Georgia’s Opportunity: Immediate Postpartum IUD and Implant Placement

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Georgia Medicaid will shortly release a bulletin allowing coverage for immediate postpartum IUD and contraceptive implant placement outside of the global fee for delivery. Georgia has joined South Carolina, New Mexico, Colorado and Iowa as early adopters of this innovative and important practice.

Why is this a good idea?
- Contraceptive implants and IUDs are the most effective reversible methods and they do not require anything to achieve this high rate of efficacy.
- This removes common barriers to IUD and implant placement (cost, access, transportation, eligibility questions, etc).
- This is a perfect time to place them:
  - The woman is definitely not pregnant.
  - The provider has easy access to the uterine cavity, instruments, pain management, etc.
  - The woman is often very motivated to avoid pregnancy.
- The traditional 6 week postpartum appointment is too late to initiate contraception. Ovulation can occur as soon as 25-28 days postpartum, and many women have reinitiated intercourse by this visit.
- Furthermore, a high proportion of women do not attend their postpartum visit.
- Immediate postpartum placement of IUDs (defined as within 10 minutes of delivery of the placenta) and Implants is supported by the US Medical Eligibility Criteria and the Selected Practice Recommendations for breastfeeding and non-breastfeeding women.
- This approach is cost effective.
- This practice is commonplace in other countries, including India, Egypt, China and Mexico.
- This can help prevent rapid repeat pregnancy. Rapid repeat pregnancy is a problem that is linked to several other negative health outcomes and quality indicators.

What does this mean?
- Providers and hospitals soon can bill for IUDs and implants using the appropriate J codes and receive reimbursement outside of the global fee for delivery.
- Associated professional placement fees, and ultrasound, as indicated, will also be covered.
- See the sidebar bulletin for details.
- Trainings for providers and other key stakeholders will be coming soon.

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References


LARC Devices Provided Immediately Postpartum in a Hospital Setting

Effective soon, Georgia Department of Community Health’s Medicaid program (DCH) will reimburse for Long Acting Reversible Contraceptive (LARC) devices inserted immediately postpartum in a hospital setting. The coverage of this service is considered an add-on benefit and is not included in the Diagnostic Related Group (DRG) reimbursement process. The following codes will be covered separately from the DRG:
- J7300: Intrauterine copper contraceptive (Paragard®)
- J7301: Levonorgestrel-releasing intrauterine system (Skylla®)
- J7302: Levonorgestrel-releasing intrauterine device (Mirena®)
- J7307: Etonogestrel Implant (Nexplanon®, formerly Implanon®) If it is decided that one of the following is used: J7300, J7301, or J7302, it must be inserted within 73 days of pregnancy.

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President’s Column

It’s hard to believe more than half of my presidential year has flown by. Our Society has stayed busy in the past few months with legislative battles (See Dr. Toledo’s column on page 4 for more details) and planning for the Society’s Annual Golf Tournament, May 14 at Bear’s Best in Suwanee, and for the 2014 GOBS Annual Meeting, August 21 to 24 at The Cloister, Sea Island, GA.

Our golf tournament is always a fun and popular event, so register soon if you have not done so already. As enjoyable as the golf tournament has been, I must say my true excitement is for our Annual Meeting. I am very excited about the excellent expertise of this year’s faculty and the scientific quality and relevance of our topics! Here are just a few of the wonderful speakers and topics you will encounter at this year’s educational meeting:

- Kevin Holcomb, MD, Associate Professor of Clinical Surgery at Weill Cornell Medical College in New York, will speak on The History and Significance of CA125 and on Serum Bio Marker Prep Assessment of the Adnexal Mass.
- John C. Jennings, MD, who will be ACOG President by our August meeting, will tell us about GOBS Workforce Trends and Possibilities for Collaborative Practice.
- Peter L. Rosenblatt, MD, Director of Urogynecology at Mount Auburn Hospital in Cambridge, MA, will present Fecal Incontinence: Managing a Dirty Little Secret and Laparoscopy: Considerations for the Obese Patient.

In addition to the fantastic program we have planned, we have the opportunity to honor John S. Inman, Jr., MD, as our 2014 Distinguished Service Award recipient. Dr. Inman, an Emory University School of Medicine graduate from 1945 and a founding member of the school’s National Council, has practiced medicine for 62 years. We will be presenting Dr. Inman with our highest award at the Saturday night Annual Awards Banquet. Please remember we are returning to the Membership’s favorite venue, The Cloister. While we have reserved almost all of the rooms in the hotel, these rooms fill up quickly, so please, if you haven’t already, call The Cloister to reserve a room (1-800-732-4752)! I’m looking forward to seeing all you at our Golf Tournament and Annual Meeting, so make plans now to attend both!

The Best GOBS Events to Come

Kevin Holcomb, MD, Associate Professor of Clinical Surgery at Weill Cornell Medical College in New York, will speak on The History and Significance of CA125 and on Serum Bio Marker Prep Assessment of the Adnexal Mass.

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Editor’s Column

Of Male Patients and Anal Cancer

Last September, The American Board of Obstetrics and Gynecology (ABOG) made a well-intended but ill-advised attempt to limit the practice of its diplomas to female patients. The resulting debate highlighted the many instances of overlap between gynecology and male health care. The most obvious are sexual dysfunction, contraceptive advice, fertility evaluations, STI treatment and newborn circumcision. But two other groups of male patients stood to lose the most: doctors and the patients themselves. Those with pelvic pain and those at high risk for anal cancer.

In response to a massive protest and reconsideration, ABOG made exceptions or reversed itself three times over the next four months. In November it allowed gyns who treat male patients with chronic pelvic pain to treat their current patients only, but no new male patients. And in January, under threat of a lawsuit, it removed gender restrictions entirely and simply defined the “majority” (down from the previous 75%) of a practice be devoted to obstetrics and gynecology.

The most interesting thing to me in all of this was gyns screening for anal cancer in males using high resolution anoscopy. Anal cancer is actually more common in females, although very little attention is given to this by our specialty. There is much study about HPV infection and cervical, vaginal and vulvar cancer. But there seems to be an invisible line drawn between the perineum and the anus. Most of us routinely do rectovaginal exams. But do we really inspect the anal region? Is it not part of the body as we do the exam? Do we teach our students that anal intercourse, smoking, multiple sex partners and HPV infection are risk factors, and that the HPV vaccine and female condoms can be protective? I would like to know when and how to do an anal smear.

If we don’t “go there,” no one else will. I had a patient with a large broad based polyp protruding from the anal verge, which made it difficult for her to clean herself. I sent her to a general surgeon who removed it surgically, but not the polyp. She explained to me this year she thought it was a polyp itself, perhaps because she “didn’t slide down far enough on the exam table.” She was too embarrassed to go back to him. A patient who might have anal problems needs a doctor who is comfortable and experienced with that part of the body. If the doctor happens to be a gynecologist and the patient happens to be male, no specialty board should stand between them. You could say that trying to isolate the practice of gynecology from the health care of the male sex makes as much sense as trying to isolate the anus from the rest of the perineum. The ABOG controversy, however awkward, clearly drove this point home.

References
Legislation was passed to expand the criteria areas where new OB/Gyns can practice, assuring they can meet their loan repayment obligations and we can keep them in our state helping in underserved areas. Amazingly, the Medicaid budget passed rather peacefully without fee cuts for physicians! In addition, the P4HB program, which allows OB/Gyns to provide birth control for low income and Medicaid women between pregnancies, was refunded enabling OB/Gyns to see these women in their practices between pregnancies. All this legislation is good news for women in Georgia and the OB/Gyns who treat them. We continue to struggle with the problem of “legislators in the exam room.” This has happened for the past 10 years, debate time was consumed again this year determining whether women should have access or payment for abortion services. This year, it was determined that certain women (those in the State Employee Benefits Plan and those buying insurance through the Exchange) should not have coverage for abortion in cases of rape, incest, anomalies or mental health conditions. This type of legislation is so time consuming and controversial that the state does not focus on important issues that would improve the health of women. Georgia has serious problems and ranks in the bottom 10 states out of 50: • 50th in the United States in maternal mortality • 41st out of 50 states in rates of teen pregnancy and has the 4th highest repeat teen pregnancy rate in the United States • 45th out of 50 states in the number of low birth weight babies • 42nd out of 50 states in premature births

While we celebrate our accomplishments in this year’s session, we have a long way to go if we want to make Georgia a healthy place for women and infants. I hope between now and next January you will not only vote, but also talk with your legislators about the real problems faced by women in Georgia. Please contact me if I can be of service as your Legislative Chair.

Legislative Day at the Capitol

On February 7th, Women’s Telehealth, the Georgia Partnership for Telehealth (GPT), and the Georgia Department of Public Health (DPH) telemedicine team all partnered to demonstrate the first-ever “live” and interactive telemedicine visit to both the House of Representatives and the Senate floor of the Georgia Capitol. It was Telemedicine Day at the Capitol. Previously, GPT had visited the Capitol to present telemedicine progress in Georgia, but this time, live interactions with patients provided a first-hand, interactive experience for participants. The GPT technology team pulled T1 lines into the Capitol building for both chambers to provide the appropriate bandwidth so congressmen and senators could experience for themselves a live telemedicine encounter with OB patients in the Albany DPH District DCH office. Dr. Anne Patterson from Women’s Telehealth in Atlanta and Dr. Jackie Grant from the Albany DPH and the legislature all connected via telemedicine. The physicians then provided a demonstration of live ultrasound scanning and patient interaction on two separate patients. From the chamber floor, participants on both sides of the camera could see each other and interact. The reality of telemedicine hit home for many when the Speaker of the House asked if the patient’s baby was a boy or girl. She replied, “It’s a boy … and you all do know I can see all of you.” Many hands then shot into the air to wave to the patient and the two-way nature of a telemedicine encounter was experienced by all.

The demonstration was a success as it showed how these entities worked together to extend high-risk obstetric care via telemedicine to areas in Georgia that often have do not have expensive high-risk OB care. Women’s Telehealth and DCH also discussed how they are working together to provide the first and only known telemedicine collaboration using a Centering Pregnancy model and a maternal-fetal medicine physician to interact with and educate patients with normal and high-risk pregnancies to prevent such complications as preterm labor and preclampsia.

The demonstration at the Capitol was an excellent way to show senators and representatives how coordinated health care technology can bring needed services into rural areas that lack some sub-specialist care in a cost-effective manner.
Help Raise Awareness:
May is National Teen Pregnancy Prevention Month and National Teen Pregnancy Prevention Day is May 7th.

The latest news on the teen pregnancy national front has been very positive. Since the early 1990s, teen pregnancy and birth rates in the United States have declined by 44 percent and 52 percent respectively and are now at record low levels.

However, much work still needs to be done, especially in Georgia. Georgia ranks about 10th in the US for teen pregnancies and 4th in the nation for repeat teen births (25% of births to teens in this state are to teens that are already parenting).

For additional information and materials to promote National Teen Pregnancy Prevention Month, visit http://thenationalcampaign.org/event/national-day-2014.

LARC Devices Provided Immediately Postpartum in a Hospital Setting

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ten minutes of birth. These devices should be available in the birthing suite to ensure timely insertion, which decreases the likelihood of expulsion by 40%.

The following Categories of Service (COS) are eligible to bill for the reimbursement of the insertion of 37300, 37301, 37302, and 37307:

• COS 430: Physician Services (use Modifier PP, and Place of service 21)
• COS 070: Outpatient Hospital
• COS 010: Inpatient Hospital

Physicians who are billing for the device, or for the insertion, must indicate the place of service, Inpatient Hospital (21) on the CMS1500 [version 02/12] claim form. Providers should continue using the Family Planning (FP) modifier.

Additional information for LARC Codes
LARC Procedures/Codes UB-04 Hospital
International Classification of Diseases (ICD-9 or ICD 10) Codes

- Diagnostic
  - V25.1 – Header code
  - V25.2 – (230.2)
  - V25.5 – (230.49)
  - V25.11 – (230.430)
  - V25.12 – (230.432)
  - V25.13 – (230.433)
  - V25.02 – (230.018)
- Ultrasound - 76857 / 76830 / 76998
  - Payment % of charge for hospital
  - The Ultrasounds are non-obstetric transvaginal/ultrasound guidance/ intraoperative for placement.

When it comes to ICD-10CM coding, one area that has seen significant changes is in the way you’ll select codes for annual well-child visits.

With ICD-10CM, there are entirely new options for general medical exams as well as gynecological visits. In addition, there are even bigger changes in the way we will select ICD-10CM codes for vaccine administration. I thought we could start there – Vaccine Administration.

Encounter for Immunization
In the past, we had to have an exhaustive list of several diagnosis codes for each individual vaccine that was administered. For example, when providing a patient with a flu vaccine, we had to use V04.81. For HPV vaccine we would submit ICD-9CM code V04.89. With ICD-10CM, we no longer will be required to know all those vaccine administration diagnosis codes. In fact, they are all replaced with one ICD-10CM code: Z23 – Encounter for immunization. In fact, Z23 replaces 39 current ICD-9CM codes. As a coder, this is one of the small gifts we will have with the implementation of ICD-10CM.

General Medical Exam
Next, let’s talk about the ICD-10CM codes we’ll use to report a general well physical examination (GME). The

CP codes used to reflect these services are 99381-99397. Most providers in primary care seem to be using one of those Evaluation and Management codes (EM Code) along with the ICD-9CM code diagnosis of V70.0. V70.0 is an ICD-9CM code that read the following device in general physical examination at a health care facility.

In ICD-10CM, that one code will now be replaced with two codes:
• Z00.00 - Encounter for general adult medical examination without abnormal findings
• Z00.01 - Encounter for general adult medical examination with abnormal findings

So, let’s use this information in a clinical example.

Example 1:
Stephanie is an established 45 year old white female in for an annual well visit and an influenza vaccine.
- 99360 Z00.00 (GMW without abnormal)
- 90471 Z23 (Encounter for Immunization)
- 90658 Z23 (Encounter for Immunization)

Example 2:
In this event, a separable identifiable service is also documented during her visit (maybe there is a lump in her breast that required additional history, exam and decision-making to support a 99213).

ICD-10 Implementation Delayed to 2015

In April, United States law makers snuck a seven-line addition to the Medicare sustainable growth rate (SGR) bill that prevented ICD-10-PCS from being implemented by at least one year.

The bill, H.R. 4302, Protecting Access to Medicare Act of 2014, mainly creates a temporary “fix” to the Medicare sustainable growth rate (SGR) and prevents cutbacks in reimbursement to physicians. However, a seven-line section of the bill states that the Department of Health and Human Services (HHS) cannot adopt the ICD-10 code set as the standard until at least October 1, 2015.

The industry had been preparing to switch to the ICD-10 code set on October 1, 2014. However, the Centers for Medicare and Medicaid Services (CMS) made an administrative decision to bump it from 2013 to 2014, giving both providers and payers more time to prepare for the transition. In February, the CMS said it absolutely, positively would not move the date again — except that now it must, by act of Congress. The timing of this latest delay is particularly awkward for large organizations that have poured great effort into information systems changes and training with the understanding that the deadline would not be moved.
The Georgia Department of Public Health is planning to revise the
administrative regulations currently codified as Chapter 511-5
(“Testing for inherited disorders in the newborn”). These revisions are intended
to add new tests to the roster of required screenings of newborn babies in
Georgia including the testing for Critical Congenital Heart Defects (CCHDs).

According to the National Center on Birth Defects and Developmental Disabilities, Congenital heart defects account for nearly 30% of infant deaths due to birth defects. In the United States, about 7,200 (or 18 per 10,000) babies born every year have CCHDs (also known as congenital heart disease).

CCHDs represent a group of heart defects that cause serious, life-threatening symptoms and requires intervention within the first days or first year of life. CCHD is often treatable if detected early. Newborn screening using pulse oximetry can identify some infants with a CCHD before they show signs of the condition. If detected early, infants affected with CCHD can often be treated by a cardiologist and receive specialized care so they can lead longer healthier lives.

With the new revisions to the NBS rules and regulations, CCHD screening will become available to every newborn in Georgia. The proposed effective date for implementation will be 7/1/15.

The proposed revised regulation can be found on the Society website: www.georgiaobgyn.org. Interested persons may submit comments on these proposed revisions in writing addressed to: Sidney R. Barrett, Jr., General Counsel Georgia Department of Public Health, 2 Peachtree Street, NW, 15th
Floor, Atlanta, GA. 30303. Comments may also be presented in person at a public meeting scheduled for 1:30 p.m., May 2, 2014, in room 9-260 at 2 Peachtree Street, 15th Floor, Atlanta, GA.

In order to comply with the ACOG policy of encouraging the tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) during pregnancy, Georgia Medicaid, AmeriGroup, PeachState and Wellcare will now cover provision of the Tdap vaccine during pregnancy. The billing code for reimbursement is 90715.

Tdap Vaccine Covered During Pregnancy by Medicaid and CMOS

CODING CORNER

Coding of Well Visits

The 2014 ACOG Annual Clinical Meeting

The 2014 ACOG Annual Clinical Meeting, April 26-30 in Chicago, will be open and the Annual Clinical Meeting will offer cutting edge topics, lunch and learn seminars, hands-on courses, postgraduate courses and clinical seminars. For additional meeting information visit the ACOG ACM webpage at http://www.acog.org/acm.
Presenting: Steve Adams

Topics Include:

• ICD-10-CM for OB Services
• OBGyn Coding Updates for 2014
• 2014 Compliant Evaluation and Management Coding for OBGyn
• Reducing Risks...Improving Outcomes
• Understanding and Implementing the Affordable Care Act.

CEUs for Staff Personnel and CMEs for Physicians will be available.

Call the Society for additional details at 770-904-0719 or visit our website at georgiaobgyn.org.

May Awareness Campaigns:

• National Teen Pregnancy Prevention Month and Day (May 7th), http://thenationalcampaign.org/event/national-day-2014
• Hepatitis Awareness Month, http://www.liverfoundation.org/chapters/ham/
• Women’s Health Week (May 11-17), http://womenshealth.gov/nwhw/
• National Woman’s Checkup Day (May 10), http://www.wvhrh.org/mch/wvdh/phw/checkup_day_fact_sheet.pdf
• HIV Vaccine Awareness Day (May 18), http://aids.gov/news-and-events/awareness-days/hiv-vaccine-awareness-day/

News from Around the State

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Spirit Foundation’s Run/Walk for Hope Raises Funds for Cervical Cancer Screening

January 25 was one of the coldest days of the year, but that didn’t stop the Spirit Foundation’s 2014 5K Run & Walk for Hope. Participants just bundled up and braved the cold to raise funds to provide cervical cancer screenings with free pap tests for underserved women and educational intervention programs for women suffering from cervical cancer. The Spirit Foundation is a non-profit 501(c)(3) health organization headquartered in Atlanta whose mission is to increase awareness about Human Papilloma virus (HPV) and provide clinical services towards the detection and prevention of cervical cancer in Georgia, several other US states, Latin America and Africa.

Runners and walkers braved the cold to raise funds for the Spirit Foundation.

Dr. Lisa Flowers (on right), of Emory University’s Department of Gyn/Ob, participated in the Spirit Foundation’s 2014 5K Run & Walk for Hope.