

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.

# Make sure the claim for the device and procedure is **pulled out** of the claim for the delivery – submit as a **separate claim**!

# 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.*

|  |  |  |
| --- | --- | --- |
| **Steps** | **Yes, completed** | **No, not completed** |
| Hospital documentation before claim: |  |  |
| Identify the patient’s Medicaid/MCO plan  |  |  |
| Device ordered and documented in medical record |  |  |
| Device scanned into MAR and documented by nursing  |  |  |
| Device inserted and documented in medical record |  |  |
| *If practitioner* ***not*** *salaried by hospital, then* |
| * Appropriate CPT code billed for insertion in addition to delivery charge (this may be done differently by each private provider)
 |  |  |
| * Practitioner’s individual National Provider Identification (NPI) used
 |  |  |
| Documentation on claim: |  |  |
| Completed the appropriate form:1. Electronic claim form: 837P
2. Paper claim form:
	1. Traditional Medicaid fee-for-service -HFS 2360.
	2. 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 CM and PCS 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 (The National Drug Code is set nationally and your pharmacist is very familiar with the NDC numbers).*

# Intrauterine Devices (IUDs)

|  |  |
| --- | --- |
| **CPT Code** | **Description of what you did** |
| 58300 | Insertion of IUDa  |
| **HCPCS – J Code** | **Brand Name** | **Description** | **NDC Number** |
| J7296 | Kyleena | Levonorgestrel-releasing intrauterine contraceptive, 19.5 mg | 5041942401 |
| J7297 | Lilleta | Levonorgestrel-releasing intrauterine contraceptive, 52mg, 3yr | 0002358580152544003554 |
| J7298 | Mirena | Levonorgestrel-releasing intrauterine contraceptive, 52mg, 5yr | 50419042101b 50419402301 |
| J7300 | Paragard | Intrauterine copper contraceptive | 51285020401b 51285020402 |
| J7301 | Skyla | Levonorgestrel-releasing intrauterine contraceptive, 13.5 mg | 50419042201 |
| **ICD-10 CM** | **Description of why you did the insertion** |
| Z30.430  | Encounter for insertion of intrauterine contraceptive device (IUD)c |
| Z30.014 | Encounter for initial prescription of intrauterine contraceptive device (IUD) c  |
| **ICD-10 PCS for INPATIENT HOSPITAL** | Encounter for insertion of an intrauterine contraceptive device  |
| Possible ICD-10 PCS: 0UH97HZ, 0UH98HZ, 0UHC7HZ, or 0UHC8HZ (Use with any of the above IUD J-codes) |

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.*](https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Practitioner.aspx)

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, though more often Z30.430 is the one most accepted by insurers

# Contraceptive Implant

|  |  |
| --- | --- |
| **CPT Code** | **Description of what you did** |
| 11981 | Insertion of non-biodegradable drug delivery implanta |
| **HCPCS – J Code** | **Brand Name** | **Description** | **NDC Number** |
| J7307 | Nexplanon | Etonogestrel implant system, including implant and supplies | 0005243300100052027401b |
| **ICD-10 CM** | **Description of why you did the insertion** |
| Z30.017  | Encounter for initial prescription of implantable subdermal implant |
| **ICD-10 PCS for INPATIENT HOSPITAL**  | Encounter for prescription of implantable subdermal implant (IMPLANT) |
| Possible ICD-10 PCS: 0H8BXZZ, 0H8CXZZ, 0H8DXZZ, 0H8EXZZ, 0JH60HZ, 0JH63HZ, 0JH80HZ, 0JH83HZ, 0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHH3HZ, 0JHL0HZ, 0JHL3HZ, 0JHN0HZ, 0JHN3HZ, 0JHM0HZ, 0JHM3HZ, 0JHP0HZ, or 0JHP3HZ. (Use with J7307) |

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.*](https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Practitioner.aspx)

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.

# Identifying the Breakdown in the Medicaid 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?**
	* Identify a patient who received an immediate postpartum LARC device – have the patient’s RIN handy.
	* Confirm with your hospital’s billing department that the claim for the insertion and device were sent and were *separately* from the delivery bundle.
	* If the claim was sent separately from the delivery bundle, use the checklist above to make sure all required elements were included in the claim – double check the place of service!
	* Use the MEDI system (described below) to track the status and progress of the claim – this is where you’ll need the patient’s RIN!
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

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](https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/GettingStarted.aspx).

* + Claim status can be verified through MEDI. See [instructions here](http://www.ilpqc.org/docs/Claim%20Status%20Inquiry%20HFS.pdf) 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.
1. **What if we are not receiving the appropriate reimbursement rate?**
	* If the cost was different from expected, check the [**current practitioner fee schedule**](https://www.illinois.gov/hfs/SiteCollectionDocuments/52318PractitionerFeeSchedule.pdf) **(**which lists the reimbursement rates for the devices) based on the date of service**.** 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.**
	* Note the date it was last updated.
	* If this does not resolve your issue, reach out to ILPQC and submit a report to this [online portal](https://www.illinois.gov/hfs/medicalproviders/cc/pages/managedcarecomplaints.aspx).
2. **Who do we contact with questions?**
	* The Illinois Department of Healthcare and Family Services (HFS), also referred to as Medicaid, is the appropriate state agency to contact. *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.
3. **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.
	* Keep a log in L&D of devices placed and review with billing/coding team members to ensure reimbursement was received for all devices.
	* Documentation is helpful – you may report issues with Managed Care Organizations to this [online portal](https://www.illinois.gov/hfs/medicalproviders/cc/pages/managedcarecomplaints.aspx).

# 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. All MCOs have *confirmed* they reimburse for IPLARC. If your hospital identifies a specific MCO that is not reimbursing IPLARC after reviewing the steps, please contact their [medical director here](http://iamhp.net/page-18114) and let ILPQC know. You can also submit a claim to the HFS online portal [here](https://www.illinois.gov/hfs/medicalproviders/cc/pages/managedcarecomplaints.aspx).
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. In July 2015, HFS released guidance outlining the statewide policy to reimburse for immediate postpartum LARC outside of the delivery DRG.
2. Physicians are paid for the insertion and hospitals are paid for the LARC device.
3. 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.

# 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 CM and ICD-10 PCS.
7. The place of service (POS) should be designated as **in-patient hospital**, 21,on the claim.