The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 460 • July 2010

Committee on Adolescent Health Care

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

The Initial Reproductive Health Visit

ABSTRACT: The American College of Obstetricians and Gynecologists recommends that the first dedicated reproductive health visit take place between the ages of 13 years and 15 years. This visit will provide health guidance, screening, and preventive health care services and offers an excellent opportunity to begin a physician–patient relationship. This visit does not generally include an internal pelvic examination.

Timing and Scope of Initial Visit

The first visit to the obstetrician–gynecologist 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). 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 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 of topics, including pubertal development, normal menses, timing of routine gynecologic visits, healthy eating habits, sexually transmitted infections (STIs), pregnancy prevention, sexual orientation and gender identity, substance use and abuse, and acquaintance rape prevention is important. Depending on training and experience, not all primary health care providers who otherwise care for adolescents, including pediatricians, family medicine physicians, adolescent medicine specialists, and clinical nurse practitioners, choose to provide reproductive care (3). It is important to assess the level of reproductive care previously received by the patient and work as a team with the other health care provider(s) to ensure the provision of comprehensive reproductive health care. One way to assess whether an adolescent is getting appropriate care from another health care provider would be to ask the parent if the primary health care provider allows time for the adolescent to speak with him or her alone. The obstetrician–gynecologist can then supplement the care provided by a primary health care provider, if necessary. If the obstetrician–gynecologist is unable to provide appropriate and adequate care, then he or she should refer the patient to another reproductive health care provider.

Creating an Adolescent-Friendly Environment

If feasible, the obstetrician–gynecologist may strive to concentrate adolescent visits on a dedicated office day or time. Many adolescents prefer before or after school appointments. It should be noted that a reception area full of obstetric patients often intimidates nonpregnant 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 deemphasizing 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' (the College) publication *Tool Kit for Teen Care*, Second Edition.)

Confidentiality

It is helpful to discuss issues of confidentiality with both the adolescent and her parent* (4). Lack of confidentiality often is a barrier to the delivery of health care services, especially reproductive health care, for adolescents (5). To overcome this obstacle, 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 physician–patient relationship. For example, the health care provider should explain that if the patient discloses any evidence or risk of bodily harm to herself or others, confidentiality would be breached (6). 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/spibs/index.html 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 discussion with the parent alone, if desired, 3) a confidential visit between the health care provider and patient, and 4) a concluding consultation with the patient and parent again. Please note the patient has the right to decide if she does not want the parent's presence at any point during the visit. (For more information please refer to "Confidentiality in Adolescent Health Care" and "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 College recommends the first Pap test at age 21 years (7). Many adolescents and their parents are unaware of the difference between a Pap test and a pelvic examination. This presents an opportunity for the clinician to dispel any confusion and clarify any questions (8). A review of the patient's medical history, family history, and immunization status should be assessed, and appropriate vaccinations should be provided at this time. The family history should include family history of venous thromboembolism; cardiovascular disease; familial gynecologic conditions such as endometriosis or leiomyomas; breast, colon, ovarian, or uterine cancer; or polycystic ovary disease. In addition, conversations regarding normal pubertal development and menstruation are important, along with an assessment for dysmenorrhea, and discussion about nonsteroidal antiinflammatory drugs as effective treatment options for menstrual cramps. 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 both menarche, if it has not yet occurred, and normal menstrual variation. Discussions regarding appropriate menstrual flow, menstrual hygiene, and duration and frequency of bleeding can help the adolescent assess if her menstrual cycle is normal (9).

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

After the initial consultation with both the patient and parent, it can be helpful to speak briefly with the parent alone to identify any concerns about the patient, to assess awareness of any risk-taking behaviors, observations about other behaviors (eg, lack of exercise or disordered eating), and to provide anticipatory guidance. The confidential nature of the physician–patient relationship should be reiterated to the parent and the patient. The consultation with the parent should be done before the confidential visit with the patient. This will reassure the adolescent and emphasize to the parent that the information the adolescent provides will not be shared with the parent unless required by law.

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 will become sexually active. Forty-seven percent of females aged 15–19 years have engaged in intercourse, which increases with age from 14% of 15-year-olds to 75% of 19-year-olds (11). Many adolescents are at risk of engaging in unhealthy and risky behaviors, such as tobacco, alcohol, and other substance use, and these issues should be identified and addressed. According to the 2007 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 (43%); had five or more drinks in a row on at least 1 day (24%); drove when drinking alcohol (8%); and rode with a driver who had been drinking alcohol (30%)(12, 13). Screening for eating disorders and other weight issues; anxiety; depression; and physical, sexual, and emotional abuse is important.

*Use of the word "parent" throughout the document also means "guardian."

Screening for many of the previously mentioned issues can be facilitated by 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 *Tool Kit for Teen Care*.)

Examination

The patient should be provided with a description of the examination process and asked if she would like her parent present. An internal pelvic examination generally is unnecessary during the initial reproductive health visit. A general physical examination, including a visual breast examination and external genital examination, may be done because it allows assessment of secondary sexual development, reassurance, and education. A teaching external-only genital examination can provide an opportunity to familiarize adolescents with normal anatomy, assess adequacy of hygiene, and allow the health care provider an opportunity to visualize the perineum for anomalies. If the patient has had sexual intercourse, annual screening for chlamydia, gonorrhea, and human immunodeficiency virus (HIV) is recommended (1). Chlamydia and gonorrhea screening can be performed with a vaginal swab specimen that is obtained by either the patient or health care provider. Such screening also can be done with urine testing using nucleic acid amplification techniques (14). Urine testing is often more acceptable to the patient.

Pelvic examinations are recommended for symptomatic patients. Because the College currently recommends that females have their first Pap test at age 21 years (7), some adolescents may visit the gynecologist several times before a speculum examination is indicated. Such visits allow the development of a comfortable physician–patient relationship, in addition to adequate patient preparation before the first pelvic examination is performed. A developmentally appropriate pelvic examination may be performed if issues or problems are discovered in the medical history (eg, pubertal aberrancy, 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. (Refer to the College's Patient Education Pamphlet, "Your First Gynecologic Visit," http://www.acog.org/publications/patient_education/bp150.cfm). When choosing a speculum for the examination, the patient's age, 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. 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.

Current Procedural Terminology Coding†

To decrease or avoid claim delays and denials, the health care provider's office will be well served by developing resources for accurate 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

Code 99384 is used for the initial comprehensive preventive medicine evaluation and management of a new patient aged 12–17 years. It covers the history; examination; counseling, anticipatory guidance, and risk factor reduction interventions; and the ordering of appropriate immunization(s) and laboratory or diagnostic procedures. It is important to note that laboratory services, radiologic services, immunizations, and other procedures and screening tests identified with their own codes are separately reported.

Code 99394 is used for a preventive visit of an established patient aged 12–17 years. 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 many visits for patients younger than 21 years. The length of time is not reported for these visits. It is important to remember that evaluation and management (E/M) guidelines do not apply to preventive services codes.

Preventive medicine services provided to asymptomatic patients may be used only once a year by any health care provider. This is problematic because some health care providers offer the full range of care from general preventive care to reproductive health care, but many times no one clinician provides all the recommended care an adolescent needs. Therefore, "well-child" care

may require two visits, a general preventive visit and a dedicated reproductive health visit. Both are critical and each of these visits should be covered.

Individual Counseling in Preventive Medicine

Codes 99401–99404 are used for individual counseling in preventive medicine or risk factor reduction or both for individuals without a specific illness to promote health and prevent illness or injury or both. These codes are time based and range from 15 minutes to 60 minutes. When the preventive counseling service is distinct from a problem-oriented E/M service, both services can be reported at the same time.

Preventive Services and a Problem-Oriented Visit

When preventive and problem-oriented care is provided in the same visit, two separate codes are necessary: 1) The preventive medicine code and 2) The code for added level of E/M service with modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service). It is important to check with insurers to assess coverage for both preventive and problem-oriented codes because some insurers will not accept both during the same encounter. (For more information, refer to "Coding Information" in *Tool Kit for Teen Care.*)

Conclusion

The initial reproductive visit provides an excellent opportunity for the obstetrician–gynecologist to start a physician–patient relationship, build trust, and counsel patients and parents regarding healthy behaviors 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, 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 behaviors. The initial reproductive health visit does not include an internal pelvic examination unless indicated by the medical history.

References

1. American College of Obstetricians and Gynecologists. Primary and preventive health care for female adolescents. In: Tool kit for teen care. 2nd ed. Washington (DC): ACOG; 2009.
2. Sanfilippo JS, Davis A, Hertweck SP. Obstetrician gynecologists can and should provide adolescent health care. ACOG Clin Rev 2003;8(7):1,15–6.
3. Akinbami LJ, Gandhi H, Cheng TL. Availability of adolescent health services and confidentiality in primary care practices. Pediatrics 2003;111:394–401.
4. American College of Obstetricians and Gynecologists. Confidentiality in adolescent health care. In: Tool kit for teen care. 2nd ed. Washington, DC: ACOG; 2009.
5. McKee MD, Fletcher J, Schechter CB. Predictors of timely initiation of gynecologic care among urban adolescent girls. J Adolesc Health 2006;39:183–91.
6. Center for Adolescent Health and the Law. Policy compendium on confidential health services for adolescents. 2nd ed. Chapel Hill (NC): CAHL; 2005.
7. Cervical cytology screening. ACOG Practice Bulletin No. 109. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;114:1409–20.
8. Blake DR, Weber BM, Fletcher KE. Adolescent and young adult women's misunderstanding of the term Pap smear. Arch Pediatr Adolesc Med 2004;158:966–70.
9. Menstruation in girls and adolescents: using the menstrual cycle as a vital sign. ACOG Committee Opinion No. 349. American Academy of Pediatrics; American College of Obstetricians and Gynecologists. Obstet Gynecol 2006; 108:1323–8.
10. Menstrual manipulation for adolescents with disabilities. ACOG Committee Opinion No. 448. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009: 114:1428–31.
11. Chandra A, Martinez GM, Mosher WD, Abma JC, Jones J. Fertility, family planning, and reproductive health of U.S. women: data from the 2002 National Survey of Family Growth. Vital Health Stat 23 2005;(25):1–160.
12. Eaton DK, Kann L, Kinchen S, Shanklin S, Ross J, Hawkins J, et al. Youth risk behavior surveillance--United States, 2007. Centers for Disease Control and Prevention (CDC). MMWR Surveill Summ 2008;57(SS-4):1–131.
13. Alcohol use among high school students - Georgia, 2007. Centers for Disease Control and Prevention (CDC). MMWR Morb Mortal Wkly Rep 2009;58:885–90.
14. Association of Public Health Laboratories. Laboratory diagnostic testing for Chlamydia trachomatis and Neisseria gonorrhoeae. Silver Spring (MD): APHL; 2009. Available at: http://www.aphl.org/aphlprograms/infectious/std/Documents/CTGCLabGuidelinesMeetingReport.pdf. Retrieved March 29, 2010.

ISSN 1074-861X

The initial reproductive health visit. Committee Opinion No. 460. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;116:240–3.