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.

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: a) Electronic claim form: 837P b) Paper claim form: i. Traditional 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 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 IUD[a]		
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	00023585801 52544003554
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
ICD-10 CM	**Description of why you did the insertion**		
Z30.430	Encounter for initial prescription of intrauterine contraceptive device (IUD)[c]		
Z30.014	Encounter for insertion 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.*

[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 implant[a]		
HCPCS – J Code	**Brand Name**	**Description**	**NDC Number**
J7307	Nexplanon	Etonogestrel implant system, including implant and supplies	00052433001 00052027401[b]
ICD-10 CM	**Description of why you did the insertion**		
Z30.017	Encounter for 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.*

[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 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. Note 340B is only for outpatient.**
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. **What if we are not receiving the appropriate reimbursement rate?**
    - Check the HFS fee schedule available here and 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.
4. **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.
5. **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.
    - Documentation is helpful – you may report issues with Managed Care Organizations to this online portal.

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. You can also submit a claim to the HFS online portal here.
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 CM and ICD-10 PCS.
7. The place of service (POS) should be designated as **in-patient hospital**, 21, on the claim.

MCO	Have they reimbursed for IPLARC	Tips for billing	Tips for verifying MCO eligibility before billing	Out-of-network patients	Contact information
BCBSIL	Yes – if billed in alignment with standard practice, the plan will reimburse	No documented differences. BCBS allows the use of all NDCs that are present and valid per DataBank/Medispan	Check MEDI prior to billing or call customer service at 877-860-2837 or submit a 270/270 eligibility validation transaction	Prior authorization required	Customer/provider support services 877-860-2837
CountyCare	Yes – a small number of claims have been submitted and reimbursed	Inpatient claims are billed on a APR-DRG basis; CountyCare utilizes the Medicaid Reimbursement guidance for inpatient billing: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/APL010118.aspx Reference the preferred drug list for NDC guidance: www.countycare.com/pdl	HFS MEDI system; CountyCare offers eligibility look-up via our Member Services call center (312-864-8200) and online look-up via our Provider Portal http://countycare.valancecare.com	Prior authorization required	Specific clinical questions: Andrea McGlynn, Dir of Clinical Services (amcglynn@countycare.com); General Provider Services/Billing: Provider Services team box, ProviderService@CountyCare.com
Harmony	Yes - Harmony pays per contract, typically at 100% of the State fee schedule.	The LARC codes are on the Practitioners Fee schedule and denoted by a "U" in the note column. Specific NDCs are not required The greatest pitfall would be if the provider is not in network.	Eligibility can be verified through MEDI	Refer to an in-network provider or, upon approval, a single case agreement may be executed	Tasha Brown – Director of Provider Relations, (312) 516-4929 or Tasha.Brown1@Wellcare.com
Humana MMAI	Yes, they have processed claims for IPLARC	Use NDCs outlined on HFS website: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150630a.aspx and ensure authorization is on file. *Prior authorization is required.*	These services require prior authorization, so eligibility should be determined through prior authorization	Prior authorization is required	Name: Erin Maday Phone: (502) 302-3619 Email: esmith35@humana.com
IlliniCare	Yes – IlliniCare will pay for IPLARC	No differences - System is modeled after HFS. Providers must submit the claim as a HCFA for separate reimbursement. Common pitfalls in billing include: not billing the item on a HCFA / Not applying the necessary NDC codes for appropriate billing	Utilize MEDI, PLAN Web Portal, and / or call into Provider Services and check eligibility via the phone.	Prior authorization required	Name: Keive Dixon, Director Phone: (866) 329-4701 Email: Keive.J.Dixon@illinicare.com

MCO	Have they reimbursed for IPLARC	Tips for billing	Tips for verifying MCO eligibility before billing	Out-of-network patients	Contact information
Meridian	Yes – they pay for the insertion and the device	Claims are hand-priced using FFS logic to adjudicate. The NDC and HCPC code S4989 is needed. Ensure that the accurate NDC is used	MEDI, Meridian Portal, and our Member Services line 888-437-0606	Prior authorization or single case agreement required	Region 1: Ron Lampert, 312-810-2728, Ron.Lampert@mhplan.com Region 2: Beth Smith, 217-419-8507, Beth.Smith@mhplan.com Region 3: Malissa Vance, 312-705-2900, Malissa.Vance@mhplan.com Region 4-5: Crystal Klier, 312-415-7170, Crystal.Klier@mhplan.com
Molina	Yes, they allow separate reimbursement for hospitals, over DRG for LARC when inpatient	NDCs are required and a missing NDC will result in claim denial. Use FFS NPI when billing. Use form 837P or HCFA and do not include as part of inpatient hospital claim. Place of service is 21. Common pitfalls include using the wring form, wrong NPI, incorrect place of service.	Confirm via MEDI or with Molina directly	Prior authorization required	Phone: 630-200-8504 Email: Michael.manade@molinahealthcare.com
NextLevel	Yes, they have reimbursed for this service	Yes. Make sure to use the correct NDC and diagnosis code. Ensure the patient is eligible. *Prior approval, for both in-network and out-of-network patients, is required.* 1-833-ASK-NLHP (833-275-6547) or by fax at 844-895-2705 or online: https://nextlevelhealthil.com/for-providers/prior-authorizations//	Collect information about the patient's insurance coverage eligibility ahead of the delivery	Prior approval required	Phone: 312.300.5780x959 Email: Tina.Barksdale@nlhpartners.com
AETNA MMAI	Yes	Standard billing methodology required, timely filing of services, appropriate NDC for J-code is required, missing data will cause delays or rejection.	MEDI, or call UM Dept. or Member Services	For urgent admission the plan will review. Claims are not denied because of out-of-network	UM Department 866 212 2851, Selection Option 2, and then select Option 1

BCBS

1. Have they (MCO) reimbursed for IPLARC?
   Pending code list from HFS, no edit would deny these services if billed in alignment with IL Medicaid standard practice.

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful?
   Yes, no documented differences, potentially.
   a. Specific NDCs to use for claims.
      BCBS allows the billing and use of all NDCs that are present and valid per First DataBank/Medispan. This would include all relevant NDCs. BCBS would not direct the use of specific NDCs, as these may not align with the material procured by the hospital.
   b. Typical pitfalls for claims not being processed.
      No typical pitfalls related to IPLARC billing are known.

3. Tips for verifying MCO eligibility before billing.
   We encourage all providers to check MEDI prior to billing. Alternatively, providers may call customer service at 1-877-860-2837 or submit a 270/271 eligibility validation transaction.

4. What to do if the patient's MCO is not in-network with the hospital.
   The provider will need to request prior-authorization as a non-network facility.

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers?
   Phone: Providers may contact our customer/provider services at 1-877-860-2837
   Email:

CountyCare

1. Have they (MCO) reimbursed for IPLARC?
   Yes, on the outpatient side (POS 22 – Outpatient Hospital). Currently few inpatient claims have been receive for LARCs and were reimbursed following the 2015 HFS Provider Guidance: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150630a.aspx

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful?
   Please note that Inpatient claims are billed on a APR-DRG basis; there is a set calculator for inpatient billing per the HFS Medicaid Reimbursement schedule. CountyCare utilizes the Medicaid Reimbursement guidance for inpatient billing: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/APL010118.aspx
   a. Specific NDCs to use for claims. Reference our Preferred Drug List (www.countycare.com/pdl) for the appropriate device.
   b. Typical pitfalls for claims not being processed. There is currently no special reimbursement rules set up for this service. Inpatient claims are paid on an APR-DRG basis, since this isn't a significant procedure it would not receive any additional payment outside of the delivery/postpartum care inpatient billing.

3. Tips for verifying MCO eligibility before billing. HFS MEDI system; CountyCare offers eligibility look-up via our Member Services call center (312-864-8200) and online look-up via our Provider Portal (http://countycare.valancecare.com)

4. What to do if the patient's MCO is not in-network with the hospital. All out of network services must be prior approved by submitting a request to our UM department. More information can be obtained by visiting: www.countycare.com

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers? Specific clinical questions can be sent to Andrea McGlynn, Dir of Clinical Services (amcglynn@countycare.com); more general Provider Services/Billing questions can be sent to our Provider Services team box:
   Phone: CountyCare Provider Services
   Email: ProviderService@CountyCare.com

Harmony

1. Have they (MCO) reimbursed for IPLARC?
   Harmony: Yes. The LARC codes are on the Practitioners Fee schedule and denoted by a "U" in the note column. Harmony pays per contract, typically at 100% of the State fee schedule.

U	A $35.00 dispensing is fee allowed when billed with the "UD" modifier for highly effective birth control methods purchased through the 340B federal Drug Pricing Program.

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful?
   Harmony: Billing should follow the guidelines referenced above using the UD modifier.
   a. Specific NDCs to use for claims. Harmony: Specific NDCs should not be required.
   b. Typical pitfalls for claims not being processed. Harmony: The greatest pitfall would be if the provider is not in network. See answer #3. For FQHCs, the service should be billed separately from the T1015 code.

3. Tips for verifying MCO eligibility before billing. Harmony: Eligibility can be verified through MEDI.

4. What to do if the patient's MCO is not in-network with the hospital. Harmony: If the hospital or provider is not in network with the MCO, the patient may be referred to an in network provider. If that is not a viable option, upon approval, a single case agreement (SCA) may be executed with the non-par provider.

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers? Harmony: Tasha Brown – Director of Provider Relations
   Phone: (312) 516-4929
   Email: Tasha.Brown1@Wellcare.com

IlliniCare

1. Have they (MCO) reimbursed for IPLARC? –
   IlliniCare health does pay the IPLARC codes.

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful?
   Yes; our submission system is modeled after HFS. Providers must submit the claim as a HCFA for separate reimbursement.

   A. Specific NDCs to use for claims –

BUS_UNIT	JCODE	NDC_NBR
IL	J7300	51285020401
IL	J7301	50419042201
IL	J7302	50419042101
IL	J7302	50419042301
IL	J7302	52544003554
IL	J7307	00052027401
IL	J7307	00052433001

   B. Typical pitfalls for claims not being processed. -- Only pitfalls preventing FFS payout of claims would be not billing the item on a HCFA / Not applying the necessary NDC codes for appropriate billing.

3. Tips for verifying MCO eligibility before billing. –
   Providers have a variety of ways to check eligibility before billing. They can either utilize MEDI, PLAN Web Portal, and / or call into Provider Services and check eligibility via the phone.

4. What to do if the patient's MCO is not in-network with the hospital. –
   Prior authorization will have to be obtained for providers not considered in network with PLAN.

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers?

   Name: Keive Dixon, Director
   Phone: (866) 329-4701
   Email: Keive.J.Dixon@illinicare.com

Meridian

1. Have they (MCO) reimbursed for IPLARC?
   Yes, we pay for the insertion and the device.

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful? *These claims are hand-priced using FFS logic to adjudicate.*
   a. Specific NDCs to use for claims. *We need the NDC and the HCPC code s4989 so that we can hand price.*
   b. Typical pitfalls for claims not being processed. *Not having the accurate NDC will not allow us to price it out accurately.*

3. Tips for verifying MCO eligibility before billing.
   Providers can utilize MEDI, Meridian Portal, and our Member Services line 888-437-0606

4. What to do if the patient's MCO is not in-network with the hospital.
   Members can receive services from out of network hospitals with prior authorization and/or single case agreement from Meridian Health Plan

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers?
   Phone:
   Email:

Beth Smith	Crystal Klier	Malissa Vance	Ron Lampert
Beth.Smith@mhplan.com	Crystal.Klier@mhplan.com	Malissa.Vance@mhplan.com	Ron.Lampert@mhplan.com
217-419-8507	312-415-7170	312-705-2900	312-810-2728
Region 2	Region 4-5	Region 3	Region 1

Molina

1. Have they (MCO) reimbursed for IPLARC?
   Yes, we allow separate reimbursement to the hospitals, over the DRG for LARC when the patient is inpatient

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful?
   a. Specific NDCs to use for claims. NDC's are required in order for the claim to be paid. A missing NDC will result in a claim denial. Of the sample reviewed, many used the same NDC's on the provider notice from 2015, however, a few had different NDC's that worked. NDC's are often updated frequently with changes in manufacturers.
   b. Typical pitfalls for claims not being processed.
      - ☐ Claims should be billed on an 837P or a HCFA and should not be included as part of the inpatient hospital claim
      - ☐ Providers are required to use their FFS NPI vs. their hospital/facility NPI as the reimbursement will come from the practitioner fee schedule vs. the DRG calculator/payment methodology
      - ☐ When the patient is inpatient, the place of service that should be on the claim is place of service 21
        - We have many providers who are billing with place of service 22 or 11
        - As a side note, IF the service is being provided in an outpatient setting versus the inpatient setting, all of the same rules apply, however the place of service should be changed from a POS 21 to a POS 11. HFS does not accept POS 22 for these claims.
      - ☐ The majority of denials are related to:
        - The incorrect claim form (UB in error vs. the HCFA/837P)
        - Provider using the wrong NPI (hospital vs. professional/FFS NPI)
        - Provider billing with incorrect place of service (most often billing with POS 22 which is incorrect)
3. Tips for verifying MCO eligibility before billing.
   a. It is important that providers validate MCO eligibility, either through the MCO directly or through MEDI, to confirm which MCO the member is enrolled with on the date of service.

4. What to do if the patient's MCO is not in-network with the hospital.
   a. Non-par services always require a prior authorization
   b. At this time, if billed correctly, claim would pay at 100% of the Medicaid fee schedule

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers?
   Phone: 630-200-8504
   Email: Michael.manade@molinahealthcare.com

NextLevel

1. Have they (MCO) reimbursed for IPLARC?
   NLH has reimbursed for this service.

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they?
   Yes to our understanding

   Can the MCO provide tips for hospitals to be successful?

   (1) hospitals can receive separate reimbursement for the LARC device when provided immediately postpartum in the inpatient hospital setting. (2) Insertion, removal, or removal and reinsertion of a long-acting reversible contraceptive (LARC) is separately reimbursable from an evaluation and management service.

   a. Specific NDCs to use for claims.
      Provider would use same NDC as listed in provider notices issued by the state and depending on the type of services rendered, 51285020401, 50419042201, 50419042301, 50419042101, 52544003554, 00052027401, 00052027201, 00052433001
   b. Typical pitfalls for claims not being processed.
      Not eligible, NDC not listed or Diagnosis incorrect

3. Tips for verifying MCO eligibility before billing.

   Collecting information about a patient's insurance status prior to an appointment can facilitate an understanding of requirements pertaining to the patient's coverage.

4. What to do if the patient's MCO is not in-network with the hospital.
   The hospital whether in network or out of network is required to seek prior approval through contact with the Plan by calling the following number : 1-833-ASK-NLHP (833-275-6547) or by fax at 844-895-2705.

   Additionally the hospital can request prior authorization through use of the Health Plan's provider web portal at https://nextlevelhealthil.com/for-providers/prior-authorizations//

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers?
   The point of contact for hospital providers is Tina Barksdale in Provider Network Services.
   Phone: 312.300.5780x959
   Email: Tina.Barksdale@nlhpartners.com

AETNA MMAI

1. Have they (MCO) reimbursed for IPLARC? *Yes.*

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful?

   - Standard hospital billing methodology is required: rev codes, HCPC, CPT, ICD10, etc.

   - Timely filing of services, obtaining an authorization prior to scheduled services, attachment of IZ for outlier claims or primary EOB when MCO is secondary.

   - provide request medical records to UM department within requested timeframe when requesting authorization for in-patient services.

   a. Specific NDCs to use for claims.

   - *The appropriate NDC for the J code billed is required for drug codes.*

   b. Typical pitfalls for claims not being processed.

   - missing data, member name, ID number, DOS, bill type, HCPC codes, missing APL codes for outpatient claims or missing authorizations for services .

3. Tips for verifying MCO eligibility before billing.
   Verifying member eligibility is done through MEDI, calling the UM Dept. or Member Services. Providers can access the Medi system since this is the state as long as they have the member information.

4. What to do if the patient's MCO is not in-network with the hospital.
   F*or urgent admission, the health plan will review the requested service. We do not deny because they used an out of network provider.*

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers*?*
   Providers can work directly with our Network Account Managers. They can contact the UM Department directly especially when seeking clarification if the service being requested requires prior authorization.

Phone: *UM Department 866 212 2851, Selection Option 2, and then select Option 1*
Email: *We do not use email.*

HUMANA MMAI

1. Have they (MCO) reimbursed for IPLARC?
   Yes, we have processed claims for IPLARC.

2. Is billing for IPLARC to MCOs the same as FFS Medicaid? If there are differences, what are they? Can the MCO provide tips for hospitals to be successful?
   a. Specific NDCs to use for claims.
   NDCs specified on the HFS website, here:
   https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150630a.aspx

NDC	Drug Name	Label Name
50419042101	Mirena	Mirena 20 mcg/24 hr (5 years) intrauterine device
50419042301	Mirena	Mirena 20 mcg/24 hr (5 years) intrauterine device
50419042308	Mirena	Mirena 20 mcg/24 hr (5 years) intrauterine device
50419042201	Skyla	Skyla 14 mcg/24 hour (3 years) intrauterine device
51285020401	ParaGard T 380A	ParaGard T 380A 380 square mm intrauterine device
51285020402	ParaGard T 380A	ParaGard T 380A 380 square mm intrauterine device
00023585801	Liletta	Liletta 19.5 mcg/24 hour (4 years) intrauterine device
52544003554	Liletta	Liletta 19.5 mcg/24 hour (4 years) intrauterine device
50419042401	Kyleena	Kyleena 17.5 mcg/24 hour (5 years) intrauterine device
50419042408	Kyleena	Kyleena 17.5 mcg/24 hour (5 years) intrauterine device
00052433001	Nexplanon	Nexplanon 68 mg subdermal implant

   b. Typical pitfalls for claims not being processed.
   Authorization not on file.

2. Tips for verifying MCO eligibility before billing.
   These services require prior authorization, so eligibility should be determined through the prior authorization process.

4. What to do if the patient's MCO is not in-network with the hospital.
   The hospital will be required to get an authorization for the services.

5. Who is the MCOs point of contact for ILPQC and/or hospitals providers?
   Name: Erin Maday
   Phone: (502) 302-3619
   Email: esmith35@humana.com

Health Plan Responses to Durbin, Duckworth, et. al., request for information re: maternal and infant postpartum care from major insurers

In July 2018, U.S. Senators Dick Durbin (D-IL) and Tammy Duckworth (D-IL), and U.S. Representative Robin Kelly (D-IL-02) today led 23 Senators and 11 U.S. Representatives in requested from 15 major U.S. health insurers information regarding what pregnancy and postpartum health care services are covered by their insurance plans, including IPLARC, in order to better understand what steps they are taking to reduce racial disparities and improve maternal and infant health outcomes.

Health Plan	Response
Molina	No comment on IPLARC
Anthem	*"Seventeen of the 21 Medicaid markets served by Anthem's affiliated health plans have the ability to reimburse for immediate postpartum LARC placement during the postpartum inpatient stay. Anthem provides our consumers and care providers with many different educational pieces about the benefit, including brochures, fliers, and web resources. We also work closely with care facilities to ensure LARC devices are available in the facility setting to aid in postpartum placement should a woman request the benefit."*
Centene (Ambetter)	No comment on IPLARC
BCBSIL	*"We cover contraceptives in all 18 FDA categories and will continue to offer contraceptives in accordance with state and federal law. Contraceptive coverage includes Immediate Postpartum Long Acting Reversible Contraception (LARC), which is unbundled from the delivery bundle of care."* – there is a caveat about variations in contraceptive coverage, for example religious employers, grandfathered plans.
Humana	Response specific to Florida's TANF program
United	No comment on IPLARC