AMWA

Check In On Menopause

A telehealth model of care to address the needs of perimenopausal and postmenopausal patients.

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The Need:

- Research has shown that healthcare practitioners across specialties (gynecology, internal medicine, family medicine) may not be well-educated on or feel well equipped to diagnose and manage menopause symptoms and related health conditions.[1]
- There is often limited time during office visits to address menopause-related issues when addressing multiple chronic conditions in a midlife woman.
- Patients are sometimes not aware that their symptoms are related to their menopause transition.
- Midlife women often have questions about menopause but may not seek help from professionals.
- Conflicting information about menopause from varied sources may cause confusion in both women and their healthcare practitioners, especially when it relates to compounded bioidentical hormone therapy.
- Menopause symptoms often impact work productivity as well as relationships and quality of life.[2]

Benefits of Telehealth:

- Telehealth is now a widely accepted platform for patient care.
- Health issues of midlife women may initially be evaluated through telehealth.
- Telehealth could be a comfortable platform for discussion of menopause-related issues.
- Addressing midlife issues remotely may be time- and cost-effective.
- Digital engagement may be preferable in times of a viral pandemic.

Key Takeaways:

- Focused, efficient visit for important and commonly overlooked menopause concerns.
- Virtual visit allows for efficient time management and discreet setting for busy women.
- Dedicated menopause visits ensure that any concerns related to menopause are discussed.
- Opportunity to address menopause symptoms early in the transition when hormone therapy benefits largely outweigh the risks.
- Cost effective use of provider/patient time.
- Use of established E/M billing and CPT diagnosis codes.
- Expanded access to care for women in remote locations.
- Provider education on menopause management and telehealth care will ensure better patient outcomes and enhance quality of life.

We encourage healthcare practitioners to become members of AMWA and be highlighted as menopause practitioners and visit the The North American Menopause Society (NAMS) website for resources and/or to become a NAMS Certified Menopause Practitioner, with eligibility for listing on the NAMS website as such.

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The NAMS Menopause Practice: A Clinician's Guide and Menopause A to Z Slide Set are excellent resources for up to date, evidence-based information about menopause symptoms, evaluation of the midlife woman, recommendations and contraindications for treatment. These are available at www.menopause.org/publications.

Pre-visit data

- For new patients, the NAMS Menopause Health Questionnaire, or the provider's own screening form should be completed to rule out the need for an in-person visit for the complex patient. Your institution may have specific data that needs to be evaluated at each visit to ensure appropriate Medicare reimbursement.

- For established patients, an abbreviated version of the questionnaire may be used to focus on menopause-related questions.

- Appointment for virtual visit is then scheduled, giving enough time to evaluate any screening tests before the visit. Having the results of screening tests may help streamline the visit and allow for appropriate treatment decisions to be made at that time.

- Recommended screenings for women aged 50 years and older may be performed (preferably prior to the virtual visit) as the patient's age and insurance status dictate.
  - Blood pressure – recommended once yearly (U.S. Preventive Services Task Force - USPSTF) [3]
  - Breast cancer screening – mammogram recommended every 2 years (ages 50-74). (USPSTF) [3] There may be an indication for increased frequency and additional supplemental imaging based on individualized breast cancer risk and breast density. (American Cancer Society - ACS) [4]
  - Cervical cancer screening – recommended (for women ages 30-65 years) every 3 years with cervical cytology alone, or every 5 years with high risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing). For women over 65 years, screening is not recommended if they have had adequate prior screening and are not otherwise at high risk for cervical cancer. (USPSTF) [3]
  - Osteoporosis screening – a bone measurement test (Ex. central bone density scan - DXA) recommended for women over 65 years or postmenopausal women under 65 years "who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool." (USPSTF)[3]
  - Cholesterol screening – cholesterol panel recommended every 5 years in adults and more frequently in the presence of cardiovascular risk factors. (CDC)[5]

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Pre-visit data (continued)

- Diabetes screening – fasting glucose, HbA1c, or oral glucose tolerance test is recommended at least every 3 years in adults (ages 40-70 years) who are overweight or obese. Consider earlier screening in patients with a family history of diabetes, personal history of gestational diabetes or polycystic ovarian syndrome, or who are members of certain racial/ethnic groups (e.g., African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders) or in patients with these risk factors and a normal body mass index. (USPSTF)[3]
- Colorectal cancer screening – recommended beginning age 45 or earlier based on family history. Frequency is determined by type of screening. (1) High-sensitivity guiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) every year, (2) sDNA-FIT every 1 to 3 years, (3) CT colonography every 5 years, (4) Flexible sigmoidoscopy every 5 years, (5) Flexible sigmoidoscopy every 10 years + FIT every year, (6) Colonoscopy screening every 10 years. Selective screening should be offered between the ages of 76-85 years. (USPSTF).[3]
- Lung cancer screening – annual screening with low-dose computed tomography (LDCT) in patients (ages 50 to 80 years) who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. (USPSTF)[3]
- Sexually transmitted infection (STI) screening – behavioral counseling is recommended for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs). “Adults at increased risk for STIs include those who currently have an STI or were diagnosed with one within the past year, do not consistently use condoms, have multiple sex partners, or have sex partners within populations with a high prevalence of STIs.” It is important to remind women that menopause does not protect against STIs. Diagnostic testing recommendations vary depending on risk profiles. (USPSTF)[3]
- Vaccine recommendations (CDC)[6]
  - Influenza (yearly)
  - Td or Tdap (booster every 10 years)
  - Zoster (2 doses over age 50)
  - Pneumococcal (1 dose of PCV 15 or PCV20 for all adults over age 65. If PCV15 is used, a dose of PPSV23 is recommended one year later. If prior pneumococcal vaccination has been given or if the patient has certain chronic medical conditions or additional risk factors, there are additional specific guidelines at cdc.gov.
  - COVID-19 (in accordance with the FDA approvals and Emergency Use Authorization protocols)[7]

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The Virtual Menopause Visit

- Greet patient in usual manner, introductions, confidentiality, check in on comfort level.
- Review the NAMS Menopause Health Questionnaire.
  - Section 1: Personal Information – Update electronic medical record (EMR) with personal details
  - Section 2: Today's Office Visit – Main concerns
  - Section 3: Height and Weight Information – Document BMI, self-reported blood pressure monitoring
  - Section 4 and 5: Medical History and Major Illness and Injury
    Is there any medical or family history that would be considered a relative or absolute contraindication to the use of hormone therapy?

Contraindications for Hormone Therapy (NAMS 2017 hormone therapy position statement)[8]

Undiagnosed abnormal genital bleeding
Prior estrogen-sensitive breast or endometrial cancer
Personal history or inherited high risk of thromboembolic disease
Coronary heart disease
Stroke
Dementia
Severe liver disease
Hypertriglyceridemia
Porphyria cutanea tarda
Concern that endometriosis, migraine headaches, or leiomyomas may worsen

  - Section 6, 7, and 8: Gynecologic, Obstetrical, and Sexual History
  - Section 9 and 10: Allergy and Medications
  - Section 11 Family History
  - Section 12: Personal Habits (exercise, diet, tobacco, alcohol & drug, caffeine, abuse, stress management)
  - Section 13: Symptoms
  - Section 14: Perspectives on Menopause

- Review midlife health screenings and other test results.

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The Virtual Menopause Visit (continued)

- Menopause discussion
  - Address any issues arising from the NAMS Menopause Questionnaire or other discussion during the visit.
  - Determine whether further testing is warranted.
  - Determine whether an in-person examination is warranted to address more complex issues or to confirm any self-reported data (e.g. blood pressure, BMI). A physical examination should be performed prior to beginning hormonal therapy.
  - Address questions/concerns about either current or potential future menopausal symptoms.
  - Does this patient have early menopause (between ages 40-45 years)? Work-up for these women may include a pregnancy test, prolactin and thyroid stimulating hormone (TSH) levels. These women are also at increased risk for the long-term effects of early estrogen deficiency compared with women who experience menopause at the average age and should be on hormone therapy (HT) at least until the average age of menopause.
  - Does this patient have premature menopause (<age 40)? Complete an appropriate work up to evaluate for secondary causes. These women are also at increased risk for the long-term effects of early estrogen deficiency compared with women who experience menopause at the average age and should be on HT at least until the average age of menopause. A good resource is the International Menopause Society White Paper on Premature Ovarian Insufficiency (POI).
  - Does this patient have menopause symptoms?
    - If No, provide general health information that may be relevant.
    - If Yes, discuss possible therapeutic approaches Consider using the NAMS Utian Quality of Life (UQOL) Scale to determine the degree to which menopause symptoms are affecting quality of life. *(Recommend a physical exam if genitourinary symptoms of menopause are present or if menopause symptoms persist)*
      - Monitor symptoms – ask the patient to keep a symptom checklist for 1-3 months and schedule a follow-up or physical exam as needed.
      - Therapeutic interventions
        - Behavioral – consider cognitive behavioral therapy and keep a symptom checklist for 1-3 months and return for re-evaluation or physical exam.
        - Trial of pharmacologic therapy. *(Recommend a physical exam prior to starting hormonal therapy)*
          - Hormone
          - Non-hormone

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The Virtual Menopause Visit (continued)

- Share information about midlife and age-related body changes and common symptoms and diseases of midlife women. References for these evaluations and treatments can be found in the NAMS Menopause A to Z Slide Set (for healthcare practitioners). Consider distributing the NAMS MenoNotes and *The Menopause Guidebook* to patients.
- Address preventive health needs – screening tests or vaccinations needed.

- Discuss general health behaviors, including diet, exercise, and sleep, to improve physical health and brain health.

- Documentation and E&M Coding
  - Epic smart phrases:
  - [.MENO] The Menopause Health Questionnaire was reviewed and symptoms were discussed. Various treatment options were presented, and the pros and cons of each treatment were reviewed.
  - [.HT] We discussed the benefits and risks of hormone therapy as it pertains to this patient's specific case. Current evidence as summarized by guidance from The North American Menopause Society and the American College of Gynecology support that the benefits outweigh the risks for hormone therapy in this case.
  - [.MENOINFO] Information about menopause resources from The North American Menopause Society (NAMS) were shared to provide general knowledge about the menopause transition, common menopause signs and symptoms, and menopause treatment options: (1) The *Menopause Guidebook* and (2) MenoNotes. (www.menopause.org/publications/consumer-publications)
  - ICD-10 Codes
    - N95.1 Menopause
    - N95. 9: Unspecified menopausal and perimenopausal disorder
    - Z79.890 Counseling hormone therapy
    - R23.2 Vasomotor symptoms

    While these are generally reimbursable ICD-10 codes, please check with individual carriers.

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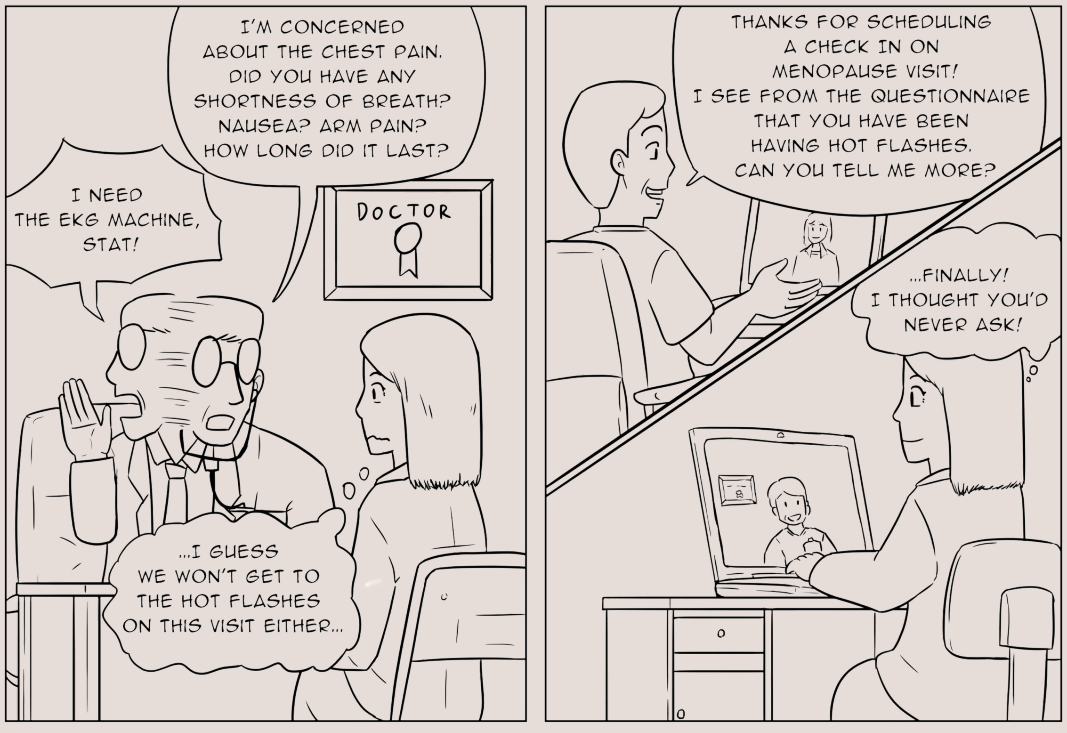
Post-visit Follow-up

- Depending on the clinical situation, the follow-up appointment may be an in-person visit for a physical examination and additional diagnostics or a telehealth visit. Follow-up appointments are recommended to evaluate the effectiveness of treatment (if relevant), any persisting symptoms, or any side effects or adverse events.

- At this post-visit, one might address additional treatments, alternative therapies, additional testing.

- Determine the need for future Check In On Menopause Visits and frequency.

- Share resources with patients by directing them to on-line resources or mailing them materials:
  - *The Menopause Guidebook* - Woman-centered midlife history and symptom form in lay language available at www.menopause.org/publications/consumer-publications.
  - MenoNotes available at www.menopause.org/publications/consumer-publications.



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The following resources are from the North American Menopause Society (NAMS):

Menopause Practice: A Clinician's Guide
Menopause A to Z Slide Set
Menopause Health Questionnaire
Utian Quality of Life (UQOL) Scale
MenoNotes

The American Medical Women's Association thanks the following individuals for their help and input: Dr. Eliza Chin, Dr. Margery Gass, Jodi Godfrey, Dr. Risa Kagan, Dr. Juliana Kling, Dr. Janice Werbinski.