

WEST VIRGINIA POSTPARTUM LARC TOOLKIT



A RESOURCE FOR PROVIDING LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC) SERVICES IN THE HOSPITAL POSTPARTUM SETTING



This toolkit contains information that may expand or change as West Virginia hospitals gain more experience in postpartum LARC services. For the most current version of this toolkit, visit:

Office of Maternal, Child and Family Health

<http://www.wvdhhr.org/mcfh>

Family Planning Program

<http://www.wvdhhr.org/fp>

WV Perinatal Partnership

<http://www.wvperinatal.org>

Marshall University Department of OBGYN

<http://marshallhealth.org/services/obstetrics-gynecology/>

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Background

Immediate postpartum long acting reversible contraceptive (LARC) insertion involves either placement of a subdermal implant in the immediate postpartum period before hospital discharge, or placement of an intrauterine device (IUD) in the delivery room after placental delivery.

Starting in 2012, several states began implementing immediate postpartum insertion of long acting reversible contraceptives (LARC). In 2014, the Association for State and Territorial Health Officials (ASTHO) convened an Immediate Postpartum LARC Learning Community to assist states in implementing postpartum LARC initiatives. The first cohort in this learning community included six states that had Medicaid policies reimbursing for LARC insertion in the inpatient setting. Leaders from these states participating in this initiative came together to identify successes, barriers and challenges to full policy implementation. The ASTHO LARC Learning Community has since expanded yearly, and West Virginia joined this program in the third cohort of states in 2016.(1)

The strategic action plan formulated by the West Virginia team includes the goal of successfully decreasing unintended and teen pregnancy rates in West Virginia by engaging and training providers, supporting provider champions, and working collaboratively to improve access to LARC. As of January 1, 2017, immediate postpartum LARC insertion is reimbursed separately from the global obstetric fee among most West Virginia insurers, and reimbursement is for the LARC device and the insertion fee (see Billing). Despite these improvements in provider reimbursement, many barriers to implementation exist. This toolkit is designed to highlight the importance and benefits of immediate postpartum LARC and help providers navigate institutional barriers to implementation.

Importance of Immediate Postpartum LARC Services

LARC methods include the subdermal implant and intrauterine devices. These methods have an effectiveness of greater than 99%, and are the most effective form of reversible contraception, as well as have the highest rates of continuation among all reversible methods.(2)

In the Contraceptive CHOICE project, one of the largest and most recent studies on contraceptive effectiveness, over 9000 women aged 14-45 were provided counseling and no-cost reversible contraception. After standardized counseling:

- 75% of women chose a LARC method
- 86% of women who chose a LARC method were still using that method one year later, compared to 55% of women who chose a non-LARC method
- Rates of unintended pregnancy were 20 times higher among women using a non-LARC method.
- The abortion rate among CHOICE study participants was less than half the national and regional rates.
- Women using LARC methods had highest rates of satisfaction with their method one year later.(3)

This study illustrates the impact that removing cost barriers can have on women accessing effective contraception. This is especially important in the immediate postpartum period for the following reasons:(4)

- 40-57% of women have unprotected sex before the six week follow up visit after a delivery, and in the first year postpartum, 70% of pregnancies are unintended.
- 10-40% of women do not attend their postpartum visit, and 40-75% of women who plan to use an IUD postpartum do not obtain it.
- Pregnancy within a year of delivery, defined as a short-interval pregnancy, can be a risk factor for preterm delivery and adverse neonatal outcomes.

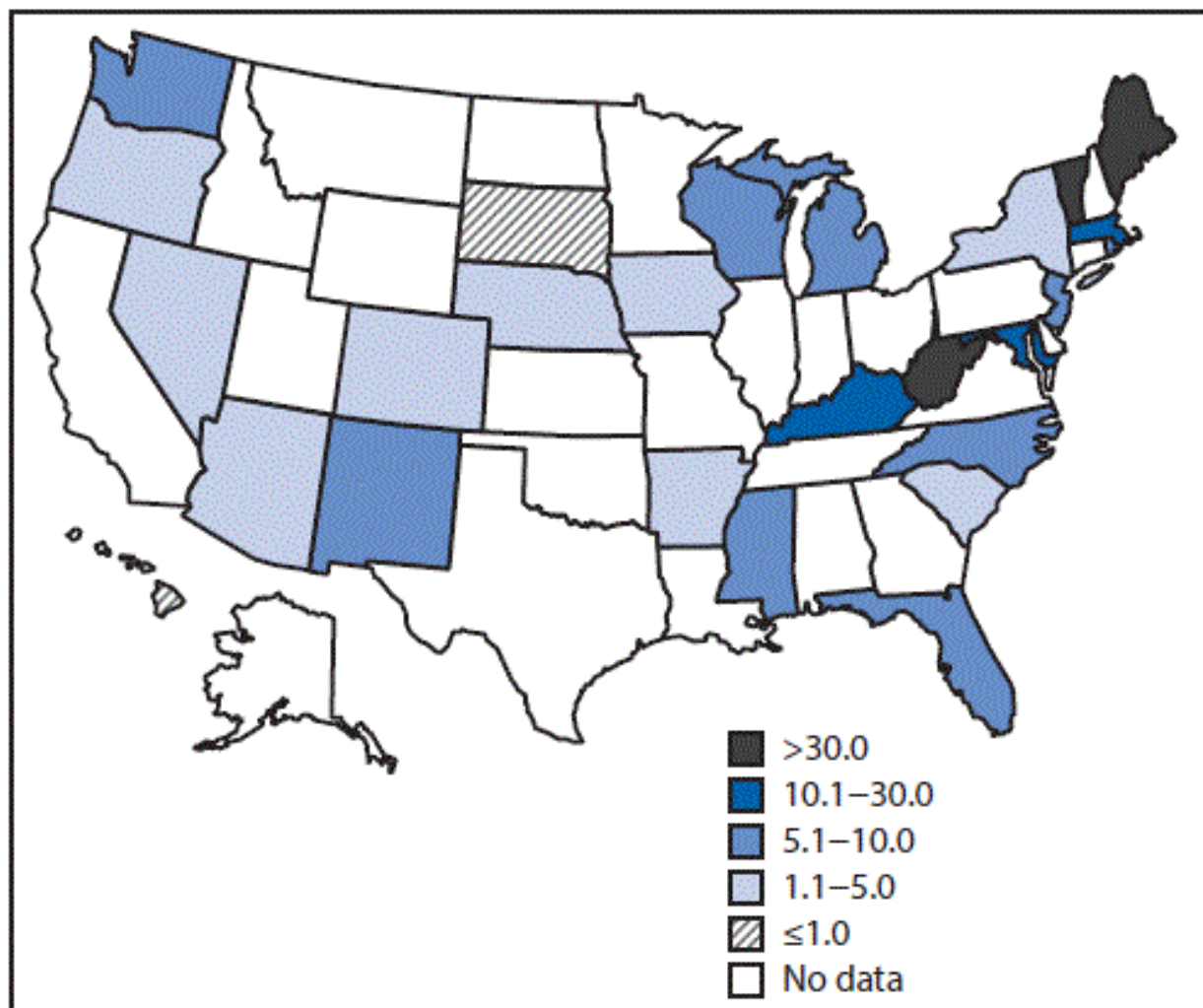
Postpartum outpatient visits may have further barriers to LARC provision including provider availability, device availability, concern for pregnancy, or need for repeat visit for placement.

Indirect Impact on Decreasing Unintended Pregnancy: Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS) is a drug- withdrawal syndrome among newborns exposed to addictive prescription and/or illicit drugs, such as opioids, during pregnancy. Clinical features of NAS include tremors, irritability, high-pitched crying, increased muscle tone, hyperactive deep tendon reflexes, seizures, poor feeding and gastrointestinal tract dysfunction. All of which contribute to a prolonged hospital stay and high health care costs associated with this condition.(5)

Over the past decade there has been a dramatic increase in NAS incidence in the United States, with West Virginia having the highest reported rates of 33.4 cases per 1000 births in 2013.(6) Another study reported that almost 1 in 5 babies had evidence of drug or alcohol exposure.(7) For babies that have NAS, the median length of hospital stay is 19 days, which adds significant health care cost.(8)

Primary prevention of NAS includes decreasing unintended pregnancies among those patients with drug addiction, which includes promotion of LARC methods. In women enrolled in substance abuse programming throughout the state, immediate postpartum LARCs, as with other populations, can decrease the risk of short interval pregnancy.



Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016;65:799–802. DOI: <http://dx.doi.org/10.15585/mmwr.mm6531a2>.

METHODS: INTRAUTERINE DEVICES AND THE SUBDERMAL IMPLANT

Intrauterine Device

Types:

Copper IUD (Paragard®)- effective for 10 years

Progestin IUDs (Mirena®, Liletta®, Kyleena®, Skyla®)- effective for 5,3,5, and 3 years respectively

Safety/Contraindications:

Insertion immediately postpartum is safe and effective, defined by the US Medical Eligibility Criteria for

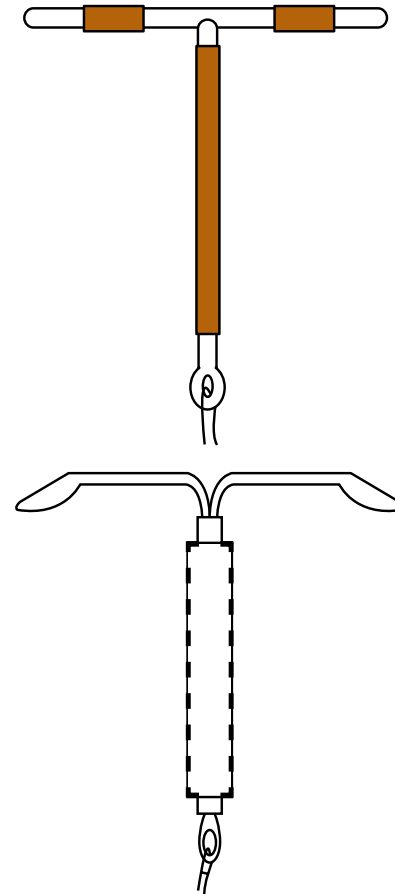
Contraceptive Use as a category 1 or 2, with advantages outweighing any theoretical or proven risks.(5)

Contraindications to IUD placement immediately after placental delivery include chorioamnionitis, puerperal sepsis, and mullerian anomalies.(4)

Risks:

Expulsion rates for immediate postpartum IUD insertions are higher than for interval or postabortal insertions. The incidence varies by study, but is estimated between 10-27%.

(4) Women should be counseled about the risk of expulsion.



Subdermal Implant

Type:

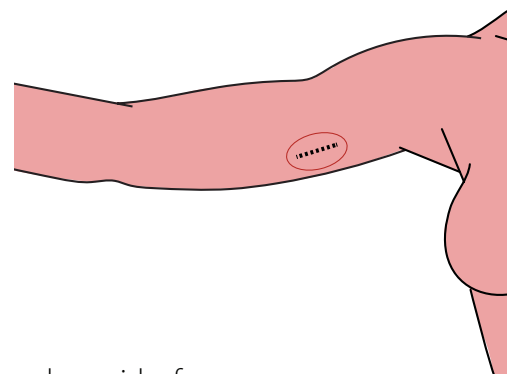
Nexplanon®- effective for 3 years

Safety/Contraindications:

Insertion in the immediate postpartum period is safe and effective, defined by the US Medical Eligibility Criteria for Contraceptive Use as a category 1, in which there is no restriction in use.(5) There are no known contraindications to use.

Risks

Risk of insertion are minor, and include the risk of bruising at the site of insertion, and rare risk of hematoma formation, infection, and difficult insertion. Women should be counseled about the irregularity of menstrual bleeding following insertion.(6)



LARC Use with Lactation:

Both IUDs and the subdermal implant are safe effective methods for lactating women. They are defined as category 2 in safety by the US Medical Eligibility Criteria for Contraceptive Use, meaning benefits outweigh any theoretical or proven risk.(5) Observational studies of progestin only contraceptives suggest no effect on successful initiation and continuation of breastfeeding.(7)

Implementation

Identifying a physician champion and nursing leader within the hospital is necessary to facilitate the administrative coordination, lead the clinical process development, and ensure that clinical staff receives sufficient training.

Physician champions at West Virginia academic institutions have served to initiate immediate postpartum LARC insertions successfully and may be used as a local resource.

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The following is a general guideline for hospital implementation, and has been used successfully within West Virginia academic institutions.

1. Infrastructure

Convene leadership from hospital administration, clinical staff, pharmacy and billing.

- **Provide education** to leaders on the importance and value of offering postpartum LARC services to women.
- **Discuss reimbursement.** Hospitals will be reimbursed for the devices in addition to global labor and delivery charges and physicians will receive reimbursement for the insertion procedures.
- **Establish billing procedures.** Claims submitted for inpatient LARCs must include the proper billing codes specified in the payers policy. Hospitals also should identify a mechanism to reconcile reimbursements with patient accounts and monitor and resolve denials.
- **Develop pharmacy procedures.** Hospital pharmacies should make sure the devices are included in their order system then determine initial inventory levels. It should be decided if the devices will be stocked on the hospital floor or in the central pharmacy.
- **Create order sets** or add to billing forms. Order sets include the contraceptive device and local anesthetic.

2. Develop the process for insertions

Physicians and nurses should develop a process that includes patient identification, consent, and device insertion, and patient education.

- **Convene physicians or physicians and nursing staff together** to develop the postpartum insertion procedure. This can be incorporated into existing nurse meetings or shift change, or through a grand rounds presentation and discussion with physicians.
- **Identify patients** desiring immediate postpartum LARC insertion. Prenatal care and counseling procedures and documentation should be reviewed to make sure that women's preferences are documented and transferred to the hospital.
- **Patient Consent.** A unified consent process should be performed by all providers. The consent for IUD insertion can be obtained upon patient admission to labor and delivery or just prior to procedure. Consent for subdermal implant can be obtained on either labor and delivery or the postpartum unit. Consent forms accompanying the LARC devices or consent forms as approved by the individual hospital systems may be used.

- **Procedure.** Roles and responsibilities of the physicians and nurses should be discussed regarding documentation and gathering supplies. A patient checklist for the procedure may be used.
- **Patient Education.** Standard patient education is recommended for patients receiving LARC. This includes risks, signs of IUD expulsion, and any anticipated changes in menstrual bleeding.

3. Build Clinical Support for Postpartum LARC

Identify any concerns among physicians, residents, nurses and lactation consultants. This is best facilitated through use of the institution physician champion.

- **Educate nursing staff.** Nurses spend time as patient advocates and play a critical role in patient education.
- **Educate lactation consultants.** Lactation consultants may need education and reassurance that the LARC methods will not interfere with breastfeeding. It is important to ensure that patient education offered by nurses and lactation consultants is consistent with physician counseling.

4. Train all clinical staff.

- **Prenatal care providers.** Prenatal care providers whose patients deliver at the hospital need to understand how the LARC procedure at the hospital works so they can provide complete patient education and answer questions.
- **Physicians, including residents** (if applicable). All physicians must be trained prior to performing insertions. Some hospitals with residency programs incorporated LARC training into their new resident curriculum.
- **Nurses.** Once the insertion procedures are determined, conducting an in-service with current nursing staff will ensure all nurses are knowledgeable and prepared to support patient education and assist during the procedures.

5. Make adjustments as needed to improve process.

- **Reconvene clinical leadership** as appropriate, to review how the postpartum LARC procedures are working and identify any needed changes.
- **Review the payments received** against claims submission data to identify any issues with denials.
- **Resolve any billing issues.** Billing staff should contact payer representatives to discuss and resolve any billing or reimbursement issues.
- **Monitor the proportion** of women choosing a postpartum LARC. This can provide evidence of the policy's impact on LARC access and be used in quality improvement efforts.

TRAINING

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 (www.acog.org/goto/larc) provides a list of clinical training resources for each of the devices.

PROCEDURE

All patients should receive postpartum contraception counseling at their prenatal visits prior to arriving at the hospital. Counseling should include all forms of contraception along with benefits, risks, possible side effects, bleeding patterns, and effectiveness. Additional counseling can be performed in the hospital by OBGYN staff.

Women who choose immediate postpartum LARC should be counseled and consented. A nurse should be available to assist with LARC insertion. A time out should be taken prior to LARC insertion. During this time, verify the patients name, date of birth and procedure to be performed.

Intrauterine Devices:

- Following vaginal delivery: Placement of the intrauterine device should ideally be done within 10 minutes of delivery of the placenta. Strings are cut to 10cm and the IUD is grasped gently with a ring forcep (not clamped) or manually. The IUD is placed gently at the fundus. Ultrasound guidance can be used.(4)
- At the time of cesarean delivery: Placement of the intrauterine device should ideally be done within 10 minutes of delivery of the placenta. After initiating closure of the hysterotomy incision, the IUD is placed at the fundus with the inserter, ring forcep, or manually. Strings are placed through the cervix and the hysterotomy is closed completely. (4)

Subdermal Implant:

- The technique for implant placement in the immediate postpartum period does not differ from that for interval insertion.

A note describing the insertion procedure should be complete and documented in the patient's medical record. Patient instructions should be provided verbally and in written form.

Subdermal Implant Procedure Resources

Postpartum Implant Supply Checklist

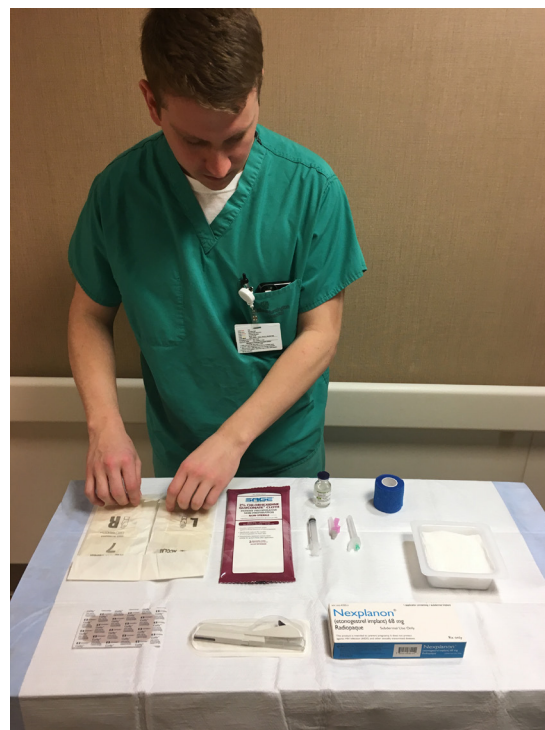
- Sterile gloves
- Sterile towels
- Chucks pad
- Betadine or Hibiclens swabs
- Marking pen
- Sterile ruler
- Lidocaine without epinephrine
- 5 cc syringe
- 18 or 20 gauge needle (drawing up lidocaine)
- 25 gauge 1.5inch needle for subcutaneous lidocaine injection
- Band aids
- Ace wrap
- One pack sterile 4x4's
- Nexplanon insertion device

Postpartum Implant Order Set

- Nexplanon® (etonogestrel 68 mg) in insertion device for subdermal insertion
- 5 mL Lidocaine 1% for subcutaneous injection

Postpartum Implant Patient Checklist

- Verify patient has been counseled on implant
- Obtain patient consent for procedure and answer any questions
- Order implant, prepare for procedure (see implant supply checklist)
- Obtain nursing assistance for placement
- Timeout: Verify patient name and date of birth, verify procedure



Dr. Andrew Martin prepares to place an implant on the Mother-Baby unit at Marshall University

Postpartum Implant Patient Instructions

- Keep the wrap on your arm for 24 hours following placement of the implant.
- Pain and bruising are common and expected.
- Use ice packs and ibuprofen for pain control.
- Use backup contraception for one week after implant insertion.
- The implant is compatible with breastfeeding.
- Your periods will likely be different not only in the postpartum period, but also with the Nexplanon® implant. Irregular menstrual bleeding is not unusual with Nexplanon®, especially in the first six months after insertion.
- Call your doctor with any of the following: redness, swelling, drainage/discharge from the area of insertion.

Postpartum Implant Procedure Note

Date _____

Performed by: _____

Supervised by: _____

Informed consent was obtained.

Area measured and marked on (right/ left) arm.

Area was prepped in the normal sterile fashion with (Betadine/ Hibiclens)

1% lidocaine was injected.

The Nexplanon was inserted in the usual fashion.

Rod palpated at end of procedure.

Area wrapped.

Complications: _____

Intrauterine Device Procedure Resources

Postpartum IUD Supply Checklist

- Sterile gloves
- Weighted speculum
- Right angle retractor
- Large Q-tip swabs
- Betadine or Hibiclens solution in sterile cup
- Ring forceps

Postpartum IUD Patient Checklist

- Verify patient has been counseled on IUD
- Obtain patient consent for procedure and answer any questions
- Order IUD, prepare for procedure (see IUD supply checklist)
- Obtain nursing assistance for placement
- Timeout: Verify patient name and date of birth, verify procedure

Postpartum IUD Order Set (Example: Mirena®)

- Mirena® (Levonorgestrel-releasing intrauterine system 52 mg)

Postpartum IUD Patient instructions (Example Mirena®)

- Cramping is expected after the procedure.
- Use ibuprofen for pain control.
- Use backup contraception for one week after insertion.
- The IUD is compatible with breastfeeding.
- Your periods will likely be different not only in the postpartum period, but also with Mirena®. Women using Mirena® frequently have lighter periods and some women using Mirena® do not have a period at all. However, irregular menstrual bleeding is not unusual for up to six months after insertion.
- The risk of IUD expulsion is increased with postpartum insertion. This is not dangerous but you will need contraception if this occurs so call your doctor if this happens.
- Call your doctor with any of the following: severe pain, nausea and vomiting, fever or chills, if the IUD is expelled



Dr. Arifa Khokar prepares to place an IUD during a cesarean section at Marshall University

Postpartum IUD Procedure Note

Date _____

Performed by: _____

Supervised by: _____

Informed consent was obtained.

Weighted speculum placed in vagina. Cervix was prepped in the normal sterile fashion with (Betadine/ Hibiclens)

The Mirena® was inserted using the rings forceps to the fundus.

Complications: _____

Billing

Long Acting Reversible Contraception (LARC) Coverage by West Virginia Payers

The payers listed below have developed policies that allow for the placement of intrauterine contraceptive devices and Etonogestrel Implant systems to be inserted during the delivery admission with separate billing and reimbursement.

Aetna, The Health Plan, Unicare, WV Family Health, and PEIA

Professional Services Codes	DX Codes	Devices Covered
11981 – Insertion Subdermal implant	Z30.017	J7307
58300 - Insertion IUD	Z30.430 Z30.433	J7297 J7298 J7300 J7301

Device Codes:

J7297	Levonorgestrel-releasing contraceptive system, 52 mg, 3 year duration (Liletta)
J7298	Levonorgestrel-releasing contraceptive system, 52 mg, 5 year duration (Mirena)
J7300	Intrauterine copper contraceptive (Paragard)
J7301	Levonorgestrel-releasing contraceptive system, 13.5 mg (Skyla)
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (Nexplanon)

DX Codes:

Z30.430 Encounter for insertion of intrauterine contraceptive device (IUD)

Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device

Z30.017 Encounter for initial prescription of implantable subdermal contraceptive

No preauthorization is needed for any of these devices for any of the payers.

Note: OMFCH and Fee for Service Medicaid are in the process of changing and approving a policy for similar reimbursement.

Association of State and Territorial Health Officials, Long Acting Reversible Contraceptives Medicaid Policy, Codes and Guidance. Provides links to state policies and guidance on LARCS.

<http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/Medicaid-Policies/?terms=LARCS+postpartum>

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

https://www.nationalfamilyplanning.org/file/documents---reports/LARC_Report_2014_R5_forWeb.pdf

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