The Evolving Well Woman Visit
April 26, 2018

Dr. Michael Policar:

Examinations and basically who has written the guidelines for those exams, and then we're going to focus on three particular areas of debate and evolution in terms of the kinds of things that we do in the well woman visits.

Dr. Michael Policar:

With that, let me start by saying that I don't have any relevant disclosures to make about any sorts of commercial interest. Before you, you have the learning objectives for our webinar this afternoon.

Dr. Michael Policar:

I'm going to start with a case study, and we will discuss Marisella, both in terms of her medical history, the kinds of screening tests that she might need at her well woman visit, and then near the end of the webinar we'll also talk about how to code her visit, as well.

Dr. Michael Policar:

So, Marisella is a 28-year-old [gravida] two pair zero abortion two established client, which means that she's been seen in our clinic in the last three years, who now comes in for a well woman visit. She's been in a monogamous relationship for the past two years, she's feeling well and has no complaint of a vaginal discharge, abnormal vaginal bleeding, or painful intercourse. Her last cervical cytology was two years ago in another city. She's currently using oral contraceptives, would like to continue to use OCs and requests a year's supply. So, we'll start with a couple of questions. First one is, which screening test does the US Preventative Services Task Force recommend for Marisella? Second is, what do you think the single most important question is to ask her in regard to her well woman visit based on the information that I've given you, or for that matter, have not given you, so far.

Dr. Michael Policar:

The first thing is, is that these are the potential screening tests that might be offered to Marisella given her age. I want you to think about two things. Number one, if you were the clinician taking care of Marisella, which of these tests would you order. The second is to go back to my original question, which was, which of these tests would be indicated for Marisella given the history that I provided to you so far.

Dr. Michael Policar:

The answer is actually only a single test, and that's an HIV-1 serology. For the remainder of the webinar, we will be talking about the reasons that you would do that test in Marisella's situation, but that you would not be doing any of the other tests that are on the list.

Dr. Michael Policar:

Now, from my point of view, the most important question to ask that I haven't really told you the answer to already is to be sure to ask Marisella about whether or not she already has a primary care provider. The part about the women's health provider is if you are acting as a primary care provider, you'd ask, "Are we you also a patient at a family planning clinic," or, " Do you see an obstetrician, gynecologist, or a nurse midwife," for example.

Dr. Michael Policar:

If Marisella said that she had a primary care provider, what I'd ask is, "Where did you see her," or it might be him, and "When you did see your primary care provider, which tests were performed for you? When were they performed, and do you know the results?" That's critically important because of the fact that eight years ago, as the result of the Affordable Care Act, many, many more women than in the past now have either full scope MediCal or commercial insurance, even though they're coming to see us as family planning providers. We need to know whether or not they are also getting primary care and screening services from another providers, most specifically a primary care provider.

Dr. Michael Policar:

We want to tailor the content of today's visit in deciding, does she not have a primary care provider, in which case she may need a more comprehensive well woman visit, or because some of these tests have been done already by her primary care provider or her clinic, is this going to be much more focused on her family planning needs.

Dr. Michael Policar:

Other things that are important is that we want to make sure that she gets the services that have not yet been performed, but we don't want to duplicate things that she's already received. As a way of trying to minimize any sort of fragmentation of care that she might have by going to two different providers.

Dr. Michael Policar:

Now, let's talk a little bit more about how the well woman visit developed and what the various guidelines say about the content of well woman visits. First off, checkup examinations have been recommended in the United States since the 1920s and they've gone through a number of different names. Sometimes they're referred to as an annual physical exam or an annual visit, sometimes they're referred to as a checkup visit, but at least in terms of the literature and national guidelines, those are considered to be out of date terms. The visits that we'll be talking about this afternoon, the US Preventative Services Task Force refers to as periodic health screening visits. CPT Coding book refers to them as preventive medicine visits. ACOG for many years has referred to this as well woman visits, abbreviated the WWV, and that's what I'll be focusing on this afternoon is using the term well woman visit for periodic health screening visits for women of reproductive age.

Dr. Michael Policar:

Now, there are a number of objectives for women coming in for well woman visits. The most important of which are anticipatory guidance, being able to talk with her not only about her medical history, but whether or not she's engaged in any risky behaviors, and if so, helping her to avoid those risky

behaviors. Second is to screen for asymptomatic conditions, going all the way back to AMA recommended checkup visits in the 1920s, it was based on the idea that people might have symptoms or signs of diseases that to them were not significant enough to come in and be evaluated. So, one of the main purposes that we ask otherwise healthy and asymptomatic women to come in for their well woman visit is to evaluate them for asymptomatic conditions, and we do that primarily through a screening test.

Dr. Michael Policar:

We also know that for people who come in for periodic health screening visits that if they're told that everything is okay, they have a sense of well-being and satisfaction. If you're able to see the same client or patient over the years, you might develop more of a relationship with them because you see them more often. There's also some data which says that people who come in for checkup visits and particularly if they're told that everything is okay or they get anticipatory guidance, that they're more likely to take action toward maintaining their good health. In a family planning context, we have a more specific focus to make sure that the patient is happy with her method, and if not, to be able to discuss with her a variety of other methods that are available to her, to check her understanding of the correct and the consistent use of the method that she's chosen for family planning, as well as clarifying her reproductive intentions, and doing other interventions to optimize her reproductive health. Now, in some ways, it would be helpful if there were a single national guideline that defined the specific menu of well woman services, but unfortunately, we have to deal with guidelines coming from a number of different places. However, the good news is, is that they are mostly very close to each other, there are not very many divergences, and, in a few minutes, we'll be talking about where some of those divergences exist.

Dr. Michael Policar:

Probably the mother of all preventive services guidelines in the United States are produced by the US Preventative Services Task Force, and most primary care specialty societies, for example the American College of Physicians, which are the internal medicine docs, the American Academy of Family Physicians, and others, have simply adopted the US Preventative Services Task Force guidelines as their own. Most commercial health plans use these, as well.

Dr. Michael Policar:

ACOG has a similar, but slightly different set of guidelines for the well woman visits, which are called primary and preventative care guidelines. The American Cancer Society has screening guidelines for various types of cancers that I'll be referring to today. The federal title 10 program, operated from the Office of Population Affairs working with the CDC developed a group of guidelines that included well woman visits, which are called the QFP, providing quality family planning services. The Affordable Care Act itself has a whole menu of women's preventive services that need to be available to women without any cost sharing, and that's not an issue in Family PACT, of course, but for women who do have either MediCal or who have commercial insurance, they have to receive certain services that are either A or B recommendations from US Preventative Services Task Force or additional services that were added by the [CNS].

Dr. Michael Policar:

One of the things that I'll also be mentioning here is the recommendations that the US Preventative Services Task Force use, in terms of explaining how good the evidence is that we should be either routinely or more selectively doing a particular screening test. So, to the degree that a screening test has an A or a B recommendation, that's one that we should be offering to most people. C means that in a population of people, the benefits and the harms of a particular screening test are about an equal balance. In that circumstance, we have to make a decision, a shared decision-making with the patient, about whether or not that particular test will be right for her.

Dr. Michael Policar:

We'll also talk about some Ds and Is. A D is when a particular test has no benefit or when the harms outweigh the benefits. In that circumstance, we should abandon the use of the test and not do it routinely. Finally, we'll look at one or two Is, which means that there's just not enough evidence for the US Task Force to be able to make a decision.

Dr. Michael Policar:

Now, when you look at the ACOG well woman recommendation, and we've included a link to their website, you'll see that it's broken into different age groups. So, Marisella fits into that age group category of 19 to 39, where ACOG would give us their recommendations about screening, interventions, laboratory tests, evaluation and counseling, and immunizations for a woman in that age group, as well.

Dr. Michael Policar:

Now, some questions that come up commonly about well woman visits is, first off, is a physical examination necessary with every well woman visit? The answer is, is that you only need to exam particular areas of the body as needed for scheduled screening tests. For example, if a person like Marisella, who is 28, is receiving her cervical cytologies or pap smears every three years, then of course, we'd have to put in a speculum to do that pap smear on a three-year basis.

Dr. Michael Policar:

Then, of course, a persona might come in for a well woman visit and have other complaints, pelvic pain, irregular bleeding, vaginal discharge, dyspermia, and in that circumstance, she would need a physical assessment, not as a screening physical exam, but as a diagnostic exam when symptoms or signs are present, [inaudible]. It is important for us to realize that for many women who come in for a well woman visit that, that will primarily be a visit that's involved in counseling and education, and without any need for a physical assessment beyond a blood pressure check, as long as she's not due for a pap smear or if she has no specific signs or symptoms or complaints that need to be evaluated.

Dr. Michael Policar:

The next question is, do these well woman visits need to be done every year? The answer is it all depends on who you ask. The US Preventative Services Task Force says that well woman visits should be done everyone to three years, depending on the health status and the risk behaviors of the client. Meaning that if a woman is very healthy, has few or no risky behaviors, no chronic diseases, every two or three years is probably fine for her. On the other hand, if it's a person who has risky behaviors, chronic diseases, or just needs reassurance more often, the having a well woman visit every year is

equally acceptable. ACOG, on the other hand, still recommends that well woman visits be performed annually.

Dr. Michael Policar:

Now, I mentioned this guideline earlier because I think it's important for any of us who do family planning services, it's called the providing quality family planning guidelines, abbreviated as the QFP, and it's intended to be a companion to the CDC medical eligibility criteria, which has to do with the safety of using various contraceptives, as well as the selected practice recommendations from the CDC that are guidelines about how to help women effectively use their method of contraception. What the QFP does is it sort of fills in the gaps in what the other CDC family planning guidelines don't do. So, they contain sections on pregnancy testing and counseling, helping women to achieve pregnancy and managing basic infertility, preconception care, and then preventive health screening of both women and men, as well as a really helpful section on contraceptive counseling. This is yet another source of guidelines on well women visits.

Dr. Michael Policar:

What the QFP says is that given the fact that we only have a limited time with each patient, typically 15 or 20 minutes if you're seeing three or patients an hour, that there are some things that are considered to be core family planning services that need to be done at the time of a well woman visit. They include a discussion of reproductive life plan, helping a person, of course, make a decision about which method she'd like to use and then advising her about the safe and effective use of that contraceptive, assuming that she wants to avoid pregnancy for now. Screening for reproductive coercion or birth control sabotage, asking about sexual behaviors, and also sexually transmitted risk screening, asking her about alcohol, tobacco, and drug use, and also asking at least screening questions about a family history of breast and ovarian cancer. Now, those are considered to be mandatory for any family planning either initial visit or follow-up of, let's say, a well woman visit or periodic health screening visit.

Dr. Michael Policar:

The second level in the QFP guidelines or the cancer screening tests that we'll do, and we'll talk more about those in just a moment. Then they have a third level of visits which are called other preventive services. These are all things that are important for a woman's health status, both now and going forward, but they really don't have any direct relationship to the core family planning services. They are things like talking about a healthy diet or, "Have you seen your dentist," or things that you can do to prevent injury, or how to stop smoking or get into a drug treatment program or having vaccinations for things that are not directly related to reproduction. Or, for that matter, even screening for other kinds of cancers which are not related to reproduction.

Dr. Michael Policar:

Basically, the way that the QFP looks at these is that if we have time, after we've covered the core family planning services, that these are things that can all be addressed, that they really fall more into the domain of primary care and are secondary for us to do within the context of a family planning unit. Even if the patient doesn't have a primary care provider and even if we'd like to be able to do these, the other family planning topics that I just mentioned really have priority when we only have a limited amount of time with each patient.

Dr. Michael Policar:

So, let's go back to Marisella and talk about the kinds of tests that she needs. So, first, does she need any sexually transmitted infections screening test? This table basically refers to various screening tests for different types of sexually transmitted infections in different age groups. Remember that Marisella is 28 and in mutually monogamous relationship. With that being the case, she really doesn't meet the criteria for targeted screening for gonorrhea and chlamydia, she doesn't have any of the risk behaviors that would tell us that she needs to be screened for GC and CT.

Dr. Michael Policar:

The next possibility is HIV, and we have no evidence based on the history that I gave you that Marisella had ever been tested for HIV, so that would be an important screening test for her, given the recommendations from the CDC, the US Task Force, ACOG, and others, about a once in a lifetime HIV test, even for low-risk individuals. Finally, for syphilis, vaginal trichomoniasis, hepatitis C, none of those would be appropriate in her case, given the history that I gave you a few minutes ago.

Dr. Michael Policar:

Just to remind you very quickly about what the guidelines do say about routine screening for chlamydia and gonorrhea, I'll tell you about true important guidelines. One is the US Preventative Services Task Force guidelines that I mentioned at the beginning, and number two is guidelines form our own California Department of Public Health. I actually think that the CDPH guidelines are a little more specific and that makes them a little better.

Dr. Michael Policar:

So, when it comes to routine screening for gonorrhea and chlamydia, the US Task Force says that we should be screening all sexually active, non-pregnant women who are 24 years of age or less, annually, older women who are at increased risk, and for men, they make no recommendation about routine screening for gonorrhea and chlamydia. The California STD Control Branch adds to that, if your practice-site specific prevalence of gonorrhea or chlamydia is elevated, then you might screen everyone in your practice. The cutoffs are, if the chlamydia rate in your practice is three percent or more, or if the gonorrhea rate in your practice is one percent or more, that you should be doing routine screening for gonorrhea and chlamydia.

Dr. Michael Policar:

Now, an obvious question is, how do you find out what the rate of gonorrhea and chlamydia is in your own practice? The answer is, is that someone from your practice can get in touch with the laboratory that you use and make a request for, "Tell us about our rate of positivity for gonorrhea and chlamydia over the last year or two," you can even break that down by individual age groups. The best way to do that is by five-year age groups. When you have an age group of, let's say, women who are 26 to 30 who have rates of chlamydia higher than three percent or gonorrhea higher than one percent, then those are groups of people who should be screened routinely.

Dr. Michael Policar:

Now, the US Preventative Services Task Force goes on to define high risk or increased risk for gonorrhea and chlamydia as women who have had a previous or who have a concurrent STI, new or multiple sexual

partners, a sex partner who has other partners, a sex partner who had a sexually transmitted infection, inconsistent condom use among people who are not in a mutually monogamous relationship, and those who exchange sex for money or drugs. The trouble is, is that I don't find those guidelines very helpful in regard to defining new or multiple partners over what time period, for example.

Dr. Michael Policar:

That's, I think, one of the real values of the guidelines that were published by the California Department of Public Health a few years ago, where they say that gonorrhea and chlamydia screening in women 25 years of age and older, and when the practice site specific prevalence of gonorrhea and chlamydia in your practice is low, chlamydia's less than three percent, gonorrhea's less than one percent, basically you need to look at four things in deciding who needs to be screened. Does the woman have a history of gonorrhea, chlamydia, or PID within the last two years? Has she had more than one sexual partner in the last 12 months? Has she had a new sexual partner in the last 90 days? Or does she have reason to believe that her partner is having sex with other people in the last year.

Dr. Michael Policar:

If not, the question is, is it theoretically possible that your partner's having sex with someone else, or do you think your partner's having sex with someone else. It turns out that there's a low correlation with chlamydia or gonorrhea positivity if you ask the question in those ways. If you ask, " Do you have reason to believe that your sex partner has had other partners in the last year," that is correlated with a higher likelihood of being gonorrhea or chlamydia positive. This is a very simple way to ask four questions for women who are 25 and older about whether or not they need to be screened for gonorrhea and chlamydia. In Marisella's case, she answered, "No," to all those questions, and therefore, she doesn't need to be screened for either.

Dr. Michael Policar:

Now, what she does need to be screened for is for HIV because as I mentioned, ACOG and the US Preventative Services Task Force recommends that both men and women who are between 15 and 65 years of age be screened for HIV at least once in their lifetime. Then subsequently they should be re-screened at least once a year based on a variety of risk factors. So, injection drug users, sex partners of injection drug users, and so on down the list. I would add to that, that if Marisella, let's say with the pregnancies that she's had, if she was tested for HIV in the course of receiving prenatal care, for example, and her HIV test is negative, that counts as the once in a lifetime HIV test, but we learned from Marisella that given the fact that she's not been in prenatal care, she's not had a term pregnancy, she's never had an HIV test, and therefore, she does meet the criteria for this once in a lifetime HIV test given to low risk individuals.

Dr. Michael Policar:

The US Task Force says that only those persons who are at increased risk of syphilis should be screen for syphilis. That's men having sex with men, who account for two-thirds of syphilis diagnoses, men and women living with HIV, a history of incarceration or commercial sex work, certain racial and ethnic groups ... Oops, disappeared there for a moment. African Americans have higher rates of syphilis than Hispanics, which in turn are higher than White, and being a male less than 29 years of age. Probably most importantly is living in an area of what's called a hot spot. If you've been informed by your local county health department that you are practicing in an area that's considered to be a hotspot for

syphilis, then changes are good that most of your patients, if not all of them, will not be screened for syphilis. If you're not in a hotspot and your patient does not meet these criteria, then it's not necessary to screen for syphilis.

Dr. Michael Policar:

Now, let's switch over to metabolic screening. Is there anything that Marisella needs, given the fact that she wants to continue using birth control pills. In her age group, again remember she's 28, the recommendations state that she should have a blood pressure check at least every two years, as well as having her body mass index calculated. Remember, that's a combination of her height and weight. That's basically, according to guidelines, that's really all that needs to be done. Depending on whose guidelines you look at, that's screening for type two diabetes or for checking lipids. Basically she, based on the history that I gave you, is not a candidate for either diabetes testing or hyperlipidemia testing, but at the time of her well woman visit, we would want to check her blood pressure and also calculate her BMI.

Dr. Michael Policar:

Are there any special tests that need to be done relative to the fact that she wants to use oral contraceptives? She's been using them successfully; she'd like to be able to continue. Here, we're going to look at the CDC guidelines that I hope you're using called the US Selective Practice recommendations. This has a list of the tests that should be done based on what method of contraception a woman chooses to use. Given the fact that she is a successful user of oral contraceptives, the CDC guidelines recommend that we should check her blood pressure and her BMI, but there's no reason to check anything else on the list that has to do with her choice of using oral contraceptives. So, no reason for a bimanual pelvic exam, clinical breast exam, evaluation of glucose, lipids, liver enzymes, and so on, that have any linkage to safe use of oral contraceptives.

Dr. Michael Policar:

All right, so that's what we're going to offer to Marisella. The next question is, where are those areas that I mentioned earlier in the context of well woman visits? Which are quite controversial at this time and where there's sort of a moving target of what we might do and where we're going in terms of the content of the things that we discuss with women or the tests that we perform at the time of their well woman visit. I'm going to focus on four areas, reproductive goals counseling, changes in cervical cancer screening, whether or not it's necessary to do a screening clinical breast exam, and a screening pelvic exam.

Dr. Michael Policar:

First off, let's start with what I had mentioned earlier in the CDC OTA guidelines where they recommended that at the time of a well woman visit, we should discuss her reproductive life plan. That term has been used since the CDC published guidelines about preconception care in 2006, so it's been at least a decade that we have discussed this concept of a reproductive life plan and there have been various recommendations about how that actually be implemented as we do patient care.

Dr. Michael Policar:

The thing is, is that this has been evolving based on the fact that the term "plan" doesn't really resonate with some women because of cultural or religious or socioeconomic reasons. I'll tell you more about that in just a moment.

Dr. Michael Policar:

Now, reproductive life plan questions have been evaluated or defined in a lot of different ways. Originally, in the CDC preconception care guidelines, it was a fairly long list of questions. For example, do you hope to have children? Or if you have children now, do you hope to have more children? What is your ideal family size? How many children do you hope to have? How long do you plan to wait until you become pregnant? How much space would you like between your pregnancies? What do you plan to do until you're ready to become pregnant in terms of your family planning method and what can I do today to help you achieve your plan? It was a fairly long version of the questions that needed to be asked.

Dr. Michael Policar:

At the other end of the spectrum is best exemplified by a program that was pioneered in the state of Oregon, well over a decade ago, called One Key Question, which was really more focused on primary care providers than it was on us as reproductive healthcare providers, but the recommendation was that when a woman came to her primary care provider for her well woman visit, that the most important question to ask relative to her reproductive plans is, "Would you like to become pregnant in the next year?" They actually looked at many different ways of asking that question, they found that that was the one that people were most comfortable answering. They also came up with guidelines that were fairly binary like, "Yes, I would like to become pregnant in the next year," at which time you do preconception counseling and maybe some counseling about how to become pregnant and so on. Or if a woman said, "No, I don't want to become pregnant in the next year," then that would direct a whole series of interventions that had to do with family planning.

Dr. Michael Policar:

The thing is, is that we've come to realize that pregnancy intentions are not binary, they're not, "Yes, I want to get pregnant," or "No, I don't." It's much more complicated than that and what's now being referred to as a multidimensional concept. That is that plans are the decisions about when to become pregnant and actually the formulation of that action plan. It's a little different than intentions, it's timing-based ideas about if and when to become pregnant and can include wants without actual plans. Another level is a person's feelings or their emotional orientation toward pregnancy. Then their desires, which has to do with the strength of their inclination, either to get pregnant or to avoid pregnancy.

Dr. Michael Policar:

It's important to realize that as we're asking about pregnancy intentions, we understand that plans, and intentions, and desires, and feelings are all different concepts, and some women may find all of them meaningful, but others may only find certain ones a possibility, meaningful for them. What is difficult for us as clinicians to understand sometimes is that they often appear inconsistent with each other.

Dr. Michael Policar:

What do I mean by that? This is a really helpful way of looking at pregnancy intention beyond the binary, "Yes, I want to become pregnant," or "No, I don't." On the x-axis on the bottom is how strong they feel about her desire to avoid pregnancy. On the y-axis, it has to do with how strongly she feels about actually becoming pregnant. So, if a woman feels very strongly that, "I want to become pregnant and I have no intention of avoiding pregnancy," then that is what's referred to as a pro-natal response. On the other hand, if a woman says, "I have no desire at all to become pregnant and I will do everything I need to, to avoid pregnancy," that's referred to as anti-natal response. Those are the two ends of the spectrum, the binary approach I mentioned a moment ago, either "I want to be pregnant," or "I don't want to be pregnant."

Dr. Michael Policar:

There are two other categories. One is when a woman has relatively low desire to become pregnant, but she also has a relatively low desire to avoid pregnancy. That's what's referred to as an indifferent attitude like, "I can live with getting pregnant, I don't particularly want to, but if I get pregnant, that's okay." Then the fourth one is what's considered being an ambivalent attitude, "I very strongly don't want to become pregnant, but on the other hand, there's another part of me that really loves the idea of being pregnant like that," so there's no indifference here, they're very strong emotions and feelings and, "Part of me wants to be pregnant and another part of me does not want to be pregnant," and that's referred to as ambivalence.

Dr. Michael Policar:

An interesting thing about One Key Question is that it has evolved over time from a binary answer of yes or no, "Would you like to become pregnant in the next year," to one that's a little more nuanced, "Yes, no, I'm not sure," in other words, "I'm ambivalent," or "It's okay either way." Basically, now there are four different algorithms that help us as clinicians to advise women based on the answers they give. They say, "Yes," we can help with preconception care and ideas about how to get pregnant. If, "No," then we'll talk with them about their plans for preventing pregnancy. The women who are okay either way, are more or less indifferent, the ones who are unsure, is, "A part of me wants to get pregnant, a part of me doesn't," and by the way, on the One Key Question website, they provide algorithms for each of the four different pathways.

Dr. Michael Policar:

The one thing I'd like to mention is that another approach is becoming fairly widespread. I think this is really nicely done, published in an article by Lisa Callegari and a number of other investigators in the American Journal of OBGYN last year. It's called the PATH questions, PATH, which means Pregnancy Attitudes, Timing, and How important is pregnancy prevention. Instead of the things that I mentioned to you a moment ago about these various either short term or single question approaches that we might take, basically you ask three questions. The first is, "Do you think you might like to have children at some point?" Or, "If you already have children, would you like to have more children at some point?" Then the next question is, if she says yes, "When do you think that might be," and "Would you like to become pregnant in the next 12 months?" Then the third question in the PATH approach is, "How important is to you to prevent pregnancy until then?" That gives you some idea about her resolve to prevent pregnancy or not. So, again, sort of a shortcut to getting at what her pregnancy intentions are without using the

word "plan" in a way that's been field tested and seems to be quite successful as a way of evaluating pregnancy intentions.

Dr. Michael Policar:

Now, let's go to the next of the controversies, which is around the area of cervical cancer screening. Where we stood in 2016 was quite a great deal of agreement between various approaches to cervical cancer screening. The US Preventative Services Task Force on the first line, what's called the Triple A guideline on the second line, which was the ASCCP, the American Cancer Society, and one of the pathology organizations, and the third being ACOG.

Dr. Michael Policar:

Basically, they all agreed that in the first column, for women under 21, that they should not be receiving any cervical cytology screening at all. One exception to that is women under 21 who are HIV positive. For women between 21 and 29, the recommendation is a cervical cytology every three years. Then for women 30 and older, either co-testing, which is cytology plus an HPV test every five years, or cytology alone every three years. We've been doing this for quite a while and quite successfully. However, the FDA approved a test about two or three years ago referred to as the cobas HPV test. Recently, they also approved the second test for this purpose, which is called primary HPV screening. In this particular approach, a woman comes in, has a sample taken from her vagina, and sent to a lab. It's evaluated for 14 different types of human papilloma virus. If it is HPV negative, then she's re-screened three years later. Now, at the bottom, if she is HPV16 or 18 positive, then she goes straight to colposcopy given the fact that infection with HPV16 is considered to be very high risk for having an underlying high-risk dysplasia, like a CIN2 or a CIN3. Then the middle pathway is that if she tests positive for one of the 12 other HPVs, then the next step is actually to do a cytology or a pap smear as the reflex test, as the backup test. If that comes back normal, then she has a follow-up HPV test 12 months later. On the other hand, if the cytology is ASC-US or worse, then she's referred to colposcopy. So, basically, to summarize this, instead of starting with a pap smear or a cytology, you start with an HPV test, most women will test negative, the 16/18s will go straight to colposcopy, and then women who test positive for other HPVs have a reflex cytology done.

Dr. Michael Policar:

Now, once this was FDA approved, a number of organizations, the Society for Gynecologic Oncology, ASCCP, ACOG, American Cancer Society, and others came up with guidelines about how to use this test. They said that if HPV alone is done then it shouldn't be started until 25 years of age, should not be done before that age, and when a woman screened negative for HPV, her screening test should be repeated no sooner than every three years. They also went on to say that the advantage of primary HPV only screening was that it had better sensitivity for picking up a CIN two or three than a pap smear alone.

Dr. Michael Policar:

It was less expensive than co-testing because for most people it meant only an HPV test and not a pap smear, and it was very adaptable to using this as a cervical cancer screening strategy in low resource countries. The trouble is, is that there are a significant number of people who are HPV positive who don't have high grade dysplasia, but nonetheless, many of those women will be referred to colposcopy only to find that it was a false alarm, and they don't actually have a lesion. So, while this has a higher

pickup rate for high grade dysplasia, it does have more false positives, meaning that more women will have colposcopies.

Dr. Michael Policar:

Now, last year, the US Preventative Services Task Force came up with a draft of an update for cervical cancer screening. By the way, this is still in draft form, it's not finalized yet, probably will be in the next month or two. What the US Task force suggested is that high risk HPV alone replace co-testing in women between 30 and 65 years of age. Then a woman tests negative for high-risk HPV, that her next test could be in five years rather than in three years, which is what the guideline I mentioned a moment ago recommended. So, the rationale for that was that co-testing actually increases follow-up testing by two-fold in comparison to HPV alone, but really doesn't improve on the pickup rate of high-grade dysplasia lesions. They also felt that the five-year interval, primarily based on European studies, was the best balance of harms and benefits. I was just at the ASCCP National Colposcopy Meeting in Las Vegas last week, there was a lot of discussion about this, but I think in general, among colposcopy experts, there's a lot of support for this particular approach. Although they'd like to see co-testing phased out rather than immediately going away.

Dr. Michael Policar:

So, assuming that the US Preventative Services Task Force actually does finalize the guidelines that I mentioned a moment ago, the main area of change will be for women 30 to 65 years of age, who will now have the option of a cytology every three years, or an HPV only test done every five years, in comparison to the co-test that was in the previous guideline every five years.

Dr. Michael Policar:

Now, there are not very many labs that are offering this yet in California, nor is it a Family PACT benefit yet, but it is the direction that we're going in, in terms of cervical cancer screening, and those people are thinking that using cytology, particularly in women 25 and older, will slowly disappear and be replaced with primary HPV screening.

Dr. Michael Policar:

The next area of controversy has to do with the screening clinical breast examination. This summarizes breast cancer screening guidelines that have been published by the US Preventative Services Task Force in the first column, ACOG in the second column, and the American Cancer Society in the third column. We'll only have time today to talk about the areas that I've highlight in red, which have to do with clinical breast exams. So, this is the breast exam that we do for women 21 and older when they come in for a well woman visit, but have no complaints related to their breasts, no nipple discharge, breast tenderness, lumpiness, anything else, they're in for a well woman visit. Significantly, in 2015, the American Cancer Society no longer recommended this screening breast exam. ACOG now says that, that should be based on a shared decision.

Dr. Michael Policar:

Specifically, what the American Cancer Society said is that they do not recommend screening clinical breast examination among average risk women at any age. The reason that they say that is that there's no evidence of any benefit of clinical breast exam by itself or done at the same time as a mammogram, in terms of whether or not it actually leads to a higher pickup of breast cancer, a better survival in

women who are diagnosed with breast cancer. However, there is moderate-quality evidence that adding clinical breast exam to mammography actually increases the rate of false alarms, the false-positive rate. So, it really doesn't seem to be doing much good, but it does seem to be doing some harm. Now, they do acknowledge the fact that clinical breast exam detects a small number of additional breast cancer cases, somewhere between two and six percent of all breast cancer patients, which are missed by mammography alone. On the other hand, given the harms of screening clinical breast exams, false-positive tests that lead to workups that women don't need, the American Cancer Society is recommending that we no longer do them in women who have no symptoms.

Dr. Michael Policar:

I think that this is an important quote from the ACS guidelines. "Recognizing the time constraints in a typical clinic visit, clinicians should use this time instead for taking a family history," particularly about gene mutations like the RCA one and two, a family history of breast cancer in a mom or sister before menopause, "And counseling women on the importance of being alert to breast changes and the potential benefits, limitations, and harms of mammography." In other words, focus on what works, which is looking for the possibility of a hereditary breast cancer risk and talking to women about mammography, rather than doing a clinical breast exam in women who have no symptoms.

Dr. Michael Policar:

Now, even ACOG has pulled back on their recommendation, which had previously been that women who are older than 21 should have a clinical breast exam everyone to three years between 21 and 39 years of age. Now they say that screening clinical breast exam can be offered in the context of shared decision-making, where we inform women about the benefits and harms of a clinical breast exam, and that for women who choose to have them, for women between 19 and 39, that they should still be done everyone to three years. So, even ACOG no longer recommends that every woman needs a screening clinical breast exam if she has no symptoms, and that's true, by the way, regardless of which method of contraception she's using.

Dr. Michael Policar:

All right, let's get to our last discussion and then in our final time then I'll talk very briefly about coding.

Dr. Michael Policar:

This one has to do with the screening pelvic examination. For decades, we've been doing screening bimanual pelvic examinations primarily as a way for looking for ovarian cancer. However, the US Preventative Services Task Force has said over the last 25 years that there is no good way to screen for ovarian cancer in asymptomatic women, whether that's pelvic exam, CA125, ultrasound, none of them are recommended.

Dr. Michael Policar:

Now, in this discussion about screening pelvic exam, we're only talking about a vulvar inspection, speculum exam by manual exam at the time of a well woman visit in an otherwise asymptomatic patient. That's different than a diagnostic pelvic exam in a woman who has complaints or putting in a speculum to do a pap smear.

Dr. Michael Policar:

So, historically, we have considered the potential benefits of a screening pelvic exam to look for ovarian cancer or let's say a benign ovarian tumor, a dermoid, for example, that could become torse, an ovarian torsion, which may cause her to lose her ovary, in a woman who's otherwise asymptomatic. Or we might find a symptomatic condition that a patient's just unwilling to disclose to us, or she doesn't recognize that it's a problem. Maybe she has urinary incontinence or pelvic organ prolapse or sexual issues like genital urinary syndrome of menopause, or maybe has a high-grade lesion of her vulva, and she just didn't realize that that was a problem.

Dr. Michael Policar:

However, there is some evidence that there are a variety of things that have been promoted as maybe reasons to do a screening pelvic exam where there's fairly good evidence that it's not worthwhile. So, when it comes to looking for trichomoniasis or bacterial vaginosis or VIN, or fibroids, or urinary incontinence, or changes in the vagina that occur during menopause, there are either no studies which support doing them or other ways we can find out about them.

Dr. Michael Policar:

So, part of how this whole debate came to a head was that in 2014 the American College of Physicians came out with their recommendation that basically said that we shouldn't be doing the screening pelvic exams based on the fact that the accuracy of finding ovarian cancer was quite low, there were no studies that assessed the benefit of screening pelvic exams for other conditions like PID, fibroids, other kinds of GYN cancers. Outcomes are definitely not improved in terms of reducing ovarian cancer mortality, we know that from some very large studies that have been done in both in Europe and the US. We know that sometimes with the false alarms that occur, that there is harm done to women based on findings in a pelvic exam. So, unnecessary laparoscopies or laparotomies, fear and anxiety that goes along with a false-positive test, embarrassment, pain, and discomfort from having a pelvic exam in the first place, and it adds unnecessary cost.

Dr. Michael Policar:

The American College of Physicians said in this recommendation that we should not be doing screening pelvic exams in asymptomatic, non-pregnant women because it's a low value care, it should be omitted.

Dr. Michael Policar:

ACOG on the other hand has kind of evolved over time. In 2015, they said that for women 21 and older, that we should do a once a year look at the vulva and then inclusion of a speculum exam, a bimanual exam, or both should be a shared informed decision between the patient and the provider. In other words, when we see women for a well woman visit, we should tell the about the pros and cons of having a bimanual pelvic exam and let them decide whether or not they want to have that done.

Dr. Michael Policar:

Then finally the US Preventative Services Task Force got in the middle of this debate and in March 2017 did a reassessment of all the literature out there and said, "You know what? We still can't make a decision. The current evidence is insufficient in order to assess the balance of the harms and the benefits of performing screening pelvic exams." To quote them directly, they said that "Clinicians are

encouraged to consider risk factors for various gynecologic conditions like fibroids and the patient's values and preferences and engage in shared decision making to determine whether or not to perform a pelvic exam."

Dr. Michael Policar:

This is a tough one for us. ACOG says, "We think we know, go ahead and do it, but discuss it first." The American College of Physicians says, "We know you should not be doing a pelvic exam." The US Task Force says, "We don't know, but you may want to discuss it with the patient." So, we've got three national organizations that have three different viewpoints about whether or not we should be doing screening pelvic exams.

Dr. Michael Policar:

So, what are we supposed to do as clinicians? Well, an active approach would be to say, there are three national guidelines, each one's different, all three of those guidelines agree that there's no benefit of a bimanual pelvic exam if you don't have any symptoms, but there is evidence of false alarms and complications. A passive approach is just not to say anything about screening pelvic exams and only do it if the patient asks for one or to respond to questions about whether or not she should actually have an exam.

Dr. Michael Policar:

Let's finish up with our discussion about Marisella. This will only take a few more minutes and then I'm happy to address your questions. So, we know a little bit about Marisella's reproductive background, she's now done with her well woman visit. Her blood pressure and her BMI were recorded, a screening breast exam was done because she asked to have that performed, but she declined a screening pelvic exam. She was dispensed 13 cycles of oral contraceptives. The face-to-face time with Marisella was a half hour and the time that she was counseled was 22 minutes. So, the question is, is how would you code her visit on the encounter form?

Dr. Michael Policar:

Remember whenever we as clinicians check off an encounter form or a super bill, that we're trying to tell the payer, in this case Family PACT or with other patients it might be MediCal, basically what we did, why we did it, and if we need to, to give an additional explanation to a modifier. What we did or the services we performed, that's going to be a CPT code procedure or an [ENM] visit, drugs or supplies that we might have provided. Why we did it, which is the ICD-10 diagnosis and occasionally we need to use a modifier. So, in order for Family PACT, MediCal, any other payer to establish medical necessity for every "what", which is the ENM code or the CPT code, there must be a "why" which is the ICD-10 code. Every now and then, you need to explain unusual circumstances with a modifier.

Dr. Michael Policar:

Remember, there are two different ways to calculate an E/M level. One is what's called the key components, which are history, physical, medical, decision-making, or we use time, but we can only use time when at least 50% of their visit was spent in counseling and coordination of care. This is just a quick reminder that when you bill on a basis of time it falls into two tables, one is for new patients on the left, on the right is for established patient, and Marisella is an established patient, and then how much face-to-face time she actually spent with the clinician. Given how much time she spent with the clinician, I

mentioned it was 30 minutes, then this qualifies as a 99214 visit and at least half the visit was spent in counseling.

Dr. Michael Policar:

Now, for other payers, there's a set of codes called the preventive medicine visits. By the way, MediCal and Family PACT do not recognize these, but other payers may. It's based on for people who come in for a well woman visit or a checkup visit for men, whether you're a new patient or an established patient, given Marisella's age is 28 and she's an established patient, with another payer that one might come out as a 99395 for this preventive medicine visit.

Dr. Michael Policar:

Just to remind you, for that code set, it's specifically intended for checkup visits and it's based on your age and gender appropriate history, but only as much physical exam as is indicated. Marisella's case, that was just a blood pressure check and checking her weight. It also includes counseling, anticipatory guidance risk reduction, ordering laboratory tests, and addressing insignificant problems. In this particular code set, face-to-face time or physical exam components are not used.

Dr. Michael Policar:

Now, what else did we do for her? We gave her 13 cycles of birth control pills, so we use what's called a HCPCS code that's used in MediCal and Family PACT to show that, S4993 for contraceptive pills. Also, we did a well woman visit, which is an encounter for a routine gynecologic exam, Z01.411, which is a GYN exam without abnormal findings.

Dr. Michael Policar:

In addition, we evaluated her use of birth control pills, she was using them before and continued on birth control pills, and that has its own ICD10 code, which is Z30.41, surveillance of contraceptive pills.

Dr. Michael Policar:

The Family PACT answer to the way that you would code this visit is that there were no procedures, no supplies, she was given 13 cycles of birth control pills, so that's S4993 times 13 units. She had an HIV test ordered, but your clinic is not going to bill for that unless it's a point of care HIV test, the lab is going to bill for it, however, on the lab slip, you need to indicate what her method of contraception is, so that's the Z30.41, which is to say she's a pill user. Now, in Family PACT, you would code this visit as a 99214 as the E/M code, and the diagnosis codes that you would list are Z01.419, which is her GYN exam with no abnormal findings, and a Z30.41, which is surveillance of a contraceptive pill user.

Dr. Michael Policar:

Now, if she were not a Family PACT or MediCal patient, then it may be that the payer in that circumstance would either cover the 99395, which is preventive medicine visits, or as a problem visit, basically. The last slide basically just has some advice about how you decide which of those codes to use.

Dr. Michael Policar:

So, let's wrap it up then and I'll answer a few of your questions. I think the important take-home messages from this webinar are that the well woman visit has shifted from the examination room to the consultation room. What I mean by that is that in the majority of cases now for women who come in for a well woman visit, they are very much like Marisella, in even in their 30's and 40's, where basically the only physical assessment which is needed is a blood pressure check and checking their weight, unless they're due for a cervical cytology test or unless of course they have symptoms. There's less physical assessment and more counseling in the well woman visit.

Dr. Michael Policar:

Number two is that shared decision-making is much more prominent. When we talk about reproductive intentions or a family planning method that would be most appropriate for the patient, or whether she wants a screening breast or pelvic exam. We didn't talk about mammography, but the age at which to start mammography. These are not black and white issues and therefore, we use shared decision-making to be able to discuss those decisions with our patient.

Dr. Michael Policar:

Debate continues regarding the value and the timing, and certain components of the well woman visit, but particularly cervical cancer screening, which tests should be used, the interval at which they're offered, whether or not to do screening breast exams and screening pelvic exams. Also, to remember that not all recommended components of a well woman visit have to be done at the same visit or necessarily by the same provider, that we need to coordinate those services to make sure that everything that needs to get done will be performed, but that we don't duplicate things.

Dr. Michael Policar:

Remember that the ACA still removes the need for out-of-pocket costs for virtually every component of the well woman visit. Again, not an issue in MediCal or in Family PACT, but that is important for your patients with other kinds of insurance where the ACA is still the law of the land and most preventive services are available to women without any out-of-pocket cost.

Dr. Michael Policar:

Other things that you can do to prepare for these kinds of evolutionary changes is be sure to ask every patient if she also has a primary care provider. Determine the screening policies for your practice, try to look for consistency among your providers. It's very [inaudible] for a patient if, let's say, one of the nurse practitioners tells a patient, "Oh, you know, you really don't need a breast exam or a pelvic exam," and then she comes back maybe a few months later and is told by a different clinician, "Oh yeah, that's something which should be done." When It comes to screening tests, try to develop a policy within your practice that specifies how you all want to do things in your practice, and make sure that everyone, the front desk, front office people, the back-office RNs, and all the clinicians are aware of the policies for your practice. Inform your clients of the changes that apply to them and also keep track of benefit changes that are made by your payers. Most benefits have not changed yet regarding screening, although things like not doing cytology on women under 21 are already very well established, but over time, we may see changes in the policies of payers to be more consistent with what I've mentioned.

Dr. Michael Policar:

One last word and then we'll take questions. That is, I know I gave you a lot of information, but if you're a person who really likes to use medical apps, there are three of them that are really good, that have to do with well woman visits. First is one that's actually published by the US Preventative Services Task Force, it's called the ARHQ Electronic Preventive Services Selector, and it will tell you what the US Task Force basically recommends for someone like Marisella.

Dr. Michael Policar:

The second is the NPWH Center, Nurse Practitioners in Women's Health, had a really nice app that references quite a number of different guidelines for well woman visits. Then I mentioned the QFP on a number of occasions here and the QFP has its own app, as well, which you can get at FPNTC, that's the Family Planning National Training Center in Kansas City put together this app and it basically gives you really nice shortcuts to getting to the contents of the QFP in regard to what it recommends for well woman visits.

Dr. Michael Policar:

That, I think, is my last slide. I'm going to wrap up the didactic portion of the webinar and now go to a few of your questions. Let me find them here. Okay, so, first question that's on the list is, "What are the California hotspots for congenital syphilis?" There are a number of them that I could tell you about off the top of my head, otherwise, I would certainly go to the California Department of Public Health website or just check with your local county health department. I know that there are certain parts of Los Angeles and Orange County that are considered to be hotspots. I understand that Fresno is considered to be a hotspot and then certain parts of the East Bay here in northern California in East Oakland, for example. Beyond that, I really can't tell you off the top of my head, but in the Q&A, which will be posted on the familypact.org website, we'll try to give you more specific information from the California Department of Public Health about those areas that are considered to be hotspots for congenital syphilis.

Dr. Michael Policar:

Second question is, "For women thinking that they don't want to have kids, wouldn't we suggest counseling regarding LARC, as well as sterilization?" Well, absolutely. In that very first question in the PATH questions that I told you about earlier is, "Are you thinking about ever having kids or if you have kids currently, do you think you want to have more?" There are some patients who will say, "Look, I am absolutely, 100% positive that I don't want to have a child or another kid in the future," in that circumstance, it's certainly worthwhile to at least include tubal occlusion and discectomy as part of the discussion. On the other hand, there are those women who will say, "I don't think I want to have more kids, but I'm not so sure about that," and of course, a discussion about one of the LARC methods, an implant or an IUD, is completely appropriate in that circumstance because people change their minds and we know that both implants and IUDs work just as well over a long period of time as surgical sterilization does, but of course they are completely reversible for the person who may at some point want to revisit the question of childbearing. All right, next is, "How would you respond to a woman who is insistent that she have a pap smear annually?" That's really tough just because of the fact that there are some patients who, consumers basically, who from the time that they were little girls were told about how important it was to have a once-a-year pap smear. The way that we try to respond to that,

where I've worked over the years at San Francisco General, is to remind women that pap smears not only have benefits in picking up pre-invasive conditions of the cervix, but that they also have risks. That if you do pap smears too often or at an age, time in a women's life, when they're not indicated, that you're far more likely to get harms than you are benefits. If you screen too often, what that leads to is the possibility of more false positives that lead to unnecessary colposcopies, potentially even treatments like leaps, and cryotherapy, and other treatments that might be unnecessary, as well.

Dr. Michael Policar:

For the patients that I've had who just insist, "No, I don't want to use the three-year interval, I want a pap smear every year," my response to that is that "Given the fact that your pap smears have been negative so far and given your age group, to do a pap smear once a year is actually to do you more harm than it is good. I'm giving you very strongly felt advice that you should try to live with the intervals that are considered to be national standard of care now because if we screen you too often, it has the possibility of hurting you without helping you." I'm going to have a patient who didn't get that. I think this discussion is a lot more than just saying, "You know what? There are harms or false alarms or false positives, but if I screen you every year instead of every three years, I'm not going to really get any additional benefit, I'm not going to improve the pickup rate for a high-grade dysplasia. So, I don't want to expose you to something that will potentially hurt you without really helping you, that's why we really want to stick with the three-year screening interval with cervical cytology or the five-year screening interval with either co-testing now or HPV testing alone as we transition to that in the future."

Dr. Michael Policar:

Next question, "Regarding billing, isn't the OC code the primary code and not the Z01.419?" The question is, [inaudible], the primary code in Family PACT would be the method that the patient is using. It's a great question and an important observation, and it points out the difference in the categorical program like Family PACT, where it's absolutely important and necessary to have the ICD10 code for the fact that she uses oral contraceptive in the claim, it absolutely has to be there. However, the way that things work is that the way that the CPT book is written, if it says that what you're supposed to list on the first claim line is the main reason that the patient came in for the visit in the first place. Which in Marisella's case was she was there for a well woman visit and, "By the way, I'm also here because I want to take birth control pills for another year." Those are sort of equally important.

Dr. Michael Policar:

I think in terms of making sure that the Family PACT claims are done correctly, and by the way, this very likely will not be done by you as a clinician, it's going to be done by someone in the billing office, is that they will list the primary code for a Family PACT patient as the method of contraception that she's using. The secondary code will be her well woman visit. With other payers, it would be equally reasonable to list the checkup code first, Z01.419, and to list the maintenance of oral contraceptives secondly. The point is, is that most billing systems are going to pick up both codes and they're going to be considered to be acceptable. In Family PACT, it's a really good point that what the biller is going to want to do is to list the family planning code first and the checkup code second.

Dr. Michael Policar:

Now, a follow-up question is, "If my patient does have a primary care provider and she's already been seen in this calendar year for a checkup, should I not bill the 99395 preventive medicine visit when she

comes to see me for a well woman visit planning code?" You know, that's going to be very provider specific. Before the days of the Affordable Care Act, many payers, and this is true of commercial health plans like Health Net and others, would only pay one preventive medicine visit a year. In other words, their claim systems were programmed in such a way that they would only pay one 99395. Oops, I lost you there for a minute. They would only pay one 99395 and that was it.

Dr. Michael Policar:

The way things work with the Affordable Care Act, with the new cost sharing, there's very specific language that says that well woman visits may take more than one visit, it may take two or three visits during the year. That being the case, the payer really should be paying the 99395 more than once. Now, a way of avoiding denials on that might be something that your biller puts into the remarks box which says that the well woman services took more than one visit during the year. The point is, is that you should not be running into any problems of using that more than once during the year.

Dr. Michael Policar:

I just got the red lights saying we have to wind up but do remember that this recording will be available and that the Office of Family Planning will publish the text of the Q&A on their website and will be more specific in some of our answers.

Dr. Michael Policar:

Thank you very much for hanging in there with us.

Renyea Colvin:

Thank you, Dr. Policar for a very informative and engaging presentation, we really appreciate that, and we are ending right on time. Just to let participants know, the evaluation link and the PowerPoint slides will be remaining on the screen for a few more minutes so that you can grab those. Anyone who has registered via email will receive the recorded webinar and the answers to any remaining questions in their inbox.

Renyea Colvin:

Thank you everybody for participating and have a great day.