

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Senior Deputy Director

Transmittal 14-24

To: Providers

From: Claudia Schlosberg, JD
Acting Senior Deputy Director and State Medicaid Director

Date: **SEP 22 2014**

Subject: Medicaid Coverage of Long Acting Reversible Contraception

This transmittal is intended to provide guidance to physicians, hospitals and clinics enrolled with the District of Columbia Medicaid Program regarding coverage and reimbursement for long acting reversible contraceptives (LARC). Clarification on existing LARC coverage policy, prior authorization (PA) requirements and billing procedures, as well as new changes to reimbursement methodology will be provided.

I. BACKGROUND

LARCs are long-acting, reversible contraceptives, such as intrauterine devices (IUD) and the implant. Studies have shown that LARCs are generally safe and effective for most women, and have the highest rates of continuation and satisfaction. In 2012, the American Congress of Obstetricians and Gynecologists (ACOG) published practice guidelines recommending that LARCs be offered as first-line contraceptive methods and encouraged as options for most women. The major advantage of LARCs compared with other reversible contraceptive methods is that they do not require ongoing effort on the part of the user for long-term and effective use.

For some time now, the District has engaged in a multi-pronged effort to address the rising rate of unintended teen pregnancies. Consequently, there is increased attention being paid to educating physicians and patients about the benefits of postpartum insertion of a LARC as an alternative to other less effective methods, such as oral contraceptives, the patch or ring. Although the District Medicaid program provides coverage and reimbursement for all forms of FDA-approved birth control including LARCs, it appears that physicians and hospitals may lack a clear understanding of how to bill for LARCs in both inpatient and outpatient settings.

Recently, several stakeholder groups requested clarification of the different reimbursement methodologies for physicians and hospitals and whether the District Medicaid program has variable coverage policies for LARCs depending on the site of service provision.

II. COVERAGE

The District's Medicaid Program provides coverage for several different types of Intrauterine Devices (IUDs): Paraguard® (Copper IUD); Mirena® and Skyla® (levonorgestrel releasing IUD); and etonogestrel hormonal implant, Nexplanon.

a. Fee-for-Service

When a provider performs LARC services in an office setting for a beneficiary in the fee-for-service Medicaid program, Medicaid pays the provider for the procedure based upon DHCF's published fee schedule. If the provider has supplied the IUD or implant, the provider can also bill Medicaid and be paid for the covered supplies or devices. When a provider performs LARC services in an in-patient hospital setting for a fee-for-service Medicaid beneficiary, the provider bills DC Medicaid separately for his/her professional services, but will receive a discounted or "facility" rate to account for the fact that the doctor is not responsible for overhead and other administrative expenses in a hospital setting. The provider must bill his/her services on a Professional Claim form (CMS 1500).

If the procedure is done in a hospital on an in-patient basis, DHCF also provides the hospital payment through our fee-for-service reimbursement methodology known as Diagnosis Related Groups (DRG). The DRG system is a per-case reimbursement mechanism under which inpatient admission cases are divided into distinct patient categories called diagnosis-related groups based on diagnosis, procedures, age, sex and discharge status along with complex clinical algorithms to identify the reason for admission and the presence of complications and comorbidities. Thus, in a situation where a woman has delivered a baby in the hospital and receives a LARC method immediately post-partum, the provider would submit his or her bill to include separate claims for the labor and delivery and for the insertion of the device on a CMS 1500. The hospital's bill would also include codes for all the procedures performed, any ancillary services provided such as laboratory and x-ray and all supplies, drugs and devices administered, including the LARC method. The hospital's claims for the patient's stay are fed into the DRG system and the claim is paid upon the assigned DRG. The District's in-patient hospital payment methodology has been designed to provide hospital payment rates that cover – on average – 98 percent of their costs. Therefore, the cost of supplying LARC methods on an inpatient basis is factored into the rates paid to District hospitals.

b. Managed Care

When a provider provides LARC services in an office setting for a beneficiary enrolled in a Medicaid Managed Care Organization (MCO), the provider is paid based upon his/her provider agreement with the MCO. Similarly, if these services are provided in a hospital setting, both the provider and the hospital must submit their claims to the MCO for payment. Rates are established by the MCO. IL requires all of our Medicaid health plans to cover the same services our regular Medicaid covers.

DHCF pays each plan a set amount per member per month. These rates are established, in part, on analysis of claims data and are designed to be actuarially sound. For labor and deliveries, DHCF also pays an additional "kick" payment in the month of the mother's delivery.

This is an additional, lump-sum payment to the MCO to cover all labor and delivery costs, including all hospital and physician charges, as well as any pre-natal or post-partum care in the month of delivery. The value of the kick payment is \$8,933.00. All DC Medicaid MCOs report that they provide coverage for LARCs in office and in hospital in-patient settings.

III. NEW POLICIES

In order to ensure that DHCF's coverage and reimbursement policies do not act as a disincentive to LARC services, DHCF has taken the following actions:

1. DHCF has eliminated the differential payment for fee-for-service physician services in office based and in-patient settings for Procedure Codes 11981 and 58300. Effective October 1, 2014, providers will receive the higher office rates associated with these procedure codes for fee-for-service beneficiaries.
2. For fee-for-service beneficiaries, DHCF will allow providers to supply and bill for the LARC device/supply in an inpatient setting. Effective October 1, 2014, a provider billing for the insertion of the device/supply may also procure the device/supply and then bill for it on the same CMS 1500 claim form as the delivery procedure indicating the place of service as 21 (inpatient hospital setting). The provider may only bill for the device/supply if he or she has procured it. Further, DHCF will only make one payment for reimbursement for the supply/device to the provider or the hospital whichever has provided the LARC. If the hospital has not procured and supplied the LARC, it cannot be included on the hospital claims submission.
3. DHCF encourages hospitals and Medicaid MCO's to examine coverage and reimbursement policies for LARC's to ensure there are no impediments or barriers to access.
4. DHCF annually reviews its fee schedule including reimbursement for LARCs.

IV. REIMBURSEMENT FOR LARC DEVICES AND SUPPLIES

Table 1 – Fee-for-Service Reimbursement rates for LARCs

Procedure Code	LARC Service	Prior Authorization Needed	Physician supplied – Office or In-Patient Setting	Hospital Supplied – In-Patient Setting
			Reimbursement Per Fee Schedule	Reimbursement Per DRG Assignment
J7300	Paraguard, copper IUD	No	\$600	DRG Assignment
J7302	Mirena, levonogestrel-releasing intrauterine device system, 52 mg	No	\$759.29	DRG Assignment
J7307	Nexplanon Etonogestral i	Yes*	\$675.04	DRG Assignment

	mpplant 68 mg rediopaque			
J7301	Skyla Levonorgestrel-releasing intrauterine contraceptive system 13.5 mg	Yes	Currently requires manual pricing but fee schedule will be updated 1/1/2015	DRG Assignment

Table 2 – Fee-for-Service Reimbursement for Physician Services Associated with LARC Services

Physician Services**				
Procedure Code	Procedure Description	Office Setting	In-Patient Setting (Old)	In-Patient Setting (New)
11981	Insertion non-biodegradable drug delivery implant	\$126.88	\$73.83	\$126.88
58300	Insertion IUD	\$63.81	\$46.24	\$63.81

Questions regarding these policies should be directed to Donald Shearer – Director of Health Care Operations at the Department of Health Care Finance. You can reach Mr. Shearer by email at Donald.Shearer@dc.gov or by phone on 202-698-2007.

*NOTE: Procedure code J7307 requires a Prior Authorization for office-based service. The Prior Authorization is obtained by submitting a completed Form 719A (Prior Authorization Request/Approval) signed and dated by the requesting physician. The Form 719A should be faxed to DHCF at 202-610-3209 to obtain approval before services are provided.