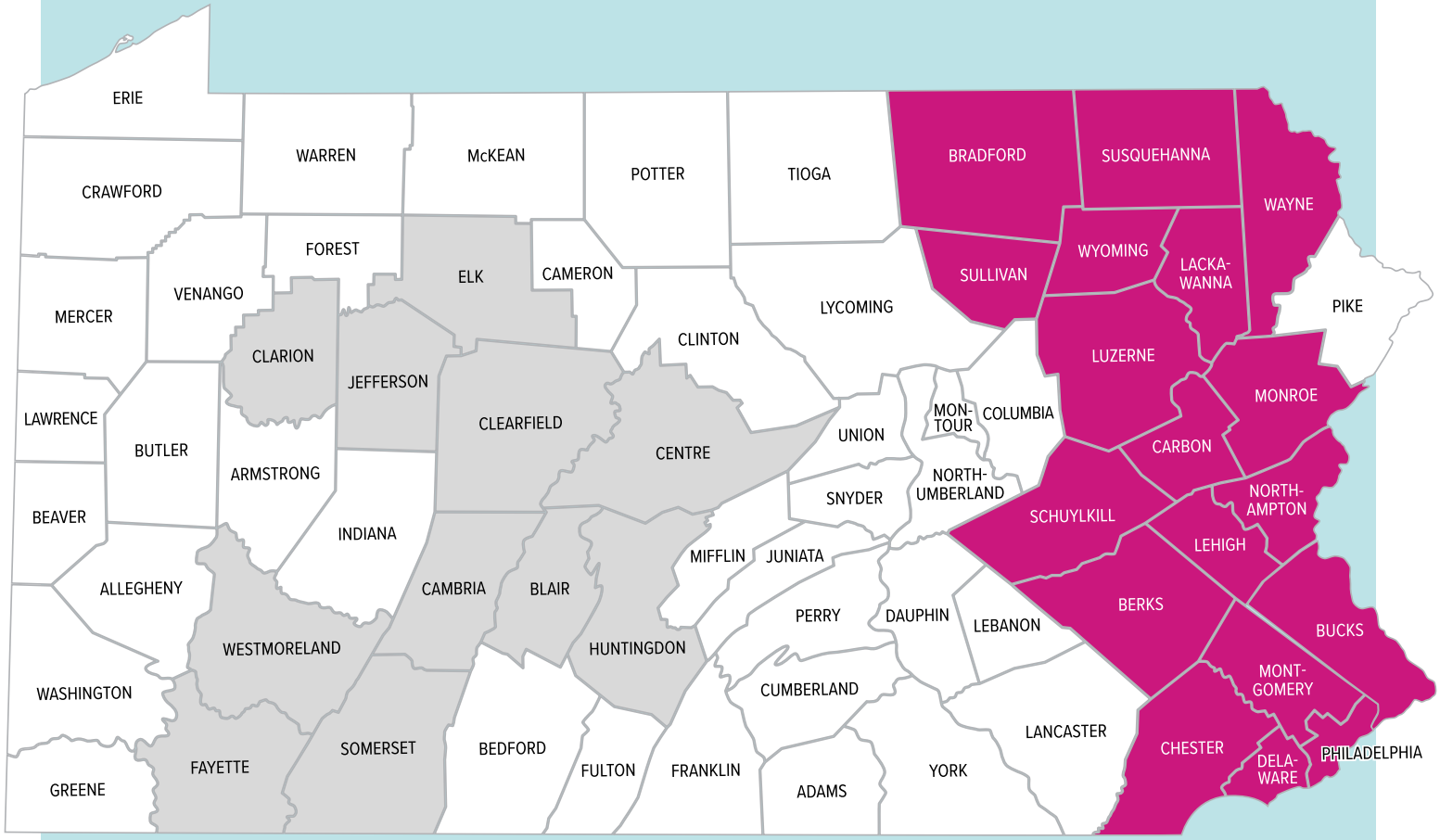
Provider Newsletter

pa health & wellness | ambetter. FROM pa health & wellness | wellcare By allwell.

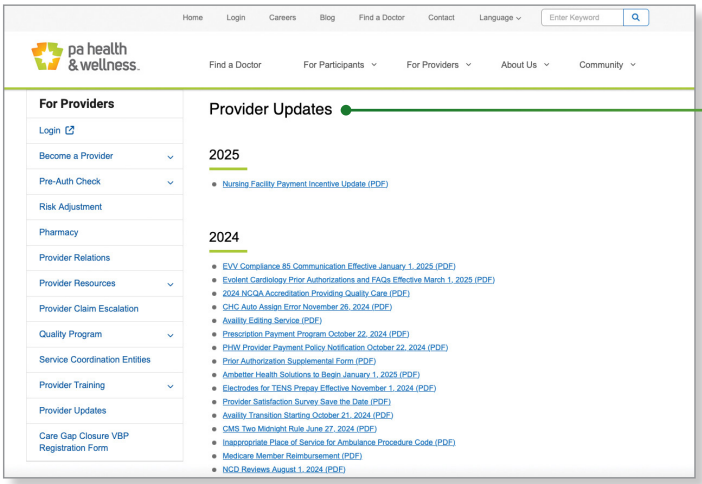
Volume 18

Ambetter from PA Health & Wellness is pleased to offer an **expanded service area in eleven western Pennsylvania counties for plan year 2025**. Eligible individuals now have another choice to shop for Affordable Care Act Marketplace benefits. Please connect with your Provider Representative for more information.



Current Ambetter Service Area (19 counties)

PY2025 Ambetter Service Area Expansion (11 counties)



Provider Updates

Please visit
https://www.pahealthwellness.com/providers/provider-updates.html
regularly to stay up to date on updates from PA Health & Wellness.

Annual Wellness Visit

- The annual wellness visit improves patient outcomes and is a good way for providers to optimize revenue, especially when paired with another billable service.
- The annual wellness visit is covered every 12 months (365 days at PA Health & Wellness). The patient pays nothing if only the AWV takes place. If paired with another service, there may be a fee or copayment.
- The aim of the AWV is to develop/update a Personalized Prevention Plan (PPP) and complete a Health Risk Assessment (HRA).
- Your office nurse can complete sections of the AWV services via Telehealth prior to your patient's scheduled appointment. Services include patient reported blood pressure, completing your patients Health Risk Assessment (HRA), COA-Functional Status and scheduling your patient's appointment.

Turning a Sick or Chronic Visit into a Well Visit

- The 25 modifier is used when billing both an Evaluation and Management (E&M) code and an Annual Wellness Visit (AWV). This situation arises in several ways. Some examples include:
- The patient presents for a scheduled AWV, but mentions a condition that requires evaluation and management, like a rash or swollen feet.
- The patient has a scheduled E&M visit, but it has been more than 365 days since the last AWV.
- In order to bill for both services, there must be two separate and distinct notes. The 25 modifier is attached to the E&M visit, not the AWV. The 25 modifier tells the payer that both services should be paid.

Care For Older Adults (COA)

Assesses members ages 66 and older who had each of the following

- Medication Review
- Functional Status Assessment

Why does it matter

As a person ages, physical and cognitive function may decline, and pain can become more prevalent. Older adults may also be taking multiple medications. Identifying areas of concern and addressing them helps ensure that older adults receive the care they need to optimize their quality of life.

Medication Review

Evidence of Medication Review:

- Conducted by a prescribing physician or a Clinical Pharmacist
- Signature is evidence that medications were reviewed
- If no signature, a review statement must be present

AND

Presence of Comprehensive Medication List:

- Medication lists may contain the names of medications only (does not need the dosage/frequency).
- An EMR standalone list is acceptable if there is documentation to indicate it was reviewed by the appropriate provider.

OR

Documentation that the member is taking no medications
Medication Review MAY be performed without the member present
Medication Review May Not be performed in an in-patient setting

Functional Status Assessment

Notation for a complete functional assessment must include **ONE** of the following

Activities of Daily Living (ADL): Notation that **at least five** of the following were assessed.
Bathing, dressing, eating, using the toilet, walking, transferring (getting in and out of bed/chair)

Instrumental Activities of Daily Living (IADLs): Notation that at least four of the following were assessed
Shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.

Result of an Assessment using a standardized functional assessment tool.
SF-36®, Assessment of Living Skills and Resources (ALSAR), Barthel ADL Index Physical Self-Maintenance (ADLs) Scale©, Bayer ADL (B-ADL) Scale, Barthel Index©, Edmonton Frail Scale©, Extended ADL (EADL) Scale, Groningen Frailty Index Independent Living Scale (ILS), Katz Index of Independence in ADL©, Kenny Self-Care Evaluation, Klein-Bell ADL Scale Kohlman Evaluation of Living Skills (KELS), Lawton & Brody's IADL Scales©, Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales©

Note: This is a list of acceptable standardized functional status assessment tools and are not all-inclusive.

Description	Codes
Medication Review (would need both CPT-CAT ll codes to get credit) **1159F** (Medication List) & **1160F** (Medication Review)	**CPT:** 90863, 99605, 99606, 99483, 99495, 99496 **CPT-CAT-ll:** 1159F, 1160F **HCPCS:** G8427
Functional Status Assessment	**CPT:** 99483 **CPT-CAT-ll:** 1170F **HCPCS:** G0438, G0439

Convenient Care Options

You have the best interest of your patients at heart. More than that, you have their trust. But you aren't available 24/7/365. So when your office is closed, we want to help them get the care they need, when they need it. Discussing alternatives to the Emergency Room (ER) for non-emergent needs gives patients a choice in how they can access care when you are not available.

Care Options for Wellcare Patients

24/7 Nurse Advice Line

For all patients all the time!

Wellcare members can talk to a registered nurse any time — day or night with this free service. The 24/7 Nurse Advice Line provides quick, reliable advice for both mental and physical health concerns that aren't life-threatening.

Virtual Care

For patients who feel the need to "see" a provider ASAP.

Wellcare offers Virtual 24/7 Care for non-emergency health issues. They can use this option to get the medical advice they are seeking by phone or video. They can set up an account on **Teladoc.com/wellcare**.

Urgent Care Center

For patients that seek in-person, after hours care for a non-emergent injury or illness.

Many patients think Urgent Care Centers are just not as good as an ER. But many Urgent Cares offer a variety of services that patients are often looking for like lab testing and imaging — and without the ER wait. Wellcare members can find an in-network Urgent Care on our website or by calling member services.

Urgent Care: sprain or broken bone, ear infection, sore throat, body pain with fever/wheezing, minor cuts and burns.

Emergency Room: thoughts of self harm/suicide, bleeding that doesn't stop, drug overdose, severe pain, chest pain, coughing or vomiting blood.

For more than 20 years, Wellcare has offered a range of Medicare products, which offer affordable coverage beyond Original Medicare. Beginning Jan. 1, 2022, our affiliated Medicare product brands, including Allwell, Health Net, Fidelis Care, Trillium Advantage, and 'Ohana Health Plan transitioned to the newly refreshed Wellcare brand. If you have any questions, please contact Provider Relations.

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By Allwell
By Fidelis Care
By Health Net
By 'Ohana Health Plan
By Trillium Advantage

Local Pharmacist

For patients who may struggle with medication management or a chronic condition.

If you have patients that frequently end up in the ER because of a medication concern, remind them that their pharmacist can also help. They can assist in-person or over the phone with questions about side-effects and often teach patients how to use health equipment.

988 Suicide and Crisis Line

For patients needing immediate mental health assistance.

The 988 Suicide & Crisis Lifeline provides confidential help for mental health, drug use or suicidal concerns when members need it quickly. They can text or call 988 or chat at **988lifeline.org/**. Spread the word about this resource and order free 988 materials for your office at **orders.gpo.gov/SAMHSA988/Pubs.aspx**.

Scan to access the Wellcare provider portal for more resources to support you and your practice.

Tips for Patients with a Pattern of ER use:

- Ask your Wellcare Engagement Representative for a list of your high ER utilizing patients.
- Determine symptoms that led the member to go the ER.
- Discuss symptoms awareness, tracking, and self-management skills for at home.
- Wellcare provides care management programs for those with complex needs and/or those that need support managing their conditions. Contact your Provider Engagement Representative for assistance with a referral.
- Ask if they know when and where to seek care when they can't see you.
- Learn more about incentives available for lowering your patient ER utilization.
- Request materials for your office about Wellcare care options.

Thank you for being a trusted partner in the health care decisions of those you care for.

For more information, please contact your Wellcare Provider Engagement Representative.

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At Wellcare by Allwell, our members are at the heart of every service we provide. We want them to get the care they need when they need it. Everything from routine care and screenings to dental, vision, and much more. Many of our plans include these additional supplemental benefits:

- Dental care, dentures & implants
- Vision care & eyewear allowance
- Hearing exams & hearing aids
- Prescription drug coverage
- OTC, gas, healthy food, rent & utility assistance
- Transportation to medical appointments
- Gym memberships & home fitness kits
- Personal Emergency Response System

Notable for Plan Year 2025:

Wellcare Spendables™ is an easy-to-use benefit which combines an allowance into one card that can be used at participating retailers, online, via mobile app, or by phone. Depending on the plan, the allowance can be used for over-the-counter items, healthy foods, gas (pay-at-pump), rent & utility Assistance and, NEW for 2025, Home Improvement and Safety Items!

EXPRESS SCRIPTS®

NEW for 2025, the Part D benefit consists of three phases: annual deductible, initial coverage, and catastrophic coverage. Member's out-of-pocket prescription costs will not exceed $2,000 with the option to pay in the form of monthly payments over the course of the plan year.

twill™

In 2025, Twill will be offered to all active members on a Wellcare Medicare Advantage plan. This digital solution platform can help members manage stress, anxiety and loneliness. Twill focuses on members' mental health by delivering behavioral services for a personalized, online experience.

We offer a range of plans that provide members with affordable access to doctors, nurses, and specialists:

HMO D-SNP	HMO	PPO	PPO D-SNP
H2915-002 Wellcare Dual Access H2915-007 Wellcare Dual Access	H2915-003 Wellcare Simple H2915-011 Wellcare Assist H2915-013 Wellcare Patriot Giveback H2915-016 Wellcare Simple	H2128-002 Wellcare Simple Open H2128-004 Wellcare Giveback Open	H2128-005 Wellcare Dual Access Open H2128-006 Wellcare Dual Reserve Open

With our Dual Eligible Special Needs Plans (D-SNP), members who are aligned with PA Health & Wellness for both Medicare and Medicaid experience the additional benefits and valuable "all-in-one" coverage.

Get Better. Together.

Community HealthChoices | pa health & wellness + wellcare By allwell =

GOOD FOR YOU...

- One claim= less paperwork
- More patient care time
- More efficient for practice staff
- Improved patient health outcomes

GOOD FOR YOUR PATIENTS...

- **Expanded drug coverage**
- **Preventive services**
- **More rides** to doctors appointments
- **Lab services**
- **One call** for customer services
- **One care** to carry
- **Care team** to plan and coordinate care
- **No additional cost**
- **Caregiver support**

As always, Wellcare By Allwell is committed to working with you to ensure your patients receive the best care. If you have any questions, please visit our website www.wellcare.com/allwellPA or contact us at:

Wellcare By Allwell Medicare Provider Services
HMO, PPO: 1-800-977-7522 (TTY:711)
HMO, PPO D-SNP: 1-844-796-6811 (TTY:711)

Preparing for the Upcoming HEDIS® Season

As we approach the upcoming HEDIS® season, I wanted to provide some important updates and express our gratitude for your continued partnership.

This season, as part of our work to meet both **NCQA** and **State audit** requirements, we will once again be reaching out to obtain medical records from your office. These requests serve two important purposes:

- **Primary Source Verification (PSV)** to validate our data sources and ensure the accuracy of the information you provide.
- **The HEDIS® Hybrid Season**, where we request medical records to close care gaps for the final time in the measurement year, specifically for members selected in the sample. This helps confirm and complete compliance for the current year.

Please note that these two requests do not always occur simultaneously, as they address different requirements. While this may result in multiple requests, we strive to minimize any inconvenience and greatly appreciate your patience and collaboration.

Your support last year was invaluable, and we look forward to working together again this season. Your timely responses are crucial in ensuring that we meet these standards and help improve care for our members.

Thank you again for your partnership. If you have any questions or need clarification, please feel free to reach out.

Best regards,

PHW Quality Teamhetrmj

CoC (Continuity of Care) Bonus Program

A basic guide to reviewing and submitting appointment agendas

CoC HCC Validation

- Providers should schedule and conduct a comprehensive exam with the patient, assessing the validity of each condition on the appointment agenda.
- Submit the signed appointment agenda
  - AND submit the same diagnosis code in the medical claim
  - OR gap addressed by checked exclusion box in the dashboard

✓ **'Active Diagnosis & Documented'**

Patient is currently presenting with this condition. Provider must submit a claim with a diagnosis code that maps to this Disease Category listed on the agenda.

✓ **'Resolved/Not Presented'**

Patient is not presenting with this condition. Provider must submit a claim with a 2025 face-to-face visit and should submit appropriate diagnosis codes for conditions the patient is currently presenting.

ALL conditions must be addressed for the agenda to be complete

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Agenda ID: 17913504 — Page 1 of 1 — 2/1/2022 1:21:52 PM

MEMBER NAME — Member Phone

Member DOB

TIN Name

Provider Name and ID :

2022 APPOINTMENT AGENDA - Use as a guide during the patient's visit.

Health Condition History / Continuity of Care

These conditions are based on claims submitted by providers and/or the member's medical history as of 1/7/2022. Please update diagnoses, as these conditions may no longer exist, their severity level may have changed, or they may have been replaced by other conditions.

Suspected Rx/Condition	Type	Source	Diagnosis	Active Diagnosis & Documented	Resolved / Not Present
Diabetes with Chronic Complications	Predictive Gap	ICD-10	E08.21 Diabetes mellitus due to underlying condition with diabetic nephropathy	☐	☐
Disorders of Immunity	Persistency Gap	ICD-10	D61.810 Antineoplastic chemotherapy induced pancytopenia	☐	☐
Metastatic Cancer and Acute Leukemia	Persistency Gap	ICD-10	C77.0 Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck	☐	☐

Persistency = DX Code(s) have appeared in prior claims — Predictive = Possible condition(s) based on prior claims

Care Guidance

Address and document the Care Gaps below. Care Gaps are closed by a claim, CPT, CPTII, HCPCS, DX codes or applicable documentation. For additional information, please reference your Care Gap Report.

No data returned for this view.

For questions on the Appointment Agenda form, please contact your Provider Representative.

All current Diagnoses and Care Gaps for 2022 dates of service must be documented in the patient's chart and submitted on claims.

Provider Signature : _____ Date : _____

Provider Printed Name : _____ Provider Credentials : MD, DO, PA, NP (circle one)

Sample

Contact Information

- PHW will manage the bonus calculation, reconciliation, and payment processing.
- You may also email or fax paper agendas to
  - Agenda@centene.com
  - Fax: 1-813-464-8879

Questions?

- Want to know more information? We here at PHW have created a step-by-step guide for CoC provider portal navigation in the below link
  - https://www.pahealthwellness.com/providers/risk-adjustment.html
- At the bottom of this page, you will find Risk Adjustment tools and resources
  - Click "CONTINUITY OF CARE/HCC ACCURACY PROGRAM"
  - In this section, you will find a PDF with our Continuity of Care Provider Presentation with detailed instructions and images to aid in your agenda submissions, as well as other acceptable submission methods including vendor and EMR bi-directional feed solutions.

Clinical Documentation Improvement (CDI) 2025 Webinars

Learn more about: Risk Adjustment Documentation and Coding

Each webinar includes an overview of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs).
To register, *please visit https://www.pahealthwellness.com/providers/provider-training.html*

Topics will include:

Navigating Annual Wellness Encounters: Visit Types and Benefits
2025 ICD-10 and CMS Updates
Unpacking Healthcare Risk Adjustment
Risk Adjustment 101: With Case Studies
The Importance of Accurate Documentation and Coding: A Provider's Perspective
The Ultimate Guide to Risk Adjustment Coding: The Basics Everyone Should Know
Top HCC Codes for Primary Care: With Case Studies
ICD-10 Clinical Concepts for OB/GYN

Unable to attend live webinars?

- Good news! We also have pre-recorded, on-demand webinars available.
- Please reach out to PHW_RiskAdjustment@PaHealthWellness.com for registration and webinar links.

Dear Provider,

Centene has partnered with Evolent (formerly New Century Health), to implement a new prior authorization program. Evolent's Cardiology Solutions Program is intended to help providers effectively deliver quality patient care.

Effective March 1, 2025, interventional cardiovascular procedures and services will require prior authorization through Evolent prior to being rendered in a provider office, outpatient hospital, ambulatory, or inpatient setting (planned professional services only). This prior authorization management program will apply to your PA Health & Wellness' Wellcare by Allwell (Medicare), and Ambetter from PA Health & Wellness (Marketplace) members 18 years of age and older.

Evolent uses clinical criteria based on nationally recognized guidelines to promote evidence-based practices. Providers may begin contacting Evolent on March 1, 2025, to seek prior authorization for procedures scheduled on or after March 1, 2025.

The Evolent program will apply to all specialties for the following interventional cardiovascular services:

- Cardiac catheterization and intervention
- Electrophysiology
- Vascular radiology and intervention
- Cardiac surgery
- Vascular surgery

Prior authorization requests for interventional cardiology services can be submitted to Evolent:

- Evolent (CarePro) provider portal at my.newcenturyhealth.com.
- Via telephone at 1.888.999.7713, cardiology (option 1). Staff are available Monday -Saturday from 8:00 a.m. to 8:00 p.m. EST.

Evolent offers providers the ability to:

- Real-time member eligibility verification through the Evolent CarePro portal prior to entering a treatment plan.
- Obtain real-time approvals when selecting evidence-based treatment care pathways.
- Determine the clinical documentation required for medical necessity review.
- View all submitted requests.
- A true peer-to-peer match with clinicians to discuss treatment options.
- A dedicated Evolent Provider Solutions Manager to use as a direct point-of-contact for any issues or questions.

Approvals issued before March 1, 2025, are effective until the authorization end date. Upon expiration, authorization requests must be submitted to Evolent. For services/treatment that did not require an authorization prior to March 1, 2025, an authorization may be required from Evolent for service/treatment dates on and after March 1, 2025.

Centene is proud to be your healthcare partner. If you frequently request interventional cardiovascular services and are new to this process, Evolent representatives will contact you soon to schedule an introductory meeting and in-service training.

We will provide additional information as we get closer to the implementation date. If you have questions, please contact the appropriate Provider Services Department; **Wellcare by Allwell HMO/PPO: 1.800.977.7522; (TTY: 711), HMO/PPO D-SNP: 1.844.796.6811; (TTY: 711); Ambetter from PA Health & Wellness 1.833.510.4727 (TTY: 711)**. If you have questions about the **Evolent Cardiology Solutions Program**, please email providertraining@evolent.com or call **1.888.999.7713, (option 6**).

We look forward to offering you this program and hope it will enhance your experience with cardiology service authorizations.

Sincerely,
PA Health & Wellness

Frequently Asked Questions:
Cardiology Solutions Program

Wellcare by Allwell (Medicare)
Ambetter from PA Health & Wellness (Marketplace)
Effective March 1, 2025

- **Who is Evolent?**
  - Evolent (formerly New Century Health) is a comprehensive Cardiology Solutions Program's goal is to apply evidence-based treatment to the delivery of cardiovascular care.

- **What is the Cardiology Solutions Program?**
  - The Cardiology Solutions Program provides prior authorization management for interventional cardiovascular services rendered in a physician's office, outpatient hospital, and ambulatory or inpatient setting (planned professional services only). The program emphasizes and supports the selection of preferred pathways for patient care and authorizations are administered by Evolent.

- **What members are included in this program?**
  - Wellcare by Allwell (Medicare), and Ambetter from PA Health & Wellness (Marketplace) members 18 years of age and older.

- **When will the program begin?**
  - The program will begin **March 1, 2025**.

- **How can a physician's office request training for this program?**
  - A Provider Solutions Manager will contact you to schedule an introductory meeting and training. If you have any questions prior to the introductory meeting, please contact Evolent at **1.888.999.7713, option 6** or email providertraining@evolent.com.

- **What are some key features of the program?**
  - Evolent offers providers:
    - Real-time authorizations for treatment care pathways
    - Real-time status of authorization requests
    - Quick turnaround on authorization requests
    - Eligibility verification
    - Physician discussions with cardiologists
    - Support staff with dedicated provider solutions representatives available to assist

- **How do I contact Evolent authorization support?**
  - Call **1.888.999.7713 (option 1)** Staff is available Monday-Friday 8:00 am to 8:00 am EST

- **What is the transition of care process?**
  - Approvals issued before **March 1, 2025**, are effective until the authorization end date. Beginning **March 1, 2025**, please submit prior authorization requests to Evolent.

- **Who is responsible for obtaining prior authorization?**
  - The physician organization ordering cardiovascular services must request prior authorization through Evolent.

- **How do I obtain prior authorization?**
  - By submitting requests to Evolent:
    - Online my.newcenturyhealth.com.
    - Via telephone at **1.888.999.7713 (option 1)**

- **What is the turn-around time (TAT) for processing prior authorization requests?**

Request Type	Medicare - Marketplace
Medical Services	Standard: Within 2 business days Expedited: Within 24 hours

- **What services / specialists are included in the program?**

  The program will apply to all specialties for the following interventional cardiovascular services only:
  - Cardiac catheterization and intervention
  - Electrophysiology
  - Vascular radiology and intervention
  - Cardiac surgery
  - Vascular surgery

- **Who reviews cardiovascular requests?**
  - Evolent medical reviewers are licensed cardiologists using nationally recognized clinical guidelines when performing reviews. Clinical guidelines are available at my.newcenturyhealth.com or by contacting Evolent at 1.888.999.7713, option 1.

- **What happens if the authorization request does not meet guidelines?**
  - If the request does not meet evidence-based treatment guidelines, Evolent may request additional information or initiate a physician discussion with the requesting provider.

- **What will the Evolent authorization number look like, and how long is it valid?**
  - The Evolent authorization will start with "AR" followed by at least seven digits (e.g., AR1000000) and be valid for the 60-day duration indicated on the Service Request Authorization (SRA).

- **Which place(s) of service are included in this program?**
  - Cardiovascular services rendered in a physician's office, outpatient hospital, ambulatory, or inpatient setting (planned professional services only).

- **Does prior authorization guarantee payment?**
  - No. Prior authorization does not guarantee payment for services. Payment of claims is dependent on eligibility, covered benefits, provider contracts, and correct coding and billing practices. For specific details, please refer to your Provider Manual.

- **Who is responsible for responding to grievances and appeals?**
  - Wellcare by Allwell (Medicare), and Ambetter from PA Health & Wellness (Marketplace) will maintain the grievance and appeal processes.

- **What will happen if the physician does not request and obtain an authorization?**
  - If authorization is not obtained, Wellcare by Allwell (Medicare), and Ambetter from PA Health & Wellness (Marketplace) may deny payment for the relevant services. Members may not be held responsible or billed for denied charges/services. Providers may only be able to collect the applicable cost share amount directly from the member.

evolent™

Fraud, Waste and Abuse

There are several things, as a Provider, that can be done to reduce and mitigate the risk of False Claims Act liability. Making sure there is an understanding of the rules that relate to the services and good being billed. The information included in claims should always be as accurate and complete as possible. It is also important to ensure there is awareness of any potential billing problems. Below are resources related to Fraud, Wase, and Abuse:

FALSE CLAIMS ACT:

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the Government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying Government property from an unauthorized officer of the Government
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims act, please visit:
https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd032207att2.pdf

STARK LAW:

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies.

For more information regarding the Stark Law, please visit:
https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

ANTI-KICKBACK STATUTE:

The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid, and other federally-funded programs.

For more information regarding the Stark Law, please visit:
https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

Reporting Fraud, Waste and Abuse

If you suspect fraud, waste, or abuse in the healthcare system, you must report it to PA Health & Wellness and we'll investigate. Your actions may help to improve the healthcare system and reduce costs for our participants, customers, and business partners.

To report suspected fraud, waste, or abuse, you can contact PA Health & Wellness in one of these ways:

- PA Health & Wellness anonymous and confidential hotline at **1-866-685-8664**
- Pennsylvania Office of Inspector General at **1-855-FRAUD-PA (1-855-372-8372)**
- Pennsylvania Bureau of Program Integrity at **1-866-379-8477**
- Pennsylvania Department of Human Services **1-844-DHS-TIPS (1-844-347-8477)**
- Mail: Office of Inspector General,
  555 Walnut Street, 8th Floor,
  Harrisburg, PA 17101
- Mail: Department of Human Services,
  Office of Administration,
  Bureau of Program Integrity,
  P.O. Box 2675,
  Harrisburg, PA 17105-2675

You may remain anonymous if you prefer. All information received or discovered by the Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, corporate law department, market medical directors or senior management).

MEET YOUR PROVIDER RELATIONS TEAM

Mollie Lewis
Project Manager, Provider Communications
phwproviderrelations@pahealthwellnes.com
1-844-626-6813

We can't wait to meet you!

Provider Relations is your primary contact for PA Health & Wellness, including Wellcare By Allwell and Ambetter from PA Health & Wellness.

We're here to be your partner. My primary focus is to drive resolution, provider performance, ongoing education and more!

Feel free to reach out with any questions, concerns, or even just to say, "hello!".

Get to know our Provider Relations team even better by visiting https://www.pahealthwellness.com/providers/ProviderRelations.html

Get connected with our Provider Relations Team at PHWProviderRelations@PAHealthWellness.com

Thank you for continuing to provide our Members with high quality and compassionate care. We're looking forward to our continued partnership.

Meeting appointment accessibility standards

Are your patients able to obtain services when they are needed?

PA Health & Wellness monitors the availability of our network practitioners. Availability is key to participant care and treatment outcomes.

PA Health & Wellness follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. We monitor compliance with these standards annually and use the results of monitoring to ensure adequate appointment availability and reduce the unnecessary use of emergency rooms. Please review the appointment availability standards in the Provider Manual.

1. CHC & Medicare: https://www.pahealthwellness.com/providers/resources/forms-resources.html

2. Marketplace: https://ambetter.pahealthwellness.com/provider-resources/manuals-and-forms.html

Medical Necessity Appeal

Providers or Participants may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing:

Mail to:
PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd, Suite 200
Mechanicsburg, PA 17055

Email: PHWComplaintsandGrievances@PAHealthWellness.com

Phone: 844-626-6813 TTY: 711

NOTE: PHW will not accept data stored on external storage devices such as USB devices, CD-R/W, DVD-R/W, or flash media.

Overpayment Refund Submission

When needing to submit a refund check for claims overpayments checks should be made payable to PA Health & Wellness. The submission should also include a list of the claims that were overpaid.

Mail to:
PA Health & Wellness
P.O. Box 3765
Carol Stream, IL 60132-3765

Provider Newsletter

pa health & wellness™ | ambetter. FROM pa health & wellness™ | wellcare By allwell.™

1700 Bent Creek Blvd, Suite 200, Mechanicsburg, PA 17050