ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS
District II

Dispelling Long-Acting Reversible Contraception (LARC) Myths & Misconceptions Fact Sheet

MYTH: Adolescents and nulliparous women are not appropriate candidates for IUDs.	FACT: Adolescents and nulliparous women can be offered LARC methods, including IUDs.[1] The *U.S. Medical Eligibility Criteria for Contraceptive Use*, classifies both women who haven't had children and adolescents as Category 2, finding the advantages generally outweigh the risks. IUDs and implants have the highest effectiveness, continuation rates, and user satisfaction of all reversible methods.[2]
MYTH: IUDs cause infertility.	FACT: IUDs do NOT cause infertility or make it harder to conceive in the future. Infertility is no more likely after discontinuation of IUD use than after discontinuation of other reversible methods of contraception.[3] In the past, there was concern that IUD use could lead to infertility due to increased chance of sexually transmitted infections (STIs). While untreated STIs can lead to pelvic infection, preventing some women from getting pregnant, ample research shows that today's IUDs do not increase STI infection rates or lead to infertility. STI testing should be performed at the time of IUD insertion, if indicated. However, all women, including those using IUDs, should see a health care provider if they have new or unusual vaginal discharge or pelvic pain.
MYTH: IUDs cause ectopic pregnancy.	FACT: The IUD does not cause ectopic pregnancy. An ectopic pregnancy happens when a fertilized egg implants somewhere outside the uterus, like in the fallopian tubes. There is a chance any pregnancy could be ectopic, and in the very unlikely event a woman becomes pregnant while using an IUD, her chances of having an ectopic pregnancy may be increased. However, since the chance of becoming pregnant while using an IUD is so low, the overall risk of having an ectopic pregnancy is greatly reduced while using an IUD as compared to not using any contraceptive method.
MYTH: A woman who has had an ectopic pregnancy should not use an IUD.	FACT: Women who have had an ectopic pregnancy can use IUDs.[4] IUDs decrease the absolute risk of ectopic pregnancy, whether a woman has had an ectopic pregnancy before or not. Since the chance of becoming pregnant with an IUD is so low, the overall risk of having an ectopic pregnancy is greatly reduced while using an IUD as compared to not using any contraceptive method.
MYTH: If a woman using an IUD develops an STI or pelvic inflammatory disease (PID), the IUD should be removed immediately.	FACT: If a woman using an IUD develops an STI or PID she should be treated with antibiotics right away and can keep the device in place if her symptoms improve within 72 hours (3 days). If the symptoms do not improve within that time, the device should be removed.

[1] American College of Obstetricians and Gynecologists. ACOG Practice Bulletin: *Long-Acting Reversible Contraception: Implants and Intrauterine Devices*, Number 121, July 2011; reaffirmed 2015.
[2] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy, Number 642, October 2015.
[3] Ibid.
[4] Ibid.

MYTH: Results of STI screening must be confirmed before IUD insertion.	FACT: Studies show that IUD insertion in patients without clinical signs of an STI is safe. Requiring testing and then a return visit for IUD insertion decreases the chance that a patient gets her IUD, leaving her at risk for an unintended pregnancy. For this reason, same-day insertion of an IUD is a recommended best practice, with routine treatment of any subsequent positive STI screening results undertaken following insertion. Routine antibiotic prophylaxis to prevent pelvic infection is not recommended before IUD insertion.[5]
MYTH: Patients should be menstruating for IUD insertion *(i.e., return to the office/ clinic when menses starts).*	FACT: Studies show that there is no clinical advantage to IUD insertion during menses[6] and that it decreases the chance that a patient will actually return to the office to get an IUD, potentially leaving her at risk for an unintended pregnancy. For this reason, same-day insertion of an IUD is a recommended best practice as long as pregnancy may be reasonably excluded. Refer to the CDC US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2016.
MYTH: Immediate Postpartum (IPP) IUD insertion is associated with high expulsion rates.	FACT: IUD expulsion rates are slightly higher with immediate postpartum placement (10-27% versus 2-10% for interval insertion).[8,9] The vast majority of women who receive an IUD immediately postpartum will not experience an expulsion and the advantages of IPP placement outweigh the risks.[7,8] Many women do not return for postpartum follow-up appointments when contraception is often discussed. Therefore, immediate postpartum LARC insertion presents an opportunity to provide a woman with a contraceptive method of her choice while in the hospital for delivery and should not be dismissed.
MYTH: Breastfeeding mothers are not appropriate candidates for immediate postpartum LARC.	FACT: Most women can successfully breastfeed after immediate postpartum initiation of any LARC method. Women considering immediate postpartum hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that the preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.[9] The *U.S. Medical Eligibility Criteria for Contraceptive Use* rates the copper IUD a category 1 (no restriction) for breastfeeding women due to its lack of hormones and the hormonal IUD and implant a category 2 less than 4 weeks postpartum (otherwise a category 1), making LARC an option for immediate postpartum use.

[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: *Clinical Challenges of Long-Acting Reversible Contraceptive Methods*, Number 672, September 2016.
[9] American College of Obstetricians and Gynecologists. ACOG Committee Opinion: *Immediate Postpartum Long-Acting Reversible Contraception*, Number 670, August 2016.

This education is made possible through educational grant funding from Merck and has been created independently by ACOG District II.

March 2017

NON-CONTRACEPTIVE INDICATIONS FOR HORMONAL CONTRACEPTIVE PRODUCTS

Medical Conditions Caused or Exacerbated by Menses	
• Menorrhagia • Dysmenorrhea • Premenstrual syndrome • Endometriosis • Menstrual migraines • Irregular menses	• Iron-deficiency anemia • Some seizure disorders • Menstrual flares of rheumatoid arthritis • Coagulation defects (e.g., menstrual porphyria)
Conditions in this group often improve with any hormonal contraceptive product (progestin-only or combined estrogen-progestin). However, for additional benefit and enhanced convenience, hormonal contraceptives can be used continuously – that is, women can skip the hormone-free week of pills, patch, or vaginal ring. Continuous use of hormonal contraceptives provides extra benefit for the conditions above by eliminating menses.	
Other Conditions Alleviated by Hormonal Contraceptives	
• Vasomotor symptoms of perimenopause • Acne	• Hirsutism • Polycystic ovary syndrome
Risk Reduction through Use of Hormonal Contraceptives	
• Ovarian cancer • Endometrial cancer	• Colorectal cancer • Osteoporosis
List of Hormonal Contraceptive Product Types	
• Oral contraceptive pills: progestin-only • Oral contraceptive pills: estrogen-progestin • Contraceptive patch: estrogen-progestin	• Contraceptive vaginal ring: estrogen-progestin • Progestin depot injection • Progestin implant • Progestin-releasing intrauterine device

Terrah Stroda, CNM, APRN

FlintHills OBGYN
Delivering Change: Healthy Families, Healthy Communities

The Case for LARC

- Why they are awesome. Period.
- What are LARCs & what they are not
- Revisit 2018 convo: Mom/Baby OUTCOMES
- Myths vs facts
- What's all this cost?!
- How to provide LARC if you don't provide LARC
- Shameless PLUG for upcoming LARC conference

Statewide LARC workgroup

Ivonne Rivera-Newberry, BSN, RN
Family Planning Clinical Consultant
Kansas Department of Health and Environment

Mai Nguyen, PA-C, MPH
General Clinic Manager
Sedgwick County Division of Health

Kristi Wilson, MPA
Director
Bureau of Family Health, Reproductive Health & Family Planning Program

Maria Salas, B.A., CPB, CPCO, AAPC Fellow
Program Supervisor – HIPAA Officer
Unified Government of WyCo/KCKS - Public Health Department

Cris Loomis, MPA, CPM
Clinical Health Services Manager
Department of Health and Environment

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Merck Women's Health

Danielle Ast, MBA, RD, LD, IBCLC
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Anne Maack, MPA
Early Childhood Initiatives Coordinator
WSU Community Engagement Institute

Kelli Mark
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Bureau of Family Health, Maternal and Child Health Program

Terrah Stroda, CNM
Flint Hills Obstetrics & Gynecology

LARC

Case for LARC

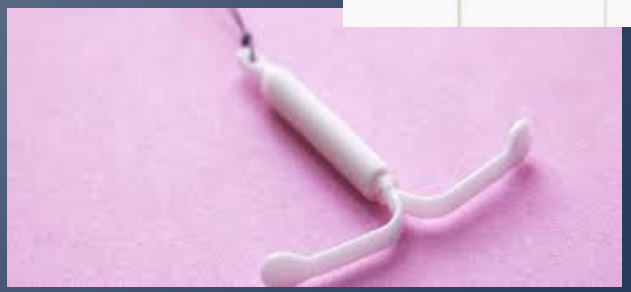
Why are we after this BEAST?

- ✓ The are AWESOME!
- ✓ Contraception
- ✓ Maternal Pregnancy Outcomes
- ✓ Fetal Outcomes
- ✓ Gynecologic Outcomes
- ✓ Cost effectiveness
- ✓ High Patient Satisfaction

- ✓ FUN Procedure!

LARC IUDs as of 4-3-19 ☺

- Cu T3804 A (ParaGard) is the only non-hormonal LARC device
- 3 Levonorgestrel-releasing intrauterine systems with varying dosages: Mirena, Liletta, Kyleena, and Skyla



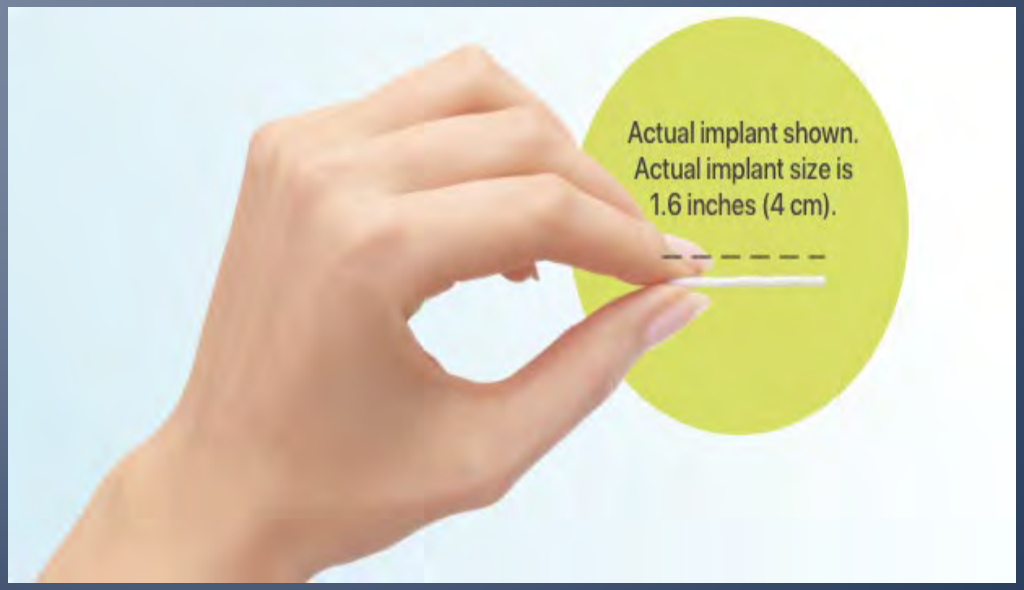
DAZED & CONFUSED:
Providers & Patients be like WHAT?!

IUCD	Effectiveness
Paragard	10 years
Mirena	5 years
Liletta	5 years
Skyla	3 years
Kyleena	5 years

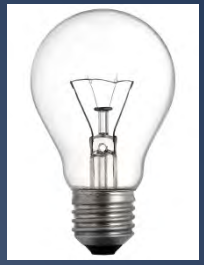
LARC as of 4-3-19 ☺

Progestin Rod Implant/Contraceptive Implant

- Nexplanon: 3 years



Contraception: ACOG Statements



ACOG: Committee Opinion (2015)

Access to Contraception

ABSTRACT: Nearly all U.S. women who have ever had sexual intercourse have used some form of contraception at some point during their reproductive lives. However, multiple barriers prevent women from obtaining contraceptives or using them effectively and consistently. All women should have unhindered and affordable access to all U.S. Food and Drug Administration-approved contraceptives. This Committee Opinion reviews barriers to contraceptive access and offers strategies to improve access.

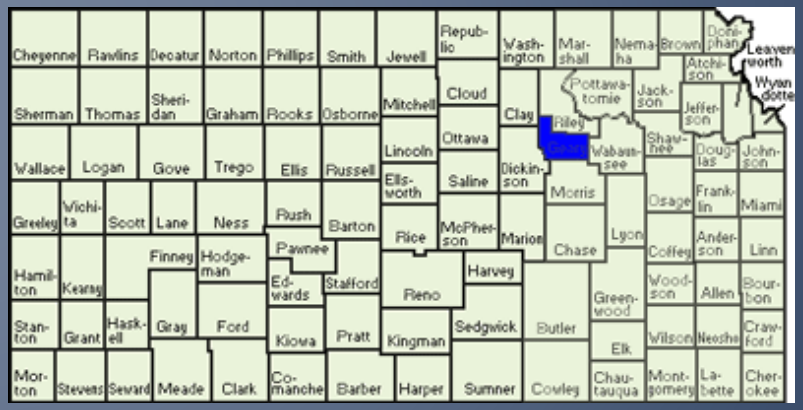
ACOG: Committee Opinion (2015)

Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy

ABSTRACT: Unintended pregnancy persists as a major public health problem in the United States. Although lowering unintended pregnancy rates requires multiple approaches, individual obstetrician–gynecologists may contribute by increasing access to contraceptive implants and intrauterine devices. Obstetrician–gynecologists should encourage consideration of implants and intrauterine devices for all appropriate candidates, including nulliparous women and adolescents. Obstetrician–gynecologists should adopt best practices for long-acting reversible contraception insertion. Obstetrician–gynecologists are encouraged to advocate for coverage and appropriate payment and reimbursement for every contraceptive method by all payers in all clinically appropriate circumstances.

Our Call to Action:

- The IMR in Geary County for 2006-2010:
  - 10.4/1,000 live births
  - (1 of the 4th highest in the state)



Delivering Change™

Improving Maternal Health

Before Pregnancy

- Health Behaviors
- Knowledge Before Pregnancy
- Quality Healthcare

During Pregnancy

- Early Access to Prenatal Care
- Education during Pregnancy
- Navigators

After Pregnancy

- Quality Care
- Education, Screening & Referral

Reproductive Life Plan

- Planning Pregnancy
- Contraception
- Optimum Birth Spacing

Delivering Change™

Improving Maternal Health

Geary County, KS

Inadequate Birth Spacing

- 2011- 13%
- 2017- 11.6%

Birth Numbers:

- 2011- 930
- 2015- 1115 (*highest year)
- 2017- 890

Number of LARC devices inserted at FHOB

- 2014- 211
- 2015- 255
- 2017- 284

Delivering Change™

Case for LARC:
Contraceptive vs Treatment (or BOTH!)

NON-CONTRACEPTIVE INDICATIONS FOR HORMONAL CONTRACEPTIVE PRODUCTS

Medical Conditions Caused or Exacerbated by Menses	
• Menorrhagia • Dysmenorrhea • Premenstrual syndrome • Endometriosis • Menstrual migraines • Irregular menses	• Iron-deficiency anemia • Some seizure disorders • Menstrual flares of rheumatoid arthritis • Coagulation defects (e.g., menstrual porphyria)
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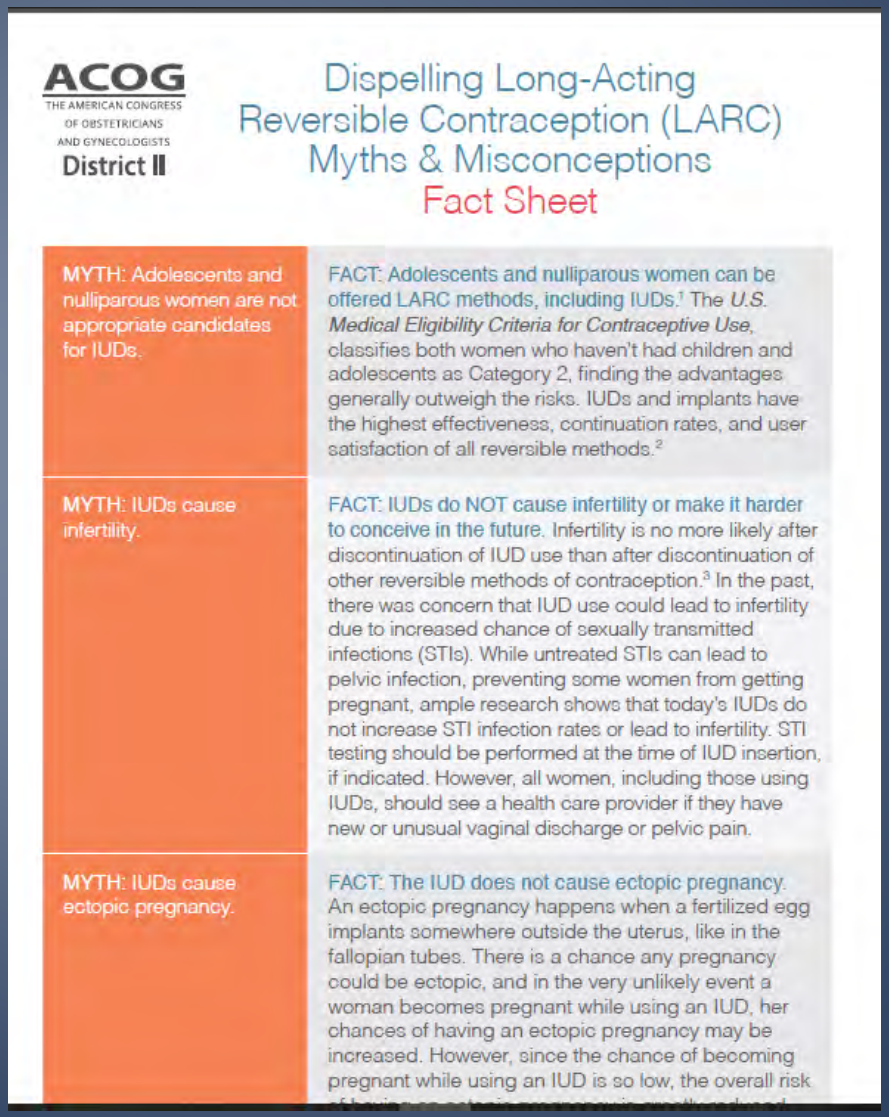
Case for LARC: Myths vs Truths



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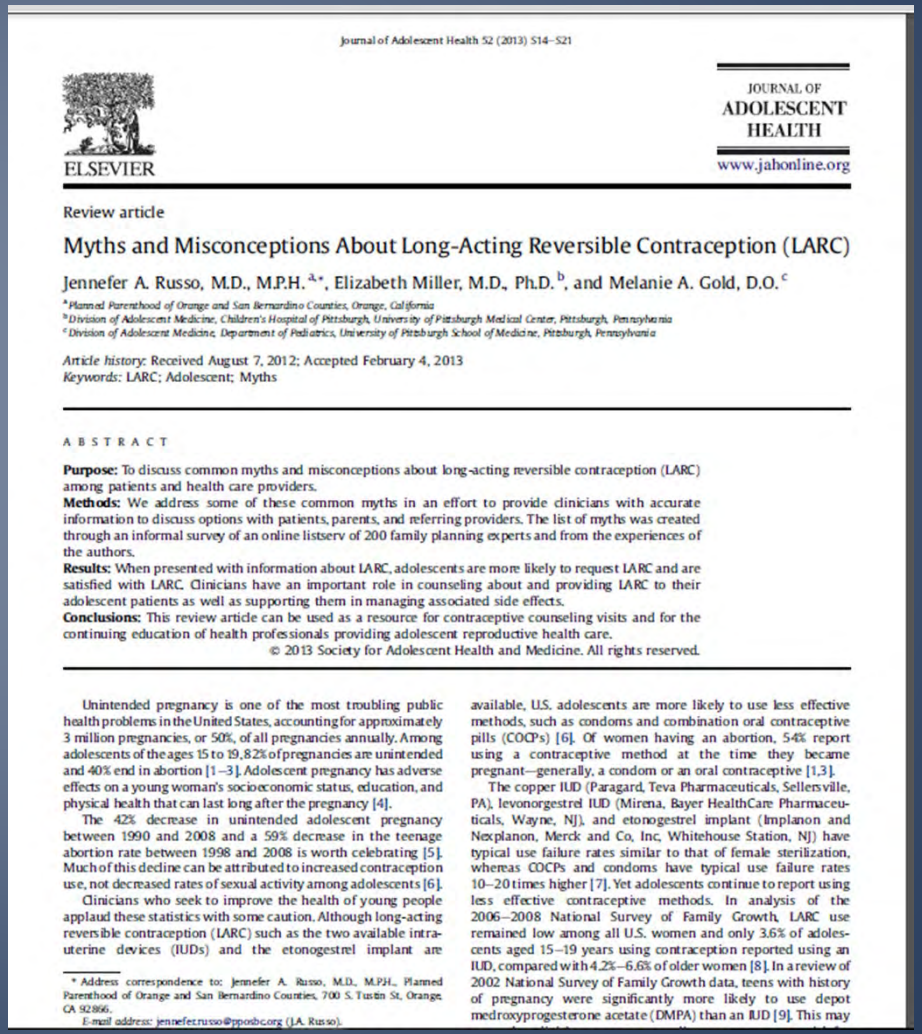
ACOG, March 2017

Adolescent Health



Journal of Adolescent Health 52 (2013) S14–S21

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH

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Review article

Myths and Misconceptions About Long-Acting Reversible Contraception (LARC)

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[b] Division of Adolescent Medicine, Children's Hospital of Pittsburgh, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania
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Article history: Received August 7, 2012; Accepted February 4, 2013
Keywords: LARC; Adolescent; Myths

ABSTRACT

Purpose: To discuss common myths and misconceptions about long-acting reversible contraception (LARC) among patients and health care providers.
Methods: We address some of these common myths in an effort to provide clinicians with accurate information to discuss options with patients, parents, and referring providers. The list of myths was created through an informal survey of an online listserv of 200 family planning experts and from the experiences of the authors.
Results: When presented with information about LARC, adolescents are more likely to request LARC and are satisfied with LARC. Clinicians have an important role in counseling about and providing LARC to their adolescent patients as well as supporting them in managing associated side effects.
Conclusions: This review article can be used as a resource for contraceptive counseling visits and for the continuing education of health professionals providing adolescent reproductive health care.

Unintended pregnancy is one of the most troubling public health problems in the United States, accounting for approximately 3 million pregnancies, or 50%, of all pregnancies annually. Among adolescents of the ages 15 to 19, 82% of pregnancies are unintended and 40% end in abortion [1–3]. Adolescent pregnancy has adverse effects on a young woman's socioeconomic status, education, and physical health that can last long after the pregnancy [4].

The 42% decrease in unintended adolescent pregnancy between 1990 and 2008 and a 59% decrease in the teenage abortion rate between 1998 and 2008 is worth celebrating [5]. Much of this decline can be attributed to increased contraception use, not decreased rates of sexual activity among adolescents [6].

Clinicians who seek to improve the health of young people applaud these statistics with some caution. Although long-acting reversible contraception (LARC) such as the two available intrauterine devices (IUDs) and the etonogestrel implant are available, U.S. adolescents are more likely to use less effective methods, such as condoms and combination oral contraceptive pills (COCPs) [6]. Of women having an abortion, 54% report using a contraceptive method at the time they became pregnant—generally, a condom or an oral contraceptive [1,3].

The copper IUD (Paragard, Teva Pharmaceuticals, Sellersville, PA), levonorgestrel IUD (Mirena, Bayer HealthCare Pharmaceuticals, Wayne, NJ), and etonogestrel implant (Implanon and Nexplanon, Merck and Co, Inc, Whitehouse Station, NJ) have typical use failure rates similar to that of female sterilization, whereas COCPs and condoms have typical use failure rates 10–20 times higher [7]. Yet adolescents continue to report using less effective contraceptive methods. In analysis of the 2006–2008 National Survey of Family Growth, LARC use remained low among all U.S. women and only 3.6% of adolescents aged 15–19 years using contraception reported using an IUD, compared with 4.2%–6.6% of older women [8]. In a review of 2002 National Survey of Family Growth data, teens with history of pregnancy were significantly more likely to use depot medroxyprogesterone acetate (DMPA) than an IUD [9]. This may

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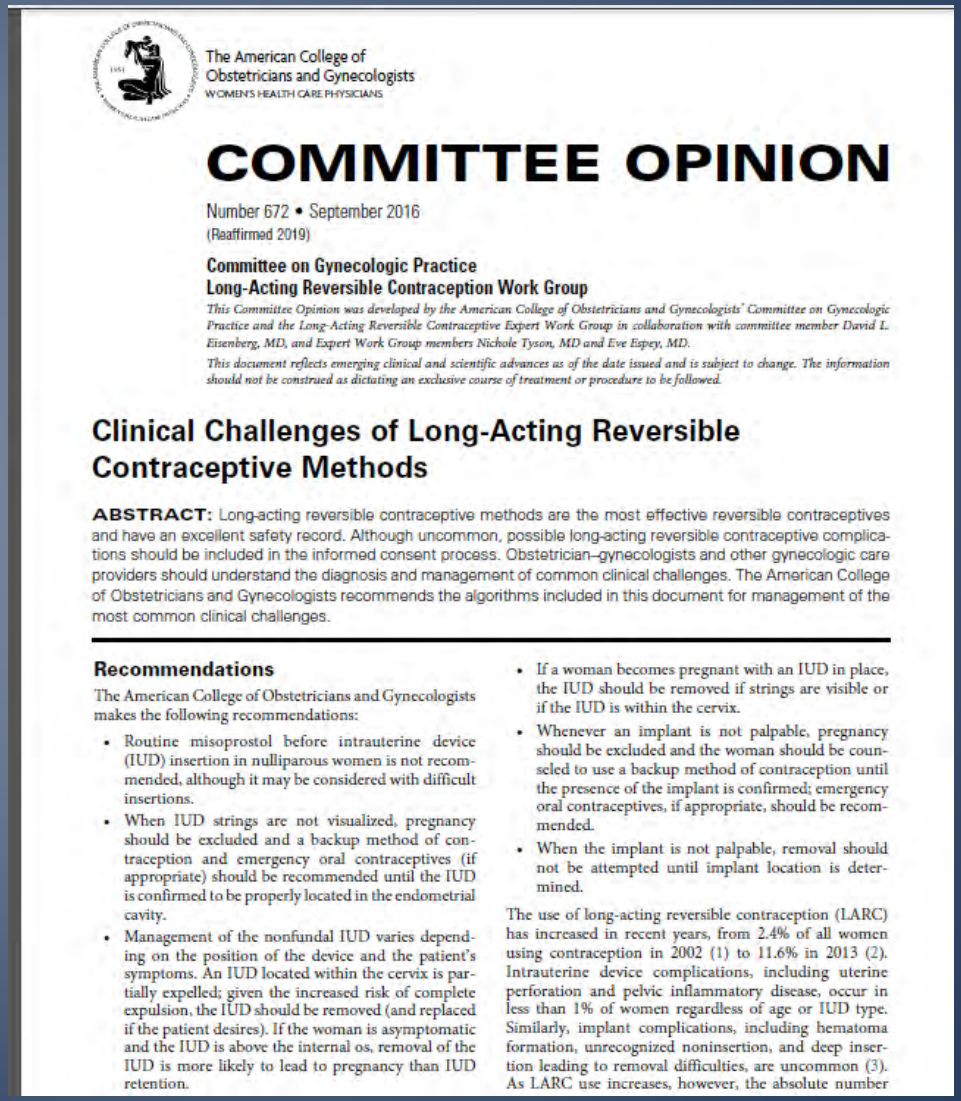
JAH, 2013

Case for LARC:
Quit being afraid of your own shadow

- Provider Training
- Clinical Challenges… and Champions
- Documentation
- Follow Up
- Nurse/Front Desk Triage

Clinical Challenges



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 672 • September 2016
(Reaffirmed 2019)

Committee on Gynecologic Practice
Long-Acting Reversible Contraception Work Group

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and the Long-Acting Reversible Contraceptive Expert Work Group in collaboration with committee member David L. Eisenberg, MD, and Expert Work Group members Nichole Tyson, MD and Eve Espey, MD.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Clinical Challenges of Long-Acting Reversible Contraceptive Methods

ABSTRACT: Long-acting reversible contraceptive methods are the most effective reversible contraceptives and have an excellent safety record. Although uncommon, possible long-acting reversible contraceptive complications should be included in the informed consent process. Obstetrician–gynecologists and other gynecologic care providers should understand the diagnosis and management of common clinical challenges. The American College of Obstetricians and Gynecologists recommends the algorithms included in this document for management of the most common clinical challenges.

Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations:

- Routine misoprostol before intrauterine device (IUD) insertion in nulliparous women is not recommended, although it may be considered with difficult insertions.
- When IUD strings are not visualized, pregnancy should be excluded and a backup method of contraception and emergency oral contraceptives (if appropriate) should be recommended until the IUD is confirmed to be properly located in the endometrial cavity.
- Management of the nonfundal IUD varies depending on the position of the device and the patient's symptoms. An IUD located within the cervix is partially expelled; given the increased risk of complete expulsion, the IUD should be removed (and replaced if the patient desires). If the woman is asymptomatic and the IUD is above the internal os, removal of the IUD is more likely to lead to pregnancy than IUD retention.
- If a woman becomes pregnant with an IUD in place, the IUD should be removed if strings are visible or if the IUD is within the cervix.
- Whenever an implant is not palpable, pregnancy should be excluded and the woman should be counseled to use a backup method of contraception until the presence of the implant is confirmed; emergency oral contraceptives, if appropriate, should be recommended.
- When the implant is not palpable, removal should not be attempted until implant location is determined.

The use of long-acting reversible contraception (LARC) has increased in recent years, from 2.4% of all women using contraception in 2002 (1) to 11.6% in 2013 (2). Intrauterine device complications, including uterine perforation and pelvic inflammatory disease, occur in less than 1% of women regardless of age or IUD type. Similarly, implant complications, including hematoma formation, unrecognized noninsertion, and deep insertion leading to removal difficulties, are uncommon (3). As LARC use increases, however, the absolute number

ACOG, 2016

Converting Over

Preventing Gaps When Switching Contraceptives

RUTH LESNEWSKI, MD, MS, *Beth Israel Residency in Urban Family Practice, New York, New York*
LINDA PRINE, MD, *Albert Einstein College of Medicine of Yeshiva University, Bronx, New York*
REGINA GINZBURG, PharmD, *St. John's University College of Pharmacy and Allied Health Professions, New York, New York*

Unintended pregnancy can occur when women stop one birth control method before starting another. To prevent gaps in contraception, physicians should ask women regularly about adverse effects, cost, difficulty remembering the next dose, and other issues that affect adherence. Women who want to change contraceptive methods need accurate advice about how to do so. Some contraception transitions require an overlap between the old method and the new method. To switch safely from one contraceptive to another without overlap, women may go directly from the old method to the new method, abstaining from sexual intercourse or using a barrier method, such as condoms or spermicide, for the first seven days. (*Am Fam Physician*. 2011;83(5):567-570. Copyright © 2011 American Academy of Family Physicians.)

▶ **Patient information:** A handout on how to switch birth control methods, written by the authors of this article, is provided on page 575.

EB CME

This clinical content conforms to AAFP criteria for evidence-based continuing medical education (EB CME). See CME Quiz on page 537.

The United States has one of the highest rates of unintended pregnancy in the developed world.[1] Healthy People 2010 aimed for all women at risk of unintended pregnancy to use birth control.[2] Despite this target, rates of contraceptive use declined between 1995 and 2005, with the greatest decrease seen among nonwhite, low-income groups.[1] A survey of U.S. physicians identified several barriers to successful family planning.[3] Physicians cited inadequate contraception counseling as a considerable obstacle.

Unintended pregnancy can occur during a gap in contraception (i.e., the interval between stopping one method of birth control and starting another). A recent survey of American women found that most gaps in contraception are related to method dissatisfaction or transitions in housing, jobs, or relationships.[4] When women experience adverse effects, or when they cannot afford to renew their prescription, they may stop using their contraceptive without starting a new one. This occurs more often among women who have difficulty reaching their physician,[4] underscoring the importance of physician availability to address problems with and questions about contraceptives. Understanding the correlation between personal transitions and contraceptive gaps can help physicians anticipate the risk of contraceptive failure.

To help prevent gaps in contraception, physicians should ask women about adverse effects, cost, difficulty remembering to take the next dose, and other issues affecting adherence. Women who experience spotting or breast tenderness during the first few weeks of a new contraceptive method should be reassured that these adverse effects will likely resolve within two to three months.[5] However, women who find early adverse effects intolerable often benefit from switching to a new product.

Women need accurate and detailed advice about how to switch contraceptives without raising their risk of pregnancy. When advising women how to switch from one contraceptive method to another, physicians should instruct them to avoid any gap between methods. In many cases, overlapping methods by a few days may help maximize effectiveness *(see table in patient education handout on page 576)*. In each of the following scenarios, women may choose to add a barrier method, such as condoms or spermicide, for the first few days of the new method rather than overlapping with the previous method. Because estrogen-

AAFP, 2011

Hot Topics

One Key Question/Reproductive life planning- are we ready for the answer??

- Women want BC yet we create barriers: protocols, lack of information, insurance/reimbursement, problem-focused phone calls and clinic visits

Irony of LARC availability vs Governmental control of conversations (local, state, fed)

Clinic Barriers to care

YouTube insertion videos

Hot Topics

KDHE LARC Workgroup Survey 2019:

- KDHE's MCH grantee Network (Title V and Title X), safety net clinics (through Community Care Network) and OB/GYNs (through ACOG) in Kansas in January of 2019

Survey Results

RESULTS:

Responded: 69 unique organizations

Local Health departments	Health Centers	Other Community Organizations
63	2	4

Response Rate: Unknown (used listserv)

Methodology: SurveyMonkey

Question Breakdown:

Does your organization provide INSERTION of Long Acting Reversible Contraceptives (LARC)?

YES	NO
26	43

Does your organization provide REMOVAL of LARC?

YES	NO
26	41

If your organization does NOT provide LARC insertion, what barriers prevent you from offering this service?

We currently do not have staff trained for Insertions	23
The devices are too expensive	8
Our providers do no support the use of LARC	1
Our administration does not support the use of LARC	3
The LARC reimbursement level is too low	1
Provider only visits clinic once every other month	1
Low patient volume	1
Costs and ability to remove if device migrates	1
No facility for women's health services	1
Do not employ clinical staff	2
Do not have a family planning clinic	1
We do Nexplanon but are not comfortable with IUD	1

If your organization does NOT provide LARC insertion, do you provide LARC education for your clients?

YES	NO
32	7

If NO, what kind of support would you need to provide LARC education to your clients?

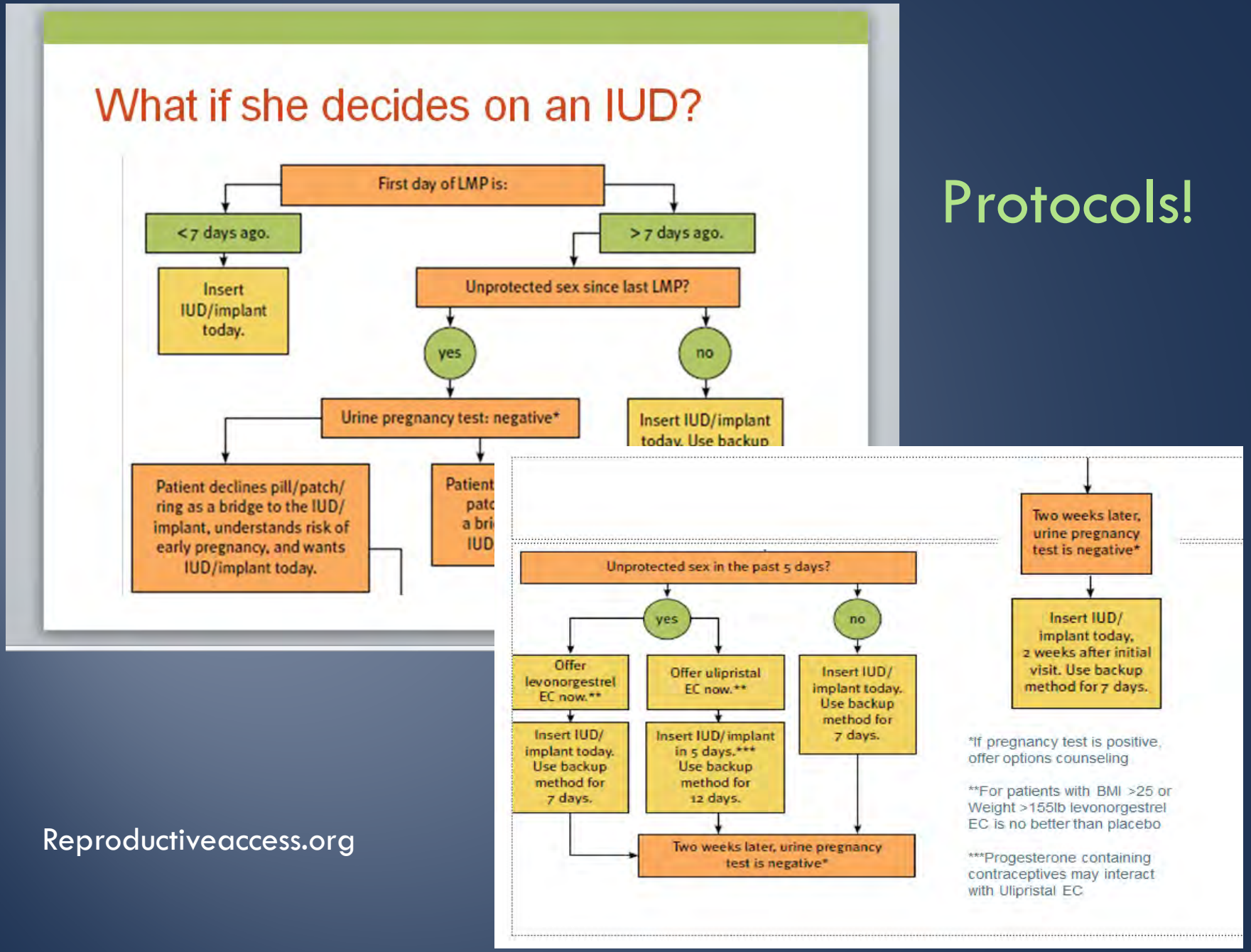
Additional Staff Training	1
Handouts/written material for clients/training	6

If your organization does NOT provide LARC insertion, do you provide referrals for LARC insertion?

YES	NO
26	41

How to, When to, & Where to

Protocols!



Reproductiveaccess.org

Policy & Procedure!

Family Practice Name

Implant Policy and Procedures

Procedure: **Progestin Implant Insertion**

Policy: It is the policy of the Family Practice Name to provide Progestin Implant Contraception

1. **Nursing triage**: A urine sample is obtained for a pregnancy test, and the medical assistant or nurse completes the test. The test and the control results are documented in the chart. Vital signs are obtained by the medical assistant and noted in the chart.

2. **Counseling and patient selection**: The provider will counsel the patient on the available contraceptive options. Patients should be either be within 5 days of her menses, or pregnancy should be reliably excluded.

The follow are contraindications to Progestin Implant insertion .
-known or suspected pregnancy
-thrombotic disease
-hepatic tumors or active liver disease
-undiagnosed abnormal genital bleeding
-breast cancer.

Patients on medications such as barbituates, griseofulvin, rifampin, phenytoin, carbamazepine, felbamate, topiramate and modafinil along with other drugs that induce hepatic enzymes, will be counseled that these drugs may lower the efficacy of the implant. St. John's Wort may also have this effect.

3. **Consent**: The patient has will sign a consent form; it is to be scanned into the Electronic Health Record. Counseling on side effects will include the expected irregular bleeding pattern. Possible complications of this procedure include infection at the insertion site. Placement below the subdermal level requires a more complicated procedure at removal.

4. **Procedure**:
The patient is place in a supine position and the nondominant arm is marked with a pen at the insertion site 6-8 cm above the elbow in the groove between the triceps and biceps. The insertion site is cleaned with an antiseptic. 2 cc of lidocaine is place along the insertion canal. The progestin implant rod is confirmed to be in the progestin implant inserter. The skin is stretched and the cannula is inserted into the skin at a 20 degree angle. The skin is then lifted and tented and the needle inserted to its full length. The seal of the applicator is broken by pressing the obturator support. The obturator is then turned 90 degrees. The obturator is then fixed while the cannula is retracted. Placement is confirmed by palpation. A small adhesive bandage is placed over the insertion site. Patients are instructed to use condoms for 7 days post insertion and to return for rod removal in three years.

Subject: Policy and Procedure for IUDs		Department: Clinical
Date:	Prepared by:	Approved by:

I. Evaluation of insurance eligibility for IUDs

Note: this should not be necessary in most cases, with the Affordable Care Act, which mandates coverage of all FDA approved contraceptives without co-pays or deductibles. Some grand-fathered plans will not be in compliance, and for those the following paragraph applies.

The appropriate support staff will verify with the patient's insurance company to ensure the IUD is covered; this will preferably occur the day before the procedure. The results of this verification will be conveyed to nursing. Patients without insurance coverage should be referred to a case manager or entitlement counselor before their IUD insertions so that they can be enrolled in the appropriate health insurance plan or so that a patient assistance program with the appropriate pharmaceutical company can be applied for (Teva for the Paragard and Merck for the Mirena. Patient Assistance is currently not available for Skyla or Liletta.)

II. The Procedure

In many cases, patients will be coming in first for contraceptive options counseling. They may or may not be making a decision during this visit about whether they elect to have an IUD. The Policy and Procedure statement that follows applies to the IUD insertion visit.

- **Arrival**: Patients who come for an IUD will enter the health center as do all patients. They will be registered and have vital signs performed. They will be called to the exam/treatment room in the order of their appointment.
- **Counseling and consent**: Each patient will have the opportunity to discuss all contraceptive options before the procedure. The patient will be carefully counseled on the side effects of each type of IUD, especially the changes in bleeding pattern and the cramping that will be experienced. The procedure consent form will be signed at this time.
- **Set up**: All equipment needed for the procedure will be stored in a supply room or closets where equipment for other procedures is stored. The proper IUD will be supplied to the clinician by the nursing staff, who will record the lot number and the expiration date of the IUD in the nursing notes in the medical record. The provider will offer the patient 800mg of ibuprofen to be given prior to the procedure and the nurse will administer it, if the patient agrees and is not allergic.
- **Procedure**: The clinician and a staff member or additional clinician will be with the patient during the procedure. The patient will undress from the waist down, be covered with a paper sheet, and lie in lithotomy position on the exam table. A bimanual exam will be performed. The speculum will be inserted and a Pap, gc, Chlamydia culture will be done, as medically indicated. The vagina will be dabbed with antibacterial solution. No-Touch Technique will be observed throughout the procedure: any instruments, or parts of instruments, that enter the uterus must

III. Quality Improvement

The insert facility name here maintains a Quality Improvement committee, which consists of practice medical directors, trained clinicians, administrators and other staff. The committee will review the procedures and outcomes for important indicators on a regular schedule, and will report findings in committee minutes.

IV. Facilities and equipment

1. Facility

At the facility name providers have private exam rooms, for both consultation and treatment. Providers currently perform other procedures in these rooms, including sonography, endometrial biopsy, and uterine aspiration. Patients will have the IUD insertion in an exam/treatment room, and recover in the same room (see above).

2. Equipment

Sterile instrument trays will be made up of the following:

1 sponge stick/ring forcep
Single tooth tenaculum
One plastic uterine sound
Sterile gauzes
Medicine cup
Scissors

Additional equipment for the procedure will be kept available:

10 cc syringes
21 gauge 2" needles
18 gauge 1" needles
Denniston dilator size 5/6 or a set of os finders
Betadine
Lidocaine
Sodium Bicarbonate (1cc to be mixed with 3 cc of lidocaine)

3. Disposal of medical waste and cleaning of instruments

The facility name has a procedure for the removal of medical waste such as blood and other infectious body fluids, as well as contaminated equipment. This procedure will continue to be

Aftercare instructions!

XXXXXX Health Center
Address
Phone:

Nexplanon (progestin implant) take-home sheet

- The implant starts working in 7 days to prevent pregnancy.
- You should use a back-up method for the first 7 days after implant placement.
- The implant can remain under your skin for 5 years.
- Removal date: _____ (5 years from today)

Things to know:

- Common side effects include: **Irregular** bleeding. Your periods may change. You may have more bleeding, less bleeding, or no bleeding, and periods may last longer than usual.
- Bruising and swelling at site are common in the first 24 hours. Keep the dressing on for 24 hours. After 24 hours, you can remove the dressing and take a shower or bath.
- You can check the implant by pressing your fingertips over the skin where the implant was inserted. You should feel a small rod. If you do not feel your implant, call your health care provider.

You may return to school or work after your visit.

The implant does **NOT** protect against sexually transmitted infections (STIs). You should use latex condoms and/or dental dams to prevent STIs. Most people should get tested for STIs once a year.

Warning Signs:

Within First Week

- Redness, warmth, or drainage from insertion site
- Fever (>101 degrees)

At Any Time

- Feeling pregnant (breast pain, nausea)
- Positive home pregnancy test

However, the studies done on Implanon had NO failures – it prevented pregnancy 100% of the time!

If you develop any of the above warning signs you should be seen by a health care provider. You can call us at XXX-XXX-XXX, or go to your usual health care provider.

Billing & Coding, OH MY!

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 injections, 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-biodegradeable 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 contractive 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.
- Z30.432: Encounter for removal 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

HCPCS Code	Description	Brand Name	FDA Approved Duration Use	KS Medicaid Reimbursement Rate (1)
J7296	Levonorgestrel-releasing intrauterine contraceptive system	Kyleena	5 years	$909.83
J7297	Levonorgestrel-releasing intrauterine contraceptive system	Liletta	3 years	$725.44
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
	BILLING CODES			
11981	Insertion, non-biodegradable drug delivery implant			$51.47
11982	Removal, non-biodegradable drug delivery implant			$60.46
11983	Removal with reinsertion, non-biodegradable drug delivery implant			$104.90
58300	Intrauterine contraceptive device insert			$55.00
58301	Intrauterine contraceptive device removal			$79.86

KDHE LARC Workgroup, 2018

Don't be a barrier: The Case for an MOU

LARC Referral Process

LARC Referrals for Agencies/Entities Covered Under 340B Program

(including Title X Family Planning Service Sites)

Agencies and entities covered by the 340B Program must ensure that the processes for handling referrals outside of their agency for consultations and services are clearly defined and covered in a written agreement and in their 340B written policies and procedures. Failure to do so could place their 340B status in jeopardy. Covered entities are responsible for demonstrating compliance with all terms of the 340B Program guidelines. The information below comes from the Frequently Asked Questions section of the Apexus 340B Prime Vendor Program website regarding referrals (https://www.340bpvp.com/resource-center/faqs

A covered entity may refer an individual for consultation to an outside clinic not registered for the 340B Program and consider that patient 340B eligible only if the individual receives health care from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity (61 Fed. Reg. 55156 (October 24, 1996)). If the covered entity can document that it retained responsibility for the health care services provided to the referred individual, then that individual may be eligible to receive 340B drugs from the covered entity. How a covered entity counts referrals under the 340B Program should be addressed in their written policies and procedures.

HRSA encourages covered entities to retain legal counsel to develop contract terms based on the patient definition guidelines that apply to their unique situations. Under any contract arrangement, medical responsibility for the health care service provided and the use of any 340B drugs transferred to an individual must remain with the covered entity. The 340B entity should maintain documentation in the entity's record of health care that justifies the 340B entity had responsibility for the health care resulting in the 340B referral prescription. The entity should be able to produce documentation of the both the request for referral, as well as a summary of the referral visit, is accessible in the patient's medical record.

Memorandum of AGREEMENT

FOR TITLE X FAMILY PLANNING SERVICES & LONG ACTING REVERSIBLE CONTRACEPTIVE REFERRALS

Delivering Change: Healthy Moms, Healthy Babies (Geary County)

1. **Parties to Agreement**

   1.1. Konza Prairie Community Health Center (KPCHC);

   1.2. FlintHills OBGYN (FHOBGYN); and

   1.3. Geary Community Healthcare Foundation (GCHF).

   The Parties agree to the following terms and conditions.

2. **Purpose of Agreement** – The purpose of this Agreement is to outline the process Parties will implement and monitor regarding Long Active Reversible Contraceptive (LARC) referrals and Title X Family Planning services. The Parties are mutually interested in working collaboratively through the *Delivering Change: Healthy Moms, Healthy Babies* Program to decrease unplanned pregnancy and increase interconception periods. The approach focuses on health promotion and education on inter-birth intervals, family planning, and prenatal care as well as increasing the number of eligible individuals who obtain reliable, longer acting methods of contraception such as Nexplanon Hormonal Implant, Mirena IUD, Paragard IUD, Lilleta and Skyla IUD.

   2.1. The source of funding for this agreement is one or more of the following:
   - 2.1.1. Healthy Start Grant, reserved for Geary county residents ONLY, supported by The U.S. Department of Health and Human Services, Health Resources and Services Administration [CFDA 93.926; Grant Number: H49MC27818; Grantee: Kansas Department of Health and Environment; Sub-recipient: Geary Community Healthcare Foundation];
   - 2.1.2. Title X Family Planning Services Grant, supported by the U.S. Department of Health & Human Services, Office of Population Affairs [CFDA 93.217; Grant Number: FPHPA076219-01-00; Grantee: Kansas Department of Health and Environment; Sub-recipient: KPCHC]; and
   - 2.1.3. Third Party Payors (Medicaid, TriCare, BCBS, etc.).

   2.2. KPCHC provides comprehensive gynecology, reproductive and sexual health care to any and all individuals and provides referral to FHOBGYN in the event that such services are unavailable.

   2.3. All Family Planning and gynecology care is provided through KPCHC on a sliding fee scale based on Federal Poverty Guidelines.

   2.4. In certain situations, it is necessary to refer patients to a specialty provider for services outside the scope of KPCHC practice.

3. **Period of Agreement** – The initial term of this Agreement shall be one (1) year from the effective date, unless otherwise terminated as indicated below. At the end of the initial one (1) year term, this Agreement shall renew for an additional one (1) year term and shall continue to renew for successive one (1) year terms thereafter. Either Party may decide not to continue as a Party to this Agreement at the end of the initial term or any renewal term upon written notice no earlier than 60 days and no later than 30 days prior to expiration of the applicable term. Terms of this agreement, including services to be provided and compensation are contingent upon the availability of federal funds.

4. **Compensation** – Depending on the source of funding/payment, the following applies.

   4.1. Healthy Start Grant Funding: KPCHC and FHOBGYN will receive payment from the GCHF for all costs not otherwise paid or reimbursed by a third party for LARC devices and related services for all individuals *who are Geary County*

A few of my favorite things

- Reproductiveaccess.org
- Bedsider.org
- ACOG.org
- http://www.kdheks.gov/c-f/index.html

Title X Resources:

- *Providing Quality Family Planning Services-Recommendations of CDC and US OPA:* https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
- *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016:* https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf
- *U.S. Selected Practice Recommendations for Contraceptive Use, 2016:* https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf
- http://www.contraceptivetechnology.org/the-book/
- Title X Clinical Protocols: http://www.kdheks.gov/c-f/downloads/2016-17_Family_Planning_Clinical_Protocols.pdf
- Title X Clinical Appendix with Documentation Protocols:
- http://www.kdheks.gov/c-f/downloads/Clinical_Appendix.pdf

- *ACOG LARC Program: www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception

- Access to Women's Healthcare in the US-
- www.acog.org/-/media/Statements-of-Policy/Public/64AccesstoWomenHlthCare2016-1.pdf

Straight to the source

IUD Vendor Websites:

- Liletta: https://www.lilettahcp.com
- Kyleena: https://hcp.kyleena-us.com
- Mirena: http://hcp.mirena-us.com/
- Paragard: https://hcp.paragard.com
- Skyla: http://hcp.skyla-us.com/

Nexplanon Vendor Website:

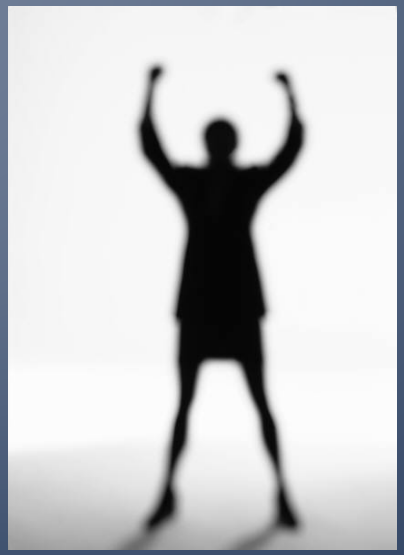
- https://www.merckconnect.com/nexplanon/dosing-administration/

Advocacy: We're not alone

www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Advocating-for-Access-to-LARC

Take home messages

- Use resources
- Push conversation
- Don't let fear win
- Educate- Medical/Public domains equally



Don’t miss event!

LARC Action Kit, Meet Clinical Champions, Onsite Training

LARC Ground Rounds

September 27, 2019, 8 a.m. - 4:30 p.m.

Courtyard by Marriott - Convention Center, 310 Hammons Dr., Junction City 66441

Please join us for an exciting day of learning and discussion around Long Acting Reversible Contraceptives. This training will include information about LARC resources, LARC billing and Coding, an expert panel discussion and hands-on insertion training.

This training is supported in part by Delivering Change and The Kansas Department of Health and Environment with funding through the Office of the Assistant Secretary of Health (OASH) Award No. FPHPA006316. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OASH.

Delivering Change
Healthy Families – Healthy Communities

Kansas Department of Health and Environment

KANSAS MATERNAL & CHILD HEALTH