

The South Carolina Postpartum LARC Toolkit

A resource for implementing South Carolina's Medicaid policy on providing long-acting reversible contraceptive (LARC) services in the hospital postpartum setting.

A collaboration of the Choose Well Initiative & the South Carolina Birth Outcomes Initiative (SCBOI)

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About This Publication

This toolkit contains information that may expand or change as South Carolina hospitals gain more experience in postpartum LARC services. For the most current version of this toolkit, visit www.choosewellsc.org — or directly, www.choosewellsc.org/SC_Postpartum_LARC_Toolkit.pdf.

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The Choose Well Initiative is a four-year state-wide initiative (2017-2020) that seeks to reduce unintended pregnancy by developing and disseminating culturally appropriate information about all contraceptive methods, increasing women's, men's, and teens' access to contraceptive counseling and clinical services, and removing cost barriers so women and men can access highly effective contraceptive methods, if they desire. Our work seeks to achieve the following goals:

- › Improve access to effective contraceptive methods, especially costly implants and IUDs
- › Train and support health care providers to counsel about and offer contraceptive methods
- › Engage with community members to improve awareness of methods and services
- › Work to create a more positive policy environment that will enable women and men to access the services that they need and demand

When people have the tools and resources they need to take control of their reproductive health, they are empowered to truly Choose Well.

The South Carolina Birth Outcomes Initiative is directed by the South Carolina Department of Health and Human Services (SCDHHS) and comprised of participants from the South Carolina Hospital Association, March of Dimes, Blue Cross Blue Shield of South Carolina and over 100 stakeholders ranging from health care providers to researchers who aim to improve the health outcomes for newborns and mothers throughout the state's population.

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I. Introduction

Since 2011, the South Carolina Birth Outcomes Initiative (SCBOI) — a coordinated effort among South Carolina’s Department of Health and Human Services (SCDHHS), the South Carolina Hospital Association, March of Dimes, Blue Cross Blue Shield of South Carolina, and over 100 stakeholders — has worked to improve maternal and newborn health through the Medicaid program and for people throughout the state.

Recognizing the high personal, social, and financial costs of unintended pregnancies and the underutilized opportunity for contraceptive services in the immediate postpartum period, the SCBOI prioritized expanding access to long-acting reversible contraceptives (LARCs) soon after birth, before women are discharged from the hospital. LARCs — intrauterine devices (IUDs) and contraceptive implants — are safe, highly effective, and recommended first-line methods of pregnancy prevention for most women (including sexually active adolescents).^{*1,2}

In 2012, as a result of SCBOI efforts, South Carolina, through SCDHHS, was the first state in the nation to institute a Medicaid policy enabling hospitals and providers to receive full reimbursement (outside the global fee for delivery) for the LARC device and the physician insertion procedure fee when women received a LARC postpartum, prior to being discharged from the hospital.³ All the managed care organizations (MCOs) that contract with Medicaid in South Carolina have adopted the reimbursement policy. This policy has removed a substantial barrier to providing LARC services to women in the immediate postpartum period, enabling new mothers to choose and initiate highly effective methods of contraception in a timely manner. This is important given that approximately 55% of women using Medicaid to cover costs related to labor and delivery miss their six-week postpartum visit. Many women are not seen again by a physician until they return with an unintended pregnancy.

Successful hospital implementation of this policy involves changes in prenatal care counseling, educational outreach on billing and pharmacy procedures, and patient care during the hospital stay, requiring a coordinated effort among multiple hospital departments and with payers (insurers).

Inserting and removing LARCs is also within the scope of practice of Advanced Practice Registered Nurses (APRNs) in South Carolina.

THE POSTPARTUM LARC TOOLKIT

Based on the experiences of three South Carolina hospitals — Greenville Health System, Palmetto Health, and Spartanburg Regional Health System — and in consultation with DHHS/SCBOI, this toolkit provides guidance and resources for:

- › Planning for implementation
- › Clinical resources and training
- › Contraception counseling in prenatal care
- › Patient procedures in the hospital
- › Pharmacy ordering and stocking
- › Billing and reimbursement

This toolkit primarily presents experiences with contraceptive implants — the predominant LARC service offered by these South Carolina hospitals to date. The online version of this toolkit will be updated regularly as hospitals gain experience with immediate postpartum IUD insertions.

To date, 27 Medicaid agencies have adopted reimbursement policies for postpartum LARCs.³ We expect this toolkit will be an important aid for South Carolina hospitals as well as hospitals in other states interested in implementing postpartum LARC policies.

WHY POSTPARTUM LARC SERVICES?

LARCs are the most effective methods of reversible contraception, endorsed by the American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics, and the American Academy of Family Physicians.*

- › Use of LARCs reduces human error, can last three to 12 years, and is 99% effective.³
- › With typical use, 9 out of 100 and 18 out of 100 women will get pregnant within one year with the birth control pill and male condom, respectively.^{4,5}

The United States and the state of South Carolina continue to have high rates of unintended pregnancies and low use of LARCs.

- › Approximately 45% of all pregnancies and 75% of teen pregnancies are unintended.⁴
- › Nearly 1 in 5 teen births is a repeat birth.⁶
- › Use of LARCs has grown to 11.6% of women in the United States.³

The social and economic consequences of unintended or closely spaced pregnancies are substantial — for individual women, families, and society — including increased risk for adverse birth outcomes and health care costs.⁷

Prenatal and postpartum periods are ideal opportunities to provide contraceptive care. Women have increased contact with health care providers and may be more motivated to prevent a subsequent pregnancy than when they are not pregnant. Many women resume sexual activity before their postpartum checkup or do not attend this checkup. Offering women the option to choose a contraceptive method and providing LARC methods free of charge to women before their hospital discharge is critical for increasing contraceptive access and reducing the number of repeat, unintended pregnancies.¹

REMOVING BARRIERS TO LARC ACCESS

According to ACOG, a number of strategies can increase uptake of LARCs:¹

- › Offering continuing physician education on current practice guidelines, improvements in the current devices, and insertion procedures
- › Providing comprehensive patient counseling on the safety and effectiveness of LARCs
- › Reducing high up-front costs for devices (e.g., through the Affordable Care Act and Medicaid)
- › Changing clinical protocols to permit postpartum insertions and single-visit outpatient insertions

THE CONTRACEPTIVE CHOICE PROJECT

Positive Impacts of Expanding Access to LARCs

Increasing counseling and removing cost barriers result in higher use of LARCs and lowered rates of abortion and unintended pregnancy.

The Contraceptive CHOICE Project in St. Louis, Missouri, provided counseling and no-cost reversible contraception to more than 9,200 diverse women and adolescents wanting to prevent pregnancy for at least 12 months.^{5,8}

- › After standardized counseling on contraceptive methods, **75%** of women chose a LARC.
- › **86%** of women who chose a LARC method were still using that method one year later, compared with **55%** of women who chose a non-LARC method.
- › Rates of unintended pregnancy were **20 times higher** among women using a non-LARC method (birth control pill, patch, or ring).
- › The abortion rate among the CHOICE participants was **less than half** the national and regional rates.
- › The teen birth rate among the CHOICE participants was **6.3 births** per 1,000, compared with the national rate of **34.3 births** per 1,000.⁸

*For readers of the print version, the appendix includes web links.

II. Planning for Implementation

The three hospitals that participated in preparing this toolkit reported that the planning and implementation process for instituting postpartum LARC services took about six months. The timeline will vary depending on how quickly different hospital departments can convene for planning, the amount of effort needed to adjust the billing processes to meet the policy requirements, and the training needs for clinical staff.

Identifying a physician champion and nursing leader within the hospital who can facilitate the administrative coordination, lead the clinical process development, and ensure that clinical staff receives sufficient training is critical for success. Lactation consultant leadership may also be helpful to build support. The clinical leaders interviewed for the toolkit described the following implementation process:

1. BUILD ADMINISTRATIVE SUPPORT AND INFRASTRUCTURE

Convene clinical leadership and management representatives from billing and pharmacy departments.

- › Educate billing and pharmacy leadership on the importance and value of offering postpartum LARC services to women (see Why Postpartum LARC services?).⁹
- › Present SCDHHS Medicaid policy and discuss how hospitals will be reimbursed for the devices in addition to global labor and delivery charges and how physicians will receive reimbursement for the insertion procedures (see Hospital Billing and Reimbursement).

Build billing and pharmacy infrastructure.

- › Establish billing procedures. Claims submitted for inpatient LARCs must include the exact billing codes specified in the SCDHHS Medicaid or managed care organization (MCO) policy, involving varying levels of customization to claims processes depending on the hospital's system. Hospitals also should identify a mechanism to reconcile the Medicaid reimbursements with patient accounts and monitor and resolve denials (see Hospital Billing and Reimbursement).
- › Develop pharmacy procedures. The hospital pharmacy's role in providing postpartum LARCs involves changing institutional procedures to support physicians providing LARC services.⁹ Hospital pharmacies should make sure the devices are included in their order system then determine initial inventory levels. Hospitals interviewed recommended the devices be stocked on the

hospital floor rather than in the central pharmacy to avoid potential delays in performing insertion procedures. The devices are treated like any other medication that is stocked on the hospital floor.

- › Create order sets or add to billing forms for physicians to use when conducting an insertion procedure to ensure that the supplies, device, and procedure are appropriately billed. Order sets include the contraceptive device, local anesthetic, and steps for printing the consent form, garnering final consent, and performing the procedure before discharge.

Seek approval from administration.

- › One hospital described seeking approval from senior administration (hospital nursing leadership and the hospital's chief operating officer) before moving forward with implementation. For other hospitals, the clinical leadership determined this was unnecessary.

2. DEVELOP PROCESS WITH PHYSICIANS AND NURSES FOR INSERTIONS

Build clinical support for postpartum LARCs.

- › The need for building consensus regarding the value and appropriateness of the service will vary from hospital to hospital. Physician champions and nursing leaders should identify and resolve any concerns among physicians, nurses, or lactation consultants.
- › Physicians may be concerned about fitting in another procedure during rounds and believe

that the postpartum visit is the more appropriate time to offer contraceptive care. Physicians providing postpartum LARCs highlighted how the insertion procedure is very easy and quick (5-10 minutes).^{*} Sharing research regarding how quickly women resume sexual activity and the substantial proportion of women who do not return for postpartum visits can address these concerns (see Why Postpartum LARC services?).

- › While physicians are responsible for the contraceptive counseling and the procedure, RNs spend much more time with patients, serve as patient advocates, and are involved in explaining medications and side effects. Lactation consultants also play a critical role in patient education. RNs and lactation consultants may need education and reassurance that the LARC methods will not interfere with breastfeeding (see Clinical Resources and Training). It is important to ensure that patient education offered by nurses and lactation consultants is consistent with physician counseling.

Convene clinical staff to develop the counseling, consent, and insertion procedures.

- › Hospitals chose either to convene physicians only or physicians and nursing staff together to develop the postpartum insertion procedure.
- › One or more meetings with clinical staff will be necessary to determine the logistics of the process among physicians and nursing staff.
- › Considerations include timing and location for counseling/consent and the procedure, roles and responsibilities for nursing regarding supplies, and documentation processes.
- › Prenatal care counseling procedures and documentation should be reviewed to make sure that all women receive education on postpartum LARC options, and that women's preferences are documented and transferred to the hospital. Hospital clinicians should be able to identify women who plan to receive a LARC method in the hospital and those who may need additional counseling immediately postpartum.

Develop a process that is integrated into the usual operations of the labor and delivery or postpartum floor.

- › Hospitals did not identify a need to develop written policies specific for insertions. Once the billing and pharmacy infrastructure was developed, the insertion procedure is treated as any other hospital process. Hospitals reported this integration was both easy and necessary.
- › One hospital developed a checklist for nursing and physician reference prior to conducting the insertion process.
- › Another hospital developed written procedure notes for resident and attending physicians' chart documentation and a pre-printed patient instructions sheet (see the Appendix).

3. TRAIN ALL CLINICAL STAFF

- › Prenatal care providers. Prenatal care providers whose patients deliver at the hospital need to understand how the LARC procedure at the hospital works so they can provide complete patient education and answer questions. In-services or continuing education on best practices in contraceptive counseling are also key to providing evidence-based counseling to increase women's interest in postpartum LARC services (see Prenatal Contraceptive Counseling). Training on documentation of contraceptive counseling and women's plans may also be necessary.
- › Physicians, including residents (if applicable). All physicians must be trained prior to performing insertions (see Clinical Resources and Training). Some hospitals with residency programs incorporated LARC training into their new resident curriculum.
- › Nurses. Once the insertion procedures are determined, conducting an in-service with current nursing staff will ensure all nurses are knowledgeable and prepared to support patient education and assist during the procedures. As new RNs are hired, they will primarily learn the process through on-the-job training.

- › Lactation consultants. Because of their role in providing patient education about contraceptive methods while breastfeeding, conducting a short in-service will give lactation consultants the information, tools, and resources they need to support women's decision-making regarding postpartum LARCs. In particular, training should emphasize that the contraceptive implant has a much lower dose of progesterone than the birth control shot (Depo-Provera).

4. MAKE ADJUSTMENTS AS NEEDED TO IMPROVE PROCESS.

- › The clinical leadership should reconvene clinical staff on a regular basis, or as appropriate, to review how the postpartum LARC procedures are working and identify any needed changes.
- › Billing staff should review the payments received against claims submission data to identify any issues with denials.
- › Billing staff should hold meetings with Medicaid staff or MCO representatives to discuss and resolve any billing or reimbursement issues (see Hospital Billing and Reimbursement).
- › 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. Because many women will visit a different provider for future family planning services, monitoring removal rates and reasons may not be accurate at the provider level.

^{*}Please note that this refers to insertion of the contraceptive implant prior to discharge from the hospital.

III. Clinical Resources & Training

LARCS ARE SAFE AND EFFECTIVE WHEN INSERTED IMMEDIATELY POSTPARTUM

Clinical practice guidelines from the Centers for Disease Control and Prevention and the American Congress of Obstetricians and Gynecologists support immediate postpartum insertions for both IUDs and contraceptive implants, with few contraindications.

Although the use of IUDs and contraceptive implants immediately postpartum are off-label, insertions are safe and effective and supported by the US Medical Eligibility Criteria for Contraceptive Use.¹⁰

INTRAUTERINE DEVICES (IUDS)

The copper IUD (ParaGard®) can be used for 10 years, and the levonorgestrel IUDs (Skyla®, Liletta®, Mirena®, and Kyleena®) from three to five years, with failure rates similar to female sterilization. ACOG's Practice Bulletin #121 provides guidance on patient counseling for complications and side effects.

For all IUDs, immediate postpartum insertions are safe and effective. When inserted within 10 minutes of placental separation, the copper-containing IUD (ParaGard) has no restrictions on its use (medical eligibility criteria category 1). After this period up to four weeks postpartum, the advantages of insertion generally outweigh the theoretical or proven risks (medical eligibility criteria category 2).^{10,11}

For the levonorgestrel IUDs (Skyla®, Liletta®, Mirena®, and Kyleena®) the advantages of postpartum insertion generally outweigh the theoretical or proven risks (medical eligibility criteria category 2). The hormonal content of the levonorgestrel IUD poses a theoretical concern for milk production and infant growth and development, although published research has not documented this effect.^{10,11}

Contraindications for immediate postpartum IUD insertion include peripartum chorioamnionitis, endometritis, and puerperal sepsis.

In interviews with South Carolina hospitals offering postpartum LARCs, providers indicated that the recommended insertion timing (within 10 minutes of placental delivery) can pose logistical challenges. Some providers also expressed concern with expulsion rates; the expulsion rate

for insertions between 10 minutes post-placental delivery and 48 hours may be as high as 24%.⁹ Intra-cesarean insertions may have lower expulsion rates (8% in a recent randomized control trial).¹² Given this evidence, SC hospitals should offer IUD placement to women requiring cesarean delivery. For both vaginal and cesarean deliveries, the benefits of convenience and pregnancy prevention may exceed the expulsion risk.

CONTRACEPTIVE (HORMONAL) IMPLANT

The contraceptive implant (Nexplanon®) can be used for three years, and is a highly effective method of reversible contraception. ACOG's Practice Bulletin #121 provides guidance on patient counseling for complications, which are uncommon, and side effects.

For non-breastfeeding women, the implant has no restrictions on immediate postpartum use (medical eligibility criteria category 1). Limited data on hormonal methods' effects on breastfeeding indicate no negative effects on breastfeeding outcomes. Because of theoretical concerns related to hormonal effects on milk production and infant growth and development, the advantages of insertion generally outweigh the theoretical or proven risks (medical eligibility criteria category 2).

CLINICAL TRAINING OPPORTUNITIES

All health care providers performing LARC insertions must complete appropriate training. Providers performing implant insertions and removals must complete manufacturer training. ACOG's LARC Program provides a list of clinical training resources for each of the devices.

IV. Prenatal Contraceptive Counseling

The goal of contraceptive counseling is to provide women with information and support to select the method — including a postpartum LARC — that best fits their preferences and meets their needs. Counseling can address women's knowledge and misconceptions about LARCs. Because the quality of counseling affects women's method selection and their satisfaction with their choice,¹³ prenatal contraceptive counseling is critical for ensuring that when women do choose a LARC, they feel fully informed about and comfortable with the method.

Contraception counseling should begin at the first prenatal visit. For women who are not ready to commit to a method, reproductive life planning questions and motivational interviewing techniques can help them begin to consider their options.¹⁴

A shared decision-making model of contraceptive counseling — defined as a collaboration between patients and providers where health care decisions are made together, after considering women's preferences, values, and the best scientific evidence — is both useful and efficient, and keeps patient preferences at the forefront. In ACOG's Contraceptive Counseling and LARC Uptake webinar, Dr. Christine Dehlendorf offers guidance for providers on the shared decision-making process with women (including adolescents), including:

- › Establish rapport with patients and take an interest in them as people. The relationship is important.
- › Focus on women's preferences. Ask them what is important to them about their contraceptive method. Probe for preferences related to effectiveness, how the method is used, returning to fertility, and side effects.
- › Provide context by comparing and contrasting the different methods' characteristics.
- › Describe effectiveness and side effects in easy-to-understand frequencies.
- › Respectfully ask for permission to provide information on other methods so women can make a decision based on full information.
- › Tailor information by considering women's preferences and their relative importance.
- › Address misconceptions respectfully by validating women's experiences or beliefs and providing information.

- › Discuss the logistics of getting their selected method — including costs and insurance coverage, and hospital procedures for postpartum LARCs.
- › Offer an opportunity for women to ask questions and discuss a plan if they are not satisfied with their choice.

Women should also be counseled about the importance of using condoms to reduce the risk for sexually transmitted infections and HIV infection.

BEDSIDER.ORG

Medically Accurate, Interactive Contraceptive Counseling

At **Bedsider.org**, women can compare different methods, view real stories from women and men about their experiences with different methods, find providers, and sign up for appointment and birth control reminders. The site highlights implants and IUDs as recommended methods. Spanish version: bedsider.org/es

The providers' version of Bedsider.org provides tools and content to support providers' capacity to provide contraception counseling. The site is operated by the National Campaign to Prevent Teen and Unplanned Pregnancy.

Ongoing research on Bedsider.org supported by ACOG indicates women using Bedsider.org as an addition to provider contraceptive counseling had increased knowledge of contraceptive methods and intention to use LARCs. Women found the site informative, engaging, and easy to use.

Visit ACOG's LARC Practice Resources for more information on incorporating this support tool into clinical practice.

Providers will also benefit from new research on LARC messaging by the National Campaign to Prevent Teen and Unplanned Pregnancy.

V. Patient Procedures at the Hospital

CONTRACEPTIVE IMPLANTS & IUDS

Hospitals offering immediate postpartum insertions of contraceptive implants follow similar procedures for patient counseling and consent as well as method insertion. All the providers interviewed for the toolkit stated that it was easy to integrate these procedures into their hospital operations.

Prenatal contraceptive counseling

- › Ensure that all women receive contraceptive counseling during prenatal care, including postpartum LARC options. These counseling activities are documented in medical charts (see Prenatal Contraceptive Counseling).
- › Transfer women's contraceptive plans to the hospital. For systems with integrated electronic medical records, hospital clinicians can easily identify women who have chosen a postpartum LARC. Other hospitals receive this information through other information-sharing strategies (for example, faxing the hospital with patient problem list and prenatal flow sheet upon admission for delivery).

Counseling and consent postpartum

- › During rounds, ensure that physicians provide brief counseling on the contraceptive implant to all women* — including those who have already been identified as wanting a contraceptive implant and those who may be undecided or interested in learning about this option. Counseling needs to emphasize possible side effects, particularly risks for irregular bleeding (see Prenatal Contraceptive Counseling).
- › For women who decide to have the contraceptive implant procedure, the nursing staff must make sure physicians have consent forms for women to sign. Hospitals use a general consent form, not one specific to the contraceptive implant. Women sign the consent form. A "time out" is done before starting the procedure to confirm that the correct patient, site, and procedure have been identified, and that all required documents and equipment are available and ready for use.

*Processes at some hospitals include verifying insurance coverage, including Medicaid coverage. Physicians may not offer postpartum LARCs to women who are self-pay because of the high up-front costs. Hospitals may need to seek pre- authorization from some insurance plans for implants or IUDs.

Contraceptive implant insertion procedure

- › Insertions at the bedside. Two hospitals perform the implant insertion procedure bedside. Nurses obtain the devices and the local anesthetic (the supplies that are to be charged to the patient's account) from the pharmacy supply cabinets on the floor. One hospital keeps general supplies needed in a tackle box; at another hospital, nurses use brown paper bags stocked with supplies. Nurses are present at the procedure.
- › Insertions in the procedure room. One hospital already had a room on the postpartum floor for conducting procedures, which they now use for implant insertions as well. The room is stocked with needed supplies and clinical staff can refer to a posted checklist (see Appendix) when conducting insertions. Nurses take the devices and any supplies that will be charged to the patient's account to the procedure room. Nurses are present for the insertion procedure.
- › Device stocking. Hospital pharmacies should authorize devices to be stocked on the delivery or postpartum floor. Alternatively, pharmacies may require physicians to order the devices immediately before the procedure.
- › Documentation. The procedure must be documented in the medical charts (see Appendix sample) and women should receive a patient handout with instructions (see Appendix sample).

Contraceptive IUD insertion procedure after vaginal delivery

- › Remove the sterile gloves worn during the delivery, replacing them with a clean pair of sterile gloves.
- › Using a hand or retractor, expose and visualize the anterior cervix.
- › Grasp the cervix with another ring forceps. Clean the cervix with Betadine.
- › Prepare the IUD applicator as usual or grasp the IUD with the ring forceps at a slight angle so that the stem and the strings are parallel to the forceps; this will help prevent the strings from being entangled with the ring forceps. The ring forceps should not be locked since this could crush the IUD device.
- › While retracting gently on the cervix and under direct visualization, introduce the IUD through the cervix into the lower uterine segment.

- › Release the hand that is holding the ring forceps attached the cervix and place it on the abdomen. Stabilize the uterus with this hand.
- › Advance the IUD to the uterine fundus. Confirm fundal placement with both the abdominal hand and the inserting hand.
- › Release the IUD from the ring forceps or IUD applicator.
- › Rotate the ring forceps about 45° and remove the instrument laterally to avoid dislodging the IUD. If using a Mirena IUD applicator, it can be removed in the typical fashion.
- › Inspect the vagina; if IUD strings are visible, the IUD may be placed too low and reinsertion should be considered. The strings usually descend spontaneously through the cervix and can be trimmed at a follow-up visit.
- › If fundal placement is confirmed and strings are seen, trim strings to the level of the cervix. They may be trimmed further if needed at the 6-weeks postpartum check.

Contraceptive manual IUD insertion after vaginal delivery procedure

Manual insertion can be accomplished requiring no instruments; however, it may be more painful than insertion with ring forceps or the IUD applicator in the absence of anesthesia.

- › Remove the sterile gloves worn during the delivery, replacing them with a clean pair of sterile gloves.
- › Using a hand or retractor, expose and visualize the anterior cervix.
- › Locate cervix. Clean the cervix with Betadine.
- › Introduce the IUD through the cervix into the lower uterine segment.
- › On the abdomen, stabilize the uterus with a hand on the fundus.
- › Advance the IUD to the uterine fundus.
- › Release the IUD, and withdraw hand slowly.
- › If fundal placement is confirmed and strings are seen, trim strings to the level of the cervix. They may be trimmed further if needed at the 6-weeks postpartum check.

Contraceptive IUD placement at the time of C-section

- › The preoperative time out should include IUD placement as part of the procedure and the device accounted for as an implant.
- › At cesarean insertion, place the IUD in the uterus at the top of the uterine fundus with the insertion device, ring forceps, or manually. If using the insertion device or ring forceps, the surgical assistant can place a hand outside the uterus to stabilize the IUD in the fundus as the inserter is withdrawn. Strings are then gathered and placed inside the uterus, directed towards the cervix.
- › Be certain that the IUD remains at the fundus of the uterus prior to closing the uterine incision.
- › Before closing the uterine incision, place the strings in the lower uterine segment.
- › The strings will usually descend spontaneously through the cervix during the puerperal period. If needed, the strings can be trimmed further at the 6-weeks postpartum follow-up visit.

Immediate postpartum placement of intra-uterine contraception in the delivery room or operating room is safe, effective and offers the patient an advantage in immediate protection and convenience, avoiding the necessity of additional visits and possible loss of opportunity for placement. Additional information can be found at the following websites:

<https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb186.pdf?dmc=1&ts=20171025T1219247445>

RESOURCES FOR DEVELOPING HOSPITAL PROCEDURES

The South Carolina Birth Outcomes Initiative conducted a webinar in March 2015 titled **Long-Acting Reversible Contraceptives (LARCs): Postpartum Contraceptive Access in South Carolina**. Greenville Health System and Palmetto Health Richland shared their processes and experiences with postpartum contraceptive implants in this webinar. Access the presentation and recorded webinar at www.scdhhs.gov/organizations/boi.

Rhonda Quiñones

Ms. Quiñones, the director of nursing at Palmetto Health, shows the procedure room used for contraceptive implant insertions. A checklist is posted on the wall for clinician reference.

Dr. Ty Robinson

Dr. Robinson demonstrates, at Spartanburg Regional, the supplies (gathered in a simple paper bag) for a bedside implant insertion procedure.

Dr. Megan Nguyen

Dr. Nguyen presents the tackle box of insertion supplies used at Greenville Memorial Hospital (Greenville Health System).

Implant insertions take just 5-10 minutes and are easy to fit in to the routine on the postpartum floor.

SUPPLY LIST

- › Sterile gloves
- › Sterile towels
- › Betadine swabs
- › Sterile marking pen
- › 18- & 23-gauge needles
- › Band-Aids
- › Dressing

VI. Hospital Billing & Reimbursement

The South Carolina Postpartum LARC Medicaid policy states that the LARC device cost is an “add-on,” in that it is covered in addition to the global overall charges for labor and delivery billed under the diagnosis-related group (DRG). Physicians who perform LARC insertions bill and are paid separately, with payment based on the South Carolina Medicaid fee schedule.

Hospitals providing LARC services have adopted varying techniques for billing and reimbursement alignment. All sites acknowledged the importance of:

1. Determining whether the billing system is adaptable to allow for line items outside the DRG and when possible altering the program to streamline billing for LARCs.
2. Submitting all required information exactly according to the policy to avoid claims being denied.
3. Working with the assigned Medicaid program coordinator/manager and Medicaid managed care company outreach staff.

Hospitals should consult South Carolina DHHS' Clarification Bulletin on Long-Acting Reversible Contraceptives provided in an Inpatient Hospital Setting for detailed billing guidance. DHHS reimburses hospitals through a gross-level credit adjustment after receiving the hospital claim. Providers receive a monthly list of claims included in the gross-level adjustment for verification.

Required Information

Part A: UB-04 (CMS 1450)

- › HCPCS Code for device (636 revenue code)
- › ICD-10 Surgical Code
- › ICD-10 Diagnosis Code

Part B: CMS 1500

- › Device insertion CPT codes — In SC for MCOs, this will be dependent on contract obligations.

Note that the capitation rates for the managed care organizations contracted with Medicaid include coverage for postpartum inpatient and outpatient LARCs.

The codes listed in the table on the next page are intended for guidance and subject to change. Please verify information to ensure accuracy for billing.

BILLING RESOURCES

South Carolina Department of Health and Human Services, Clarification Bulletin on Long-Acting Reversible Contraceptives provided in an Inpatient Hospital Setting. Provides detailed instructions for billing inpatient LARCs. The billing process remains the same with ICD-10.

Association of State and Territorial Health Officials, Long-Acting Reversible Contraception Medicaid Policies, Codes, and Guidance. Provides links to South Carolina and other state policies and guidance on LARCS.

Intrauterine Devices and Implants: A Guide to Reimbursement describes public and commercial coverage of LARCs and provides resources for stocking, reimbursement, and other issues related to LARCs. The guide was developed by the American College of Obstetricians and Gynecologists, the National Family Planning & Reproductive Health Association, the National Health Law Program, the National Women's Law Center, and the University of California, San Francisco, Bixby Center for Global Reproductive Health.

ICD-10 CODES FOR INPATIENT LARC BILLING

HCPCS CODES	
J7297	Levonorgestrel IU contraceptive, 52mg (Liletta®)
J7298	Levonorgestrel IU contraceptive, 52mg (Mirena®)
J7300	Intrauterine copper contraceptive (ParaGard®)
J7301	Levonogestrel IU contraceptive, 13.5mg (Skyla®)
J7307	Etonogestrel contraceptive (Implanon®/Nexplanon®)
Q9984	Levonogestrel IU contraceptive, 19.5mg (Kyleena®)
A4264*	Essure™
ICD-10 SURGICAL CODES	
OUH97HZ	Insertion of Contraceptive Device into Uterus, Via Opening
OUH98HZ	Insertion of Contraceptive Device into Uterus, Endo
OUHC7HZ	Insertion of Contraceptive Device into Cervix, Via Opening
OUHC8HZ	Insertion of Contraceptive Device into Cervix, Endo
OUL74CZ	Occlusion Bi Fallopian Tube w Extralum Dev, Perc Endo
OUL74DZ	Occlusion Bi Fallopian Tube w Intralum Dev, Perc Endo
OUL78DZ	Occlusion of Bi Fallopian Tube with Intralum Dev, Endo
OU574ZZ	Destruction of Bilateral Fallopian Tubes, Perc Endo Approach
OU578ZZ	Destruction of Bilateral Fallopian Tubes, Endo
OUL78ZZ	Occlusion of Bilateral Fallopian Tubes, Endo
OUL74ZZ	Occlusion of Bilateral Fallopian Tubes, Perc Endo Approach
ICD-10 DIAGNOSIS CODES	
Z30.013	Encounter for initial prescription of injectable contraceptive
Z30.014	Encounter for initial prescription of intrauterine contraceptive device
Z30.018	Encounter for initial prescription of other contraceptives
Z30.019	Encounter for initial prescription of contraceptives, unspecified
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z30.49	Encounter for surveillance of other contraceptives
CPT CODES	
58300	Insertion of intrauterine device
11981	Insertion of contraceptive implant
58565-33	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

*Although this toolkit focuses on LARCs, billing information for Essure is provided as it is included in the Medicaid bulletin.

VII. References

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14. Diedrich J. Provider to provider: Contraception as empowerment. <http://providers.bedsider.org/articles/contraception-as-empowerment>. 2014 9/10/14. Accessed June 30, 2015.

VIII. Appendix

ADDITIONAL RESOURCES

American College of Obstetricians and Gynecologists: Committee Opinion Number 186, Long-Acting Reversible Contraception: Implants and Intrauterine Devices (2017)	https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins---Gynecology/Public/pb186.pdf?dmc=1&ts=20171025T1219247445	Curtis KM, Jataoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1-66.	https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm
American College of Obstetricians and Gynecologists: Committee Opinion Number 642 (2015), Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy	http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Increasing-Access-to-Contraceptive-Implants-and-Intrauterine-Devices-to-Reduce-Unintended-Pregnancy	Health Resources and Services Administration: 340B Drug Pricing Program	http://www.hrsa.gov/opa
Whoops Proof Birth Control: Increasing Awareness and Positive Regard for IUDs and the Implant Through an Advertising Campaign (2017). Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.	https://thenationalcampaign.org/resource/whoops-proof-birth-control-2017	American Academy of Family Physicians: Practice Guidelines for the Use of Long-Acting Reversible Contraceptives (2012)	http://www.aafp.org/afp/2012/0215/p403.html
South Carolina Department of Health and Human Services and American College of Obstetricians and Gynecologists: Revenue Cycle for Immediate Postpartum LARC Webinar	https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=490885&PCAT=2791&CAT=10707	American Academy of Pediatrics: Policy Statement, Contraception for Adolescents (2014)	http://pediatrics.aappublications.org/content/134/4/e1244.full
Crockett, AH, Pickell, LB, Heberlein EC, Billings, DL, Mills, B. (2016). Six- and twelve-month documented removal rates among women electing postpartum inpatient compared to delayed or interval contraceptive implant insertions after Medicaid payment reform. pii: S0010-7824(16)30145-7. doi: 10.1016/j.contraception.2016.07.004.	https://www.ncbi.nlm.nih.gov/pubmed/27400823	American College of Clinical Pharmacy, Women's Health Practice and Research Network: Role of Pharmacist in Use of Safe and Highly Effective LARC (2014)	https://www.accp.com/docs/positions/opinionPapers/LARC%20PRN%20Opinion.pdf
South Carolina Department of Health and Human Services: Clarification Bulletin on Long Acting Reversible Contraceptives provided in an Inpatient Hospital Setting (2013).	https://www.scdhhs.gov/press-release/clarification-bulletin-long-acting-reversible-contraceptives-provided-inpatient	American College of Obstetricians and Gynecologists LARC Program: LARC Clinician Education and Training	http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Clinician-Education-and-Training
Association of State and Territorial Health Officials: Long-Acting Reversible Contraception Medicaid Policies, Codes, and Guidance	http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies/?terms=LARCs+postpartum	American College of Obstetricians and Gynecologists LARC Program: LARC Practice Resources	http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Practice-Resources
		American College of Obstetricians and Gynecologists LARC Program: Projects to Assess Bedsider in Ob-Gyn Practice	http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Projects-to-Assess-Bedsider-in-Ob-Gyn-Practice
		American College of Obstetricians and Gynecologists On-Demand Webinars: Contraceptive Counseling and LARC Uptake, with Christine Dehlendorf, MD, MAS (2014)	https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=490885&PCAT=2791&CAT=9049
		American College of Obstetricians and Gynecologists, the National Family Planning & Reproductive Health Association, the National Health Law Program, the National Women's Law Center, and the University of California, San Francisco, Bixby Center for Global Reproductive Health: Intrauterine Devices and Implants: A Guide to Reimbursement	http://www.nationalfamilyplanning.org/file/documents---reports/LARC_Report_2014_R5_forWeb.pdf

CONTRACEPTIVE IUD CHECKLIST

(Courtesy of Palmetto Health)

- › Verify patient's name and birth date
- › Counsel patient, provide informational pamphlet
- › Patient signs IUD consent
- › Order IUD 'On Call' from order set in EMR
- › Call nurse to verify that IUD is on the floor, or in the Pyxis, and instruct nurse to bring in the room before delivery
- › Provider verifies if they will place by hand, with the introducer, or with ring forceps
- › Procedure performed at time of placental delivery, and documented in nursing note
- › Procedure card signed, dated, and given to patient
- › Procedure included by Provider in Delivery or Operative Note

SAMPLE ORDER SET

Choose one:

- › **Mirena® IUD** (52 mg levonorgestrel-releasing intrauterine system)
- › **Kyleena® IUD** (19.5 mg levonorgestrel-releasing intrauterine system)
- › **Skyla® IUD** (13.5 mg levonorgestrel-releasing intrauterine system)
- › **Paraguard® IUD** (copper-releasing intrauterine system)

Device ordered from EMR 'On Call' so it can be brought to the floor as soon as needed

Have ultrasound available to evaluate fundal placement as needed

On Mayo stand or delivery table:

- › Sterile gloves
- › Rings forceps x2
- › Betadine

CONTRACEPTIVE IMPLANT CHECKLIST

(Courtesy of Palmetto Health)

This checklist can be modified and posted in the procedure room or can accompany the supplies.

- › Verify patient's insurance (do not place if self-pay or enrolled in emergency Medicaid)
- › If Tricare insurance, the patient will need to have preauthorization
- › Provider has 3 observed placements with upper level or attending
- › Counsel patient
- › Order Nexplanon and Lidocaine
- › Call nurses to verify that Nexplanon is on the floor and nurses are available for placement
- › Patient signs Nexplanon consent
- › Procedure performed in treatment room
- › Compression bandage placed for 24 hours

NEXPLANON PATIENT INSTRUCTIONS

(Courtesy of Spartanburg Regional Healthcare System)

These instructions can be given to patients after the insertion procedure.

- › Keep the wrap on your arm for 24 hours. You can take the Band-Aid off in 2-3 days.
- › You may have some pain and bruising. You can use ice packs and ibuprofen to help with this.
- › If you develop any signs of infection (redness, swelling, discharge), please contact our office.
- › Remember, this takes about 5 days to start working — you should use another form of birth control until then.

SAMPLE ORDER SET

(Courtesy of Greenville Health System)

- › **Etonogestrel (Nexplanon)** 68 mg Implant for Subdermal Insertion
- › **Etonogestrel** 68 mg IMPLANT x 1 dose prior to discharge
- › **Lidocaine** 2% 3-5 ml SBQ x 1 dose for Etonogestrel insertion
- › Patient to receive Nexplanon Implant prior to discharge
- › Initiate/Print Consent for Nexplanon Insertion
- › Initiate/Print Bedside Timeout

SAMPLE PROCEDURE NOTE

(Courtesy of Spartanburg Regional Healthcare System)

Date: _____

Time: _____

Nexplanon Insertion

After informed consent was obtained, area was prepped in sterile fashion. 1% lidocaine was used for local anesthesia. Nexplanon was inserted in usual fashion without difficulty.

Obturator was seen. Rod was palpated by me and patient. Band-Aid and coban were placed over site. Post-procedure instructions were discussed with patient. Patient tolerated procedure well. Insertion card was given to patient.

Resident

I was present for entire procedure. Above resident physician has undergone appropriate training for procedure

Attending

[NEXPLANON INSERTION STICKER]

[PATIENT STICKER]

A collaboration of the Choose Well Initiative & the South Carolina Birth Outcomes Initiative (SCBOI)

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