Editorial

»Robert L. Barbieri, MD Editor in Chief

SECOND OF 2 PARTS

Let's increase our use of implants and DMPA and improve contraceptive effectiveness in this country

We do not use long-acting reversible contraceptives in the United States at the rate they are used in Europe, and we have a high unplanned pregnancy rate to show for it. Expanding the patient population to which we prescribe implants and depot medroxyprogesterone acetate could help us in our mission to decrease the number of unplanned pregnancies.

In the United States, approximately 49% of pregnancies are reported to be unplanned. From 1995 to 2008 the rate of unintended pregnancy decreased by 42% in Europe, but did not decrease at all in North America.[1] One factor contributing to the difference: in Europe, long-acting reversible contraceptives (LARCs) are more widely used than in North America. In the United States, increasing the use of LARCs would cause a decrease in the unplanned pregnancy rate.

In this 2-part editorial, I am focusing on the expanding clinical indications of LARCs, including:

- copper intrauterine device (IUD)
- levonorgestrel-releasing intrauterine system (LNG-IUS)
- etonogestrel-releasing implant (Implanon, which is being transitioned to Nexplanon [see "Completing the Nexplanon training process" on page 10])
- depot medroxyprogesterone acetate (DMPA) injection, which is also a highly effective contraceptive method.

In last month's editorial, I focused on the copper IUD and the LNG-IUS. Here, I am focusing on the etonogestrel-releasing implant and DMPA.

Instant Poll

What recommendations do you have for our readers concerning the use of the etonogestrel implant or DMPA injections for contraception?

Tell us—at **robert.barbieri@qhc.com**. Please include your name and city and state.

The implant: appropriate for adolescents, in breastfeeding

CASE 1 A 16-year-old G1P1 has just spontaneously delivered a healthy son. She is immediately returning to high school and is not intending to breastfeed. She asks if she can have an etonogestrel implant placed prior to her discharge.

Would you place an etonogestrel implant in this postpartum adolescent?

Evidence for implant use in adolescents. Inserting an etonogestrel implant *immediately postpartum* can be advantageous for a few reasons:

1. You can be confident that the patient is not pregnant at the time you are inserting the implant.
2. You are reducing the risk of loss of the patient to postpartum follow-up.
3. You are reducing the occurrence of an unintended rapid repeat pregnancy.

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Tip for placing the etonogestrel implant (Hint, sit down!)

In practice, I observe most clinicians placing the etonogestrel implant from a standing position. One complication of insertion is placing the implant too deeply in the arm (for example, placing the implant in the biceps muscle). You can reduce the potential for this complication by sitting down and directly observing implant placement from the side of the patient's upper arm, rather by standing above her arm.

Consider the findings of Tocce and colleagues.[2] In their recently published study, 396 new mothers aged 13 to 24 years were offered either the insertion of an etonogestrel implant prior to their postpartum hospital discharge or the initiation of any contraceptive they selected at a follow-up postpartum visit. A total of 171 mothers selected immediate postpartum insertion of the etonogestrel implant, and 225 mothers chose to initiate contraception at a postpartum visit. Six months following delivery, none of the etonogestrel implant users were pregnant; 9.9% of the patients who were offered postpartum initiation of contraception were pregnant. These data indicate that inserting the etonogestrel implant postpartum may be an especially effective method for preventing rapid repeat pregnancy in adolescents.

Evidence for implant use when breastfeeding. Similar to other progestin-only contraceptives, the etonogestrel implant does not appear to have a clinically significant effect on lactation or on the development of infants who are breastfed. Researchers compared the etonogestrel implant to a non-hormone-medicated IUD and found that neither reduced the volume of breast milk production or altered the concentration of fat, protein, or lactose.[3] In addition, weight gain of the breastfed infants did not differ between groups. Results of this study, and others,[4,5] indicate that the available progestin-only contraceptives do not significantly impact lactogenesis or the development of exclusively breastfed infants.

The implant and obesity: Effectiveness not defined, but not shown to be ineffective

CASE 2 A 65-in, 250-lb (body mass index, 41.7 kg/m^2) woman asks if she can have an etonogestrel implant.

Would you place an etonogestrel implant in this obese woman?

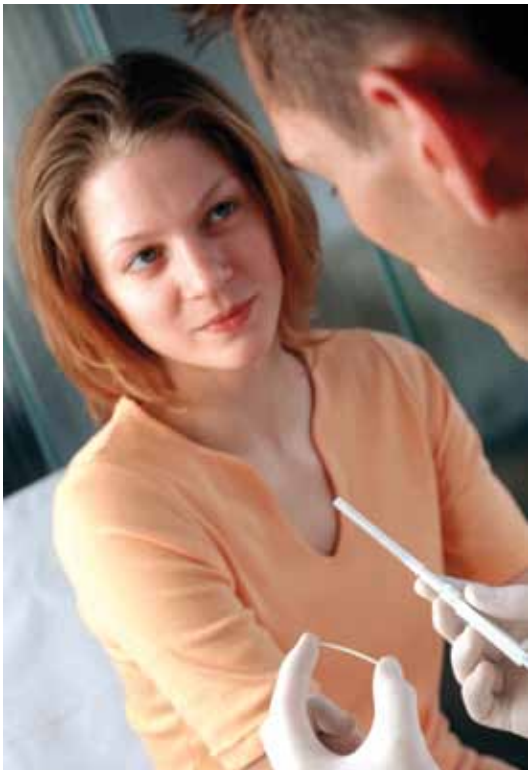

PHOTO: PHANIE / PHOTO RESEARCHERS, INC

Argument for etonogestrel implant use in obesity. The FDA-approved package insert for the etonogestrel implant states, "The effectiveness of the etonogestrel implant in women who weighed more than 130% of their ideal body weight has not been defined because such women were not studied in clinical trials. Serum concentrations of etonogestrel are inversely related to body weight and decrease with time after implant insertion. It is therefore possible that Nexplanon may be less effective in overweight women, especially in the presence of other factors that decrease serum etonogestrel concentrations such as concomitant use of hepatic enzyme inhibitors."[6] Drugs that induce cytochrome P450 3A4 (CYP3A4) increase the metabolic clearance of etonogestrel. CYP3A4 inducers include barbiturates, phenytoin, topiramate, carbamazepine, and St. John's wort.

Completing the Nexplanon training process

The Implanon device is being transitioned to the Nexplanon device. Nexplanon has an improved insertion system, with a safety needle. Unlike Implanon, Nexplanon can be imaged by standard x-ray because it has barium impregnated in the device.

For providers who have previously completed training for the Implanon device, training for the Nexplanon device can be completed online. You can sign up for the Web-based or the in-person clinical training program through Merck's Web portal for Nexplanon (http://www.nexplanon-usa.com/en/hcp/learn-about-it/request-training/index.asp).

Coding for contraceptive implants and DMPA

In the August 2012 issue of OBG Management, I discussed coding and billing for an intrauterine device (IUD). See "Reimbursement for your IUD insertion, and reinsertion, work," on page 45 of "Malpositioned IUDs: When you should intervene (and when you should not)." This month, I continue with coding for other types of long-acting reversible contraceptive methods, namely the under-the-skin contraceptive implant system and contraceptive-strength injections of depot medroxyprogesterone (DMPA).

Etonogestrel-releasing implant

Changes to Current Procedural Terminology (CPT) which were effective January 1, 2012, had an impact on coding for the etonogestrel-releasing implant (Nexplanon). Prior to that date, most payers required the contraceptive insertion code 11975 (*Insertion, implantable contraceptive capsules*). After this date, and with the deletion of CPT code 11975, the insertion is reported with:

- **11981** (*Insertion, non-biodegradable drug delivery implant*)
- linked to the diagnosis code **V25.5** (*Insertion of implantable subdermal contraceptive*).

A caveat. You should be aware, however, that if a patient comes in for removal of Norplant capsules and has a Nexplanon rod inserted at the same encounter, CPT instructions are to report **11976** and **11981**. That means you will submit a claim with 11976 linked to diagnosis code **V25.43** (*Surveillance of previously prescribed contraceptive methods; implantable subdermal contraceptive*) and **11981-51** (*Insertion, non-biodegradable drug delivery implant; multiple procedures*) linked to diagnosis code **V25.5**. As with all multiple procedures, the highest valued code is always listed first to maximize reimbursement.

In-office insertion. When the insertion is performed in the office setting, the relative value is higher due to the increased practice expense and includes the drug supply (**J7307**, *Etonogestrel (contraceptive) implant system, including implant and supplies*). Unless your payer is not reimbursing using relative value units, you should not be coding the implant system separately. Be sure to check payer guidelines to avoid payment delays and possible denials for this supply.

DMPA

When a patient selects an injectable contraceptive instead of the subdermal implant, coding becomes more straightforward. The injection procedure is reported using:

- **96372** (*Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*)
- **J1055** (*Injection, medroxyprogesterone acetate for contraceptive use, 150 mg*).

Note that CPT rules do not allow reporting code 99211 (*Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services*) with the injection code. If a separate significant E/M service is provided at the time of the visit (meaning 99201-99205 for new patient visits, or 99212-99215 for established patient visits), a modifier -25 must be added to the E/M service or the injection procedure will be denied as bundled. The injection code also requires direct physician supervision. If the billing provider is not in the office at the time of the injection and an **RN administers the injection**, code **99211** is billed instead of 96372. Keep in mind, however, that this might mean that some payers will deny the injection procedure under "incident to" rules for ancillary services.

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In a large, prospective observational study of 1,168 women who received the etonogestrel implant, only one pregnancy occurred over 1,377 woman-years.[7] The pregnancy occurred in a woman with a BMI of 30.7 kg/m^2. In this study, the contraceptive failure rate was not significantly different between normal, overweight, and obese women. The cumulative contraceptive failure rate among the obese women was 0.23 per 100 woman-years. By contrast, the contraceptive failure rate among 1,527 women using a contraceptive pill, patch, or vaginal ring was 4.55 per 100 woman-years.[8] Based on results from these and other studies, **I feel comfortable providing etonogestrel implants to overweight and obese women.**

DMPA is safe immediately postpartum

CASE 3 **A 23-year-old G1P1 woman is planning on exclusively breastfeeding her newborn daughter. She has used DMPA successfully in the past and she asks you to prescribe an injection before her hospital discharge.**

Would you prescribe DMPA injections to this breastfeeding woman?

Argument for DMPA use immediately postpartum. The FDA-approved product information for DMPA recommends initiating injections 4 to 6 weeks postpartum regardless of the mother's breastfeeding

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status. The World Health Organization recommends that DMPA not be initiated prior to 6 weeks postpartum in breastfeeding women. The available research suggests, however, that DMPA is safe to administer immediately postpartum because:[9]

- DMPA has no significant effect on the development of breastfed infants
- DMPA has a low risk of maternal complications.

The bottom line. Considering the high rate of unintended pregnancy, it is reasonable to prescribe the woman in case 3 an immediate postpartum DMPA injection and schedule her for appropriate postpartum follow-up.

"Lead, follow, or get out of the way"

In the pivotal year of 1776, Thomas Paine coined the phrase, "Lead, follow, or get out of the way."[10] Among medical specialists, only we ObGyns have the training and passion to lead the charge to wider use of LARCs.

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