interChange Provider Important Message

FAQs Provision of Immediate Postpartum LARC in the Hospital Setting

Billing and Coverage Questions

1. Is immediate postpartum LARC insertion bundled or is it paid separately?

Hospitals will be separately reimbursed for a LARC device provided immediately postpartum in the inpatient hospital setting when the LARC is billed on an outpatient claim. The services related to the labor and delivery provided by the hospital will continue to be billed on the inpatient hospital claim and reimbursement for the LARC will be made to the hospital in addition to the Diagnosis Related Group (DRG) reimbursement for labor and delivery.

Please contact your institution's billing and coding department to set-up this process.

2. Who supplies the LARC devices in the inpatient setting?

The hospital must buy the LARC devices and after they provide it to the HUSKY member the hospital can submit for reimbursement on the outpatient claim.

3. What is the process for hospital reimbursement for immediate postpartum LARC?

Hospitals will submit for reimbursement of a LARC on the outpatient hospital claim using RCC 253 (take home drugs), the applicable Healthcare Common Procedure Coding System (HCPCS) code and the applicable National Drug Code (NDC) for the LARC provided. Please note that the HCPCS and NDC should match for the specific LARC device provided to the HUSKY member.

RCC 253 (take home drugs) has been loaded for all hospitals to use and can be used only when billing for a LARC device. Please refer to the table below for the HCPCS codes and the applicable description.

HCPCS Codes

J7297	Levonorgestrel iu 52mg 3 yr
J7298	Levonorgestrel iu 52mg 5 yr
J7300	Intraut copper contraceptive
J7301	Levonorgestrel iu 13.5 mg
J7307	Etonogestrel implant system

The place of service code (POS) on the outpatient claim for the LARC should be designated as inpatient hospital (POS 21).

Due to current MMIS system limitations, one set max fee of $810.57 will be reimbursed for a LARC billed by a hospital until July 2016. Effective for dates of service on or after July 1, 2016 reimbursement for LARCs will be determined by the specific HCPCS code billed for the LARC device inserted/placed and the rate will be determined by the rate for the HCPCS published on the physician office and outpatient fee schedule or, for 340B hospitals, the family planning fee schedule.

4. How does a practitioner bill for immediate postpartum LARC?

Practitioners can submit a claim for the professional service associated with the insertion/placement of a LARC immediately postpartum to an inpatient delivery on the CMS 1500 and the practitioner will be reimbursed outside of the DRG as outlined in PB 2014-20.

5. What are the codes to bill for immediate postpartum LARC insertion?

Subdermal implant insertion	CPT: 11981	ICD-10: Z30.018
IUD insertion	CPT: 58300	ICD-10: Z30.430

6. Can I put in another IUD if a postpartum IUD has been expelled? How is that going to be charged?

Medicaid will cover for replacement; however, only one device (implant or IUD can be inserted per day). In a training settings, sometimes institutions have special arrangements with the manufacturers for devices. Please contact your institution and/or manufacturer directly if this applies to your practice setting.

There is no lifetime limit per patient of how many intrauterine devices can be placed.

7. Is immediate postpartum LARC covered for patients with Emergency Medicaid?

No, immediate postpartum LARC is <u>not</u> covered for patients with Emergency Medicaid only.

8. **What resources do patients with Emergency Medicaid only have in accessing contraception?**

Patients can also receive contraception services at local Planned Parenthood providers or community health centers according to their self-pay fee schedule.

Some academic institutions provide LARC devices to uninsured or underinsured patients through grant programs. We encourage these institutions to give these patients a written document of local health centers where they can go if they have problems with their LARC device or desire its removal.

Find a local Planned Parenthood:

https://www.plannedparenthood.org/health-center/CT

Find a local community health center:
http://www.ct.gov/dph/cwp/view.asp?a=3138&q=406054

9. **Are there specific codes for hospital-based services that are performed by mid-level practitioners (non-physicians)?**

The codes are the same. Reimbursement is 90% of physician-fee, which is the standard across Connecticut Medicaid reimbursement policy.

10. **Does immediate postpartum LARC affect the global fee payment for OB care?**

The global fee payment is not affected by provision of immediate postpartum LARC. The global fee for OB care should be only billed if a patient completes prenatal care, delivery, and a postpartum visit in the same facility or practice. Attendance rates at the postpartum visit do not affect Medicaid reimbursement rates.

Clinical Practice Questions

11. Why is access to immediate postpartum LARC important?

LARC methods are the most effective types of contraception with high rates of patient satisfaction and continuation.1 Many women are motivated and interested in receiving LARC methods in the postpartum period.2 This makes the immediate postpartum period, an ideal opportunity to offer and initiative highly effective contraception.

Growing evidence demonstrates that adequate pregnancy spacing is beneficial for maternal and child health.3-6 A short interpregnancy interval, defined as less than 18 months between a birth and subsequent pregnancy, is associated with low birth weight and prematurity as well as maternal health complications.4 LARC methods can increase birth spacing and help reduce preterm birth.7

For more information, please visit:

ACOG Practice Bulletin #670 (August 2016): Immediate Postpartum Long-Acting Reversible Contraception

http://www.astho.org/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception/LARC-Fact-Sheet/

12. When can immediate postpartum LARC devices be placed?

The American College of Obstetricians and Gynecologists and the Center for Disease Control have well established the safety of LARC in the immediate postpartum period and in women who are breastfeeding.

IUDs can be placed within 10 minutes of delivery of the placenta after vaginal or cesarean section delivery. Subdermal implants can be placed any time during the inpatient postpartum stay.

For more information, please refer to:

ACOG Practice Bulletin #670 (August 2016): Immediate Postpartum Long-Acting Reversible Contraception

CDC Medical Eligibility Criteria (updated July 2016)

http://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm?s_cid=rr6503a1_w

13. Where can I get trained to do immediate post-placental IUD insertion? Do I need specific training before I can start placing post-placental IUDs?

Placement of an intrauterine device immediately postpartum requires a special technique. There is no specific training or credentialing process for immediate postpartum insertion. We recommend you speak with your credentialing department and/or medical director of maternity services at your institution to confirm.

Resources for training are available on the ACOG website.
https://www.acog.org/-/media/Departments/LARC/IPPLARCResourceDigest-2-12-16v2.pdf?la=en

A sample protocol from Colorado for immediate postpartum intrauterine device is available at:
http://www.astho.org/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception/Post-placental-IUD-Protocol-Colorad/

14. Where can I get trained to do immediate postpartum insertion of the subdermal contraceptive implant?

Insertion of a subdermal contraceptive implant in the immediate postpartum period is no different than standard insertion.

Training for implant insertion is available through the manufacturer.

Please visit their website at:
http://www.nexplanon-usa.com/en/hcp/services-and-support/request-training/

15. Does immediate postpartum LARC insertion affect breastfeeding?

Although older studies have described a theoretical concern regarding introduction of exogenous progestin and its effects on breastfeeding, the CDC Medical Eligibility Criteria states that the advantages outweigh the risks of initiating progestin-only contraception immediately after birth and for combined hormonal methods at 1 month postpartum.

In a recent Cochrane review, most recent trials did not show significant differences in breastfeeding duration, breast milk composition, or infant growth between women on hormonal contraception and the control group. Negative effects on breastfeeding parameters were described in older studies but had limited data reported.

The full summary of the Cochrane review can be found here:

http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003988.pub2/epdf

All contraception options should be discussed with breastfeeding patients. Practitioners should discuss these concerns within the context of a woman's plan to breastfeed and her risk of unintended pregnancy and desire to start contraception. Breastfeeding support should be given to all women who desire to breastfeed.

For more information, please refer to these ACOG resources:

> ACOG Practice Bulletin #670 (August 2016): Immediate Postpartum Long-Acting Reversible Contraception
>
> http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice

16. Is a postpartum IUD that is expelled considered a "failure" or can the patient get another one?

Expulsion risk with post-placental IUD placement is a consideration. The rates of expulsion range from 5-30% depending on the study and if it is placed at time of vaginal delivery or cesarean section. In general, an expelled IUD that is placed immediately postpartum is not considered a "failure."

For more information regarding the data on expulsion risks, please refer to:

> Lopez LM, Bernholc A, Hubacher D, Stuart G, Van Vliet HAAM. Immediate postpartum insertion of intrauterine device for contraception. Cochrane Database of Systematic Reviews 2015, *Issue* 6*. Art. No.: CD003036. DOI:* 10.1002/14651858.CD003036.pub3
>
> http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003036.pub3/abstract;jsessionid=8A18159D4E45900B47AA01C67EBA8919.f01t03#pdf-section

17. Which patients should not get immediate PP LARC?

In general, patients with a distorted uterine cavity or patients that have been treated for intrapartum infection such as chorioamnionitis or endometritis or have active pelvic inflammatory disease or cervicitis, should not receive an immediate post-placental IUD but could still obtain a subdermal implant if they desired that method. The only absolute contraindication to the inserting a subdermal implant is active breast cancer.

CDC Medical Eligibility Criteria (updated July 2016)
http://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm?s_cid=rr6503a1_w

18. Is a patient able to get an immediate postpartum LARC device following a miscarriage or an induced abortion?

If patients are admitted for inpatient management of a miscarriage or induced abortion, their LARC device can be inserted post-abortally and will be reimbursed under the same mechanism described above.

If patients are undergoing an outpatient procedure for a miscarriage or an induced abortion, the LARC device can be billed as a separate outpatient procedure and will be reimbursed accordingly.

19. Is a patient able to get an immediate postpartum LARC device following an ectopic pregnancy?

If patients are admitted for inpatient management of an ectopic pregnancy, their LARC device can be inserted post-abortally and will be reimbursed under the same mechanism described above on an outpatient claim.

If patients are undergoing an outpatient procedure for an ectopic pregnancy, the LARC device can be billed as a separate outpatient claim and will be reimbursed accordingly.

20. Is there a specific consent that patients need to sign?

Institutions should establish their own protocols and policies for immediate postpartum LARC placement in pregnant women and pregnant minors. In other states, patients are consented during their prenatal care for immediate postpartum LARC placement. There are no special consents or forms required for Medicaid patients for insertion of immediate postpartum LARC devices.

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Providers with questions may contact the Provider Assistance Center at 1-800-842-8440 Mon. – Fri. 8:00 a.m. to 5:00 p.m.

References

1. Peipert J, Zhao Q, Allsworth J, Petrosky E, Madden T, Eisenberg D, Secure G. Continuation and Satisfaction of Reversible Contraception. Obstet Gynecol. 2011; 117(5): 1105-1113.
2. Tang J, Dominik R, Re S, Brody S, Stuart G. Characteristics associated with interest in long-acting reversible contraception in postpartum population. Contraception. 2013; 88: 52-57.
3. Shachar BZ , Lyell DJ. Interpregnancy Interval and Obstetrical Complications. Obstet Gynecol Surv. 2012;67:584-96.
4. Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta analysis. JAMA 2006;295:1809–23.
5. Gemmill A, Duberstein Lindberg L. Short Interpregnancy Intervals in the United States. Obstet Gynecol. 2013;122: 64-71
6. Conde-Agudelo A, Rosas-Bermudez A, Castaño F, Norton MH. Effects of birth spacing on maternal, perinatal, infant, and child health: a systematic review of causal mechanisms. Stud Fam Plan 2012;43:93–114.
7. Rodriguez MI, Chang R, Thiel de Bocanegra H. The impact of postpartum contraception on reducing preterm birth: findings from California. *Am J*