waiver of Liability Statement
- Submitting appeal case files to the Independent Review Entity (IRE) contracted by the Centers for Medicare and Medicaid Services (CMS) for a member's appeal when the WindsorSterling's decision is not fully favorable
- Maintaining a grievance process for addressing issues that do not involve initial determinations (Organization Determinations and Coverage Determinations) and adhering to strict processing timeframes for both standard and expedited grievances.
- Record keeping of all appeals and grievances received and reporting to CMS as required

Claims

The Claims department is dedicated to processing claims in a timely manner according, to CMS and WindsorSterling guidelines. Functions include:

Adjudicating professional, facility and ancillary provider claims. See claims processing chapter.

Network Services

The Network Services department maintains the WindsorSterling networks, serving as the first line of communication between providers and WindsorSterling to ensure that providers have an active voice, and members have “adequate” access to quality health care providers. WindsorSterling monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary providers, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. Some of the functions performed by the Network Services department include the maintenance of a provider network, ongoing and timely communication and education regarding WindsorSterling, and assistance with resolution of claims payment issues.

Network Services Contact Information

Communication with the WindsorSterling provider network is a major portion of a Network Services Representative's job. Network Services Representatives spend time in the field and on the telephone communicating with network providers. Representatives may not be immediately available on first contact, but the Network Services Representatives monitor their voicemails and emails on a daily basis. Providers are encouraged to contact the Network Services Representatives directly as often as necessary, and should feel assured that, if their Network Services Representative is not immediately available, they will receive a timely response.

In the event that a Network Services Representative is not available and a provider has an immediate need, the provider should utilize one of the general contact methods listed later in this chapter. An individual from one of our offices will direct any urgent issues to the appropriate person(s) or department(s) for follow-up as needed.

The regional Network Services staff is available to help providers with the following:

- Provider participation requests
- Material requests
- Contractual issues
- Claims issues

Reasons to Call Your Network Services Representative

- Schedule an in-service for new staff
 - Request Supplies such as:
 - Provider Manual
 - Provider Directories
 - Provider Quick Reference Guide (Prior Authorizations/Guidelines)
 - Drug Formularies
 - Report Changes to:
 - Tax ID
 - Practice Name
 - Practice Address
- Add or Terminate a Physician as a Participating Provider
 - Contract Questions
 - Clarification of WindsorSterling Policies and Procedures
- Complex Service Issues (Please contact the Provider Help Desk for all standard service issues)
- Find out how you can use our website to check eligibility, benefits, and much more. Access these services at www.windsorhealthplan.com any time, day or night.

The Provider Network

For a complete listing of participating Primary and Specialty physicians, Hospitals and other facilities and providers, please refer to the WindsorSterling Provider Directory available at www.windsorhealthplan.com and search the online Provider Directory.

➤ Credentialing

WindsorSterling Credentialing Program is designed to support goals that reflect WindsorSterling's goals and objectives, Provider Network and Contracting mission, and all applicable regulatory and accrediting requirements. Verifying credentials of practitioners and other health care providers is a key part of evaluating quality services.

The WindsorSterling Credentialing Program provides information to determine whether practitioners, and other health care providers, licensed by the State and under contract with WindsorSterling meet certain standards. The program strives to adhere to minimum credentialing requirement defined by the Center for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

WindsorSterling evaluates those healthcare providers and practitioners with whom it contracts or intends to contract in those networks that require credentialing status. **Credentialing must be completed prior to contracting with a practitioner/provider.** This scope of credentialing and contracting encompasses, but is not limited to, physicians and other licensed practitioners who wish to participate in WindsorSterling's Provider Network. WindsorSterling will not differentiate or discriminate in the treatment of practitioners and other health care providers seeking credentialing on the basis of race, age, sex, national origin, religion or solely on the basis of a health care professional's license or certification. Policies and procedures regarding the suspension or terminations of plan providers are available upon request.

➤ Access and Availability Standards

Providers are expected to provide care within the following timeframes:

Standards	Time
Routine non-symptomatic Primary Provider or OB/GYN office visit (i.e., annual physical exam, annual gynecologic exam, immunizations or preventive care)	4-6 weeks
Non-urgent symptoms – Primary Provider or OB/GYN office visit	3-10 days
Urgent symptoms - Primary Provider or OB/GYN office visit	48 hours
Routine member call during office hours	Same day
Routine member call after office hours	90 minutes
Urgent member call during office hours	15 minutes
Urgent member call after office hours	30 minutes
Waiting time for member in office	Not to exceed 45 minutes
Greeting of member	Within 15 minutes of arrival

Medical care must be accessible and available to members 24 hours, 7 days a week. Access to care may be provided with an answering service and appropriate call coverage in place after normal business hours, with the exception of facilities that are required to provide continuous access. Acceptable on-call and after hours procedures include a live answering service which can reach the practitioner 24 hours a day, 7 days a week, a voice mail message which provides a number where the practitioner can be reached or an outgoing message directing the member to the nearest emergency room.

➤ Primary Provider's Role

- Agree not to bill or balance-bill a member for covered services as per contract guidelines.
- Agree not to hold the member liable for services provided where required prior authorization is not obtained.
- Provide and coordinate services for members immediately upon enrollment.
- Provide comprehensive Primary services including preventive services.
- Manage and coordinate care of members for all medical problems.
- Abide by access and availability standards.

- Follow all prior authorization procedures and guidelines as required by the Health Services department.
- Refer members for consultation when additional knowledge or skills are needed for that member's care.
- Prescribe medications using the Windsor formularies.
- Be willing to meet with Windsor's Clinical Pharmacists to discuss medication utilization.
- Agree to participate in all Quality Management activities as required by the Quality Management department.
- Maintain an on-call system for 24-hour coverage, seven days a week. Physicians participating in the on-call system who are not participating providers must follow WindsorSterling policies and agree to accept the fee schedule.
- Comply with all other WindsorSterling policies and procedures as may be reviewed or approved by the Medical Advisory Committee, Operational Performance Committee or the Pharmacy and Therapeutics Committee.
- Comply with Medication Therapy Management Program mandated by CMS.
- Review Controlled Substance Monitoring Notices.
- Follow all Medicare Part D coverage determination procedures, guidelines and criteria for members immediately upon enrollment.
- Provide supporting documentation or statement for Medicare Part D coverage determination and exceptions.
- Uphold FDA Class I or Voluntary Recalls.
- Collect specified co-payments from members for office visits as specified on the member's WindsorSterling ID card.
- Not require a baseline history and physical from potential WindsorSterling members before providing and coordinating care. Pre-screening (screening done prior to accepting a member) is not allowed.
- Refer members appropriately to participating providers within the dictates of good medical practice and in the best interest of the member. If a member has been receiving care from a non-participating physician, refer to a participating specialist physician. In cases where there is no participating specialist physician who can provide the services needed within the dictates of good medical practice and in the best interest of the member, request an authorization for out-of-network services through WindsorSterling Health Services.
- Coordinate all care for members within current WindsorSterling guidelines. Obtain required authorizations from Health Services. This also holds true for any non-participating physician covering calls for the Primary provider.
- Comply with all federal and state regulatory requirements and processes (appeals, reporting, advanced directives, etc.) Comply with the Civil Rights Act, Americans with Disabilities Act,

Age Discrimination Act, Health Insurance Portability and Accountability Act, and all other applicable federal and state laws.

- Submit encounter data, medical records, and certify completeness and truthfulness.
- Provide health care services to plan members in the same manner offered to Provider's other patients.
- Provide clinical and non-clinical services in a culturally competent manner accessible to persons of diverse ethnic backgrounds.
- Make good faith effort to provide to all affected members written notice of termination of participation in the network at least 30 days prior to the effective date of termination.
- Provide notice of termination per contractual requirement.

➤ **Specialist's Role**

- Agree not to bill or balance-bill a member for covered services or as per contract guidelines.
- Agree not to hold the member liable for services provided where required prior authorization is not obtained.
- Coordinate care with the member's Primary Provider to enhance continuity of care and communicate all findings to the Primary Provider, as well as recommend appropriate follow-up treatment plans.
- Agree to comply with prior authorization policies and procedures as required by Health Services for prior authorization.
- Agree to comply with all Quality Management policies and procedures as required by the Quality Management Department.
- Prescribe medications using the Windsor formularies.
- Be willing to meet with Windsor's Clinical Pharmacists to discuss medication utilization.
- Use participating providers, except for services that cannot be provided by participating providers within the dictates of good medical practice, and in the best interest of the member. If services cannot be provided by a participating provider, prior authorization must be obtained from the WindsorSterling Health Services department.
- Comply with all other WindsorSterling policies and procedures as may be reviewed or approved by the Medical Advisory Committee, Operational Performance Committee or the Pharmacy and Therapeutics Committee.
- Comply with Medication Therapy Management Program mandated by CMS.
- Comply with all federal and state regulatory requirements and processes (appeals, reporting, advanced directives, etc.) Comply with the Civil Rights Act, Americans with Disability Act, Age Discrimination Act, Health Insurance Portability and Accountability Act, and all other applicable federal and state laws.
- Submit encounter data, medical records and certify completeness and truthfulness.

- Review Controlled Substance Monitoring Notices.
- Follow all Medicare Part D coverage determination procedures, guidelines and criteria for members immediately upon enrollment.
- Provide supporting documentation or statement for Medicare Part D coverage determination and exceptions.
- Uphold FDA Class I or Voluntary Recalls
- Collect co-payments from members for office visits as specified on the member's WindsorSterling ID card.
- Provide health care services to plan members in the same manner as offered to Provider's other patients.
- Provide clinical and non-clinical services in a culturally competent manner, accessible to persons of diverse ethnic backgrounds.
- Made good faith effort to provide to all affected members written notice of termination of participation in the network at least 30 days prior to the effective date of termination. Provide notice of termination per contractual requirement.

➤ **Member Rights**

The goal at WindsorSterling is to ensure that members have the opportunity to receive high quality healthcare services. To help us accomplish this please review the members' rights listed below.

- To be treated with dignity, respect and fairness at all times
- To have private health information protected and confidential.
- To receive information about covered services, plan and providers, to get prescriptions filled within a reasonable time frame.
- To receive information about treatment choices and participate in decisions about health care options.
- To receive information about healthcare coverage and costs.
- To make complaints and appeals without discrimination and expect problems to be reviewed.
- To receive information about Windsor Health Plan and the WindsorSterling plans.

➤ **Member Responsibilities**

WindsorSterling expects members to adhere to the following list of responsibilities.

- To do their part in managing their own healthcare by providing information to WindsorSterling's practitioners and providers. Improve own health condition by following their physician's treatment plans.

- To comply with requests for information regarding illnesses or accidental injury for which another party may be liable. These requests may be referred to as subrogation requests or Windsor Health Plan's "right of recovery". Compliance with the subrogation provision of your health plan is an important step toward helping Windsor Health Plan control insurance costs and avoiding duplication of payment to providers.
- To accept the financial responsibility for any co-payment or co-insurance associated with covered services received while under the care of a physician or while a patient at a facility.
- To review information regarding covered services, policies and procedures as stated in their Evidence of Coverage information.
- To identify themselves as WindsorSterling members when scheduling services and upon arrival at any medical treatment facility by presenting their WindsorSterling membership card.
- To notify WindsorSterling of any changes in their personal situation that may affect our ability to communicate with you, including change of address or telephone number.
- To report if their WindsorSterling membership card is lost or stolen.
- To understand their grievance and appeal rights and follow WindsorSterling grievance and appeals procedures.
- To let us know if they have any questions, concerns, problems or suggestions by calling WindsorSterling Customer Services.

WindsorSterling Contact Reference Sheet

<p>Health Services 7100 Commerce Way, Suite 285 Brentwood, TN 37027 Phone (888) 904-8387 Fax (615) 782-7822</p> <p>Medical and Part B Pharmacy Prior Authorizations Care Management</p>	<p>Grievance & Appeals 7100 Commerce Way, Suite 285 Brentwood, TN 37027 Phone (888) 839-9052 Fax (615) 782-7971</p> <p>Member Appeals Member Grievances Non-Contracted Provider Appeals</p>	<p>Provider Help Desk 7100 Commerce Way, Suite 285 Brentwood, TN 37027 Phone (888) 839-9052 Fax</p> <p>Status of Claims General Claim Issues Verification of Eligibility Benefits</p>
<p>Behavioral Health 7100 Commerce Way, Suite 285 Brentwood, TN 37027 Phone (888) 904-8387 Fax (615) 782-7901</p>	<p>Windsor Home Care Network 7100 Commerce Way, Suite 285 Brentwood, TN 37027 Phone (800) 793-3684 or Fax (615) 661-4741</p> <p>Home Health Home Infusion DME Medical Supplies Orthotics Prosthetics</p>	
<p>Routine Vision – EyeMed P.O. Box 8504 Mason, OH 45040-7111 Phone ((866) 339-3633</p> <p>All Routine Vision Claims</p>	<p>Fraud & Abuse Hotline Phone (615) 782-7899</p> <p>For reporting suspected member or provider fraud</p>	<p>TTY/TDD 711</p> <p>Hearing Impaired</p>
<p>Pharmacy Department 7100 Commerce Way, Suite 285 Brentwood, TN 37027 Phone (866) 715-7519 Fax (615) 782-7869</p> <p>Prior Authorizations Part D Coverage Determinations</p>		

An overview of various issues related to membership including plan enrollment and disenrollment, and plan ID card sample

This chapter details the qualifications for membership with WindsorSterling, the member and provider responsibilities related to membership, how to identify WindsorSterling members and details of the member's responsibility for co-payments, coinsurance, and deductibles.

Enrollment

➤ Eligibility

To enroll in one of WindsorSterling's Medicare Advantage plans, potential members must meet **all** of the following requirements:

- Live in the WindsorSterling service area for the product chosen.
- Be entitled to Medicare Part A, enrolled in Medicare Part B, and continue paying Part B premiums to traditional Medicare.
- Not currently diagnosed with end-stage renal disease, (that is, permanent kidney failure which requires regular kidney dialysis or a transplant to maintain life).

Individuals meeting the above conditions cannot be denied membership in WindsorSterling based on their health status.

➤ Enrollment

Medicare eligible individuals may submit completed enrollment application forms to WindsorSterling during appropriate election periods. To obtain information regarding enrollment or speak with a WindsorSterling Enrollment Counselor call (877) 243-5844.

➤ Effective Date

The member's actual effective date is determined by CMS, not WindsorSterling. It is typically the first day of the month following receipt of the enrollment application. The effective date of enrollment is confirmed in a letter sent by WindsorSterling to the member after CMS sends acceptance to the plan.

➤ Primary Care Provider's Role

- Ensure the provision of necessary care for a member immediately upon enrollment.
- Verify current enrollment eligibility by calling Provider Help Desk (866) 270-5223 or on our website www.windsorhealthplan.com.

➤ Specialist's Role

- Verify current enrollment eligibility by calling Provider Help Desk (866) 270-5223 or through our website www.windsorhealthplan.com.

Disenrollment

➤ Voluntary Disenrollment

WindsorSterling members may disenroll from the plan. However, as explained in this section, there are limits to when they may leave, how often changes can be made, and what type of plan can be joined after the member leaves.

There are limits to when and how often members can change the way they receive Medicare benefits and what choices they can make when they make a change. Some guidelines are as follows:

1. From October 15th through December 7th, anyone with Medicare will have one chance to switch from one way of obtaining Medicare to another with an effective date of January 1st.
2. From January 1st until February 14, anyone with Medicare can disenroll from a Medicare Advantage plan and return to Original Medicare. This enrollment period does not allow people in an MA plan to switch to another MA plan or people in Original Medicare to join an MA plan.

Generally, members cannot make any other changes during the year unless they have a special election from CMS. Contact Provider Help Desk for more information.

In most cases, the disenrollment date will be the first day of the month that comes after the month WindsorSterling receives the member request to disenroll. For example, if WindsorSterling receives a member request to leave during the month of February, the disenrollment date will be March 1.

To disenroll, a member must do one of the following:

- Notify WindsorSterling in writing, or
- Contact the nearest Social Security office or Railroad Retirement Board office, or
- Enroll in another Medicare Advantage Plan.

WindsorSterling sends a letter to inform the member of his/her disenrollment date. Until the effective date of disenrollment, members will continue to be covered by WindsorSterling and must follow all plan requirements and guidelines until the disenrollment becomes effective.

➤ Involuntary Disenrollment

WindsorSterling may terminate membership only under the following conditions:

- Loss of entitlement to Medicare Part A (hospital insurance) or Part B (medical insurance).

- Member permanently moves out of the WindsorSterling service area. Absence from the service area for a continuous period of 6 months is considered to be a permanent move from the service area. WindsorSterling requires the member to notify the plan of any address changes. WindsorSterling is required to provide emergency or urgently needed care as well as out of area dialysis treatment for these members until their WindsorSterling termination is effective with CMS.
- Member supplies fraudulent information or misrepresents data on the enrollment application form that affects eligibility to enroll in WindsorSterling.
- Member allows another person to use his/her WindsorSterling ID card to obtain services.
- Member is disruptive, abusive, unruly, or uncooperative to the extent that WindsorSterling's ability to provide services is impaired. This includes abusive and disruptive behavior during the provision of services by any provider within the WindsorSterling network. CMS must review and approve termination for this reason.
- WindsorSterling's annual contract with CMS is not renewed. If this occurs, members receive 90 days notice before the end of the contract explaining the member's options.

NOTE EXCEPTION: *WindsorSterling may not enroll an individual who has been medically determined to have end-stage renal disease. However, a member who develops end-stage renal disease while enrolled in Windsor may not be disenrolled for that reason.*

If a member is terminated, WindsorSterling will send written notification for termination. The member's termination will become effective as specified in the termination notice. The notice also will provide information about the member's right to appeal the termination under certain circumstances. Members do not have the right to appeal termination due to loss of entitlement to Medicare Part A or Part B. Members may file a complaint regarding the termination through WindsorSterling's grievance procedure.

Until the effective date of termination, members remain covered by WindsorSterling and must follow all plan requirements and guidelines until the disenrollment becomes effective. No member will be terminated from enrollment due to health status or for any reason other than those previously mentioned.

➤ **Provider's Role**

- Provide all covered services within plan requirements and guidelines until the disenrollment becomes effective.
- Check member eligibility at each visit.
- Document and notify WindsorSterling of any member who:
 - Refuses to pay his/her co-payment
 - Is disruptive, unruly or uncooperative
 - Refuses to accept treatment deemed necessary
- Engages in fraudulent activity

Co-payments, Co-Insurance and Deductibles

Collection of co-payments is the sole responsibility of the provider of the associated service. WindsorSterling will deduct the co-payment and co-insurance amount from the reimbursement for specific services.

➤ Provider's Role

- To collect the required co-payment/coinsurance for covered services
- To explain the co-payment/coinsurance requirement to the member

➤ Discrimination

Discrimination against beneficiaries is prohibited. Windsor will not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in Windsor on the basis of any factor that is related to health status, including, but not limited to the following:

- (1) Medical condition, including mental as well as physical illness
- (2) Claims experience
- (3) Receipt of health care
- (4) Medical history
- (5) Genetic information
- (6) Evidence of insurability, including condition arising out of acts of domestic violence
- (7) Disability

Membership

WindsorSterling Member Identification Card

Each WindsorSterling member receives an ID card.

The graphic below represents a composite of all of the cards enlarged to show all the detail.

**WINDSOR
STERLING** Medicare limiting charges apply

NAME:
ID:
ISSUER: 80840

PLAN CODE:
PLAN NAME: GOLD CONNECT (PFFS)

IN-NETWORK COPAYS:
PRIMARY CARE: \$10 RxBin: 012320
SPECIALIST: \$30 RxPCN: MEDDADV
ER: \$65 RxGrp: RX5094

MedicareRx
Prescription Drug Coverage

MEMBERS: Please carry this card with you at all times. Present this card when you receive care. Do not present your Medicare card. In case of emergency, go to the nearest emergency room. Fees may be waived if admitted.
Customer Service: 1-888-858-8551 (TTY: 711) 8 am - 8 pm, 7 days a week

SUBMIT MEDICAL CLAIMS TO:
WindsorSterling, P.O. Box 269003, Plano, TX 75026-9003
Electronic Payor ID 67829

Call for Terms and Conditions of Payments
Provider Help Desk: 1-888-839-9052
MD Pharmacy Prior Authorization: 1-866-715-7519 FAX: 615-782-7869
Pharmacist Technical Help: 1-800-364-6331
Provider Service – Vision: 1-888-581-3648
Provider Service – Dental: 1-888-696-9549
Visit us anytime at www.WindsorSterlingPlans.com

Depending on the Member's plan, their card will be slightly different from the composite above but it should match the basic details of the card shown above.

An overview of the prior authorization requirements for all providers participating in WindsorSterling

Notification/Pre-Authorization

Notification is requested, but is not required for Private Fee-for-Service (PFFS) members.

Preferred Provider Organization (PPO) members may require pre-authorization for some services.

Planned services requiring pre-authorization should be submitted timely in order to allow for sufficient processing time. Please call 888-904-8387 for a more detailed explanation of prior authorization requirements.

Notification of planned admissions should be submitted 10 days prior to the planned admission date.

Unplanned admissions should be reported to WindsorSterling within 24 hours. Weekend and holiday admissions should be reported by 5 p.m. next business day.

Pre-authorization is required for the following services:

Services requiring pre-authorization:

- Inpatient Admissions (including SNF and LTAC)
- Rehabilitation Services; Specialized Structured Programs, Inpatient and Outpatient beyond first eight (8) OP visits
- Planned and Unplanned Outpatient/Observation Admissions.
- Inpatient and Outpatient Behavioral Health/Chemical Dependency beyond the first eight (8) OP visits
- Bariatric surgery
- Diagnostic and Therapeutic Radiology
- Outpatient Surgery Procedures (including those performed at a hospital, office or ASC)
- Reconstructive/potentially cosmetic procedures
- Transplant services

- Accidental dental services
- Non-Emergent ambulance transportation
- Durable Medical Equipment (over \$750)
- Home Health / Home Infusion
- Hyperbaric Oxygen Therapy
- Genetic Testing
- Sleep Apnea services (including sleep studies and surgery)
- Specialized Pain Management Services

Additional online tools and resources, including the provider manual, billing tips and reimbursement methodologies are available at www.windsorhealthplan.com

WindsorSterling Provider Quick Reference Guide

The WindsorSterling Quick Reference Guide lists the prior authorization requirements for the WindsorSterling plan. In addition, these invaluable documents include telephone and fax numbers for all of the most frequently contacted departments. Copies of this helpful guide are available on the website www.windsorhealthplan.com. Providers may also obtain a hardcopy of the reference guide from their Network Services Representative.

➤ Specialized Authorization Requirements

Home Health, Home Infusion, Hospice, Diabetic Supplies, DME and supplies must be arranged through Windsor HomeCare Network. To request Prior Authorization for these services, call Windsor HomeCare Network at (800) 793- 3684. Fax number is (615) 661-4741.

The following durable medical equipment items are covered without authorization when dispensed from the office of a physician that is contracted to provide these services. The identified codes below are used for billing these supplies and all other codes will require prior authorization. For additional coverage information please contact our Provider Help Desk at 1-888-839-9052.

Product Description	Billing Code
Universal cradle arm sling	A4565
Canvas cock-up wrist splint, lace-up front with Velcro closure	L3908
Uni-fit wrist splint, cock-up style	L3908
Cervical collar-foam	L0120
Cervical collars—semi rigid, adjustable	L0140
Straight cane—adjustable or fixed	E0100
Quad cane	E0105
Crutches, aluminum, underarm	E0114
Crutches, wood, underarm	E0112
Crutches, aluminum, forearm	E0110

Care Management and Medical Management for WindsorSterling members

WindsorSterling members can expect the highest quality care due to the extensive efforts of the Medical Care Management and Health Services departments. Each department is devoted to ensuring that WindsorSterling members receive medically necessary and appropriate care in the most cost-effective manner possible.

➤ **Care Management**

WindsorSterling, in recognition of the healthcare needs experienced by an aging population, has an established Medical Care Management department to assist in the management of those needs. All WindsorSterling members are eligible to receive Care Management services. The goal of WindsorSterling is to provide a comprehensive approach to total care management, including Care Management services and disease management services. This department has a proactive focus and works to ensure members receive medically indicated healthcare services in the most appropriate and cost-effective settings. WindsorSterling enrollees are evaluated for indicated preventive Medical Management and/or health education.

The Care Management staff follows a consistent practice in its approach and works with WindsorSterling members and providers to:

- Assess the healthcare needs of members**
- Accept Care Management referrals**
- Implement Care Management services**

➤ **Health Assessment Procedure**

In an effort to identify members who may be at high medical risk, WindsorSterling asks members to voluntarily complete a Health Assessment (HA). Completion of this assessment assists WindsorSterling in determining whether Care Management services are indicated. An attempt will be made to administer the Health Assessment (HA) on all WindsorSterling members within 90 days of enrollment into the plan. WindsorSterling will continue to follow up on all unsuccessful attempts to complete an HA.

If the member's responses indicate a possible need for Care Management services, a Care Management Nurse will contact the member to assess his/her needs. If Care Management services are indicated, the Care Management Nurse will work closely with the member's Primary Provider and Specialists to develop and implement a coordinated plan of care.

The results of the HA do not affect the member's coverage with WindsorSterling. The results will be used solely to assist in the provision of Care Management, coordination and management of services, or with the various prevention and wellness programs for which the member may be eligible. Eventually, the results of these assessments will facilitate the development or coordination of programs specific to the Medicare population.

➤ **Provider's Role**

- Identification of medical issues that would benefit from Care Management intervention
- Notification to the Medical Management Care Management Department of members with potential Care Management needs
- Interactive communication with the Care Management Nurse as it relates to medical management of a WindsorSterling member
- Willingness to work closely with the Care Management Nurse to achieve well-coordinated medical care

➤ **Care Management Procedures**

Accepting Care Management Referrals

The following procedure provides the basic framework that the Care Management Nurse will follow in accepting referrals for Care Management services.

1. Members can be referred or self-refer for Care Management services at any time following enrollment.

Note: If a provider is aware of a prospective WindsorSterling enrollee with continuity of care needs, the provider is encouraged to contact the Care Management department. Although services cannot be provided until the member is effective with WindsorSterling, Care Management Nurse can assist the member and the provider to ensure that there is no lapse in medically necessary healthcare services.

2. Once a referral is received, the Care Management reviews the request and obtains additional information, as needed. Sources may include, but are not limited to:
 - The member
 - The Health Assessment
 - The member's Primary Physician
 - The member's spouse, family members, caregiver, or the person designated as the responsible party
 - Current healthcare provider(s)
 - Internal data which indicates high risk situations

Implementing Care Management Services

The procedure for the Care Management implementation and evaluation is as follows:

1. Once identified as appropriate for Care Management services, the member is assigned to a Care Management Nurse. The Care Management Nurse will verify the member has continued enrollment and eligibility in the WindsorSterling program.
2. The Care Management Nurse, in conjunction with the member and the member's Primary Physician, will develop a Care Management plan specific to the patient and the patient's healthcare needs. If the member is not able to participate in the Care Management process, the member's designee can act on the member's behalf. The plan will consider and incorporate the following, as appropriate:
 - The member's health and functional status, both physical and psychosocial
 - The member's benefit level, specifically coverage for certain items or services
 - Physician recommendations - both Primary Provider and specialist
 - Other provider recommendations, initiated by a hospital, home care agency, skilled nursing or extended care facility, physical/occupational/speech therapist, other resources, etc.
 - Community resources, family/caregiver support network and any additional resources
 - The results of evaluations and recommendations by WindsorSterling staff assisting in the coordination of care, such as Medical Management and discharge planning
 - Clinical and/or care pathways appropriate to the member's condition/diagnosis
3. The Case Manager will determine interventions based on severity stratification as suggested by nationally documented practice guidelines.
4. Upon development of a Care Management plan, authorization for services can be obtained as needed through the designated Medical Management process, according to accepted WindsorSterling criteria.
5. It is the responsibility of the Care Management Nurse to monitor the effectiveness of the Care Management plan on an ongoing basis.
6. Revisions to the Care Management plan should be documented clearly and communicated to the member or designee prior to implementation. Where appropriate, the member or designee's agreement with the revisions will be obtained. Any revisions affecting clinical care require the approval of the member's physician prior to implementation.
7. Revisions to the Care Management plan that are non-clinical do not require the approval of the member's physician, but the member's physician will be notified of the changes prior to implementation when possible.
8. The Care Management Nurse will continue to assess the member's (or designee's) satisfaction with the care plan and provision of services on an ongoing basis, with concerns or issues reviewed and investigated as appropriate.

9. Once it is determined that Care Management services are no longer indicated, (e.g., goals met, or the member is no longer effective with WindsorSterling, etc.) the care plan will be closed with appropriate documentation, and the Primary Provider will be notified. Documentation should include, but is not limited to:
 - Member's health status
 - Status of care plan indicators
 - Reason for closure
 - Any ongoing community services being utilized
 - Resource information provided (if not noted previously, while case active)

➤ **Prior Authorization Protocols**

Notification, prior authorization and concurrent review for inpatient admissions of WindsorSterling members will be handled through WindsorSterling's Medical Management department.. WindsorSterling and its providers are subject to the claims payment regulations set forth by the Centers for Medicare and Medicaid Services.

➤ **Criteria**

WindsorSterling criteria will be reviewed and approved annually by the WindsorSterling Medical Advisory Committee.. When a coverage determination is made (favorable or adverse), WindsorSterling shall provide, upon reasonable request and free of charge access to and/or copies of the clinical criteria used in making the determination. Providers can request copies through the WindsorSterlingHealth Services staff at 888-904-8387. In all cases, HIPAA regulations will apply.

➤ **Authorization for Inpatient Care and Concurrent Review**

For emergency admissions, WindsorSterling members are encouraged to notify (or have someone notify) their Primary Provider or WindsorSterling of the admission as soon as possible. As part of their contract with WindsorSterling, participating hospitals agree to notify the plan of a member's admission by the next business day. This includes emergency admissions and observation care. In the event that a Primary Provider becomes aware of an admission through an avenue other than WindsorSterling, the Primary Provider should contact WindsorSterling Health Services department to advise the plan of the admission. Authorization will be provided for the medically necessary level of care.

➤ **Provider's Role**

- Refer members to participating WindsorSterling providers whenever available and appropriate, and follow all procedures, policies and criteria as they pertain to Medical Management.
- Obtain necessary prior authorization from WindsorSterling's Health Services or Care Management departments before making arrangements for inpatient admission
- Provide Medical Records as needed and requested for medical determinations and/or review.

➤ **Emergency, Post-Stabilization and Urgently Needed Care**

Emergency Care

In case of an emergency, the member is instructed to go to the closest emergency room. WindsorSterling will cover medically necessary services, regardless of the provider's network status and whether member is in or out of the WindsorSterling service area.

Emergency services are covered as inpatient or outpatient services that are furnished by a provider qualified to furnish emergency services.

A medical emergency condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

If a WindsorSterling member is receiving emergency care out of the service area, transfer to a plan provider is not required if the transfer poses a risk to the member's health or would be unreasonable given the distance involved and nature of the medical condition.

➤ **Urgently Needed Care**

Urgent Care is any medical care or treatment where the application of the usual Prior authorization procedure and time periods (1) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (2) in the opinion of a treating health care practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment. Any claim that a treating Physician determines is a claim involving Urgent Care shall be treated as such a claim.

➤ **Clinical/Status Changes**

End-Stage Renal Disease (ESRD)

End-stage renal disease (ESRD) is the stage of kidney impairment appearing irreversible, permanent and severe enough to require lifetime dialysis or kidney transplantation to maintain life. ESRD patients are eligible for Medicare and may be eligible for social security payments if found to be disabled.

According to the guidelines established by the Center for Medicare and Medicaid Services (CMS), Medicare enrollees with ESRD are not eligible to participate in WindsorSterling, unless the member already is enrolled in WindsorSterling. Additionally, WindsorSterling members who develop ESRD cannot be involuntarily disenrolled from WindsorSterling after being diagnosed with ESRD.

In addition, an individual who receives dialysis treatments for ESRD, but subsequently recovered

WindsorSterling members who elect hospice care are not disenrolled from WindsorSterling. During the time the member has elected hospice coverage and is in hospice care, all claims related to extra benefits (non-Medicare Covered Services) provided by WindsorSterling should be submitted to the Health Plan.

native kidney function and no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of WindsorSterling eligibility. Such an individual may also elect to enroll in WindsorSterling, if he/she meets other applicable eligibility requirements.

If a beneficiary no longer requires regular dialysis or has had a successful transplant, the beneficiary should obtain a note or records from the beneficiary's physician showing that the ESRD status has changed. Submit it with the enrollment election of WindsorSterling.

WindsorSterling will pay for renal dialysis services that are provided while the beneficiary is temporarily outside the plan's service area.

The process for submitting ESRD documentation to CMS involves the following steps:

1. The CMS form 2728-U4 (Chronic Renal Disease Medical Evidence Report) must be completed by the physician. This form is available online at <http://www.cms.hhs.gov/>.
2. The physician sends the appropriate ESRD network office a completed CMS 2728-U4. A copy of the completed form should be forwarded to WindsorSterling's Medical Management staff to provide notification of a pending change in member status. (CMS sends renal care providers an ESRD Program Instruction Manual that lists the ESRD network offices.)
3. The date on the CMS 2728-U4 is verified by the ESRD network, who forwards the form to CMS's ESRD support section.
4. CMS updates the ESRD database if the member already is enrolled in Medicare because of his/her age. CMS does not update the ESRD database until the Social Security Administration advises CMS of entitlement.

➤ **Provider's Role**

- The physician sends the completed CMS 2728-U4 to the appropriate ESRD network office.
- A copy of the completed form should be forwarded to WindsorSterling's Health Services staff to provide notification of a pending change in member status. (CMS sends renal care providers an ESRD Program Instruction Manual that lists ESRD network offices.)
- Provider notifies WindsorSterling of the development of ESRD by a current member.

➤ Hospice Care

Current WindsorSterling Members

WindsorSterling members eligible for hospice care are those patients diagnosed with a terminal illness having a life expectancy of six months or less.

CMS guidelines state that WindsorSterling cannot provide or administer hospice benefits to its members. Accordingly, WindsorSterling members eligible for hospice care should be instructed to contact their local Social Security office.

Upon contacting the local Social Security office, WindsorSterling members will be advised of the steps required to formally make a “Hospice Election.” These steps include:

- Designation of a “Hospice Election” effective date.
- The selection of a referral to a Medicare certified hospice program, in lieu of traditional hospital benefits.
- Completion of a form by the member acknowledging the waiver of certain services (such as waiving cure-oriented services in a hospital setting for supportive services including home care and pain control).
- Certification (and periodic re-certification) of the member’s need for hospice care by the member’s attending physician and the medical director or staff physician of the hospice.
- The CMS membership database is updated, identifying the member as a hospice participant.

If a WindsorSterling member elects hospice care after the 1st of a month, the health plan is responsible for providing any Medicare Covered Services unrelated to the terminal condition or hospice care only for the balance of the month of hospice election. Payment will be made by WindsorSterling for these services only for the balance of the month of hospice election. Beginning the 1st of the month following hospice election, Original Medicare is responsible for all Medicare Covered Services.

➤ Quality Improvement Program

The Quality Improvement Program (QIP) is the frame work for the health plan’s processes and continuous monitoring of our performance according to, or in comparison with objective, measurable performance standards. The QIP assures identification and evaluation of issues that impact our ability to continually better our performance and improve the health care and administrative services provided to our members.

To receive benefits under hospice, a WindsorSterling member must elect traditional Medicare hospice coverage.

Windsor Health Plan is dedicated to administering benefits to our members effectively and efficiently and is committed to providing our members access to high quality, comprehensive, and cost effective medical and pharmacy benefits care. To this end, Windsor Health Plan maintains a team of qualified health plan personnel, provides a comprehensive system of health care providers, and supports the clinical practice of these health care providers.

The QIP includes a written program description, work plan, program evaluation and a committee structure that supports the program. Windsor Health Plan believes that quality improvement is a company-wide endeavor and is consequently supported by all departments.

Windsor Health Plan may disclose upon request to CMS, quality & performance indicators for plan benefits regarding disenrollment rates for beneficiaries enrolled in the plan for the previous two years, enrollee satisfaction and health outcomes.

➤ **Provider's Role**

- Providers in the WindsorSterling network are required to follow Windsor Health Plan, Inc.'s Quality Improvement Program protocol. Adherence to these quality standards will be monitored and measured according to established policies and procedures and nationally recognized standards.
- Contracted providers may be asked to participate in the program by serving on committees, project/work teams, participating in studies and programs, providing expert opinions and confidential peer review, and responding to surveys or requests for information.
- Contracted providers are required to participate in addressing quality of care issues by providing medical records and responding to requests for information.

➤ **Practice Guidelines**

Windsor Health Plan, Inc. supports the utilization of "best practice" guidelines currently in place from nationally recognized organizations. The guidelines are adopted or developed in collaboration with contracted practitioners based on the identified needs of the health plan population or variations in practice patterns within the health plan. As much as possible, clinical practice guidelines are evidence-based, that is, specific recommendations embedded in the guidelines are based on data published in peer reviewed literature. In addition, whenever appropriate, clinical practice guidelines published by nationally recognized organizations are adopted.

Evidence-based preventive guidelines are adopted or developed by Windsor Health Plan, Inc. based on population needs, CMS benefits and current recommendations of the U.S. Preventive Task Force and the American Board of Family Practice.

Guidelines are reviewed and updated periodically, at least every two years. The Medical Advisory Committee may advise on development and implementation, and approve content of clinical practice guidelines. The Chief Medical Officer, as he deems necessary, may solicit input and/or comment from practitioners who are from specialties and would be using the guidelines or experts in

the guideline content. All guidelines, prior to final approval, are compared for consistency with the health plan's decisions regarding utilization management, enrollee educations, and coverage of service.

The adopted guidelines can be viewed via direct links found on the WindsorSterling website at www.windsorhealthplan.com. Paper copies of these guidelines are available upon request.

➤ Advance Directives Overview

Health plans, hospitals and other institutional healthcare providers face a number of responsibilities under the Patient Self-Determination Act of 1990. This federal law requires all institutional providers delivering Medicare or Medicaid services to comply with several requirements related to advance directives.

An advance directive is a document stating a patient's future treatment choice, for use if the patient is unable to communicate the choice for himself/herself.

Compliance with advance directive policies is part of WindsorSterling's quality review process.

There are two forms of advance directives:

1. Living will
2. Power of attorney for healthcare

The living will is a written statement about a patient's wishes not to be resuscitated if a physician believes the patient will be in a coma or would otherwise require life support in order to survive. A power of attorney for healthcare states the patient's wishes regarding treatment and appoints an advocate or surrogate to make all treatment decisions for the patient. The advocate acts only when the patient is incapable of making his/her wishes known and must act in accordance with the wishes stated in the directive. If life-support is to be withheld, this must be written in the directive.

Primary Physicians are required to ask each new WindsorSterling member if he/she has an advance directive. The physician must document the member's response in the medical record.

Under federal law, Medicare Advantage plans must maintain written policies regarding advance directives. Medicare Advantage plans cannot discriminate against any person based on whether or not the individual has an advance directive. Physicians whose moral or religious beliefs prevent them from full support of a patient's advance directive may transfer the patient to a facility or provider who will support the directive.

WindsorSterling physicians are asked to review materials related to the Patient Self-Determination Act and honor patients' wishes as described in their advance directives. All WindsorSterling members are encouraged to discuss their advance directives and any treatment options with their Primary Physician.

WindsorSterling will continue to provide important information about advance directives to members, physicians, and other providers. Any questions regarding advance directives can be directed to the WindsorSterling Provider Help Desk toll free at (866) 270-5223.

➤ **Provider's Role**

- Ask each WindsorSterling patient if he/she has an advance directive. Document the answer and contents in medical records. If the member does not have an advance directive, that should be noted and the physician should ensure that the member understands advance directives. Physician support of this effort is required.
- Honor the wishes of a member as outlined by an advance directive and not discriminate against any member based on the existence or content of his/her medical record.
- Transfer a member whose advance directives you refuse to follow.

➤ **Notice of Denial of Medical Coverage**

When an organizational determination has been made to deny services requested, the provider and the member will be notified of the denial. A Notice of Denial of Medical Coverage is sent to the member with a copy being delivered as well to the requesting provider. The member, member's assigned representative and/or the ordering physician have the right to appeal the decision as outlined in the letter.

➤ **Notice of Discharge and Medicare Appeal Rights (NODMAR)**

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage organizations issue a written notice of non-coverage in the following situations:

- A Medicare Advantage enrollee expresses dissatisfaction with their impending discharge from inpatient hospital care
- The Medicare Advantage organization (or the hospital that has been delegated the responsibility of NODMAR issuance by the Medicare Advantage organization) is not discharging the individual from inpatient hospital care, but no longer intends to continue coverage of the inpatient stay

CMS has developed the model Notice of Discharge and Medicare Appeals Rights (NODMAR) for use by Medicare Advantage organizations, or their delegated hospitals. The language of the model NODMAR fulfills the requirements for notification of non-coverage set forth in the Medicare regulations 42 CFR 417.440(f) and the Medicare Advantage regulations 42 CFR 422.620(c). According to these regulations, Medicare Advantage organizations or their delegated hospitals are required to distribute this notice to enrollees no later than 6:00 p.m. of the day before their inpatient hospital coverage ends.

Additionally, each Medicare Advantage organization or their delegated hospital has at its discretion the option to modify the model language of the NODMAR in any way, as long as three pieces of information are included:

1. The reason why the inpatient care is no longer needed
2. The effective date of the enrollee's risk of financial liability
3. The enrollee's right to appeal

All changes to the model language are subject to approval by the CMS Regional Office plan manager. WindsorSterling is responsible for submitting any changes to the model NODMAR language made by a delegated hospital to CMS for approval.

Any delegated hospital not wishing to follow this process for changes to the NODMAR must use the model NODMAR language, as set forth in the sample NODMAR included in this manual in the appendix. Each delegated hospital is bound by the notice requirements set forth in 42 CFR 422.620(c). In accordance with these regulations, it is our obligation and intent to verify that each delegated hospital participating in the WindsorSterling plans has a policy, process, or method in place to distribute NODMAR notification to all WindsorSterling patients admitted to their facility on an inpatient basis. WindsorSterling reserves the right to conduct unannounced audits at any time to verify compliance with the NODMAR distribution requirements.

➤ Medicare Advantage Member Appeal Rights

A Medicare Advantage enrollee who wishes to remain in the hospital must appeal the Medicare Advantage organization's decision that inpatient care is no longer necessary or covered must request an immediate review of the determination from their regional Quality Improvement Organization (QIO).

The following rules apply to the immediate QIO review process:

1. On the date that the QIO receives the enrollee's request, the QIO must notify the Medicare Advantage organization that the enrollee has filed a request for immediate review;
2. The Medicare Advantage organization and/or hospital must supply any information that the QIO requires in order to conduct its review. This must be made available by phone, fax, or in writing, by the close of business of the first full working day immediately following the day; the enrollee submits the request for review;
3. In response to a request from the Medicare Advantage organization, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day the Medicare Advantage organization makes its request;
4. The QIO must solicit the views of the enrollee who requested the immediate QIO review;
5. The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the enrollee, the hospital, and the Medicare Advantage organization by close of business of the first working day after it receives all necessary information from the hospital, the Medicare Advantage organization, or both.

A Medicare Advantage enrollee who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with the Medicare Advantage organization. The Medicare Advantage organization is encouraged to expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the noon filing deadline and forwards that request to the Medicare Advantage organization, the Medicare Advantage organization should expedite that request. Thus, the Medicare Advantage organization would generally make another decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation. Refer to the CMS web site at www.cms.gov for further information about the financial liability rules.

➤ **Provider's Role**

- Delegated hospitals must provide the NODMAR to WindsorSterling enrollees as outlined above, and as required by all applicable federal regulations pertaining to Medicare and Medicare advantage coverage and appeals rights.
- Delegated hospitals must use an appropriate and pre-approved version of the NODMAR notification as required by all applicable federal regulations pertaining to the notification of non-coverage for hospital inpatient stays.
- Respond quickly and completely to related requests.

Notice of Medicare Non-Coverage (NOMNC)*

Effective January 1, 2004, enrollees of Medicare Advantage plans have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their Medicare Advantage plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulations in a final rule published on April 4, 2003 (68 FR 16652).

➤ **What is "Grijalva?"**

"Grijalva" refers to *Grijalva v. Shalala* – a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied, reduced, or terminated. Following extended legal negotiations -- and significant changes to appeals procedures that resolved many issues -- CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

➤ **New Regulations**

Based on the provisions of the April 2003 final rule, Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehab Facilities must provide an advance notice of Medicare coverage termination to Medicare Advantage enrollees no later than 2 days (or 2 visits if services are not rendered on a daily basis) before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in their State, and the enrollee's Medicare Advantage plan must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review. The new SNF, HHA, and CORF notification and appeal requirements distribute responsibilities under the new procedures among four parties:

1. The Medicare Advantage organization generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, Medicare Advantage organizations may choose to delegate these responsibilities to their contracting providers.)
2. The provider is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to all enrollees no later than 2 days (or 2 visits if services are not rendered on a daily basis) before their covered services end. Providers must also fax a signed copy of the notice to WindsorSterling within 24 hours of issue. The signature and date must correspond with the 2 days prior to the last covered date. (EX. If the last covered date of services is 11/03/2011, the letter must be signed and dated no later than 11/01/11). CMS requires that the MCO keep a copy of all notices on file. Provider may fax a copy of the completed notice to WindsorSterling to 615-782-7868 for SNF services or 615-661-4741 for Home Care Services.
3. The patient/Medicare Advantage enrollee (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.
4. The QIO is responsible for immediately contacting the Medicare Advantage organization and the provider if an enrollee requests an expedited review, and making a decision on the case by no later than the day Medicare coverage is predicted to end.

These new notice and appeal procedures went into effect on January 1, 2004. Providers should also be aware that the Medicare law- section 1869(b) (1)(F) -of the Social Security Act establishes a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries. This new notice and appeal procedure for "fee-for-service" Medicare beneficiaries went into effect on July 1, 2005.

➤ **Notice of Medicare Non-Coverage (NOMNC)**

The NOMNC (formerly referred to as the Important Medicare Message of Non-Coverage) is a short, straightforward notice that informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS has developed a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider.

➤ **When to Deliver the NOMNC**

Based on the determination of the Medicare Advantage member's physician or the Medicare Advantage organization of when services should end, the provider is responsible for delivering the NOMNC no later than two (2) days (or 2 visits if services are not rendered on a daily basis) before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a 2-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. CMS encourages providers to work with Medicare Advantage organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but the provider still has a responsibility under their Medicare provider agreement to carry out this function.

➤ **How to Deliver the NOMNC**

The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. The signature and date must correspond with the 2 days prior to the last covered date. (EX. If the last covered date of services is 11/03/2011, the letter must be signed and dated no later than 11/01/11) Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

➤ **Expedited Review Process**

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the Medicare Advantage organization and the provider of the request for a review and the Medicare Advantage organization is responsible for providing the QIO and enrollee with a detailed explanation of why coverage is ending. The Medicare Advantage organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with Medicare Advantage organization requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

➤ **Importance of Timing/Need for Flexibility**

Although the regulations and accompanying CMS instructions do not require action by any of the four responsible parties until 2 days (or 2 visits if services are not rendered on a daily basis) before the planned termination of covered services, it is important to emphasize that whenever possible, it is in everyone's best interest for the Medicare Advantage organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible.

Delivery of the NOMNC by the provider as soon as it knows when the Medicare Advantage organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the QIO to ask for a review, the more time the QIO has to decide the case, meaning that the provider and/or Medicare Advantage organization may have more time to provide required information.

➤ More Information

Further information on this process, including an electronic copy of the NOMNC and related instructions can be found on the CMS website at: <http://www.cms.gov/MMCAG/Downloads/NOMNCInstructions.pdf>

An electronic copy of the NOMNC can also be found under the Forms section of the CMS web site at www.cms.gov/bni/09_MAEDNotices.asp (Also, the regulations are at 42 CFR 422.624, 422.626, and 489. The Grievances and Appeals chapter of the Medicare Advantage Manual includes information on the process as well.)

➤ Model NOMNC Forms

Delegated WindsorSterling providers must deliver an advance, completed copy of the NOMNC to enrollees receiving skilled nursing, home health, or comprehensive rehabilitation facility services not later than 2 days before the termination of services as set forth above and in the federal regulations at 42 CFR 422.624(b)(2) Medicare Decisions and Your Rights (MDYR).

The current regulations governing Medicare Advantage plans state that Medicare Advantage plans must provide their enrollees, upon request, with "a detailed notice of a Primary practitioner's decision to deny a service in whole or in part..." (42 CFR 422.568 d).

The Center for Medicare and Medicaid Services (CMS) has established guidelines for the provision of this notification that state that "at each patient encounter with a [Medicare Advantage] plan enrollee, a practitioner must notify the enrollee of his or her right to receive, upon request, a detailed written notice from the [Medicare Advantage] organization regarding the enrollee's services..." (42 CFR 422.568 c). This notification may be provided in writing.

➤ Provider's Role

- Fulfill the obligation to inform members of their appeal rights whenever a decision to deny care to a member is made.
- Inform each member verbally of their right to receive written notification from their Medicare Advantage plan regarding the denial of their services.

➤ Pharmacy Department

The primary mission of the Pharmacy Department is to strive for the appropriate and cost effective drug therapy for all Medicare Part D beneficiaries. We take numerous approaches in trying to accomplish this goal. Education is perhaps our most important tool. Other important aspects are:

- Providing medication therapy management
- Designing drug benefits
- Developing and managing the Part D WindsorSterling formulary
- Managing the WindsorSterling Part D coverage determinations which includes prior authorizations, exceptions and safety limit determinations
- Monitoring pharmacy claims
- Evaluating and contracting with our pharmacy providers
- Oversight and monitoring of the pharmacy benefit manager
- Contracting with pharmaceutical manufacturers
- Integrating inpatient and outpatient pharmaceutical care
- Managing individual cases
- Servicing the needs of patients, physicians, and pharmacy providers
- Monitoring Fraud, Waste and Abuse

➤ How to Contact Us

MAPD (Pharmacy)

Phone: (866) 715-7519

Fax: (615) 782-7869

7 AM – 6 PM, Central Standard Time,
Monday thru Friday

Windsor Medicare Part D

➤ Drug Formularies

WindsorSterling maintains, under the auspices of the Windsor Pharmacy and Therapeutics (P&T) Committee, comprehensive Medicare Part D formularies. Our formularies should be your guide to choosing high quality and cost-effective drug therapy. Our formularies represent the prescription therapies believed to be a necessary part of a quality treatment program. Windsor will generally cover the drugs listed in our formularies as long as the drug is medically necessary, the prescription is filled at a Windsor network pharmacy and other plan rules are followed. The content of the formularies is decided by the Windsor Pharmacy and Therapeutics Committee (consisting of community physicians and pharmacists) and is subject to updates on a monthly basis. Prescribers may access the formularies at our website at <http://www.windsorhealthplan.com/Providers> for both WindsorSterling and Windsor Rx formularies. We have also included Prior Authorization and Step Therapy Criteria for your convenience.

➤ Description of Windsor’s Formularies

Windsor utilizes Medical and Pharmacy experts to determine category and class of formulary medications. The formulary is initially reviewed by Therapeutic Categories which include pharmacological class and drugs within the class. There is also an alphabetical drug index at the end of the formulary listing the generic and brand name with the page number location. All beneficiaries may receive up to a maximum of 30 days supply of FDA approved dosages or a 90 day supply for maintenance drugs. We will have two closed formularies that are associated with the following plans:

Plan Names	Formulary
<i>MA/MAPDPlans</i>	
WindsorSterling Silver Connect and Silver Access	No Part D Benefit
WindsorSterling Gold Plus	MAPD Formulary
WindsorSterling Gold Connect	MAPD Formulary
WindsorSterling Emerald Connect	MAPD Formulary

➤ Positive and Negative Formulary Changes

If the Windsor P&T Committee recommends removing a current Medicare Part D formulary drug or adding prior authorizations, quantity limits and/or stepping therapies on a drug, or moving a drug to a higher cost-sharing tier, we must notify providers and beneficiaries of the “negative” change. All “negative” drug changes will be adjusted 60 days from the date of the notification was sent.

If the Windsor P&T Committee recommends adding Medicare Part D eligible drugs or removing current prior authorizations, quantity limits and/or step therapies, or moving a drug to a lower cost-sharing tier for the member, we will notify providers and beneficiaries of the “positive” changes through our website. All “positive” drug changes will be implemented in the pharmacy claims processing system promptly.

If the Food and Drug Administration (FDA) deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to providers and beneficiaries affected by the removal within 14 days.

➤ Medicare Part D Formulary Exclusions

The following class and example medications have been excluded by Medicare as not being Part D eligible:

- 1) Agents when used for anorexia, weight loss, or weight gain - Xenical
- 2) Agents when used to promote fertility – Clomid, Lupron
- 3) Agents when used for cosmetic purposes or hair growth – Retin-A, Avita
- 4) Agents when used for the symptomatic relief of cough and colds – Dimetapp
- 5) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- 6) Non-prescription drugs – Over-the-Counter Drugs
- 7) Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
- 8) Barbiturates - Phenobarbital
- 9) Benzodiazepines – Valium, Xanax, Ativan
- 10) Erectile Dysfunction Drugs (Viagra, Levitra)

➤ Early Refills

Network pharmacies cannot dispense refill medications to beneficiaries until the beneficiary has used at least 75% of the previous supply (or 70% for Ophthalmics). This edit is in place to eliminate stock-piling, sharing medications and to alert pharmacist to a potential compliance issue. If the dose has increased, the pharmacist can obtain a dose increase override from the pharmacy claims processor by calling 1-800-364-6331. If the medication was lost or stolen, the beneficiary will be responsible for 100% of the drug cost, except in the cases of natural disasters.

➤ Drug Utilization Review (DUR)

The objective of DUR is to improve the quality of pharmaceutical care by ensuring that Prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes.

1. WindsorSterling seeks to ensure the safety of dispensed medications by notifying dispensing providers of potential adverse events at the point-of-dispensing when potential adverse events may occur for medications being dispensed to members. The online messaging process classifies events at different levels of severity and includes drug-to-drug interactions and therapeutic duplications. The following is a description of the DUR Program.
 - 1.1. Windsor's concurrent DUR program checks for the following potential concerns each time a prescription is adjudicated to our pharmacy claims processor:
 - 1.2. Drug-Drug Interaction alert
 - 1.3. Drug-Dose (Low and High) alert
 - 1.4. Adherence alert
 - 1.5. Therapeutic Duplication alert
 - 1.6. Over/Under Utilization alert
 - 1.7. Drug Age/gender limits
 - 1.8. Drug-Allergy alert
 - 1.9. Clinical abuse/misuse alert
2. Additionally, Windsor codes the following utilization review edits within the adjudication platform:
 - 2.1. Refill Too Soon
 - 2.2. Prior Authorizations
 - 2.3. Step Therapies
 - 2.4. Quantity Limits (quantity over time)
 - 2.5. Safety Edits – (daily dose limits)
3. For therapeutic duplications, the DUR program searches for therapy that is duplication and not medically indicated and may potentially result in adverse events. The system sends a message back to the pharmacy regarding the alert regarding overlapping periods of time that include:
 - 3.1. Two or more doses of the same drug;
 - 3.2. At least two drugs from the same therapeutic class; and
 - 3.3. At least two drugs from different therapeutic classes with similar pharmacological effects being used for the same indication.
4.
 - 4.1. For drug interactions, the DUR program searches for interactions at the point-of-dispensing that may potentially result in adverse events and notifies the dispensing provider of such interactions, including their type and severity level. Drug interactions are classified into the following five severity level.

- 4.2. Level 1: A potentially severe or life-threatening interaction. The occurrence has been suspected, established, or probable in well controlled studies. Contraindicated drug combinations may also have this severity level;
- 4.3. Level 2: The interaction may cause deterioration in a patient's clinical status. The occurrence is suspected, established, or probable in well controlled studies;
- 4.4. Level 3: The interaction causes minor effects. The occurrence suspected, established or is probable based on well-controlled studies;
- 4.5. Level 4: The interaction may cause moderate-to-major effects, but data is very limited; and
- 5. Level 5: Interaction may cause minor-to-moderate effects. The occurrence is unlikely or there is not good evidence of an altered clinical effect.
- 6. Messages for severity Level 1 and 2 are transmitted to a dispensing provider at point of dispensing to inform the prescribing provider of the potential adverse interaction. Messages for severity Levels 3, 4, and 5 are not sent to the dispensing provider.
- 7. Quarterly and/or monthly reports are analyzed for trends and actions and will be communicated to prescribers if outliers are identified. Trends are presented to Windsor's Pharmacy and Therapeutic Committee for discussion.

➤ Coverage Determinations

Utilization Management Tool

The following are definitions of the utilization management tools requiring coverage determination or exceptions to be requested that are currently utilized by Windsor Pharmacy Department:

1. **Prior Authorization (PA)** - These are drugs, which the Windsor P&T Committee decides can be used only in specific circumstances. Prior authorization is required for coverage of the medication before the beneficiary goes to the pharmacy. Below is a description of the coverage determination process.
2. **Quantity Limits (QL)** - Quantity Limits are established to promote safe and appropriate cost-effective use of specific classes of medications for formulary agents. All QL will be listed on the formulary as an established number of units per 30 days. The system will count all units received within the therapeutic class and will only allow payment of the quantity established. The process used to establish the limit of the identified drug is the current approved Food and Drug Administration (FDA) dosing. Prescribers may request an exception to our Quantity Limits by completing a Part D Coverage Determination form as described below.
3. **Step Therapy** – Step therapy drugs are established through utilization review of the Windsor P&T Committee recommendations. When step therapies are established, they are coded in the pharmacy claims processing system. The code mandates a certain drug within a therapeutic class be tried before obtaining a different drug within the same class.

In order to determine if a drug requires a PA, you may access our formularies at <http://www.windsorhealthplan.com/ProvidersAnydrug> that requires a PA, QL, or ST will be included in the NOTES column of the applicable formulary.

➤ **Coverage Determination Policy Statement**

Prior Authorizations (PA), Step Therapy (ST), and Quantity Limits (QL) will be used for drugs that pose potential efficacy, toxicity or utilization problems. The WindsorSterling Pharmacy Department manages the Medicare Part D Coverage Determination process utilizing clinical criteria approved by the Windsor Pharmacy and Therapeutics Committee. Those drugs that require PA and other Utilization Management (UM) are established yearly for the Medicare Part D Program.

➤ **Coverage Determination Policy Description**

Prior Authorizations (PA) and other Utilization Management (UM) tools are used to promote cost effective and appropriate use of pharmaceuticals.

Drugs are considered for PA or other UM requirements, when any of the following criteria are met:

1. The drug has the potential to be used for cosmetic purposes.
2. The drug has the potential to be used for indications that are not covered benefit.
3. There is significant concern about potential overuse of an agent.
4. The drug has the potential to be used for off-labeled or experimental purposes.
5. The drug identifies potential Case Management referrals promptly.
6. The drug has the potential for significant use that is deemed not to be cost effective.
7. There is significant concern regarding the potential for sub-optimal use.

PA or other UM criteria fall into three main categories:

1. Diagnostic criteria identify indications that constitute acceptable uses for a formulary drug.
2. Prescriber criteria identify prescribers who are approved to use specific drugs or drug classes.
3. Drug-specific criteria identify approved doses, frequency of administration, duration of therapy, or other aspects that are specific to use of a drug.

PA and other UM requirements are based upon information contained in authoritative sources and local practice conditions. Information reviewed includes:

1. Micromedex (CMS approved compendia)
2. American Hospital Formulary Service (AHFS) (CMS approved compendia)
3. Clinical Pharmacology (CMS approved compendia)
4. National Comprehensive Network (NCCN) (CMS approved compendia)
5. Published scientific literature for approved FDA indications
6. Facts and Comparison Formulary services
7. Medical or pharmacy review services
8. National Guidelines Clearinghouse, Agency for Healthcare Research and Quality (AHRQ), US Department of Health and Human Services.

9. FDS-approved manufacturer labeling information (Package Insert).
10. The recommendations of organizations such as, but not limited to: CDC, AAP, ACC and NIH.

Upon Windsor Pharmacy & Therapeutics approval of prior approvals and other utilization management requirements the Vice President of Pharmacy will ensure the following:

1. Verify entry of the approved PA or other UM requirement in the Windsor P&T meeting minutes.
2. Notify the pharmacy claims processor of the approved PA or other UM requirement to be applied for drug coverage and accompanying POS messaging. (NOTE, all beneficiaries and providers shall be given a 60-day advance notice of all new Coverage Determination before placing into the claims processing system).
3. Formally document the PA or other UM criteria.
4. Arrange for automated messaging to request the prescriber to complete PA or other UM request if such was not obtained.
5. Arrange for new formulary posting of the PA or other UM requirement to the Windsor website along with the coverage determination request form (See below).
6. Arrange for notification of the PA or other UM requirement in Windsor's quarterly provider and beneficiary newsletter.

The information needed to support a PA or other UM request is described on the Windsor website, and is also available by phone and in print form, upon request, from Windsor Pharmacy Department.

Windsor makes all reasonable attempts to obtain information needed to make a timely coverage determination by contacting the requesting physician, other ordering practitioners, and/or designated facility staff to obtain any needed information.

➤ Coverage Determination Process

The processes outlined below are followed in making coverage determinations which include PA, ST, QL, and additionally, to make non-formulary (NF), or a tier exception requests.

1. Windsor Pharmacy Department may receive, from a physician or beneficiary, a Coverage Determination Request Form (See below). If a Coverage determination form is not available, all information may be given orally. A physician may use the Model Medicare Part D Coverage Determination Form for physicians (a/k/a model Part D Exception and Prior Authorization Form) to request an override for a PA, ST, QL, NF, and PA exceptions. **Note:** When a beneficiary or a beneficiary's prescribing physician is seeking an exception to a PA or other UM requirement in which a beneficiary would suffer adverse effects if he or she were required to satisfy the PA requirement, the prescribing physician may use the Coverage Determination Request Form and/or submit a supporting statement that is made in writing. Additionally beneficiaries may request tier and formulary exceptions, but will not be processed until the beneficiary's prescribing physician submits a coverage determination

form which is accompanied by a written or oral supporting statement and/or documentation.

2. Patient information on the Coverage Determination Request Form must include the beneficiary's first and last name, date of birth and WHP ID number. A completed Coverage Determination Request form must indicate the current relevant diagnosis, medications failed, and the reason for the medical exception. Incomplete forms will be faxed back (using a HIPAA compliant cover sheet and verified FAX number) or called to obtain the missing information.
3. Beneficiary eligibility is verified. Verification of eligibility includes, but is not limited to: matching date of birth and gender with Coverage Determination request.
4. Utilization may also be verified. This may include but is not limited to, checking claims profile and noting any abnormalities, abuses, or trends.
5. Upon receipt of the required information, the Coverage Determination will be reviewed by a Clinical Pharmacy Technician a First Level Reviewer and if the request meets the established clinical criteria, approved by the Windsor P&T Committee, approval will be granted by the Clinical Pharmacy Technician.
6. If the Coverage Determination is approved, the medication approved, date and length of the approval, and reviewing Clinical Pharmacy Technician will fax (using a HIPAA compliant cover sheet and verified FAX number) back to the provider. An authorization is then entered into the pharmacy claims processing system. . All coverage determinations are logged into the Coverage Determination Database and all correspondence documented or filed. A test claim is processed to ensure a paid claim. The pharmacy is called and asked to process the claim if a rejected claim exists. If the pharmacy offers to call the member regarding the approved prescription, then we will document such. If not, Windsor will make one attempt to call member regarding the approval, if phone number is available.
7. Medical Necessity denials shall be determined by a Clinical Pharmacist against criteria approved by the Windsor P&T. A letter notifying the physician and the beneficiary of the non-coverage of the requested drug is generated and is either faxed or mailed. Additionally, Windsor will attempt one time to notify the member of the denial, if a phone number is available. Windsor will provide the following information both orally (if phone attempt is successful) or by letter: the name of the denied medication, the specific clinical reasons that coverage was denied, a statement that the clinical criteria is available upon request and free of charge, the notice of the right to file an appeal, and whom to contact for more information. The appeals process is available for any denial.

8. Prior Authorizations Coverage Determinations will be processed in accordance with the following timeframes:

TYPE OF COVERAGE DETERMINATION/TIERING EXCEPTION	TIMEFRAME
STANDARD PA coverage determinations	As expeditiously as the enrollee's health condition requires, but no later than 72 HOURS after receipt of the request/supporting statement
EXPEDITED PA coverage determinations	As expeditiously as the enrollee's health condition requires, but no later than 24 HOURS after receipt of the request/supporting statement

NOTE: For Coverage Determination Exceptions (Non-formulary, Step Therapy, Quantity Limits, and Tiering Exceptions), if no supporting statement/documentation is received for the requested exception, the request shall be denied for lack of clinical supporting documentation after waiting a minimum of 48 hours not to exceed 96 hours for expedited and 96 hours not to exceed 192 hours for standard requests from the time of the original request before issuing its determination on the exception. The denial process as indicated above will be performed.

9. Part D Beneficiaries have the following rights:

- A. The right to a timely coverage determination.
- B. The right to request an expedited coverage determination.
- C. The right to receive information from a network pharmacist regarding the beneficiary's ability to obtain a detailed written notice from Windsor regarding the beneficiary's Part D Benefits.
- D. The right to a detailed written notice of Windsor's decision to deny a benefit in whole or in part, which includes the beneficiary's appeal rights.
- E. The right to receive notice when a coverage determination is forwarded to the Independent Review Entity (IRE).

10. A beneficiary, his or her appointed representative, or the beneficiary's prescribing physician, may request that a Part D plan sponsor expedite a coverage determination when the beneficiary or his/her physician believes that waiting for a decision under the standard time frame may place the beneficiary's life, health, or ability to regain maximum function in serious jeopardy.

11. If Windsor does not provide notice of its standard or expedited coverage determination within the required time frame, the complete case file will be forwarded to CMS within 24 hours of the expiration of the adjudication time frame. Windsor must have the prescribing physician written supporting statement. Please see APPENDIX for WindsorSterling Pharmacy Coverage Determination Form

➤ **DEA/NPI Numbers Needed**

When pharmacists transmit prescriptions electronically, the provider's or practitioner's NPI is transmitted, not the name. It is very important that the pharmacy have this number. The pharmacy must have your NPI number for ALL Part D claims.

➤ **Beneficiary Copays**

For the WINDSORSTERLING PART D BENEFIT, the amount a beneficiary pays depends on which drug tier you prescribe as described above. WindsorSterling will pay part of the costs for covered drugs and the beneficiary will pay part.

➤ **Special Help for People with Low Incomes**

There is special help for people with low incomes and assets. The government will help pay the part D benefit for people with incomes less than 100% of federal poverty level. The government will pay most of the cost share.

➤ **List of Participating Pharmacies**

The Windsor Pharmacy Network includes most major chain and independent pharmacies in Tennessee and surrounding states. More information concerning participating pharmacies is available at <http://www.windsorhealthplan.com/Providers>.

Windsor Medicare Part B

Drugs administered in a practitioner or provider's office or ambulatory clinic setting and diabetic supplies such as diabetic machines and lancets are considered by Medicare as a part B benefit and will be separate from the Part D Program. Part B drugs are always "incident to a physician office visit." A list of Part B Drugs which require prior authorization can be found on our website <http://www.windsorhealthplan.com/Providers>. You may utilize our coverage determination form to make your request. Additionally, we have provided a CMS chart summarizing part B versus Part D coverage issues.

Medicare Parts B/D Coverage Issues

(NOTE: TABLE PROVIDED BY MEDICARE)

This table provides a quick reference guide for the most frequent Medicare Part B drug and Part D drug coverage determination scenarios facing Part D plans and Part D pharmacy providers. It does not address all possible situations. For a more extensive discussion, please refer to “Medicare Part B vs. Part D Coverage Issues” at:

https://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf

Part B Coverage Category	Part B Coverage Description	If Retail Pharmacy, Which Part Pays? ¹	If LTC Pharmacy, Which Part Pays?	Comments
Durable Medical Equipment (DME) Supply Drugs Only available for people living at “home” ²	Drugs that require administration via covered DME (e.g., inhalation drugs requiring a nebulizer, IV drugs “requiring” ³ a pump for infusion, insulin via infusion pump) ⁴	B	D	Blood glucose testing strips and lancets covered Part B DME benefit are never available under Part D because they are not Part D drugs.

¹ For purposes of this chart, retail pharmacies include home infusion pharmacies.

² In addition to a hospital, a SNF or a distinct part SNF, the following LTC facilities cannot be considered a home for purposes of receiving the Medicare Part B DME benefit:

- A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF)
- A Medicaid-only NF that primarily furnishes skilled care;
- A non-participating nursing home (i.e., neither Medicare nor Medicaid) that provides primarily skilled care; and
- An institution which has a distinct part SNF and which also primarily furnishes skilled care.

⁴ The DMERC determines whether or not an IV drug requires a pump for infusion.

⁵ The DMERC determines whether a nebulizer or infusion pump is medically necessary for a specific drug/condition.

Part B Coverage Category	Part B Coverage Description	If Retail Pharmacy, Which Part Pays? ¹	If LTC Pharmacy, Which Part Pays?	Comments
Drugs furnished "incident to" a physician service (i.e., the drug is furnished by the physician and administered either by the physician or by the physician's staff under the physician's supervision).	Injectable/intravenous drugs 1) administered incident to a physician service and 2) considered by Part B carrier as "not usually self-administered"	D	D	Not covered by Part B because a pharmacy cannot provide a drug incident to a physician's service (i.e., only a physician office would bill Part B for "incident to" drugs).
Immunosuppressant Drugs	Drugs used in immunosuppressive therapy for people who received transplant from Medicare-approved facility and were entitled to Medicare Part A at time of transplant (i.e., "Medicare-Covered Transplant")	B or D: Part B for Medicare-Covered Transplant Part D for all other situations	B or D: Part B for Medicare-Covered Transplant Part D for all other situations	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.
Oral Anti-Cancer Drugs	Oral drugs used for cancer treatment that contain same active ingredient (or pro-drug) as injectable dosage forms that would be covered as 1) not usually self-administered and 2) provided incident to a physician's service	B or D: Part B for cancer treatment Part D for all other indications	B or D: Part B for cancer treatment Part D for all other indications	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.
Oral Anti-emetic Drugs	Oral anti-emetic drugs used as full therapeutic replacement for IV anti-emetic drugs within 48 hrs of chemo	B or D: Part B for use w/in 48 hrs. of chemo Part D all other situations	B or D: Part B for use w/in 48 hrs. of chemo Part D all other situations	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.

Part B Coverage Category	Part B Coverage Description	If Retail Pharmacy, Which Part Pays? ¹	If LTC Pharmacy, Which Part Pays?	Comments
Erythropoietin (EPO)	Treatment of anemia for persons with chronic renal failure who are undergoing dialysis	B or D: Part B for treatment of anemia for people undergoing dialysis Part D all other situations	B or D: Part B for treatment of anemia for people undergoing dialysis Part D all other situations	EPO may also be covered under Part B for other conditions if furnished incident to a physician's service. (A physician, not a pharmacy, bills for "incident to" drugs.)
Prophylactic Vaccines	Influenza; Pneumococcal; and Hepatitis B (for intermediate to high-risk individuals)	B or D: Part B for Influenza, Pneumococcal, & Hepatitis B (for intermediate to high risk) Part D for all others	B or D: Part B for influenza, pneumococcal , & Hepatitis B (for intermediate to high risk) Part D for all others	Vaccines given directly related to the treatment of an injury or direct exposure to a disease or condition are always covered under Part B.
Parenteral Nutrition	Prosthetic benefit for individuals with "permanent" dysfunction of the digestive tract (must meet "permanence" test)	B or D: Part B if "permanent" dysfunction of digestive tract Part D for all other situations	B or D: Part B if "permanent" dysfunction of digestive tract Part D for all other situations	Part D does not pay for the equipment/supplies and professional services associated with the provision of parenteral nutrition or other Part D covered infusion therapy.

Avenues available to members for filing appeals and grievances related to Medicare Advantage benefits and Part D prescription drug benefits

The appeals process for WindsorSterling members is governed by regulations from the Centers for Medicare and Medicaid Services (CMS). WindsorSterling is required by CMS to implement grievance and appeal procedures that meet the requirements established in the regulations.

➤ **Member Appeals Overview**

The Centers for Medicare and Medicaid Services (CMS) has specific guidelines regarding the handling of grievances and appeals. Although the administration of these issues is the responsibility of the health plan, as a WindsorSterling provider you may be called upon to provide information to assist in the resolution of a grievance or an appeal. The following information is meant to provide only a general overview of the grievance and appeal procedures.

An appeal is defined as the right of a member to request a review of any decision related to a denial of payment or coverage by WindsorSterling for Medicare Advantage services or benefits that the member believes WindsorSterling should cover. For members with a Part D prescription drug benefit, an appeal is defined as the right of a member to request a review of any decision related to a denial of payment or coverage of a Part D prescription drug.

The appeals process used by members of WindsorSterling is dictated by CMS regulations. There are several steps involved in the appeals process, depending on the resolution at each step, as well as the amount of money in question. The steps in the process include:

➤ **Initial Determination**

The appeals process may begin once an initial determination is issued by the plan. There are two types of initial determinations: Organization Determinations and Coverage Determinations

- (1) An Organization Determination is a decision on whether WindsorSterling will cover medical care or services being requested or pay for medical care or services already received.
- (2) A Coverage Determination is a decision on whether WindsorSterling will cover a Part D drug and what the member's cost share is for the drug or a decision on whether WindsorSterling will pay for a Part D prescription drug a member has already received. Coverage Determinations include exception requests.

➤ **Appealing the Initial Determination with WindsorSterling**

Parties to the initial determination have the right to appeal the adverse initial determination with WindsorSterling. The plan level appeal process for Medicare Advantage benefits is known as reconsideration. The plan level appeal process for Part D prescription drug benefits is known as a redetermination. The reconsideration and redetermination processes provide the member or member's designee with a mechanism for an objective and timely review of an adverse initial determination, in accordance with CMS regulations. If WindsorSterling's reconsideration or redetermination decision is not fully favorable to the member, the member has further appeal rights with an Independent Review Entity (IRE).

➤ **Independent Review Entity (IRE)**

- When WindsorSterling's reconsideration decision is not fully favorable to the member, the appeal will be automatically forwarded to the IRE.
- When WindsorSterling's redetermination decision is not fully favorable to the member, the member has the right to ask for a review by the IRE.

The IRE has a contract with CMS and has no connection with WindsorSterling. The IRE will review the appeal and determine whether or not WindsorSterling's decision to deny was appropriate. If the IRE determination is fully favorable to the member, WindsorSterling must abide by the IRE's determination. If the IRE determination is not fully favorable to the member, the member has the right to request a review by an Administrative Law Judge.

➤ **Administrative Law Judge (ALJ)**

Any party to the reconsideration or redetermination (with the exception of WindsorSterling) who is dissatisfied with an unfavorable IRE determination has the right to a hearing before an Administrative Law Judge (ALJ) if the amount in controversy meets the appropriate threshold amount established annually by CMS.

- If the ALJ decision regarding Medicare Advantage benefits is dissatisfactory to any party (including WindsorSterling), the party may request a review by the Medicare Appeals Council (MAC).
- If the ALJ decision regarding Part D prescription drugs is dissatisfactory to the member, the member may request a review by the MAC.

➤ **Medicare Appeals Council (MAC)**

The Medicare Appeals Council (MAC) may grant or deny a request for review. If it grants a review, it may either issue a final decision or dismissal, or remand the case back to the ALJ with instructions on how to proceed with the case.

- If the MAC decision regarding Medicare Advantage benefits is dissatisfactory to any party (including WindsorSterling), the party may request judicial review.
- If the MAC decision regarding Part D prescription drugs is dissatisfactory to the member, the member may request judicial review.

➤ Judicial Review

No party may obtain a court review unless the MAC has acted on the case, either in response to a request for review or on its own motion. Any party to the hearing (including WindsorSterling for Medicare Advantage appeals only) may request judicial review of the ALJ's decision or a decision by the MAC if:

- The MAC denied the party's request for review, and
- The amount remaining in controversy meets the appropriate threshold amount established annually.

In addition, any party may request judicial review of a MAC decision if:

- The MAC denied the party's request for review; or
- It is the final decision of the CMS; and
- The amount remaining in controversy meets the appropriate threshold amount

➤ Appeal Processing Timeframes

The appeals process can follow either a *standard* or an *expedited* timeframe. Most appeals will follow the standard process while specific criteria must be met in order to obtain an expedited appeal. The following text details the standard and expedited timeframes.

➤ Standard Appeals

Standard appeals include requests for review of adverse initial determinations. All standard appeals must be filed within 60 calendar days of the date of the initial determination issued by WindsorSterling unless good cause exists for a delay in filing.

- If a denial of payment is appealed for a Medicare Advantage benefit, WindsorSterling must reconsider the initial determination of denial within 60 calendar days of receiving the request for appeal.
- If a denial of service for a Medicare Advantage benefit is appealed, WindsorSterling must reconsider the initial determination of denial as expeditiously as the member's health requires, but no later than within 30 calendar days of receiving the request for appeal.
- If a denial of coverage for Part D prescription drug is appealed, WindsorSterling must reconsider the initial determination of denial as expeditiously as the member's health requires, but no later than within 7 calendar days of receiving the request for appeal.
- If a denial of payment for a Part D prescription drug is appealed, WindsorSterling must reconsider the initial determination of denial within 7 calendar days of receiving the request for appeal.

A party may request a standard appeal by filing a signed written request with WindsorSterling. Requests should be mailed or faxed to:

WindsorSterling
Attn: Grievance and Appeals Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027
Fax: 615-782-7971

Additional information may be provided to help support the appeal. This information may be faxed, mailed or delivered in person to WindsorSterling.

➤ **WindsorSterling Grievance and Appeals Form**

Requests for standard appeals must be submitted in writing to WindsorSterling. In order to facilitate a member's request for a standard appeal, the member may choose to complete a Member Grievance and Appeals Form. The form is available on our web site at www.windsorhealthplan.com or by contacting our Customer Service department at 1-888-858-8551.

Once completed, the member should mail the form or fax to:

WindsorSterling
Attn: Grievance and Appeals Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027
Fax: 615-782-7971

➤ **Expedited Appeals**

The expedited appeals process is reserved for reviews of adverse initial determinations where processing the request under the standard appeal timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function. All expedited appeals must be filed within 60 calendar days of the date of the initial determination issued by WindsorSterling unless good cause exists for a delay in filing.

WindsorSterling must process an expedited appeal and make a determination as expeditiously as the member's health requires, but no later than within 72 hours after receiving the request for an expedited appeal.

Examples of situations wherein the member's health could seriously be harmed by waiting for a standard appeal include, but are not limited to:

- Certain acute care services
- Certain types of nursing facility care
- Certain types of home health and therapy services
- Situations where non-cosmetic surgery and hospital stays are denied or terminated

The decision timeframe for an expedited appeal regarding Medicare Advantage benefits can be extended by up to 14 calendar days if the member, member's representative, or member physician requests the extension or if WindsorSterling needs additional information and the extension benefits the member. The decision timeframe for an expedited appeal regarding Part D prescription drug benefits cannot be extended.

Member requests for an expedited appeal are reviewed by WindsorSterling to determine if the criteria for an expedited appeal have been met. If the criteria have not been met, the request for an expedited appeal is denied and the request is automatically transferred to the standard appeal timeframe. The member will have the right to request an expedited grievance regarding WindsorSterling's decision not

to grant an expedited review. (Please refer to the Grievance section for further information regarding the expedited grievance process.)

Any physician, regardless of his/her affiliation to WindsorSterling, may file a request for an expedited appeal regarding Medicare Advantage benefits on behalf of a member when the physician indicates that applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. A prescriber may request an expedited appeal on behalf of a member when the prescriber indicates that applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. In light of the short timeframe for expedited appeals, a physician/prescriber does not need to be an authorized representative to request an expedited appeal on behalf of a member.

Any physician (for Medicare Advantage benefits) or prescriber (for Part D prescription drugs) may also provide oral or written support for an expedited request made by the member.

If any physician (for Medicare Advantage benefits) or prescriber (for Part D prescription drugs) requests an expedited appeal on behalf of a member or supports a member's own request for an expedited appeal, WindsorSterling must honor the request for expedited processing of that appeal.

A member, member's representative, any physician (for Medicare Advantage benefits), or the prescriber (for Part D prescription drugs) may request an expedited appeal either verbally or in writing if he/she feels that applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

To file a request verbally, the party should call 1-888-858-8551. WindsorSterling will document the request in writing.

The party can fax the request to 615-782-7971.

The member can hand deliver or mail the request to:

WindsorSterling
Attn: Grievance and Appeals Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

In light of the expedited nature of the request, we recommend that requests for expedited appeals be filed verbally or via facsimile.

Additional information may be provided to help support the expedited appeal. This information may be faxed, mailed or delivered in person to WindsorSterling.

Appeals of Certain Provider Settings

➤ Appeals if a Member Thinks He / She is Being Discharged from a Hospital Too Soon

The Centers for Medicare & Medicaid Services (CMS) requires that a Medicare health plan issue a written Notice of Discharge and Medicare Appeal Rights (NODMAR) in the following situations:

- A Medicare Advantage member expresses dissatisfaction with his/her impending discharge from inpatient hospital care; or
- The Medicare Advantage organization (or the hospital that has been delegated the responsibility of NODMAR issuance by the Medicare health plan) is not discharging the member from inpatient hospital care, but no longer intends to continue coverage of the inpatient stay. In other words, the Medicare health plan or delegated hospital intends to lower the member's level of care from inpatient acute to, for example, skilled nursing, within the same hospital facility (a change that would be transparent to the member if no notice were provided).

Before the Medicare health plan or delegated hospital can provide the member with a NODMAR, the physician who is responsible for the member's inpatient hospital care must concur with the decision to discharge the member or lower the member's level of care within the same hospital facility.

The Medicare health plan or its delegated hospital is required to distribute this notice to member no later than 6:00 p.m. of the day before their inpatient hospital coverage ends. The member or the member's representative will be asked to sign and date the NODMAR to acknowledge receipt.

The NODMAR tells the member:

- Why he/she is being discharged
- The date that WindsorSterling will stop covering the hospital stay
- What the member can do if he/she thinks he/she is being discharged too soon
- Who to contact for help

If the member feels that he/she is being discharged too soon, the member has the right to request *fast review* from the Quality Improvement Organization (QIO) in the State where the services are being rendered.

Appropriate QIO contact information will be made available to the member in the NODMAR. The member must make his/her request for a fast review to the QIO *no later than noon* on the first working day after receiving the NODMAR. If the member meets this deadline, he/she will be allowed to remain in the hospital without incurring financial liability until the QIO makes a decision.

If the member misses the deadline to request a fast review from the QIO, the member may still contact WindsorSterling and request an expedited appeal. However, if the member asks for an expedited appeal from WindsorSterling and stays in the hospital past his/her discharge date, he/she runs the risk for having to pay for the hospital care received past the discharge date.

➤ **Appeals if a Member Thinks His/Her Coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) Services are Ending Too Soon**

When a Medicare health plan has approved coverage of a member's admission to a SNF, or coverage of HHA or CORF services, the Centers for Medicare & Medicaid Services (CMS) requires that the Medicare health plan issue a written Notice of Medicare Non-Coverage (NOMNC) *at least 2* calendar days in advance of the services ending. All members receiving covered SNF, HHA, or CORF services must receive a NOMNC upon termination of services, even if they agree that the services should end. The member or the member's representative will be asked to sign and date the NOMNC to acknowledge receipt.

If the member does not agree that services should end, the member has the right to request a fast review from the QIO in the State where the services are being rendered. Appropriate QIO contact information will be made available to the member in the NOMNC.

If the member receives the NOMNC 2 calendar days before coverage ends, he/she must request the fast review from the QIO no later than noon of the day after he/she receives the NOMNC.

If the member received the notice more than 2 calendar days before coverage ends, he/she must request the fast review from the QIO no later than noon of the day before the date that the coverage ends.

If the member misses the deadline to request a fast review from the QIO, the member may still contact WindsorSterling and request an expedited appeal.

Provisions for both Standard and Expedited Appeals

➤ Who May File an Appeal?

- The member may file an appeal.
- A member's representative may file an appeal on behalf of the member.
- A member may appoint any individual to act as his/her representative. A representative who is appointed by the court or who is acting in accordance with State law may also file a request on behalf of a member. Either a signed representative form or other appropriate legal document must be submitted for each appeal request.
- A member may use the CMS-1696, Appointment of Representative (AOR) form, or other equivalent notice, to appoint a representative. The Appointment of Representative form is available on our web site at www.windsorhealthplan.com or by contacting our Customer Service department at 1-888-858-8551.
- A non-contracted physician or provider may file a standard appeal for payment of a Medicare Advantage benefit with a properly executed Waiver of Liability Statement wherein the physician or provider formally agrees to waive any right to payment from the member for a service regardless of the appeal outcome
- A treating physician, regardless of affiliation with WindsorSterling, may file an expedited appeal on behalf of a member regarding Medicare Advantage benefits only. A treating physician may also file a standard pre-service appeal on behalf of the member upon notifying the member.
- A prescriber may file an expedited appeal on behalf of a member regarding a Part D prescription drug benefit only. A prescriber may file a standard pre-benefit appeal on behalf of a member upon notifying the member.

➤ Support for the Appeal

WindsorSterling must gather all of the information needed to make a decision about an appeal. If the member's assistance is needed in gathering this information, WindsorSterling will contact the member. The member is not required to, but has the right to obtain and include additional information as part of his/her appeal. For example, the member may already have documents related to the issue, or may want to get the doctor's records or the doctor's opinion to help support his/her request. The member can provide WindsorSterling with any supporting documentation in any of the following ways:

- In writing, to WindsorSterling Attn: Grievance & Appeals department, 7100 Commerce Way, Suite 285, Brentwood, TN 37027
- By fax, at 615-782-7971
- By telephone, at 615-782-7878 or call Toll Free 1-888-858-8551 (TTY users should call 711).
- In person, at WindsorSterling, 7100 Commerce Way, Suite 285, Brentwood, TN 37027

The member also has the right to ask us for a copy of information regarding his/her appeal. The member can call or write us to request this information.

➤ **Help with an Appeal**

WindsorSterling will make every attempt to assist the member with the appeals process. Therefore, should a member need assistance in filing an appeal, he/she should first contact our Customer Service department at 1-888-858-8551. A member may have a friend, lawyer, or someone else assist in the appeals process.

➤ **Provider's Role**

- When the member disagrees with a practitioner's decision to deny a service or a course of treatment, in whole or in part, the member has the right to request and receive a detailed notice regarding the practitioner's decision from the Medicare health plan. The provider is responsible for advising the member of his/her right and advising the member to contact WindsorSterling's Customer Service department to request a detailed explanation. The detailed explanations are referred to as an Organization Determination for Medicare Advantage benefits and a Coverage Determination for Part D prescription drug benefits.
- If a physician or the physician's office staff is asked to provide information related to a member's appeal, it is important to adhere to the timeframes noted in the request. This helps facilitate the resolution of an appeal. Providers must respond to requests for additional information, including medical records, in a timely manner.
- The provider's role in the expedited appeal/fast review process includes providing information necessary for WindsorSterling or the Quality Improvement Organization (QIO) to make a determination. The provider is also responsible for appropriately handling the member's care in the event that an expedited appeal is denied. The provider should be familiar enough with the requirements of the expedited appeals process to discuss the process with the member as needed. The provider must cooperate fully with any requests from the QIO, including responding promptly to the initial request for information.

➤ **Member Grievances**

A grievance is any complaint expressing dissatisfaction with the Medicare health plan or its providers, other than one that involves an Organization Determination or Coverage Determination.

Examples of grievances include, but are not limited to the following complaints:

- Waiting times for appointments
- Waiting times to fill a prescription
- Physician or office staff behavior
- Pharmacist or pharmacy staff behavior
- Involuntary disenrollment concerns
- Quality of care concerns

➤ **Formal Grievance Process**

If a member has concerns related to medical care, WindsorSterling urges the member to first contact his/her Primary provider. Often the Primary provider can promptly address the concerns. If the member is not satisfied with the Primary provider's response, the member should be instructed to contact WindsorSterling's Customer Service department.

Members can contact a Customer Service Representative to discuss concerns or questions related to coverage or services. It is expected that most, if not all, member inquiries and disputes will be resolved on an informal basis with a Member Services Representative. If the Member Services Representative is unable to resolve the complaint to the member's satisfaction, the member may file a formal grievance. All formal grievances must be filed within 60 calendar days of the incident that precipitated the grievance.

➤ **Standard Grievances**

- The member may file a grievance either verbally or in writing. Every attempt will be made to resolve the member's complaint within 30 calendar days. WindsorSterling may extend the 30 calendar day timeframe by up to 14 calendar days if the member requests the extension or WindsorSterling justifies a need for additional information and documents how the delay is in the interest of the member. When WindsorSterling extends the deadline, it must immediately notify the member in writing of the reasons for the delay.
- Grievances filed in writing will be responded to in writing.
- Grievances concerning quality of care concerns, regardless of how the request was filed, will be responded to in writing.

➤ **Quality Improvement Organization Complaint Process**

If a member is concerned about the quality of care he/she has received, the member may file a complaint with the local Quality Improvement Organization (QIO) and/or WindsorSterling. The QIO is an organization comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. They review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The QIO also reviews continued stay denials in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs). The QIO must determine whether the quality of services (including both inpatient and outpatient services) provided meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. The Medicare health plan and providers must recognize the authority of the QIO with respect to timely submission of requested information/documentation.

➤ Expedited Grievances

A member may request an expedited grievance when WindsorSterling extends the timeframe to make Medicare Advantage benefits or WindsorSterling does not grant a request for an expedited Organization Determination or expedited Coverage Determination.

A member may request an expedited grievance when WindsorSterling does not grant a request for an expedited Coverage Determination or expedited Coverage Determination.

A member may file an expedited grievance either verbally or in writing. Expedited grievances will be responded to within 24 hours of receipt.

➤ Provider's Role

- The provider should be familiar with WindsorSterling's grievance process.
- As with appeals, the physician and the physician's staff must adhere to the timeframes for documentation or information requests. This will assist in the timely resolution of member grievances.
- It is important for providers to understand the grievance process, as they are often the member's first point-of-contact for the process. Providers may be called upon by their patients to discuss, explain, or refer them to the grievance process. Providers must respond to requests for additional information, including medical records, in a timely manner.

To assist the member with any complaints he/she may have about the provider or the provider's staff, and to resolve the problem immediately whenever possible.

An overview of the benefits offered for each of the WindsorSterling Medicare Advantage Plans

The Benefit Plan Comparison tables in the appendix depict the benefit structure of the WindsorSterling plans.

NOTE: Beneficiaries may directly access (through self-referral) screening mammography and influenza vaccine. Additionally there is NO co-pay for influenza and pneumococcal vaccines.

➤ **Benefit Exclusions and Limitations**

In addition to any exclusions or limitations described in the Benefits Chart, in membership materials, or anywhere else in this document, the following items and services are not covered by WindsorSterling:

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered.
2. Services which are not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a covered service. We provide all covered services according to Medicare guidelines.
3. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental or investigational procedures and items are those procedures and items determined by Original Medicare to not be generally accepted by the medical community.
8. Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.
9. Private room in a hospital, *unless* medically necessary.
10. Private duty nurses.
11. Personal convenience items such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Nursing care on a full-time basis in your home.
13. Homemaker services.
14. Charges imposed by immediate relatives or members of your household.
15. Meals delivered to your home, unless explicitly covered in benefit plan and authorized.

16. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
17. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
18. Routine dental care (such as cleanings, fillings, or dentures) or other dental services unless specified in the plan. Certain dental services that you get when you are in the hospital will be covered.
19. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine) and is limited according to Medicare guidelines.
20. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
21. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
22. Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- 23.
24. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.
27. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
28. Acupuncture.
29. Naturopaths' services.

➤ Provider's Role

If a provider is prescribing a service that is not covered by WindsorSterling, the provider must clearly explain the member's responsibility for non-covered services prior to the provision of services.

WindsorSterling participates in and provides many services designed to enhance the benefit of Medicare insurance for members

➤ **Health and Wellness Programs**

WindsorSterling's Health Services and Care Management areas, as well as the Quality area, are responsible for the identification, development, implementation, and evaluation of wellness and disease management programs and services for all members—including WindsorSterling members. Program and service development will be based on identified needs of WindsorSterling and WindsorSterling members. Wherever appropriate, these innovative programs and services may include partnerships with providers and vendors, utilizing both internal and external resources.

➤ **Provider's Role**

- Provide support and assistance critical to the development of wellness and disease management. WindsorSterling seeks provider input and partnership for wellness initiatives.
- Respond quickly and completely to requests for clinical information used to formulate health and wellness for our care management plans.
- Network providers will be asked to assist with program evaluation wherever appropriate and individual patient care plans.

WindsorSterling has taken several steps to ensure timely claims processing. Those affecting providers include:

- Claims submitted on behalf of WindsorSterling members will be processed by a dedicated WindsorSterling approved vendor.
- A separate post office box for WindsorSterling claims has been established to facilitate the timely identification and processing of WindsorSterling claims.
- Claims should be submitted on a CMS 1500 (Physician Claims) claim form or UB04 (Hospital) claim form.
- Claims must be submitted for payment within 120 calendar days of the date of service.

While these steps may appear basic, it is important that they be followed for WindsorSterling to remain in compliance with CMS payment regulations.

➤ **Claims Submission Address**

The correct address to use when submitting claims via paper to WindsorSterling is:

WindsorSterling Claims Department
P.O. Box 269003
Plano, TX 75026-9003

➤ **Electronic Claims Filing Information**

WindsorSterling has established a relationship with the following clearinghouse for electronic data submission:

- The SSI Group at www.thessigroup.com or 251-345-0000/800-881-2739
- Emdeon at www.emdeon.com/Paylists/payerlists.php or 888-598-0731

➤ **Our payor ID is 67829**

If you are already using another clearinghouse for your EDI claims, you may want to contact them to determine that they will transmit your WindsorSterling claims.

Guidelines for Claims Submission

➤ Primary Provider Visits

- All services for a single date of service should be billed on one claim.

➤ Specialist Visits

- All services for a single date of service should be billed on one claim.
- No reimbursement of covered supplies, such as radiopharmaceuticals, will be made unless invoice is submitted with claim (coverage limited in accordance with Medicare regulations).

➤ Chiropractic Visits

- Services limited to manual manipulation of the spine to correct subluxation.
- Visits for manual manipulation must be billed with **procedure codes 98940-98943 with modifier AT**.
- Evaluation/Management office levels are not payable to chiropractors.

➤ Podiatry

- Routine foot care is not a covered benefit.
- The only exceptions are:
 1. A diagnosis of Mycosis (any disease induced by fungus)
- Foot care that may pose a hazard if performed by a nonprofessional on patients with a systemic condition or patients with diminished sensation in their legs or feet.

➤ Vision

- WindsorSterling members must obtain routine vision care from providers contracted with EyeMed to provide services for WME members. Contact WindsorSterling directly for all routine vision services at (888) 839-9052 or access Windsor's website at www.windsorhealthplan.com to locate a participating provider. All claims are filed to Windsor Health Plan, PO Box 396, Thiensville, WI 5309. However, if a medical condition is found, the member must obtain treatment from a participating ophthalmologist or therapeutic optometrist. Medical claims are filed to WindsorSterling.
- Cataract surgery is a covered benefit as long as an intraocular lens is inserted. Lens insertion is not paid separately.
- WME covers one pair of conventional eyeglasses or contact lenses furnished up to 6 months after each cataract surgery. This hardware is payable thru EyeMed.

➤ Behavioral Health and Substance Abuse

- All services which are not covered by Traditional Medicare should be billed on the UB04. WindsorSterling members obtain behavioral health related services and substance abuse services by calling Customer Service at (888) 858-8551 or accessing the WindsorSterling Provider Directory at www.windsorhealthplan.com for a list of participating providers. All behavioral health related claims should be filed directly to WindsorSterling.

➤ Emergency Care

- Facilities billing for emergency services must include appropriate CPT Codes.
- Physicians billing for emergency services must bill with place of service 23.

➤ Ambulance Services

- Reimbursement will be made for base rate and mileage only.
- Providers should bill with an appropriate place of service.
- Non-emergency transportation requires prior authorization.

➤ Diagnostic Tests, Lab and X-rays

- No reimbursement for covered supplies, such as radiopharmaceuticals, will be made unless invoices are submitted with the claim (coverage limited in accordance with Medicare Regulations).
- Hospitals billing for ancillary services must identify the ordering physician in field 82 or 83 of the UB04 form.
- A specialist billing for ancillary services must identify the referring physician in field 17 of the CMS 1500 form.

➤ Global Radiology Procedures

- Hospitals performing the technical component should bill with the modifier TC.
- Physicians performing the professional component should bill with the modifier 26.

➤ Anesthesia

- The provider must submit with anesthesia ASA codes and appropriate modifiers.
- The provider must submit with the total number of minutes during which anesthesia was administered in field 24g of the CMS 1500.

➤ Durable Medical Equipment, Ortho and Prosthetic Devices

- All covered DME rental items, and purchase items require prior authorization, except for A4565, L3908, L0120, L0140, E0100, E0105, E0114, E0112, E0110. These codes represent items that may be dispensed from a physician office without prior authorization.
- All covered prosthetic items require prior authorization.

- All orthotic devices require prior authorization.
- DME claims should be billed completely with a from and through date, appropriate HCPCS codes, and appropriate modifiers to indicate if the item is for rental or purchase.

➤ **Outpatient Rehabilitation Services**

- Occupational therapy, physical therapy, and speech-language therapy require prior authorization.

➤ **Home Infusion Therapy**

Instructions for billing Home Infusion Therapy using a CMS 1500 form. Complete fields 1-23 as required on the CMS 1500.

24a Complete the dates of service for which you are billing. This requires spanning the dates.

24b Complete the place of service. Example: 12=home, 99=Ambulatory Infusion Center, 11=office
24c Complete the type of service.

24d Complete the HCPCS code for the drug or CPT code 99499 for the per diem and description of the HCPCS or per diem. Example: J0696 Rocephin 1gm or 99499 IV antibiotic per diem. NOTE: If the patient is on more than one kind of IV therapy, perhaps antibiotics and pain management, the description of the 99499 per diem code should indicate for which therapy the billed code is applicable to.

24e Complete the number for the diagnosis code applicable to the service.

24f Complete the charges for the drug or per diem billed.

24g Complete the number of units for the dates of service billed. Example: If you are billing for 7 calendar days of Rocephin 1gm daily, the qty would be 28 since each HCPCS unit for Rocephin is 250mg.

24h-24j Not a required field.

24k Can be used to supply the NDC number for the drug billed.

25-33 Continue completion of the CMS 1500 as required.

➤ **Home Health Services**

Instructions for billing Home Health Services using a UB-04 form. Complete fields 1-41 as required on the form.

42 Complete Revenue codes for services provided.

43 Complete description of services provided.

44 Complete HCPCS codes for supplies only.

45 Complete the date for the service provided.

46 Complete the quantity for the service provided.

47 Complete your charges for the service provided.

48-86 Complete the fields as required on the form.

➤ **Skilled Nursing Facility**

Facilities should bill on a UB-04 form using the following guidelines:

1. Field 42 should contain the revenue code 0022. The appropriate RUG code should be reported in the HCPCs field.
2. Field 44 should contain the appropriate RUG code.
3. Prior Authorization is required and the number should appear in field 60 of the form.

➤ **Dialysis Claims**

Effective 1/1/2011 dialysis claims must include Y or N in FL49

Y=ESRD Provider waived blended payment, pay full PPS

N=ESRD Provider did not waive blended payment

Effective 1/1/2011 dialysis claims must include Y or N in FL57

Y=Low Volume Facility

N=Not a Low Volume Facility

➤ **Therapy Services**

Error 41: Invalid Billing of Therapy Services (APC HOPD Only)

This return code will be issued for claims with a from date on or after April 1, 2011 that contain (1) more therapy modifier (GN, GO or GP) on a single claim line or (2) one of the below therapy revenue codes without one of the below required therapy modifiers on a single claim line. This new logic is applicable only to claims with a bill type of 012X or 013X

Revenue Code	Required Modifier
042X (Physical Therapy)	GP
043X (Occupational Therapy)	GO
044X (Speech-Language Pathology)	GN

➤ **Corrected Claims**

- A CMS-1500 corrected claim should be filed on paper and stamped as corrected. A UB-04 corrected claim can either be filed on paper and stamped as corrected, filed on paper and have a Type of Bill with “7” in the third position (i.e. XX7) indicating corrected bill, or filed electronically with a Type of Bill with “7” in the third position.

➤ **Timely Filing**

- The provider of service has 120 calendar days to file a claim from the date of service or discharge.
- The provider of service has 180 calendar days to file a corrected claim from the date of the remittance advice.
- The provider of service has 120 calendar days from the date of a traditional Medicare or other carrier's remittance advice to file a claim to WindsorSterling.
- The provider of service has 180 calendar days to file an appeal from the date of the FIRST remittance advice.

➤ **WME Member ID Cards**

If a member presents more than one insurance card always verify eligibility before providing services.

➤ **Medical Record Review**

Medical Record Review, through claims validation audits, determines compliance with appropriate billing practices and ensures appropriate charting which must support medical necessity and covered services of specific codes billed. These audits are in accordance with our members' contracts and existing WindsorSterling Health Plan provider contracts.

Reporting Medicare Fraud

➤ What is Fraud and Abuse?

While most health care providers, beneficiaries and employees are honest, a small minority commit health care fraud and abuse that can cost the Medicare program a lot of money every year and harm beneficiaries.

Fraud is an intentional representation that a person knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person.

The most frequent kind of fraud arises from a false statement or misrepresentation that can affect a person's eligibility, enrollment or payment under the Medicare program. The violator may be any person in a position to file a claim for Medicare benefits, sell a plan, or write or fill a prescription.

Fraud schemes range from those committed by individuals acting alone to more complex activities committed by institutions or groups of individuals. It can be telemarketing and other promotional techniques that misrepresent the health plan and its benefits or it can be offering kickbacks to providers or other individuals to steer a beneficiary's enrollment into a specific plan.

Although Medicare beneficiaries tend to be the victims of fraud, sometimes they can be perpetrators of fraudulent, wasteful behavior. Windsor takes fraud and abuse of all kinds seriously and has processes in place to detect and report cases of suspected unethical activities.

➤ Examples of beneficiary fraud, waste or abuse:

- **Misrepresentation of status:**
 1. A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive the drug benefit.
 2. Enrollees who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.
- **Identity theft:** Perpetrator uses another person's Medicare card to obtain prescriptions.
- **True out of Pocket (TrOOP) manipulation:** A beneficiary manipulates TrOOP to push through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible.
- **Prescription forging or altering:** Where prescriptions are altered, by someone other than the prescriber or pharmacist with prescriber approval, to increase quantity or number of refills, especially narcotics.
- **Prescription diversion and inappropriate use:** A beneficiary obtains prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a beneficiary's medications by a caregiver or anyone else.

- **Resale of drugs on black market:** Beneficiary falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
- **Prescription stockpiling:** Beneficiary attempts to “game” their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.
- **Doctor shopping:** Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of any underlying scheme, such as stockpiling or resale on the black market.
- **Improper Coordination of Benefits:** Improper coordination of benefits where beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to “game” the system.

➤ Health Plan Marketing Schemes and Sales Tactics

A beneficiary may be victimized by a marketing scheme where a health plan, or its agents, violates the Medicare Marketing Guidelines, or other Federal or State Laws, Rules, and Regulations to improperly enroll the beneficiary in a Part D Plan. Some examples of marketing or sales fraud and abuse are:

- **Misrepresentation:** The plan must provide beneficiaries with complete and accurate information. This includes information on the use of network vs. non network providers, benefit limits and co-pays and other plan requirements that can effect payment of a claim or access to services.
- **Discrimination: A plan must enroll all eligible** Medicare beneficiaries who want to enroll, regardless of their age, health status or the amount or cost of the health services needed unless the beneficiary has End Stage Renal Disease (ESRD) and is receiving dialysis. Beneficiaries with ESRD however, should keep their original Medicare coverage until off of dialysis or until after a kidney transplant.
- **Gifts for enrolling:** It is illegal for a health plan to offer gifts or incentives to get anyone to enroll in their plans. Gifts can be distributed at marketing events as long as the value of the gift is under \$15.00 and as long as everyone at the event is eligible for the gift regardless of whether they enroll in the plan. There should never be an obligation attached to a marketing promotion.
- **Unsolicited Sales Visits:** Sales representatives are not allowed to go to people’s homes unless they have been given permission by the beneficiary in advance. This restriction applies to any personal residence, including a room in a nursing home, rest home or assisted living arrangement.
- **Non-Compliance with Anti-Kickback Laws:** The purchase or sale of goods and services must not lead to employees, providers or agents receiving kickbacks. Kickbacks or rebates may take many forms and are not limited to direct cash payments or credits. If an employee, agent or a provider stands to gain personally through a transaction, it is prohibited.

➤ How to Report Your Concerns

Windsor Health Plan, Inc. wants to hear from you if you have any concerns. WHP has a “fraud hotline” through which employees, health care providers, and enrollees can report potential violations. This “hotline” ensures that these reports cannot be diverted by supervisors or other personnel. This is a confidential phone number and you may stay anonymous if you prefer. The “hotline” number is made available to all employees, enrollees, providers and independent contractors. Simply call 615-782-7899, toll free 1-866-379-2438, TTY: 1-800-848-0298.

You can also write Windsor Health Plan, Inc. to report suspected fraud. Please send your concerns to:

**Windsor Health Plan, Inc.
7100 Commerce Way Suite 285
Brentwood, TN 37027
Attention: Compliance Department**

You can also contact the following government offices:

**Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd.
Baltimore, MD 21244-1850
1-800-633-4227, TTY 1-877-486-2048 or
1-877-7SAFERX (1-877-772-3379)
24 hours a day; seven days a week**

Medicare

Suspensions of fraud or abuse may also be reported to Medicare’s Customer Service Center at:

1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: 866-226-1819

www.medicare.gov

or by contacting:

**Social Security Administration - Office of Public
Inquiries Windsor Park Blvd.
6401 Security Blvd.
Baltimore, MD 21235
1-800-325-0778 / TTY 1-800-325-0778
7 a.m. – 7 p.m.
www.ssa.gov**

➤ **Healthcare Providers Who Have been Excluded from the Medicare Program**

The HHS Office of Inspector General is responsible for excluding individuals who have participated or engaged in certain impermissible, inappropriate, or illegal conduct. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all healthcare providers and facilities currently excluded from participation in the Medicare and other Federal health care programs. The exclusion list, along with other information pertaining to OIG exclusions, may be accessed at <http://oig.hhs.gov/fraud/exclusions.html> via the Internet.

Contacting the HHS OIG Hotline

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-8164

By [E-Mail: HHSTips@oig.hhs.gov](mailto:HHSTips@oig.hhs.gov)

By TTY: 1-800-377-4950

By Mail:

Office of Inspector General

Department of Health and Human Services

Attn: HOTLINE

330 Independence Ave., SW

Washington, DC 20201

➤ **The General Services Administration (GSA) Website**

The GSA is responsible for maintaining an index of individuals and entities that have been excluded throughout the U.S. Government from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits. The GSA maintains the Excluded Parties List System (EPLS), which may be accessed at <http://epls.arnet.gov> via the Internet.

➤ **Clean Claims Defined**

Listed below are fields for both the CMS 1500 and the claim forms required for Medicare Risk Adjustment reporting. Please note that all claims submitted must meet these criteria or the claim will be denied. The provider is then responsible for correcting the data and resubmitting the claim in a timely manner. Patients cannot be held liable for claims denied due to missing required information.

➤ **WindsorSterling Claim Field Requirements**

WindsorSterling also has requirements that certain fields must be completed on the CMS 1500 and UB04 claim forms in order to properly process those claims. Failure to bill any of these fields may result in claims processing delays or denial. The requirements are as follows:

➤ Required CMS 1500 Form Locators

The following fields are required fields for each claim submission according to WindsorSterling business rules.

Field 1	Type of Plan
Field 1a	Insured's ID Number
Field 2	Member's Name
Field 3	Member's Date of Birth
Field 4	Insured's Name (if applicable)
Field 5	Member's Address and Telephone Number
Field 6	Member's Relationship to Insured (if block 4 is filled in)
Field 7	Insured's Address (if blocks 4 and 11 are filled in)
Field 8	Member Status
Field 9	Other Insured's Name (if applicable)
Field 9a	Other Insured's Policy Number (if applicable)
Field 9b	Other Insured's Date of Birth (if applicable)
Field 9c	Employer's Name or School Name
Field 10a, b, c	Is Member's Condition Related To
Field 11	Insured's Policy Group or FECA Number
Field 11a	Insured's Date of Birth
Field 11b	Employer's Name or School Name (if applicable)
Field 11c	Insurance Plan Name
Field 11d	Is There Another Health Benefit Plan
Field 12	Patient's or Authorized Person's Signature
Field 13	Insured's or Authorized Person's Signature
Field 14	Date of Current Illness, Injury or Pregnancy (if applicable)
Field 15	If patient has had Same or Similar Illness (if applicable)
Field 16	Dates Patient Unable to Work in Current Occupation (if applicable)
Field 17	Name of Referring Provider or Other Source
Field 17a	ID Number of Referring Provider
Field 17b	Referring provider's NPI
Field 18	Hospitalization Dates (if applicable)
Field 21	Diagnosis or Nature of Illness or Injury
Field 22	Medicaid Resubmission (if applicable)
Field 23	Prior Authorization Number (if applicable)
Field 24a	Dates of Service
Field 24b	Place of Service
Field 24c	Type of Service
Field 24d	CPT-4 or HCPCS code, modifiers
Field 24e	Diagnosis Codes
Field 24f	Charges
Field 24g	Days or Units
Field 24h	EPSDT / Family Plan (if applicable)
Field 24i	EMG (if applicable)
Field 24j	Rendering Provider's NPI
Field 25	Federal Tax Identification Number
Field 26	Member's Account Number
Field 27	Provider Accepts Assignment

Field 28	Total Charges
Field 29	Amount Paid
Field 30	Balance Due
Field 31	Signature of Provider
Field 32	Provider's practice address, if different from the billing address
Field 33	Group Provider's Name, billing address, & Group provider number and Group Provider's NPI

➤ **Required UB04 Form Locators**

The following fields are required fields for each claim submission according to WindsorSterling business rules.

Form Locator 1	Provider name, address, telephone number
Form Locator 2	Pay to Location
Form Locator 3	Member control number
Form Locator 4	Type of Bill
Form Locator 5	Federal Tax Number
Form Locator 6	Statement covers period
Form Locator 7	Covered days (Converted to Value Code)
Form Locator 8	Non-covered Days (Converted to Value Code)
Form Locator 9	Coinsurance Days (Converted to Value Code)
Form Locator 10	Lifetime Reserve Days (Converted to Value Code)
Form Locator 12-15	Member name, address, birthday, sex
Form Locator 16	Patient Marital Status
Form Locator 17-18	Admission date and hour
Form Locator 19	Type of Admission
Form Locator 20	Source of Admission
Form Locator 21	Discharge Hour
Form Locator 22	Member status
Form Locator 23	Medical/Health Record number
Form Locator 24-28	Condition codes
Form Locator 29	Accident State (to denote state where accident occurred)
Form Locator 30	Condition code
Form Locator 32-35	Occurrence codes and dates
Form Locator 36	Occurrence span code and dates
Form Locator 39-41	Value codes and amounts
Form Locator 42	Revenue Code
Form Locator 43	Revenue Description
Form Locator 43-44	Page ___ of ___
Form Locator 44	HCPCS/Rates
Form Locator 45	Creation Date
Form Locator 46	Units of service
Form Locator 47	Total charges (by revenue code category)
Form Locator 50	Payer identification
Form Locator 51	Provider number
Form Locator 52	Release of information certification indicator
Form Locator 53	Assignment of Benefits certification indicator
Form Locator 54	Prior payments - payer and member

Form Locator 55	Estimated amount due
Form Locator 56	National Provider Identifier (NPI)
Form Locator 57	Other Payer Identifier
Form Locator 58	Insured's name
Form Locator 59	Member's relationship to insured
Form Locator 60	Certificate/social security number/health insurance claim/identification number
Form Locator 61	Insured group name
Form Locator 64	Employment Status Code
Form Locator 66	International Classification of Diseases (ICD Version Qualifier (i.e.ICD-9)
Form Locator 67	Principal diagnosis code
Form Locator 68-70	Other diagnosis codes
Form Locator 71	Prospective Payment System (PPS) Code
Form Locator 76	NPI for Attending Physician
Form Locator 77	NPI for Operating Physician
Form Locator 78, 79	NPI for Other Physicians
Form Locator 80	Principal procedure code and date
Form Locator 81	Code (Overflow field for additional codes that do not fit into other fields)
Form Locator 83	Other Provider identification (UPIN number) Admitting Provider's identification
Form Locator 80	Principal procedure code and date
Form Locator 85	Provider Representative
Form Locator 86	Provider Representative Signature Date

➤ CMS 1500 Risk Adjustment Data Requirements

CMS 1500 Risk Adjustment Data Requirements		
FIELD #	DESCRIPTION	INDICATOR
1a	Insured's ID Number	R
21	Diagnosis of Nature of Illness or Injury	R
24a	Date(s) of Service	R

➤ CMS 1450 Encounter Data Requirements

Risk Adjustment Data Requirements		
FIELD #	DESCRIPTION	HOSPITAL INPATIENT
6	Statement Covers Period	R
51	Medicare Provider Number	R
60	HI Claim/Identification Number	R
67	Principal Diagnosis Code (Discharge Diagnosis)	R
68-75	Other Diagnosis Code(s)	RA

➤ **Coordination of Benefits**

WindsorSterling is the primary payer for Medicare-covered services provided to WindsorSterling members. With the exception of certain services referenced below that may only be covered when billed to WindsorSterling as the secondary payer. Please be sure to first file claims with the primary carrier and then include that primary carrier's EOB for further consideration. Job-related illness or injury covered by workers compensation is not a covered benefit and will not be reimbursed by WindsorSterling. WindsorSterling claims paid, as primary incorrectly will be recovered. Per Federal guidelines, there is no statute of limitations on the recovery. This means it does not matter how old the claim may be WindsorSterling is obligated to recover the incorrect payment.

➤ **Medicare as Secondary Payer (MSP)**

Medicare as the secondary payer (MSP) refers to those situations where hospital and medical expenses of a Medicare beneficiary are billed first to another insurance plan (primary) and only the unpaid amounts are then billed to the member's Medicare managed care organization (secondary).

In 1980, the United States Congress began to pass a series of laws to help control Medicare costs. These acts increased the number of situations in which healthcare providers must bill other insurance plans before billing the member's Medicare managed care organization.

There are four situations addressed by legislative acts which make WindsorSterling the secondary payer:

➤ **Third-Party Liability**

WindsorSterling becomes the secondary payer when services are reimbursable under automobile, medical, no-fault, or any liability insurance, including workers' compensation.

➤ **End-Stage Renal Disease (ESRD)**

When the individual is entitled to Medicare benefits solely on the basis of ESRD, WindsorSterling becomes the secondary payer for a period of up to 30 months after entitlement to Medicare, if the Medicare beneficiary is covered under an Employer Group Health Plan (EGHP).

➤ **Working Aged**

WindsorSterling becomes a secondary payer when a Medicare beneficiary age 65 or older is covered by an Employer Group Health Plan (EGHP) by reason of their own current employment or the current employment of a spouse (of any age), when the Employer Group employs 20 or more employees.

➤ **Disabled**

WindsorSterling becomes a secondary payer when a disabled (other than ESRD) Medicare beneficiary under the age of 65 is covered by a large group health plan (LGHP) by reason of their current employment or the current employment of a spouse or family member if the Employer Group employs 100 or more employees.

In situations where WindsorSterling is determined to be the secondary payer, the provider is authorized to bill the primary payer for the services performed. WindsorSterling is responsible for paying the balance of charges, up to the benefit limit for the services rendered.

➤ **Programs Not Paid by WindsorSterling**

There are some programs that a Medicare beneficiary may qualify for that are not paid for by WindsorSterling (or any MA Plan). Such programs include:

- Veterans Administration (VA) – for more information, contact the VA Administration at 1-800- 827-1000.
- Black Lung Benefits – for injury or illness related to Black Lung. All other claims should be submitted to WindsorSterling. For more information, contact the Federal Black Lung Program at 1-800-638-7072.
- Hospice – claims related to the Hospice condition should be submitted to Traditional Medicare for payment. Claims for injury or illness that are not related to the Hospice condition should be submitted to WindsorSterling. For more information, contact the Hospice Association of America at 1-202-546-4759 or the National Hospice and Palliative Care Organization at 1-800-658-8898.

Although a beneficiary is enrolled in WindsorSterling, if they also qualify and enroll in one of these programs, the claims associated with these programs should not be submitted to WindsorSterling, but to the appropriate program.

➤ **Provider Responsibilities and Subrogation**

Subrogation occurs when it is determined that there is a possibility for third-party liability on a claim for health care services. Examples include automobile accidents and work-related injuries. Providers who are aware that injuries treated are related to an automobile accident or a work-related injury are to use the appropriate field of the CMS 1500 or claim forms to specifically indicate that the patient's condition is related to an injury. Field 10a of the CMS 1500 form is used to indicate whether the patient's condition is related to current or previous employment. Field 10b is used to indicate whether the patient's condition is related to an auto accident. Field 10c is used to indicate whether the patient's condition is related to any other type of accident.

On the UB04, fields 18-28 are used to report the nature of the patient's condition that precipitated the services currently being billed. Certain codes billed in this field may indicate that the patient's condition is related to the patient's current or past employment. Fields 31-36 on the form are used to report the nature of the event or occurrence that precipitated the services currently being billed. Certain codes billed in this field may indicate that the patient's condition is related to an accident of some type, including automobile accidents and employment-related accidents.

Please note that the following third-party payers are primary to WindsorSterling (i.e., are billed and pay for covered medical expenses before WindsorSterling): state or federal workers' compensation, no-fault insurance, and any liability insurance policy or plan, including self-insured plans. Providers are authorized to and must bill identified and verified third-party payers liable for payment for a member's covered medical expenses before billing WindsorSterling. To the extent the carrier, employer, or entity already has paid the member for covered medical expenses, the provider is authorized to and must bill the member for the covered medical expenses before billing WindsorSterling.

Benefits and Eligibility for behavioral health and substance abuse services for WindsorSterling members may be confirmed by calling our Provider Help Desk at 1-888-839-9052. Eligibility may also be verified by going to www.windsorhealthplan.com.

Authorization decisions are made using evidence based criteria and CMS coverage determinations.

Prior authorization is not required for emergency inpatient services. Notification is required within 48 hours of an emergency inpatient admission. Emergency admission is defined an urgent condition or situation that without psychiatric intervention, is certain to place at risk the safety of the member or others.

An Authorization requests for inpatient behavioral health requires notification with 48 hours of admission. Inpatient admissions can be to a general hospital or free standing psychiatric facility. Prior authorization is required for Partial Hospital Program.

Prior authorization may be required for some planned non-acute outpatient services; refer to the Behavioral Health Utilization Guidelines for Contracted Providers. Prior authorization is required for all outpatient psychological testing and neuropsychological testing. Requests for authorizations should have supporting documentation that is submitted with the Authorization Request Form.

Windsor Health Plan Providers may obtain authorization for outpatient Behavioral Health services as needed by contacting

Toll Free: 888-904-8387

Local: 615-782-7851

BH FAX: 615-782-7901

A listing of all behavioral health participating providers can be accessed in the WindsorSterling Provider Directory, online at www.windsorhealthplan.com or by calling Windsor Provider Help Desk at (888) 839-9052.

Level of Care Definitions

➤ Inpatient Treatment Programs

Inpatient treatment is distinguished by different levels: traditional inpatient, medical detoxification, and psychiatric residential treatment services. If inpatient, then it is acute inpatient treatment with the full range of diagnostic and treatment services offered and available on a 24 hour basis. A physician will be available 24 hours each day.

Inpatient treatment units can be free standing psychiatric hospitals, free standing alcohol and drug treatment centers, or psychiatric or detoxification units that are part of a general hospital. A psychiatric unit may provide detoxification services, but it would be atypical for a detoxification unit to provide care for severe psychiatric disorders. For co-occurring concerns (e.g. mental health and substance abuse or mental and physical health), coordination will be promoted through consultation with specialty and medical providers. Continuity of care will be key to a successful discharge plan and transition between levels of mental health and substance abuse care.

➤ Partial Hospital Program

Partial Hospitalization Program (PHP) is an alternative to acute inpatient psychiatric hospitalization for both mental health conditions and chemical dependency conditions. PHP is an intensive psychiatric outpatient treatment program of less than 24 hours of daily care. PHP treatment is a time limited hospital diversion treatment program to be utilized in lieu of an acute inpatient treatment setting if determined by a physician.

➤ Outpatient Treatment

Outpatient treatment providers include the full range of licensed behavioral health clinicians; that is, psychiatrist or other doctor, clinical psychologist, physician assistant, licensed clinical social worker, clinical nurse specialist and nurse practitioner. An outpatient mental health or substance abuse provider will schedule an appointment for the patient depending upon medical necessity. The frequency of these appointments will vary depending upon the patient's need and the prescribed treatment plan. Individual, group, medication, family, couples, and behavior modification therapy are examples of customary treatment approaches at an outpatient level of care. Behavioral health utilization reviews are conducted on a quarterly basis using claims data. Outpatient service utilization greater than below stated frequencies may require submission of clinical documentation, GAF scores, and a clearly defined treatment plan.

Routine Vision services are available to all WindsorSterling members.

Benefits for routine vision services are available to all WindsorSterling members through EyeMed.

➤ **EyeMed**

Members must obtain routine vision services from EyeMed. The member or the member's Primary Provider may contact EyeMed to locate a participating provider.

A listing of all EyeMed participating providers can be accessed at Windsor's online Provider Directory at www.windsorhealthplan.com or by calling the Provider Help Desk at (888) 839-9052.

Submit all Routine Vision services claims to:

Windsor Health Plan, Inc.
PO Box 396
Thiensville, WI 53092
Claims Questions – (800) 840-7032

However, if a medical condition is found, the member must obtain treatment from an in-network participating ophthalmologist. Medical claims are filed to WindsorSterling.

WindsorSterling recognizes the importance of the availability of laboratory services and has contracted with local, regional and national laboratory vendors.

For a complete list of contracted laboratories, contact the Provider Help Desk at (888) 839-9052.

Physician offices may perform laboratory services for which they are CLIA certified and contracted to provide Lab work for infertility or impotence is not covered.

Lab work performed in the provider's office will be reimbursed on the current payment arrangement negotiated for that physician.

*An overview of the resource tools
available at www.windsorhealthplan.com*

The WindsorSterling internet website provides a wide variety of simple tools designed to speed up administrative tasks, so you can spend more time caring for your patients.

If you are not currently using WindsorSterling's website, please go online at www.windsorhealthplan.com. Click on "Providers" for access to Eligibility, Claims Status, Provider Directories, Provider Forms, Prior Authorization List, etc.

WINDSOR STERLING

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