The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 598 • May 2014 *(Reaffirmed 2016)* *(Replaces Committee Opinion Number 460, July 2010)*
(Reaffirmed 2016)

Committee on Adolescent Health Care

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

The Initial Reproductive Health Visit

ABSTRACT: The initial visit for screening and the provision of reproductive preventive health care services and guidance should take place between the ages of 13 years and 15 years. The initial reproductive health visit provides an excellent opportunity for the obstetrician–gynecologist to start a patient–physician relationship, build trust, and counsel patients and parents regarding healthy behavior while dispelling myths and fears. The scope of the initial reproductive health visit will depend on the individual's need, medical history, physical and emotional development, and the level of care she is receiving from other health care providers. A general exam, a visual breast exam, and external pelvic examination may be indicated. However, an internal pelvic examination generally is unnecessary during the initial reproductive health visit, but may be appropriate if issues or problems are discovered in the medical history. Health care providers and office staff should be familiar with state and local statutes regarding the rights of minors to consent to health care services and the federal and state laws that affect confidentiality.

Timing and Scope of the Initial Visit

The initial visit for screening and the provision of reproductive preventive health care services and guidance should take place between the ages of 13 years and 15 years (1, 2). This may be a patient's first visit to an obstetrician–gynecologist. From a developmental standpoint, patients of this age may manifest characteristics of early, middle, or late adolescence. An attempt to determine the patient's developmental stage is helpful during the interview and evaluation. It is important to recognize that growth in any one developmental area (eg, cognitive, physical, or psychosocial) may or may not correspond with the patient's chronological age.

The scope of the initial reproductive health visit will depend on the individual's need, medical history, physical and emotional development, and the level of care she is receiving from other health care providers. An age-appropriate discussion and anticipatory guidance about reproductive health-related topics, including pubertal development, normal menses, timing of routine gynecologic visits, sexually transmitted infections (STIs), pregnancy prevention, sexual orientation and gender identity, and acquaintance rape prevention is important. Because a young person may be seen by a range of clinicians who may or may not have addressed reproductive health, it is important to assess the level of reproductive care and guidance previously received by the patient and work as a team with the other health care providers to ensure the provision of comprehensive reproductive health care. If the health care provider is uncomfortable providing appropriate and adequate care to adolescents, then he or she should refer the patient to another reproductive health care provider.

Creating an Adolescent-Friendly Environment

If feasible, the obstetrician–gynecologist should strive to concentrate adolescent visits on a dedicated office day or time. Before or after school appointments are more convenient for adolescents. It should be noted that a reception area full of adults or obstetric patients may intimidate adolescents. It may be helpful to include age-appropriate and culturally inclusive reading materials and audiovisual aids in the reception area and examination rooms. Having one or two rooms where adolescents are seen and examined allows for the removal or de-emphasizing of materials and equipment that may make adolescents uncomfortable. The use of visual materials, such as models, diagrams, and charts is strongly encouraged for teaching about anatomy and physiology of the

reproductive tract. (For more suggestions about creating an adolescent-friendly office environment, see "Preparing Your Office for Adolescent Health Care" in the American College of Obstetricians and Gynecologists' *Tool Kit for Teen Care*, Second Edition.)

Confidentiality

It is imperative to discuss issues of confidentiality with both the adolescent and her parent (3). Lack of confidentiality is often a barrier to the delivery of health care services, especially reproductive health care, for adolescents (4). Health care providers should initiate a discussion of this topic at the initial visit and advise the adolescent and her parent of relevant state and local statutes. The importance of open communication between the health care provider, patient, and parent should be emphasized. Parents and adolescents should be informed of any legal restrictions on the confidential nature of the patient–physician relationship. For example, the health care provider should explain that if the patient has a major medical problem, or if the patient discloses any evidence or risk of bodily harm to herself or others, confidentiality may not be maintained (5). Furthermore, state laws mandate the reporting of physical or sexual abuse of minors. Health care providers and office staff should be familiar with state and local statutes regarding the rights of minors to consent to health care services and the federal and state laws that affect confidentiality. For a listing of state laws that is updated monthly, go to www.guttmacher.org/statecenter/ and consult with your state medical society.

The Initial Visit

The primary goal of the initial reproductive health visit is to provide preventive health care services, including educational information and guidance, rather than problem-focused care. The visit also allows patients and parents the chance to visit the office, meet the health care provider, alleviate fears, and develop trust. After greeting the adolescent and parent, a thorough explanation of the scope of the visit and confidentiality issues should be provided. A model office visit would include: 1) an initial consultation with both the patient and parent together, 2) a confidential visit between the health care provider and patient, and 3) a concluding consultation with the patient and parent again. If a parent desires time alone with the health care provider, this should be discussed with the adolescent patient and occur before the health care provider spends time alone with the patient, if possible, to reassure the adolescent patient that her confidentiality will be maintained. Health care providers should try to accommodate patients' requests for privacy from parents during the visit when possible and appropriate. (For more information please refer to "Confidentiality in Adolescent Health Care" and the "ACOG Adolescent Visit Record" in *Tool Kit for Teen Care*.)

During the initial consultation with the patient and parent, the health care provider should inform them that the visit does not require an internal pelvic examination, unless indicated, and that the American College of Obstetricians and Gynecologists (the College) recommends the first Pap test at age 21 years (6). Many adolescents and their parents are unaware of the difference between a Pap test and a pelvic examination (7). This presents an opportunity for the clinician to dispel any confusion and clarify any questions. A review of the patient's medical history, family medical history, and immunization status should be assessed, and appropriate vaccinations should be provided. The family medical history should be inclusive and specifically should include family history of venous thromboembolism; cardiovascular disease; diabetes; hypertension; mental illness; substance abuse; familial gynecologic conditions, such as endometriosis or leiomyomas; delayed puberty; breast, colon, ovarian, or uterine cancer; and polycystic ovary syndrome.

Conversations regarding normal pubertal development and menstruation are important. Because menarche and subsequent menses are physiologically and emotionally important milestones in an adolescent's development, it is beneficial to educate patients and their parents regarding expectations for normal menstrual variation. Discussions regarding menstrual flow, hygiene, and symptoms, as well as duration and frequency of bleeding, can help the adolescent assess if her menstrual cycle is within normal limits (8). Clinicians should ask detailed questions about the patient's menstrual cycle to help uncover abnormalities that may be easily managed (eg, dysmenorrhea and nonsteroidal antiinflammatory drugs as an effective treatment) or may be linked to a more serious underlying concern (eg, bleeding, müllerian, and endocrine disorders) (8).

Adolescents with disabilities and developmental delays may especially benefit from an initial reproductive health visit with an obstetrician–gynecologist. Depending on the degree of disabilities or developmental delay, the patient and caregivers may need an in-depth discussion of menstruation, fertility, hygiene, options for menstrual manipulation (9), and contraception (10).

During the confidential visit with the patient, the health care provider should include a discussion of contraception and STIs because some adolescents are and some may soon become sexually active. Forty-seven percent of females aged 15–19 years have engaged in intercourse, which increases with age from 31% of females aged 15–17 years to 67% of females aged 18–19 years (11). Rates of oral sex are similar and many teens have also had anal sex (11). Health care providers should discuss previous sexual activity, including noncoital sexual activity (12), and ask the patient about her plans for sexual activity. This offers an opportunity to discuss pregnancy and STI prevention strategies in an anticipatory manner.

Many adolescents are at risk of engaging in unhealthy and risky behavior, such as tobacco, alcohol, and other substance use, and these issues should be identified and addressed. According to the 2011 Youth Risk Behavior

Surveillance Report, female students in grades 9–12 indicated that in the past 30 days they had at least one drink of alcohol (38%); had five or more drinks in a row on at least 1 day (20%); drove when drinking alcohol (7%); and rode with a driver who had been drinking alcohol (25%). Thirty percent also report sending a text or e-mail while driving. Many youth are exposed to dating violence. The 2011 Youth Risk Behavior Surveillance Report showed that 9% reported experiencing dating violence and 12% reported forced sex (13). Screening for eating disorders; anxiety; depression; and physical, sexual, and emotional abuse also is important. Screening for risk-taking behavior can be facilitated by the use of a questionnaire as an alternative to direct interviewing. (See the "ACOG Adolescent Visit Record" and "ACOG Adolescent Visit and Parent Questionnaires" in *Tool Kit for Teen Care*. For more information on these topics, refer to the "Primary and Preventive Health Care for Female Adolescents" chapter in *Guidelines for Adolescent Health Care*, Second Edition.) Reviewing the questionnaire with the adolescent can help facilitate discussion.

Examination

The necessary components of the physical examination may vary depending on the patient, her concerns, and previous encounters with other clinicians. A general examination, a visual breast examination, and an external pelvic examination may be indicated. However, an internal pelvic examination generally is unnecessary during the initial reproductive health visit. If the patient has had sexual intercourse, annual screening for chlamydia and gonorrhea is recommended. In addition, screening for human immunodeficiency virus (HIV) at least once is recommended (1). Chlamydia and gonorrhea screening should be done using nucleic acid amplification techniques. This can be performed using a urine sample or a vaginal swab specimen that is obtained by either the patient or health care provider (14). Vaginal swabs are more sensitive than urine tests (15). Both have been found to be acceptable to young patients (16).

Pelvic examinations are recommended for symptomatic patients. Because the College currently recommends that females have their first Pap test at age 21 years (6), some adolescents may visit the gynecologist several times before a speculum examination is indicated. Such visits allow the development of a comfortable patient–physician relationship, in addition to adequate patient preparation before the first pelvic examination is performed. However, an internal pelvic examination may be appropriate if issues or problems are discovered in the medical history (eg, abnormal bleeding or discharge, or abdominal or pelvic pain). If a speculum or bimanual examination is necessary, a thorough explanation and patient assent should always precede the procedure. It is helpful to provide the adolescent with written information regarding the first complete pelvic examination if it is to occur. Patients can be referred to the College's Patient Education FAQ, "Your First Gynecologic Visit" (www.acog.org/~/media/For%20Patients/faq150.pdf). When choosing a speculum for the examination, the patient's pubertal developmental status, hymenal opening, and sexual experience should influence the decision. Typically, a Pederson or Huffman speculum should be used.

On completion of the physical examination, consultation with the patient should address physical findings, diagnosis, and treatment options, if needed. If she is sexually active, or considering becoming sexually active, contraceptive options, including emergency contraception and long-acting reversible contraception, should be reviewed and provided. Once a mutually agreed-on treatment plan is established, the adolescent is encouraged to include her parent in treatment planning. It is helpful to assess specifically what information can be shared with the parent. At the conclusion of the visit, the patient, her parent, and the health care provider should meet again. During this meeting, findings and recommendations are discussed, if appropriate. Any remaining concerns also can be addressed and the parent can be offered guidance on adolescent development. Health care providers can have a powerful role as educator of parents when it comes to issues surrounding reproductive health, and resources should be provided to both the adolescent patient and her parent, if possible. (For teen and parent educational resources, please refer to ACOG's *Tool Kit for Teen Care* and ACOG's Adolescent Health Care Resource Guides [www.acog.org/goto/teens].)

Current Procedural Terminology Coding

To decrease or avoid insurance claim delays and denials, the health care provider's office will be well served by developing resources for accurate *Current Procedural Terminology* (CPT) coding and billing to be used for the initial reproductive health visit. These resources should contain the "covered benefits" of the office's most frequently billed third-party payers. It also should include the copayment amounts for the different beneficiaries.

Preventive Medicine Services

The initial comprehensive preventive medicine evaluation and management of a new patient aged 12–17 years uses CPT code 99384. It includes an age and gender appropriate history; examination; counseling, anticipatory guidance, and risk factor reduction interventions; and the ordering of appropriate immunizations and laboratory or diagnostic procedures. It is important to note that laboratory services, radiologic services, immunizations, and other procedures and screening tests are identified with specific codes and are separately reported. Medical record systems and billing practices may not fully protect the confidentiality of adolescent patients receiving sexual and reproductive health services. Health care providers are encouraged to discuss these limitations

with teens. Review of the College's Committee Opinion Number 599, *Adolescent Confidentiality and Electronic Health Records* (17), may be useful.

A periodic comprehensive preventive medicine visit of an established patient aged 12–17 years uses CPT code 99394. Annual gynecologic visits also may be included in this category. Different payers may vary in their definition of an annual gynecologic visit; however, a pelvic examination, a breast examination, and a Pap test are included in this nomenclature. It is important to note, however, that a Pap test will likely not be a part of visits for patients younger than 21 years. The length of time is not reported for these visits, and the documentation guidelines for problem visits (eg, chief concern or history of present illness) do not apply for preventive medicine visits. Preventive medicine services are provided to asymptomatic patients and may be used once a year by any health care provider. This may be problematic because some health care providers offer the full range of care from general preventive care to reproductive health care, but many times one clinician may not provide all the recommended care an adolescent may need. Therefore, "well-child" care may require two visits, a general preventive visit and a dedicated reproductive health visit. Both visits are critical and each visit should be covered.

Counseling on Risk Factor Reduction and Behavior Change Intervention

Individual counseling in preventive medicine or risk factor reduction or both for individuals without a specific illness to promote health and prevent illness and/or injury uses CPT codes 99401–99404. They are distinct from preventive counseling services and can be reported during the same encounter. These codes are time based and range from 15 minutes to 60 minutes.

Preventive Services and a Problem-Related Visit

When a preventive service and problem-related visit is provided during the same encounter, both codes may be separately reported. When appropriate, a preventive medicine code (eg, 993XX) and problem visit code appended with modifier 25 (significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) (eg, 992XX-25) is allowed. However, it is important to check with insurers to assess coverage for both preventive and problem-related codes. Some insurers will not reimburse for two evaluation and management services performed during the same encounter. (For more information, refer to "Coding Information" in *Tool Kit for Teen Care.*)

Conclusion

The initial reproductive health visit provides an excellent opportunity for the obstetrician–gynecologist to start a patient–physician relationship, build trust, and counsel patients and parents regarding healthy behavior while dispelling myths and fears. It also will assist an adolescent in negotiating entry into the health care system when she has a specific reproductive health care need. Health care for the adolescent should include review of normal puberty and menstruation, diet and exercise, healthy sexual decision making, the development of healthy and safe relationships, immunizations, depression, substance use, STI screening, and STI and pregnancy risk reduction and prevention. Preventive counseling also is beneficial for parents or other supportive adults and can include discussions regarding physical, sexual, and emotional development; signs and symptoms of common conditions affecting adolescents; and encouragement of lifelong healthy behavior. The initial reproductive health visit does not include an internal pelvic examination unless indicated by the medical history.

Resources

American College of Obstetricians and Gynecologists' Resources

American College of Obstetricians and Gynecologists, editor. Guidelines for adolescent health care. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2011.

American College of Obstetricians and Gynecologists. Tool kit for teen care. 2nd ed. Washington, DC: ACOG; 2009.

American College of Obstetricians and Gynecologists. Your first gynecologic visit. ACOG Patient Education Pamphlet AP150. Washington, DC: ACOG; 2011.

American College of Obstetricians and Gynecologists' Coding Department
http://www.acog.org/About_ACOG/ACOG_Departments/Coding

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