Los Angeles County

Immediate Postpartum Long-Acting Reversible Contraception Toolkit

A resource for implementing Medi-Cal policy for providing long acting reversible contraceptive services in the hospital setting

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A resource for implementing Medi-Cal policy for providing long acting reversible contraceptive (LARC) services in the hospital setting

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Introduction

OVERVIEW

The purpose of this toolkit is to guide providers in Los Angeles County in their efforts to offer long-acting reversible contraceptives (LARC) to their postpartum patients immediately after birth, and to help hospitals overcome administrative and logistical barriers to immediate postpartum LARC provision.

Long Acting Reversible Contraception (LARC)

LARC methods are highly effective forms of birth control. LARC methods, which include intrauterine devices or systems (IUD/IUS) and contraceptive implants, are 10-20 times more effective than birth control pills, the patch or vaginal ring.[1]

- IUDs and implants yield less than 1 pregnancy per 100 women in a year.
- Oral contraceptive pills typically result in 9 pregnancies per 100 women each year.
- External condoms, conversely, yield 18 or more pregnancies per 100 women each year.[2]

Effective forms of contraception can promote women's long-term physical and emotional well-being.[3] Due to their high efficacy rates and low day-to-day maintenance, LARC methods are a highly desirable form of contraception for many women.

Immediate Postpartum (IPP) LARC

Though LARC can benefit women at any time, the prenatal and postpartum periods are ideal opportunities to provide contraceptive counseling and care including LARC. During these months, women have increased contact with health care providers and may be more motivated to take charge of their reproductive health to prevent or plan the timing of a subsequent pregnancy.

Why Immediate Postpartum (Post-Placental) LARC?

- Women at highest risk of short-interval pregnancies have the lowest rates of postpartum follow-up visits, further benefiting from immediate placement.
- 40-75% of women who plan to use an IUD postpartum do not obtain it.[4]
- Access to a clinician is one of the many barriers to LARC, but immediately after having a baby, the clinician and patient are physically in the same place at the same time.
- Nationally, 40-57% of women have unprotected sex before the six-week postpartum visit after a delivery,[5] and 10-40% of women do not attend their postpartum visit.[6,7]
- In the first year postpartum, 70% of pregnancies are unintended.[8]
- Women with immediate inpatient postpartum implant insertion are less likely to seek removal. One study found that at 12 months post-insertion, inpatient insertions were removed in 7% of patients, as opposed to 14% of patients requesting removals from outpatient insertions.[9]

The Los Angeles County Department of Public Health, with support from the Centers for Disease Control and Prevention 6|18 Initiative and the Association of State and Territorial Health Organizations Improving Access to Contraception Learning Community, has joined states around the nation to advance postpartum women's access to these highly effective, convenient forms of contraception.

Despite new evidence, physicians, nurses, and other health professionals commonly hold misunderstandings about LARC.

The fact sheet on the following pages, courtesy of ACOG District II, which serves New York and Bermuda, clarifies important clinical issues.

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS
District II

Dispelling Long-Acting Reversible Contraception (LARC) Myths & Misconceptions Fact Sheet

MYTH: Adolescents and nulliparous women are not appropriate candidates for IUDs.	FACT: Adolescents and nulliparous women can be offered LARC methods, including IUDs.[1] The *U.S. Medical Eligibility Criteria for Contraceptive Use*, classifies both women who haven't had children and adolescents as Category 2, finding the advantages generally outweigh the risks. IUDs and implants have the highest effectiveness, continuation rates, and user satisfaction of all reversible methods.[2]
MYTH: IUDs cause infertility.	FACT: IUDs do NOT cause infertility or make it harder to conceive in the future. Infertility is no more likely after discontinuation of IUD use than after discontinuation of other reversible methods of contraception.[3] In the past, there was concern that IUD use could lead to infertility due to increased chance of sexually transmitted infections (STIs). While untreated STIs can lead to pelvic infection, preventing some women from getting pregnant, ample research shows that today's IUDs do not increase STI infection rates or lead to infertility. STI testing should be performed at the time of IUD insertion, if indicated. However, all women, including those using IUDs, should see a health care provider if they have new or unusual vaginal discharge or pelvic pain.
MYTH: IUDs cause ectopic pregnancy.	FACT: The IUD does not cause ectopic pregnancy. An ectopic pregnancy happens when a fertilized egg implants somewhere outside the uterus, like in the fallopian tubes. There is a chance any pregnancy could be ectopic, and in the very unlikely event a woman becomes pregnant while using an IUD, her chances of having an ectopic pregnancy may be increased. However, since the chance of becoming pregnant while using an IUD is so low, the overall risk of having an ectopic pregnancy is greatly reduced while using an IUD as compared to not using any contraceptive method.
MYTH: A woman who has had an ectopic pregnancy should not use an IUD.	FACT: Women who have had an ectopic pregnancy can use IUDs.[4] IUDs decrease the absolute risk of ectopic pregnancy, whether a woman has had an ectopic pregnancy before or not. Since the chance of becoming pregnant with an IUD is so low, the overall risk of having an ectopic pregnancy is greatly reduced while using an IUD as compared to not using any contraceptive method.
MYTH: If a woman using an IUD develops an STI or pelvic inflammatory disease (PID), the IUD should be removed immediately.	FACT: If a woman using an IUD develops an STI or PID she should be treated with antibiotics right away and can keep the device in place if her symptoms improve within 72 hours (3 days). If the symptoms do not improve within that time, the device should be removed.

[1] American College of Obstetricians and Gynecologists. ACOG Practice Bulletin: *Long-Acting Reversible Contraception: Implants and Intrauterine Devices*, Number 121, July 2011; reaffirmed 2015.
[2] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy, Number 642, October 2015.
[3] Ibid.
[4] Ibid.

MYTH: Results of STI screening must be confirmed before IUD insertion.	**FACT: Studies show that IUD insertion in patients without clinical signs of an STI is safe. Requiring testing and then a return visit for IUD insertion decreases the chance that a patient gets her IUD, leaving her at risk for an unintended pregnancy.** For this reason, same-day insertion of an IUD is a recommended best practice, with routine treatment of any subsequent positive STI screening results undertaken following insertion. Routine antibiotic prophylaxis to prevent pelvic infection is not recommended before IUD insertion.[5]
MYTH: Patients should be menstruating for IUD insertion *(i.e., return to the office/ clinic when menses starts).*	**FACT: Studies show that there is no clinical advantage to IUD insertion during menses[6]** and that it decreases the chance that a patient will actually return to the office to get an IUD, potentially leaving her at risk for an unintended pregnancy. For this reason, same-day insertion of an IUD is a recommended best practice as long as pregnancy may be reasonably excluded. Refer to the CDC US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2016.
MYTH: Immediate Postpartum (IPP) IUD insertion is associated with high expulsion rates.	**FACT: IUD expulsion rates are slightly higher with immediate postpartum placement (10-27% versus 2-10% for interval insertion).[8,9]** The vast majority of women who receive an IUD immediately postpartum will not experience an expulsion and the advantages of IPP placement outweigh the risks.[7,8] Many women do not return for postpartum follow-up appointments when contraception is often discussed. Therefore, immediate postpartum LARC insertion presents an opportunity to provide a woman with a contraceptive method of her choice while in the hospital for delivery and should not be dismissed.
MYTH: Breastfeeding mothers are not appropriate candidates for immediate postpartum LARC.	**FACT: Most women can successfully breastfeed after immediate postpartum initiation of any LARC method.** Women considering immediate postpartum hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that the preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.[9] The *U.S. Medical Eligibility Criteria for Contraceptive Use* rates the copper IUD a category 1 (no restriction) for breastfeeding women due to its lack of hormones and the hormonal IUD and implant a category 2 less than 4 weeks postpartum (otherwise a category 1), making LARC an option for immediate postpartum use.

[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: *Clinical Challenges of Long-Acting Reversible Contraceptive Methods*, Number 672, September 2016.
[9] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: *Immediate Postpartum Long-Acting Reversible Contraception*, Number 670, August 2016.

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WHY IMMEDIATE POSTPARTUM LARC?

Reproductive health inequities: Unintended and short interval pregnancy, and infant mortality in LA County

LARC holds great potential to decrease unintended and short-interval pregnancies, which are both associated with adverse maternal and child health outcomes, such as delayed prenatal care, premature birth, low birth weight, and negative physical and mental health effects for children.[10] (Short interval pregnancies are defined as those that occur within one year of a delivery). In 2010, they resulted in $21 billion in direct medical costs in the U.S.[11]

The Los Angeles Mommy Baby (LAMB) Survey, a population-based survey of new mothers, found that 43% of all births in the County in 2016 were unintended-- that is, the mother reported that her baby resulted from a pregnancy that was unwanted or mistimed. This figure does not include unwanted or mistimed pregnancies that resulted in miscarriage or abortion, so the actual proportion of pregnancies that are unintended in LA County is substantially higher than 43%.

Table 1: Percent of Los Angeles County Live Births Described as Unintended by Mother, 2016

LA County	**42.7**							
By Mother's Race/Ethnicity	**Asian**		**Black**		**Latina**		**White**	
	23.8		52.0		55.9		30.0	
By Service Planning Area (SPA)	**SPA 1 (Antelope Valley)**	**SPA 2 (San Fernando)**	**SPA 3 (San Gabriel)**	**SPA 4 (Metro)**	**SPA 5 (West)**	**SPA 6 (South)**	**SPA 7 (East)**	**SPA 8 (South Bay)**
	50.1	38.5	40.0	42.3	22.2	57.1	45.7	41.7

Rates of unintended births in LA County in 2016 varied starkly by race/ethnicity. Table 1 demonstrates that black and Latina women in LA County reported much higher rates of unwanted or mistimed births than did white and Asian women. Troubling geographic disparities also exist, with LAMB data showing that women who live in the Antelope Valley and South Service Planning Areas (SPAs) had much higher rates of unintended births than women in the West, San Fernando, and San Gabriel SPAs.[12]

Effective contraception that meets women's needs is also a key factor in protecting maternal health and preventing infant mortality, which is most commonly a consequence of preterm birth and low birth weight.[13] While infant mortality overall in LA County is 4.2 deaths per 1,000 infants, better than the overall U.S. rate of 5.8 deaths per 1,000,[14] African American infant mortality in LA County remains 10.4 deaths per 1,000, compared to 2.0 babies per 1,000 born to Asian mothers (see Table 2).[15,18] This inequity generally reflects not racial/ethnic variation in personal behaviors, but rather differential exposures to chronic, intergenerational stress and developmental trajectories during pregnancy and across the life span.[16,17] Nonetheless, improving women's knowledge of and access to all contraceptive methods, including LARC, is key to enabling them to prepare for, plan, and space their pregnancies. Provision of immediate postpartum LARC allows expectant mothers to consider their family planning desires while they are pregnant, and leave the hospital knowing that their contraceptive needs have been addressed.

Table 2: Infant Death Rates in Los Angeles County per 1,000 live birth by Race/Ethnicity, 2016[18]

LA County	**4.2**							
By Mother's Self-Reported Race/Ethnicity	**Asian**		**Black**		**Hispanic**		**White**	
	2.0		10.4		3.9		3.2	
By Service Planning Area (SPA)	**SPA 1 (Antelope Valley)**	**SPA 2 (San Fernando)**	**SPA 3 (San Gabriel)**	**SPA 4 (Metro)**	**SPA 5 (West)**	**SPA 6 (South)**	**SPA 7 (East)**	**SPA 8 (South Bay)**
	6.5	3.1	4.0	3.6	2.4	7.1	3.3	3.3

A LARC Success Story: Colorado

Between 2009 and 2014, Colorado made more progress than any other state in reducing unplanned pregnancies. A key factor to this success was improving access to effective contraception. In 2008, the Colorado Department of Public Health and Environment (CDPHE) launched the Colorado Family Planning Initiative (CFPI), which provides LARC to low-income women throughout the state. As a part of this initiative, local Title X health centers* across Colorado received private funding to augment their long-standing publicly-funded family planning programs. CFPI provided funding for the acquisition of LARC devices, trained physicians, and provided outreach and operational support. Through this process, clinics were able to hire new medical and operational staff members, upgrade medical equipment, and change billing procedures. Women faced fewer barriers to choosing and using the birth control method that works best for them, and more women were able to access contraceptive services.[1] By 2015, more than 36,000 women had received LARC, with excellent outcomes. Between 2009 and 2014,

- Abortion and birth rates both declined by 48% among 15-19 year-old women
- The number of repeat teen births dropped 58%
- Abortion and birth rates declined by nearly 20% for women ages 20-24.
- An estimated $54.6 and $60.6 million in entitlement programs were averted.

[1]Colorado is Reducing Unplanned Pregnancy. Available at: www.LARC4CO.com.

*Title X clinics are funded by a federal grant program that provides low income individuals with comprehensive family planning and related preventive health services.

A LARC Success Story: The St. Louis Contraceptive CHOICE Project [a]

The Contraceptive CHOICE Project, conducted through Washington University in St. Louis, Missouri studied 10,000 women between the ages of 14 and 45 who wanted to avoid pregnancy for at least one year. Currently, in the United States, less than 3% of women use LARC, but through CHOICE, which eliminated many common barriers to LARC, 67% of patients selected LARC (with 56% opting for an IUD, and 11% selecting an implant). This discrepancy indicates the high levels of interest of LARC, given its high efficacy rates, and lack of dependence on patient adherence. The CHOICE project attributes high LARC rates to three factors: 1) offering a standardized description of LARC to all women; 2) eliminating financial barriers; and 3) offering all women LARC, regardless of their age, previous births, and STI history. In sum, by removing these barriers and addressing common misconceptions, CHOICE was able to provide 1,700 of its initial 2,500 participants with LARC. After three years, CHOICE followed up with these participants, and found that continuation of LARC was 70% higher than non-LARC methods, indicating further success of the study.[b]

More information about the Contraception CHOICE Project can be accessed here.

THE CONTRACEPTIVE CHOICE PROJECT

a Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. The contraceptive CHOICE project: reducing barriers to long-acting reversible contraception. Am J Obstet Gynecol. 2010;203(2):115.e1-115.e7. doi:10.1016/j.ajog.2010.04.017.

b Diedrich JT, Zhao Q, Madden T, Secura GM, Peipert JF. Three-year continuation of reversible contraception. Am J Obstet Gynecol. 2015;213(5):662.e1-662.e8. doi:10.1016/j.ajog.2015.08.001.

Planning for Implementation

Sections of this chapter were adapted from South Carolina Choose Well Initiative and South Carolina Birth Outcomes Initiative.

States that have successfully implemented immediate postpartum LARC provision, including South Carolina, West Virginia, and Georgia, all report that multidisciplinary communication and engagement are key to a successful process.[19,20,21] In order to integrate all aspects of the process, physicians, nurses, pharmacists, billing and reimbursement leadership, and hospital clinical leadership should participate in planning. Involving lactation consultant leadership may also be helpful to build support.

Planning and implementation of immediate postpartum LARC provision in the inpatient setting typically takes at least six months. The timeline will vary depending on how quickly different hospital departments can convene for planning, the amount of effort needed to adjust billing processes to meet policy requirements, and the training needs of clinical staff.

BUILDING ADMINISTRATIVE SUPPORT AND INFRASTRUCTURE

- **Identify a clinician champion (or champions)** to facilitate administrative coordination and lead clinical process development. Physician, advanced practice clinicians, and nursing champions also must ensure that clinical staff receives sufficient training.

- **Educate leaders and key stakeholders** on the importance and value of offering immediate postpartum LARC services to women. Share the evidence via:
    - Grand Rounds or staff meeting presentations for physicians
    - Nursing in-service presentations
    - Meetings with pharmacy, billing and reimbursement, and hospital clinical leadership

- **Convene the champion and other clinical leadership** including physician and nursing leadership, and management representatives from billing and pharmacy departments. Create an interdisciplinary Immediate Postpartum (IPP) LARC implementation team with this group, and delegate each with their own responsibilities:
    - Clinicians (Physicians, Advanced Practice Clinicians, and Nurses)
        - Develop and organize clinical documents such as policies, patient educational materials, consent forms, and clinical protocols.
        - Organize and ensure adequate clinician training.
        - Partner with pharmacy on device ordering and stocking.
        - Work with pharmacy, billing, and IT to ensure the Electronic Health Record (EHR) connects clinician charting, pharmacy inventory, and charge capture. Help ensure codes are in place for all services and supplies linked with IPP LARC provision.

- Pharmacy
    - Ensure devices are on formulary, working with clinicians to apply to the Pharmacy and Therapeutics Committee.
    - Partner with clinicians on device ordering.
    - Investigate options for bulk purchasing through device manufacturers (*See Section 5 on Placement Procedures*).
    - Create distribution plans for devices -- they may be housed in a central pharmacy and released upon receipt of a clinician order, or pharmacy may authorize stocking LARC devices on the Labor and Delivery and/or postpartum floor(s).
- Billing and reimbursement (*See Section 7 on Billing and Reimbursement*)
    - Create charge codes for billing and reimbursement.
    - Establish MediCal billing procedures. Claims sent to MediCal for inpatient LARCs must be submitted on an outpatient UB-04 claim form with the LARC ICD code as the primary diagnosis.
    - Identify a mechanism to reconcile reimbursements with patient accounts, as well as monitor and resolve denials.

o **Contact hospital administration** to notify them of the IPP LARC Implementation team efforts or gain approval if necessary.
    - Depending on the policies and processes at a given institution, involving administration in the initial planning may or may not be necessary.
    - Higher level support from clinical administration will ease the path to implementation.

DEVELOP PROCESS FOR INSERTIONS

- **Convene physicians and nursing staff together to develop postpartum insertion procedures**. One or more meetings with clinical staff will be necessary to finalize the logistics of the process among physicians and nurses.

- **Develop processes for identifying patients who desire immediate postpartum LARC**
    - Are prenatal care providers submitting documentation of contraceptive counseling to labor and delivery?
    - How are patient preferences for postpartum contraception transferred to the hospital from the prenatal chart? How can the transfer of such information be improved?
    - Is contraceptive counseling by prenatal care providers consistent with best practices? If not, are hospital personnel able to provide or coordinate training? (*see Section 4 on Contraceptive Counseling*)
    - How are patients currently counseled about postpartum contraception in the hospital? Can such counseling be improved? (*see Section 4 on Contraceptive Counseling*)

- **Develop processes for consenting patients on labor and delivery, placing the devices, and providing patient education.** Plan for processes to be integrated into the usual operations of the labor and delivery or postpartum floor.

    Considerations include:
    - Determining a location for counseling/consent and the procedure
    - Outlining roles and responsibilities for nursing regarding supplies and documentation practices
    - Creating standard order sets that include the contraceptive device, local anesthetic (for implant placement), and nursing orders
    - Developing written policies specific for insertions of IUDs and implants- this may be particularly helpful in teaching hospitals
    - Creating a checklist for nursing and physician reference prior to the procedure
    - Developing standardized EHR templates for written procedure notes and pre-printed patient instructions sheets (*see Section 5 on Placement Procedures).*
    - Clarifying a unified consent process to be performed by all providers
        - Consent for IUD insertion can be obtained upon patient admission to labor and delivery or just prior to procedure.
        - Consent for subdermal implant can be obtained on either labor and delivery or the postpartum unit.

TRAINING CLINICAL STAFF

All clinicians who care for maternity patients must understand LARC so that information shared with patients is accurate and messages are consistent.

Prenatal Care Providers

- Must understand delivery hospital immediate postpartum (IPP) LARC procedures to provide complete patient education and answer questions during prenatal care.
- Can request information from delivery hospitals regarding their IPP LARC protocols and processes.
- Should attend in-service trainings or receive other continuing education on best practices in contraceptive counseling. These practices are key to providing evidence-based counseling, which expands women's understanding of their options and increases interest in postpartum LARC services (*see Section 4 on Contraceptive Counseling*).
- May also require training on documentation of contraceptive counseling and women's plans for IPP LARC, including timely sharing of such information with delivery hospital.

Physicians

- Must be trained and proctored on LARC methods prior to performing insertions. Training should include residents (if applicable) and advanced practice clinicians.
- *See Appendix A for Educational and Training Resources.*

Nurses

- Should be knowledgeable and prepared to support patient education and assist during the procedures. Training should include all labor and delivery, antepartum, and postpartum nurses.
- Can receive in-service training presentations to understand IPP LARC procedures and clarify clinical protocols.
- As new RNs are hired, they will primarily learn the process through on-the-job training.

Lactation Consultants

- Can play an important part in IPP LARC implementation initiatives because of their role in providing patient education about contraceptive methods while breastfeeding. Many common misconceptions exist around LARC and breastfeeding.
- Should have a short in-service training to provide them the information, tools, and resources they need to support women's decision-making regarding postpartum LARC.
- *See Section 4 on Contraceptive Counseling for more information.*

Reproductive Justice

Reproductive Justice is defined as the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights.[22] More specifically, reproductive justice refers to the human right to maintain bodily autonomy, have children, not have children, and parent children in safe and sustainable communities.[23] This serves as an important framework for the delivery of contraceptive services, particularly long acting reversible contraception (LARC), because it offers all women and girls, regardless of race, income level, or family background, the opportunity to advocate for their own health choices.

A History of Injustice

Black, Latina, Native American and other disenfranchised women in the United States have experienced forced sterilization, including thousands of well-documented cases in North Carolina,[24] Puerto Rico,[25] and California.[26] From 1960 to 1970, as many as one in four Native American women were subjected to sterilization without either their knowledge or consent.[27] At around the same time in Los Angeles County hospitals, women of Mexican descent unknowingly consented to bilateral tubal ligations while undergoing emergency cesarean sections.[26] Also, in California between 2006 and 2010, as many as 150 incarcerated women were coercively or forcibly sterilized.[26, 28] Additionally, long term hormonal birth control methods were specifically marketed towards poor women of color in urban areas in the 1990's, when welfare incentives were offered in exchange for use of a particular contraceptive implant method.[29]

When supporting diverse populations, the reproductive justice frame enables us to appreciate the intersecting oppressions that low-income women of color have been subjected to, especially surrounding reproductive health. It is important to be cognizant of the various historic forms of reproductive oppression that have affected communities of color, how ongoing reproductive coercion persists, and how perceptions of these targeted injustices may influence a woman's concerns regarding her own reproductive autonomy.[30]

While providers typically approach each individual patient with the intention to offer access to effective forms of contraception, many physicians now preferentially promote LARC because these methods are so highly effective and easy to use. When offering LARC, providers should appreciate the history of fertility control in women of color so as not to pressure women. According to Gandhi et al., a "reproductive justice approach would involve the perfect balance between reducing barriers to LARC access, especially amongst those who have poor access to healthcare, while respecting a decision to not use these methods."[31] Providers should also assure women that they can request LARC removal at any time as their reproductive health decisions change—and then follow through by providing prompt access to LARC removal.

LARC Removal

Though access to LARC is increasing, accessibility of removal services remains insufficient. It is often difficult for patients to identify providers who are capable of removing a device, and there are frequently prohibitive costs associated with removal.[32] When supporting programs that increase the availability of LARC, it is imperative that device removal is considered simultaneously, and that the fee for insertion covers the fee of removal.[33] In California, Family PACT covers insertion and removal, but individuals without Family PACT coverage may be unable to obtain removal services.

To achieve balance in contraceptive counseling, cultural sensitivity is essential. Cultural sensitivity involves being "sensitive to the ways in which community members' values and perceptions about health care differ" from those of the health care provider.[34] In addition, culturally competent systems focus on awareness of the "integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations."[35] Studies have shown that providers with deeper understandings of the cultures with which their patients identify are able to better serve their patients. For example, the importance of including male partners in contraceptive decisions has been identified within Hispanic cultures, and recognition of Latinx subgroup differences and gender roles may be paramount for effective counseling with some patients.[36] Providers should always maintain openness to learning and cultural humility, an ongoing process of reflecting on one's own preconceptions, and respecting any differences from those of the patient while continuing to optimize her care.[37]

When counseling individuals on contraceptive options, we must always present patients with the complete scope of what is available. This toolkit exists specifically to provide resources and information on LARC, but by no means implies that LARC is the best option for all women.

Contraceptive Counseling

When providing contraceptive options, the goal is to ensure that each patient can access a method that will best serve her needs and preferences. Compassionate and culturally sensitive counseling ensures that patients are fully informed and completely comfortable with their decision (*see Section 3 on Reproductive Justice*). When patients are active participants in decision making surrounding their contraceptive use, they are more likely to be satisfied with their choice.[38] Method satisfaction is associated with continued use, which reduces vulnerability to unintended pregnancy.[39,40]

Ideally, contraceptive counseling should begin at the first prenatal visit. When discussions about contraception begin early in a woman's pregnancy, she is given more time to consider her options and ask any pertinent questions. Prenatal counseling combined with postpartum counseling has been shown to greatly increase effective use of contraception for postpartum women, with even greater effects for women with Medicaid or no insurance.[41] Proactive conversations about family planning emphasize the woman's desires for future fertility, rather than framing the conversation around her current partner or current pattern of sexual activity.[42] At a minimum, providers should review and discuss the pros and cons of various contraception methods several weeks before birth. Ideally, lactation consultations are also included in these conversations, ensuring that everything is done to help patients make well-informed decisions based on their needs.[43]

Motivational interviewing techniques can be useful for influencing patient behavior around contraceptive use.[44] Motivational interviewing is defined as a "directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence."[45] This technique is most effective when the provider has already established trust with the patient.

Recommendations on Shared Decision-Making from the Association of State and Territorial Health Organizations[43]

In a shared decision-making model, healthcare providers and patients engage in a dialogue to determine the best treatment for a patient. The model acknowledges that both parties are experts essential to the decision-making process: the healthcare provider regarding the science, the patient regarding their own best interests. If a woman is concerned about using LARC, the provider should provide information and guidance on other contraceptive methods.

Such patient-centered discussions are particularly important for women of color and other populations who have been selectively counseled toward LARC or permanent sterilization in the past.

The American College of Obstetrics and Gynecologists notes that certain general conversational techniques are effective during patient/provider interactions:

- Express empathy and avoid arguments
- Assist patient in understanding the existing gap between a patient's goals and current behavior
- Prepare for resistance, and respond with personalized feedback, which indicates active listening
- Support self-efficacy and internal motivation[44]

It is important to remember that each patient is the expert on her own life, symptoms, and strengths. While the physician or advanced practice clinician holds a specialized body of knowledge, the patient has knowledge outside the scope of the practitioner.[46] Factors the patient may consider in her decisions about contraception include a need for discrete methods of contraception that are not detectable to a partner, a desire for protection against sexually transmitted infections, and her comfort with her own body.

BEST PRACTICES FOR SHARED DECISION MAKING

Dr. Christine Dehlendorf and colleagues have developed best practice guidelines for shared decision making around family planning.[47]

Establish rapport with patient. Make sure patient feels comfortable speaking about her contraceptive options. Demonstrate interest in each patient's care.

Focus on each woman's contraceptive preferences. Determine patient's contraceptive priorities, and how each method may follow or contradict these priorities. It is particularly vital to touch upon the following topics:

Effectiveness	• There are common misconceptions surrounding contraceptive efficacy. Validate any preconceived notions but give patient the facts. • Use visual aids (See Appendix A and B). • Explain statistics using palatable terms (i.e.: less than 1 in 100 women get pregnant while using an IUD, and 9 in 100 women get pregnant on the patch/pill/ring).
Ability to Return to Fertility	• Explain the differences with each method.
Everyday Expectations Requirements, Logistics	• Describe the process of obtaining each method. • Explain the possibility of pain associated with insertion of LARC. • Discuss costs, insurance coverage, and hospital procedures associated with each method. • Describe the process of obtaining each method; many patients do not understand that LARC can be removed earlier than the time period for which it is approved.
Specific Side Effects	• Inform each patient of the side effects and benefits of each method. For example, hormonal IUDs can lead to abnormal bleeding and amenorrhea, but can also lead to decreased cramping. • Answer all questions, and validate patient's concerns, fears, and confusions.

Provide scaffolding for decision making. As patients are given more information, check in with them to see if there is anything that they have questions about, or ask if a particular method seems more interesting to them. **Facilitate the discussion, without stating opinions that are based on anything other than the patient's preferences.**

Once the decision is made:

- Provide patient with an opportunity to ask any remaining questions.
- Work with each patient to determine a proactive plan for obtaining/inserting the method.
- Discuss the process of removal, and what the patient needs to do, both in case of desiring early removal, or removal after the device is no longer effective. Establish a plan for the patient if they decide later they do not like the chosen option.
- Direct patients to online resources, so that patients can access answers when they are not able to contact their provider.

BREASTFEEDING AND IMMEDIATE POSTPARTUM LARC

- **There are common theoretical concerns and misconceptions regarding postpartum LARC and breastfeeding, including:**
    - Hormonal LARC can hinder lactation because of higher levels of progestins, which could reduce milk production.[48]
    - Progestins in LARC can transfer to breast milk and negatively affect infants' reproductive, neuroendocrine, and cognitive development.
- One study of 96 women found a difference in duration of breastfeeding among women who received immediate postpartum LARC compared to those who received LNG-IUD at their 6-week postpartum visit. Only 6% of women whose LARCs were placed immediately postpartum were still breastfeeding at 6 months compared to 24% of women who delayed LNG-IUD placement. In addition, only 2% of women in the immediate postpartum group were exclusively breastfeeding vs. 13% percent of women in the delayed group.[49,50]
- **<u>However, other available evidence does not support either of the above claims.</u>**
    - Most studies show no effect of immediate postpartum hormonal LARC on women's ability to initiate and maintain breastfeeding, or on infant growth and development.
        - A published review found no adverse effects of various progestogen-only contraceptive methods on multiple measures of breastfeeding performance through 12 months postpartum. This review also demonstrated no adverse effects of progestogen-only contraceptive methods on infant growth, health, or development from 6 months to 6 years of age.[51]
        - A non-inferiority randomized control trial inclusive of 259 women found no differences in time to lactogenesis, breastfeeding at 8 weeks, or exclusive breastfeeding at 6 months between the group receiving the LNG-IUD immediately after delivery or delayed to the postpartum visit.[52]

- A randomized trial of 183 women who received a two rod progestin implant either within 3-5 days of delivery vs. 6-8 weeks post delivery found no differences in lactogenesis, infant growth, or breastfeeding continuation at 3 or 6 months postpartum.[53]

Tip for Successful Contraceptive Counseling for Prenatal and Postpartum Patients

It is important to ensure that patient education offered by nurses and lactation consultants is consistent with physician counseling.

(See Section 2 on Planning for Implementation)

RESOURCES FOR EFFECTIVE CONTRACEPTIVE COUNSELING:

Bedsider
https://www.bedsider.org/
https://providers.bedsider.org/

Beyond the Pill
http://beyondthepill.ucsf.edu/educational-materials

Cardea
http://www.cardeaservices.org/resourcecenter/providing-quality-contraceptive-counseling-education-a-toolkit-for-training-staff

Reproductive Health Access Project
https://www.reproductiveaccess.org/contraception/

The American College of Obstetricians and Gynecologists (ACOG):
LARC Practice Resources:
https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Practice-Resources

University of California, San Francisco (UCSF) Bixby Center for Global Reproductive:
Contraceptive Counseling and LARC Uptake (Visual Aids p. 42-44)
https://client.blueskybroadcast.com/ACOG/downloads/Final--Contraceptive%20Counseling.pdf

Placement Procedures

POSTPARTUM COUNSELING AND CONSENT

For IUD utilization, the patient's decision must be made before delivery, as the device should be placed within 10 minutes of delivery of the placenta or before closure of the hysterotomy during a caesarean section.

For implant utilization, the device can be placed at any time before the patient is discharged home.

During rounds, physicians should provide brief contraceptive counseling to all women, even if prenatal counseling already occurred. Even if contraceptive counseling has been documented, physicians should reiterate key counseling points. Nursing staff can hold further in-depth conversations with patients and provide more detailed information.
Refer to Section 4, Contraceptive Counseling, for guidelines, and see Appendix for resources.

During counseling, ensure emphasis on possible side effects, especially changes in bleeding patterns, which are the most commonly cited reason for patient dissatisfaction with the contraceptive implant.[54]

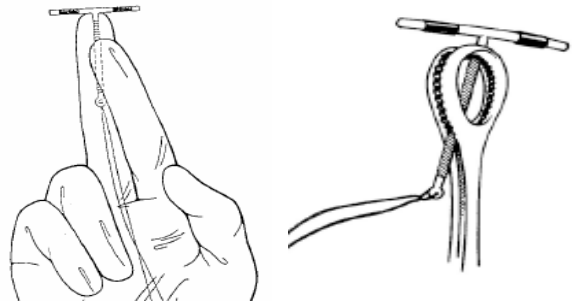
Nursing staff should ensure proper consent forms are readily available for patients. Generally, hospitals use a standard consent form that is not specific to the particular device. Ideally, women desiring an IUD will sign a consent form at a prenatal visit that can be transferred to the hospital, but if logistical barriers prevent the transfer of records or if a woman has not previously consented, she may sign the consent during labor.

INTRAUTERINE DEVICE PROCEDURE

Contraindications	
• Chorioamnionitis • Hemorrhage • Atony • Malignant or persistent GTD	• Pelvic TB • Current cervical cancer • Anatomical abnormalities • Trauma (severe cervical laceration)

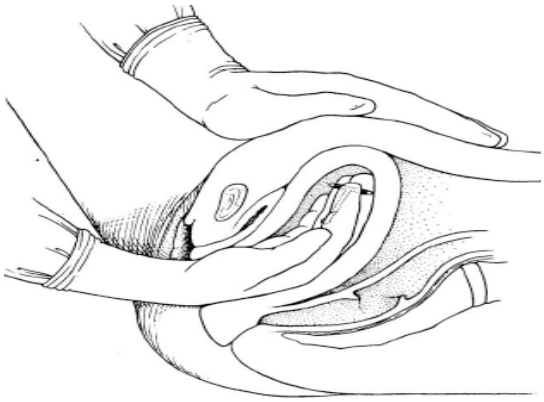
Instruments Needed[55]	
• IUD • Tenaculum • Small Graves speculum • Pair of long, curved scissors • Sponge forceps • Uterine sound (disposable or reusable) • Betadine Wipes • Light source • Sterile Gloves • Chux and sterile drapes • Autoclaving bags, indicator strips, autoclave tape • Sanitary napkins for post-procedure	

Insertion



Use fingers or ring forceps

Place IUD at fundus gently, with device arms horizontal



Diagrams courtesy of LAC+USC Section of Family Planning, 2013

Following vaginal delivery[48]
• Placement of the IUD should ideally be done within 10 minutes of delivery of the placenta (before repair). • Change sterile gloves & clean perineal area • Trim LNG IUD strings to 10cm; do not trim strings of Copper IUD • The IUD is grasped gently with a ring forceps (not clamped) or placed manually. • The IUD is placed gently at the fundus with arms horizontal • Ultrasound guidance can be used.

At the time of cesarean delivery
• Placement of the IUD should ideally be done within 10 minutes of delivery of the placenta. • After initiating closure of the hysterotomy incision, the IUD is placed at the fundus with the inserter, ring forceps, or manually. Strings are placed through the cervix and the hysterotomy is closed completely.[48] • Pinch at fundus during cesarean hysterotomy repair.

Common side effects include
Progestin Intrauterine System • Amenorrhea • Intermenstrual or unscheduled bleeding • Abdominal/pelvic pain (post-insertion)
Copper IUD • Heavy menstrual bleeding • Intermenstrual bleeding • Dysmenorrhea • Abdominal/pelvic pain (post-insertion)
Risk of expulsion • Rates of IUD expulsion are higher for immediate postpartum insertion than interval insertion, ranging from 10-40%[56,57,58,59] • Expulsion rates are higher for progestin vs. copper IUDs • Nonetheless, ACOG notes that the benefits of immediate postpartum insertion may outweigh the risk of higher expulsion.
Rare adverse events for both forms of IUD: • Uterine perforation, migration of IUD, ectopic pregnancy

Follow Up
• Women with post-placental IUD insertion should be scheduled for follow-up at one month.[60] • "Missing strings" are more common after postpartum IUD insertion than after interval insertion.[60] This should be managed according to the usual clinic protocol for this situation. • Patients should be instructed that if the IUD is expelled then they will need another form of contraception. • At the postpartum visit, trim the IUD strings and evaluate for uterine placement.

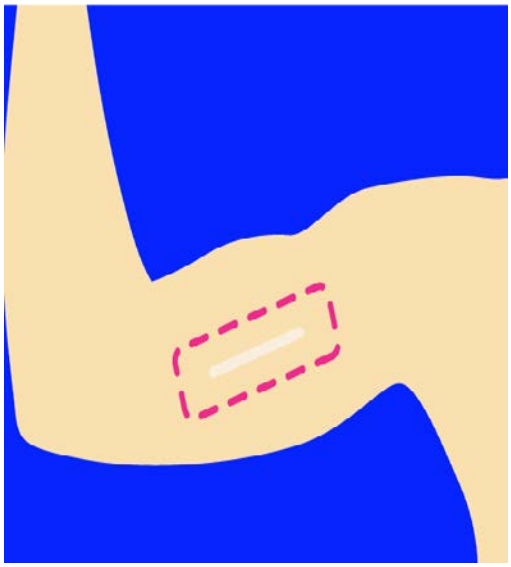
IMPLANT PROCEDURE

Contraindications	
• Current or past history of thrombosis or thromboembolic disorders • Liver tumors, benign or malignant, or active liver disease • Undiagnosed abnormal genital bleeding	• Known or suspected breast cancer, personal history of breast cancer, or other progestin-sensitive cancer, now or in the past. • Allergic reaction to any of the implant components.

Instruments Needed	
• Applicator with implant • Sterile gloves • Sterile towels • Sterile marking pen • Betadine swabs • Antiseptic solution	• 20cc syringes • 18- and 23-gauge needles • Local anesthetic • Band-aids • Dressing pads and wraps

Insertion

- Insertion procedures are provided in mandatory Nexplanon trainings, provided by Merck. (*See Appendix A for more information*).
- Typically, insertions are performed at the **bedside.** Nurses obtain the device, local anesthetic, and other supplies, and assist with the procedure as needed.
- Some hospitals conduct insertions in a **procedure room**.
- A checklist may be posted in the supply area, or implant supply kits pre-organized to facilitate access.
- Implant insertions take 5-10 minutes and are easy to fit into the flow of a postpartum floor.
- See Merck's Prescribing Information Highlights for complete instructions for implant insertion.



Graphic by Jocelyn Runice

Common side effects include:

- Irregular bleeding: it is possible to have more, less, or no bleeding.
- Bruising and swelling at insertion site are common within 24 hours.

Follow Up

- The implant begins working within seven days, so it is vital that patients be instructed to use a backup method within the first week of insertion.
- The implant can remain for up to 4 years.
- After 24 hours, the dressing can be removed, and patient can now take a shower or a bath.
- The implant can be checked by pressing fingertips over the skin where the implant was inserted. Patients should be instructed to call their healthcare provider if they do not feel a small rod.
- There are no activity limitations after implant insertion.
- See *Appendix A* for sample take home sheet for patients.[61]

Quality Improvement

When introducing a new health care service or expanding an existing one, it is essential to build continuous quality improvement processes and measurements into the initiative to gauge progress. Engagement with quality improvement practices is likely to increase positive patient experiences and outcomes, lower financial cost, and enhance provider experience.[62] In order to maintain provider satisfaction and the availability of postpartum LARC for your patients, it is important to regularly adjust the immediate postpartum LARC implementation plan, as needed, to improve and streamline patient care.

The U.S. Office of Population Affairs (OPA) has developed clinical performance measures that can be used to improve access to client-centered contraceptive care. Additionally, such measures can be employed to reduce rates of unintended pregnancies in the US, California, and Los Angeles County.[63]

Importantly, we do not strive for these measures to reach 100%, because the most important goals in contraceptive care are to educate patients about all options and to respect their preferences. There are always women who will make informed decisions to opt for less effective methods or no contraceptive method at all.[63] While improvement in these measures over time typically reflects enhancements to patient counseling and expanded utilization of highly effective methods, *these measures should not encourage high rates of use, as to avoid coercive practices* (*See Section 3, Reproductive Justice for more information on coercive contraceptive practices*).

Contraceptive care measures help to ensure that the 61 million women of reproductive age in the United States have access to high quality care, in order to reduce maternal and infant mortality and other pregnancy related complications.[64] The National Quality Forum (NQF) endorses these measures, as access to quality contraceptive counseling and comprehensive health care increases economic security. Further, these measures address gaps in quality healthcare and improve postpartum care by helping women space healthy pregnancies. The Immediate Postpartum Monitoring tool, as described below, seeks to employ qualitative and quantitative methods to address these measures, and to assist women and families achieve their desired number and spacing of healthy children.[65]

The Contraceptive Care Measures[64]	
Most & Moderately Effective Methods for **Postpartum Women**	The percentage of women aged 15-44 years who had a live birth that is provided a most effective (sterilization, implants, IUD/IUS) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method within 3 and 60 days of delivery (NQF #2902)
Access to LARC for **Postpartum Women**	The percentage of women aged 15-44 years who had a live birth that is provided a LARC method (implants or IUD/IUS) within 3 and 60 days of delivery (NQF #2902)
Most & Moderately Effective Methods for **All Women**	The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (that is, sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method (NQF #2903)
Access to LARC for **All Women**	Access to LARC: The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible contraceptive (LARC) method (implants or IUD/IUS) (NQF #2904)

These measures should be used to assess whether access to LARC is limited or nonexistent. For example, if less than 1-2% of a population are using LARC, it may be indicative of lack of accessibility. *In 2017, fewer than 1% of new mothers received immediate postpartum LARC in Los Angeles County.*[66]

The Association of State and Territorial Health Organizations (ASTHO) *Increasing Access to Contraception Collaborative* has developed tools for monitoring implementation of immediate postpartum LARC at the state level;[67] we have adapted these tools for use by individual hospitals.

You can access this tool at http://publichealth.lacounty.gov/owh/index1.htm

IMMEDIATE POSTPARTUM (IPP) MONITORING TOOL

Quantitative Tracking

LARC use within a hospital may be tracked quantitatively via several different methods:

<table>
<tr><th colspan="2">Claims based</th></tr>
<tr><td colspan="2">

- Tracking the number of claims submitted to or paid by Medicaid (*see IPP Monitoring Tool in Appendix B*)
- Extracting from the Family Planning Annual Report (FPAR) of federal Title X funds

</td></tr>
<tr><th colspan="2">Electronic health records[68]</th></tr>
<tr><td>Tracking CPT codes for IUD or subdermal implant</td><td>

- 11981 Insertion, non-biodegradable drug delivery implant
- 11982 Removal, non-biodegradable drug delivery implant
- 11983 Removal with reinsertion, non-biodegradable drug delivery implant
- 58300 Insertion of IUD
- 58301 Removal of IUD

</td></tr>
<tr><td>Tracking ICD codes (Z30 Encounter for Contraceptive Management code series)</td><td>

- Z30.018 Encounter for initial prescription of other contraceptives
- Z30.09 Encounter for other general counseling and advice on contraception
- Z30.430 Encounter for insertion of intrauterine contraceptive device
- Z30.431 Encounter for routine checking of intrauterine contraceptive device
- Z30.432 Encounter for removal of intrauterine contraceptive device
- Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device
- Z30.49 For checking, reinsertion, or removal of the implant

</td></tr>
<tr><td>Tracking supply with HCPCS (Healthcare Procedural Coding System) codes</td><td>

- J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration
- J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
- J7300 Intrauterine copper contraceptive
- J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
- J7307 Etonogestrel [contraceptive] implant system, including implant and supplies

</td></tr>
</table>

Inventory based
• Evaluating pharmacy LARC inventory stock and purchasing orders
Provider based
• Tracking provider-specific LARC placement rates
Patient based
• Surveying patients upon discharge to identify current or desired contraceptive method

Qualitative tracking

In addition to a quantitative review of Postpartum LARC access, a variety of qualitative efforts can be utilized to ensure steady progress. Particularly during the initial phases of the program, efforts should be made to periodically evaluate for unintended consequences, provider burden, and operational issues.

Consider specifically eliciting feedback from the following program participants:

Physicians	In the hospital with delivering privileges
	Referring prenatal patients
	Caring for patients postpartum
Nursing	On the labor and delivery floor
	On the postpartum floor
Pharmacy Staff	Distributing LARC devices to providers
	Ordering LARC inventory for the hospital
Billing Staff	Involved in coding visits (ICD) or procedures (CPT, HCPCS)
	Submitting Medicaid claims
	Coordinating the receipt of government funds (Medicaid, Title X)

Specific suggestions for evaluating for quality improvement:

Clinical Staff	The clinical leadership should reconvene clinical staff on a regular basis, or as appropriate, to review postpartum LARC processes and identify any needed changes.
	Immediate postpartum LARC implementation should be reviewed regularly at Quality Improvement meetings with special attention to systems barriers that can be addressed with Quality Improvement projects.
	Periodic survey evaluation by participating clinicians to obtain individual insights into the program's effectiveness and utility.

Billing	Billing staff should review the payments received against claims.
	Submission data to identify any issues with claims denials. (See information below about reporting rejected claims to National Health Law Program).
	Billing staff should hold meetings with Medi-Cal staff or Medi-Cal Managed Care organization (e.g. LA Care, Health Net) representatives to discuss and resolve any billing or reimbursement issues (see Hospital Billing and Reimbursement).

Patients	Monitoring the proportion of women choosing a postpartum LARC can provide evidence of the policy's impact on LARC access and be used in quality improvement efforts.

Billing and Reimbursement

BACKGROUND

In 2016, the U.S. Center for Medicaid and CHIP Services (CMCS) launched the Maternal and Child Health Initiative. To improve birth spacing, CMCS identified approaches to Medicaid reimbursement that promote the availability of effective contraception, including immediate postpartum LARC. California, like many other states, took steps even before 2016 to incentivize providers to deliver this important service.

In 2014, the California Preconception Care Council and Interconception Care Project, programs of the California Department of Public Health Maternal, Child, and Adolescent Health Division; ACOG District IX; and the March of Dimes coordinated an effort to reimburse post placental IUD placement for providers participating in the California Comprehensive Perinatal Services Program (CPSP). CPSP provides pregnancy and postpartum services for women enrolled in Medi-Cal. This work resulted in the creation of new Medi-Cal billing codes for post placental IUD placement. While providers place the IUD in the hospital setting, the procedures are charted in the office and billed as a separate outpatient office visit.

This change was formalized in a bulletin issued in June 2015. Effective July 1, 2015, general acute care hospitals as defined in Section 1250 of the California Health & Safety Code may submit claims for the long-acting reversible contraceptive methods listed below on an outpatient claim, even when treatment is provided on an inpatient basis, thereby unbundling the cost of LARC provision from global pregnancy reimbursement.

For ease of reference and for sharing the Medi-Cal regulation with payers, see:

> Medi-Cal Update Inpatient Services | June 2015 | Bulletin 489
> **http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/ips201506.asp#a8**

Unfortunately, to date, many obstetrics providers report difficulty obtaining reimbursements for LARC devices and placement from Medi-Cal managed care plans in the Los Angeles region and beyond. Despite the coding changes in 2015 and the passage and implementation in 2016 of SB 1053, the Contraceptive Coverage Equity Act, consumers and providers continue to experience delays and denials in care. SB 1053 requires that health plans provide access to the full range of contraceptive methods approved by the U.S. Food and Drug Administration (FDA) without cost-sharing, prior authorizations, or denials of coverage.

If providers who are seeking reimbursements for LARC devices and placement are being denied by Medi-Cal managed care plans, they should request written confirmation of the denials, appeal the denials, and notify the National Health Law Program. The National Health Law Program is tracking these denials through an online survey, which is available here (*Note: You must have or create a Google account to access this form*). The National Health Law Program also has an online toolkit where you can find sample appeals and grievance letters, as well as documentation explaining the requirements under SB 1053. If you have any questions, please contact National Health Law Program Staff Attorneys Amy Chen at chen@healthlaw.org and Priscilla Huang at huang@healthlaw.org.

GUIDE TO IMMEDIATE POSTPARTUM LARC CODING

Healthcare Common Procedure Coding System (HCPCS-- commonly pronounced “hicks-picks”)

J codes cover the cost of LARC devices. HCPCS codes are used in conjunction with ICD 10 diagnosis and procedure codes to allow for reimbursement of the procedure and physician time, in addition to reimbursement for the device itself.

HCPCS Code	Contraceptive Method
J7300	Intrauterine copper contraceptive (Paragard)
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg (Skyla)
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Liletta)
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (Nexplanon)
J7296*	Levonorgestrel-releasing intrauterine contraceptive system, 19.5 mg (Kyleena)

** New J code as of January 1, 2018*

ICD-10 (International Classification of Diseases, 10th version) diagnostic codes are maintained by the U.S. Centers for Disease Control in partnership with the World Health Organization; they are used internationally to track, identify and analyze clinical services and treatments. ICD-10 codes must be used properly on billing forms to ensure hospital and physician reimbursement by payers. Key ICD-10 codes for immediate postpartum LARC payment follow.

ICD 10 Diagnosis Codes - LARC	
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.017	Encounter for initial prescription of implantable subdermal contraceptive
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device

ICD 10 Procedure Codes - IUDs	
0UH97HZ	Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening
0UH98HZ	Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening Endoscopic
0UHC7HZ	Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening
0UHC8HZ	Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening Endoscopic

ICD 10 Procedure Codes – Contraceptive Implant	
0JHD0HZ	Insertion of Contraceptive Device into Right Upper Arm Subcutaneous Tissue and Fascia, Open Approach
0JHD3HZ	Insertion of Contraceptive Device into Right Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHF0HZ	Insertion of Contraceptive Device into Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach
0JHF3HZ	Insertion of Contraceptive Device into Left Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach

CPT (Current Procedural Terminology) coding is a U.S. standard maintained by the American Medical Association. CPT codes are used in conjunction with ICD-10 codes for electronic billing. Important CPT codes for immediate postpartum LARC provision include:

CPT Procedure Codes	
58300	Insertion, non-biodegradable drug delivery implant
11981	Insertion of IUD

In addition, **anesthetic injection codes** are reimbursable when anesthesia is necessary during insertion of implantable contraceptive capsules.

Other key ICD 10 and CPT codes for LARC include those for follow up/surveillance, removal, and difficulties such as missing strings. *Beyond the Pill,* a project of the Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF), provides an excellent resource through its LARC Quick Coding Guide Supplement, available at:

http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/LARC%20Quick%20Coding%20Guide%20Supplement%20for%20training_updated%20jan%202017.pdf

Additional LARC coding information is available from UCSF and from the American College of Obstetricians and Gynecologists (ACOG) at:

UCSF: http://larcprogram.ucsf.edu/coding

ACOG: https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Coding-and-Reimbursement-for-LARC

Successful Billing for IPP Implant Insertion

While administrative and logistical barriers should not occur in billing and reimbursement for immediate postpartum LARC, many providers have faced challenges. In response, some hospitals in LA County have identified successful work-arounds and are billing and receiving full reimbursement for providing this service to Medi-Cal patients, including Medi-Cal managed care patients.

Helena Diep, Revenue Integrity Director with Navigant Cymetrix, describes the process through which Martin Luther King, Jr. Community Hospital in Los Angeles has successfully billed Medi-Cal managed care plans for immediate postpartum contraceptive implant insertion. While this guidance will not work for successful reimbursement on all claims, which must be accurately coded on a case by case basis, the tips provided by Ms. Diep may be helpful.

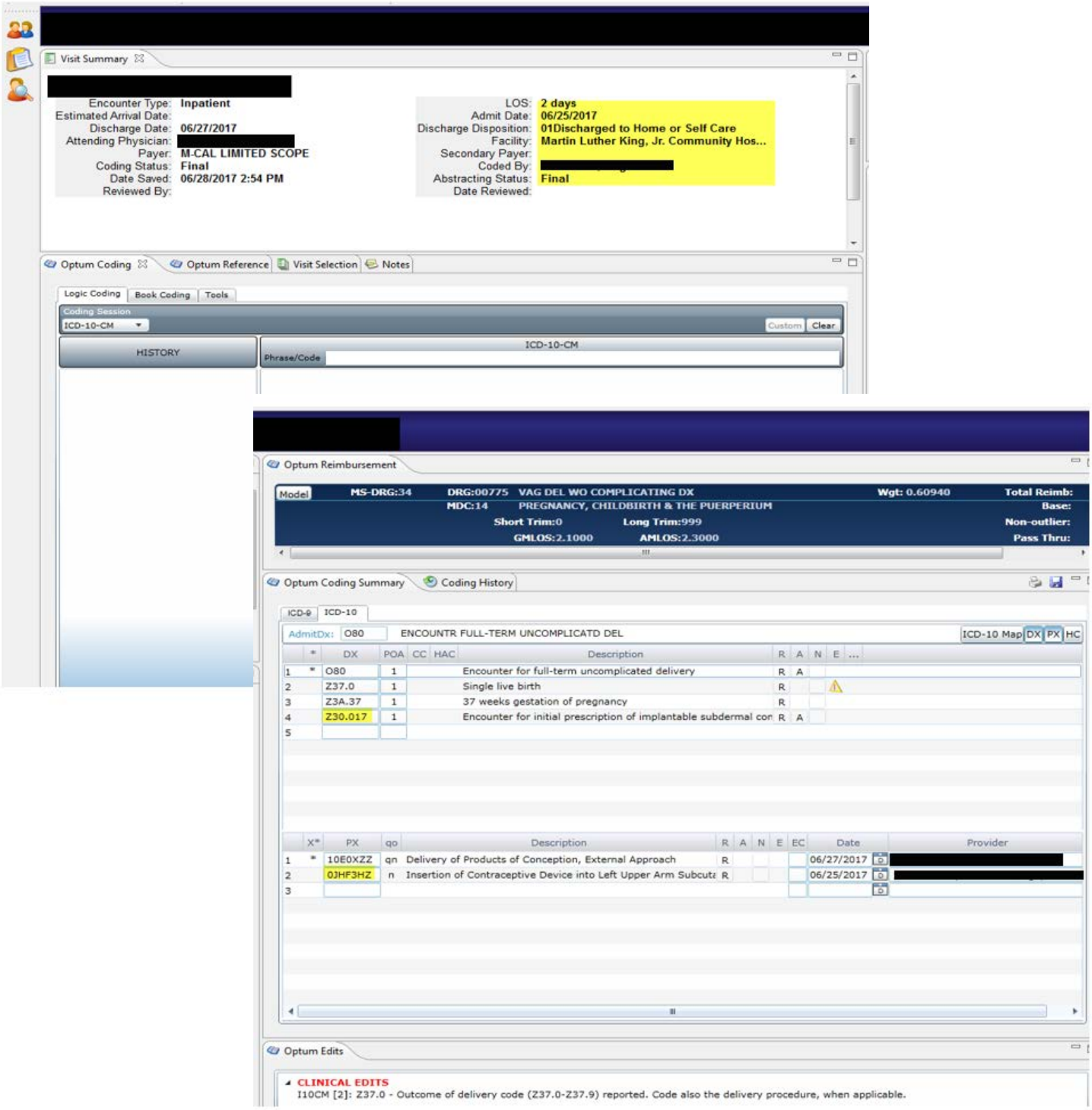
1. Per CMS, LARC performed in the inpatient setting may be billed on an outpatient claim. Based on this guidance, we set up a claim rule to split inpatient (IP) services and carve LARC J7307 on an outpatient (OP) UB-04 claim. The same patient will have two separate claims, one IP (11x) and one OP (13x). There would be an APR-DRG payment along with Medi-Cal OP fee schedule.

2. The sequencing of the ICD_10 diagnosis/procedures codes will remain exactly the same on the IP claim. However, we've found with the OP claim, if diagnosis Z30.017 is not in the first primary position on the claim, no payment is made. When Z30.017 is changed to the first primary position on the OP claim, we received a payment of $844 from Medi-Cal. Please note, on OP claims ICD_10 procedure codes are not submitted. Coding abstract does not change and will remain the same for both IP/OP.

3. Workflow and systematic setup may vary depending on EHR system. The EHR system used at MLK is Cerner.

LARC: HIM Coding Abstracting, Payment Received Example

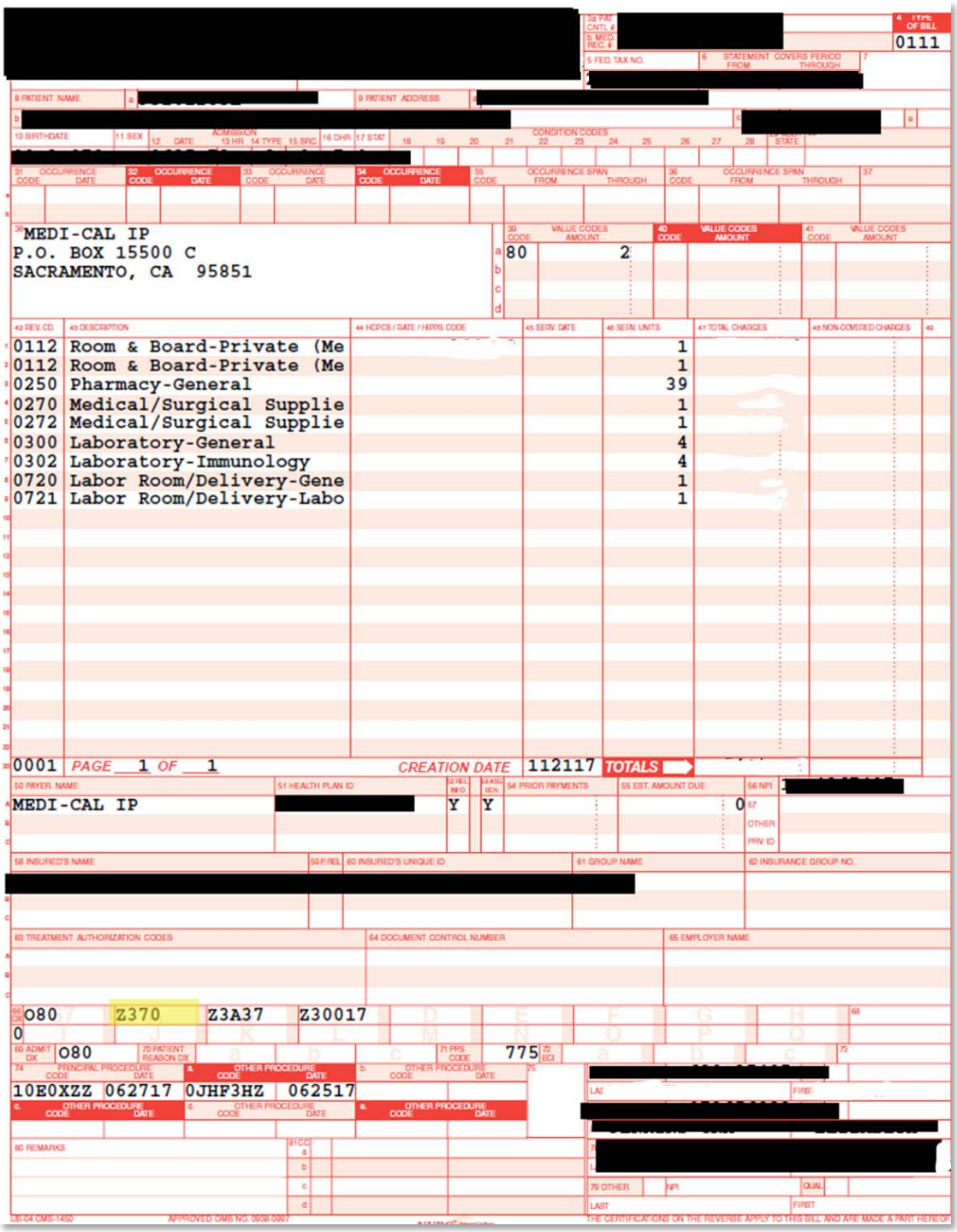
Payment received for both **inpatient and outpatient**.



LARC CLAIM SAMPLES

Payment Received, Example 1

Inpatient claim sample (TOB 11x). All ICD-10 CM/PCS sequencing remains the same. Received APR_DRG Payment.



MEDI-CAL IP
P.O. BOX 15500 C
SACRAMENTO, CA 95851

REV. CD.	DESCRIPTION	SERV. UNITS
0112	Room & Board-Private (Me	1
0112	Room & Board-Private (Me	1
0250	Pharmacy-General	39
0270	Medical/Surgical Supplie	1
0272	Medical/Surgical Supplie	1
0300	Laboratory-General	4
0302	Laboratory-Immunology	4
0720	Labor Room/Delivery-Gene	1
0721	Labor Room/Delivery-Labo	1

0001 PAGE 1 OF 1 CREATION DATE 112117 TOTALS

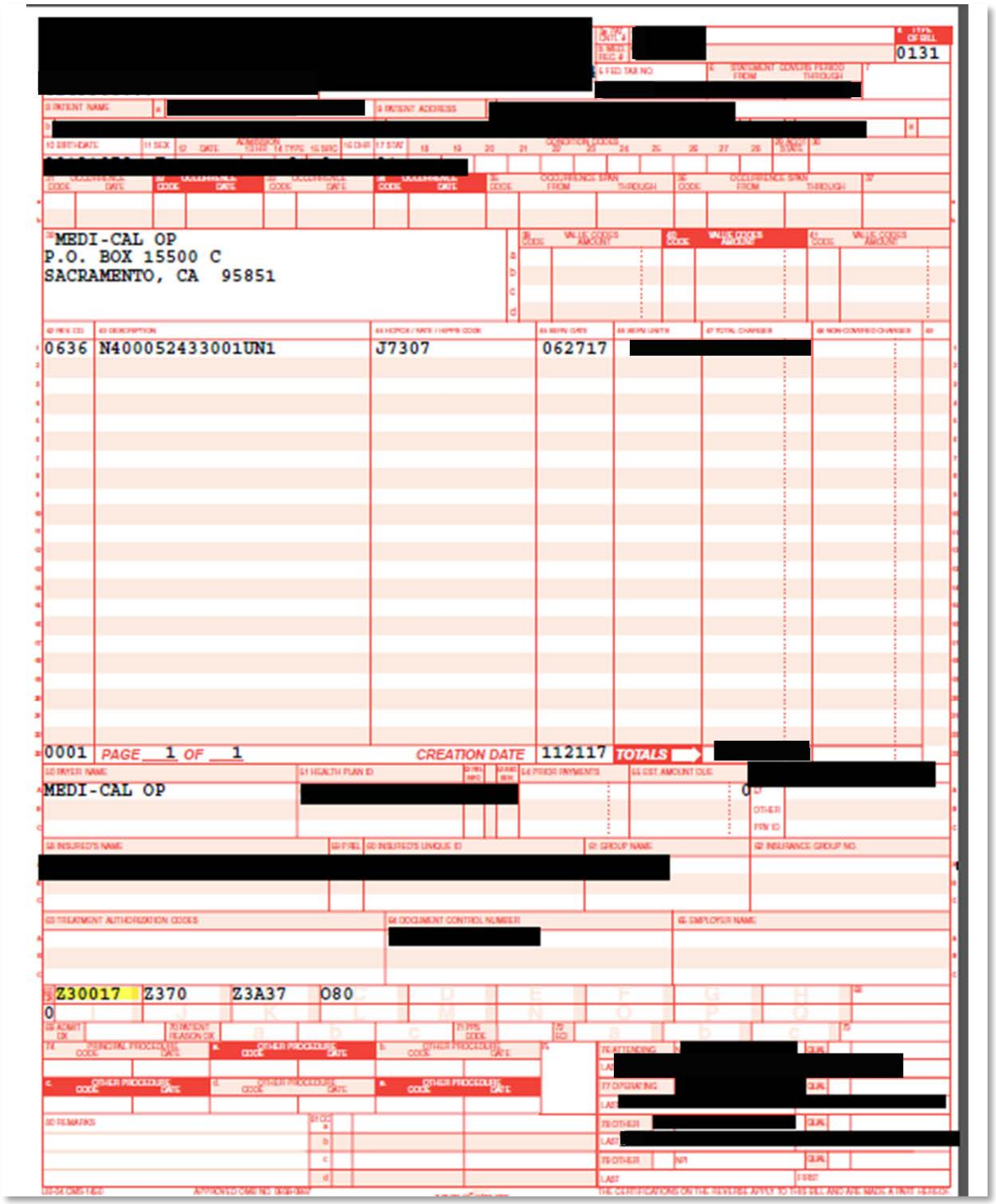
MEDI-CAL IP

O80 Z370 Z3A37 Z30017
0

Payment Received, Example 2

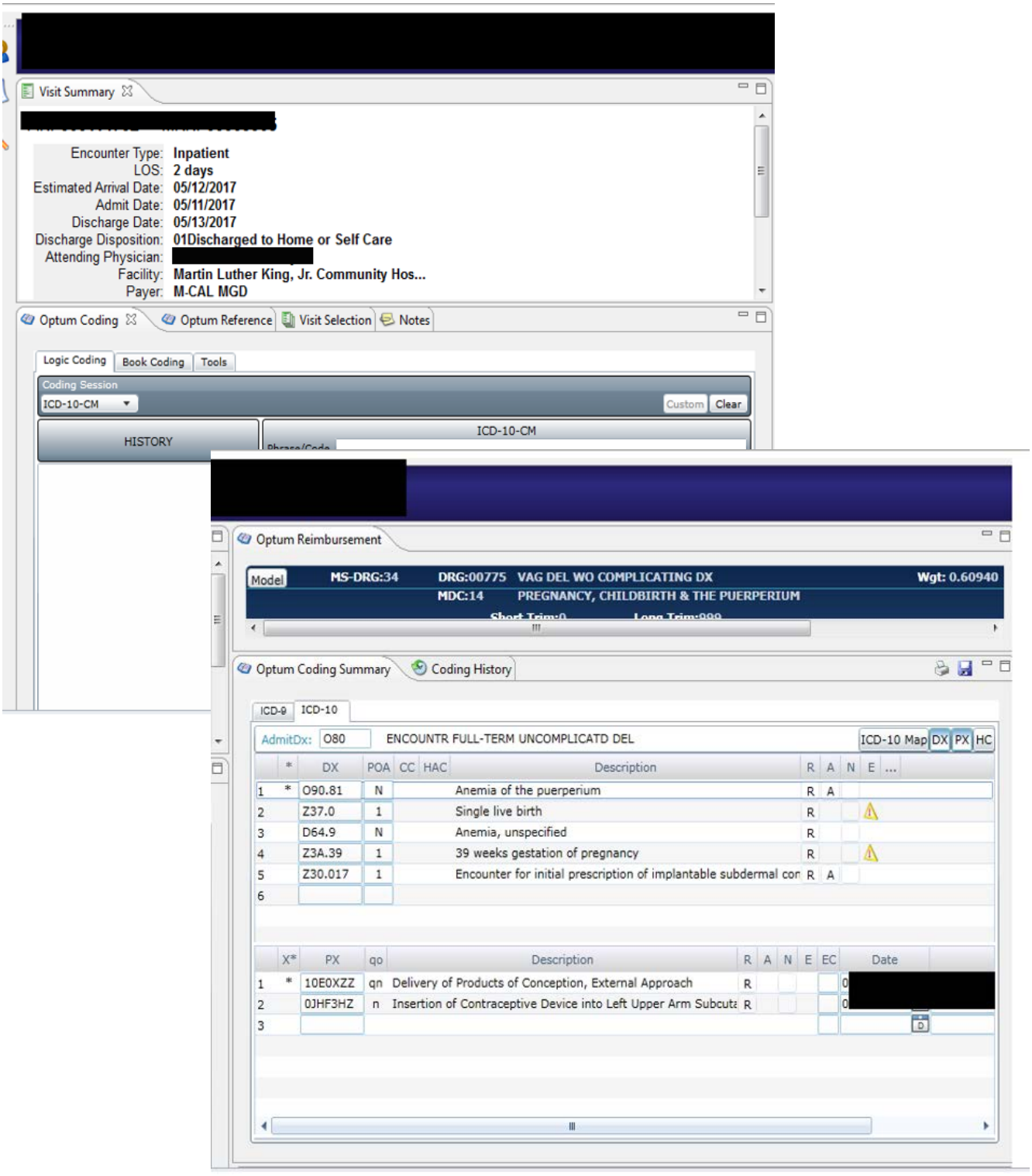
Same patient, **outpatient** claim split (TOB 13x). Z30017 changed to first primary position on the claim. HIM abstracting remains the same. No changes to diagnosis sequencing on abstract.

Received $844 payment.



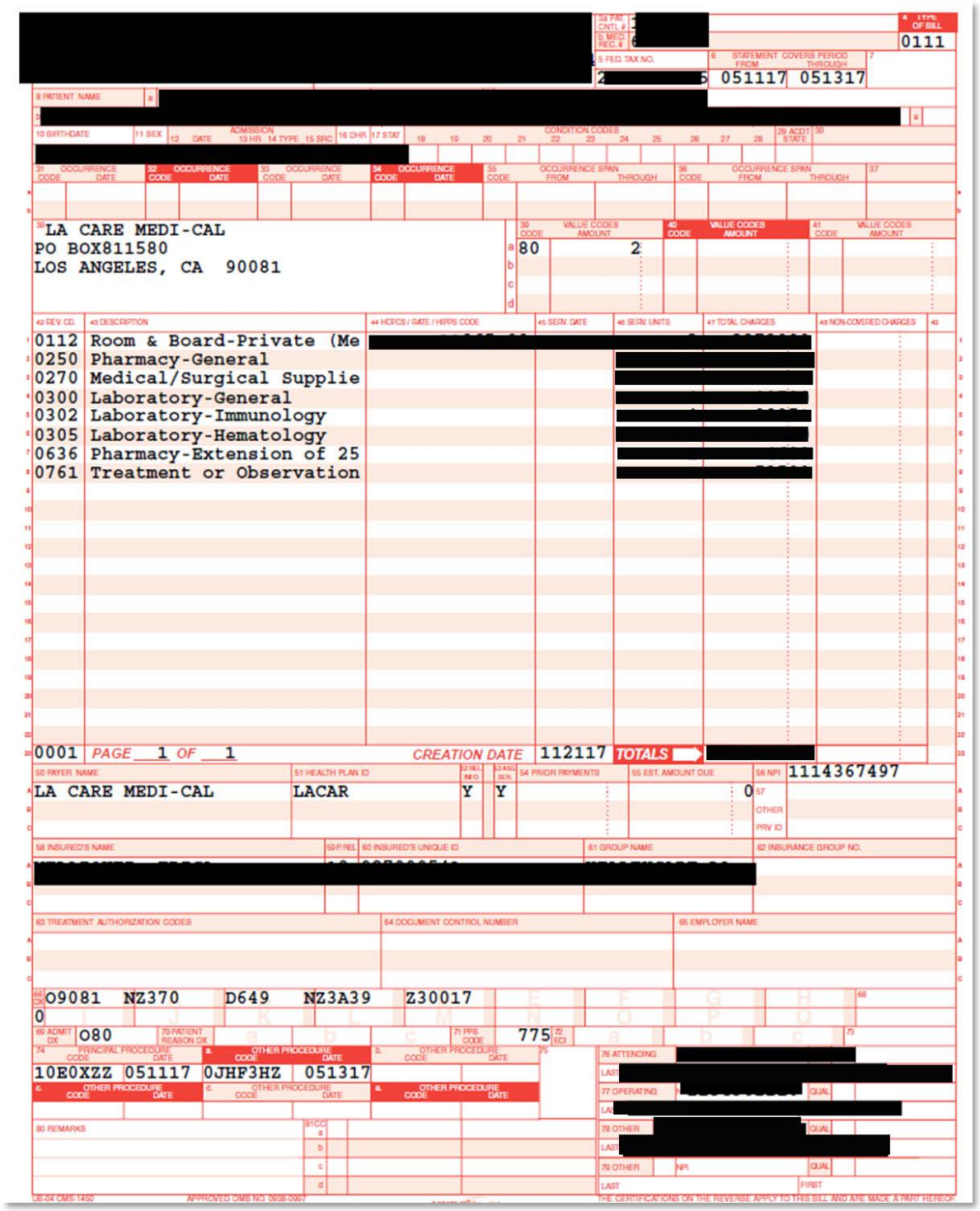
LARC: HIM Coding Abstracting, No Payment Received Example

Payment received for APR_DRG, no payment on **outpatient** claim.



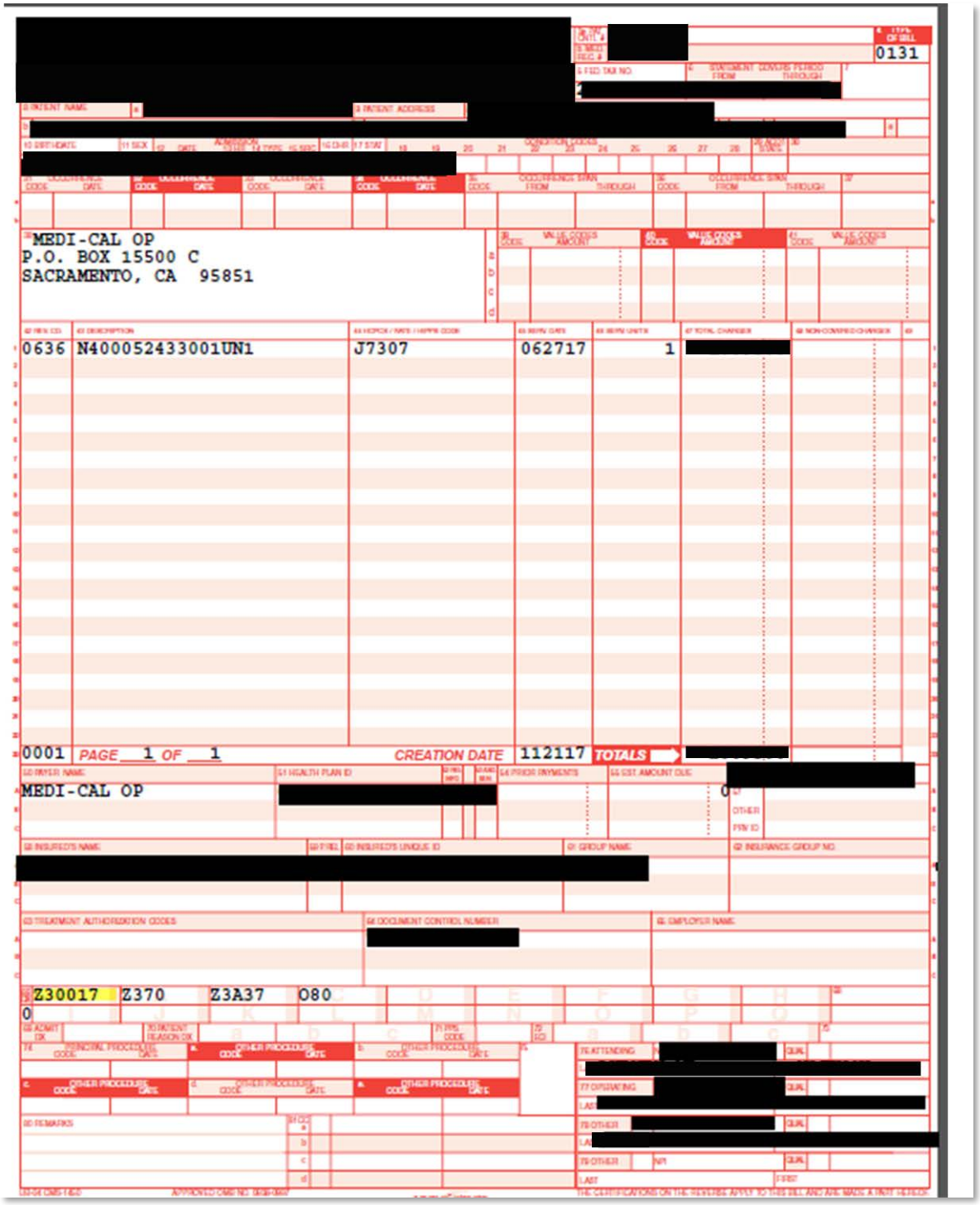
No payment on Outpatient Claim, Example 1

LARC Inpatient claim sample. ICD_10 CM/PCS sequencing remains the same. APR_DRG payment received.



No payment on Outpatient Claim, Example 2

Same patient, LARC Outpatient claim sample split. ICD_10 DX Z30017 did not move to first primary position. No payment received.



BILLING AND FINANCE RESOURCES

American College of Obstetricians and Gynecologists (ACOG)

https://www.acog.org/~/media/Departments/LARC/HMAPostpartumReimbursmentResource.pdf

ARCH Patient Assistance Program

Patients who do not have MediCal or private insurance that covers LARC may be able to access progestin-containing IUS from:

http://www.archpatientassistance.com

Association of State and Territorial Health Officials (ASTHO)

http://www.astho.org/MCH/LARC/White-Bagging-Factsheet/

National Family Planning & Reproductive Health Association

https://www.nationalfamilyplanning.org/file/documents----reports/LARC_Report_2014_R5_forWeb.pdf

National Health Law Program Toolkit for Access to Reproductive Health in Medi-Cal Managed Care

https://healthlaw.org/resource/briefs-on-public-coverage-of-family-planning-and-abortion-services/

University of California, San Francisco (UCSF) Bixby Center for Global Reproductive Health: Intrauterine Devices & Implants: A Guide to Reimbursement

http://larcprogram.ucsf.edu/

Appendix A:

Clinician Educational Resources and Training

Clinician Educational Resources and Training

Online Resources	
American Congress of Obstetricians and Gynecologists (ACOG)	▪ ACOG District II Immediate Postpartum LARC Training: Long Acting Reversible Contraception: A Hospital-Based Physician Initiative ▪ LARC Clinical Training Opportunities ▪ Practice Bulletin: Long-Acting Reversible Contraception: Implants and Intrauterine Devices
American Family Physician	▪ Easy-to-read clinical guidelines on Family Planning on Contraception for the primary care provider
Beyond the Pill	▪ Maintains a variety of research, training, and educational materials. ▪ Contraceptive Trainings
Bixby Center for Global Reproductive Health	▪ Free online training: An Update on Long-Acting Reversible Contraception ▪ Helps clinic staff bring LARC into routine contraceptive care
Center for Disease Control (CDC) Division of Reproductive Health	▪ Good source for information handouts for patients, and to refer patients to check out on their own.
Essential Access Health	▪ Features free and fee-based courses on sexual and reproductive health ▪ LARC Series: Best Practices for Improving Patient Experiences with Long Acting Reversible Contraception ▪ Best Practices in Birth Control Education
Insertion and Removal Videos	▪ Kyleena ® ▪ Liletta ® ▪ Mirena ® ▪ ParaGard ® ▪ Skyla ®

Reproductive Health Access Project	▪ Offers trainings, clinical tools, and publications. ▪ Hands-on Reproductive Health Training Center offers training to competency in LARC insertion and removal. ▪ Equipment and Supplies Lists ▪ LARC: The Basics and Advanced
Society of Family Planning	▪ Good resource for methodically rigorous, evidence based, clinical guidelines
Society of Teachers of Family Medicine (STFM)	▪ Quick, easy search for teaching and educational resources for health professionals
Stanford Program for International Reproductive Education and Services (SPIRES)	▪ Postpartum IUD Insertion Demonstration
US Medical Eligibility Criteria (USMEC) for Contraceptive Use	▪ Recommendations for specific contraceptive methods by individuals with specific medical conditions.

In Person Training Opportunities	
Bayer HealthCare Pharmaceuticals	▪ Offers trainings for **Kyleena ®**, **Mirena ®**, and **Skyla ®**. ▪ Request at 888-84-BAYER (888-842-2937).
Cardea	▪ Delivers customized trainings to family planning providers, based on 2017 US HHS Quality Family Planning Recommendations (as of January 2019).
Contraceptive Technology	▪ Hosts conferences covering women's health and contraception ▪ Find upcoming conferences here.
Essential Access Health	▪ Is a certified provider of continuing education credits for physicians (CME), nurses, health educators (CHES), and public health professionals (CPH) ▪ Offers in-person trainings and hands-on clinical practica
Medicines360	▪ Offers trainings for **Liletta ®.** ▪ To request, call 800-678-1605, or online.
Merck & Co., Inc.	▪ Offers trainings for **Nexplanon ®.** ▪ To request, call 877-467-5266 or online. ▪ You may also directly contact LA area representative Michael Schloffer, MBA ▪ cell: 714-615-2035 email: michael.schloffer@merck.com
National Clinical Training Center for Family Planning	▪ Provides family planning training for providers at all levels, both online and in person. ▪ Find LARC Training opportunities here or contact Tracy VanVlack at 866-91-CTCFP (866-912-8237) or vanvlackt@umkc.edu
Teva Women's Health, Inc.	▪ Offers trainings for **Paragard ®.** Request at 877-PARAGARD (877-727-2427).

Patient Resources	
Bedsider.org	▪ Colorful, easy-to-read evidence-based educational resources for patients regarding various contraception options. ▪ Features video testimonials of patients describing their experience of using different methods. ▪ Opportunities for providers to sign up for clinic resources.
Condom Finder	▪ Website that assists patients with finding locations distributing free condoms in their area.
Family Planning, Access, Care, and Treatment (Family PACT)	▪ Multitude of patient education materials in many languages (contraception, STI, IPV).
FPA Women's Health	▪ Patient information and community resources on abortion, contraception, pregnancy, gynecology, sexual health in English and Spanish. ▪ Free clinic brochures
Power to Decide	▪ Easy-to-read visual and educational resource for patients considering different options. ▪ Closely affiliated with Bedsider and the CDC. ▪ Opportunities for providers to sign up for clinic resources.
Reproductive Health Access Project	▪ Printable fact sheets for patients are available in many languages, including: - Birth Control Choices - IUD Fact Sheet and IUD Aftercare Instructions
They Fit	▪ Website to assist patients with finding the perfect condom fit in an effort to increase effective and satisfying use of condoms.

Adapted from ACOG's LARC Clinical Training Opportunities

Appendix B:

Quality Improvement Tool

For a usable, excel version of this quality improvement tool, please see:

http://publichealth.lacounty.gov/owh/LARC.HTM

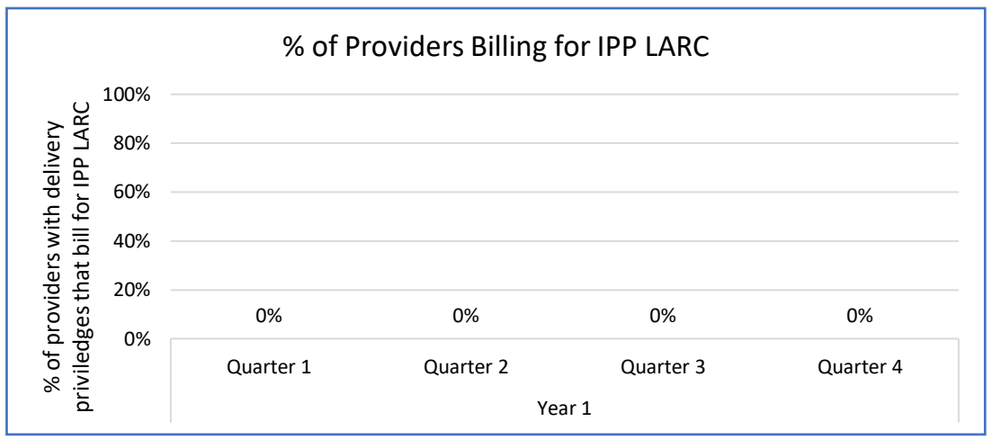
Immediate Postpartum LARC Implementation - Annual Summary Indicators

Indicator Name	Numerator Description	Numerator #	Denominator Description	Denominator #	Measure % Description	Measure %	What this evaluates	How to use this measure	Limitations of measure
IPP LARC coverage	Total number of Medicaid deliveries in the hospital that have billed for IPP LARC		Total number of Medicaid deliveries in the hospital		Proportion of Medicaid deliveries in the hospital that bill for IPP LARC		Proportion of delivering women with the opportunity to recieve IPP LARC through Medi-Cal, who received an IPP LARC method	Demonstrate level of IPP LARC among Medi-Cal patients in the hospital and how this level changes over time; demonstrate proportion of women without access to or declining IPP LARC	Hospital may have other LARC funding sources and not bill Medi-Cal, so this may be underestimated. To supplement data, hospitals can include a column for number of non-billed LARCs
3. IPP LARC uptake	# of paid IPP LARC claims		# of Medicaid deliveries at hospital		Proportion of delivering women given IPP LARC		Rate of paid IPP LARC claims	Track delivery of IPP LARC over time; estimate future claims and supply needs; demonstrate IPP LARC acceptability and impact	*See above*
4. IUD removal	# of Medicaid-enrollees with IPP IUD placement claim who have an IUD removal claim within 60 days of placement		# of paid IPP IUD placement claims		Proportion of IUDs removed within 60 days of IPP placement		Removal rate of IPP IUDs	Measure of sustained acceptability of IPP IUDs for women.	Will likely underestimate removals, since only those paid for by Medicaid within the first 2 months will be captured.
5. Implant removal	# of Medicaid-enrollees with IPP implant placement claim who have an implant removal claim within 60 days of placement		# of paid IPP implant placement claims		Proportion of implants removed within 60 days of IPP placement		Removal rate of IPP implants	Measure of sustained acceptability of IPP implants for women.	Will likely underestimate removals, since only those paid for by Medicaid within the first 2 months will be captured.

1. Provider Billing for IPP LARC

Percentage of providers in the hospital with delivery privileges that have billed for IPP LARC

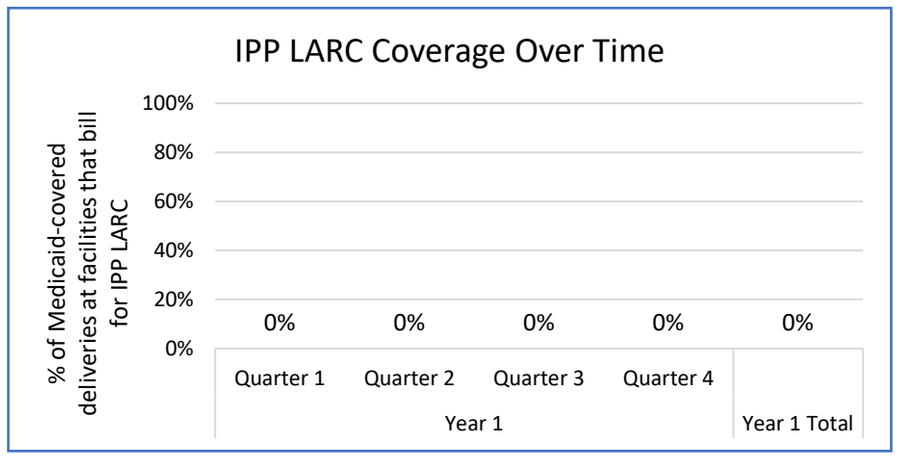
	Year 1			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total number of providers with delivery priviledges **that have billed** for IPP LARC				
Total number of providers with delivery priviledges **in the hospital**				
Proportion of providers with delivery priviledges that have billed for IPP LARC, by quarter				



2. IPP LARC Coverage

Data on proportion of Medi-Cal deliveries that billled for IPP LARC

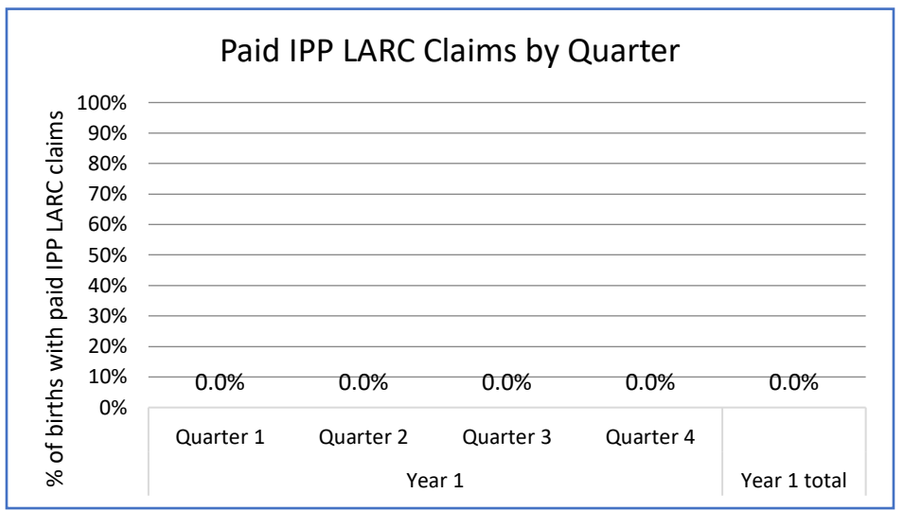
	Year 1				Year 1 Total
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Total number of Medicaid deliveries in the hospital that have billed for IPP LARC					0
Total number of Medicaid deliveries in the hospital					0
Proportion of Medicaid deliveries in the hospital that bill for IPP LARC, by quarter					



3. IPP LARC Uptake

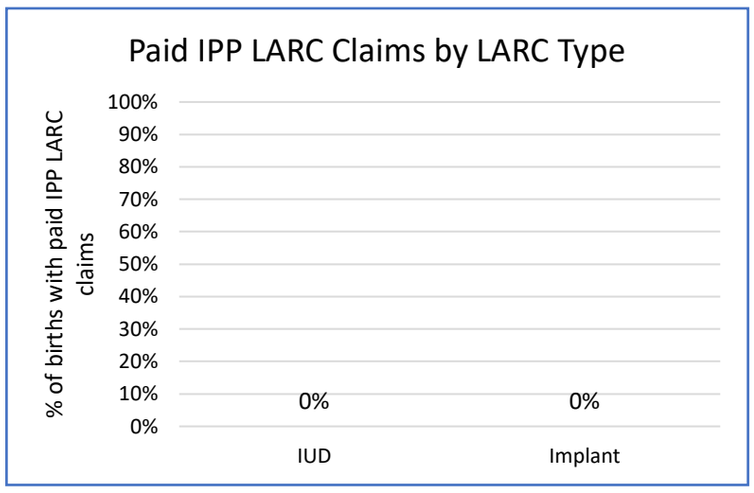
Data on how many Medicaid deliveries are associated with an IPP LARC claim

	Year 1				**Year 1 total**
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
# of paid IPP LARC claims					0
# of Medicaid deliveries at hospital					0
% of delivering women given IPP LARC, by quarter					



1 year data stratified by LARC type

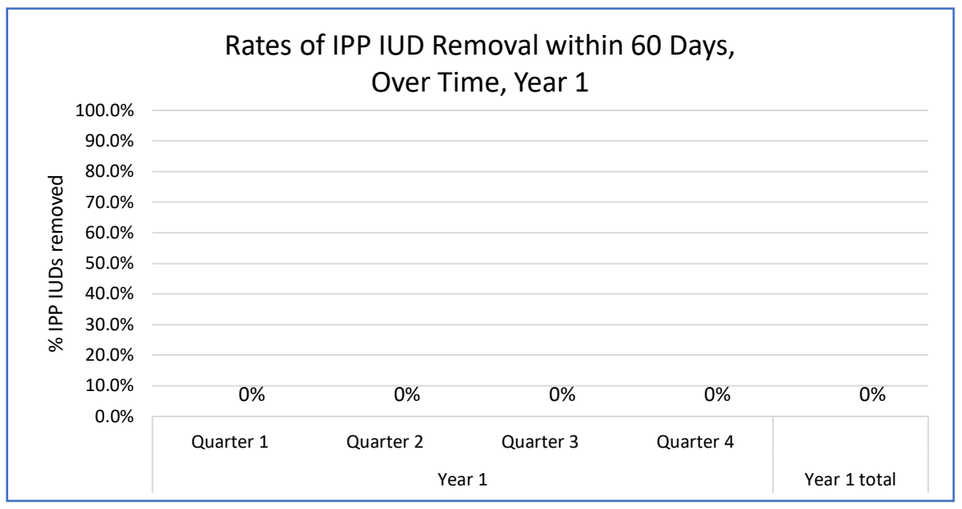
	LARC type	
	IUD	Implant
# of paid IPP LARC claims		
# of Medicaid deliveries at hospital		
% of delivering women given IPP LARC, by device type		



4. IUD Removal

Data on how many IUDs are removed within the first 60 days after immediate postpartum placement

	Year 1				Year 1 total
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
# of Medicaid-enrollees with IPP IUD placement claim who have an IUD removal claim within 60 days of placement					0
# of paid IPP IUD placement claims					0
% of IUDs removed within 60 days of placement, by quarter					



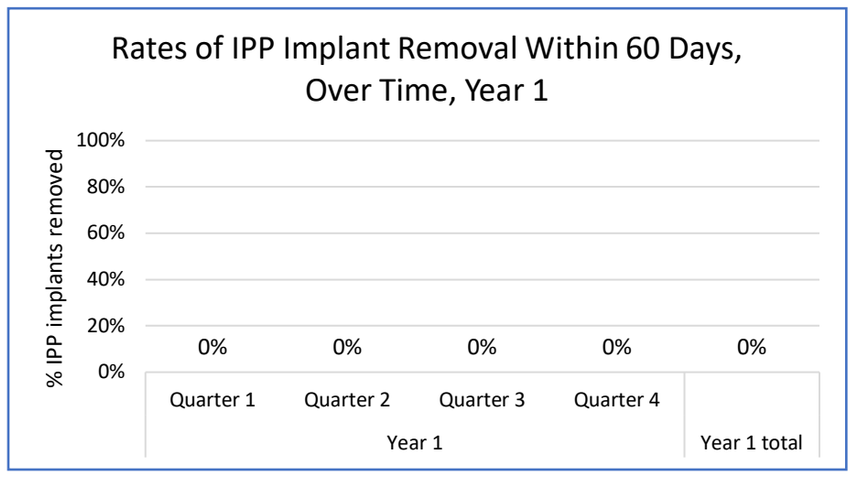
1 year data stratified by IUD type

	Type of Intrauterine Device	
	Copper T	Levonorgestrel
# of women with IPP IUD placement claim who have an IUD removal claim within 60 days of placement		
# of paid IPP IUD placement claims		
Proportion of IUDs removed within 60 days of placement		

5. Implant Removal

Data on how many implants are removed within the first 60 days after immediate postpartum placement

	Year 1				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year 1 total
# of Medicaid-enrollees with IPP implant placement claim who have an implant removal claim within 60 days of placement					0
# of paid IPP implant placement claims					0
% of IPP implants removed within 60 days of placement, by quarter					



Definitions: definitions of terms used in this document

Term	Suggested Definition	Definition Source
LARC	Long-acting reversible contraception (IUD, implant)	ACOG, accessed online at http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices on 2/16/2016
IUD	Intrauterine devices (Copper T280A IUD, levonorgestrel intrauterine system)	ACOG, accessed online at http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices on 2/16/2017
Implant	Single-rod contraceptive implant	ACOG, accessed online at http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices on 2/16/2018
IPP	Immediate postpartum contraception insertion--within 10 minutes of placental delivery	Levi EE, Stuart GS, Zerden ML, Garrett JM, Bryant AG. Intrauterine device placement during cesarean delivery and continued use 6 months postpartum: A randomized controlled trial. Obstet Gynecol 2015; 126:5-11.
Hospital	A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services.	Centers for Medicare and Medicaid Services, accessed online at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html on 2/16/2016

Codes: health system codes used to identify deliveries, contraceptive placements, and removals

Description	ICD-9	ICD-10	CPT	Healthcare Common Procedure Coding System Code (HCPCS)	NDC
IUD placement	V25.11, Encounter for insertion of intrauterine contraceptive device Procedure Code: 69.7, Insertion of intrauterine contraceptive device	Z30.430 Encounter for insertion of intrauterine contraceptive device Procedure Codes: 0UH97HZ, Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening 0UH98HZ, Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening Endoscopic 0UHC7HZ, Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening 0UHC8HZ, Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening Endoscopic	58300, Insertion of IUD	J7300, Intrauterine copper contraceptive (Paragard) J7301, Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg (Skyla) J7302, Levonorgestrel- releasing intrauterine contraceptive system, 52 mg (Mirena) Q0090, Levonorgestrel-releasing intrauterine contraceptive system, (Skyla), 13.5 mg J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration (Liletta) J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration (Mirena) S4989, Contraceptive intrauterine device (e.g. progestacertiud), including implants and supplies S4981, Insertion of levonorgestrel- releasing	50419042101, Mirena 50419042301, Mirena 67207042101, Mirena 50419042201, Skyla 50419042208, Skyla 50419042271, Skyla 51285020401,ParaGard 51285020402, ParaGard 52544003554, Liletta
IUD removal	V25.12 Removal of intrauterine contraceptive device Procedure Code: 97.71, Removal of intrauterine device	Z30.432 Encounter for removal of intrauterine contraceptive device Procedure Codes: 0UPD7HZ, Removal of Contraceptive Device from Uterus and Cervix, Via Natural or Artificial Opening 0UPD8HZ, Removal of Contraceptive Device from Uterus and Cervix, Via Natural or Artificial Opening Endoscopic	58301, Encounter for removal of intrauterine contraceptive device		
Implant placement	V25.5, Encounter for insertion of implantable subdermal contraceptive	Post October 1, 2016: Z30.017 - Encounter for initial prescription of implantable subdermal contraceptive	11981, Insertion, non-biodegradable drug delivery implant, Implanon or Nexplanon	J7306, Levonorgestrel (contraceptive) implant system, including implants and supplies J7307 Etonogestrel [contraceptive] implant system, including implant and supplies	00052027201, Etonogestrel implant system (Implanon) 00052027401, Etonogestrel implant system (Nexplanon) 00052433001, Etonogestrel implant system (Nexplanon)
Implant removal			11976, Removal, non-biodegradable drug delivery implant, Norplant 11982, Removal, non-biodegradable drug delivery implant, Implanon or Nexplanon		
Delivery	650, V27.0, V27.2, V27.3, V27.5, V27.6; 640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.x1, 646.x1, 646.x2, 647.x1, 647.x2, 648.x1, 655.x1, 656.01, 656.11, 656.21, 648.x2, 649.x1, 649.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.x2, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.x1, 665.x2, 666.x2, 667.x2, 668.x1, 668.x2, 669.x1, 669.x2, 670.02, 671.x1, 671.x2, 672.02, 673.x1, 673.x2, 674.x1, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2, 678.x1, 679.x1, 679.x2; 670.12, 670.22, 670.32, 670.82, Procedure codes for dates of service from January 1, 2015-September 30, 2015): 72.0-73.99, 74.0-74.20, 74.40, 74.99	Procedure codes for dates of service from January 1, 2015-September 30, 2015): 10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10E0XZZ	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622		

Source: Technical Specifications for FFY 2016 Reporting, Office of Population Affairs/Centers for Disease Control and Prevention

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