



#### Applicable To:

- Medicare
- Medicaid – excluding Arizona, Kentucky, Nebraska, and North Carolina
- Children's Medical Services Health Plan (CMS Health Plan)

#### Claims and Payment Policy: LONG ACTING REVERSIBLE CONTRACEPTION

**Policy Number: CPP-125**

**Original Effective Date: 7/11/2013**

**Revised Effective Date(s): 7/10/2014; 12/4/2014;  
8/6/2015; 9/27/2016; 7/6/2017; 7/5/2018**

#### BACKGROUND

According to the a study entitled “Effectiveness of long-acting reversible contraception” from the New England Journal of Medicine, long-acting reversible contraception (LARC) is more effective than other methods (e.g., pill, patch, or ring). Risk of failure using oral contraceptive pills, transdermal patches or vaginal rings was 20 times higher than when using LARC.

The American College of Obstetricians and Gynecologists (ACOG) published an update in 2011 to the 2005 practice bulletin on the efficacy of LARC. Only 6 percent of women use this type of contraception, despite less chance of complications. Intrauterine devices (IUDs) and implants were found to be more effective despite having the highest rate of continuation, largely due to minimal effort once placed. There are two types of IUDs that are placed in the uterus. Copper IUDs can prevent pregnancy for 10 years by releasing a small amount of copper into the uterus which prevents fertilization. Hormonal IUDs can be effective for up to 5 years. This type of IUD works through the release of progesterin into the uterus which thickens cervical mucus and thins the uterine lining; this can make sperm less active. Contraceptive implants are matchstick-size rods that are inserted under the skin of the upper arm. The rods have a controlled release of ovulation-suppressing hormone; they can be effective for up to 3 years and is the most effective LARC.

LARCs can be inserted or implanted at any time during a member's menstrual cycle, providing pregnancy can be reasonably excluded. The postpartum period immediately following a member giving birth is particularly favorable as members are known not to be pregnant, are motivated to use contraception and the hospital offers convenience. Unintended pregnancies are most likely to occur in the period immediately after delivery. Forty-five percent of study participants reported that they did not abstain from sexual intercourse until 6 weeks postpartum as instructed by their provider at time of delivery.

The U.S. Medical Eligibility Criteria for Contraceptive Use classifies immediate postpartum copper IUD insertion as Category 1 and immediate postpartum levonorgestrel intrauterine system insertion in both non-breastfeeding and breastfeeding women as Category 2. Immediate postpartum IUD insertion (done within 10 minutes of placental separation) appears safe and effective; insertion of both the copper IUD and levonorgestrel intrauterine system after 10 minutes post-placental separation up until 4 weeks postpartum is classified as a U.S. Medical Eligibility Criteria for Contraceptive Use Category 2, and insertion at or after 4 weeks postpartum is classified as a U.S. Medical Eligibility Criteria for Contraceptive Use Category 1. Patients should be seen 1–2 weeks after insertion to have the strings cut.

Insertion of the implant is safe at any time in non-breastfeeding women after childbirth (Category 1 rating). The U.S. Medical Eligibility Criteria for Contraceptive Use classifies the 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. Implants may be offered to women who are breastfeeding and more than 4 weeks after childbirth because the U.S. Medical Eligibility Criteria for Contraceptive Use classifies delayed insertion as Category 1. Although long-term data on the effect of hormonal methods on breastfeeding are limited, observational studies of progestin-only contraceptives suggest they have no effect either on a woman's ability to successfully initiate and continue breastfeeding or on an infant's growth and development (40). A randomized trial compared postpartum insertion of the etonogestrel contraceptive implant at 1–3 days with standard insertion at 4–8 weeks postpartum. The study reported no differences in breastfeeding outcomes between groups, including lactogenesis and the risk of lactation failure (41). In addition, a prospective nonrandomized comparative study examined breast milk composition in 80 women using the contraceptive implant versus a nonhormonal IUD, initiated at least 28–56 days after childbirth. Breast milk composition, measured by total protein, fat, and lactose content, did not differ between the groups, nor did the quantity of breast milk (42). After a 3-year follow-up, there was no difference between the groups in terms of neonatal body length, biparietal head circumference, and body weight.

According to ACOG, the expulsion rate associated with immediate postpartum insertion is higher than that for interval insertion and may be as high as 24%. Differences in expulsion rates are similar with manual insertion versus use of ring forceps, but may differ depending on the experience of the inserter. Immediate insertion after cesarean delivery may be associated with a lower risk of expulsion than after vaginal delivery. Benefits of immediate insertion may outweigh the increased risk of expulsion. Disadvantages of waiting 4–6 weeks postpartum for interval insertion include failure to return for follow-up and not obtaining an IUD at the follow-up visit.

An advantage of the copper IUD is its lack of hormonal content, avoiding any theoretic effect on breastfeeding. However, in a single randomized control trial examining the effect of IUDs on breastfeeding in women randomized either to insertion of a levonorgestrel intrauterine system (n=163) or a copper IUD (n=157) at 6–8 weeks postpartum, there were no differences in breastfeeding duration or infant growth between the two groups. Immediate postpartum insertion is contraindicated among women in whom peripartum chorioamnionitis, endometritis, or puerperal sepsis is diagnosed. The International Planned Parenthood Federation, in collaboration with WHO and other international organizations, developed guidelines that include the restriction of IUD insertion within 3 months of treatment of puerperal sepsis.

### *Post-Abortion Insertion*

Insertion of an IUD or implant immediately after either an abortion or miscarriage is safe and effective and has many of the same advantages as immediate postpartum insertion. Immediate insertion of the copper IUD or levonorgestrel intrauterine system after a first-trimester abortion is classified as Category 1 in the U.S. Medical Eligibility Criteria for Contraceptive Use, and Category 2 for second-trimester post-abortion insertion (25) because of a higher risk of expulsion compared with insertion after a first-trimester abortion. Contraceptive implant insertion immediately after a first-trimester abortion or second-trimester abortion also is classified as Category 1, but is based on studies of a levonorgestrel implant system no longer marketed in the United States. Women who have an abortion are at high risk of repeat unintended pregnancy, and ovulation may resume within 10 days of abortion (48). Thus, prompt initiation of a

contraceptive method is critical. Women who have an IUD inserted immediately after abortion have higher rates of use compared with interval insertion, and lower rates of repeat abortion than those who choose another method. Intrauterine device insertion immediately after first-trimester suction aspiration appears to have a low risk of complications similar to that of interval insertion (51). One randomized controlled trial has evaluated immediate versus delayed insertion of IUDs after first-trimester abortion. The immediate insertion group showed a higher risk of expulsion versus the delayed group, but 42% of women in the delayed group did not return for a follow-up visit. Immediate IUD insertion is contraindicated within 3 months after septic abortion.

## POSITION STATEMENT

### Applicable To:

- Medicaid – All Markets
- CMS Health Plan - CHIP

Long acting reversible contraception (LARC) are **medically necessary** and a **covered benefit** when the criteria below are met.

### Contraceptive Implants

Contraceptive implants can be implanted at any time during a member's menstrual cycle, including women who have given birth.

### Intrauterine Devices

IUDs can be inserted at any time during a member's menstrual cycle. This also includes insertion during the post-partum period.

Post-partum insertion **is not recommended** for members with any of the following diagnoses; members should wait 3 months for post-partum insertion of an IUD to minimize complications:

- Peripartum chorioamnionitis
- Endometritis
- Puerperal sepsis

NOTE: Providers should educate members on the expulsion rate of postpartum insertion of IUDs; the rate can be as high as 24% following vaginal delivery and is lower after cesarean delivery.

### *Safety and Efficacy*

Safety and efficacy of Mirena have been established in women of reproductive age. Efficacy is expected to be the same for postpubertal females under the age of 18 as for users 18 years and older. Use of this product before menarche is not indicated.

ParaGard® is not indicated before menarche. Safety and efficacy have been established in women over 16 years old.

Safety and efficacy of IMPLANON have been established in women of reproductive age. Safety and efficacy of IMPLANON are expected to be the same for postpubertal adolescents. However, no clinical studies have been conducted in women less than 18 years of age. Use of this product before menarche is not indicated.

## MARKET SPECIFIC CRITERIA

**Florida:** Services associated with the decision to use long-acting injectable or implantable contraceptives are covered using the appropriate family planning code. Reimbursement for the medication is covered using the appropriate HCPCS code and valid NDC number. The NDC number can be found on the product that is being administered to the recipient. Medicaid utilizes the 11 digit format, and this may require insertion of leading zeros if they do not appear on the

package, for example: 00001-0234-05. Note: Refer to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for billing guidelines.

**Georgia.** Physicians, nurse practitioners, midwives and physicians' assistants will be reimbursed for the insertion and removal of implantable contraceptive capsules and intrauterine devices only after their training requirements have been completed. The insertion, management and removal of the capsule must be accomplished according to the manufacturer's recommendations (Chapter 901.5, 901.6). Additional items are noted under the Coding section.

**Hawaii.** The state Medicaid manual does not contain information pertaining to LARC.

**Illinois.** Contraception (including all FDA-approved methods) are covered, including medically necessary laboratory tests. Coverage includes contraceptive drugs and supplies may be dispensed, prescribed or ordered. Prescriptions for family planning drugs and supplies may be refilled as prescribed by the practitioner for up to one year. The practitioner may also submit charges for the administration or dispensing of contraceptive drugs or supplies they purchased using the appropriate HCPCS Code.

When FQHC/RHCs purchase long-acting contraceptive devices (LARCs) and transcervical sterilization devices, the clinic can bill for the device fee-for-service. Charges must be submitted separately from the encounter. The following reimbursement criteria apply:

- To the extent that the LARCs and Transcervical Sterilization Devices were purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC or RHC's actual acquisition cost with a UD modifier.
- Reimbursement shall be made at the FQHC or RHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is less.
- This reimbursement shall be separate from any encounter payment the FQHC or RHC may receive for the insertion procedure.

**Kentucky.** The state Medicaid manual does not contain information pertaining to LARC.

**Missouri.** The MO HealthNet Division (MHD) will allow separate reimbursement for long-acting reversible contraception (LARC) devices inserted during an inpatient hospital stay for a delivery. LARC devices, including intrauterine devices (IUDs) and birth control implants, are defined as implantable devices that remain effective for several years to prevent pregnancies. Separate reimbursement applies to the LARC device only. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital per diem rate. To receive separate reimbursement for LARC devices inserted during inpatient hospital stays for delivery, providers can submit an outpatient or pharmacy claim with the most appropriate National Drug Code (NDC). Providers will receive their inpatient per diem rate in addition to being reimbursed separately for the LARC device. For intrauterine devices (IUD), the fee for procedure code 58300, insertion of an IUD, includes the physician's fee for insertion of the IUD. Procedure code 58301, removal of an IUD, includes the physician's fee for removal of the IUD.

Non-biodegradable drug delivery implant systems are covered. The following procedure codes are for insertion only, removal only, or removal with reinsertion only and do not include reimbursement for the device: 11981 (Insert Non-Bio Drug Del Implant), 11982 (Remove Non-Bio Drug Del Implant), and 11983 Remove/Reinsert Non-Bio Drug Del Implant). The E/M procedure code may not be billed in addition to any of the non-biodegradable drug delivery implant system procedure codes, as it is included in the reimbursement for insertion or removal.

**New Jersey.** The state Medicaid manual does not contain information pertaining to LARC.

**New York.** Family planning services enable individuals, including minors who may be sexually active, to plan their families in accordance with their wishes, including the number of children and age differential, and to prevent or reduce the incidence of unwanted pregnancies. Such services include, but are not limited to professional medical counseling, insertion of Norplant, and prescription drugs. Family planning services do not include hysterectomy procedures or sterilization of individuals less than 21 years of age; nor the treatment of infertility.

**South Carolina.** The Checkup Program provides coverage for contraceptive supplies (e.g., birth control pills or male condoms) and contraceptive services such as an injections, IUD, Essure, or sterilization. Long Acting Reversible Contraceptives (LARCs) are covered through the pharmacy program. Any LARC billed by a pharmacy will be shipped

directly to the provider's office for insertion. Providers should take extra care to ensure that they bill Medicaid only for reimbursement of the insertion of the device, and not the device itself, when it is obtained and billed through the pharmacy benefit. Providers ordering LARCs through the pharmacy benefit must order them through the following specialty pharmacies:

- Paragard Direct 877-727-2427
- Mirena/Skyla CVS 803-551-1030
- Implanon/NexaplanonCVS 800-571-2767

Additional items are noted for South Carolina under the Coding section.

## CODING & BILLING

### Covered ICD-10-CM Diagnosis Codes

- Z30.013** Encounter for initial prescription of injectable contraceptive  
**Z30.014** Encounter for initial prescription of intrauterine contraceptive device  
**Z30.017** Encounter for initial prescription of implantable subdermal contraceptive  
**Z30.018** Encounter for initial prescription of other contraceptives  
**Z30.019** Encounter for initial prescription of contraceptives, unspecified  
**Z30.2** Encounter for sterilization  
**Z30.8** Encounter for other contraceptive management  
**Z30.9** Encounter for contraceptive management, unspecified  
**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  
**Z30.40** Encounter for surveillance of contraceptives, unspecified  
**Z30.42** Encounter for surveillance of injectable contraceptive  
**Z30.46** Encounter for surveillance of implantable subdermal contraceptive  
**Z30.49** Encounter for surveillance of other contraceptives

### Covered CPT® Codes

- 11981** Insertion, non-biodegradable drug delivery implant  
**11982** Removal, non-biodegradable drug delivery implant  
**11983** Removal with reinsertion, non-biodegradable drug delivery implant  
**58300** Insertion of intrauterine device (IUD)  
**58301** Removal of intrauterine device (IUD)

### Covered HCPCS® Codes

- J7297** Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg  
**J7298** Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg  
**J7300** Intrauterine copper contraceptive (Use this code for Paragard T380A)  
**J7301** Levonorgestrel-releasing intrauterine system (Skyla®)  
**J7306** Levonorgestrel {contraceptive} implant system, including implants and supplies  
(Use this code for Norplant II)  
**J7307** Etonogestrel (contraceptive) implant system, including implant and supplies  
**S4989\*** Contraceptive intrauterine device {e.g. Progestacert IUD}, including implants and supplies  
\*Non-Medicare

NOTE: J7300 and J7307 can be billed for Point of Service (POS 22, 23, or 24). If it is decided that one of the following is used: J7300, J7301, or it must be inserted within 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%.

## MARKET SPECIFIC CRITERIA

### **Georgia**

Providers should use the codes below when billing for implantable contraceptives; an FP modifier must be used:

- **J7307** Etonogestrel (Implanon/Nexplanon) Implant System - Modifier FP
- **11981 11976** Removal, Implantable Contraceptive Capsule – Modifier FP
- **11981** Insertion, non-biodegradable drug delivery implant – Modifier FP
- **11982** Removal, non-biodegradable drug delivery implant – Modifier FP
- **11983** Removal with reinsertion, non-biodegradable drug delivery implant – Modifier FP  
Insertion, Implantable Contraceptive Device – Modifier FP

Insertions are limited to one within a three year period. The insertion or removal may be billed in conjunction with one of the following visits: (a) Initial and Annual Comprehensive Family Planning Visit; (b) Brief Medical Visit; or (c) Comprehensive Medical Visit.

Providers should use the codes below when billing for intrauterine implants; an FP modifier must be used:

- **J7300** Paragard / Intrauterine copper contraceptive – Modifier FP
- **J7297** Liletta IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 3 year – Modifier FP
- **J7298** Mirena IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 5 year – Modifier FP
- **J7301** Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5MG- Modifier FP
- **58300** Insertion of Intrauterine Device – Modifier FP
- **58301** Removal of Intrauterine Device – Modifier FP

For injectable contraceptives, the Depo-Provera injection may be billed with any type of visit code. Coverage is limited to one injection every three months or one every 12-13 weeks. Providers should use the code below when billing for this service. The FP modifier must be used with this code.<sup>5</sup>

- **J1050** Medroxyprogesterone Acetate 1 mg (Injection) Modifier FP  
1 mg = 1 unit. Provider must bill the appropriate units administered to the patient

### **South Carolina**

The following are covered codes:

- **J7300** Paragard / Intrauterine copper contraceptive – Modifier FP
- **J7297** Levonorgestrel-releasing intrauterine contraceptive system (Liletta) 52mg
- **J7298** Mirena IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 5 year – Modifier FP
- **J7300** Intrauterine copper contraceptive
- **J7301** Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5MG- Modifier FP
- **J7306** Etonogestrel implant system, including implants and supplies
- **J7307** Etonogestrel (Implanon/Nexplanon) Implant System - Modifier FP
- **S4981** Insertion of Levonorgestrel-Releasing Intrauterine sytem
- **58300** Insertion of Intrauterine Device – Modifier FP
- **58301** Removal of Intrauterine Device – Modifier FP
- **11981** Insertion , non-biodegradable drug delivery implant
- **11982** Removal, non-biodegradable drug delivery implant
- **11983** Removal with reinsertion, non-biodegradable drug delivery implant

\*Removal of an IUD due to a uterine or pelvic infection is not covered.

\*Removal of contraceptive implants due to medical complications is not covered

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

**DEFINITIONS**

|                                    |   |
|------------------------------------|---|
| <b>Chorioamnionitis</b>            | Also known as intra-amniotic infection is an inflammation of the fetal membranes due to a bacterial infection. It typically results from bacteria ascending from the vagina into the uterus and is most often associated with prolonged labor. The risk of developing chorioamnionitis increases with each vaginal examination that is performed in the final month of pregnancy, including during labor.   |
| <b>Contraceptive implants</b>      | An implantable medical device used for the purpose of birth control. The implant may depend on the timed release of hormones to hinder ovulation or sperm development, the ability of copper to act as a natural spermicide within the uterus, or it may work using a non-hormonal, physical blocking mechanism. As with other contraceptives, a contraceptive implant is designed to prevent pregnancy, but it does not protect against sexually transmitted infections. |
| <b>Endometritis</b>                | An inflammatory condition of the lining of the uterus, usually due to an infection. We'll explain what puts you at risk and what to do. Endometritis is an inflammatory condition of the lining of the uterus, usually due to an infection.   |
| <b>Etonogestrel</b>                | This product is a small, thin plastic rod that is inserted under the skin to prevent pregnancy. The rod slowly releases etonogestrel into the body over a 3-year period. Etonogestrel is similar to a natural hormone made in your body.  |
| <b>Intrauterine devices (IUDs)</b> | Also known as intrauterine contraceptive device or coil, is a small, often T-shaped birth control device that is inserted into a woman's uterus to prevent pregnancy. IUDs are one form of long-acting reversible birth control. One study found that female family planning providers choose LARC methods more often than the general public. Among birth control methods, IUDs, along with contraceptive implants, result in the greatest satisfaction among users.     |
| <b>Lactogenesis</b>                | Lactogenesis is the initiation or onset of lactation.   |
| <b>Levonorgestrel</b>              | Levonorgestrel is a hormonal medication which is used in a number of birth control methods. As an emergency birth control, sold under the brand name Plan B among others.   |

|   |   |
|---|---|
| <p><b>Long Acting Reversible Contraception (LARC)</b></p> | <p>Long-acting reversible contraceptives are methods of birth control that provide effective contraception for an extended period without requiring user action. They include injections, intrauterine devices and subdermal contraceptive implants. They are the most effective reversible methods of contraception because their efficacy is not reliant on patient compliance. Their 'typical use' failure rates, at less than 1% per year, are about the same as 'perfect use' failure rates.</p> |
| <p><b>Postpartum Period</b></p>                           | <p>A postpartum period begins immediately after the birth of a child as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state. The terms puerperium or puerperal period, or immediate postpartum period are commonly used to refer to the first six weeks following childbirth.</p>  |

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**IMPORTANT INFORMATION ABOUT THIS DOCUMENT**

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan’s contract with Medicare and/or a state’s Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member’s particular benefit plan, including those terms outlined in the member’s Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member’s policy documents, the terms of a member’s benefit plan will always supersede the CPP. The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member’s benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member’s eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan’s policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at [www.wellcare.com](http://www.wellcare.com). Select the “Provider” tab, then “Tools” and then “Payment Guidelines”.

*Care1st Health Plan Arizona, Inc. ~ Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona  
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance  
WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

**RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS**

| Date       | Action  |
|------------|---|
| 10/30/2019 | <ul style="list-style-type: none"> <li>• Approved by RGC</li> </ul> |