

Who do I call if I have a question regarding a claims denial?

The Provider Help Desk is available to assist with claims denial questions. The number is 1-888-839-9052.

What fee schedule does Windsor use to pay providers?

Windsor Sterling Health Plan is a product of Windsor Health Plans, Inc., a Medicare Advantage organization with a Medicare contract, therefore we use the current Medicare fee schedule for the state where the services are rendered.

Can a provider dispense DME items?

If a provider is a licensed DME supplier, is contracted with Windsor to supply DME, and has provided Windsor with their Durable Medical Equipment Regional Carrier (DMERC) letter with the assigned number, the provider may dispense DME items. Please note, a list of items that do not require a Prior Authorization can be found in the Quick Reference Guide. Contact Health Services at 1-888-904-8387 with authorization requests for any DME not listed.

Is there an annual limit for Physical Therapy, Occupational Therapy or Speech Therapy like Medicare?

Windsor Sterling Health Plan does not have an annual limit for Physical Therapy, Occupational Therapy or Speech Therapy. Benefits are based on medical necessity and Prior Authorization is required. Contact Health Services at 1-888-904-8387 with authorization requests.

What is included in an Annual Comprehensive Exam (ACE)?

ACE includes medical history, health risk assessment and an evaluation of overall physical condition.

How do I file an Annual Comprehensive Evaluation (ACE) claim?

There is a 3-Step Submission Process:

- Complete the Annual Comprehensive Exam for the patient. Bill the services as you normally would with the appropriate CPT and specific ICD-9 code.
- Confirm the documentation conforms to the medical record requirements that have been outlined. We also accept Electronic Medical Records (EMR) provided they meet the required elements. Fax a copy of the ACE documentation to Windsor at (615) 782-7829.
- Submit a separate claim with CPT 99420 and ICD-9 V70.9 for each ACE document submitted.

How often are participating providers required to re-credential?

Participating provider are required to re-credential every three years.

How will I know when my new provider has been credentialed?

The credentialing process includes final approval from the Medical Advisory Committee (MAC). Upon completion of the process, a letter is sent advising the provider of his/her acceptance into the network.

What fields on the claim forms are the NPI numbers supposed to be entered?

- The individual provider's NPI number goes in Box 24J on the CMS 1500.
- The group NPI number goes in Box 33A on the CMS 1500.
- The attending physician's NPI number goes in Box 76 on the UB-04.
- The operating physician's NPI number goes in Box 77 on the UB-04.

Who do I bill for post-cataract lenses/glasses?

Claims for post-surgery lenses/glasses should be filed with EyeMed. Call (866) 339-3633 to coordinate care.

How does Windsor Sterling Health Plan Determine if non-emergency ambulance transportation is covered?

Windsor Sterling Health Plan uses Medicare guidelines to determine if a non-emergency transportation meets medical necessity. All non-emergent transports require prior authorization. Please contact Health Services at 1-888-904-8387 with authorization requests.

Can I bill the patient if my payment from Windsor was not what I anticipated?

The member should not be billed any more than the copay, coinsurance or deductible. Please note that copays, coinsurance and deductible amounts for dual eligible members should be billed to the appropriate state Medicaid program. If you believe the payment is inconsistent with the current Medicare fee schedule or the denial reason is incorrect, please submit a Claims Reconsideration with the appropriate documentation to support your belief. You may also call your local Network Services Representative for further explanation.

What should I do if I bill Medicare, the claim is denied and I find out the member had Windsor at the time of service but timely filing has passed?

If a claim has not been filed, please file the claim. Once the denial is received, submit a Claims Dispute Resolution form along with supporting documentation as evidence that your initial verification showed that the member had Medicare. Also, submit a copy of the Explanation of Medicare Benefits (EOMB) for the purpose of determining Timely Filing. The claim has to be filed within 120 days of the Medicare denial to meet the Timely Filing deadline.