



**Windsor Medicare Extra “Quick Reference Sheets”
Phone Numbers and Authorization Grid**

Provider Help Desk:	Nashville Local or Toll Free	1-615-782-7851 1-866-270-5223
Health Services:	Nashville Local or Toll Free	1-615-782-7851, Option 2 1-866-270-5223, Option 2
Behavioral Health:	Nashville Local or Toll Free	1-615-782-7851, Options 2, 4 1-866-270-5223, Options 2, 4
Rx Prior Auth Requests:	1-866-715-7519	
Transportation:	1-866-420-6187	TTY/TDD: 1-866-288-3133

Home Health, Home Infusion, DME, Orthotics, Prosthetics and supplies must be arranged through Windsor HomeCare Network at **1-800-793-3684**.

✦ **Exception:** If the physician is a licensed DME supplier, is contracted with Windsor Health Plan to provide these services, and has a DMERC number, the provider’s office must supply Windsor Health Plan with a copy of the DMERC letter to load into the Windsor Health Plan system. Once the DMERC information is loaded, providers may dispense DME items with authorization obtained directly from Windsor Health Plan at 1-866-270-5223. If the provider is not contracted to provide these services and does not have a DMERC number on file, they must call Windsor HomeCare Network at 1-800-793-3684.

All Routine Vision Services must be referred to EyeMed at 1-866-339-3633, including glasses provided post-cataract surgery.

Reference Laboratories: Labcorp, Quest Diagnostics, CardioNet, The Lab of Pathology, Woodbury Clinical Lab, AEL of Memphis, NWA Pathology Association, Dianon, Pinnacle Pathology Associates, Pathology Lab of AR, Physicians Med Lab, Skin Pathology, US Labs, AmeriPath and Gamma Healthcare. Physician offices may perform laboratory services for which they are CLIA certified and contracted to provide.

Referrals to Specialists: Member may self-refer to any in-network participating specialist without a referral from a Primary Physician or prior approval from Windsor Medicare Extra.

Authorization Grid Effective 1/1/2010

Procedures and Services	Comments
All Out-of-Network Services	This includes Out-of-Area
Ambulance (non-emergency)	
Cardiac Rehabilitation	Includes Professional
Epidural procedures	Includes Epidural Injections, Nerve Blocks and Facet Injections
Durable Medical Equipment	All DME, orthotics and prosthetics must be arranged through Windsor HomeCare Network
Durable Medical Equipment, Prosthetic, Orthotics and other Equipment Dispensed by Physician Offices	See page 3 for items physician offices can dispense
Home Health Care And Home Infusion	
Hospice	
Hospital Observations	
Inpatient Admissions	Includes all Acute, Behavioral Health, rehabilitation, LTAC and Skilled Nursing. Prior authorization is required for all elective, pre-arranged and direct

Authorization Grid Effective 1/1/2010

Laser Therapies	In office
MRA, MRI, CT, CT Ultra Fast and CT Angiography	
Behavioral Health Services	See Page 4 for additional information
Neuro-Psych and Cognitive Testing	
Outpatient Therapies	Includes physical therapy, occupational therapy, speech therapy, dietary and audiology
Physical and Occupational Therapies	All in-network providers of physical, occupational and speech therapy will be allowed to complete an initial evaluation without prior authorization. Once the initial evaluation is complete the provider needs to submit the evaluation, plan of care, goals and physician order with the prior authorization (PA) request form for review. On the PA request form please indicate how many additional visits you are requesting. Additional visits are not approved until you receive an authorization from Windsor Medicare Extra.
Nutritional Therapy Meal Delivery	Please use Home Delivery Form
Orthotics and Prosthetics	Coverage is limited to medically necessary
Outpatient Surgery	Exceptions that do not require prior authorization include: Any site of service – office, outpatient, ASC: Bronchoscopy, colonoscopy, sigmoidoscopy, laryngoscopies, EGD. Office Setting: 69433- Typanostomy (requiring insertion of ventilating tube) when local or topical anesthesia used in office setting.
Part B medication infusions and injections excluding chemotherapy	See attached table. Medications not FDA approved for diagnosis or off-label use cannot be authorized.
PET Scans/SPECT	

Authorization Grid Effective 1/1/2010

Pulmonary Rehabilitation	
Sleep Studies	
Skilled Nursing Facilities/Subacute	Windsor DOES NOT REQUIRE the 3-day qualifying hospital stay in order for a member to be admitted into a nursing home/skilled nursing facility.
TMJ Diagnosis and Therapy	
Transplants	Includes organ and bone marrow and all evaluations
Wound Center – Procedures/ Services	

**Durable Medical Equipment, Prosthetics, Orthotics and Other
Equipment Dispensed by Physician Offices**

To qualify as durable medical equipment an item must withstand repeated use, be primarily and customarily used to serve a medical purpose, be generally not useful to a person in the absence of sickness or injury, and be appropriate for use in the home.

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 1-866-270-2273.

Product Description	Billing Code
Universal cradle arm sling	
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

Behavioral Health Providers

- No authorizations required for outpatient behavioral health services with the **EXCEPTION** of intensive outpatient modalities: Group Therapy, Case Management, CTT, IOP programs, OP ECT, and Psychological/Neuropsychological Testing.
- **All inpatient services continue to require authorization within 48 hours of admission.** These include Crisis Resolution, Crisis Intervention, Crisis Stabilization, Partial Hospitalization, and Inpatient Hospitalization. Authorization request form and clinical data/reports should be faxed to: 615-782-7901.
- 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.
- All below require authorization within 48 hours of admission:
 - H0035 Crisis Resolution and Mobile Crisis Assessment – up to 12 hours (*Fusion Plan Benefit Only*)
 - H0045 Crisis Intervention/Respite (*Fusion Plan Benefit Only*)
 - H2013 Crisis Stabilization Units- Utilized for an alternative to an inpatient stay. If the patient is a dual eligible, you must coordinate with Medicaid, TennCare or the secondary payor. Utilization will be monitored on a monthly basis to confirm ER visits are not occurring. Windsor Health Plan, Inc. retains the right to review for medical necessity. (*Fusion Plan Benefit Only*)
 - H2020 Partial Hospitalization Program – Minimum of five tx hours per day X five days
 - H0043 Psychiatric Residential Treatment Facility, Supervised (includes facility cost – additional services are billed separately)
 - H0044 Psychiatric Residential Treatment, Unsupervised (*Fusion Plan Benefit Only*)
- Submit Claims directly to WME: Windsor Medicare Extra
P.O. Box 269025
Plano, TX 75026-9025



Windsor Medicare Extra

Windsor Medicare Extra Part B Prior Authorization Drugs ONLY*		
BRAND NAME	GENERIC NAME	CODE
Alimta	PEMETREXED	J9305
Aranesp	DARBEPOETIN ALFA	J0881
Avastin	BEVACIZUMAB	J9035 (do not use J3590 for Macular Degeneration)
Boniva	IBANDRONATE	J1740
Botox, Myobloc	BOTULINUM TOXIN TYPE A & TYPE B	J0585, J0587, J0586
Caverject, Edex, Prostin VR, MUSE	ALPROSTADIL (PROSTAGLANDIN E1; PGE1)	J0270, J0275
Cinryze	C1 ESTERASE INHIBITOR (HUMAN)	J0598
Cimzia	CERTOLIZUMAB PEGOL	J0718
Copaxone	GLATIRAMER ACETATE	J1595
Cubicin	DAPTOMYCIN	J0878
Enbrel	ETANERCEPT	J1438
Epogen, Procrit	EPOETIN ALFA	J0885
Factor Medications (Anti-hemophilic Factors)	MULTIPLE BRANDS	J7185-J7199
Feraheme	FERUMOXYTOL	Q0138
Forteo	TERIPARATIDE RDNA INJECTION	J3110
Growth Hormone	MULTIPLE BRANDS	J2940, J2941
Herceptin	TRASTUZUMAB	J9355
Humira	ADALIMUMAB	J0135
Immune Globulins (All)	MULTIPLE BRANDS	J1460-J1563, J1566, J1565, J1568, J1569, J2788-J2792, 90765, 90766, 90767, 90768, J7504, J7511
Interferons (All)	ACTIMMUNE, ALFERON-N, AVONEX, BETASERON, INFERGEN, INTRON-A, PEGASYS, PEG-INTRON	J9212-J9216, Q3025, Q3026, J1825, J1830, S0145, S0146
Iron Dextran	IRON DEXTRAN	J1750
Kineret	ANAKINRA	NO J-CODE
Lucentis	RANIBIZUMAB	J2778
Lupron	LEUPROLIDE ACETATE	J1950
Milrinone Lactate	MILRINONE LACTATE	J2260
Nplate	ROMIPLOSTIM	J2796
Neulasta	PEGFILGRASTIM	J2505
Neupogen	FILGRASTIM	J1440, J1441
Orencia	ABATACEPT	J0129
Reclast, Zometa	ZOLEDRONIC ACID	J3488, J3487
Remicade	INFLIXIMAB	J1745, 90765, 96415
Sandostatin	OCTREOTIDE ACETATE	J2352, J2353, J2354
Synagis	PALIVIZUMAB	90378
Synvisc, Synvisc One, Orthovisc, Hyalgan, Supartz, Euflexxa, Hyaluronan or derivative	HYALURONAN OR DERIVATIVE	J7321, J7322, J7323, J7324, J7325
Tysabri	NATALIZUMAB	J2323
Vectibix	PANITUMUMAB	J9303
Venofer	IRON SUCROSE	J1756
Ventavis	ILOPROST, INHALATION SOLUTION	Q4074
Xolair	OMALIZUMAB	J2357
Zemplar	PARICALCITOL	J2501
Any office injectable with cost of course of therapy greater than \$500		J3490, J9999, J3590, J8498

2010 Windsor Medicare Extra Part B Diagnosis Drugs ONLY**

Brand Name	Generic Name	CODE
Amevive	ALEFACEPT	J0215
Aranesp	DARBEOETIN ALFA	J0882
B-12 Injection	CYANOCOBALAMIN	J3420
Bexxar	TOSITUMOMAB AND IODINE	77300, 78804, 79403, A9544,
Campath	ALEMTUZUMAB	J9010
Campostar	IRINOTECAN	J9206
Cerezyme	IMIGLUCERASE	J1785
Doxil	DOXORUBICIN	J9001
Elaprase	IDURSULFASE	J1743
Ellence	EPIRUBICIN	J9178
Eloxatin	OXALIPLATIN	J9263
Epogen, Procrit	EPOETIN ALFA	J0886
Erbix	CETUXIMAB	J9055
Faslodex	FULVESTRANT	J9395
Feraheme	FERUMOXYTOL	Q0139
Gemzar	GEMCITABINE	J9201
Ixempra	IXABEPILONE	J9207
Leukine	SARGRAMOSTIM(GM-CSF)	J2820
Neumega	OPRELVEKIN	J2355
Orthoclone OKT3	MUROMONAB-CD3	J7505
Prolastin, Zemira, Aralast	ALPHA1-PROTEINASE INHIBITOR (HUMAN)	J0256
Rituxan	RITUXIMAB	96413, 96415, J9310
Sandostatin LAR Depot	OCTREOTIDE DEPOT	J2353
Soliris	ECULIZUMAB	J1300
Supprekin LA, Vantas	HISTRELIN IMPLANT	J9226, J9225
Taxol, Onxol, Abraxane, Paxene-B	PACLITAXEL	J9264
Taxotere	DOCETAXEL	J9170, J9171
Torisel	TEMSIROLIMUS	J9330
Treanda	BENDAMUSTINE	J9033
Velcade	BORTEZOMIB	J9041
Viadur	LEUPROLIDE ACETATE	J9219
Vidaza	AZACITIDINE	96401, J9025
Visudyne	VERTEPORFIN	J3395
Zevalin	IBRITUMOMAB	78804, 79403, A9542, A9543
Zoladex	GOSERELIN ACETATE	J9202

A9545

** If the correct diagnosis is not on the claim, then Prior Authorization is required. If drug is being administered in the Physician Office, the drug must be provided by the office.

Nutritional Therapy Meal Delivery

Nutritional Therapy:

Purpose: To address malnutrition and nutritional compromise related to medical treatment and acute illness for which adequate nutrition is an important component of the optimum treatment plan.

Benefit Design:

One meal daily for up to 100 days, which is the yearly limit.

This treatment will require **Prior Authorization** with following criteria:

1. Prescribed by physician for up to 30 day intervals:
AND
2. One of the following:
 - Patient hospitalized for 7 or more days discharged to home and meals are ordered within 3 days of discharge to home
 - Patient had major surgical procedure and meals are ordered within 3 days of return home
 - Patient has burns or skin breakdown or wound and BMI < 20 and receiving home health services
 - Patient has BMI < 20 and recent documented weight loss of 10 lb or more over the last 3 months and has completed evaluation by physician for medical and psychiatric causes of weight loss and physician feels that trial of nutritional therapy is appropriate clinical diagnosis of malnutrition by history and physical findings with BMI < 20 and supporting labs such as reduced albumin or pre-albumin in the absence of conditions affecting protein balance such as liver disease or nephrotic syndrome
3. Authorizations of additional treatment beyond 30 days require documentation of re-evaluation by prescribing physician to assure continued medical necessity.

Dermatology
In-Office Procedures/Services

No Prior Authorization Required

The following procedures/services do not require prior authorization:

95044 patch test
11900 intralesional
11901 over 7 lesions
96902 trichogram
10060 I & D
10061 I & D
11100 Biopsy
11101 Biopsy
11055, 11056, 11057 paring / curretage
10140 I & D
10120 Foreign body removal
11700 debride nail (with appropriate diagnosis codes)
Skin Lesions- 11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, 11313,
11400, 11401, 11402, 11403, 11420, 11421, 11422, 11423, 11440,11441, 11442, 11443, 11600, 11601,
11602, 11603, 11620, 11621, 11622, 11623, 11640, 11641, 11642, 11643, 17260, 17261, 17262, 17263,
17270, 17271, 17272, 17273, 17280, 17281, 17282, 17283

Lesion Destruction - 17000, 17001, 17002, 17004, 17003, 17110, 17111

Wound Repairs - 12031, 12032, 12034, 12051, 12052, 12053, 14040, 14060

Prior Authorization Required

The following procedures/services do require prior authorization:

10040 Acne surgery will require auth > age 35
96910 and 96912 phototherapy require auth
Dx Code 701.4 Keloid/H. Scarp. ⌀ will require medical review/auth

Non-Covered Benefits

The following procedures/services are not a covered benefit (provider can call to request prior authorization if it is felt that procedure is not cosmetic and will meet medical necessity to be payable by the Plan):

Dx Code V50.1 Cosmetic - not covered
11200 and 11201 skin tag removal is considered cosmetic - not covered
36469 sclerotherapy considered cosmetic - not covered

** All services are subject to periodic retro review. Medical Records may be requested on selected Claims for Audit.**



Ophthalmology
In-Office Procedures/Services

The following CPT and HCPCS Codes do not require Prior Authorization when rendered In-Office by an Ophthalmologist and billed with Place of Service 11.

10060	68840	J0690
10061	76512	J0713
11100	76514	J1100
11440	76529	J3301
11441	92002	J3370
11640	92004	J9035
65205	92012	
65210	92014	
65222	92020	
65272	92083	
65435	92135	
65800	92226	
65805	92230	
65920	92235	
67005	92240	
67025	92250	
67028	92270	
67105	92275	
67110	92283	
67121	99024	
67141	99201	
67145	99202	
67208	99203	
67210	99204	
67220	99211	
67221	99212	
67228	99213	
67500	99214	
67515	99215	
67800	99241	
67801	99242	
67820	99243	
68110		
68200		
68761		
68801		
68810		

** All Services rendered with Place of Service 21, 22 or 24 require Prior Authorization.

Identification of a Windsor Medicare Extra Member

Each Windsor Member will have a Windsor Medicare Extra card and has been instructed to present it at each visit. This should help you identify the patient as a Windsor Member.

The card will provide most of the information you need to process the patient through your system, including co-payment information and important phone numbers. Please see the sample card below.



FRONT OF CARD

BACK OF CARD

Eligibility Verification

There are two ways to verify eligibility of a Windsor Member:

1. Log on to www.WindsorExtra.com and click on "I am a Provider." Click on "Provider Login for Eligibility and Claims" at the top of the left -hand column, then click on "Register New User" at the top of the page. You will receive a return email letting you know your registration is complete and that you can begin checking eligibility on our Web page.
2. Call Provider Services and **select option 1**. Then **press 1** for eligibility and benefits information.

Provider Directory

The Provider Directory is available on our Website: www.WindsorExtra.com. Click on "I am a Provider," then click "Provider Directory by Service Area" on the left. If you do not have internet access, hard copies are available by request.

Drug Formularies

Windsor Medicare Extra Drug Formulary can be accessed on our Web page at www.WindsorExtra.com.



Claims Processing

Filing Claims

- (1) The Windsor Medicare Extra EDI Vendor Number is **62153**
- (2) The Windsor Medicare Extra address for paper claims is as follows:

**WHP Medicare
P.O. Box 269025
Plano, TX 75026-9025**

- (3) Should a preauthorization number be associated with the claim, place the number in Box 23 of the CMS1500 or Box 63 of the UB92 and UB04. If you are submitting your claims via the preferred method by electronic submission, please submit using the following field locators:

HCFA 1500: 837p: Loop 2300, 2-180-REF02 (G1)

UB92/UB04: 837i: Loop 2300, REF02

- (4) Timely Filing of Claims: 120 days from Date of Service.
- (5) Appeal Time Frame: 180 days from Date on original Windsor Remittance Advice.
- (6) Corrected Claims: 180 days to submit corrected claim from date of original Windsor Remittance Advice.

Claim Status

There are two ways to check claims status:

1) Log on to www.WindsorExtra.com and click on "I am a Provider". Click on "Provider Login for Eligibility and Claims" in the left hand column, then click on "Register New User" at top of page. You will receive a return email letting you know your registration is complete and can begin checking claim status on our Web page.

2) Call Provider Help Desk at 1-866-270-5223 and **select option 1**.



Windsor Medicare Extra Appeals and Claim Dispute Resolution of Contracted Providers

Please visit our website at <http://www.WindsorExtra.com/provider/appeals.html> for detailed information regarding these processes, submission requirements, and to print a copy of the appropriate forms.

Submission Time Frame: 180 calendar days from date of initial Windsor Medicare Extra Explanation of Payment (EOP)

Appeals Regarding the Denial of Claim Payment

A contracted provider may file an appeal for the following reasons:

- A prior authorization was not obtained
- Authorization obtained does not cover the services rendered
- Prior authorization was denied by the plan however provider proceeded to render services

Mail or fax the completed Contracted Provider Reconsideration (Appeal) Form and required supporting documents to:

Windsor Health Plan, Inc.
Attn: Contracted Provider Appeals
7100 Commerce Way, Suite 285
Brentwood, TN 37027

Fax: (615) 782-7971

Claim Dispute

A provider may dispute the processing of a claim for the following reasons:

- Claim denied due to untimely claim filing
- Claim paid- rate applied resulted in underpayment/overpayment
- Claim denied due to lack of prior authorization but services rendered do not require prior authorization
- Dispute of Claim Check logic application
- Claim denied as not covered by Medicare however provider disputes exclusion from Medicare coverage
- Dispute of claim denial due to other primary coverage

Mail or fax the completed Claim Dispute Resolution Form and required supporting documents to:

Windsor Health Plan, Inc.
Attn: Claim Dispute Resolution Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

Fax: (615) 782-7823



Interpreter Services - AT&T Language Line

Windsor Medicare Extra provides for interpretation services to our Providers who provide health services to our Members with limited English proficiency and diverse cultural and ethnic backgrounds.

AT&T Language Line offers 173 languages which represent approximately 98.6% of all customer requests from the 6,809 languages spoken in the world today.

If you require the services of a professional interpreter when dealing with one of our Windsor Medicare Extra members:

- Call Provider Services at 1 -866-270-5223.
- Inform the Provider Services Representative you require the services of an interpreter and specify the language needed.
- The Provider Services Representative will connect all parties via conference call with the AT&T Language Line.
- Try to group your thoughts or questions.
- Always have the Interpreter ask the name, address and telephone number of the member all in one question.
- Avoid using slang or technical terms, jargon or industry acronyms. They tend not to translate well across languages and cultures.
- Be prepared for interpreted comments to run longer than English words. Interpreters convey meaning-for-meaning, not word-for-word. Contexts familiar to us require explanation or elaboration in other languages.
- As in any conversation, confirm or clarify details. Miscommunication is experienced daily speaking English. Consider the potential for miscommunication when another language is added.

Please Note: Spanish interpretation requests will be relayed internally to the internal Windsor Medicare Extra Spanish translator.

