Postpartum LARC: Immediate, Inpatient and Beyond

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Disclosures

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Objectives

- Define IPP LARC
- Understand indications and contraindications for insertion
- Identify the risks and benefits of IPP LARC
- Discuss IPP IUD Insertion Techniques
- Describe the barriers to provision of IPP LARC
- Identify strategies to overcome barriers to IPP LARC provision
- Discuss billing challenges and opportunities

Immediate Postpartum LARC Definitions

- Long Acting Reversible Contraceptives (LARC): Intrauterine devices (IUDs) and contraceptive implants provide highly effective reversible contraception for an extended period of time with little user action.
- Immediate Postpartum (IPP): Methods placed during the hospital or birthcenter admission after delivery
- Interval Postpartum LARC: Outpatient postpartum LARC provision (typically 4 weeks postpartum or later)

Types of LARC

Intrauterine Devices

- Copper-T IUD (Paragard)
  - FDA-approved for 10 years
  - EBP 12 years
  - Non-hormonal
- LNG-IUS 52 mg(Liletta/Mirena)
  - FDA approved 5 years
  - EBP 7 years
- LNG-IUS 19.5 mg (Kyleena)
  - FDA approved 5 years
- LNG-IUS 13.5 mg (Skyla)
  - FDA-approved 3 years

Subdermal Implant

- Etonogestrel 68 mg
- FDA approved 3 years
- EBP 5 years
- Nexplanon

Benefits of IPP LARC

- Known not to be pregnant at the time of insertion
- Avoids short interval pregnancy
- Eliminates barriers –time, transportation, multiple visits
- Clinician and patient are already in the same place.
- Reduces risk of losing access to insurance coverage
- For women who desire sterilization but cannot access this method, LARC may be an alternative.

-ACOG Committee Opinion 670

Who is a good candidate for IPP LARC?

- Desires LARC method.
- Ideally, has discussed method choice with provider during prenatal appointments.
- Has insurance coverage of inpatient device insertion.

Exclusions for IPP IUD

- Patient does not desire IUD.
- Has contraindication for device
- Chorioamnionitis
- Fever
- Untreated pelvic infection
- Ongoing PP hemorrhage
- PPROM < 34 weeks gestation
- Submucosal fibroid > 3 cm
- Uterine anomaly
- Cervical cancer

Exclusion criteria Etonogestrel Implant

- Have a contraindication to the etonogestrel implant:
- Liver tumors, benign or malignant, or Severe Cirrhosis (Category 3 mostly)
- 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 components of Nexplanon

CDC Medical Eligibility Criteria

Immediate Postpartum LARCs

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant
Postpartum (in breastfeeding or non-breastfeeding women, including cesarean delivery	a) <10 minutes after delivery of the placenta			
	i) Breastfeeding	1	2	2
	ii) Nonbreastfeeding	1	1	1
	b) 10 minutes after delivery of the placenta to <4 weeks	2	2	1*/2**
	c) ≥ 4 weeks	1	1	1
	d) Postpartum sepsis	4	4	1

LNG=levonorgestrel; Cu=copper; IUD=intrauterine device. *Nonbreastfeeding women, **Breastfeeding women
Categories:
1 = A condition for which there is no restriction for the use of the contraceptive method.
2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

Adapted from Center for Disease Control and Prevention Medical Eligibility Criteria Classification for Postpartum Long-Acting Reversible Contraception (2016).

Breastfeeding

- Theoretical concerns regarding role of progesterone withdrawal in lactogenesis
- Systematic Review of 5 RCT's and 38 observational studies showed no differences in breastfeeding performance with various progesterone only methods.
- RCT comparing early insertion LNG-IUS w/ Copper-T showed no differences in breastfeeding.
- RCT of 102 women showed decreased breastfeeding rates at 6 months for women with IPP LNG-IUS. (11 vs. 3)
- RCT of 24 women showed no difference in breastfeeding after IPP Nexplanon insertion.

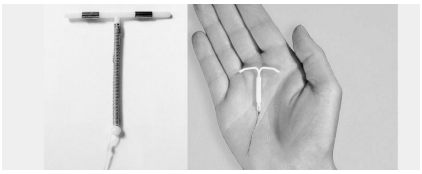
-Kapp N. et al; Shaamash AH, et al; Chen BA, et al.

Expulsion, Bleeding and Infection Risks

- Higher expulsion rates w/ IPP IUD insertion
- 2-27% post vaginal delivery
- 0-20% post cesarean
- RCT of cesarean placement vs. interval placement showed 8% expulsion rate but increased continuation at 6 months.
- No increased risks of bleeding.
- No increased risks of infection.
- No increased risk of perforation

- ACOG CO; Levi, et al

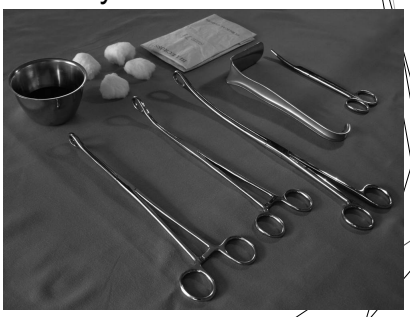
IPP IUD Insertion



Preparation

1. Discuss contraceptive intentions/desires in 3rd trimester including risks, benefits, effectiveness, etc.
2. Determine eligibility for IPP LARC
3. Document contraceptive plan in medical record
4. At admission, determine contraceptive choice and confirm with patient.
5. Obtain Informed consent
6. Ensure desired IUD and equipment is at the bedside

Figure 7.1: The Instruments Ordered on the Auxiliary Table

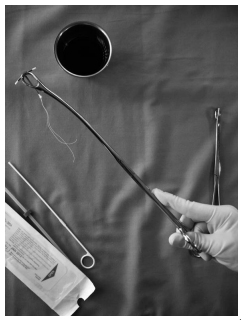


IPP IUD insertion Technique

1. Bimanual exam
2. Clean the external genital area
3. Place a clean drape over the client's abdomen and underneath her buttocks
4. Insert a retractor or gloved hand into the vagina and visualize the cervix
5. Prep the cervix and the vagina with a liberal application of an antiseptic solution
6. Gently grasp the anterior lip of the cervix with ring forceps. (Do not use a toothed tenaculum because it may tear the cervix.)
7. Grasp the IUD with a clean Ring forcep or Kelly placental forcep.

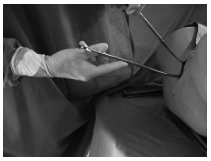
Figure 7.3:

Figure 7.6:



Insertion

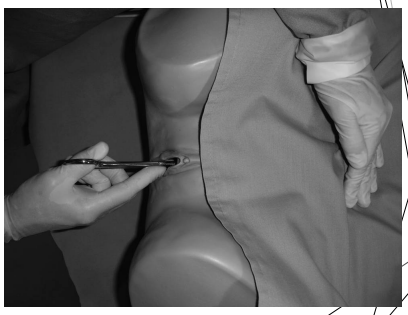
- 8. Exert gentle traction towards you of the cervix-holding forceps
- 9. Insert the forceps holding the IUD through the cervix and into the lower uterine cavity. Avoid touching the walls of the vagina with the IUD.



Insertion

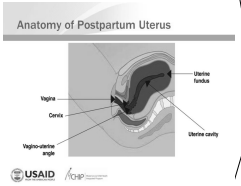
10. As the IUD passes through the cervix, release the hand that is holding the cervix-holding forceps and move this hand to the abdomen placing it over the uterine fundus.
11. With the abdominal hand, stabilize the uterus with firm downward pressure through the abdominal wall. Prevent the uterus from moving upward in the abdomen as the IUD is inserted.

Figure 7.8:



Insertion

12. Move the IUD-holding forceps IUD in an upward motion toward the fundus (in an angle towards the umbilicus). Remember that the lower uterine segment may be contracted and therefore some slight pressure may be necessary to advance the IUD and achieve fundal placement.



Insertion techniques

13. If the patient has delivered vaginally after a previous cesarean delivery, take care to avoid placing the IUD through any defect in the previous incision by maintaining your ring forceps pressured against the posterior uterine wall.
14. By feeling the uterus through the relaxed abdominal wall, confirm with the abdominal hand that the tips of the forceps reach the fundus.

Insertion

- 15. Open the forceps, releasing the IUD.
- 16. Slowly remove the forceps from the uterine cavity, keeping it slightly open, and sweeping the forceps slightly laterally to avoid entanglement with the string.

Postinsertion

17. Examine the cervix

    True for Paragard->Note: Sometimes, when the uterus is well contracted or small, the strings can be seen through the cervix. If this is the case, don't do anything. In the event of a large uterus, as per your assessment at the beginning of the procedure, if you see the strings, this will be an indication that the IUD has not reach the fundus

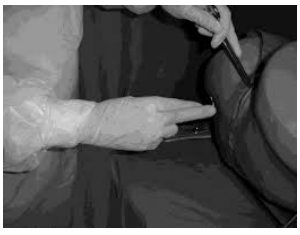
If Mirena, strings will need to be trimmed.

18. Remove the cervix-holding forceps from the anterior lip of the cervix

Manual Insertion Technique

1. Visualization the cervix with the aid of a retractor.
2. You need to have a long sleeve sterile pair of gloves or standard gloves WITH water-impermeable gown
3. Use a hand, rather than forceps to insert the IUD.
4. Hold the IUD by gripping the vertical rod between the index and middle fingers of your predominant hand.

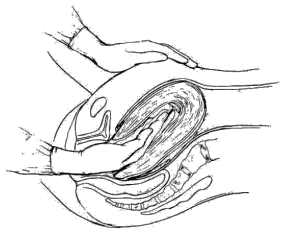
Figure 7.10:



Manual Insertion Technique

5. Slowly insert your IUD-holding hand into the vagina and through the cervix into the uterus. Direct it toward the abdominal hand, which should be firmly holding the uterine fundus through the relaxed abdominal wall. Stabilize the uterus by downward pressure to prevent it going up higher in the abdomen as you insert the IUD-holding hand. This also helps one know the direction that you need to direct the IUD-holding hand, and to confirm, by palpation with the external hand that the fundus has been reached.
6. Take particular care not to dislodge the IUD as the hand is slowly removed from the uterus.

Figure 7.13:



Postplacental Cesarean IUD Insertion

- Ideally, place within 10 minutes of delivery.
- After initiating closure of the hysterotomy incision, the IUD is placed at the fundus with ring forceps or manually.
- Strings may be directed through cervix gently with ring forceps. If done, had ring forceps off of table.
- Close hysterotomy.
- Counsel patient to return for string trim postpartum.

PP Nexplanon insertion

- Can be done anywhere!
- Any Day!
- Same insertion technique

Barriers to IPP LARC

- Patient awareness
- Provider education including shared decision making, noncoercive counseling techniques
- Cost
- Insurance coverage
- Inpatient formulary
- Staff training
- Devices not stocked on L&D or PP unit
- EHR documentation issues
- Billing issues

Overcoming IPP LARC barriers

- Develop or obtain patient educational materials.
- Take advantage of In person and Webinar provider education.
- Hold PP uterus model IUD training.
- Make sure all L&D clinicians are Nexplanon trained.
- Training on shared decision making and noncoercive contraceptive counseling techniques
- Advocate for private payer coverage
- Assemble IPP LARC teams at hospitals to address pharmacy, billing, clincal, EHR barriers

Billing Challenges and Opportunities

- Global payment: A fixed payment made to health care professionals or organizations for the care their patients may require during a contract period regardless of how many services are provided to patients and that can be adjusted to account for severity of illness.
- Episode of care: The set of services provided to treat a clinical condition or procedure. Source: Center for Medicare & Medicaid Services. A value-based bundle payment is a single payment for treating a patient with a specific medical condition across a full cycle of **care**.
- Tenncare debundling IPP LARC: insertion fee and device

Tenncare IPP LARC

Claim Reimbursement Rules

When submitting claims for the VRLAC device provided during a labor and delivery inpatient stay, please follow these guidelines:

- Hospital inpatient claims for the delivery should be submitted in the usual manner. These claims will normally pay under the Diagnosis-Related Group (DRG) methodology.
- Hospital claims for the VRLAC device should be submitted on the same inpatient claim, along with the inpatient delivery. The Managed Care Organizations will implement edits for inpatient claims processing that allow hospitals to receive a separate payment for the VRLAC device.
- The VRLAC devices will be paid on a fee schedule basis, separately from the inpatient claim, for the HCPCS Level II code billed. The following HCPCS codes will be covered.

Code Description	HCPCS Code
Intrauterine copper contraceptive (ParaGard™)	J7300
Levonorgestrel-releasing intrauterine contraceptive system (SKYLA™), 13.5 mg	J7301
Levonorgestrel-Releasing intrauterine contraceptive system (Mirena™), 52 mg	J7298
Levonorgestrel-releasing intrauterine contraceptive system (Kyleena™),19.5 mg	Q9984 (New Temporary Code effective July 1, 2017)
Levonorgestrel-releasing intrauterine contraceptive system (Liletta™), 52 mg	J7297
Levonorgestrel implant system, including implants and supplies	J7306
Etonogestrel implant system (Nexplanon™), 68 mg	J7307

Tenncare IPP LARC

Claim Codes

When submitting professional service claims for the insertion of an IUD or other products in the hospital setting, please use the following CPT codes.

Code Description	CPT Code
Insertion of intrauterine device (IUD)	58300
Insertion, non-biodegradable drug delivery implant	11981

You can help us process your claims quickly and accurately by using the following ICD-10 CM and ICD-10 PCS codes on your claims as well:

ICD-10-CM Codes

- Z30.014 – Encounter for initial prescription of IUD
- Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive
- Z30.430 – Encounter for insertion of IUD

ICD-10-PCS Codes

IUD

- 0UH97HZ – Insertion of contraceptive device into uterus, via natural or artificial opening

Implant

- 0JHD3HZ – Insertion of contraceptive device into right upper arm subcutaneous tissue and fascia, percutaneous approach
- 0JHF3HZ – Insertion of contraceptive device into left upper arm subcutaneous tissue and fascia, percutaneous approach

Billing Challenges and Opportunities

- Advocacy needed to get IPP LARC for all insurance plans.
- Guidelines on how to bill are confusing.
- Institutional differences
- MCO differences
- Requires dedicated team at institution to track billing and reimbursement.

Training resources

- SPIRES video https://www.youtube.com/watch?v=uMcTsuf8XxQ
- https://pcainitiative.acog.org/
- Another training resource for immediate PP IUD insertion is at: http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth
- https://bixbycenter.ucsf.edu/bixby-resources

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- Tennessee Department of Health
- Tenncare
- MCO's
- L&D and PP nurses
- Pharmacy staff
- And many, many more

Resources

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