

VIRGINIA Postpartum LARC TOOLKIT

A Resource for Providing
and Obtaining Payment for
Postpartum Long Acting
Reversible Contraception
(LARCs) in Hospitals

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Virginia Medicaid

Department of Medical Assistance Services

A collaboration of the Virginia Department of Medical Assistance Services, the Virginia Department of Health, and the Virginia chapter of the American College of Obstetricians and Gynecologists.

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About This Publication

This toolkit contains information that may expand or change as Virginia hospitals gain more experience in postpartum LARC services. For the most current version of this toolkit, visit [VDH's Family Planning Resources webpage](#).

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The Virginia LARC Stakeholder Workgroup is a coalition including the Virginia Department of Health, the Virginia Department of Medical Assistance Services, the Virginia chapter of the American College of Obstetricians and Gynecologists, as well as other providers and stakeholders in the state. The workgroup was developed in 2016 to increase access to the moderately and most effective contraceptive methods, including immediate post-partum access. The group aims to reduce unintended pregnancies among patients of childbearing age and increase access to quality comprehensive family planning services. In 2021, the group changed its name to the Virginia Contraceptive Access Network.

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I. Introduction

The Virginia LARC Stakeholder Workgroup (now called the Virginia Contraceptive Access Network) is a coalition of agencies and health providers working to expand contraceptive access in Virginia to improve health outcomes for birthing people and their families, and further the Virginia Department of Health's aim of becoming the healthiest state in the nation.

Recognizing the high personal, social and financial costs of unintended pregnancies and the underutilized opportunity for contraceptive services in the immediate postpartum period, the Virginia LARC Stakeholder Workgroup prioritized expanding access to long-acting reversible contraceptives (LARCs) soon after birth, including before patients 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 patients (including sexually active adolescents).^{1,2}

As of January 1, 2017, Virginia updated its Medicaid payment policy to enable hospitals and providers to receive separate reimbursements (outside the global fee for delivery) for the LARC device and the physician insertion procedure fee when patients receive a LARC immediately postpartum, prior to being discharged from the hospital. This applies to Medicaid and FAMIS Fee-for-Service members as well as those Medicaid and FAMIS members enrolled in a Medicaid Managed Care Organization (MCO). The reimbursement for the LARC will be considered a separate payment and will not be included in the Diagnostic Related Group (DRG) reimbursed to the facility. This policy removes a substantial barrier to providing LARC services to patients in the immediate postpartum period, enabling new mothers to choose and initiate highly effective methods of contraception in a timely manner. This is important because many patients using Medicaid to cover costs related to labor and delivery miss their six week postpartum visit for a variety of reasons, and may not be seen again by a physician until they return with an unintended pregnancy.

For patients with private insurance, hospitals will need to use “white bagging” in order to obtain LARC devices. This means that the hospital would need to order patient-specific medication to be shipped directly to the facility in advance of delivery. This will allow patients with private insurance who have chosen to receive a LARC method during the immediate postpartum period to access the contraceptive.

Successful hospital implementation of these policies 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 payers (insurers).

THE POSTPARTUM LARC TOOLKIT

This toolkit provides guidance and resources for Virginia hospitals who want to begin offering immediate postpartum LARCs, including information on:

- **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 includes information on both implant and IUD insertions immediately postpartum. The online version of this toolkit will be updated regularly as hospitals gain experience with both procedures.

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

UPDATES

Visit [VDH's Family Planning Resources webpage](#) for updated versions of the toolkit. Please email reproductivehealth@vdh.virginia.gov to provide information or updates that should be added to this toolkit.

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](#).

- **Fewer than 1 in 100 patients using an IUD or implant will get pregnant within one year.**⁴
- With typical use, 7 out of 100 and 13 out of 100 patients will get pregnant within one year with the birth control pill and insertive/external/male condom, respectively.⁴

The United States and the state of Virginia show declining rates of unintended pregnancies and increased LARC utilization.

- Approximately 45% of pregnancies are unintended in the United States. In Virginia, approximately 27% of birthing people indicate that their pregnancies were either wanted later or never, and 13% were unsure.^{5,6}
- 1 in 6 teen births is a repeat birth.⁷
- Approximately 14% of birthing people relied on LARC in 2014, with patients in their teens and twenties most likely to rely on contraceptive pills.⁸

Pregnancies occurring less than 18 months apart increase one's risk for adverse birth outcomes, including preterm birth, low birthweight, and infant mortality.⁹

Prenatal and postpartum periods are ideal opportunities to provide contraceptive care. Patients have increased contact with health care providers and may be more motivated to prevent a subsequent pregnancy than when they are not pregnant. Many patients resume sexual activity before their postpartum check-up or do not attend this checkup. Offering patients the option to choose a contraceptive method and providing LARC methods free-of-charge to patients 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.**

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 patients wanting to prevent pregnancy for at least 12 months.¹⁰

- After standardized counseling on contraceptive methods, 75% of participants chose a LARC.
- 86% of participants who chose a LARC method were still using that method one year later, compared to 55% of patients who chose a non-LARC method.
- Rates of unintended pregnancy were 20 times higher among participants 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 to the national rate of 34.3 births per 1,000.¹⁰

II. Planning For Implementation

The planning and implementation process for instituting postpartum LARC services 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 can also help build support.

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 patients (see Why Postpartum LARC services?).¹¹
- **Present DMAS Medicaid payment 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 for patients using Medicaid, FAMIS, or Medicaid MCO plans.** Claims submitted for inpatient LARCs must include the exact billing codes specified in the DMAS Medicaid or managed care organization (MCO) policy, involving varying levels of customization to claims processes depending on the hospital's system. Hospitals must properly train their billing staff in the correct billing procedures to ensure full reimbursement from DMAS and the MCOs (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. 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.

- **Establish “white bagging” procedures for patients with private insurance.** In order for hospitals to bill private insurance for an immediate postpartum LARC, they must directly order a LARC device for a particular patient from the manufacturer, and then have it in stock when the patient delivers. This will require physicians and their teams to proactively order supplies for a patient in advance.
- **Streamline billing process.** 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 all types of contraceptive devices available.

Seek approval from administration.

- It may be helpful to seek approval from senior administration (hospital nursing leadership and the hospital's chief operating officer) before moving forward with implementation, if clinical leaders determine this is necessary.

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. It can help to emphasize how the postpartum insertion procedure is very easy and quick (5-10 minutes). Sharing research regarding how quickly patients resume sexual activity and the substantial proportion of patients who do not return for postpartum visits can also help 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 can either 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 patients receive education on postpartum LARC options, and that patients' preferences are documented and transferred to the hospital. Hospital clinicians should be able to identify patients 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 do not need to develop written policies specific for insertions. Once the billing and pharmacy infrastructure is developed, the insertion procedure is treated as any other hospital process. Devices dispensed through the Pyxis system and charted against in the Medical Administration Record (MAR) ensure the pharmacy can bill appropriately.
- Develop user-friendly tools to help staff adjust. It might be helpful to have a checklist for nursing and physician reference prior to conducting the insertion process, written procedure notes for resident and attending physicians' chart documentation, or pre-printed patient instructions sheets (see 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 key to providing evidence-based counseling to increase patients' interest in postpartum LARC services (see Prenatal Contraceptive Counseling). Training on documentation of contraceptive counseling and patients' plans may also be necessary.
- **Physicians, including residents (if applicable).** All physicians must be trained prior to performing insertions (see Clinical Resources and Training). Hospitals with residency programs can incorporate LARC training into the 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. New nurses learn via on-the-job training.
- **Lactation consultants.** Because of their role in educating patients about contraceptive methods while breastfeeding, conducting a short in-service will give lactation consultants the information and resources they need to support patient decision-making regarding postpartum LARCs. Training should emphasize that the implant and hormonal IUD have a much lower dose of progesterone than an injection or pills.

4. MAKE ADJUSTMENTS AS NEEDED TO IMPROVE PROCESS.

- Clinical leadership should reconvene clinical staff regularly to review how postpartum LARC procedures are working and identify any needed changes.
- Billing staff should review payments received and claims submission data to identify any issues with the final reimbursement or denials.
- Medicaid and FAMIS Fee-for-Service providers can visit the [Virginia Medicaid Portal](#) to discuss and resolve billing or reimbursement issues related to LARC. In the event the member is enrolled in a Medicaid MCO, refer to the Virginia Medicaid provider memo for specific contact information for the Medicaid MCOs (see Hospital Billing and Reimbursement).
- Monitoring the proportion of patients choosing a postpartum LARC can provide evidence of the policy's impact and be used in quality improvement efforts. Because many patients will visit a different provider for future services, monitoring removal rates and reasons may not be accurate at the provider level.

III. Clinical Resources and 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.¹²

INTRAUTERINE DEVICES (IUDs)

The copper IUD (ParaGard®) can be used for up to twelve years, and the levonorgestrel IUDs (Mirena®, Skyla®, Liletta®, and Kyleena®) for up to seven, three, seven, and five years respectively. Failure rates are similar to female sterilization. [ACOG's Practice Bulletin #186](#) 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).^{12,13}

For the levonorgestrel IUDs (Mirena®, Skyla®, Liletta®, 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.^{12,13}

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

The recommended insertion timing (within 10 minutes of placental delivery) can sometimes pose logistical challenges. Some providers also may have concerns with expulsion rates; the expulsion rate for insertions between 10 minutes post-placental delivery and 48 hours may be as high as 24%.¹³ Intra-cesarean insertions may have lower expulsion rates (8% in a recent randomized control trial).¹⁴ Given this evidence, hospitals should offer IUD placement to patients 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 five years, and is a highly effective method of reversible contraception. [ACOG's Practice Bulletin #186](#) provides guidance on patient counseling for complications, which are uncommon, and side effects.

For non-breastfeeding patients, 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.¹⁵ 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 patients with information and support to select the method – including a postpartum LARC – that best fits their preferences and meets their needs. Counseling can address patient knowledge and misconceptions about LARCs. Because the quality of counseling affects patients' method selection and their satisfaction with their choice¹⁶, prenatal contraceptive counseling is critical for ensuring that when patients do choose a LARC, they feel fully informed and comfortable with the method.

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

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 patients' preferences, values, and the best scientific evidence – is both useful and efficient, and keeps patient preferences at the forefront. In Dr. Christine Dehlendorf's article "[Contraception: Counseling and Selection](#)," Dr. Dehlendorf offers guidance for providers on the shared decision making process with patients (including adolescents), including:

- Establish rapport with patients and take an interest in them as people. The relationship is important.
- Focus on patients' 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 patients can make decisions based on full information.
- Tailor information by considering patients' preferences and their relative importance.
- Address misconceptions respectfully by validating patients' 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 patients to ask questions and discuss a plan if they are not satisfied with their choice.

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

BEDSIDER.ORG

Medically Accurate, Interactive Contraceptive Counseling

At [Bedsider.org](https://www.bedsider.org), patients can compare different methods, view real stories from people 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. The Spanish version is found [here](#).

The [providers' version](#) of Bedsider.org provides tools and content to support providers' capacity to provide contraception counseling. The site is operated by The Power to Decide, formerly known as The National Campaign to Prevent Teen and Unplanned Pregnancy.

Visit [ACOG's LARC Program](#) for more information on incorporating this support tool into clinical practice.

Providers will also benefit from [new research on LARC messaging](#) by Power to Decide, formerly known as the National Campaign to Prevent Teen and Unplanned Pregnancy.

V. Patient Procedures at the Hospital

CONTRACEPTIVE IMPLANTS

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 pregnant patients receive contraceptive counseling during prenatal care, including postpartum LARC options. These counseling activities are documented in medical charts (see Prenatal Contraceptive Counseling).
- Transfer patients' contraceptive plans to the hospital. For systems with integrated electronic medical records, hospital clinicians can easily identify patients 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 – the implant:

- During rounds, ensure that physicians provide brief counseling on the contraceptive implant to all pregnant patients*— 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 patients who decide to have the contraceptive implant procedure, the nursing staff must make sure physicians have consent forms for patients to sign. Patients 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.

Contraceptive implant insertion procedure:

- **Insertions at the bedside.** To perform the implant insertion procedure bedside, nurses can 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. Some hospitals have found it's convenient to keep supplies together – for example, in a tackle box or in brown paper bags. Nurses are present at the procedure and must chart against the order in the Medication Administration Record (MAR).

- **Insertions in the procedure room.** If there is a room on the postpartum floor for conducting procedures, it can easily be used 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.
- **Documentation.** The procedure must be documented in the medical charts and patients should receive a patient handout with instructions (see sample in Appendix).

Counseling and consent postpartum – the IUD:

- Since the intrauterine device placed in the immediate postpartum period has expulsion rates as high as 24%, it is imperative that a patient receive counseling regarding this possibility. However, for patients at high risk of loss to follow up, the benefit of placement in this time period exceeds the risks of a short-interval or unintended pregnancy. During rounds, ensure that physicians provide counseling to patients wanting a contraceptive intrauterine device 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).
- Consent procedures are similar to the implant.

IUD insertion procedure:

- **Insertions immediately post-delivery:** To perform the IUD insertion procedure post-delivery, nurses can obtain the devices from the pharmacy supply cabinets (pyxis) on the floor. Providers use their hand or a ring forceps for guided insertion. Nurses are present at the procedure and must chart against the order in the medication administration record (MAR).
- **Device stocking.** Hospital pharmacies should authorize devices to be stocked on the delivery or postpartum floor.
- **Documentation.** The procedure must be documented in the medical charts and patients should receive a patient handout with instructions (see sample in Appendix).

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

RESOURCES FOR DEVELOPING HOSPITAL PROCEDURES

[ACOG's Postpartum Contraceptive Access Initiative](#) offers individualized trainings and technical assistance to sites interested in offering postpartum LARC services to patients.

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
- > Chlorhexidine
- > Sterile marking pen
- > 20 cc syringes
- > 18 and 23 gauge needles
- > Band-aids
- > Dressing pads and wraps

IUD insertions take just 5-10 minutes and can be done immediately postpartum.

Supply List

- > Sterile gloves
- > Chlorhexidine
- > Ring forceps
- > Sterile gauze
- > Scissors



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VI. Hospital Billing and Reimbursement

The Virginia Postpartum LARC Medicaid policy states that hospitals may receive Medicaid reimbursement for LARC devices provided after delivery in the inpatient hospital setting. This reimbursement is considered a separate payment and is not part of the Diagnostic Related Group (DRG) reimbursed to the facility. Regardless of the payer, physicians who perform LARC insertions bill for both the insertion and the delivery services. Payment is based on the Virginia Medicaid fee schedule. Post-delivery insertion refers to insertion/implantation of the LARC after delivery but before discharge from the hospital. Prior authorization is not required on any of the LARC J codes. The billing process for the inpatient LARC insertion differs depending on the member's coverage.

Most private insurance cover LARC methods, but likely will not reimburse providers for LARC methods during the immediate postpartum period unless “white bagging” procedures are followed. Hospitals will need to establish its own “white bagging” procedures to meet the needs of this patient population.

Important tips to remember:

- When seeking reimbursement for a member enrolled in Medicaid and FAMIS Fee for Service, Virginia Premier Health Plan, Aetna Better Health of Virginia (formerly CoventryCares), INTotal Health, Kaiser Permanente Medicaid, Humana Medicaid and FAMIS Health Plans, hospital/facility providers must submit an outpatient claim with the appropriate revenue code, as well as J code for the contraceptive device and NDC in addition to the inpatient claim for the delivery services. The outpatient claim will be reimbursed via the current DMAS EAPG payment methodology for Fee-for-Service members. The health plans will make a separate payment that is at least the DMAS Fee-for-Service rates for the J codes. **In this scenario, if the charge for the LARC is included on the inpatient claim, those charges will be bundled in with the final DRG payment and a separate payment will not be issued.**
- When seeking reimbursement for a member enrolled in Anthem HealthKeepers Plus, Optima Family Care Medicaid and FAMIS Health Plans, hospital/facility providers are to include all charges including those for the LARC on the inpatient claim. The claim must contain the revenue code 0250 as well as the appropriate LARC device J code.
- Submit all required information exactly according to the policy to avoid claims being denied.
- Work with the assigned Medicaid Program Coordinator/Manager and Medicaid managed care company outreach staff.

Hospitals should consult Virginia DMAS' memo, [Payment in an Inpatient Hospital for Members in Medicaid and FAMIS Fee-for-Service Programs and Managed Care Organizations—Effective for Dates of Service on or after January 1, 2017](#), for detailed billing guidance.

BILLING RESOURCES

Virginia Department of Medical Assistance Services (DMAS) memo: [Payment in an Inpatient Hospital for Members in Medicaid and FAMIS Fee-for-Service Programs and Managed Care Organizations](#). Provides detailed instructions for billing inpatient postpartum LARCs.

Association of State and Territorial Health Officials, [Long-Acting Reversible Contraception Medicaid Policies, Codes, and Guidance](#). Provides links to 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 LARC. 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.

Codes for Inpatient LARC Billing, Effective January 1, 2017

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 (Nexplanon®)

CPT CODES

58300	Insertion of intrauterine device
11981	Insertion of contraceptive implant

VII. References

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VIII. Appendix

WEB RESOURCES

American Academy of Family Physicians, Practice Guidelines for the Use of Long-Acting Reversible Contraceptives (2012)	http://www.aafp.org/aafp/2012/0215/p403.html
American Academy of Pediatrics, Policy Statement, Contraception for Adolescents (2014)	http://pediatrics.aappublications.org/content/134/4/e1244.full
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
American College of Obstetricians and Gynecologists LARC Program	https://www.acog.org/programs/long-acting-reversible-contraception-larc
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	https://www.nationalfamilyplanning.org/file/documents---reports/LARC_Report_2014_R5_forWeb.pdf
American College of Obstetricians and Gynecologists: Committee Opinion Number 642 (2015), Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy	https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/10/increasing-access-to-contraceptive-implants-and-intrauterine-devices-to-reduce-unintended-pregnancy

Appendix

American College of Obstetricians and Gynecologists: Committee Opinion Number 186, Long-Acting Reversible Contraception: Implants and Intrauterine Devices (2017)	https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices
Association of State and Territorial Health Officials Webinar Series, Medicaid Coverage of Postpartum LARCs by Alex Smith (2015)	http://www.astho.org/Programs/Maternal-and-Child-Health/LARC/Alex-Smith-Presentation/
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
Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Volume 65 Number 4: U.S. Selected Practice Recommendations for Contraceptive Use (2016)	https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf
Health Resources and Services Administration, 340B Drug Pricing Program	http://www.hrsa.gov/opa
Power to Decide: "Whoops Proof Birth Control." (2015)	https://powertodecide.org/what-we-do/information/resource-library/whoops-proof-of-birth-control-insights
Up to Date/Dr. Christine Dehlendorf: "Contraception: Counseling and Selection." (2020).	https://www.uptodate.com/contents/contraception-counseling-and-selection
Virginia Department of Medical Assistance Services memo: "Long Acting Reversible Contraceptives (LARC) Payment in an Inpatient Hospital for Members in Medicaid and FAMIS Fee-for-Service Programs and Managed Care Organizations- Effective for Dates of Service on or after January 1, 2017." (December 1, 2016)	https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?impersonate=true&id={A049EEAC-B0DF-4398-A742-02232677BC7A}&vsId={3C33AC0156B4-46DD-8CD3-C56E457EEAA0}&objectType=document&objectStoreName=VAPRODOS1

Appendix

CONTRACEPTIVE IMPLANT CHECKLIST

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

- **Verify patient's insurance (do not place if enrolled in emergency Medicaid)**
- **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

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

- **Keep the wrap on your arm for 24 hours. You cannot 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.**

CONTRACEPTIVE IMPLANT SAMPLE ORDER SET

- **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**

Appendix

IUD INSERTION CHECKLIST

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

- **Verify patient's insurance (do not place if enrolled in emergency Medicaid)**
- **Counsel patient**
- **Order Intrauterine device, and IUD procedure kit**
- **Call nurses to verify that IUD is on the floor and nurses are available for placement**
- **Patient signs IUD consent**
- **Procedure performed in delivery /treatment room. For detailed instructions on the procedure, please see ACOG's [committee opinion on immediate postpartum LARCs](#).**
- **IUD strings are left in place for two weeks. After two weeks, strings are trimmed at the level at the external os for progesterone IUD and will not be visible for the copper IUD.**

IUD PATIENT INSTRUCTIONS

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

- **The IUD strings has been left in place; you may feel the strings. Please do not pull the strings, they will be trimmed at your two-week follow up visit.**
- **If you develop any signs of infection (fever, discharge), please contact our office.**
- **Remember to avoid vaginal intercourse until your followup visit.**

IUD SAMPLE ORDER SET

- **Mirena/Paragard Intrauterine device**
- **One IUD device X 1 dose prior to discharge**
- **Patient to receive IUD device prior to discharge**
- **Initiate/Print Consent for IUD Insertion**



A collaboration of the Virginia Department of Medical Assistance Services, the Virginia Department of Health, and the Virginia chapter of the American College of Obstetricians and Gynecologists.

