

Immediate Postpartum LARC TIP SHEET: Medicaid Billing/Coding & Reimbursement

Did you know?

Medicaid Managed Care Organizations (MCOs) are required under contract to provide the same services as Medicaid fee-for-service (FFS) and must submit the same information to Medicaid.

Billing/Coding Checklist

Before checking to see if your hospital was reimbursed, check to see if the following steps were followed. Please see the Detailed Billing Guidance section, below, for additional information on these steps.

Step	Yes, completed	No, not completed
Hospital documentation before claim:		
Identify the patient's Medicaid/MCO plan and record below:		
Device ordered and documented in medical record		
Device scanned into MAR and documented by nursing		
Device inserted and documented in medical record		
<i>If practitioner not salaried by hospital, then</i>		
<ul style="list-style-type: none"> Appropriate CPT code billed for insertion in addition to delivery charge 		
<ul style="list-style-type: none"> Practitioner's individual National Provider Identification (NPI) used 		
Documentation on claim:		
Completed the appropriate form: <ul style="list-style-type: none"> a) Electronic claim form: 837P b) Paper claim form: <ul style="list-style-type: none"> i. Traditional Medicaid/Medicaid fee-for-service -HFS 2360. ii. MCO - HCFA 1500 		
Used hospital's fee-for-service/facility NPI		
Identified the appropriate National Drug Code (NDC)		
Billed appropriate device J-code		
Included appropriate ICD-10 diagnosis code		
Designated place of service (POS) as "in-patient hospital," POS 21.		

Coding Tables

Use the codes below for IPLARC billing. Select the appropriate code based on whether the patient received an IUD or implant and select the appropriate device NDC number (pharmacist will be able to provide the appropriate number).

CPT Code	Description of what you did		
58300	Insertion of IUD ^a		
11981	Insertion of non-biodegradable drug delivery implant ^a		
HCPCS – J Code	Brand Name	Description	NDC Number
J7296	Kyleena	Levonorel-releasing intrauterine contraceptive, 19.5 mg	5041942401
J7297	Lilleta	Levonorgestrel-releasing intrauterine contraceptive, 52mg, 3yr	00023585801
J7298	Mirena	Levonorgestrel-releasing intrauterine contraceptive, 52mg, 5yr	50419042101 ^b 50419402301
J7300	Paragard	Intrauterine copper contraceptive	51285020401 ^b 51285020402
J7301	Skyla	Levonorgestrel-releasing intrauterine contraceptive, 13.5 mg	50419042201
J7307	Nexplanon	Etonogestrel implant system, including implant and supplies	00052433001 00052027401 ^b
ICD-10 Code	Description of why you did the insertion		
Z30.018	Encounter for initial prescription of intrauterine contraceptive device (IUD) ^c		
Z30.014	Encounter for insertion of intrauterine contraceptive device (IUD) ^c		
Z30.430	Encounter for initial prescription of other contraceptives (IMPLANT)		

^a (If insertion FAILED or is EXPELLED: HFS will pay for the device without a modifier as long as the DOS is not the same. If DOS is the same, bill on paper with notes). Modifiers used by HFS can be found of the [fee schedule page](#).

^b This NDC is inactive/obsolete, per the drug manufacturer, in the system yet remains billable to allow providers use their stock. When Federal CMS deems the NDC terminated then this NDC is no longer billable.

^c Both diagnosis codes are acceptable. Providers should use the code and descriptions that matches the procedures performed.

Identifying the Breakdown in the Billing/Reimbursement Process

After you've confirmed that the appropriate steps for billing and coding were followed, use the following tips to determine what happened to the claim.

1. What should we do first?

- Confirm with your hospital's billing department that the bill for the insertion and device were sent.
- If the cost was different from expected, check the [current practitioner fee schedule](#) based on the date of service or 340B cost + \$35, which lists the reimbursement rates for the devices. The cost of the device is fixed and may fluctuate per the manufacturer's Wholesale Acquisition Cost (WAC). **Use the current CPT codes to find the reimbursement amount from the current fee schedule.**

2. What if it is taking too long to receive reimbursement? If there is a perceived delay in reimbursement, note that the timeframe for reimbursement varies by claim type:

- Paper claim delays: delays have been occurring for about 5-7 months and continue to date. If a paper claim was submitted, resubmit an electronic claim. If billing assistance is needed, connect with a NIPS billing consultant. Keep in mind the 180 day window to file claims with Medicaid.
- Electronic claims are processed quickly but do require monitoring hours via MEDI, the electronic claims system, to minimize the timeline/catch issues early:
 - Payment status is usually available in 72 hours via MEDI
 - Claim status can be verified through MEDI. See [instructions here](#) for checking claim status.
 - If the claim is not found in the system, contact HFS.
- Verify the status of the claim well before 180 days from the date of service and re-file the claim if necessary. (Claims as well as corrected claims must be received by HFS within 180 days of the date of service to be considered by payment).
- If weeks go by and there is no change in claim status, investigation is warranted.

There is a one-time registration process for MEDI, the electronic claims system where providers can check eligibility, submit claims, and check claim status. [Register for MEDI here.](#)

3. Who do we contact with questions?

- The Illinois Department of Healthcare and Family Services (HFS), also referred to as state Medicaid, is the appropriate state agency to contact. In July 2015, HFS released guidance outlining the statewide policy to reimburse for immediate postpartum LARC outside of the delivery DRG. *TIP: Identify the patient's RIN# (Recipient Identification Number) and have it handy when calling HFS to follow-up.*
- If you have a very specific billing related question, email info@ilpqc.org and we will route your question to the appropriate HFS contact.

4. Other helpful tips:

- Look for patterns in claim denials to isolate the problem and expedite reimbursement.
- Use other ILPQC IPLARC teams as a resource to help troubleshoot claims questions. It is likely that another team has experienced a similar situation.

Medicaid MCOs

To bill a Medicaid MCO, follow the same steps as billing for HFS FFS unless otherwise directed by the MCO.

1. MCOs are required to cover the same services as traditional Medicaid. HFS is reminding MCOs of the IPLARC policy and supporting continuous QI with MCOs as needed. If your hospital identifies a specific MCO that is not reimbursing IPLARC after reviewing the steps, please contact their [medical director here](#) and let ILPQC know.
2. Modify your billing system to send in-network claims to the appropriate MCO.
3. The MCOs and HFS use the standard 837P HIPAA guidelines. A different paper form is required (HCFA 1500) for MCOs.
4. MCOs may have stricter edits in place when processing claims than HFS. Therefore, a claim maybe rejected by an MCO although it was billed the same way as it was to HFS. Direct questions to a Medicaid Assistance Consultant and elevate to a manager if needed.

Did you know?

Below are key considerations/nuances of billing that may be helpful in determining reimbursement.

1. Physicians are paid for the insertion and hospitals are paid for the LARC device.
2. Is the provider inserting the LARC a salaried physician of the hospital? If so, you can only bill insertion if the cost of the physician's salary is not included in the hospital cost report.
3. There are different billing procedures for 340B Providers. If the hospital has payment through 340B, they will bill their actual acquisition cost of the LARC + \$35 dispensing fee + UD modifier + procedure code. Hospitals that are not 340B providers are reimbursed the maximum amount on the fee schedule or the provider charge amount, whichever is less..

Detailed Billing Guidance

See detailed steps below for Traditional Medicaid/HFS FFS billing.

1. A practitioner must order the device and document the insertion procedure in the hospital's medical record as well as the practitioner's medical record (there must be evidence of this procedure documented in the hospital's EMR).
2. Practitioners not salaried by the hospital may bill the appropriate **CPT** (common procedural terminology) code for the LARC insertion in addition to their delivery charge using his/her **individual NPI**. Every billing entity (person or facility) has their own NPI. If they are credentialed with the hospital, the billing team must know the NPI. NPIs are searchable using the NPPES NPI Registry.
3. The hospital must use its **fee-for-service/facility NPI** to bill the appropriate device or implant on the HFS 2360 paper claim form OR electronically (preferred) via the 837P claim transaction.
4. The hospital claim must bill the appropriate NDC and procedure code following the guidelines posted in the Chapter 200, Practitioner Handbook, [Appendix A-8, NDC Billing Instructions and coding table on page 1.](#)
5. The NDC is a nationally assigned 11-digit number and a "drug" may have several codes. The hospital should bill for the device using a **J Code** which is a group of drugs administered other than the oral route. All IPLARC devices are billed with **J codes**. The **J code** is often under the umbrella term called a **HCPCS** (Healthcare Common Procedure Coding System "hick-picks") which is a standardized coding system to identify products and supplies.
6. The hospital must include the appropriate **ICD-10** diagnosis code.
7. The **place of service (POS)** should be designated as **in-patient hospital**, 21, on the claim.