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PROVIDER NEWSLETTER - SUMMER 2022

LET YOUR PATIENTS KNOW THE BENEFITS OF ENROLLING IN A MEDICAID ADVANTAGE PLUS (MAP) PLAN

Finding the right health plan can be a daunting experience. For patients with Medicare and full Medicaid who need community-based long-term care, the AgeWell New York Advantage Plus (HMO D-SNP) MAP plan may be a great fit. This "dual plan" brings Medicare and Medicaid benefits and long-term care services together under one plan. Receiving services like home care and personal care will help people stay in their homes and communities as long as possible.

MAP plans are designed to provide more patient-centered care. The patient is assigned a care manager who helps access medical, behavioral, social, educational, financial and other services that support their care plan.

There are also benefits for providers:

- ***One Plan and one ID card*** for all Medicare, Medicaid, prescription drugs, additional supplemental benefits and community based long-term care services and supports in the home. The simplicity of having everything covered by one plan makes referring, billing and communications easier for all involved.
- ***One Payor Source*** eliminates fragmentation caused by multiple payors.
- ***Care Coordination:*** One dedicated care manager will coordinate services for your patient and offer support to your practice. This promotes better communication among providers, caregivers, and patients.

For more information about the AgeWell New York Medicaid Advantage Plus (MAP) Plan or to request materials to distribute in your practice, visit our website at **agewellnewyork.com** or call us at **1-866-586-8044**.

Inside this issue:

Toll Free 1-866-237-3210 • 7 days a week from 8:00 am - 8:00 pm

Note: From April 1 to September 30, we may use alternate technologies on weekends and federal holidays.

TTY/TDD 1-800-662-1220

info@agewellnewyork.com

agewellnewyork.com

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FROM THE DESK OF OUR MEDICAL DIRECTOR

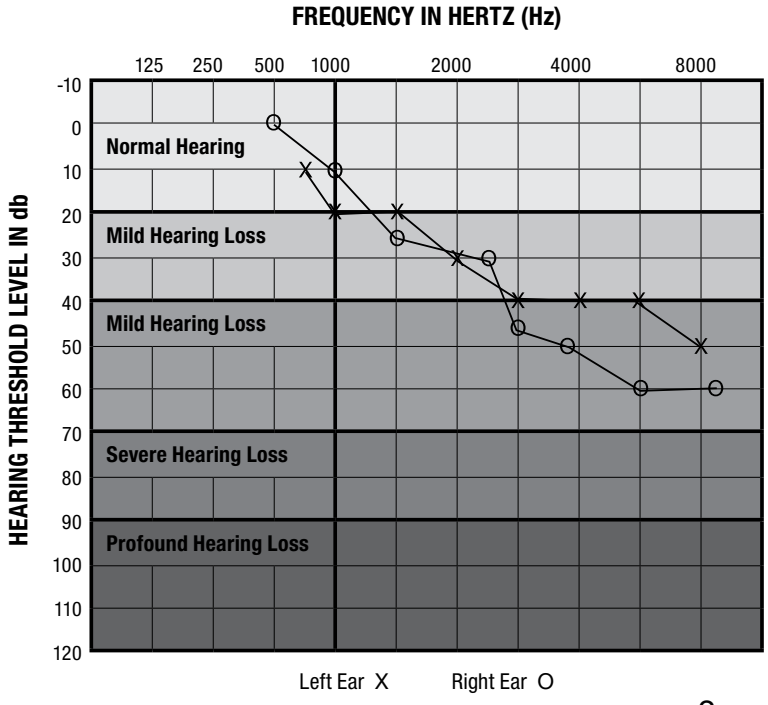
David Lichtenstein, MD
MEDICAL DIRECTOR

One of the most common problems affecting older adults is age-related hearing loss. Approximately one in three people aged 65 to 74 has hearing loss, and nearly half of those older than 75 have difficulty hearing[2]. Despite this staggering number, age-related hearing loss is an underappreciated public health concern in the United States[2].

Hearing loss brings myriad health-related consequences and impacts the economy and family dynamics. As healthcare providers, it is our responsibility to uncover effective means to improve the utilization of services to meet our aging population's hearing health demands. Enhancing awareness of the indications of hearing loss and options for assistance secondary to assessment is fundamental to ensuring good health and well-being among the general population[2]. While a hearing aid is the most effective way to manage hearing loss, identifying hearing impairment type is critical to ensure adherence[2]. Furthermore, as posited by Lin et al. (2011), of the individuals with mild hearing loss, only 3.4% use hearing aids compared to 40% and 76.6% in those with moderate and severe hearing loss, respectively, despite its apparent benefits to communication ability and quality of life[5]. It is essential to examine underlying reasons for non-adherence and investigate other strategies to potentially mitigate the adverse health and functional effects of hearing loss in older adults[2].

Developing individualized hearing health care targeting the identified modifiable and non-modifiable risk factors that are strong determinants of hearing loss is critical. Risk factors include age, sex, race, occupation, leisure time noise exposure, and smoking[1]. Diabetes mellitus is another independent risk factor postulated by Bainbridge et al. in their 2008 study[1].

As practitioners, we must appreciate that 60% of our older patients will have some elements of hearing loss and should offer hearing assessments in our annual and wellness visits. Simple inspection of the ear canal with an otoscope will diagnose ear wax impaction vs. foreign body. The Rinne and Weber test is another non-invasive procedure performed using 512-Hz tuning forks correctly during visits. Both tests differentiate between conductive and sensorineural hearing loss and are key to appropriate interventions. The Rinne test assesses bone and air conduction. Place the base of the tuning fork in the center of the forehead, and when the sound is heard in the affected ear, this indicates conductive loss and sensorineural when heard in normal ear[6]. The Weber test checks for lateral displacement, air conduction vs. bone conduction and dominance of the latter suggests sensorineural hearing loss[6]. But how effective is the Rinne/Weber bedside test? A study with these tests followed by formal audiograms showed that the Rinne test was 90% sensitive and Weber 30-60%. This simple, useful, risk-free, and quick method makes a difference in our patients' hearing health. The graph below shows an interpretation of an audiogram from the pure-tone threshold assessment[3].



AUDIOGRAM SYMBOLS	Air Conduction
	O or [△] = results for right ear
	X or [□] = results for left ear
	S = results from listening through a speaker

A sharp drop from a higher frequency is conductive loss. The low frequency across-the-board is a classic sign for sensorineural.

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Intervention: A hearing aid is the most effective intervention, but identifying the type of hearing loss is key. For example, in conductive hearing loss, a hearing aid is less effective while it is most helpful in sensorineural. Prescribing the right type of hearing aid, analog or digital, is also essential. Each comes with a specific benefit where analog converts sound to electronic signals and is better for conversation discrepancies, and digital converts sound to binary code and are flexible for programming[6].

	Severity of Impairment	
Frequency range	Mild (pure tone average threshold >25–40 dB HL)	Moderate to severe/ profound (pure tone average threshold >40 dB HL)
Low or mid frequency (0.5–2 kHz)	Slight difficulty with understanding speech under ideal listening conditions	Considerable difficulty with understanding speech under ideal listening conditions
High frequency (≥3 kHz)	Slight difficulty with understanding speech under unfavorable listening conditions	Considerable difficulty with understanding speech under unfavorable listening conditions

As effective as a hearing aid may be, continuous assessment and education are also crucial so the instrument is utilized by patients[4]. Our utilization department is ready to partner with you in ensuring your service requests are reviewed and authorized promptly. You can download the prior authorization form in the provider section of the AgeWell New York website, **https://agewellnewyork.com/for-providers/utilization-management-guidelines**. You may also call **1-718-696-0210** or email **um@agewellnewyork.com**. Please follow the Utilization Management Guideline steps for the timely processing of your requests.

Reference

1. Bainbridge, K. E., Hoffman, H. J., & Cowie, C. C. (2008). Diabetes and hearing impairment in the United States: Audiometric evidence from the National Health and Nutrition Examination Survey, 1999 to 2004. Annals of Internal Medicine. https://doi.org/10.7326/0003-4819-149-1-200807010-00231
2. Bainbridge, K. E., & Wallhagen, M. I. (2014). Hearing loss in an aging American population: Extent, impact, and management. Annual Review Public Health, 35, 139-152. https://doi.org/10.1146/annurev-publhealth-032013-182510
3. Gordon-Salant, S. (2005). Hearing loss and aging: New research findings and clinical implications. Journal of Rehabilitation Research and Development, 42(4), 9-24. https://www.rehab.research.va.gov/jour/05/42/4suppl2/gordon-salant.html
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5. Lin, F. R., Thorpe, R., Gordon-Salant, S., & Ferrucci, L. (2011). Hearing loss prevalence and risk factors among older adults in the United States. The journals of gerontology. Series A, Biological sciences and medical sciences, 66(5), 582–590. https://doi.org/10.1093/gerona/glr002
6. Marcin, J. (2018, September 29). Rinne and Weber tests. Healthline. https://www.healthline.com/health/rinne-and-weber-tests

HELP YOUR PATIENTS PLAN AHEAD WITH A DISCUSSION ON ADVANCE CARE PLANNING

Advance Care Planning (ACP) helps patients prepare for current and future decisions about their medical treatment and place of care. Advance care planning is associated with improved quality of life and as a result, the National Committee for Quality Assurance (NCQA) has implemented a stand-alone advance care planning measure for HEDIS® measurement year (MY) 2022.

What is the new Advance Care Planning HEDIS® Measure?

The new advance care planning HEDIS® measure is measuring the percentage of adults 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.

This measure will be administrative only (claims). Therefore, correctly submitting claims related to advance care planning discussions taken place during 2022 is important. Please use the table below as a guide when submitting claims to document advance care planning discussions and/or documentation with your patients.

Code	Code Description	Code System
1123F	Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr).	CPT II
1124F	Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr).	CPT II
1157F	Advance care plan or similar legal document present in the medical record.	CPT II
1158F	Advance care planning discussion documented in the medical record.	CPT II
99483	Assessment of and care planning for a patient with cognitive impairment.	CPT
99497	Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) Provided by the physician or other qualified health care professional.	CPT
Z66	Do not resuscitate.	ICD10

Speak with your patients about ACP during their Annual Wellness Visit (AWV) or routine office visit. Encourage your patients to put their choices in writing using the New York State Health Care Proxy Form, available in seven different languages at: **https://www.health.ny.gov/professionals/patients/health_care_proxy.**

They should provide copies of the form to you, family members, caregiver(s), and their designated health care proxy in case of an emergency.

Include the signed health care proxy form, or a discussion of it, in the patient's medical record.

Discuss and document your patient's wishes and encourage them to:

- Think about what's important to them and how they want to receive care
- Choose a person to speak for them if and when they can't speak for themselves
- Discuss their health care wishes with family and caregivers

Submit a claim to Agewell New York when you have advance care planning discussions with your patients.

DOCUMENTATION & CODING FOR DIABETES MELLITUS

As part of our continuing efforts to provide valuable documentation and coding support for our providers, this issue will focus on Diabetes Mellitus (DM). DM is a condition that may have many combinations and can cause challenges for accurate and complete coding.

When coding for diabetes, it is important to code to the highest level of specificity. Below, we share some key coding tips for diabetes mellitus and associated complications.

Document Diabetes Type I or II: The documentation of "insulin-dependent" or "non-insulin-dependent" is no longer considered specific enough to define the type of diabetes. When documenting Type I, the term "juvenile type diabetes" can be understood to mean Type I.

Long Term Use of Insulin: Document as "reviewed and reconciled" by the provider. Use ICD1-10-CM code Z79.41.

Diabetic Control: While the concept of "control" refers to the patient's blood glucose level, there are no firm guidelines as to what lab values or other findings constitute control or lack of control. This is up to the provider. It is important to avoid simply copying the patient's status from a previous visit. Rather, document and code the patient's diabetic control as it presents at the time of the appointment.

Diabetic Kidney Complications:

- Diabetic nephropathy: Utilizing ICD-10-CM, code to the 4th & 5th characters of 21; e.g., E11.21 (Type 2 diabetes mellitus with diabetic nephropathy).
- Diabetes may be stated as being complicated by chronic kidney disease (CKD). In ICD-10-CM, the code identifying DM with diabetic CKD should be followed by a code to identify the stage of the CKD (category N18).
- If diabetes is documented with both nephropathy and chronic kidney disease, code only the chronic kidney disease manifestation. Nephropathy is a less specific term and can be ignored in this context.

Diabetic Retinopathy:

- The provider may distinguish between non-proliferative diabetic retinopathy and proliferative diabetic retinopathy, and the proper complication/manifestation code must be selected accordingly. The provider should also be mindful of the presence or absence of diabetic macular edema, and laterality, if specified.

Diabetic Neuropathy:

- Select the appropriate 5th character, as follows, according to available documentation:
    - 0 - … with diabetic neuropathy, unspecified
    - 1 - … with diabetic mononeuropathy
    - 2 - … with diabetic polyneuropathy
    - 3 - … with diabetic autonomic (poly)neuropathy
    - 4 - … with diabetic amyotrophy
    - 5 - … with other diabetic neurological complication

Diabetic peripheral vascular disease/circulatory complications:

- ICD-10-CM identifies a subcategory for circulatory manifestations. Fifth characters identify peripheral vascular disease without gangrene, peripheral vascular disease with gangrene, and other circulatory complications.
- Use code I70.2x in addition to Exx.51 when a diabetic patient has arteriosclerotic peripheral vascular disease.
- CAD/Atherosclerosis of aorta/cardiomyopathy due to diabetes mellitus is coded to category E08 – E13 with 4th & 5th character Exx.59 or Exx.69 as applicable.

Diabetic Ketoacidosis:

- Type-2 DM with ketoacidosis will be coded to E11.10 or E11.11 with or without a coma respectively. For DOS before 10/1/2017, within the year 2017, use E13.1x code as appropriate.

TALKING TO PATIENTS/MEMBERS ABOUT VACCINATIONS CAN INCREASE VACCINATION RATES AND CLOSE GAPS IN CARE

AgeWell New York encourages you to ensure your patients are up to date on recommended vaccines. Timely vaccinations can help protect their health.

Some AgeWell New York members may have concerns about the effectiveness and safety of vaccines. Health care providers play a vital role in educating our members about the importance of immunizations. Recent studies show that health care providers are the main source of credible information on vaccines.

The CDC recommends that providers:

- Educate patients about vaccines and the diseases they can help prevent.
- Communicate the benefits of vaccines.
- Discuss risks and side effects of vaccines.
- Provide vaccine recommendations.
- Reiterate the social norm to vaccinate. Providers can help reinforce these messages by using clear language, personal stories and information from credible resources.

Below are the recommended vaccinations for older adults:

Flu - The annual flu vaccine is recommended for all adults and may reduce flu-related hospitalizations by 71%. The CDC recommends that flu vaccinations be offered in September or October but should continue throughout flu season.

Pneumonia - Pneumococcal disease is caused by bacteria and can result in a range of ailments, from mild ear infection to meningitis, sepsis and fatal pneumonia. Adults over 65, especially those with chronic illness, are at increased risk for developing pneumonia that can potentially lead to death. Prevent pneumococcal disease by getting vaccinated.

COVID-19 - The virus remains risky for older adults and those with underlying conditions. The CDC recommends that people with moderately to severely compromised immune systems receive a booster dose.

Shingles Herpes Zoster - One in three people will get shingles, usually after age 50; the risk increases with age. By the age of 85, half of adults will have had at least one outbreak. The shingles vaccine reduces the chance of the varicella-zoster virus from reemerging as shingles.

Offer Vaccine Referrals and Follow-up for Continuity of Care - If you don't offer vaccines at your practice, consider making a referral and then follow up with each patient during subsequent appointments. If the patient remains unvaccinated, try to identify and address any concerns they may have.

Below lists codes covered for these services:

Vaccine	Code
Influenza Vaccine and Administration	**90653, 90662, 90672, 90674, 90682, 90685, 90686, 90687, 90688, 90694, 90756**
Pneumococcal Vaccine and Administration	**90670, 90732, G0009**
COVID-19	
Pfizer-Biontech COVID-19 Vaccine	**91300**
Moderna COVID-19 Vaccine	**91301**
AstraZeneca COVID-19 Vaccine	**91302**
Janssen COVID-19 Vaccine [3]* **	**91303**
Novavax COVID-19 Vaccine	**91304**
Covid-19 vaccine administration inside a patient's home	**M0201**
Shingles	**9075**

*This listing is not intended to direct coding or billing. All CMS coding rules apply.

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TALKING TO PATIENTS/MEMBERS ABOUT VACCINATIONS CAN INCREASE VACCINATION RATES AND CLOSE GAPS IN CARE (CONTINUED)

Vaccination-related HEDIS® Measures

AgeWell New York reports data to regulatory entities on an annual basis. Below are the measure definitions:

Flu Vaccinations for Adults Ages 65 and Older: The percentage of Medicare beneficiaries 65 years of age and older who report receiving an influenza vaccination between July 1 of the measurement year and the date when the Medicare CAHPS survey was completed.

Pneumococcal Vaccination Status for Older Adults (PNU): Assesses adults 65 years older who report ever having received one or more pneumococcal vaccinations.

Sources used:

https://www.cdc.gov/flu

http://www.flu.gov/prevention-vaccination/vaccination/

https://www.ncqa.org/hedis/measures/pneumococcal-vaccination-status-for-older-adults/

https://www.ncqa.org/hedis/measures/pneumococcal-vaccination-status-for-older-adults/

https://www.ncqa.org/hedis/measures/flu-vaccinations/

https://www.cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration

OFFICE WAIT TIME STANDARDS

AgeWell New York is committed to ensuring that our members have access to care when they need it. To help with this process, we ask that you and your office staff follow the following recommendations.

How to create a positive patient experience

Appointment Availability – Offer same-day appointment options and extended hours (if available). Offer to wait-list patients. If someone cancels, follow up with the wait-listed patients to schedule an earlier appointment.

Improve Wait Times – We understand that it is hard to get patients in within 15 minutes of their appointment time but sometimes a simple explanation from you could help alleviate member frustration.

- Provide a clear statement of how long the wait will be at the start of the visit
- Make sure your waiting room is well stocked with current magazines to help patients pass the time

Telephone coverage after hours – Providers must have an answering service or a telephone recording that directs a patient to call another telephone number or 911 in the event of an urgent or emergent circumstance.

During normal business hours – Immediate responses to any urgent or emergency health events, within 4 hours for non urgent calls, and within 1–2 business days for routine calls.

Covering provider – When you are on extended leave like a vacation or illness, you must arrange with another participating primary care provider or specialist to provide accessible 24-hour coverage. Coverage must extend beyond 911, except in the event of an emergency or urgent situation.

Scheduling appointments appropriately

- ***Emergent*** – The patient should be assessed immediately. If appropriate, schedule patient for the same day or refer to urgent care. Patient should be directed to call 911 in the event of serious emergency or visit the emergency room for treatment.
- ***Urgent*** – less than 24 hours
- ***Routine/symptomatic*** – within one week
- ***Wellness/asymptomatic*** – within one month

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www.agewellnewyork.com/for-providers