



Indiana
Perinatal
Quality
Improvement
Collaborative

LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

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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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2. Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/social-economic-benefits.pdf>.
3. Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, <http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf>.
4. Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002* New York: Guttmacher Institute, 2015, <http://www.guttmacher.org/pubs/StateUP10.pdf>
5. Indiana Natality Report, 2014 <http://www.in.gov/isdh/reports/natality/2014/toc.htm> (Table 3)
6. *A summary of findings and quantitative investigation targeted at: Reducing Infant Mortality in Indiana*. December 2014. <https://search.yahoo.com/search?fr=mcafee&type=B111US739D20140801&p=A+summary+of+findings+and+quantitative+investigation+targeted+at%3A+Reducing+Infant+Mortality+in+Indiana.+December+2014>
7. Mathews TJ, MacDorman MF, *Infant Mortality Statistics from the 2010 Period Linked Birth/Infant Death Data Set*, National Vital Statistics Reports Volume 62, Number 8 December 18, 2013 http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_08.pdf
8. Sonfield A, Hasstedt K and Gold RB, *Moving Forward, Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014, <http://www.guttmacher.org/pubs/family-planning-and-health-reform.pdf>
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11. Damle LF(1), Gohari AC(2), McEvoy AK(3), Desale SY(4), Gomez-Lobo V(5).. *Early initiation of postpartum contraception: does it decrease rapid repeat pregnancy in adolescents?* Pediatr Adolesc Gynecol. 2015 Feb; 28(1):57–62. doi: 10.1016/j.jpog.2014.04.005 Epub 2014 May 5.

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13. Tocce KM(1), SheederJL, TealSB., *Rapid repeat pregnancy in adolescents: do immediate postpartum contraceptive implants make a difference?* Am J Obstet Gynecol. 2012 Jun; 206(6):481.e1-7. doi: 10.1016/j.ajog.2012.04.015. Epub 2012 Apr 16.

14. American Academy of Pediatrics, Committee on Adolescence, *Policy Statement: Contraception for Adolescents*, PEDIATRICS Volume 134, Number 4, October 2014.
(www.pediatrics.org/cgi/doi/10.1542/peds.2014-2299)

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.

<https://www.ncbi.nlm.nih.gov/pubmed/26410174>

16. Braga GC, Ferriolli E, Quintana SM, Ferriani RA, Pfrimer K, Vieira CS, *Immediate postpartum initiation of etonogestrel-releasing implant: A randomized controlled trial on breastfeeding impact*, Contraception. 2015 Dec; 92(6):536-42. doi: 10.1016/j.

<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.
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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:

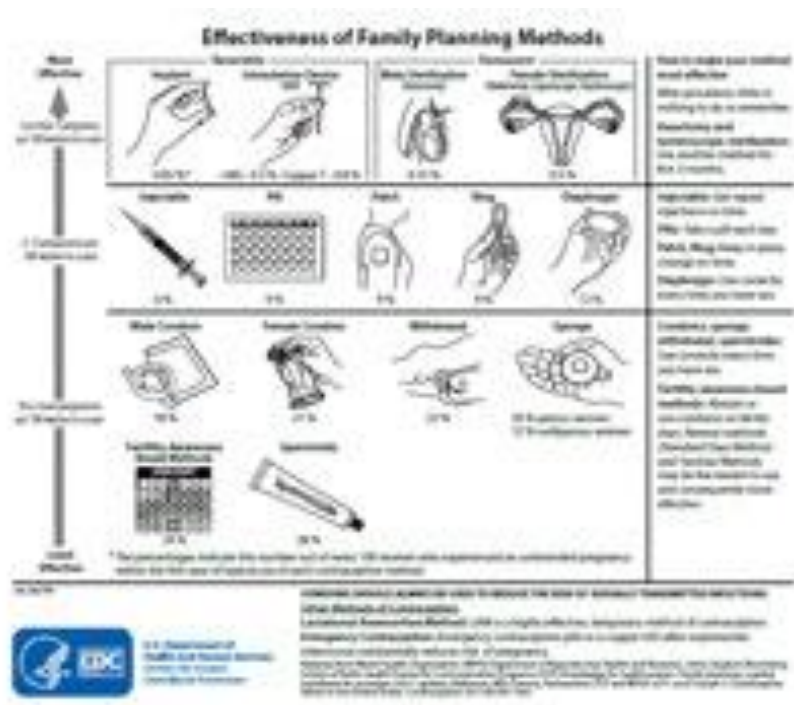
- 1) Revised recommendations for starting regular contraception after the use of emergency contraceptive pills.
- 2) New recommendations for the use of medications to ease insertion of intrauterine devices.

The US SPR can be downloaded from:

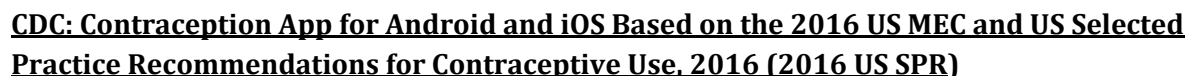
<http://www.cdc.gov/reproductivehealth/contraception/usspr.htm>

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

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



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



When to Start Using Specific Contraceptive Methods

[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 Training Center

- 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**