



Indiana
Perinatal
Quality
Improvement
Collaborative

LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

*Approved by the IPQIC
Governing Council on
November 29, 2016*

To Indiana Medical Practitioners

Since June 1, 2015, the Indiana Health Coverage Programs (IHCP) has allowed separate reimbursement (outside the global fee for delivery) of long-acting reversible contraception (LARC) devices implanted during an inpatient hospital or birthing center stay for a delivery. This reimbursement change applies to fee-for-service claims for dates of service on or after June 1, 2015.

LARC devices are defined as implantable devices that remain effective for several years to prevent pregnancies. Devices include intrauterine devices (IUDs) and birth control implants. This change in IHCP 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. 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).

However, other barriers to LARC services have been noted in Indiana. They include:

- Lack of physician and other medical practitioners' awareness of current practice guidelines, improvements in the current devices, and insertion procedures*
- Too little comprehensive patient counseling on the safety and effectiveness of LARCs*
- High up-front costs for devices (e.g., through the Affordable Care Act and Medicaid)*
- Clinical protocols that do not permit postpartum insertions and single-visit outpatient insertions.*
- Patients' misperceptions and myths regarding safety, side effects, and usefulness of LARCs*

Therefore, a multidisciplinary group consisting of Obstetrician-Gynecologists, Family Physicians, Nurse Practitioners, Pediatricians, and health care administrators has worked together to develop a toolkit to address these barriers in Indiana. This toolkit is designed to be used in whole or elements can be printed individually for medical practitioners or patients to use.

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DISCLAIMER: The committee used reasonable efforts to provide accurate information in this toolkit. Nothing contained herein constitutes medical, legal or other professional advice nor does it represent an endorsement of any treatment or particular type of contraceptive product. Information contained herein is provided without warranty of any kind, express or implied, including warranties of merchantability or fitness for a particular purpose. The information and resources included in this guide are provided for information only. Referral to specific programs, resources or websites does not imply endorsement by the toolkit's authors or the authors' organizations or their sponsors, contents, expressed views, programs or activities. Further, the authors do not endorse any commercial products referred to in this toolkit or that may be advertised or available from these programs, resources or websites. This toolkit is not meant to be comprehensive; the exclusion of a program, resource or website does not reflect the quality of that program, resource or website. Please note that websites and URLs are subject to change without advance notice.

I. Why LARC Services?

Overview

- In any given year, fully 95% of unintended pregnancies are attributable to the one-third of women who do not use contraceptives or who use them inconsistently. ⁽⁸⁾
- For every dollar spent to help women avoid unintended pregnancy, \$7.09 was saved in 2010.
- The most highly effective contraceptives are the long-acting reversible contraceptives (LARCs). Making these devices available to women would substantially help to prevent the incidence of unintended pregnancies.
- Some of the outcomes from the 2015 Labor of Love conference sponsored by the Indiana State Department of Health included focusing the state's effort to the reduction of unintended pregnancies for all women, and especially teens (age 15-19) using the most effective contraceptives. This focus would significantly contribute to other activities to improve birth outcomes for mothers and children.
- The Indiana Perinatal Quality Improvement Collaborative (IPQIC) Subcommittee on Preconception and Interconception Care has recommended:
- Expanding access to post-partum LARC by developing tools for health care providers to facilitate billing and coding.
- To increase use of LARC methods, barriers such as lack of health care provider knowledge or skills and low patient awareness should be addressed.
- Indiana Medicaid has been paying for outpatient placement or insertion of LARCs. Effective June 2015, it expanded its coverage to include immediate post-partum placement in the hospital setting.

Unintended Pregnancy

- Unintended pregnancy can have significant, negative consequences for individual women, their families and society as a whole. An extensive body of research links births resulting from unintended or closely spaced pregnancies to adverse maternal and child health outcomes and myriad social and economic challenges.^(1,2)
- In 2011, the last year for which national-level data are available, 45% of all pregnancies in the United States were unintended including three out of four teen pregnancies.
- Economically disadvantaged women are disproportionately affected by unintended pregnancy and its consequences: In 2011, the unintended pregnancy rate among women with incomes lower than the federal poverty level, at 112 per 1,000, was more than five times as high as the rate among women with incomes greater than 200% of poverty (20 per 1,000).

Incidence and Outcomes of Unintended Pregnancy in Indiana

- In 2010, 49% of all pregnancies (55,000) in Indiana were unintended. ⁽⁴⁾ Indiana's unintended pregnancy rate in 2010 was 43 per 1,000 women aged 15-44.
- The teen pregnancy rate in Indiana was 49 per 1,000 women aged 15-19 in 2011.

- In 2010, 64% of unintended pregnancies in Indiana resulted in births and 20% in abortions; the remainder resulted in miscarriages. ⁽⁴⁾

Public Cost of Unintended Pregnancy in Indiana

- In 2010, 22,900 or 64.6% of unplanned births in Indiana were publicly funded, compared with 68% nationally.⁽³⁾ In Indiana in 2010, the federal and state governments spent \$375.9 million on unintended pregnancies; of this, \$284.6 million (63%) was paid by the federal government and \$91.4 million was paid by the state. ⁽³⁾
- The total public costs for unintended pregnancies in 2010 was \$292 per woman aged 15–44 in Indiana, compared with \$201 per woman nationally. ⁽³⁾ (all from Guttmacher –State Facts about Unintended Pregnancy in Indiana)

Link between Indiana Infant Mortality Rate and Unintended Pregnancy

- Interpregnancy interval is the amount of time between pregnancies. Short interval pregnancies are associated with adverse perinatal outcomes such as significantly higher risks for low birth weight, preterm, and small-for gestational age births. The percentage of short interval pregnancies (less than 18 months or 78 weeks) in Indiana has been around 33% since 2011. (ISDH, MCH Epidemiology, unpublished report)
- In 2014, 7.5% of all live births in Indiana were to women under 20 years of age ⁽⁵⁾, a large proportion of which may be unintended. According to national rates, 75% of teen pregnancies may be unintended.
- A woman who is not planning to have a child may not be physically, psychologically and financially ready for child birth and may delay or may not receive prenatal care at all, which could result in adverse birth outcomes.
- In a statewide data analysis in Indiana in 2014, inadequate prenatal care, Medicaid enrollment and maternal age less than 20 years were found to be predictive factors for adverse birth outcomes like low birth weight and infant mortality. These high risk subpopulations accounted for only 1.6% of all births, but they accounted for 50% of total infant mortality. ⁽⁶⁾
- Disorders related to prematurity and low birth weight are the second most common cause of infant mortality.
- In 2010, mortality rate for infants born less than 32 weeks of gestation was 74 times higher than that for term infants (166.5 vs. 2.25). Similarly, mortality rate for infants born with birth weight < 1000 grams was 24 times higher than that for infants born with birth weight >2500 grams (50.98 vs. 2.13). ⁽⁷⁾
- Decreasing unintended pregnancies would decrease prematurity and low birth weight and thus infant mortality.

Why LARC for Adolescents

The 2014 American Academy of Pediatrics Policy Statement on Adolescent Contraception recommended that, “Pediatricians should be able to educate adolescent patients about LARC methods, including the progestin implant and IUDs. Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents. Some pediatricians may choose to acquire the skills to provide these methods to adolescents. Those who do not should identify health care providers in their communities to whom patients can be referred.” ⁽¹⁴⁾

- The adolescent birth rate (ages 15-19) for Indiana in 2014 was 28 births per 1,000. (ISDH)
- Mothers with short interpregnancy interval were more likely to be under 25 years of age. The highest rate of short interval pregnancies was seen in 15 to 17 year olds with approximately 80% of women with previous pregnancies giving birth less than 18 months apart every year from 2011 to 2013. Eighteen to nineteen year olds had the second highest rate of short interval pregnancies, increasing from 66.7% in 2011 to 68.8% in 2013.
- Study on trends in LARC use among teens aged 15-19 years seeking contraceptive services showed only 1.5% in Indiana chose a LARC method. ⁽⁹⁾
- Risk of rapid repeat pregnancy (within two years from previous birth) may be up to 35 times higher in adolescent moms who do not use LARC after a birth or abortion. ⁽¹⁰⁾
- Adolescent moms who start LARC within 8 weeks of delivery are less likely to have a repeat pregnancy within 2 years than those using none or other methods. ⁽¹¹⁾
- Immediate postpartum insertion of etonogestrel implant in adolescent mothers saves \$6.50 for every dollar spent, over 3 years. ⁽¹²⁾
- Immediate postpartum etonogestrel implant insertion has a continuation rate of 96.9% at 6 months in adolescent mothers; mothers in the same study who did not receive LARC had a repeat pregnancy rate of 9.9% at 6 months. ⁽¹³⁾

Why postpartum LARC?

- Immediate provision of postpartum LARC (less than 10 minutes post-placenta for IUDs (and prior to discharge for the implant) may help women to better plan for any subsequent pregnancies. Amongst adolescents, rapid repeat pregnancy accounts for 18% of teen pregnancies; risk of rapid repeat pregnancy may be up to 35 times higher in adolescent moms who do not use LARC after a birth (or abortion.) However, women of all reproductive ages can benefit from having the ability to determine the number and spacing of their pregnancies.
- Highly-effective and non-user-dependent LARC can help women to achieve longer interpregnancy intervals (at least 12-18 months), preventing some cases of preterm delivery, low birth weight, maternal anemia, preterm premature rupture of membranes (PPROM), placental abruption, congenital anomalies, and neonatal morbidity.
- By 6 weeks postpartum:
 - 40% of non-breastfeeding women have ovulated (may occur as early as 25 days)
 - More than half of women have resumed sexual activity
 - Teens, especially those living with a partner, are more likely than adult women to have resumed intercourse

- Cesarean delivery patients more likely to have resumed intercourse than vaginal delivery patients
- Many women leave the hospital with no method of contraception.
 - No-show rates for the 6-week postpartum visit have been reported to be as high as 55% for some patient groups.
- 47% of women with unfulfilled sterilization requests will become pregnant within a year of delivery
- 80% of postpartum women want to wait at least 2 years before having another child

Risks of infection, perforation, abnormal bleeding not significantly changed when IUD inserted postpartum; however, expulsion rates are higher than with 6 week or later placement.

- Expulsion rates:
 - After vaginal delivery may be 20-30%
 - After c-section may be 8%
 - May be higher with levonorgestrel-releasing IUDs than copper IUDs
- The implant can be inserted at any point after delivery. Initiation of the implant during hospital admission for delivery is associated with significantly lower rates of rapid repeat pregnancy in adolescents (19% vs. 3%)

INTERESTED IN INSERTING LARC POSTPARTUM? Go to online instruction at:
<http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth>

[Immediate Postpartum Intrauterine Device Insertion Training Workshop](#) is a video-based workshop, created at Stanford and University of Colorado, Denver that combines video-based learning with simulation, including instructions on how to build the simulation model used in the video.

What about breastfeeding?

- No concerns with copper IUD
- Almost all evidence demonstrates that levonorgestrel IUD does not influence breastfeeding and infant growth outcomes
- Immediate postpartum insertion of the etonogestrel implant has not reliably demonstrated adverse effects on breastfeeding (15, 16)

Materials for Patients: Several patient handouts, including a brochure with information on multiple postpartum contraception options (available in both English and Spanish) are available as an appendix to this toolkit. There are also postpartum-LARC specific information handouts and discharge instructions which you may use or modify for use in your hospital. (See Appendix A)

References:

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15. Phillips SJ, Kapp N, Nanda K, Temmerman M, Curtis KM, *Progestogen-only contraceptive use among breastfeeding women: a systematic review.*, Contraception. 2016 Sep; 94(3):226-52. doi: 10.1016/j.contraception.2015.09.010. Epub 2015 Sep 26.

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<https://www.ncbi.nlm.nih.gov/pubmed/26209863>

II Clinical Resources and Training for Medical Practitioners

- Clinical Practice guidelines from the Centers for Disease Control and Prevention (CDC) and the American Congress of Obstetricians and Gynecologists (ACOG) support immediate postpartum insertions for both IUDs and contraceptive implants, with few contraindications.
- Recommendations and conclusions from the **ACOG statement on Reversible Contraceptives: Implants and Intrauterine Devices.**(ACOG Practice Bulletin #121, July, 2011, Reaffirmed 2015. **Long Acting Reversible Contraceptives: Implants and Intrauterine Devices.**) include:
 - ***The following recommendation and conclusion are based on good and consistent scientific evidence (Level A):***
 - Routine antibiotic prophylaxis to prevent pelvic infection is not recommended before IUD insertion.
 - Insertion of a copper IUD is the most effective method of postcoital contraception when inserted up to 5 days after unprotected intercourse.
 - ***The following recommendations and conclusions are based on limited or inconsistent scientific evidence (Level B):***



- Intrauterine devices may be offered to women with a history of ectopic pregnancy.
 - Insertion of the implant is safe at any time in non-breastfeeding women after childbirth.
 - Implants may be offered to women who are breastfeeding and more than 4 weeks after childbirth.
 - Insertion of an IUD or implant immediately after either an abortion or miscarriage is safe and effective.
 - Immediate postpartum IUD insertion, which is an insertion within 10 minutes of placental separation, appears safe and effective.
 - ***The following recommendations and conclusions are based primarily on consensus and expert opinion (Level C):***
 - The *U.S. Medical Eligibility Criteria for Contraceptive Use* classifies placement of an implant in breastfeeding women less than 4 weeks after childbirth as Category 2 because of theoretic concerns regarding milk production and infant growth and development.
 - Nulliparous women and adolescents can be offered LARC methods, including IUDs.
 - The FDA and the WHO recommend that IUDs be removed from pregnant women when possible without an invasive procedure.
 - Long-acting reversible contraceptive methods have few contraindications, and almost all women are eligible for implants and IUDs.
 - Insertion of an IUD or an implant may occur at any time during the menstrual cycle as long as pregnancy may be reasonably excluded.
 - For women at high risk of STIs (e.g., aged 25 years or younger or having multiple sex partners), it is reasonable to screen for STIs and place the IUD on the same day (and administer treatment if the test results are positive) or when the test results are available.
 - Long-acting reversible contraceptive methods have an effect on menstrual bleeding, and patients should be given anticipatory guidance about these effects.
 - An endometrial biopsy may be performed without removing the IUD. Cervical colposcopy, cervical ablation or excision, or endometrial sampling, may be performed with an IUD left in place.
-

The United States Medical Eligibility Criteria for Contraceptive Use, 2016 (US MEC)

[The United States Medical Eligibility Criteria for Contraceptive Use, 2016 \(US MEC\)](#) includes recommendations for using specific contraceptive methods by women and men who have certain characteristics or medical conditions. The recommendations in this report are intended to assist

health care providers when they counsel women, men, and couples about contraceptive method choice.

An updated summary sheet is available that only contains a subset of the recommendations from the United States Medical Eligibility Criteria published July 2016. For complete guidance, see: <http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm>. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.

Full size available at: <http://www.cdc.gov/reproductivehealth/contraception/usmec.htm>

The appropriateness of use for the methods of contraception was determined by using the following categories of medical eligibility criteria:

Categories of medical eligibility criteria for contraceptive use

- 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.

Source: Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Medical Eligibility Criteria for Contraceptive Use. MMWR 2016;65(No. RR-3)

○ **U.S. Selected Practice Recommendations US SPR) for Contraceptive Use, 2016**

This report addresses a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods. These recommendations for health

care providers were updated by CDC after review of the scientific evidence and consultation with national experts who met in Atlanta, Georgia, during August 26–28, 2015. The information in this report updates the 2013 U.S. SPR (MMWR 2013;62 [No. RR-5]). Major updates include:

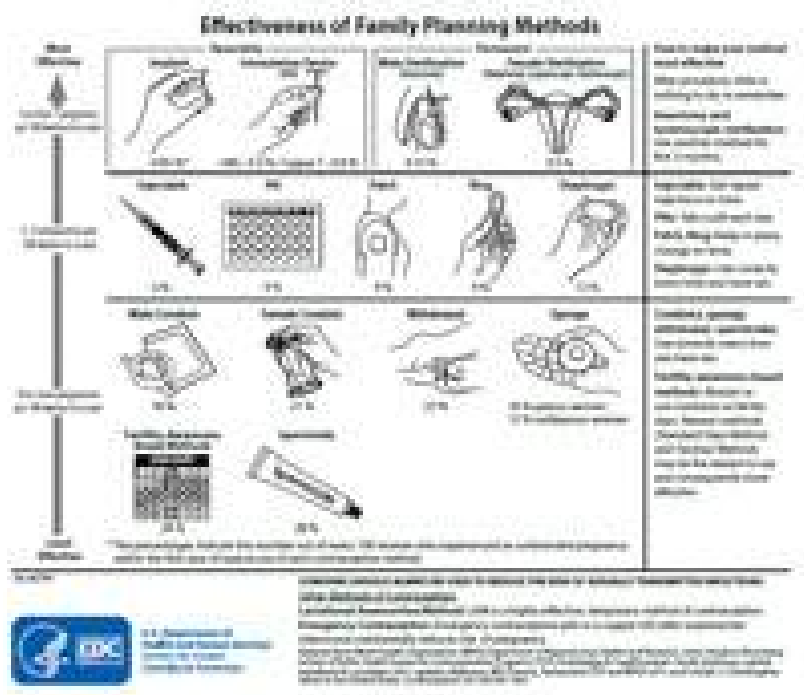
- 1) Revised recommendations for starting regular contraception after the use of emergency contraceptive pills.
- 2) New recommendations for the use of medications to ease insertion of intrauterine devices.

The US SPR can be downloaded from:

<http://www.cdc.gov/reproductivehealth/contraception/usspr.htm>

Also available is an **Effectiveness of Contraceptive Methods Chart**

(<http://www.cdc.gov/reproductivehealth/contraception/usmec.htm>)



The MEC Wheel

The MEC Wheel, other provider tools and MMWRs are available to order from CDC-INFO on Demand in limited quantities.



CDC: Contraception App for Android and iOS Based on the 2016 US MEC and US Selected Practice Recommendations for Contraceptive Use, 2016 (2016 US SPR)

The CDC has developed apps for [Android \(Google Play Store\)](#) and [iOS \(Apple App Store\)](#) based on the [US Medical Eligibility Criteria for Contraceptive Use, 2016](#) (2016 US MEC) and the [US Selected Practice Recommendations for Contraceptive Use, 2016](#) (2016 US SPR), which give providers an interactive way to access more than 1,800 recommendations for the safety of contraceptive methods among women and men with certain characteristics or medical conditions. You can also download or order updated guidance documents, provider tools, and other electronic resources as they become available on the [CDC Contraceptive Guidance for Health Care Providers](#) website.

When to Start Using Specific Contraceptive Methods

| Contraceptive method | When to start (if the provider is reasonably certain that the woman is not pregnant) | Additional contraception (i.e., back-up) needed | Examinations or tests needed before initiation ¹ |
|---------------------------------|--|--|---|
| Copper-containing IUD | Anytime | Not needed | Bimonthly examination and cervical inspection ² |
| Levonorgestrel-releasing IUD | Anytime | If >7 days after menses started, use back-up method or abstain for 7 days. | Bimonthly examination and cervical inspection ² |
| Implant | Anytime | If >7 days after menses started, use back-up method or abstain for 7 days. | None |
| Injectable | Anytime | If >7 days after menses started, use back-up method or abstain for 7 days. | None |
| Combined hormonal contraceptive | Anytime | If >7 days after menses started, use back-up method or abstain for 7 days. | Blood pressure measurement |
| Progestin-only pill | Anytime | If >7 days after menses started, use back-up method or abstain for 7 days. | None |

Abbreviations: BMI = body mass index; IUD = intrauterine device; STD = sexually transmitted disease; U.S. MEC = U.S. Medical Eligibility Criteria for Contraceptive Use.
¹Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used. U.S. MEC 1 or generally can be used U.S. MEC 2 among older women (history of smoking weight and calculating BMI (weight (kg)/height (m)²) and/or history of hypertension) for monitoring any changes and counseling women who might be concerned about weight change associated with their contraceptive method.
²Most women do not require additional STD screening at the time of IUD insertion. If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC's STD Treatment Guidelines (<http://www.cdc.gov/std/treatment/>), screening can be performed at the time of IUD insertion, and results should be deferred. (Women with current gonorrhea, chlamydia or discharge collected on genital infection should not undergo IUD insertion U.S. MEC 4).

When to Start Contraceptive Methods and Routine-Follow Up -[PDF - 158KB]

This provider tool contains information from the US SPR into a one page document. It includes How to Be Reasonably Certain That a Woman Is Not Pregnant, When to Start Using a Specific Contraceptive Methods, and Routine Follow-Up After Contraceptive Initiation.

ACOG 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 for each of these devices.

For information on training sessions, visit
<http://www.contraceptivetechnology.org/conferences/upcoming-ct-conferences/>



Family Planning National Clinical TrainingCenter

- For a list of training opportunities, visit <http://www.ctcfp.org/larc/>
- For more information, contact Kimberly Carlson at 1-866-91-CTCFP (1-866-912-8237) or carlsonkim@umkc.edu

Method-Specific Training Opportunities

- Liletta® (LNG IUS)—Medicines360
 - To watch an online insertion and removal video, visit <https://liletta.biodigital.com/#/>
 - To request a training, visit <https://www.lilettahcp.com/resources/insertion>
 - For more information, call 1-415-951-8700 or visit <http://medicines360.org/connect>
- Mirena® (LNG IUS)—Bayer HealthCare Pharmaceuticals
 - To request a training, call 1-888-84-BAYER (1-888-842-2937)
 - For more information, visit <http://hcp.mirena-us.com/contact.php>
- Nexplanon® (Contraceptive implant)—Merck & Co., Inc.
 - To request a training, call 1-877-467-5266 or fill out **this online form**
 - For more information, visit <http://www.nexplanon-usa.com/en/hcp/services-and-support/request-training/request-form/index.asp>
- ParaGard® (Copper IUD)—Teva Women's Health, Inc.
 - To request a training, call 1-877-PARAGARD (727-2427)
 - For more information, visit <http://hcp.paragard.com/>
- Skyla® (LNG IUS)—Bayer HealthCare Pharmaceuticals
 - To request a training, call 1-888-84-BAYER (1-888-842-2937)
 - For more information, visit <http://hcp.skyla-us.com/contact-us/>
- Kyleena – Bayer Health Care Pharmaceuticals
 - To request a training, call 1-888-84-BAYER (1-888-842-2937)
 - For more information, visit <https://www.kyleena-us.com/>
- [Family Planning/Community Health Centers](#)

- University of California, San Francisco (UCSF) Bixby Center for Global Reproductive Health
The Beyond the Pill program partners with health care providers, researchers, and educators to improve women's access to effective contraception and reproductive health care. This training program is designed to increase provider knowledge and skills for IUDs and implants, and improve women's access to these methods of birth control.
 - To view an online training, visit <http://beyondthepill.ucsf.edu/online-training>
 - To request an on-site training, contact Jennifer Grand at 1-415-502-0331 or Jennifer.Grand@ucsf.edu
 - For more information, visit <http://beyondthepill.ucsf.edu>
 - Upstream USASM provides onsite, comprehensive consulting and technical training to health centers so that they can provide the full range of contraceptive methods, same day, including IUDs and implants. This training includes CME/CE accredited content for clinicians such as IUD and Nexplanon placement skills. In addition, it offers counseling tips for health educators, counselors, and medical assistants as well as in depth revenue cycle management assistance and/or coding review for billing and financial staff.
 - To request a training, email Peter Belden at peter@upstream.org
 - For more information, visit <http://www.upstream.org>
- * This ACOG resource was last updated on February 19, 2016. Please email Mica Bumpus, LARC Program Manager, at MBumpus@ACOG.org with suggestions or comments.
- * The resources listed above are for information purposes only. Referral to these sources and sites does not imply the endorsement of ACOG. Further, ACOG does not endorse any commercial products that may be advertised or available from these organizations or on these web sites. These lists are not meant to be comprehensive. The exclusion of a source or site does not reflect the quality of that source or site. Please note that sites and URLs are subject to change without notice.

LARCs Are Safe and Effective When Inserted Immediately Postpartum

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.

INTERESTED IN INSERTING LARC POSTPARTUM? Go to online instruction at:
<http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth> OR

[Immediate Postpartum Intrauterine Device Insertion Training Workshop](#) is a video-based workshop, created at Stanford and University of Colorado, Denver that combines video-based learning with simulation, including instructions on how to build the simulation model used in the video.

The ACOG LARC Program's Immediate Postpartum Webinars - Immediate Postpartum Initiation of LARC Methods:

https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=490885&PCAT=2791&CAT=8604

INTRAUTERINE DEVICES (IUDs)

The copper IUD (ParaGard®) can be used for 10 to 12 years, and the levonorgestrel IUDs (Mirena®, Skyla®, and Liletta®) for five, three and three years respectively, 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). (17, 18)

For the levonorgestrel IUDs (Mirena®, Skyla®, and Liletta®), 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. (17, 18)

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

There is only anecdotal information in Indiana, but 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%. (18) Intracutaneous insertions may have lower expulsion rates (8% in a recent randomized control trial). (19) 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).

ACOG LARC Program: Immediate Postpartum LARC Resource Digest

The LARC Program compiled several of the resources and tools available on immediate postpartum LARC provision. This resource digest is ready-to-use and downloadable, and features immediate postpartum LARC resources on:

- Clinical guidance and implementation
- Billing and reimbursement
- Capacity building and systems change
- Publications on safety, efficacy, expulsion, breastfeeding, cost-effectiveness, and barriers to access.

Section II References:

17. Centers for Disease Control & Prevention. U.S. *Selected practice recommendations for contraceptive use, 2013*. Morbidity and Mortality Weekly Report. 2013; 62(5): 7-17.

18. American College of Obstetricians & Gynecologists. Long-acting reversible contraception: Implants and intrauterine devices. *Practice Bulletin 121: Clinical Management Guidelines for Obstetrician -Gynecologist*, 2011; 121.

19, Levi EE, Stuart GS, Zerden ML, Garrett JM, Bryant AG. *Intrauterine device placement during cesarean delivery and continued use 6 months postpartum: A randomized controlled trial*. Obstet Gynecol. 2015; 126(1):5-11.

III Outpatient LARC Placement and Patient Procedures

- Clinical Training Opportunities are listed in Section IV. For up to date information visit <http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Clinician-Education-and-Training>
- To the right is a photo of a typical tray of instruments used for inserting an IUD in the outpatient setting.
- A Link to resources that could be used in clinics where autoclaves aren't available is: <http://www.stradishealthcare.com/products/>



ACOG Committee Opinion on Clinical Challenges of LARC

In collaboration with the ACOG LARC Work Group, the ACOG Committee on Gynecologic Practice recently released Committee Opinion #672, "[Clinical Challenges of Long-Acting Reversible Contraceptive Methods](#)." This document reviews the diagnosis and management of LARC clinical challenges and complications not covered in other ACOG publications, and provides several algorithms for easy reference. It specifically addresses:

- Pain with IUD insertion
- Removal of IUD when strings are not visualized
- Management of uterine perforation
- Removal of non-palpable implants

View and download this Committee Opinion on the ACOG website [here](#).

IV Contraceptive Counseling

Information for Consumers

- Some of the barriers to the use of LARCs are the many myths that exist about this type of birth control. This section will concentrate on providing comprehensive patient counseling on the safety and effectiveness of LARC.
 - If a patient is considering low-maintenance birth control, consider an IUD or implant, which are among the most effective birth control methods available, providing 3 to 12 years of contraception depending on the type of birth control with failure rates of less than one percent. Some brand names include:
 - Paragard® – non-hormonal IUD, lasts up to 10 years
 - Mirena® – IUD, lasts up to 5 years
 - Skyla® – IUD, lasts up to 3 years
 - Liletta® – IUD, lasts up to 3 years
 - Kyleena® – IUD, lasts up to 5 years, approved by US FDA, expected to be available October, 2016
 - Nexplanon® – upper arm implant, lasts up to 3 years
 - See Appendix B for Patient Handout on MYTHS vs. FACTS: Long Acting Reversible Contraceptives (LARC)
 - See Appendix C for Tips on LARC Counseling for Medical Practitioners
- More resources are available at the INDIANA FAMILY HEALTH COUNCIL (www.ifhc.org)

Information for Adolescents

- Websites that offer good information for adolescents and young adults include:
- Bedsider at <https://bedsider.org/>, Phone 888-321-0383
- Stay Teen at stayteen.org
- Sex, Etc. Sex education by teens for teens at sexetc.org

Indiana University School of Medicine, Section of Adolescent Medicine sees patients in clinics throughout the greater Indianapolis area. For more information about services for adolescents or to schedule an appointment call (317) 274-8812

Information for Prenatal Clients

- Several patient education handouts are available in the Appendix A
 - The Association of Reproductive Health Professionals has an interactive tool for consumers called Method Match (ARHP.org/methodmatch). Using it, consumers can match contraceptive methods with criteria important to them
- San Francisco Sex Information -Free, confidential, accurate, nonjudgmental information about sex www.sfsi.org; questions@sfsi.org. phone: 877.401.1799
- www.itsyoursexlife.com ; CDC site
- **ACOG RESOURCE: Download the Contraceptive Counseling Resource Digest**

Obstetrician-gynecologists and other women's health care providers play a key role in ensuring women receive patient-centered contraceptive counseling. The ACOG LARC Program has two resources on this topic. The new [Contraceptive Counseling Resource Digest](#), housed on the ACOG LARC Program's [Practice Resources](#) webpage, compiles various tools and sources related to contraceptive counseling, including:

- Approaches to contraceptive counseling
 - Contraceptive decision-making resources for women with coexisting medical conditions
 - Resources for patient education materials
 - Links to documents about contraceptive counseling, coercion, and reproductive justice
- The ACOG LARC Program's on-demand webinar, [Contraceptive Counseling and LARC Uptake](#), can be viewed at any time and highlights contraceptive counseling best practices, the potential impact of provider bias, and how various counseling techniques can impact a patient's decision-making process.

To see the complete list of archived ACOG LARC Program webinars please visit the ACOG LARC Program's [webinar](#) webpage.

V Billing and Reimbursement

Obtaining supplies

In general, there are two ways that LARC methods can be covered by patients' health insurance plans: as a medical benefit or a pharmacy benefit.

- When a LARC method is covered as a *medical benefit*, a provider:
 - Buys the LARC method directly from the manufacturer or a designated pharmacy or specialty distributor.
 - Bills the patient's insurance carrier for the LARC method and insertion procedure.
 - This is commonly described as "buy and bill."

- IUDs may need to be purchased directly from the manufacturers, or through a distributor, depending on the type of or device. Implants can be purchased from the specialty pharmacies CVS Caremark, Curascript, or Therucon. When purchasing LARC methods, providers may be able to realize benefits from volume discounts, 90-day net terms, and other payment options.
- When a LARC method is covered as a *pharmacy benefit*:
 - A pharmacy or specialty distributor bills the patient's insurance carrier directly for the LARC method.
 - A provider bills the patient's insurance carrier for related procedures and services.
 - LARC methods are sometimes covered as a pharmacy benefit, which may make stocking the methods ahead of time challenging. It can take up to seven days to receive products ordered via the various specialty pharmacy programs (SPPs).

Each of these models for purchasing LARC methods has benefits and drawbacks. In general, the *medical benefit* approach may facilitate offering same-day placement of LARC methods, but may require a significant capital outlay. In general, the *pharmacy benefit* approach reduces the need for upfront capital, but may make it difficult to provide same-day placement. Patients and providers can both advocate for the model that will work best. Specifically, providers can advocate that both billing options should be available to them by giving an insurance plan medical director information regarding the benefits and safety of same-day placement of LARC methods.^{24,25,26}

- Patients purchase LARC methods using a payment plan

For patients with no insurance or who do not have the medical benefit for LARC, the provider can set up a payment plan. Patients wishing to use an implant or copper IUD are able to arrange staggered payment plans with credit cards through Curascript or Teva Women's Health, respectively. For an implant, a patient may choose to make three or six monthly payments. For a copper IUD, a patient may choose to make four or 12 monthly payments. In both cases, patients must provide a clinician's name, address, phone, and fax number to place an order, and the LARC method is shipped directly to the clinician. More information on how patients can access these programs can be found in Section 4.4 of *Intrauterine Devices and Implants: A Guide to Reimbursement* SECOND EDITION

- Can the service be provided at a lower cost?

Certain clinics are eligible to participate in the Health Resources and Services Administration 340B program or a group purchasing organization (GPO) such as the Afaxys GPO services. The Title X Family Planning grant allows non-profit clinics to become eligible 340B program. If a provider wishes to refer to a Title X clinic in Indiana, the Indiana Family Health Council (www.ifhc.org or 317-247-9151) is a resource. All Federally Qualified Health Centers (FQHC) are also eligible for 340B drug pricing. An approved 340B entity may use a product purchased through 340B pricing with any patient who meets HRSA's definition of an eligible patient, and should contact the wholesaler or GPO for more information on available discounts. Note that GPOs are prohibited for hospitals but all other Family Planning 340B-eligible entities may use them. If a provider wishes to

refer to an Indiana FQHC, the Indiana Primary Health Care Association can help locate a center (<http://www.indianapca.org/page/FindaCHC>)

In addition, Afaxys GPO members may qualify for discounts on the Bayer LNG-IUS devices separate from 340B pricing. To learn about these discounts, contact Bayer by calling (877) 229-3750 or emailing bhcpharm.customerservice@bayer.com.

Low Cost Services in Indiana

Medicaid Family Planning Eligibility Program: provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy. This program is for people who do not qualify for any other category of Medicaid and have income that is at or below 133% of the federal poverty level. Call the Division of Family Resources (DFR) toll-free at 1-800-403-0864, 8:00 a.m. to 4:30 p.m., Eastern Standard Time for any questions.

Indiana Family Health Council (www.ifhc.org or 317-247-9151) Information Title X Health Centers in Indiana which provide reproductive health services and counseling for low-income, working poor, and teens

Indiana Primary Health Care Association

(<http://www.indianapca.org/page/FindaCHC>) Will provide information on location of Federally Qualified Health Centers which provide medical services on a sliding fee scale.

Get LARC Program: Community Group Family Medicine Center, 10122 E. 10th Street Indianapolis, IN 46229 PHONE 317-355-5717 <https://www.ecommunity.com/cpn/c/cpn-community-group-family-medicine-center/> Implants and copper and levonorgestrel IUDs are available at no cost (\$34 for GC/CT testing if getting an IUD) at this location.

Some patients may qualify for reduced cost IUDs through the manufacturers' patient assistance programs such as ARCH Patient Assistance Program for Mirena and Skyla.⁵¹ More information on how patients can access these programs can be found in Section 4.4 of

Intrauterine Devices and Implants: A Guide to Reimbursement SECOND EDITION. *This guide (published July 2015) contains information about laws, policies, and practices that may change or evolve over time. For the most up-to-date version of the guide, please visit larcprogram.ucsf.edu.*

Coding for LARC methods

- Historically, Indiana Medicaid paid for LARC devices implanted during an office visit, but included the LARC device in the overall payment for delivery services if the device was implanted in the hospital after delivery. Hospitals were reluctant to accept this additional cost. The Indiana Perinatal Quality Improvement Collaborative (IPQIC) Finance Committee reviewed the literature and recommended that the cost of the device inserted post-partum in the hospital be billed separately.

- Effective June 1, 2015, the Indiana Health Coverage Programs (IHCP) allowed separate reimbursement for LARC devices implanted during an inpatient hospital or birthing center stay for delivery. The IHCP Banner Page (BR20151) explanation is in Appendix D
- An updated IHCP Banner Page (BR201639(1)) published September 27, 2016, reiterated that J7297 and J7298 LARC devices qualify for separate reimbursement if implanted during an inpatient hospital or birthing center stay for a delivery. See Appendix E for the complete Banner Page
 - For easy reference, a table listing LARC devices eligible for separate reimbursement has been added to the *Family Planning Services Codes* table on the *Code Sets* page at indianamedicaid.com.
- In addition, IHCP updated its [Family Planning Services](#) Provider Module on September 27, 2016 to include:
 - Revised language in the *Introduction* section regarding the definition and scope of family planning services
 - Updated the *Long Acting Reversible Contraception Devices* section:
 - Updated billing codes for IUDs
 - Added information about LARC reimbursement during an inpatient stay for delivery
- A simple coding guide is included below:

| IN MEDICAID & MCE'S NOW REIMBURSE FOR INPATIENT IMMEDIATE PP LARC | |
|---|---|
| Provider | Hospital– use HCPCS codes |
| • Etonogestrel Implant Placement (Nexplanon) | • J7307 – etonogestrel implant (Nexplanon) |
| • CPT: 11981 | • J7297 – levonorgestrel releasing IUD 52 mg – 3 year (Liletta) |
| • ICD 10: Z30.018 | • J7298 – levonorgestrel releasing IUD 52 mg – 5 year (Mirena) |
| • IUD Placement | • J7300 – Copper IUD (ParaGard) |
| • CPT: 58300 | |
| • ICD 10: Z30.430 | |

VI Community Education

Although at this time it is not feasible to have a statewide public campaign on the use of LARC, we are including ideas and websites an individual medical practitioner or clinic site might use to increase the use of LARC in their area of practice.

Ideas to increase knowledge about and use of LARC in the Community include:

- Conduct school based education, community outreach through community centers and health fairs, and sex education for parents' classes.
- Share statistics on teen pregnancies in the community and if possible attend community meetings to prompt discussion within community members.
- Share impact of unintended pregnancies such as drop-out rate.
- Provide trainings to community members that also work with youth throughout community and share with them questions that youth are asking about birth control and share with them updated information on LARC.
- Use Social Media. See an article from a reliable source? Repost/retweet it!
- Have " MYTHS vs. FACTS: LARC " information cards/bookmarks to give out with correct information eliminating myths! (See Appendix B)
- Offer informational brochures at community events. Also offer community resource guides for clinic locations to access LARC and other contraception methods.
- Attend health fairs, parent meetings at school to discuss comprehensive sex education programs to help parents understand importance of discussing these topics with their student.
- Work with organizations that impact youth and women of childbearing age such as:
 - Heath Care Education and Training (<http://hcet.info/>)((317) 247-9008)
 - Indiana Family Health Council (<http://www.ifhc.org/>) ((317) 247-9151)
 - Social Health Association (<http://www.socialhealth.org/>)(317-638-3628)
 - Primary Health Care Association (<http://www.indianapca.org/>)(317-630-0845)
 - Indiana University School of Medicine, Section of Adolescent Medicine (317) 274-8812
 - Local Domestic Violence Organizations
- Set up information booths/tables at Indiana events like Black Expo, Circle City Classic, sporting events such as Colts, Fever, Pacers games, art fairs such as Talbot, Penrod, Broad Ripple, local Malls

Websites useful for general information

- Bedsider at <https://bedsider.org/>, Phone 888-321-0383
- San Francisco Sex Information -Free, confidential, accurate, nonjudgmental information about sex www.sfsi.org; questions@sfsi.org. phone: 877.401.1799
- www.itsyoursexlife.com ; CDC site

VII Glossary

- **Intended pregnancy:** Pregnancy intention is based on women's self-reported desire to become pregnant right before conception occurred. An intended pregnancy was one that was desired at the time it occurred or sooner. Guttmacher counted pregnancies about which women felt indifferent along with intended pregnancies.

- **Unintended pregnancy:** Guttmacher defines an unintended pregnancy as one that was either mistimed or unwanted. If a woman did not want to become pregnant at the time the pregnancy occurred, but did want to become pregnant at some point in the future, the pregnancy was considered mistimed. If a woman did not want to become pregnant then or at any time in the future, the pregnancy was considered unwanted. (Finer, LB, Zolna, MR, Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008, American Journal of Public Health, Supplement 1, 2014, Vol 104, No. S1, pp. S43-S48)
- **Long Acting Reversible Contraceptive:** Long-acting reversible contraception (LARC) methods include the *intrauterine device (IUD)* and the *birth control implant*. Both methods are highly effective in preventing pregnancy, last for several years, and are easy to use. Both are reversible. (<http://www.acog.org/Patients/FAQs/Long-Acting-Reversible-Contraception-LARC-IUD-and-Implant>)
- **Rapid Repeat Pregnancy:** Usually means repeat pregnancy within 2 years of previous pregnancy.
- **Premature Rupture of Membranes (PROM):** Rupture of membranes after 37 weeks gestation, but before labor.
- **Preterm Premature Rupture of Membranes (pPROM):** Rupture of membranes before labor and before 37 weeks gestation

VIII Annotated Bibliography

- <http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception> The ACOG LARC Program provides a broad range of LARC resources including clinical guidance, educational materials, and more. [Sign up](#) for the LARC Program e-newsletter to receive updates.
- <http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Clinician-Education-and-Training> The ACOG LARC Program has developed a new resource highlighting "hands-on" clinical training opportunities for LARC methods, including information about trainings for the copper IUD, LNG IUS, and contraceptive implant.
- **LARC Slide Set**** The LARC Program has developed a [slide set](#) based on clinical content from Practice Bulletin #121, [Long-Acting Reversible Contraception: Implants and Intrauterine Devices](#). ACOG welcomes use of this educational resource for presentations and Grand Rounds. Individuals and groups providing patient care or clinical education in family planning have permission to copy all or any portion of this slide set for noncommercial, educational purposes, provided that no modifications are made and proper attribution is given.
- **LARC for Adolescents Slide Set**** The LARC Program has developed a [slide set](#) based on clinical content from Committee Opinion No. 539, [Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices](#) and Practice Bulletin #121, [Long-Acting Reversible Contraception: Implants and Intrauterine Devices](#). Topics covered in the

presentation include: the potential role of LARC methods to reduce unintended pregnancy rates among adolescents, counseling adolescents about LARC methods, common misconceptions on LARC use by adolescents, and the clinical effects and characteristics of LARC methods.

- Guttmacher Institute. State Facts about Unintended Pregnancy: Indiana. April, 2016, <https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-indiana>
This fact sheet contains background information about unintended pregnancy in the United States and specific statistics about incidence and outcomes, public costs, and preventing unintended pregnancy in Indiana.
- The Regents of the University of California; American College of Obstetricians and Gynecologists; National Family Planning & Reproductive Health Association; National Health Law Program; and National Women's Law Center. **Intrauterine Devices and Implants: A Guide to Reimbursement**. July, 2015. SECOND EDITION: This guide aims to explain the landscape of LARC public and commercial insurance coverage and serve as a resource for providers navigating stocking, reimbursement, and other scenarios that create barriers to the provision of these methods. The guide is intended to help alleviate financial challenges so that providers are better able to offer the full range of contraceptive methods and minimize out-of-pocket costs or delays in care for their patients. *This guide (published July 2015) contains information about laws, policies, and practices that may change or evolve over time. For the most up-to-date version of the guide, please visit <http://larcprogram.ucsf.edu/>*
- Hatcher, RA, et al. 2011. **Contraceptive Technology 20th Edition**. Ardent Media. This well-known text with more than 2 million copies in print has been the leading family planning reference for over 30 years. At nearly 900 pages, contents include:
 - Every contraceptive method, and the U.S. Medical Eligibility Criteria
 - Clinical dilemmas in understanding risks and managing side effects
 - Every STD, including a synopsis of CDC's STD Treatment Guidelines
 - A systematic approach to menstrual disorders
 - Insights into assessing abnormal pregnancies and risk of ectopic pregnancies
 - New screening guidelines for cervical cancers
 - Special considerations for teens, breastfeeding mothers, and menopausal women

Appendices

- **Appendix A: Materials for Patients on Postpartum Contraception**
 - Patient Education Postpartum IUD GENERIC
 - Patient Education Postpartum Implant GENERIC
 - Postpartum Patient Education Contraceptive Brochure Final
 - WOC Postpartum Patient Education Contraceptive Brochure
 - Spanish Patient Education Postpartum Contraceptive Brochure
 - Discharge Instructions Post Partum Mirena GENERIC
 - Discharge Instructions Post Partum Implant GENERIC
 - Discharge Instructions Post Partum Paragard GENERIC
- **Appendix B: Patient Handout on MYTHS vs. FACTS: LARC**
- **Appendix C: Tips on LARC Counseling**
- **Appendix D: IHCP Banner Page (BR20151) published April 28, 2015**
- **Appendix E: IHCP Banner Page (BR201639(1)) published September 27, 2016**

Discharge Instruction Postpartum Implant

Date:

Dear _____:

As a reminder, you had a Nexplanon® contraceptive implant placed. This implant will provide contraception for three years. It is normal to have changes in your bleeding pattern while using the contraceptive implant. If you have any questions about your implant please call the Family Planning Office- we will be happy to answer any of your questions.

Please contact us with any questions or to schedule an appointment.

Discharge Instruction Postpartum Mirena

Date:

Dear _____:

As a reminder, you had a Mirena® IUD placed. This IUD will provide contraception for five years. There is a risk the IUD will fall out before your next visit with us. If this happens you must use condoms, because you will be at risk of pregnancy. If you'd like, we will place another IUD at your 6 week follow-up visit. Please call the your doctor if your IUD does come out or if you have any concerns or questions about your IUD.

Occasionally some women may feel discomfort from the IUD string. As the uterus shrinks after pregnancy the IUD string will become longer and can occasionally be uncomfortable. You IUD strings can be trimmed at your 6 week postpartum visit with your prenatal care provider. If you would like your IUD string trimmed before then, please call your doctor to schedule an appointment

Please contact us with any questions or to schedule an appointment.

Discharge Instructions ParaGard

Date:

Dear _____:

As a reminder, you had a ParaGard® IUD placed. This IUD will provide contraception for ten years. There is a risk the IUD will fall out before your next visit with us. If this happens you must use condoms, because you will be at risk of pregnancy. If you'd like, we will place another IUD at your 6 week follow-up visit free of charge. Please call your doctor if your IUD does come out or if you have any concerns or questions about your IUD.

Occasionally some women may feel discomfort from the IUD string. As the uterus shrinks after pregnancy the IUD string will become longer and can occasionally be uncomfortable. You IUD strings can be trimmed at your 6 week postpartum visit with your prenatal care provider. If you would like your IUD string trimmed before then, please call your doctor to schedule an appointment

Please contact us with any questions or to schedule an appointment.

Family Planning After Your New Baby



We are honored to have been involved in the birth of your baby and we would like to help you plan for your future family.

When is the best time to become pregnant again?

Waiting at least a year and a half before you are pregnant again improves your health and the health of your next baby.

Most effective methods of Contraception

- IUDs and the implant are the best for preventing pregnancy- they work >99% of the time
- You can become pregnant days to weeks after removing an IUD or implant
- Great choice for most women, including women who do not want more children or have medical illnesses

Intrauterine devices (IUDs)

- Placed inside the uterus at your doctor's office after delivery , at the time of your Cesarean, or immediately following delivery

- Remove easily anytime at your doctor's office

Hormonal IUD (Mirena)

- Lowest dose of one hormone
- Good for up to 5 years
- You can expect light or no periods (uterine lining is "thinned" out)



Copper T IUD (ParaGard)

- Copper wire, no hormones
- Good for up to 10 years
- Your monthly periods may be heavier



Contraceptive Implant (Nexplanon)

- Small plastic rod, placed in upper arm, one hormone
- Good for up to 3 years
- Takes a few minutes to place
- Your periods may be irregular or stop



Effective methods of Contraception

- They prevent pregnancy 93-99% of the time.

The Birth Control Shot (Depo Provera)- one hormone



- Every 12 weeks
- Irregular light or no periods
- It can take up to 1 year after stopping the shot to become pregnant

Progestrone-only pill ("minipill" or Micronor)

- One pill each day
- Must take at the same time every day

Birth Control Pills. The Patch. The Ring



- Oral combined contraceptive pills (many brands), ring, patch
- Contain two hormones
- You will start a few weeks after delivery to lower the risk of blood clots

Less effective methods of Contraception

Only condoms prevent sexually transmitted infections such as HIV.

Condoms work to prevent pregnancy about 85% of the time.



Your doctors and nurses are excited to help you find the best birth control. Talk to your provider to learn more and figure out which method is best for you!



Left: Nuvaring

Right: Ortho Evra Patch

Sources: Association of Reproductive Health Practitioners www.arhp.org/healthmatters, Centers for Disease Control <http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm>, JAMA 2006: <http://www.fsfh.org.co/sites/default/files/birthspacingandriskofadverse.pdf> Authored by the Family Planning Division, Montefiore Ob/Gyn and Women's Health.

Planificación familiar después de su bebé



Hemos tenido el placer de haber sido parte en el nacimiento de su bebé y nos gustaría ayudarle a planificar su futura familia.

¿Cuándo es el mejor momento para quedar embarazada otra vez?

Esperar al menos un año y medio antes de quedar embarazada otra vez mejora su salud y la salud de su próximo bebé.

Los métodos anticonceptivos más eficaces

- Los dispositivos (DIUs) y el implante son los mejores métodos que son reversibles para prevenir el embarazo- funcionan más del 99%
- Tú puedes salir embarazada unos días o semanas después de sacar el DIU o el implante
- La vasectomía y la ligadura de trompas ("Salpingo") son tan eficaces como el DIU y el implante pero son permanentes

Dispositivos Intrauterinos (DIUs)

- Se coloca dentro del útero en la oficina de su médico después del parto o inmediatamente después del parto o cesaría

- Se quita fácilmente en cualquier momento en el consultorio de su médico

DIU de hormonas (Mirena)

- Una sola hormona, tiene la dosis más baja
- Dura mínimo 5 años
- Usted puede tener una menstruación ligera o puede que no sangre (provoca que la capa de la matriz se adelgace)



DIU de cobre (ParaGard)

- Alambre de cobre, no tiene hormonas
- Dura hasta 12 años
- Su menstruación puede ser más pesada



Implante anticonceptivo (Nexplanon)

- Una varilla pequeña de plástico con hormonas, se coloca en el brazo. Solo se toma unos minutos para colocar
- Dura hasta 3 años
- Su menstruación se puede ir o ser irregular



Métodos anticonceptivos eficaces

- Previenen el embarazo un 93-99%

La inyección anticonceptiva (Depo Provera) solo tiene una hormona



- Cada 12 semanas
- Menstruación ligera o se puede ir

Puede tomar largo tiempo después de detener la inyección para salir embarazada

Pastillas que contienen solo progesterona ("minipill" or Micronor)

- Una sola hormona, una pastilla cada día
- Tiene que tomársela a la misma hora cada día

Pastillas anticonceptivas/ El parche/ El anillo

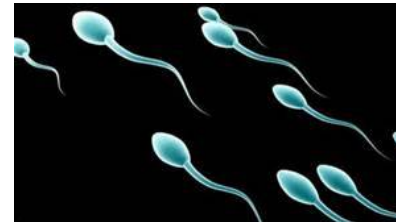


- Combinación de anticonceptivos
- Contienen 2 hormonas
- Se tiene que empezar un par de semanas después del parto para reducir el riesgo de coágulos en la sangre

Los métodos anticonceptivos menos eficaces

Solamente los condones previenen las infecciones de transmisión sexual como el VIH

Los condones funcionan para prevenir el embarazo alrededor del 85%



Sus médicos y enfermeras estarán muy contentos de ayudarle a encontrar el mejor método anticonceptivo. Hable con su proveedor para obtener más información y descubrir cual método es el mejor para usted. Es ideal de empezar un método durante 3 a 6 semanas después del parto.



Sources: Association of Reproductive Health Practitioners www.arhp.org/healthmatters, Centers for Disease Control <http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm>, JAMA 2006: <http://www.fsfh.org.co/sites/default/files/birthspacingandriskofadverse.pdf> Authored by the Family Planning Division, Montefiore Ob/Gyn and Women's Health.

Postpartum Contraceptive Implant

Why is birth control important after having a baby?

The return to fertility after having a baby can be unpredictable. You may be able to get pregnant before your next period begins. Using birth control to help plan for your future family is important. Waiting at least **a year and a half** before you get pregnant again improves your health and the health of your next baby.

What is the contraceptive implant?

The contraceptive implant (**Nexplanon®**) is a very effective form of birth control that contains a small amount of a progestin (a hormone). The hormone is safe to use after delivery, even if you are breastfeeding. The contraceptive implant is made of a thin plastic tube about the size of a paper matchstick that is placed under the skin in your upper arm. Once the contraceptive implant is placed, it works for 3 years and prevents pregnancy in over 99% of women who use it. The implant can be removed at any time.

What should I expect after placement of the contraceptive implant?

The implant may cause irregular bleeding. Some women have heavy and/or longer periods. Others have periods that are lighter and occur less often. Some women stop getting their period all together.

When can the contraceptive implant be placed?

Placement of a contraceptive implant can take place either in the doctor's office or in the hospital after you've had your baby and before you go home. Your health care provider will place some numbing medication in your upper arm and insert the contraceptive implant under your skin. It usually takes less than a minute to insert the implant.

Contraceptive implant & breastfeeding

Placement of a contraceptive implant immediately postpartum has *not* been shown to interfere with breastfeeding in healthy mothers and babies. However, you may have other risk factors for breastfeeding difficulty and use of the contraceptive implant immediately postpartum has not been studied in these situations. These risks may include having a baby born before 37 weeks, low birth weight baby, prior breastfeeding difficulty, prior breast surgery, significant anemia, obesity, diabetes, or infertility. Your health care provider can help identify these risk factors. For all women who are trying to breastfeed, it is important to feed your baby frequently on demand (8-12 times in a day) and to avoid supplementing with formula unless instructed by your baby's doctor. If your milk supply seems low, ask to speak with a lactation consultant and/or call your doctor.

Contact information

If you have questions about an immediate postpartum contraceptive implant, please contact your health care provider.

Immediate Postpartum Intrauterine Device

Why is birth control important after having a baby?

The return to fertility after having a baby can be unpredictable. You may be able to get pregnant before your next period begins. Using birth control to help plan for your future family is important. Waiting at least **a year and a half** before you get pregnant again improves your health and the health of your next baby.

What is an intrauterine device?

An intrauterine device (IUD) is a very effective birth control that is made of a T-shaped plastic rod that stays in your uterus. There are 2 types of IUDs available at our hospital:

- Copper IUD (**Paragard®**): no hormones, works for up to 10 years
- Hormonal IUD (**Mirena®**): low dose of a progestin (a hormone), works for up to 5 years

Once the IUD is placed, it prevents pregnancy in over 99% of women who use it. The IUD can be removed at any time.

What is immediate postpartum IUD?

Immediate postpartum IUD is a convenient, safe, and effective way of starting birth control right after having your baby. Immediate postpartum means that the IUD is inserted after delivery of your placenta while you are in your labor and delivery room. The IUD is usually inserted within 10 minutes of placenta delivery. This can be done after a vaginal or cesarean delivery. All types of IUDs can be inserted immediately postpartum.

How does immediate postpartum IUD compare to IUD placement in the clinic?

IUDs placed immediately postpartum may have a higher chance of falling out. This is called an IUD expulsion. An expulsion of an IUD means that the IUD partially or completely comes out of your uterus. An IUD expulsion is not dangerous and will not damage your cervix or your uterus; however, it may be uncomfortable for you and the IUD may not work correctly for birth control. The chance of having an IUD expulsion is 8% if you have an IUD placed at cesarean section, 20-30% if you have the IUD placed after a vaginal delivery, and less than 5% if you have an IUD placed in the office. Immediate postpartum IUDs may be more comfortable to place, depending on the type of pain control medication used for your labor and delivery. Placement of an IUD immediately after delivery has *not* been associated with increased rates of infection, damage to your uterus, or bleeding after delivery.

Postpartum care

If you have an IUD placed at the time of your delivery, you will receive normal postpartum care. Because you have a higher chance of IUD expulsion, it is important to follow-up with your health care provider 6 weeks after placement. At your postpartum visit, your provider will do an exam to make sure your IUD is in the correct place. Signs of expulsion include

lengthened or absent strings, feeling all or part of the IUD in your vagina, or even seeing the IUD fall out.

For women who have an IUD placed at the time of delivery, the strings may be felt lower in your vagina as your uterus returns to the normal size. If your strings are bothersome earlier than your next scheduled appointment, please contact your health care provider for an exam to adjust the IUD strings. Do not pull on the IUD strings yourself.

IUDs & breastfeeding

Placement of a hormonal (**Mirena®**): IUD immediately postpartum has *not* been shown to interfere with breastfeeding. However, you may have other risk factors for breastfeeding difficulty and use of the IUD immediately postpartum has not been studied in these situations. These risks may include having a baby born before 37 weeks, low birth weight baby, prior breastfeeding difficulty, prior breast surgery, significant anemia, obesity, diabetes, or infertility. Your health care provider can help identify these risk factors. For women with one or more of these risk factors, additional measures to protect your milk supply may be recommended. "For all breastfeeding women, it is important to feed your baby frequently on demand (8-12 times a day) and to avoid supplementing with formula unless instructed by your baby's doctor. If your milk supply seems low, ask to speak with a lactation consultant - call your doctor or 311 for a referral.

The Copper (**Paragard®**): IUD is non-hormonal and will not affect your ability to breastfeed.

Contact Information

If you have questions about an immediate postpartum IUD, please contact your health care provider.

Myths vs. Facts: Long-Acting Reversible Contraception

Long-acting reversible contraceptives (LARCs) are birth control methods including intrauterine devices (IUDs) and implants that prevent pregnancy for 3 to 12 years (depending on type) and are among the most effective contraceptives available.

Types of LARCs include:

ParaGard – copper IUD, lasts up to 12 years

Mirena – hormonal IUD, lasts up to 5 years

Liletta – hormonal IUD, lasts up to 3 years

Nexplanon – upper arm implant, lasts up to 3 years

LARCs must be placed by a doctor or nurse practitioner; once inserted, there is no daily maintenance required. LARCs may be removed at any time. Upon removal, the ability to become pregnant returns quickly.

Is a LARC right for me?

Only you and your clinician can decide if a LARC is right for you. There are many myths about LARCs, particularly IUDs. Here are some myths and facts about LARCs:

I heard IUDs increase the risk of pelvic inflammatory disease (PID), sexually transmitted diseases (STDs) or infertility.

This is a myth. IUDs don't increase the risk of PID, STDs or infertility. In fact, women with histories of STDs and PID can still use IUDs.

I heard I need a Pap test to get an implant or IUD.

Another myth. You are not required to have a Pap test to receive an implant or IUD.

I heard getting an IUD or implant is painful.

This is both myth and fact. Inserting an IUD or implant can be uncomfortable—pain tolerance varies from person to person. Some women report cramping when having an IUD inserted. It is also not uncommon to have cramping up to a few days after insertion. The cramping will go away, and pain can be managed with ibuprofen.

I heard IUDs can move around inside the body.

This is a myth. Once placed, it is not likely that an IUD will move. Rarely, IUDs can perforate the uterus (1 in 1,000 insertions). This requires the IUD to be removed.

I heard IUDs can cause an abortion.

This is a myth. IUDs do not cause abortions. In the vast majority of cases, IUDs work by preventing fertilization.

I heard IUDs and implants are expensive.

This is a fact—the cost for IUDs and implants range from \$400-\$1000 without insurance or Medicaid coverage. **However, you may qualify to receive a free IUD or implant from Planned Parenthood of Indiana and Kentucky if you are interested in receiving an IUD or implant but can't cover the costs out-of-pocket or through insurance or Medicaid.** Talk to center staff or call 800-230-PLAN to learn more and see if you qualify!

Of course, you should talk to a doctor or nurse practitioner about your questions and concerns about LARCs. For more info, please visit **www.bedsider.org**.

Did you know? In 2012, the American College of Obstetricians and Gynecologists released a committee opinion that LARCs are safe and appropriate methods for most women and adolescents and that adolescents should be encouraged to choose them. IUDs are not contraindicated for adolescents and women who haven't had children.

LONG ACTING REVERSIBLE CONTRACEPTIVES

(LARCs)

Common Questions, Myths and Facts

1. Do IUDs increase PID or infertility
 - a. No, IUDs do not increase risk of PID
 - b. No, IUDs do not decrease future fertility
2. Can women with a history of PID use an IUD?
 - a. Yes, women with PID history can use IUDs
 - b. Women who have active PID should not have an IUD inserted at that time
3. Can women who have no children use an IUD?
 - a. Yes, IUDs are appropriate for women with no children
4. Can women with a history of STIs use an IUD?
 - a. Yes. Past infections are not contraindication to any method of contraception
5. Can a women use a LARC immediately after an abortion
 - a. Yes, post-abortion LARC implant or insertion is safe and effective
 - b. Post-abortion IUD continuation and expulsion rates similar to waiting for a longer period
6. Does a woman need a recent Pap test to start the LARC method?
 - a. No, a Pap test is not required for LARC insertion
 - b. Pap tests are not related to contraception in general
 - c. Women with untreated cervical cancer should not start using an IUD
7. Is Nexplanon difficult to remove, as Norplant was?
 - a. No, the average removal procedure takes less than 4 minutes

8. Are LARC methods more expensive than pills?

- a. No, after 1-2 years of use, LARCs are cheaper than most other methods

9. Do LARC methods take a long time to reverse?

- a. No, return to fertility is faster than other hormonal methods

10. Why is LARC so effective?

- a. Users don't have to take action for method effectiveness
- b. No monthly re-supply
- c. No interruption of contraceptive use
- d. Reduced need to access health care

11. Who can use LARC?

- a. LARC is safe for women with conditions that make other methods unsafe

12. How long LARC works versus how long women should use LARC?

How long do the methods work:

- a. ParaGard – at least 12 years
- b. Mirena – at least 5 years
- c. Nexplanon – at least 3 years

How long should women use them?

- a. Just because they work that long doesn't mean women must use them that long
- b. Can be removed any time client desires

13. Does it hurt when inserted?

- a. It can be uncomfortable; for some people it can be painful. You can take ibuprofen an hour before

14. Will I have bleeding and cramping when I get home?

- a. You may have some cramping for a few days – it can be a little or a lot, and it will go away
15. Won't it move around inside my body?
- a. No, each type remains in place; it is rare that there is any change of location after correct placement
16. What about the IUDs perforating the uterus?
- a. This is a rare incident with very few women; 1 per 1,000 insertions. The IUD would need to be removed.
17. Is it going to poke my boyfriend? Will he feel the strings?
- a. No, in most cases there is no poking and no sensation of strings at the cervix during intercourse
18. Do IUDs cause an abortion?
- a. IUDs slow the movement of sperm toward the egg preventing fertilization. They are a method of contraception, not abortion.
19. Do IUDs raise a woman's risk of ectopic pregnancy?
- a. In fact, women who use IUDs are at significantly reduced risk of ectopic pregnancy compared to women who are not using contraception. However, women who do become pregnant while an IUD is in place may have a higher ratio of ectopic to uterine pregnancies.
20. Should women be screened and tested for sexually transmitted infections (STIs) at the time of IUD insertion?
- a. If there are visible STI symptoms, a woman should be treated and should get the IUD after the STI has cleared. If there are no symptoms, the device can be placed on the same day the test is done. If the test comes back positive for an STI, a woman should be treated without removing the device.

In 2012, the American College of Obstetricians and Gynecologists released a committee opinion that LARCs are safe and appropriate methods for most women and adolescents and that adolescents should be encouraged to choose them.

In 2014, the American Academy of Pediatrics updated its policy statement on contraception for adolescents with the following recommendation: “Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraception choice for adolescents.

References:

Bixby Center for Global Reproductive Health, University of California, San Francisco

Bedsider.org

AVOID WEBSITES WITH POTENTIAL MISINFORMATION

**FOR ACCURATE INFORMATION, ANSWERS TO QUESTIONS,
AND VIDEOS FOR BOTH WOMEN AND MEN:**

BEDSIDER.ORG

888.321.0383

Or

WWW.SFSI.ORG

questions@sfsi.org

877.401.1799

COUNSELING TIPS FOR LARCs

Interaction Reminders

- ✓ Language compatible with culture, education, age, etc.
- ✓ Have samples available; encourage client to handle, touch samples
- ✓ Have client restate key points to confirm understanding
- ✓ Provide written materials for reinforcement
- ✓ Provide card with name of device, date inserted, and recommended date for replacement

Talking Point Suggestions for LARCs

- + Effective – more effective than the pill, patch, or ring
- + Low or no hormones – ParaGard has no hormones; others have low dose of hormone
- + Safe – safe, easy to remove, and won't affect future fertility
- + Easy to use- don't have to remember to do anything for them to work
- + Reversible – can be removed any time; can get pregnant right away
- + Long lasting- can be used, are effective for 3, 5, or 12 years

Suggestions for Responding to Patient Concerns

1. Client Concern:

I don't want anything inside me.

Possible Response(s):

- I know it can seem strange to have something inside you; you won't be able to feel any of these methods once they are placed. And no one will need to know that they are even there but you.
- I can see you are anxious about having a method placed inside you. What concerns do you have about that?
- Many women have shared that they don't feel the method, and that they even forget that they have a method placed inside them.
- Show device sample. Let patient handle it.
- Other devices frequently and safely inserted inside body – pacemakers, knees, hips, eyes - with no harm

2. Client Concern:

It's unnatural.

Possible Response(s):

- What is it about the methods that seem unnatural to you? – Placement location? It's action? Hormones?
- If it is the hormones that bother you, perhaps you might like ParaGard since it doesn't have hormones.
- The Mirena, Skyla and the Liletta do release a dosage of low level of progestin that is both safe and effective. Progestin is a synthetic form of progesterone, a natural hormone that the body produces.
- If it is that they last so long, these methods work very similarly to many other methods available; they are longer lasting and require less effort from you.

3. Client Concern:

Aren't I supposed to get a period? What happens if I don't?

Possible Response(s):

- Doctors have determined that it is not medically necessary to get a period each month. Some women like not getting their period and others like the regularity of getting their period each month. You would need to decide what is best for you.
- Every month a woman builds a lining of blood to sustain a pregnancy. If the woman doesn't become pregnant, that lining of blood is shed. That is your period. The reason a woman may stop getting her period when using these methods is because no lining of blood is built up; and so there is no blood to shed. There are no side effects or physical harm if you stop getting your period.

4. Client Concern:

Don't IUDs cause abortion?

Possible Response(s):

- IUDs do not cause an abortion. They work by preventing fertilization of an egg, either by blocking the sperm from reaching

the egg or, in the case of the Mirena and Liletta, by also preventing the release of the egg.

5. Client Concern:

Don't long-acting methods take a long time to reverse? What if I want to have a baby next year?

Possible Response(s):

- All LARC methods are actually quite easy to remove and you can have any of them removed whenever you choose. However, we do suggest that if you are planning to get pregnant within the next six months that you may want to choose another method.
- When removed, you have virtually an immediate return to fertility.

6. Client Concern:

What if I want it out before (3, 5, 12) years?

Possible Response(s):

- While LARC methods can be effective, last for several years, you can have a LARC method removed at any time you choose.
- These methods can last for several years, but you can have it removed whenever you like.

7. Client Concern:

I'm not sure where I will be in (3, 5, 12) years from now. How do I remember to have it taken out or replaced? What if I forget about it?

Possible Response(s):

- How do you currently keep records of your health/medical history?
- We will give you a card with the name of the device, the date it is inserted, and the recommended date for removal on it.
- If you are still our patient, we will remind you.
- If you have moved, you will want to be sure to have your new doctor get your medical records from us.
- I can understand your concern, especially since this method is so low maintenance some women may forget they are using it. We will remind you. Also, whenever you go in for any medical appointment, they may ask about any medications you take,

including birth control. That question may help you remember that you are on this method.

8. Client Concern:

What about the risks? I've heard about those TV lawsuits ads about IUDs. Aren't IUDs dangerous?

Possible Response(s):

- I recommend listening to or reading about LARCs from scientific and reliable sources instead of those interested in exploiting the very rare occurrences of problems. I will give you a few trustworthy resource sites or literature before you leave.
- There were some problems with the Dalkon Shield in the 70's. However, modern IUDs are greatly improved and are actually one of our safest contraceptive methods. The scientific evidence shows risks are rare, and lower than risks of clots while on the pill or with pregnancy.

IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS

BR201517

APRIL 28, 2015

HCPSC codes added to the Medicare and TPL bypass tables

Effective June 1, 2015, the Indiana Health Coverage Programs (IHCP) will add the Healthcare Common Procedure Coding System (HCPSC) codes in Table 1 to the Medicare and Third Party Liability (TPL) bypass tables. Claims for these codes may be submitted to the IHCP as the primary payer. This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after June 1, 2015.

Table 1 – HCPSC codes added to the Medicare and TPL bypass tables for DOS on or after June 1, 2015

| HCPSC Code | Description |
|------------|--|
| E0328 | Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress |
| E0329 | Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress |
| E0373 | Nonpowered advanced pressure reducing mattress |
| J1055 | Injection, medroxyprogesterone acetate, 1 mg |
| S4993 | Contraceptive pills for birth control |

The IHCP to allow separate reimbursement for LARC devices implanted during delivery stay

Effective June 1, 2015, the Indiana Health Coverage Programs (IHCP) will allow separate reimbursement for long-acting reversible contraception (LARC) devices implanted during an inpatient hospital or birthing center stay for a delivery. This reimbursement change applies to fee-for-service claims for dates of service on or after June 1, 2015.

MORE IN THIS ISSUE

- [Providers may resubmit UB-04 outpatient claims with revenue code 614 that denied incorrectly](#)
- [Providers may resubmit claims with HCPSC code J2274 and NDC 00409113502 that denied incorrectly](#)
- [Second-quarter IHCP workshops](#)

LARC devices are defined as implantable devices that remain effective for several years to prevent pregnancies. Devices include intrauterine devices (IUDs) and birth control implants. Separate reimburse-



continued

ment applies to the LARC device only. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital diagnosis-related group (DRG) or the birthing center all-inclusive reimbursement amount.

To receive separate reimbursement for LARC devices implanted during inpatient hospital or birthing center stays for delivery, the appropriate Healthcare Common Procedure Coding System (HCPCS) code should be billed on a *CMS-1500* claim form. Providers will be reimbursed according to the [Fee Schedule](#) at indianamedicaid.com. The outpatient reimbursement methodology for covered LARC implantations remains unchanged.

Separate reimbursement for these devices is subject to IHCP coverage policies. Currently covered LARC devices eligible for separate reimbursement are listed in Table 2. Other forms of contraception will not be eligible for separate reimbursement when provided in the inpatient setting. Claims for separate reimbursement are subject to post-payment review.

Table 2 – LARC devices eligible for separate reimbursement during inpatient hospital or birthing center stays for delivery for DOS on or after June 1, 2015

| HCPCS Code | Description |
|------------|--|
| J7300 | Intrauterine copper contraceptive |
| J7301 | Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg |
| J7302 | Levonorgestrel-releasing intrauterine contraceptive system, 52 mg |
| J7306 | Levonorgestrel (contraceptive) implant system, including implants and supplies |
| J7307 | Etonogestrel (contraceptive) implant system, including implant and supplies |

Providers may resubmit *UB-04* outpatient claims with revenue code 614 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing system issue. Providers billing revenue code 614 – *Magnetic Resonance Technology-MRI-Other* on *UB-04* outpatient claim forms may have received inappropriate denials with explanation of benefits (EOB) code 4107 – *Revenue code is not appropriate/covered for service. Revenue group invalid*.

The claims processing system error is being corrected. Beginning June 1, 2015, *UB-04* outpatient claims submitted with revenue code 614 and denied for EOB code 4107 may be resubmitted for reimbursement consideration.

This applies retroactively to claims with dates of service (DOS) on or after

July 1, 2014. Claims resubmitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.



Providers may resubmit claims for HCPCS code J2274 and NDC 00409113502 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified an issue with its claims processing system. Claims for Healthcare Common Procedure Coding System (HCPCS) code J2274 – *Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg* billed with National Drug Code (NDC) 00409113502 may have been denied incorrectly with explanation of benefits (EOB) code 4300 – *Invalid NDC to procedure code combination*.

The claims processing system error is being corrected. Beginning June 15, 2015, providers may resubmit these previously denied claims for reimbursement consideration. This change applies retroactively to fee-for-service claims with dates of service (DOS) on or after **January 1, 2015**. Claims resubmitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

Check out the IHCP provider workshops that are coming soon!

Whether you are brand-new to the Indiana Health Coverage Programs (IHCP) or are a long-time provider, you will find a variety of worthwhile offerings in workshops scheduled beginning in May.

Second-quarter provider workshops

The IHCP is offering the following sessions at workshops scheduled throughout the state during May and June:

- **Benefit Packages:** This presentation provides an overview of the various IHCP benefit packages, including brief descriptions of packages, covered services, and delivery systems.
- **Billing Medicaid Secondary:** This session details how to correctly submit claims for members who have other resources, including Traditional Medicare, Medicare Replacement Plans, and commercial insurance plans, available to help pay the cost of medical care. It also outlines how to report changes in a members' primary insurance.
- **MCE Updates and Roundtable:** Anthem, MDwise, and Managed Health Services (MHS) will provide brief updates about Hoosier Care Connect and the Healthy Indiana Plan (HIP), followed by a roundtable to address questions from attendees.

Dental specialty workshop – Dental FFS and DentaQuest

In this session, you will learn valuable information about dental services provided under the fee-for-service (FFS) delivery system. This session, scheduled for dates during May and June, covers Web interChange eligibility inquiry, including how to determine aid categories, delivery systems, third-party liability (TPL) resources, and benefit limitations. Presenters will discuss dental coverage guidelines, as well as common billing issues such as claim filing, check/RA inquiry, claim inquiry, and the copy/void/replacements. DentaQuest, the HIP dental benefits administrator, will provide an overview of its program, including information about creating user accounts, accessing and using the company's web portal, and a general Q&A.

continued



IHCP 101 Workshop

This virtual training session will be offered every third Monday beginning in May 2015 and will cover the basics about providing services under the IHCP. Attendees will learn about the Healthy Indiana Plan (HIP), Hoosier Healthwise, Hoosier Care Connect, and Traditional Medicaid, including the contractors administering these programs, filing claims, obtaining and reading Remittance Advices (RAs), and more. Even better, providers can attend this class from the convenience of their home or office (telephone and computer are required).

For workshop dates and to register, visit the [Provider Education](#) page at indianamedicaid.com.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS

BR201639

SEPTEMBER 27, 2016

IHCP adds J7297 and J7298 to LARC devices qualifying for separate reimbursement

As announced in Indiana Health Coverage Programs (IHCP) *Banner Page* [BR201517](#), the IHCP allows separate reimbursement for long-acting reversible contraception (LARC) devices implanted during an inpatient hospital or birthing center stay for a delivery. Separate reimbursement for these devices is subject to IHCP coverage policies.

The LARC devices listed in Table 1, qualify for separate reimbursement. Qualification is retroactive to dates of service (DOS) on or after **January 1, 2016**.

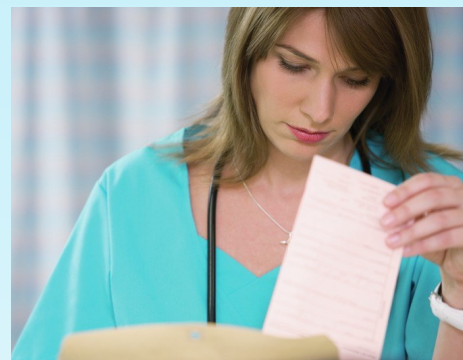


Table 1 – LARC devices qualifying for separate reimbursement for DOS on or after January 1, 2016

| HCPCS code | Description |
|------------|--|
| J7297 | Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration |
| J7298 | Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration |

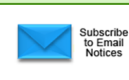
Effective immediately, providers may submit fee-for-service (FFS) claims for separate reimbursement of these devices for DOS on or after January 1, 2016. To receive separate reimbursement, these codes must be billed on a *CMS-1500* claim form. Claims submitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date. Providers will be reimbursed according to the [Fee Schedule](#) at indianamedicaid.com. The outpatient reimbursement methodology for covered LARC implantations remains unchanged. Claims for separate reimbursement are subject to post-payment review.

Individual managed care entities (MCE) establish and publish reimbursement and billing guidance within the managed care delivery system. Questions about managed care reimbursement and billing should be directed to the MCE with which the member is enrolled.

For easy reference, a table listing LARC devices eligible for separate reimbursement has been added to the *Family Planning Services Codes* table on the [Code Sets](#) page at indianamedicaid.com.

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