Postpartum Contraceptive Access in South Carolina

SC Birth Outcomes Initiative
March 26, 2015

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Director, SC Birth Outcomes Initiative

DISCLAIMER

Disclaimer: The information in this webinar is for educational purposes only, and is not meant to substitute for medical or professional judgment. Medical information changes constantly. Therefore the information contained in this webinar or on the linked websites should not be considered current, complete or exhaustive.

This webinar is being recorded.

OBJECTIVES

- **Participants will improve their ability to prescribe LARC contraception for their patients and will understand the importance of contraceptive counseling throughout pregnancy, with a focus on informed choice related to LARC acceptance and continuation.**

- **Participants will identify the procedures necessary for inpatient insertion of LARC in the immediate post-partum period and will incorporate them into the system of postpartum services.**

- **Participants will obtain information to clarify billing for immediate post-partum LARC insertion for Medicaid-eligible (enrolled) women.**

AGENDA

I. **Prenatal Counseling about LARCs**
   Deborah Billings, PhD

II. **Hospital Strategies for Inpatient LARC Insertion**
   Judith Burgis, MD
   Amy Picklesimer, MD

III. **Q & A**

IV. **Survey**

Healthy Connections

Prenatal Counseling about LARCs

Deborah Billings, PhD

Director, SC Contraceptive Access Campaign/ Choose Well initiative

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Importance of Prenatal Counseling for Postpartum Contraceptive Access

Summary Review of the Evidence Base

What we know about LARC use overall

- Overall use is low (women ages 15-44) but increasing over time: 1.5% in 2002 to 7.2% between 2011 and 2013 (*CDC NCHS Brief, 2015*)
- Women who have had at least one birth use LARCs at a higher rate compared with women who have had no previous births, and this difference has increased over time (*CDC NCHS Brief, 2015*)

HOWEVER:

- Low utilization of LARC may not reflect the true underlying demand for the intrauterine device (IUD) and implant. Contraceptive CHOICE Project (among other work) have shown a dramatic uptake of LARC when there is:

1. ***supportive counseling***
2. methods are provided at no cost (Peipert et al., 2012)

Prenatal and Postpartum Periods: Opportune Moments for Contraceptive Care

- High interest in LARC exists among postpartum women, particularly among women with a recent unintended pregnancy and women who do not desire pregnancy for at least 2 years (Tang et al., 2013)

- Over half of unintended pregnancies among women in the US occur within 2 years following delivery despite (In Potter et al., 2014):
  - Improved access to health care and insurance coverage in the immediate postpartum period
  - Women's increased motivation to prevent pregnancy

Prenatal Contraceptive Counseling

- 3 Hospitals, Austin and El Paso, TX.
- Prospective cohort study.
- 800 postpartum women aged 18-44 who wanted to delay childbearing for at least 24 months.

(Aiken et al. 2013; Potter et al., 2014)

- Women report limited contraceptive counseling during prenatal care.
- Prevalence of counseling is higher postpartum
- Either prenatal or postpartum: LARC and permanent methods often not discussed
- Preference for these methods not confined to particular segments of the population.
- Hispanic women had a higher interest in and use of LARC than other ethnic/racial groups among participants who wanted to or might have an additional child (consistent with nationally representative data)

- ***Such limited counseling*** *likely affects access to and uptake of highly effective methods, as well as subsequent risk of unintended pregnancy.*
- *Women's contraceptive needs could be better met* ***by counseling about all methods****, by reducing cost barriers and by making LAPM available at more sites.*

Prenatal Contraceptive Counseling

- 3 Hospitals, Austin and El Paso, TX.
- Prospective cohort study.
- 800 postpartum women aged 18-44 who wanted to delay childbearing for at least 24 months.

(Aiken et al. 2013; Potter et al., 2014)

- Lack of access to LARCs (and male and female sterilization) postpartum
  - lack of provider training;
  - misperceptions regarding eligibility, safety and effectiveness;
  - **insufficient counseling**;
  - structural barriers related to the postpartum provision of both LARC and female sterilization

Prenatal Contraceptive Counseling

- Atlanta study: baseline characteristic found to be most significant for intent to use LARC was **discussion about LARC with a provider during the prenatal period**, (adjusted odds ratio, 20.1; 95% CI, 6.1–66.1).
- Women's contraceptive goals postpartum are consistent with attributes of LARC methods.
- Discussion with a provider about these methods in prenatal period may influence the decision to use LARC methods

(Kotke, 2010)

Don’t wait until postpartum visit

- North Carolina study: hypothesized that women who received a “LARC script”* during their postpartum hospitalization would be more likely to report LARC use after their 6-week postpartum visit, compared to women who did not receive the script

FINDINGS:

- Administration of a LARC script to postpartum women (before leaving the hospital) did not significantly increase postpartum LARC use (at 6-week PP visit).
- However, the script ***significantly increased interest in using LARC***

*LARC script adapted from the CHOICE Project; (Tang et al 2014)

Specific Needs of Adolescents

- Adolescents who do not initiate a LARC method postpartum have up to a 35 times increased risk of rapid repeat pregnancy (RRP) compared with their peers using LARC. Risk of RRP is decreased when LARC methods are initiated earlier after an abortion or within the postpartum period. (Baldwin and Edelman, 2013)
- ***Receipt of prenatal contraceptive counseling*** and receipt of a postpartum checkup were both associated with a decreased likelihood of having sex without contraception (although LARC use low- 11% IUD and 1% implant)
- ***Enhancing the scope and quality of prenatal contraceptive counseling*** and increasing the proportion of adolescent mothers who return for a postpartum checkup may also improve postpartum contraceptive use.(Wilson et al., 2013)

Importance of Prenatal Counseling for Postpartum Contraceptive Access

High Quality Practice: Ethics and Informed Choice

Ethics and Informed Choice

- Providers as *facilitators,* who offer information that enables women to make informed decisions about their contraceptive methods in relation to their lives
- Contributes to the empowerment and dignity of women postpartum
- Respect for women's autonomy
- Core part of high quality care
- Frames our work clearly as meeting the needs of women

References

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Hospital Strategies for Inpatient LARC Insertion

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LARC: Long Acting Reversible Contraceptives

Etonorgestrel Implant

Levonorgestrel Intrauterine System

3 and 5 year options

WHY LARC?

http://www.choiceproject.wustl.edu/#CHOICE

THE CONTRACEPTIVE CHOICE PROJECT

CHOICE | MISSION | CONTACT | RESOURCES | METHODS | ePUB

THE CHOICE

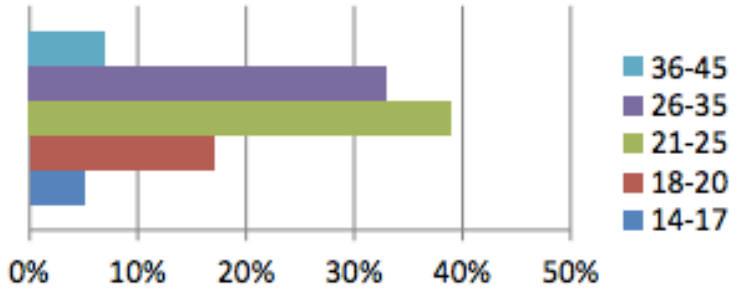
Our website provides the most up-to-date information about the CHOICE Project, publications, research findings and dissemination efforts. Start by watching an overview of our research results in "Pathway to CHOICE", check out local and national resources or learn more about your contraceptive options. The CHOICE is yours!

THE CONTRACEPTIVE CHOICE PROJECT

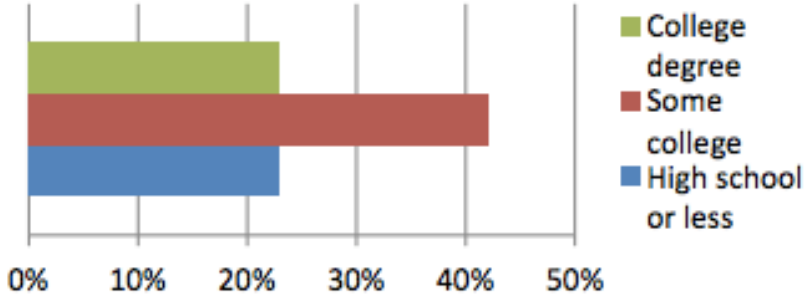
WHO ENROLLED IN THE STUDY?

A diverse group of women enrolled in CHOICE and are very similar to women who live in the St. Louis region. Each chart shows the percent of women in each category of the 9,256 enrolled.

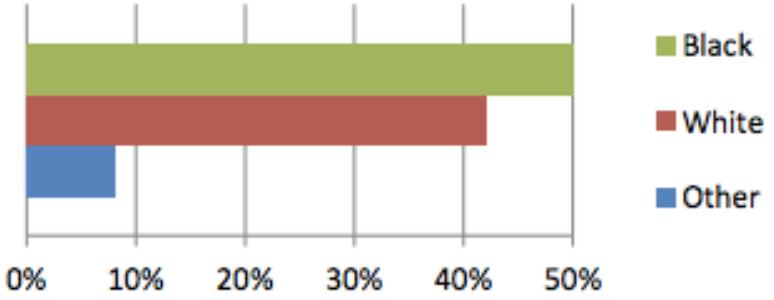
AGE (Years)



EDUCATION

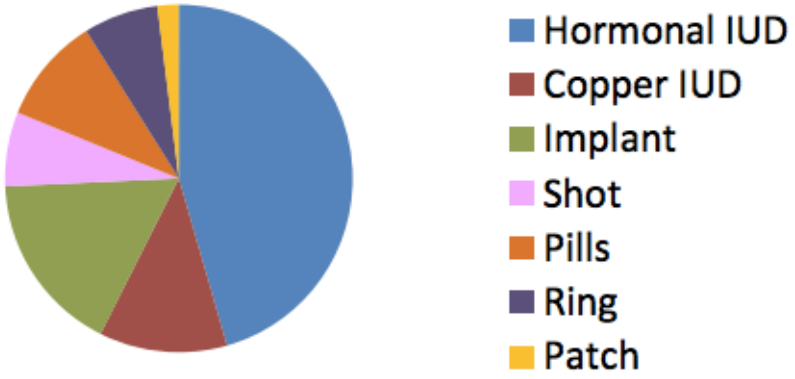


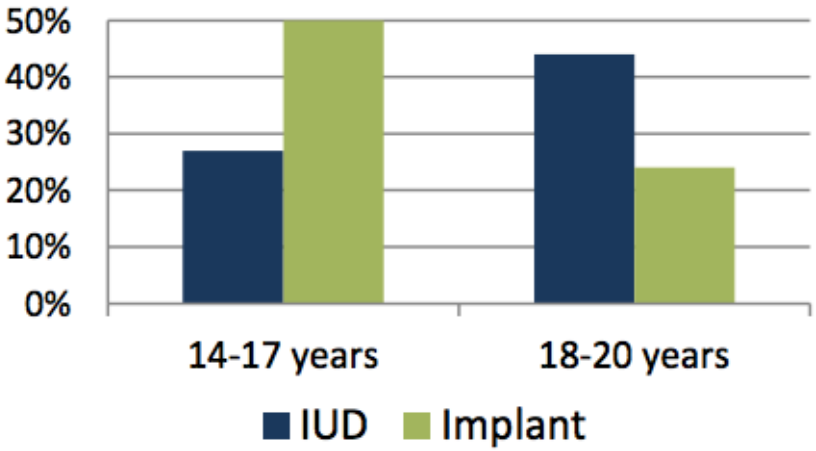
RACE



WHAT METHOD DID WOMEN CHOOSE?

This chart shows the birth control methods 9,256 women chose when they enrolled in CHOICE. Overall 75% of women chose a long-acting reversible contraceptive method (**LARC: IUD or implant**). Teens also chose LARC methods.





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ARE WOMEN STILL USING THEIR METHOD?

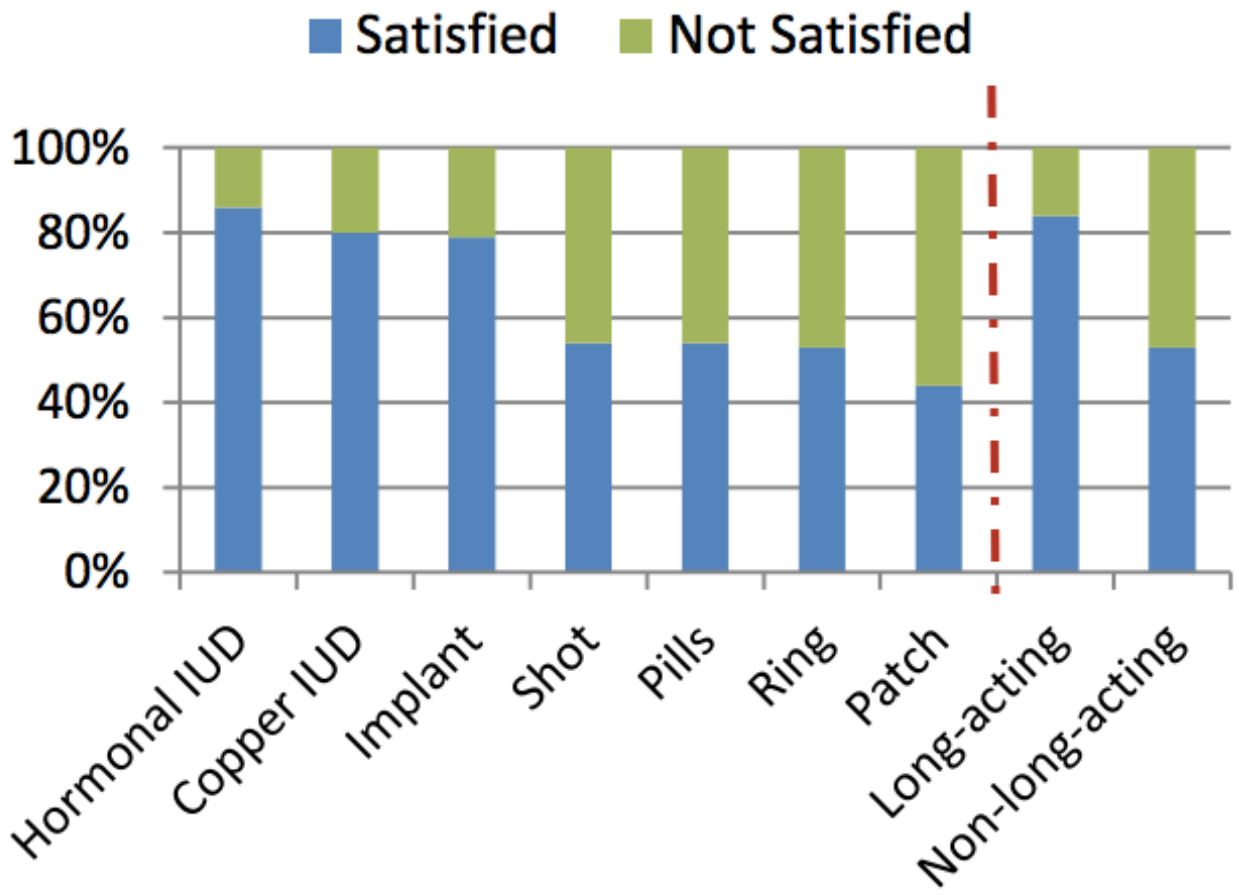
Among women who chose a LARC method, 86% were still using their method at 1 year. Only 55% of women who chose non-long-acting methods were still using their method at 1 year.

HORMONAL IUD	88%
COPPER IUD	84%
IMPLANT	83%
SHOT	57%
PILLS	55%
RING	54%
PATCH	49%
LONG-ACTING METHODS	86%
NON-LONG-ACTING METHODS	55%

THE CONTRACEPTIVE CHOICE PROJECT

ARE WOMEN SATISFIED WITH THEIR METHOD?

Women using LARC had the highest satisfaction at 1-year follow-up. Women who stopped their method were considered not satisfied.



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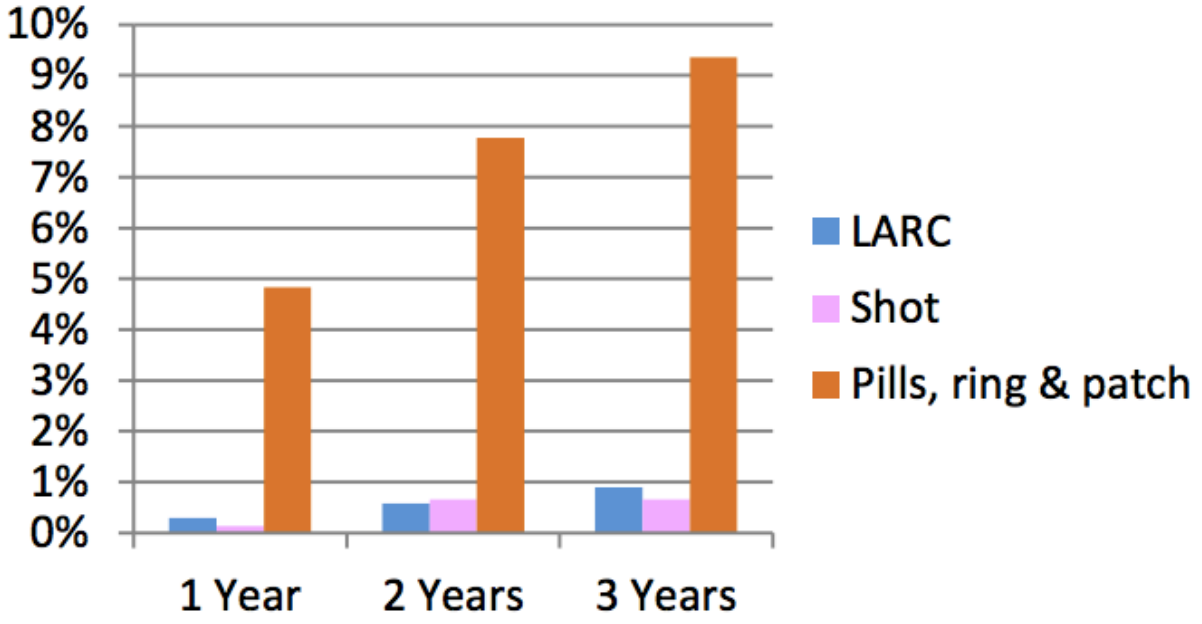
HAVE WOMEN HAD UNINTENDED PREGNANCIES?

Women using LARC or the shot had the lowest unintended pregnancy rates at 1, 2 & 3 years of follow-up. Pill, ring & patch users had a pregnancy rate that was 20 times higher than LARC users. LARC was very effective at preventing pregnancy regardless of age, but women <21 using the pill, ring or patch were 2 times more likely to get pregnant than women ≥21 years using the same methods.



THE CONTRACEPTIVE CHOICE PROJECT

WHY NOW?

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

POLICY STATEMENT

Contraception for Adolescents

COMMITTEE ON ADOLESCENCE

KEY WORDS
contraception, adolescent, birth control, intrauterine device, contraceptive implant, oral contraceptive pills, contraceptive

abstract

FREE

Contraception is a pillar in reducing adolescent pregnancy rates. The American Academy of Pediatrics recommends that pediatricians de-
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Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents.

INTRODUCTION

Pediatricians play an important role in adolescent pregnancy prevention and contraception. Nearly half of US high school students report ever having had sexual intercourse.[1] Each year, approximately 750 000 adolescents become pregnant, with more than 80% of these pregnancies unplanned, indicating an unmet need for effective contraception in this population.[2,3] Although condoms are the most frequently used form of contraception (52% of females reported condom use at last sex), use of more effective hormonal methods, including combined oral contraceptives (COCs) and other hormonal methods, was lower, at 31% and 12%, respectively, in 2011.[1] Use of highly effective long-acting reversible contraceptives, such as implants or intrauterine devices (IUDs), was much lower.[1]

Adolescents consider pediatricians and other health care providers a highly trusted source of sexual health information.[4,5] Pediatricians' long-term relationships with adolescents and families allow them to

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The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

www.pediatrics.org/cgi/doi/10.1542/peds.2014-2299

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 539 • October 2012 (Replaces Committee Opinion No. 392, December 2007 Reaffirmed 2014)

Committee on Adolescent Health Care
Long-Acting Reversible Contraception Working Group

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Adolesce… Contrace…es

Adolescents are at high risk of unintended pregnancy and may benefit from increased access to LARC methods

ABSTRACT: …he contraceptive implant—are safe… …e LARC methods are top-tier contra… …r year for perfect use and typical us… …n of all reversible contraceptives. Adolescents are at high risk of unintended pregnancy and may benefit from increased access to LARC methods.

Sexual Behavior and Contraceptive Use Among American Adolescents

In the United States, 42% of adolescents aged 15–19 years have had sexual intercourse (1). Although almost all sexually active adolescents report having used some method of contraception during their lifetimes, they rarely select the most effective methods. Adolescents most commonly use contraceptive methods with relatively high typical use failure rates such as condoms, withdrawal, or oral contraceptive (OC) pills (1). Nonuse, inconsistent use, and use of methods with high typical use failure rates are reflected in the high rate of unintended adolescent pregnancies in the United States. Eighty-two percent of adolescent

depot medroxyprogesterone acetate (DMPA) injections, are mainstays of adolescent contraceptive choices, but these contraceptives have lower continuation rates and higher pregnancy rates than LARC methods (5, 6). Of 1,387 females aged 15–24 years who initiated short-acting hormonal methods, only 11% using the contraceptive patch, 16% receiving DMPA injections, and approximately 30% using the vaginal ring and OCs were still using the same method after 12 months (6). In a study of 4,167 females aged 14–45 years that compared continuation rates for LARC and short-acting contraceptive methods, the continuation rate for LARC was 86% at 12 months compared with 55% for short-acting contracep-

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Columbia, South Carolina 29202-8206
www.scdhhs.gov
August 13, 2013
MB# 13-037

MEDICAID BULLETIN

HOSP

TO: **Providers Indicated**

SUBJECT: **Clarification Bulletin: Long Acting Reversible Contraceptives provided in an Inpatient Hospital Setting**

On January 19, 2012, the South Carolina Department of Health and Human Services (SCDHHS) issued a bulletin titled "Long Acting-Reversible Contraceptives (LARCs) provided in a Hospital Setting". In that bulletin, the agency indicated that coverage for LARCs would be considered an add-on benefit to the Diagnostic Related Group (DRG) reimbursement for all dates of service on or after March 1, 2012.

Since publishing the previous bulletin, SCDHHS has worked with providers to determine the most effective approach to code and reimburse providers for LARCs provided in an inpatient hospital setting. Effective immediately, SCDHHS will reimburse providers for these LARCs through a gross level credit adjustment process for dates of service on or after March 1, 2012, according to the process described below.

In order to process the LARC payment, hospitals are required to utilize the Healthcare Common Procedure Coding System (HCPCS) Code that represents the device, along with the ICD-9 Surgical Code and the ICD-9 Diagnosis Codes that best describes the services delivered. These codes must be included on the UB-04 or Institutional Claim so that a gross level credit adjustment can be generated. Providers will receive a monthly listing of affected claims included in the gross level adjustment and the credit will appear on a future remittance advice. Providers will be able to identify this particular credit adjustment on the remittance advice in the Adjustment Section under the "Provider's Own Reference Numbers" column. Each adjustment will have a provider's own reference number that begins with "LARC". Relevant codes are listed below:

Long Acting Reversible Contraceptives

- Challenge identified in BOI Care Coordination Workgroup. 50% of Medicaid beneficiaries miss their 6 week post-partum appointment which often results in unplanned/unwanted pregnancies
- March 1, 2012: Medicaid allowed for in-patient insertion of the device, but billed outside the DRG for full payment to the hospital.
- SC was the first state in the nation to enact this policy with 3 others recently adopting it.
- Coverage for LARC is included in the MCO capitation rate; the Plans adopted the insertion/inpatient policy as well.

Instructions for Medicaid Claims

Codes must be included on the UB-04 or Institutional Claim so that a gross level credit adjustment can be generated

The claim will adjudicate and the DRG portion will be paid in the weekly claims payment cycle. The LARC reimbursement will process as a gross level credit adjustment and will appear on a future remittance advice.

HCPS:

- A4264 Intratubal Occusal Device (Essure)
- J7300 Intrauterine (IU) copper IUD (Paraguard)
- J7301 Levonorgestrel-releasing IUD 13.5 mg (Skyla)
- J7302 Levonorgestrel releasing IUD 52 mg (Mirena)
- J7307 Etonorgestrel (contraceptive) implant system (Implanon/Nexplanon)

ICD-9 Surgical Code:

- 69.7 Insertion Contraceptive Device

ICD-9 Diagnosis Code:

- V25.02 Initiate Contraceptive NEC
- V25.1 Insertion of IUD

LARC Reimbursement Update

Code	Previous Reimbursement Rate	Current Reimbursement Rate	Insertion Code	Rate
A4264 Essure	$1,164.00	$1,674.00	58565	$247.14
J7300 Paragard	$588.43	$717.60	58300	$ Price depends on specialty and modifier
J7307 Impl/Nex	$712.17	$777.69	11981	$price depends on specialty and modifier
J7302 Mirena	$691.80	$843.66	58300	$Price depends on specialty and modifier
J7301 Skyla	n/a	$702.35	58300	$Price depends on specialty and modifier

www.cdc.gov/teenpregnancy/health-care-providers/repeat-births.htm

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC A-Z INDEX

Reproductive Health: Teen Pregnancy

- Teen Pregnancy
- About Teen Pregnancy
- Teen Pregnancy Prevention +
- Parent and Guardian Resources
- Health Care Providers −
  - Teen-Friendly Reproductive Health Visit
  - **Repeat Teen Births**
- For Teens
- Social Media Tools +

More Related Links

- Reproductive Health
- Healthy Youth
- Preventing Pregnancies in Younger Teens
- Winnable Battles
- Social Media at CDC

CDC > Teen Pregnancy > Health Care Providers

Immediate Postpartum Insertion of Long-Acting Reversible Contraception

Recommend Tweet Share

Nearly 1 in 5 teen births are repeat births, about 183 a day.

Many repeat births could be prevented through postpartum use of **long-acting reversible contraception (LARC)** such as IUDs and implants. Counseling women during prenatal visits about postpartum contraception, and offering women LARC in the hospital after delivery makes it easier for women to avoid unintended pregnancy.

A Teen-Friendly Reproductive Health Visit [PDF-1.9 MB]

South Carolina's Medicaid* [PDF - 27KB] program reimburses for LARC insertion in the hospital before women who have just given birth leave the hospital.

Learn more about South Carolina's Medicaid Health Initiatives.

GREENVILLE HEALTH SYSTEM

Nexplanon Insertion

http://youtu.be/ug7q_1RUMio

Request in-person training by calling Merck 877-467-5266
or online at http://www.nexplanon-usa.com

Supplies

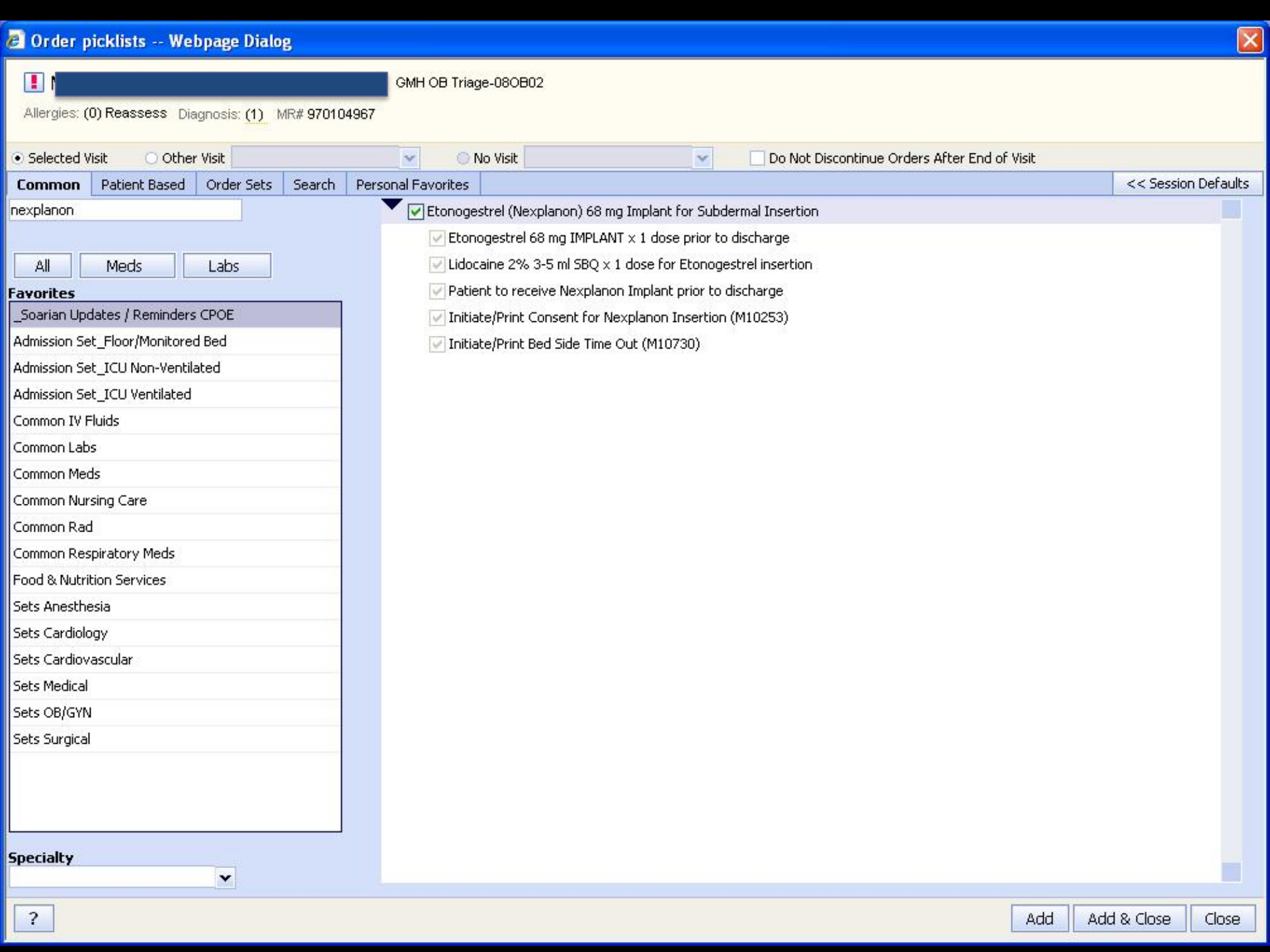
Hospital Pyxis

- Nexplanon device and local anesthetic

Supplies

Tackle Box

- Sterile gloves
- Sterile towels
- Betadine swabs
- Sterile marking pen
- 20 cc syringe
- 18 and 23 gauge needles
- Band-aid
- Dressing pads and wrap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All
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Admission Set_Floor/Monitored Bed
Admission Set_ICU Non-Ventilated
Admission Set_ICU Ventilated
Common IV Fluids
Common Labs
Common Meds
Common Nursing Care
Common Rad
Common Respiratory Meds
Food & Nutrition Services
Sets Anesthesia
Sets Cardiology
Sets Cardiovascular
Sets Medical
Sets OB/GYN
Sets Surgical
Specialty
Etonogestrel (Nexplanon) 68 mg Implant for Subdermal Insertion
Etonogestrel 68 mg IMPLANT x 1 dose prior to discharge
Lidocaine 2% 3-5 ml SBQ x 1 dose for Etonogestrel insertion
Patient to receive Nexplanon Implant prior to discharge
Initiate/Print Consent for Nexplanon Insertion (M10253)
Initiate/Print Bed Side Time Out (M10730)
?
Add
Add & Close
Close

What about breastfeeding?

The implant can be inserted at any time following delivery. The advantages generally outweigh real or theoretical risks if placed <1 month post-partum, and there is no restriction if placed >1 month post-partum

CDC MMWR June 21, 2013

Observational studies of progestin-only contraceptives suggest they have no effect either on a woman's ability to successfully initiate and continue breastfeeding, or an infant's growth and development.

ACOG Practice Bulletin #121, July 2011

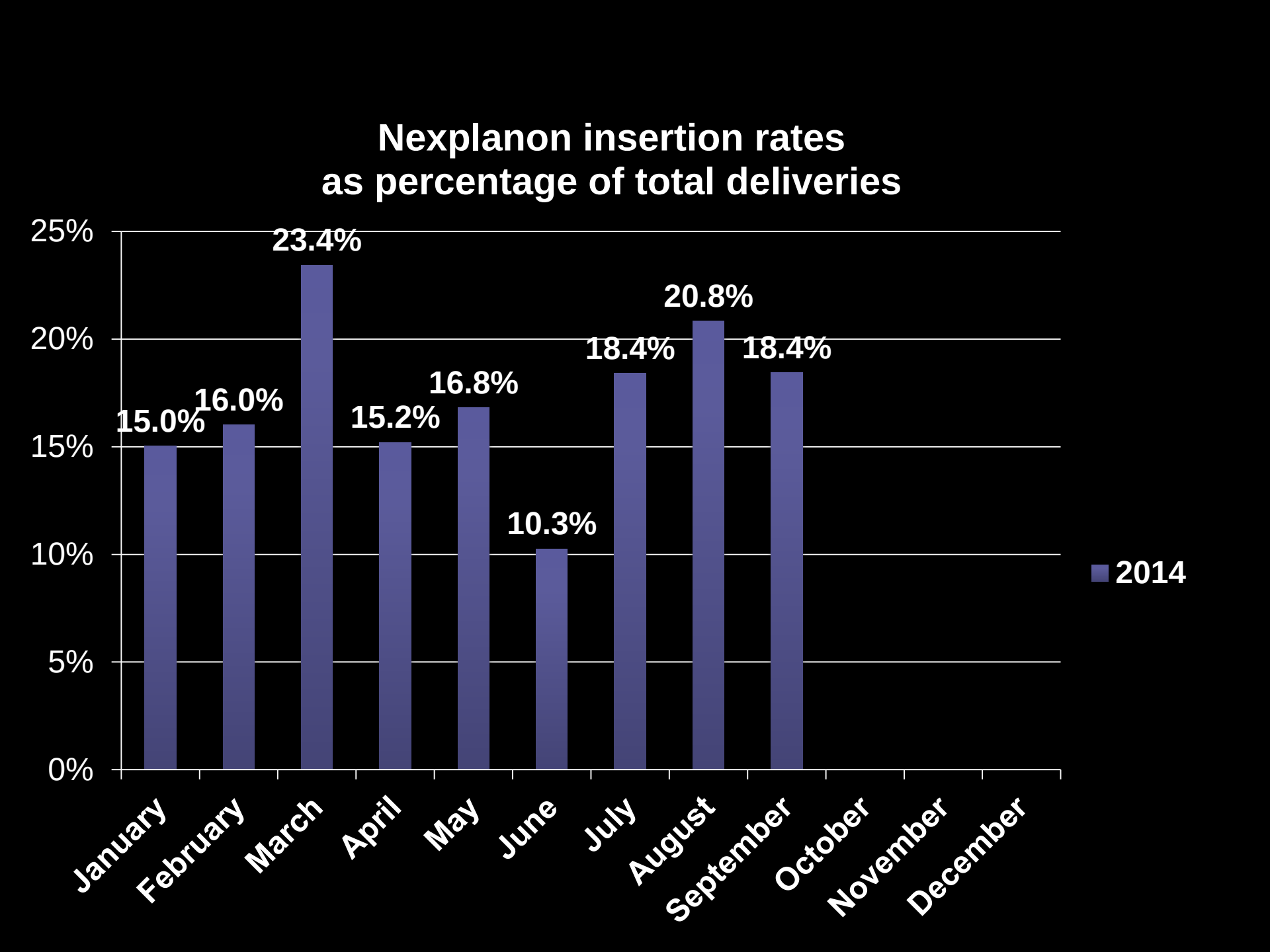
The risks of unintended pregnancy are much greater than the real or theoretic risks of progestin exposure in the post-partum period

The advantage of Nexplanon over Depo Provera is that the implant can be removed in women who are struggling with lactation

An additional advantage of Nexplanon over Depo Provera is that it has a lower peak serum concentration.

- After Depo Provera injection , medroxyprogesterone acetate plasma concentrations peak at 7 ng/ml 3 weeks after injection
- After Nexplanon insertion, etonorgestrel plasma concentrations peak at 0.8 ng/ml 4 days after insertion

Do women (and doctors) like it?


Nexplanon insertion rates
as percentage of total deliveries
25%
20%
15%
10%
5%
0%
15.0%
16.0%
23.4%
15.2%
16.8%
10.3%
18.4%
20.8%
18.4%
January
February
March
April
May
June
July
August
September
October
November
December
2014

PALMETTO HEALTH RICHLAND

Palmetto Health Richland

- Implant experience similar to GHS
- Worked with Nursing, Pharmacy, Billing and Residents place the majority
- Ongoing enrollment of adolescents to evaluate satisfaction, continuation

Intrauterine Device (IUD or IUS)

- Levonorgestrel
- Copper

- Insertion
  - Immediate post-placental (10 minutes)
  - 6 weeks post-partum
- Studied with vaginal and cesarean delivery

Insertion technique

https://youtu.be/zgi3mbW2YdA?t=2m35s

CDC and ACOG state the benefits of immediate post-placental insertion generally outweigh the risks

Complications with post-placental insertion

- Explusion
  - Post-placental insertion 20-27% expulsion
  - Insertion at 6 weeks post-partum 4.4% expulsion
- Pain – similar
- Infection rates – similar
- Breastfeeding continuation – similar

Techniques

- “Bayer” inserter
- Ring Forceps
- Manual insertion

Post-partum IUD insertion

https://youtu.be/-xNlKUl5v_0?t=38s

Questions?

SC Birth Outcomes Initiative

Healthy Connections