

OCTOBER 2020

PROVIDER QUALITY NEWSLETTER

MedPOINT
MANAGEMENT
Pointing Healthcare In The Right Direction

To access the materials referenced in this newsletter, go to:

- > medpointmanagement.com/provider-resources
- > Click on "Quality Management Information" and then "2020 Quality Newsletters."
- > All materials are listed in one PDF document.
- > Please also note that MedPOINT's Reference Guides are available under "HEDIS Documents."

I Interpreta Tip – Claims

Did you know you can view claim and encounter history for your members in Interpreta? You can also find a member's lab, immunization and pharmacy history where available. This is a great way to trouble shoot why a member is showing non-compliant for a service you know was provided. Check your member's claim history in Interpreta to see what MedPOINT has on file for them. From the Member Screen in Interpreta, click the box (tile) on the upper right side that says "Claims" to find the member's claims. You can also download the information by clicking "Export Data." For questions or to schedule a training, please contact us at qualitymeasures@medpointmanagement.com, (818) 702-0100, ext. 1353, or contact your HEDIS/Stars Specialist.



NEW MedPOINT QM Bulletin Board – Coming Soon!

MedPOINT (MPM) is rolling out a NEW Quality Management (QM) Bulletin Board. This will be an opportunity for MPM and others to post pertinent information and will provide a QM question and answer platform for all participants. Login credentials are required and the content will be reviewed by a moderator. Stay tuned!



Flu Season is Here

Thank you for all you do to promote flu shots. When members come in for their shot, take the opportunity to close out other care gaps and encourage them to come in for an appointment if they need other preventive services. Have FOBT colorectal test kits available at your immunization stations for the patients who are due for the Colorectal (COL) HEDIS measure.



Provider Satisfaction Feedback Please!

Every year, we poll our providers for their feedback on the services that MedPOINT provides. Your responses – both positive and negative – help us improve our processes and the quality of service we provide. Please watch your emails for a quick and easy Survey Monkey that will be sent to you in the next few weeks.

Please make your voice heard, share your thoughts with us and return the survey to us as soon as possible. Please contact us at qualitymeasures@medpointmanagement.com, (818) 702-0100, ext. 1353, or contact your HEDIS/Stars Specialist if you don't receive the survey.

Member Experience

Member satisfaction plays an important part in a member's willingness to take an active role in their care. The Member Experience measures are double weighted by CMS (Centers for Medicare and Medicaid Services) and NCCA (National Committee for Quality Assurance). It is expected that these measures will be quadruple weighted and will represent 41% of your overall quality rating. Are you considering member experience in all aspects of your organization? Now is the time and we can help with trainings and best practices. Ask us how.

Submit Supplemental Data Now!

Our September Newsletter included details on the ways to submit supplemental data and the measures to focus on. Please contact us to receive our updated **Interpreta Supplemental Data Portal Reference Guide** and let us know if you would like to set up a meeting to discuss the best way for you to submit supplemental data. Please note that 1/15/2021, is the deadline to submit medical records to MedPOINT for processing and submission to the health plans. The deadline for Standard Data from your EMR is due to MedPOINT by 2/28/2021.

Seniors – Annual Wellness Exams

Please make it a priority to bring your seniors in for their Annual Wellness Exams now. If Annual Wellness Exams are completed via a telehealth visit without video, CPT codes 99441-99443 (or G2025 for FQHCs) will not count for Medicare Risk Adjustment. Every effort should be made to link the chronic condition diagnoses to a video telehealth or in-person visit. Please reassure patients that it is safe to come in so that all their medical conditions can be documented and captured.

WCV & W30 Guide - Correction

Please note that the age-specific code for the W30 measure for a child younger than 1 year is 99381 (not 99382). We have corrected this in the new attached Guide. Please remember that babies who come in for immunizations (Childhood Immunization Status - CIS-10) should also receive 6 Well Child visits (W15) within the first 15 months of life.

Resources

Medi-Call HEDIS Reference Grid – Blue Shield Promise

Blue Shield Promise has released a detailed 17-page Medi-Cal HEDIS Reference Guide that includes a breakdown of the measures by MCAS, MPL, NCCA, data collection, telehealth, virtual and VIIP (incentive program). This comprehensive guide also includes descriptions, notes, exclusion parameters, documentation requirements and codes. Please access and download this important resource here: https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/quality-improvement.

Health Net's New Pulse Newsletter

Health Net has launched a new quarterly newsletter for providers that is packed with updates on operational improvements specific to UM, claims and provider relations. The first issue is available on Health Net's Provider Library site here: <https://providerlibrary.healthnetcalifornia.com/> > choose Medi-Cal in left sidebar > click Provider Pulse Newsletter.

National Breast Cancer Awareness Month

October was National Breast Cancer Awareness Month. Please continue your efforts in November and December to schedule mammograms for your patients and educate them on this important screening. Please see the great [resources attached from Optum](#) on breast cancer education and coding, plus information on telehealth before and during the visit.

Telehealth – Resources for Patients with Limited English Proficiency

Please check out the attached resources and strategies to help your Limited English Proficient patients.

Other Resources Attached

- **Molina** – JTF (Just the Fax) - Medi-Cal Managed Care Pharmacy Benefit Carveout to Medi-Cal Rx
- **Health Net** – 2019 Appointment Availability and After-Hours Access Survey Results

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Contact us at (818) 702-0100, ex 1353, or qualitymeasures@medpointmanagement.com for assistance.

Well Child Visits in First 30 Months (W30) Child and Adolescent Well-Care Visits (WCV)

Eligible:

- Commercial and Medi-Cal members.
- The W30 and WCV measures are based on the American Academy of Pediatrics “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents” (published by the National Center for Education in Maternal and Child Health).
- Visit the Bright Futures website for more information about well-child visits at <https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/>.
- The well-care visit must occur with a PCP or an OB/GYN practitioner, but the rendering service practitioner does not have to be the practitioner assigned to the member.

Coding is Critical:

- Proper and timely coding W30 and WCV encounters is essential since NCQA has designated these measures as administrative rather than hybrid, meaning a chart sample will not be obtained to improve rates and use of supplemental data (EHR extracts or medical records) may be limited at health plan discretion.
- Keep this coding tip sheet handy and revisit your coding workflows for these measures to make sure they are coded properly.
- Make sure to use the age specific CPT codes below when billing for well child visits, in addition to the routine health exam ICD-10 code.
- Get started now by properly documenting and coding well child visits for 7-11 year olds.

Measure	Requirements	Coding
W30 Well Child Visits in the First 30 Months Age 0-30 months (2.5 years)	<p>The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:</p> <ol style="list-style-type: none"> 1. <i>Well-Child Visits in the First 15 Months.</i> Six or more well-child visits before the child turns 15 months old during the measurement year. 2. <i>Well-Child Visits for Age 15 Months–30 Months.</i> Two or more well-child visits between 15 months and before the child turns 30 months old during the measurement year. 	<p>ICD-10 Z00.121 / Z00.129 - Encounter for routine child health examination with / without abnormal findings (age 0-17).</p> <p>CPT Preventive codes: 99381 - age younger than 1 year 99382 - age 1-4, new patient 99392 - age 1-4, established patient</p> <p>NOTE: Visits must be at least 14 days apart.</p>
WCV Child and Adolescent Well-Care Visits Age 3-21 years	<p>The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</p> <ul style="list-style-type: none"> ○ Ages 7-11 years have been added. ○ Measure is reported in three age stratifications: 3-11 years, 12-17 years, 18-21 years. <p><i>NOTES: Be sure to also code for the Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measure during this visit for ages 3-17.</i></p> <p><i>Well care can be done at sick visits by adding the age CPT code and the ICD-10 routine code to the list of diagnosis.</i></p>	<p>ICD-10 – Z00.121 / Z00.129 - Encounter for routine child health examination with / without abnormal findings (age 0-17). Z00.00 or Z00.01 (age 18+). Z02.5 - Sports Physical</p> <p>CPT Preventive codes: 99382 - age 1-4, new patient 99392 - age 1-4, established patient 99383 - age 5-11, new patient 99393 - age 5-11, established patient 99384 - age 12-17, new patient 99394 - age 12-17, established patient 99385 - age 18+, new patient 99395 - age 18+, established patient</p>



Summary Update: Medi-Cal 2019 Provider Appointment Availability and After-Hours Access Survey Results

See how results compared to the previous year

The Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) have requirements to ensure health care services are provided to patients in a timely manner appropriate for the nature of the patients' conditions and consistent with good professional practice. The Medi-Cal Provider Appointment Availability and After-Hours Access surveys measure how well providers comply with DMHC and DHCS availability and access requirements.

Areas for improvement

Based on 2019 survey results, the DMHC and DHCS metrics below did not meet the 80% performance goal:

- Urgent care appointment with PCP within 48 hours.
- Urgent care appointment with a specialist within 96 hours.
- Non-urgent care appointment with a specialist within 15 business days.

Go online for complete results

The complete provider update, 20-791, *Medi-Cal 2019 Provider Appointment Availability and After-Hours Access Survey Results* covers the content below in detail:

- Complete 2019 Provider Appointment Availability Survey (PAAS) and Provider After-Hours Access Survey (PAHAS) results (overall and by county).
- Corrective action plan (CAP) requirements for when timely access to care standards are not met.
- Resources to help comply with appointment availability and after-hours access standards.
- Tips to help maintain appointment access standards and after-hours messaging.

The complete update is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Updates and Letters*, then search for provider update 20-791. Providers who do not have access to the Internet may request a print copy of update 20-791 by contacting the Provider Communications Department by email at provider.communications@healthnet.com.

If you have questions about the information in this update, contact the Access and Availability Unit by email at Access_IP@healthnet.com or Health Net* Medi-Cal Provider Services at 1-800-675-6110.

THIS UPDATE APPLIES TO CALIFORNIA PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- HMO/POS/HSP
- PPO
- EPO
- Medicare Advantage (HMO)
- Medi-Cal
 - Kern
 - Los Angeles
 - Molina
 - Riverside
 - Sacramento
 - San Bernardino
 - San Diego
 - San Joaquin
 - Stanislaus
 - Tulare

PROVIDER SERVICES

1-800-675-6110

provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:**COUNTIES:**

- Imperial
- Riverside/San Bernardino
- Los Angeles
- Orange
- Sacramento
- San Diego

LINES OF BUSINESS:

- Molina Medi-Cal Managed Care
- Molina Medicare Options Plus
- Molina Dual Options Cal MediConnect Plan (Medicare-Medicaid Plan)
- Molina Marketplace (Covered CA)

PROVIDER TYPES:

- Medical Group/ IPA/MSO**
 - Primary Care**
 - IPA/MSO
 - Directs
- Specialists**
- Directs
- IPA
- Hospitals**
 - Ancillary**
 - CBAS
 - SNF/LTC
 - DME
 - Home Health
 - Other

FOR QUESTIONS CALL**PROVIDER SERVICES:**

(888) 562-5442, Extension:

Los Angeles/Orange Counties

X123017

Riverside/San Bernardino Counties

X120613

Sacramento County

X125682

San Diego County

X121735

Imperial County

X125682

Medi-Cal Managed Care Pharmacy Benefit Carveout to Medi-Cal Rx

This is an advisory notification to Molina Healthcare of California (MHC) network providers regarding Medi-Cal Managed Care Pharmacy Benefit Carveout to Medi-Cal Rx.

In this last quarter of 2020, the state and managed care plans will be notifying Medi-Cal members of the Pharmacy benefit drug carveout and the launch of the state's new "Medi-Cal Rx" program on January 1, 2021.

Medi-Cal Rx carveout will include pharmacy services that are billed as a pharmacy claim. Medi-Cal Rx will have a state-wide contracted drug list (CDL) like the current Medi-Cal FFS CDL. For any non-formulary needs Medi-Cal Rx has a new Prior Authorization (PA) review process for outpatient drugs.

A new secure portal will be available for providers to submit PAs to Medi-Cal Rx available at: <https://medi-calrx.dhcs.ca.gov/provider/>.

For information on Medi-Cal Rx Provider portal training, please visit: <https://medi-calrx.dhcs.ca.gov/home/education/>.

We have included the 30-day member notification that the MHC will be mailing out around December 1st. As part of the notification campaign you may wish to post the last 3 pages of this notification in your waiting room.

For any member questions about Medi-Cal Rx please refer them to the attached notification or to the Medi-Cal Member help line at 1-800-541-555 or TTY 1-800-430-7077, Monday - Friday 8:00 AM to 5:00 PM.

For more provider information about Medi-Cal Rx or to sign up for the new secure provider portal, please visit: <https://medi-calrx.dhcs.ca.gov/home/>.

QUESTIONS

If you have any questions regarding the notification, please contact your Molina Provider Services Representative at (888) 562-5442. Please refer to the extensions to the left.

30 Day Notice to MCP Beneficiaries Medi-Cal Rx Transition

December 1, 2020

Dear Medi-Cal Beneficiary (or Legal Designee):

On January 1, 2021, the Department of Health Care Services (DHCS) will change your pharmacy benefit. Your prescription medications will be covered by “Medi-Cal Rx”. This does not change your Medi-Cal eligibility or benefits.

If you are eligible for both Medicare and Medi-Cal, Medi-Cal Rx may cover prescriptions Medicare does not, so you should talk to your doctor or pharmacy if you have any questions.

What is changing?

Starting on January 1, 2021 you will get your Medi-Cal covered prescriptions through Medi-Cal Rx instead of Molina Healthcare of California.

DHCS is working with a new contractor, Magellan Medicaid Administration, Inc. (Magellan) to provide Medi-Cal Rx services.

There will be no change in how you pay for your medications. For most Medi-Cal beneficiaries, there is no cost.

What do I need to do?

Molina Healthcare of California, your doctors and pharmacies know about the changes and know what to do. Because of this, most people in Medi-Cal will not need to do anything.

Most people will be able to use the same pharmacy they do now on January 1, 2021. If your pharmacy does not work with Medi-Cal Rx, you may need to choose another pharmacy.

Will I need to change my medication?

Most people will not have to change their medications. The list of drugs that require prior approval may be different than the list Molina Healthcare of California uses. Your doctor may need to get approval to refill prescriptions. He or she may talk to you about changing to a medication that does not require prior approval.

Will my pharmacy change?

Most pharmacies will accept your new coverage. You can call the Medi-Cal Member Help Line (1-800-541-5555, TTY 1-800-430-7077) to ask if your pharmacy will accept Medi-Cal Rx.

If you need help finding a pharmacy on or after January 1, 2021, use the Medi-Cal Rx Pharmacy Locator online at www.Medi-CalRx.dhcs.ca.gov or call Customer Service at 1-800-977-2273 twenty-four hours a day, seven days a week or 711 for TTY Monday thru Friday, 8am to 5pm.

Note: The website pharmacy locator will be available in December 2020 and the phone number starting January 1, 2021.

What happens now?

Always bring your Molina Healthcare of California ID card and your Medi-Cal Benefits Identification Card (BIC) with you. Starting January 1, 2021, bring your Medi-Cal BIC card when you go to the pharmacy. The pharmacy will use the card to look up your information and give you your medications.

What if I have questions?

On or Before December 31, 2020

- If you have questions about your medication or other pharmacy services, please call 1-888-665-4621 or 711 for TTY, Monday thru Friday, 7am to 7pm.
- If you have questions about this notice or have Medi-Cal Rx general questions, contact the Medi-Cal Member Help Line (1-800-541-5555, TTY 1-800-430-7077), Monday thru Friday, 8am to 5pm.

On or After January 1, 2021

- You can call the Medi-Cal Rx Call Center Line (1-800-977-2273) twenty-four hours a day, seven days a week, or 711 for TTY, Monday thru Friday, 8am to 5pm.

You can also email DHCS at RxCarveOut@dhcs.ca.gov. Make sure to write that you have a question about Medi-Cal Rx. Please do NOT include personal information in your first email. DHCS staff will reply with a secure email asking for your information, if they need that information to assist you.

What happens if I have a complaint?

Magellan will accept and resolve your complaint. You can submit a complaint either in writing or by telephone.

- Visit www.Medi-CalRx.dhcs.ca.gov or
- Call Customer Service at 1-800-977-2273

Note: You can only use this website and phone number to file a complaint on or after January 1, 2021.

Your health plan will no longer handle pharmacy complaints for pharmacy services received on or after January 1, 2021.

How can I appeal a Medi-Cal Rx benefit decision?

The California Department of Social Services has a State Hearing process if you want to appeal a pharmacy benefit decision. This process is different from the appeals process you may have used with your health plan. In a State Hearing, a judge reviews your request with clinical input from DHCS pharmacists to make sure the decision aligns with Medi-Cal pharmacy policy.

If a prescription is denied or changed, a form to request a State Hearing will automatically be sent to you with the notice of denial or change. If you do not agree with a denial or change related to your pharmacy services and benefits under Medi-Cal Rx, you can ask for a State Hearing. You can ask for a State Hearing by sending the State Hearing request form to:

California Department of Social
Services State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

You may also call to ask for a State Hearing by calling toll-free at 1-800-952-5253 (TTY: 1-800-952-8349). Please note that the number can be very busy so you may get a message to call back later.

You can get more information about the State Hearing Process by going to www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx.

On or after January 1, 2021, you can also get the State Hearing request form by going to www.Medi-CalRx.dhcs.ca.gov or by calling Customer Service at 1-800-977-2273 twenty four hours a day, seven days a week, or 711 for TTY Monday thru Friday, 8am to 5pm.

TELEHEALTH Resources for Patients with Limited English Proficiency in Health Centers

JUNE 2020



THE CHALLENGE

Telehealth has the power to provide care to people in ways that were not possible before rapid communication via internet and video services. For many, telehealth has removed barriers and ensured that people receive care when and where it is most convenient. Telehealth has been especially powerful during the COVID-19 pandemic, when non-emergency services such as primary care, behavioral health, and other in-person visits have been postponed to reduce the spread of the virus. However, while telehealth can remove obstacles, if not used deliberately and thoughtfully, it can exacerbate many inequalities that exist in the United States health system. One factor that is essential to account for is **language accessibility**, which, if not provided, limits the number of patients who are able to utilize telehealth services.

People with limited English proficiency are historically less likely to visit the doctor and less likely to get preventative care services, even when controlling for literacy, health status, health insurance, regular source of care, ethnicity, and economic indicators. With the rapid move to telehealth, there is concern that these patients may be left further behind because of limited ability to address language needs via telehealth.

Telehealth efforts may fail to reach patients who are not best served in English. In 2018, there were 6,706,410 Federally Qualified Health Center (FQHC) patients best served in a language other than English, which represents 23.63% of the total FQHC patient population². In section 1557 of the Affordable Care Act³, HHS **mandates that healthcare professionals make reasonable language accommodations for people with Limited English Proficiency (LEP)⁴, which also applies to telehealth services**. However, even with this policy, LEP individuals are not always able to receive adequate care.

Many LEP people have a difficult time initially seeking care if resources do not exist in their primary language. In fact, there have already been articles highlighting that LEP patients are at a disproportionately high risk of contracting COVID-19, due to their higher representation in essential service jobs with various occupational hazards, as well as the lack of multilingual resources that describe the risks of the virus⁵.

THE CHALLENGE, CONTINUED

Masland et al. conducted a literature review on language barriers in healthcare, finding that LEP people are less likely to go to the doctor and undergo preventive care, even when controlling for “literacy, health status, health insurance, regular source of care, ethnicity, and economic indicators⁶.” Flores et al. found that **parents who speak limited English were three times more likely to report that their children have poor or fair health status**. These patients were also less likely to seek out medical care for their children⁶. If and when they do receive care, they may have lower comprehension of what their provider explains, which can lead to poor health outcomes such as adverse reactions to medication⁷. A different study by Sue et al. examined the effect of having a shared language and ethnicity among mental health providers and patients seeking care. They found that **among LEP clients, having a provider who spoke their same language positively impacted the length and outcome of their treatment⁸**.

These studies highlight the gaps in access to care due to language barriers, as well as opportunities to improve length and outcome of care by ensuring that patients and providers effectively communicate with each other. While ideally all patients would be served by providers who speak their primary language, there are various reasons why this is not always possible, such as the commonality of the language, the quantity and availability of multilingual providers, and various administrative intricacies of the healthcare system such as insurances accepted. Some practices seek to mitigate this hurdle by listing the languages that each provider speaks on their websites so that patients can filter for their language of choice. Yet many patients are still served by a provider who speaks a language different from their own. For this dilemma, there must exist translation services or other solutions to mitigate the risk of exacerbating limitations to access to care for people who are not best served in English. **Telehealth has the opportunity to make sure health care meets the needs of LEP patients by utilizing technological approaches to improve communication.**

Effectively providing linguistically appropriate care to patients with limited English proficiency improves care and reduces costs. As telehealth services expand, incorporating interpretation is extremely important. As the CEO of Language Line notes, “When healthcare organizations use qualified medical interpreters, fewer errors are made, fewer unnecessary tests are ordered, and quality care improves. Likewise, when patients receive their discharge instructions and patient educational materials in the language they speak, they are less likely to return to the emergency room.”¹

RESOURCES AND STRATEGIES TO ADDRESS THE CHALLENGE

Near-Term Strategies to Support LEP Patients with Telehealth

Various solutions can help health centers utilize telehealth during the COVID-19 pandemic and beyond. In the long term, it will be advantageous to advocate for greater language variability among the provider population. LEP patients will greatly benefit once the number of multilingual providers matches the demographic makeup of language variability in the United States. However, even if and when this goal is achieved, there will still be instances when interpretation services or other forms of multilingual care are needed. The following resources and solutions are provided for health centers to increase their telehealth capacity for LEP patients.

NEAR-TERM STRATEGIES

Interpretation Services Interpretation services have been shown to be effective in improving quality of care regardless of the method in which the visit is conducted. However, it is especially important to be mindful of language accessibility during telehealth, where there are more opportunities for information to get “lost in translation.” For example, it might be less evident to a provider that their patient is not comprehending their recommendations when they are delivered virtually. Further, patients and providers both might not be able to pick up on each others’ non-verbal cues, such as body language and hand gestures over the phone or video. Providers also may not be able to utilize visual aids such as charts or illustrations that exist in typical healthcare settings. Therefore, it is imperative that LEP patients have the resources to utilize translation services when participating in telehealth visits with providers who do not speak their language.

Translation through telehealth technology is one of the most promising interventions for ensuring that LEP individuals receive care in their language. The following resources offer potential solutions for FQHCs:

1. USE THIRD-PARTY SERVICES TO PROVIDE REAL TIME INTERPERTATION IN TELEHEALTH VISITS.

Third party interpreters may provide audio-only remote interpretation, either during a video visit or audio-only visit, or video remote interpretation. There are many options, below are a few that some health centers use:



[Language Line](#)



[Certified Languages International](#)



[Boostlingo](#)



[Propio](#)

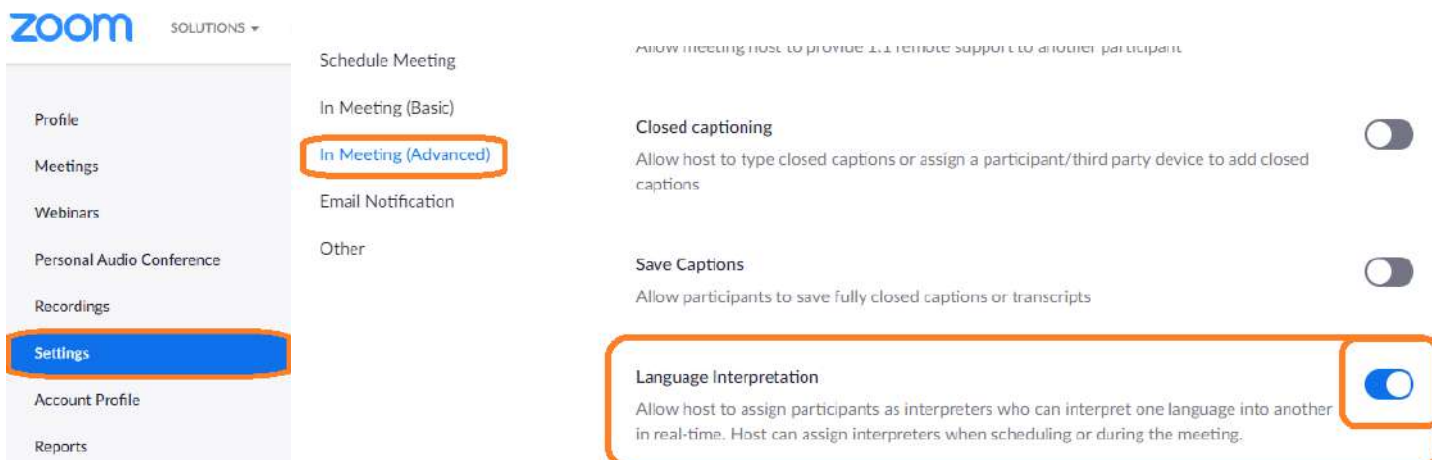
Considerations for third-party translation services:

- These solutions can be used with audio-only visits which may be better for low-broadband regions. Note: The use of video conferencing for telehealth should be a long term goal because it is demonstrably better for providing care⁹. Audio-only visits are reimbursable by many payers during the COVID-19 public health emergency, and provide a beneficial interim step for care management, but are unlikely to be a long-term solution for telehealth.
- To comply with HIPAA, third-party medical interpretation services are considered business associates and are required to protect patient data. Personal and health details about a patient are considered Protected Health Information (PHI). Medical interpreters must take special care with PHI. Specifically, provision of interpretation services is usually a health care operations function of the covered entity as defined by 45 CFR 164.501. When the covered entity (in this case, the health center) engages the services of a person or entity who is not a workforce member, to perform interpretation services on its behalf as a business associate (in this case, the third party interpretation service), a covered entity may disclose protected health information as necessary for the business associate to provide interpreter services on the covered entity's behalf¹⁰. Read more about [HIPAA and interpretation services here](#).
- Third-party interpreters can generally be located anywhere, thereby increasing a health center's access to interpreters when needed.



2. USE TECHNOLOGY FUNCTIONALITY THAT SUPPORTS EXPEDIENT AND EFFECTIVE

INTERPRETATION. Often using interpretation services for telehealth involves circuitous solutions. As one organization described it: “Once a patient gets set up on a Zoom call, [the provider] has to turn to the next logistical challenge: integrating a medical interpreter onto that call who is trained to serve as the linguistic go-between for the visit. To make it happen, she has to call the interpreter on her personal phone and conference them into the Zoom line. Then, she has to rename that caller so that the patient doesn't see her phone number.¹¹” [Zoom Language Interpretation](#) offers a strategy to address some of this. Zoom does not provide third-party interpreters but the Zoom platform allows the host, such as the provider, to designate a participant as a translator, such as an health center interpreter on staff or third party interpreter. Then, if desired, Zoom projects audio in the participant's dominant language from the interpreter instead of the speaker's language (e.g., so the patient would hear the interpreter speaking in Spanish instead while the provider is speaking in English). This serves the purpose of reducing the length of a bilingual visit, because the interpreter does not have to wait for the provider or patient to finish speaking, and potentially improving rapport with a more natural-style conversation.



- Instructions for enabling this Zoom functionality:* According to Zoom, this feature cannot be used with Personal Meeting ID, it must be used with a unique meeting ID. To enable the feature, sign into your Zoom web portal (for example, examplehealthcenter.zoom.us), then click **Settings** in the navigation panel on the left side of the screen. Then click **In Meeting (Advanced)**, then look for **Language Interpretation**, and click the slider to move it to the right and make it blue, showing the feature is enabled. See screenshot above as well as [full instructions](#) from Zoom.
- Instructions for using interpretation feature in visit:* When the session starts, the Zoom host (e.g., the provider) can start the interpretation feature by clicking **Interpretation** with a globe-style icon, and then add or remove interpreters, including naming the interpreter and starting the interpretation session from that menu. Once the host starts the interpretation, then the interpreters access to their own audio channels. **Attendees (e.g., patients) can select an audio channel to hear their language of choice.** Attendees will hear the translated audio and can choose if they want to hear the original audio at a lower volume. Again, see [full instructions](#) from Zoom.
- Adding Interpreters in Other Telehealth Platforms:* **Doxy.me:** Using a Professional or Clinic account, it is possible to have an interpreter or translator join a call using the [group call feature](#). First, the patient checks into provider's room, then the interpreter checks into provider's room, then the provider starts group call with both patient and interpreter. **Doximity:** Doximity's Dialer Video allows one click video calls, where a [third-party, such as an interpreter, can be added via email or text message.](#)

Identify or Create Resources that Assist LEP Patients with Use of Telehealth

3. IDENTIFY OR CREATE RESOURCES THAT ASSIST LEP PATIENTS WITH USE OF TELEHEALTH. These are an initial set of tools to set up LEP individuals for success regarding the logistics of participating in telehealth.

- Resources in languages other than English to raise awareness about the efficacy and ease of telehealth. Here are some examples for common health center EHRs:
 - Doximity, a telehealth platform, offers [patient-facing instructions in several languages](#).
 - eClinicalWorks offers [videos](#) for patients on how to use Healow Telehealth in Spanish.
 - LA LGBT Center, a health center in Los Angeles, has [written and video instructions](#) in Spanish as well as English on how to download Allscripts FollowMyHealth patient portal to access video visits.
 - El Rio Health, a health center in Tucson, offers a [Patient Quick Start Guide](#) in Spanish and [flyer](#) for using Otto, a NextGen telehealth platform.
- See [instructional videos on how to download Zoom](#) in more than ten languages.
- Multilingual EHR patient portals: This is a [previous HITEQ database](#) of patient portals and online patient education libraries that are available in multiple languages.

4. REMEMBER TELEHEALTH IS MORE THAN JUST VIDEO/AUDIO CALLS When thinking about telehealth, it is important to consider that care can be provided in forms other than video. For example, providers can utilize SMS text check-ins, asynchronous questionnaires, electronic intake forms, etc. that are available in multiple languages. This could increase screening rates, capture needed information in a way that works for LEP patients and the clinic, and help set context for future telehealth visits. Many of the third party interpretation services mentioned earlier offer translation services as well.

- SMS/text message check-ins with patients can be used to remind them of upcoming appointments as well as follow up on their health status or care plans. Texting can also be used to disseminate telehealth information or instructions, as outlined above. Review this [HITEQ resource on HIPAA-compliant texting](#) for helpful information.
- Ensure that intake forms, pre-visit questionnaires, and information for any asynchronous visits are available in appropriate languages and that the system is set up to use them appropriately.
 - Health centers may set up telehealth visits in the EHR's admin and scheduling functionality in languages other than English, such that the appropriate pre-visit questionnaires (e.g., intake forms, PHQ-9 depression screening, etc.) are populated and electronically sent to the patient in the patient's primary language. For example, within the system, set up *Televisit-Spanish* as a visit type, then modify the settings for that visit type to use welcome messages, consent forms, and pre-visit questionnaires in Spanish.

Remember that Telehealth is more than just Audio/ Video Calls, Continued

- Regarding how the information can be brought into the health center's health IT system for the provider to see and act on: Companies like [Accredited Language Services](#) translate intake forms for providers, but may not translate patients' unstructured or narrative responses.
- Many third-party services, such as [Language Line](#) and [Certified Languages International](#), provide translation services in addition to live interpretation. These services can be used to translate patients' responses to intake forms, asynchronous telehealth visits, or secure messages from patients at a cost.

Other Useful Information for Clinics serving LEP Patients via Telehealth

During COVID-19, UC San Francisco is compiling [resources for providers who are caring for LEP patients using interpretation services](#) in a Google Drive folder, and offers workflows for various approaches to including an interpreter in a visit. It also includes additional resources on telehealth and COVID-19 in general. It also links to [this Google Drive folder with COVID-19 resources in 50+ less common languages](#). There is also a helpful webpage that has [COVID-19 Fact Sheets in 35 languages](#).

There are also a number of FQHC websites housing prominent fact sheets in multiple languages. For example, this page from [Community Health Center Network in East Bay](#).

LONGER TERM STRATEGIES

There are a number of longer term options that require more planning and/ or resources, but may be worth pursuing to address the needs of LEP patients in utilizing telehealth if that is a significant or persistent need for your health center.

1. SHARE INTERPRETATION CAPACITY AND NEED WITH

OTHER ORGANIZATIONS. Third party interpretation is widely used due to its ease of use and breadth of language options, however the high cost can be a significant challenge. Many health centers may employ a number of on-site interpreters as well. [Health Care Interpreter Network](#) implemented pooled video interpretation across a network of organizations using VoIP technology instead of traditional phone line/cell service to a single organization. VoIP phones use internet technology to place phone calls, and are often more inexpensive and flexible in their usage than traditional phone lines. This allowed a number of member organizations to achieve economies of scale by sharing interoperation through a high quality video network.

In a study of this approach⁵, clinics automatically routed

The network connects to your organization's interpreters first, if the language and capacity is available.

If not, then it rolls over to interpreters across the network.

If the language and/ or capacity is not available across the network, then the request rolls over to a 24/7 third party interpretation service.

Description adapted from [HCIN: How It Works](#).

Share Interpretation Capacity and Need with Other Organizations, Continued

interpretation requests in 15 languages to a pool of 35 interpreters/ bilingual staff to streamline the translation process across member organizations. Results indicated that, “Interpreted LEP patients, compared to English-speaking and non-interpreted LEP patients, had the shortest emergency department stays; had the fewest tests, intravenous catheters, and medications; were more likely to follow-up in a clinic and less likely to return to the emergency department; and had the lowest overall charges.” While this study did not take place using telehealth, it highlights the importance of comprehension for LEP patients and the potential for creating health center networks to address interpretation needs. The impacts of misunderstandings between patients and providers are only exacerbated in a telehealth setting.

2. MATCH PROVIDERS WITH PATIENTS’ LINGUISTIC NEEDS. One ultimate long term goal of providing care to LEP patients is to effectively match providers and patients who speak the same language in a streamlined manner. This would first and foremost entail training bi– or multi-lingual individuals to become providers to the extent that they are able to serve communities of LEP patients proportional to the need. The availability of multilingual providers able to provide telehealth hinges on the removal of various barriers:



Language and Telehealth in Graduate Medical Education

Learning and using specific medical terminology in languages other than English is necessary for bi– and multi-lingual providers to be able to comprehensively offer care in those languages. This and may be able to be facilitated in health centers that have residency or training programs and are caring for multilingual populations. Residency program investment in live interactive video services is also important to ensure that residents are offered opportunities to use telehealth services, particularly with LEP patient populations.

Health System Trainings

Bilingual training programs can help increase the linguistic capacity of existing providers within organizations. For example, Kaiser Permanente has implemented the [Qualified Bilingual Staff Model](#), which serves to “identify, qualify, educate/enhance, mobilize and monitor an internal workforce as a key strategy to promote culturally competent care, improve health outcomes and reduce health care disparities.” This model has resulted in an increased linguistic capacity for staff in eight languages. Similar programs either in clinics or networks could expand the availability of multi-lingual staff to support telehealth and other needs of LEP patients.

Match Providers with Patient's Linguistic Needs

Retention

Long after multilingual staff are hired/trained in an organization, it is important to think about retention efforts. Leadership must recognize the burden of multilingual care and support staff accordingly, including ensuring care team support or technical solutions that ease the burden on multilingual providers.

Shorter Term Strategies to Match LEP Patients with Multilingual Providers, As Available

In the meantime, one temporary solution is to create a database of providers' proficient languages on FQHC website, call centers, fact sheets, etc. This can be done at the clinic level, as we see with [Petaluma Health Center](#)'s provider page which lists individual languages spoken. If patients are able to schedule their own telehealth or virtual visits through the website or patient portal, then allow patients to sort or search by language. There also could exist a process for intake staff to review a patient's preferred language in the EHR and recommend providers or care teams who are proficient in that language.

ADDITIONAL RESOURCES

- Centers for Medicare and Medicaid Services (2017). [How Healthcare Providers Meet Patient Language Needs: Highlights of a Medscape Provider Survey](#)
 - Centers for Medicare and Medicaid Services [Providing Language Services to Diverse Populations: Lessons from the Field](#)
-

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The information contained herein is for informational purposes and should not be taken as legal, clinical, or reimbursement guidance. Telehealth exists in a rapidly changing environment in 2020, so please review linked resources and other relevant federal, state, or local information for updates. Check with relevant regulators and payers to confirm up-to-date information.

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Focus on Breast cancer

October is Breast Cancer Awareness Month

Facts about breast cancer

In the United States, breast cancer is the most commonly diagnosed cancer and the second most common cause of cancer death in women, following lung cancer. About 1 in 8 (12 percent) women in the U.S. will develop invasive breast cancer during their lifetime. The chance that breast cancer will be responsible for a woman's death is about 1 in 36 (about 3 percent). All women are at risk for developing breast cancer, and the risk increases with age. Death rates from breast cancer have been declining since about 1989, with larger decreases in women younger than 50. These decreases are believed to be the result of earlier detection through screening and increased awareness, as well as improved treatment. The American Cancer Society recommends mammography as the screening tool for most adults.¹

Correctly reporting cancer

Determine whether the patient's cancer has been eradicated or is currently being treated. The neoplasm table in the ICD-10-CM code classification system establishes three categories of malignancy: primary, secondary and in situ. Malignant neoplasms should be coded as categorized; unknown sites (primary or secondary) must also be coded.

Current cancer vs. history of cancer²

Patients with cancer who are receiving active treatment for the condition should be reported with the malignant neoplasm code corresponding to the affected site. This applies even when a patient has had cancer surgery but is still receiving active treatment for the disease. When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion or metastasis to another site is coded as a secondary malignant neoplasm to that site.

Breast cancer

- **C50.- Malignant neoplasm of breast (by site and laterality)**
Fourth character illustrates nipple/areola (0), quadrants (2–5) or overlapping boundaries (8)
Sixth character (1) illustrates laterality (right side); (2) illustrates laterality (left side)
- **C50.811** Malignant neoplasm of overlapping sites of *right* female breast
- **C50.812** Malignant neoplasm of overlapping sites of *left* female breast
- **C50.911** Malignant neoplasm of *unspecified* site of *right* female breast
- **C50.912** Malignant neoplasm of *unspecified* site of *left* female breast

Long-term use of agents affecting estrogen receptors and estrogen levels³:

- Z17.0 Estrogen receptor positive status [ER+]
- Z17.1 Estrogen receptor negative status [ER-]
- Z79.810 Long-term (current) use of SERMs; includes tamoxifen

Examples:

Primary site with unknown secondary site

A 68-year-old female with metastatic scirrhous carcinoma at the 12 o'clock position of left breast, SBR 3-grade, ER+ (80 percent), PR+ (10 percent), HER2/neu-negative, lobular-invasive large cell

- **C50.812** Malignant neoplasm of overlapping sites of left female breast
- **C79.9** Secondary malignant neoplasm of unspecified site
- Z17.0 Estrogen receptor positive status [ER+] (*Additional ICD-10-CM codes are available for a progesterone receptor positive neoplasm [PR] and human epidermal growth factor receptor 2 [HER2 +/-] status.*)

Secondary site with active primary site

A patient is admitted with metastatic bone cancer. She had a mastectomy two months ago and is currently undergoing radiation treatments for breast cancer. The breast neoplasm was located in the right upper outer quadrant.

- **C79.51** Secondary malignant neoplasm of bone
- **C50.411** Malignant neoplasm of upper outer quadrant of right female breast
- Z90.12 Acquired absence of left breast and nipple

History of breast cancer

- Z80.3 Family history of malignant neoplasm of breast
- Z85.3 Personal history of malignant neoplasm of breast

History of mastectomy

- Z90.11 Acquired absence of *right* breast and nipple
- Z90.12 Acquired absence of *left* breast and nipple
- Z90.13 Acquired absence of *bilateral* breasts and nipples

Breast cancer screening

Medicare covers every 12 months for all female beneficiaries age 40 and older at no cost.

- Z12.31 Encounter for screening mammogram for malignant neoplasm of breast

Quality reporting³

For women age 50 through 74, document the date the mammogram was completed, or document and code an exclusion reason (such as bilateral mastectomy) in addition to reporting the appropriate CPT/HCPCS codes to close the gap in this measure.

1 American Cancer Society's publication. Cancer Facts & Figures 2017 and the National Cancer Institute Surveillance Epidemiology and End Results (SEER) database.

2 *Optum360 ICD-10-CM: Professional for Physicians 2020*. Salt Lake City: 2019.

3 "HEDIS Measures." National Committee for Quality Assurance. Web Sept 2019 <<https://www.ncqa.org/hedis/measures/>>.

Documenting and coding cancer

Medicare Advantage

Correct reporting of a diagnosis of cancer requires the determination and documentation of whether the patient's cancer has been eradicated or is currently being treated. It is important to assign the most accurate and specific ICD-10-CM neoplasm codes as possible.

To properly code neoplasms, it is necessary to determine from the record the following:¹



- **Behavior:** Malignant (primary, secondary, unknown), neuroendocrine, carcinoma in situ, benign, uncertain behavior or unspecified behavior
- **Morphology:** Histological type, stage and grade
- **Anatomic site(s):** Location, quadrants, multiple and contiguous sites
- **Laterality:** Right, left or bilateral for paired organs and the extremities

Current malignancy

When a primary malignancy has been excised, but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

Patients who are receiving active treatment for cancer should be reported with the malignant neoplasm code corresponding to the affected site. This applies even after surgical excision, but while they are still receiving current treatment for the disease, which may include:

- Surgery, radiotherapy, chemotherapy or a combination
- Adjunctive and/or adjuvant therapy following initial treatment of the cancer
- Active surveillance without any surgery or other treatment with *"watchful waiting"*



Aftercare following surgery for neoplasm

Visits to determine the effectiveness of cancer surgery that fall within the global postoperative period should be reported as Z48.3 Aftercare following surgery for neoplasm. The aftercare Z code should be used with the current neoplasm code.

Follow-up for patients with history of cancer

When using a history code, such as Z85, we also must use Z08 Encounter for follow-up examination after completed treatment for a malignant neoplasm. This follow-up code implies the condition is no longer being actively treated and no longer exists.

Cancer drugs prescribed for reason other than malignancy

Patients with no history of cancer who take cancer drugs prophylactically (for example, Z79.810, Long term (current) use of selective estrogen receptor modulators [SERMs]), should not be reported with an active cancer diagnosis or a personal history of malignant neoplasm. Instead, code the reason for the prescription.

History of cancer

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. These Z codes require additional digits to identify the site of the historical event of the cancer, and the active cancer code is not reported.

Routine surveillance (monitoring) for recurrence of a previously treated cancer is not considered active treatment and should not be documented or coded as current/active cancer. Use the appropriate Z code for *"personal history of."* Consider the following frequently asked questions:

- Has the cancer been excised, but site treatment (medication, chemotherapy, radiation) is ongoing? If so, then code as *"active"* cancer.¹
- Has the cancer been eradicated and all treatment to the site is completed? If so, code *"personal history"* of cancer.
- Does the patient have a family history of cancer and is taking cancer medications? If so, code *"family history"* of cancer with preventative therapy code(s) such as Tamoxifen.

Documentation and coding examples

Metastatic carcinoma of the liver

- **C78.7** Secondary malignant neoplasm of liver and intrahepatic bile duct
- **C80.1** Malignant (primary) neoplasm, unspecified

Metastatic carcinoma from the lung

- **C34.90** Malignant neoplasm of unspecified part of unspecified bronchus or lung
- **C79.9** Secondary malignant neoplasm of unspecified site

Metastatic bone cancer following mastectomy for a RUOQ breast neoplasm two months ago, currently receiving radiation treatment

- **C79.51** Secondary malignant neoplasm of bone
- **C50.411** Malignant neoplasm of upper-outer quadrant of right female breast
- **Z51.0** Encounter for antineoplastic radiation therapy

Frequently asked questions



Question: A patient previously diagnosed with prostate cancer had a total prostatectomy but no chemo or radiation therapy. Since his PSAs are monitored regularly, can this be considered “watchful waiting” and coded as current/active prostate cancer?

Answer: The term “watchful waiting” (active surveillance) can be used if the cancer has not been eradicated and no treatment of any kind is being directed at the cancer. If the patient’s cancer was completely eradicated by having a prostatectomy, this would be considered routine surveillance or monitoring for recurrence and should be documented and coded as Z85.462, Personal history of prostate cancer.^{3,4}

Question: Documentation supports a patient has prostate cancer, s/p permanent seed implants five years ago with no recurrence. Can this be coded active cancer?

Answer: Radioactive “seed” implants remain in place permanently; however, brachytherapy is only considered “active” treatment while the implants are in the effective period of the radiation. This varies from a few months up to approximately 10 months, depending on the type of implant. In the above case, there is no recurrence, so unless there is current/active treatment documented, this would be coded as Z85.46, Personal history of prostate cancer.³

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2020: “A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required.” The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2020.

Optum360 ICD-10-CM: Professional for Physicians 2020. Salt Lake City, UT: 2019.

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October 2020 | October is Breast Cancer Awareness Month

FOCUS ON: Breast cancer

Facts about breast cancer

More women are diagnosed with breast cancer than any other cancer (excluding skin cancer); one in eight women will develop breast cancer over a lifetime. Breast cancer is the second most common cause of death from cancer in the United States following lung cancer. Since 1989, thanks to early detection and improved treatments, the number of women who die from breast cancer has steadily declined. Currently in the United States, there are approximately 3 million women living with breast cancer. Although rare, men are also at risk, accounting for less than 1% of all breast cancers.¹ The risk of developing breast cancer increases as a woman ages, with most cancers developing in women older than 50. Mammography is an excellent screening tool for breast cancer.² Screening mammography is a Five-Star Quality measure from the Centers for Medicare & Medicaid Services (CMS) and also a Healthcare Effectiveness Data and Information Set (HEDIS)[®] quality measure.³

Current cancer vs. history of cancer

To correctly report a diagnosis of cancer, determine whether the patient's cancer has been eradicated or is currently being treated. The neoplasm table in the ICD-10-CM code book establishes three categories of malignancy: primary, secondary and in situ. Malignant neoplasms should be coded as categorized; unknown or unspecified sites (primary or secondary) must also be coded.

Patients with cancer who are receiving active treatment for the condition should be reported with the malignant neoplasm code corresponding to the affected site. This applies even when a patient has had cancer surgery, but is still receiving active treatment for the disease. Patients with a history of cancer, with no evidence of current cancer, and not currently under treatment for cancer should be reported as "Personal history of malignant neoplasm." These Z85 codes require additional characters to identify the site of the cancer and should be reported only when there is no evidence of current cancer. If a patient's presenting problem, signs or symptoms may be related to the cancer history or if the cancer history impacts the plan of care, then report the appropriate Z code and not the code for the active cancer.

Documentation and coding tips

- Patients taking antineoplastic medications (for example, tamoxifen, Femara) for treatment of breast cancer are coded to an active malignant neoplasm as long as they are taking the medications.
- Use additional code to identify estrogen receptor status (Z17.0, Z17.1), and for long-term (current) use of anti-neoplastic medications (Z79.810, Z79.818).

Documentation should include the specific site of tumor and laterality (for example, right, left, bilateral).

C50.- Malignant neoplasm of breast

- Fourth characters identify nipple/areola (0), central region (1); quadrants (2–5) or overlapping boundaries (8)
- Fifth characters identify female (1), male (2)
- Sixth characters identify laterality right (1), left (2), unspecified (9)

Examples of coding female breast cancer

- **C50.411** Malignant neoplasm of RUOQ of female breast
- **C50.919** Malignant neoplasm of unspecified site of unspecified female breast

Examples of coding male breast cancer

- **C50.029** Malignant neoplasm of nipple/areola, unspecified male breast
- **C50.829** Malignant neoplasm of overlapping sites of unspecified male breast

History of breast cancer

- Z80.3 Family history of malignant neoplasm of breast
- Z85.3 Personal history of malignant neoplasm of breast

Breast cancer screening

- Z12.31 Encounter for screening mammogram for malignant neoplasm of breast

Coding example

A 68-year-old female seeing hematology-oncology for Stage IIA, ER+ breast cancer, RUOQ, previously removed by ultrasound-guided biopsy. Radiation therapy completed, currently on Femara.

- **C50.411** Malignant neoplasm of upper-outer quadrant of right female breast
- Z17.0 Estrogen receptor positive status [ER+]
- Z79.811 Long-term (current) use of letrozole (Femara)

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2021: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2021.

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Breast cancer (female)

Medicare Advantage: Provider quick tips

ICD-10-CM	Description	HCC
C50.919*	Malignant neoplasm of unspecified site of unspecified female breast	12
C50.-*	Malignant neoplasm of breast (specified)	12
Z17.0	Estrogen receptor positive status [ER+]	Not a HCC
Z17.1	Estrogen receptor negative status [ER-]	Not a HCC
Z79.810	Long term (current) use of selective estrogen receptor modulators (SERMs)	Not a HCC
Z79.811	Long term (current) use of letrozole (Femara)	Not a HCC
Z85.3	Personal history of malignant neoplasm of breast	Not a HCC

*Be specific – identify the problem by site (topography), laterality, type such as primary or secondary metastasis and behavior, malignant, in situ, benign, etc. Also, consider specific forms: morphology, histologic type and grade (score 1–3).

➔ Documentation and coding example

Malignant neoplasm of lower-outer quadrant of left breast of female, estrogen receptor negative.

- **C50.512**
- Z17.1

*Document current cancers as active when:

1. There is current treatment directed to the site (chemotherapy, radiation, immunotherapy, adjunctive or adjuvant therapy).
2. The cancer is newly diagnosed and treatment hasn't started yet.
3. The patient elects not to have any treatment.

Examples of active cancer documentation



Patient is on hormone therapy to continue treatment. Patient is receiving chemo or radiation treatment; patient is newly diagnosed and is scheduled with oncology to assess treatment options; patient has breast cancer and elects no treatment; or the treatment plan is "watchful waiting," which typically applies if there is no treatment of any kind directed to the cancer.

Consider reviewing Optum tools related to co-existing conditions such as diabetes, heart disease, chronic kidney disease, lung disease, major depressive disorder, malnutrition, hypertension, etc., if applicable. For additional information, please see the *Documenting and coding cancer tool*.



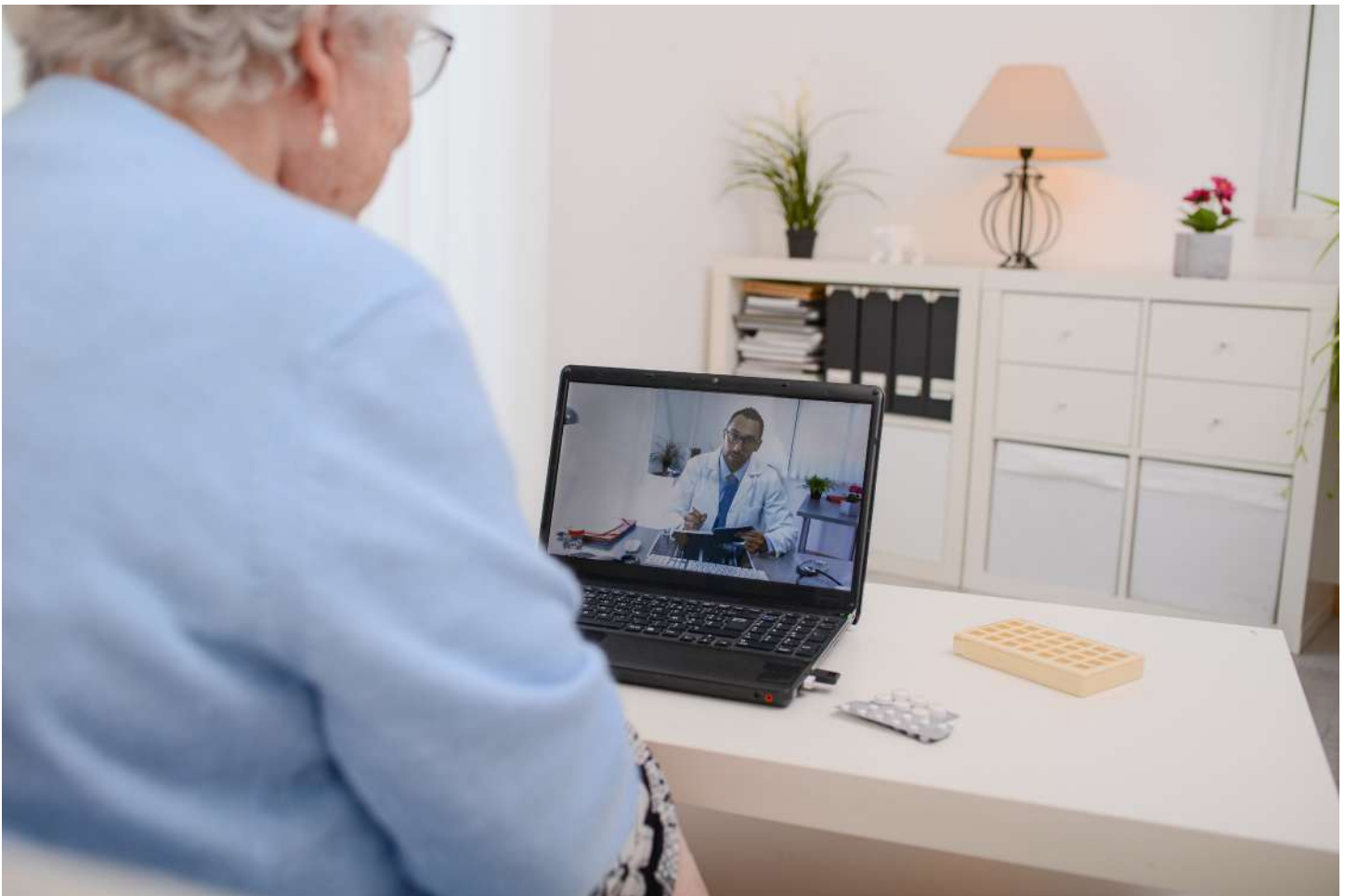
- Optum360 ICD-10-CM: Professional for Physicians 2020. Salt Lake City: 2019.

Before the visit

- ☑ Establish a workflow regarding patient scheduling, outreach, check-in process, troubleshooting, etc.
- ☑ Verify patient eligibility for telehealth, that includes audio and visual interactive capabilities, with their health plan.
- ☑ Ensure your computer/tablet/smartphone has a good quality camera and microphone so that both video and audio capability are possible to complete the visit in a manner that meets applicable privacy standards.
- ☑ Ensure that internet service is available and reliable in your location.
- ☑ Set up the right space and modality for telemedicine visits.
 - Create a dedicated space for telehealth visits to ensure privacy, proper lighting and audio, and avoid interruptions.
 - Place camera on a level stand and position at eye level if possible.
 - Ensure that the program used for communication meets HIPAA standards.
- ☑ Establish an office protocol for patients being seen via telehealth.
- ☑ Establish which face-to-face video real-time platform will be used to conduct the telehealth visit with the patient and who in the office will assist the patient in troubleshooting before the visit.
- ☑ Establish a plan for emergencies and communicate it to the patient before the visit. Have all information on hand for generating referrals and requesting transfers.

During the visit

- ☑ Obtain patient consent to receive telehealth care.
- ☑ Complete the visit in a private setting for both the provider and the patient.
- ☑ **Indicate modality of visit for video conferencing (for example, telehealth provided via real-time interactive audio and video) in your chart documentation.**
- ☑ Document the date and duration of the visit.
- ☑ Complete documentation as you would for an in-person visit. Some or all of the following may apply based on type of visit conducted:
 - Personal identifying information
 - Past medical, family and social history
 - Chief complaint
 - History of present illness
 - Associated signs and symptoms, with detailed review
 - Pertinent screenings (for example PHQ-9 screening for depression)
 - Applicable referrals for screenings to be completed outside the office
 - Medication review
 - For chronic conditions, documentation of evidence of monitoring, evaluating, assessing or treating, which can include the status and complexity
 - Provider-directed patient self-examination (including mobile medical devices if needed)
 - Assessment and plan



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