Inpatient Nexplanon Experience

Amy H. Picklesimer, MD, MSPH
Associate Professor
Department of Obstetrics and Gynecology
University of South Carolina - Greenville
WHY LARC?
The Choice Project

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

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

Women using LARC had the highest satisfaction at 1-year follow-up. Women who stopped their method were considered not satisfied.
HAVE WOMEN HAD UNINTENDED PREGNANCIES?

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

Contraception for Adolescents

abstract

Contraception is a pillar in reducing adolescent pregnancy rates. The American Academy of Pediatrics recommends that pediatricians develop policies and practices to reduce the risk of adolescent pregnancy. Previously, discussions focused on education and on the role that contraception should have in adolescent health. However, research has shown that adolescents who use contraception and are taking it correctly have lower pregnancy rates. In addition, adolescents who have used contraception have higher rates of educational achievement and are less likely to have sexually transmitted infections. For adolescents, it is important to start conversations about contraception with their pediatrician. It is also important to provide adolescents with information about their contraceptive options. Adolescents should be informed about the risks and benefits of each contraceptive method. Adolescents should also be provided with information about how to access contraceptive services.

Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents.

INTRODUCTION

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

Adolescents consider pediatricians and other health care providers a highly trusted source of sexual health information. Pediatricians’ frequent relationship with adolescents and familiarity allow them to provide important information and guidance on sexuality and contraception. In addition, pediatricians are well suited to address the unique challenges of adolescent pregnancies. Adolescents who are planning a pregnancy should be referred to local or national resources that provide comprehensive and confidential services, including prenatal care.

The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

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

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.
Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents.

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

Sexual Behavior and Contraceptive Use Among American Adolescents

In the United States, 42% of adolescents aged 15–19 years have had sexual intercourse (1). Although almost all sexually active adolescents report having used some method of contraception during their lifetimes, they rarely select the most effective methods. Adolescents most commonly use contraceptive methods with relatively high typical use failure rates such as condoms, withdrawal, or oral contraceptive (OC) pills (1). Nonuse, inconsistent use, and use of methods with high typical use failure rates are reflected in the high rate of unintended adolescent pregnancies in the United States. Eighty-two percent of adolescent depot medroxyprogesterone acetate (DMPA) injections, are mainstays of adolescent contraceptive choices, but these contraceptives have lower continuation rates and higher pregnancy rates than LARC methods (5, 6). Of 1,387 females aged 15–24 years who initiated short-acting hormonal methods, only 11% using the contraceptive patch, 16% receiving DMPA injections, and approximately 30% using the vaginal ring and OCs were still using the same method after 12 months (6). In a study of 4,167 females aged 14–45 years that compared continuation rates for LARC and short-acting contraceptive methods, the continuation rate for LARC was 86% at 12 months compared with 55% for short-acting contracep-
TO: Providers Indicated

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

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

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

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

August 2013 to Present
Reimbursement Policy

• UB-04 must have following:
  • HCPCS code for device
  • ICD-9 Surgical Code
  • ICD-9 Diagnosis Code
Instructions for Medicaid Claims

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

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

HCPS:
- J7300 Intrauterine (IU) copper IUD (Paraguard)
- J7302 Levonorgestrel releasing IUD 52 mg (Mirena)
- J7303 Etonorgestrel (contraceptive) implant system (Nexplanon)

ICD-9 Surgical Code:
- 69.7 Insertion Contraceptive Device

ICD-9 Diagnosis Code:
- V25.02 Initiate Contraceptive NEC
- V25.1 Insertion of IUD
LARC Cost Update

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<th>Code</th>
<th>Previous Reimbursement Rate</th>
<th>Current Reimbursement Rate</th>
<th>Insertion Code</th>
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*Note that all rates are the same for both in-patient and out-patient.
In-patient payment is in addition to the DRG for delivery
Updated October 2012
Nexplanon Insertion

http://youtu.be/ug7q_1RUMio

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

Hospital Pyxis

• Nexplanon device and local anesthetic
Supplies

Tackle Box

- Sterile gloves
- Sterile towels
- Betadine swabs
- Sterile marking pen
- 20 cc syringe
- 18 and 23 gauge needles
- Band-aid
- Dressing pads and wrap
Order sets and patient consent

- Etonogestrel (Nexplanon) 68 mg Implant for Subdermal Insertion
  - Etonogestrel 68 mg IMPLANT x 1 dose prior to discharge
  - Lidocaine 2% 3-5 ml SBQ x 1 dose for Etonogestrel insertion
  - Patient to receive Nexplanon Implant prior to discharge
  - Initiate/Print Consent for Nexplanon Insertion (M10253)
  - Initiate/Print Bed Side Time Out (M10730)
What about breastfeeding?

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

CDC MMWR June 21, 2013

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

ACOG Practice Bulletin #121, July 2011
The risks of unintended pregnancy are much greater than the real or theoretic risks of progestin exposure in the post-partum period

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

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

- After Depo Provera injection, medroxyprogesterone acetate plasma concentrations peak at 7 ng/ml 3 weeks after injection.
- After Nexplanon insertion, etonorgestrel plasma concentrations peak at 0.8 ng/ml 4 days after insertion.
Do women (and doctors) like it?
Nexplanon insertion rates as percentage of total deliveries

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<tr>
<th>Month</th>
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