Provider Bulletin

Long-Acting Reversible Contraceptives (LARCs) and Local Health Departments (LHDs)

Definition

Long-acting reversible contraceptives (LARC) are methods of birth control that provide effective contraception for an extended period without requiring user action. They include intrauterine devices (IUDs) and subdermal contraceptive implants.

Billing & Coding Guidelines

The insertion and/or removal of an intrauterine contraceptive device is reported using one of the following Current Procedural Terminology (CPT) codes:

- 11981: Insertion, non-biodegradable drug delivery implant
- 11982: Removal, non-biodegradable drug delivery implant
- 11983: Removal with reinsertion, non-biodegradable drug delivery implant
- 58300: Intrauterine contraceptive device insert
- 58300 with modifier -53: Intrauterine contraceptive device insert FAILED (append modifier -53).
- 58301: Intrauterine contraceptive device removal.

Most IUD services will be linked to the following International Statistical Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes:

- Z30.014: Encounter for initial prescription of intrauterine contraceptive device.
- Z30.017: Encounter for initial prescription of implantable subdermal contraceptive.
- Z30.430: Encounter for insertion of intrauterine contraceptive device.
- Z30.431: Encounter for routine checking of intrauterine contraceptive device.
- Z30.433: Encounter for removal and reinsertion of intrauterine contraceptive device.
- Z30.46: Encounter for surveillance of implantable subdermal contraceptive

The CPT codes do not include the cost of the supply. Report the supply separately using a Healthcare Common Procedure Coding Systems (HCPCS) code:

- J7296: Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5mg
- J7297: Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52mg
- J7298: Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52mg
- J7300: Intrauterine copper contraceptive (Paragard)
- J7301: Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5mg
- J7307: Etonogestrel (contraceptive) implant system, including implant and supplies (Nexplanon/Implanon)

Table 1: LARCs Coding and Billing

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Brand Name</th>
<th>FDA Approved Duration Use</th>
<th>KS Medicaid Reimbursement Rate (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7296</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system</td>
<td>Kyleena</td>
<td>5 years</td>
<td>$909.83</td>
</tr>
<tr>
<td>J7297</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system</td>
<td>Liletta</td>
<td>3 years</td>
<td>$725.44</td>
</tr>
</tbody>
</table>
### J7298
Levonorgestrel-releasing intrauterine contraceptive system

**Mirena**
5 years
$909.83

### J7300
Intrauterine copper contraceptive

**Paragard**
10 years
$857.01

### J7301
Levonorgestrel-releasing intrauterine contraceptive system

**Skyla**
3 years
$802.28

### J7307
Etonogestrel (contraceptive) implant system, including implant and supplies

**Nexplanon/Implanon**
3 years
$943.72

<table>
<thead>
<tr>
<th>BILLING CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>11981 Insertion, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11982 Removal, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11983 Removal with reinsertion, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>58300 Intrauterine contraceptive device insert</td>
</tr>
<tr>
<td>58301 Intrauterine contraceptive device removal</td>
</tr>
</tbody>
</table>

*(1) Based on Kansas Medicaid Fee Schedule as of August 2018*

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**Billing Kansas State Insurance**

For the upcoming year, 2019, Kansas Department of Health and Environment (KDHE) Secretary Jeff Andersen and State Medicaid Director Jon Hamdorf selected three managed care organizations (MCOs) that will serve the Kansas Medicaid program, known as KanCare. The contracts include one new organization and two current KanCare companies.

The companies include: Sunflower State Health Plan, Inc., United Healthcare, Midwest Inc. and Aetna Better Health of Kansas, Inc.

KanCare health plans are required to offer all the same Medicaid services to beneficiaries that were offered prior to the start of KanCare. Additionally, each of the health plans offer some extra (value-added) services to consumers at no cost to the State. The KanCare health plans must pay at least 100 percent of the current fee-for-service Medicaid rate (as of 11/9/12) to all contracted, in-plan providers. The rate cannot decrease for the life of the KanCare contracts. Providers can negotiate a different reimbursement structure if they so desire. If you do not sign up with the KanCare health plans, you will be considered an out-of-network provider. Out-of-network providers will receive 90 percent of the current fee-for-service rates. For more information about KanCare, visit www.kancare.ks.gov.

The Kansas Medical Assistance Program (KMAP) website provides information to Medicaid beneficiaries and providers. KMAP’s secure Web site is intended for providers, clerks and clearinghouses. This site gives you the opportunity to view claim status inquiry, claim summary, prior authorization inquiry and claim payment summary. Also, you may receive messages from the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) that apply specifically to providers.

A provider may access the Kansas Medicaid Fee Schedule through KMAP. Information provided on fee schedules does not guarantee coverage or payment. Providers must reference provider manuals for specific coverage information or program limitations and verify if services are covered for their provider type and specialty and the beneficiary.

**Billing Private Insurance**

Billing represents an important financial opportunity for LHDs to continue to sustainably assure population health. Many LHDs face expanded service needs and declining budgets, making billing for services an increasingly important strategy for sustaining public health service provision. Yet, little practice-based data exist to guide providers on what to expect financially, especially regarding timing of reimbursement receipt (McCullough, J. M., 2016). There are multiple
challenges confront many LHDs that are beginning or expanding clinical billing: licensing or credentialing staff members, receiving Medicare or Medicaid qualifications, contracting with private insurance payers, establishing billing systems and protocols, and training staff members in completing and submitting claims (Kilgus CD, Redmon GS., 2014). Furthermore, in some states, health departments face complex statutory requirements that may preclude billing some patients' insurance providers for certain services (Temple University Public Health Law Research Group, 2014).

A LHD will need to decide to contract with payers if the intent is to become participating providers. A LHD has the option of not contracting, thereby making their status non-participating. There are advantages and disadvantages to both methods. LHDs need to research these options beforehand to make an informed decision.

Each health plan is different therefore LHD billers will need to work closely with their provider representative to understand the plans rules and regulations.

Billing 340B Drugs

The Medicaid rebate program requires drug companies to enter into a rebate agreement with the Secretary of the Department of Health and Human Services (HHS) as a precondition for coverage of their drugs by Medicaid and Medicare Part B. Under the program, a manufacturer must pay rebates to state Medicaid programs for “covered outpatient drugs,” as defined in the Medicaid rebate statute. The rebate amount for a brand name covered outpatient drug is based in part on the manufacturer’s “best price” for that drug.

The Office of Pharmacy Affairs (OPA), which is located within the Health Resources and Services Administration (HRSA) within HHS, administers the program. HRSA and OPA are located in Rockville, MD and are responsible for interpreting and implementing the 340B law. Questions about the 340B program may be submitted to its government contractor Apexus at 1-888-340-2787 or apexusanswers@apexus.com.

Covered entities should review their Medicaid managed care contracts to ensure that their 340B billing practices comply with the contracts. Entities also should ask their state Medicaid agencies whether they have any requirements regarding billing 340B drugs to managed care. CMS said that reimbursement for retail 340B fee for service (FFS) drugs cannot exceed the 340B ceiling price. Prior to the regulation, many states already required covered entities to bill retail 340B FFS drugs at actual acquisition cost (AAC) and paid them that amount plus the state-allowed dispensing fee (https://www.340bhealth.org/members/340b-program/overview/). CMS also said that states may pay higher dispensing fees for retail 340B FFS drugs to accommodate 340B pharmacies’ increased dispensing costs. With respect to non-retail (i.e., physician-administered) 340B FFS drugs, AAC billing requirements are less common for such drugs. Providers should contact State Medicaid agency their state if they have any questions regarding the state’s Medicaid billing and reimbursement rules for 340B drugs.

Pharmaceutical prices available through the 340B program are significantly lower than both retail and wholesale prices. In 2015, the Government Accountability Office reported that program participants can save an estimated 20-50% off drug costs.

Strategies to improve billing and coding:

- Review Fee Schedules at least annually and intermittently when changes are announced.
- Conduct EOB audits to ensure health plans are reimbursing correctly per their contracted fee schedule.
- Code and bill what is documented. Remember, if it isn’t documented, it didn’t happen!
- Services must be medically necessary.
- Avoid unspecified codes. Code to the highest specificity.
- Utilize the most current coding manuals (CPT, ICD-10 and HCPCS).
- Review specific carrier policies annually and when new bulletins are released.
- Include chart audits as part of your compliance program and regularly audit charts. Missing charges equates to lost revenue.
• Regularly review denials to ascertain trends. Use your findings for training and education of staff.
• Keep apprised of industry standards by attending billing and coding training such as workshops, webinars, online training, etc.

Resources:

• Center for Medicare and Medicaid Services (CMS). https://www.cms.gov/
• Provider representatives for each health plan that the LHD participates with.
• Kansas Local Health Department Clinical Services Coding Resource Guide, http://www.kalhd.org/publications/kansas-local-health-department-clinical-services-coding-resource-guide/ . This manual was created with guidance by Kansas Local Health Departments in the NW Region. It is updated annually by Wichita State University staff.
• American Academy of Professional Coders (AAPC) association and other healthcare organizations.
• CoverHer Hotline provides guidance on how to obtain coverage for birth control. Call 1-866-745-5487 or email coverHer@nwlc.org.
• www.lilettaaccessconnect.com 1-855-545-3882
• Paragard and Nexplanon can be purchased through your contraceptive vendors.

References

