Effective Contraceptive Use

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

State Benchmark: 53.9% (2017 CCO 90th percentile)

Who: All female patients aged 15–50-years-old

Why: For women and adolescents between the ages of 15 and 50, reproductive health care is an essential part of their overall health care. For many women, reproductive health concerns are the only reason they seek routine medical care. Almost 50% of pregnancies in Oregon are unintended, and have been so for more than three decades. Among women with an unintended pregnancy, 43% reported using contraception, but they were using it incorrectly or inconsistently. Fifty-two percent reported using no contraception method at all.

What: Evidence of one of the following methods of contraception during the measurement period: sterilization, IUD, implants, contraception injection, contraceptive pills, patch, ring, or diaphragm.

How:

- Discuss contraception or family planning at every visit (consider One Key Question®).
- Create EHR templates that help providers code correctly every time.
- Improve the availability of long acting reversible contraceptives.
- Use telephone visits to surveille contraception for women who may not need an in-person visit every year.

Exclusions: History of a hysterectomy or bilateral oophorectomy, menopause, female infertility, and pregnancy during the measurement year.

Permanent numerator hits: female sterilization anytime throughout the claims history in OHA's system.

Coding: Except for tubal ligations, there must be claims evidence of the contraceptive method every year. A procedure for administering or implanting contraception or a pharmacy fill will satisfy this requirement. Some birth control methods (long acting reversible contraception) last for several years after insertion. These methods **need to be surveilled annually** to be captured in the measure. See the accompanying coding cheat sheet for most common surveillance codes (not an exhaustive list).

Effective Contraceptive Use FAQ

Q: What are workflows we can implement to improve our process?

A: One Key Question® is the recommended approach for pregnancy intention screening in Oregon.

Q: Why are adolescents included in the measure?

A: Ensuring that adolescents have access to contraception is an effective strategy for reducing teen pregnancy. However, OHA acknowledges that not all adolescent females are sexually active, in fact only approximately 40% of female teens have a contraceptive need. This was taken in to account by the OHA when selecting the measure benchmark. The goal is not to prescribe contraceptives to all teens, but rather to ensure that the 40% who have a contraceptive need, have that need met.

Q: What if the woman does not have sex with men, is not sexually active/abstinent, is trying to become pregnant, or has a monogamous partner who had a vasectomy?

A: Unfortunately, these are all limitations of the measure. Because the Effective Contraceptive Use measure is a claims-based measure there is no way to capture these scenarios. In addition, there could be ethical reasons why these circumstances should not be coded on claims. This was taken in to account by the OHA when selecting the measure benchmark.

Q: My patient had a tubal ligation, do I need to code that every year?

A: It depends, if surveilled on a claim prior to 2019, the OHA will count ANY claims history of a tubal ligation or sterilization as a permanent numerator hit unless there is evidence the tubal ligation was reversed. If your patient had a tubal ligation and this is not reflected in your CareOregon member list you have two options:

1) Conduct surveillance and coding of the tubal ligation status during a 2019 visit and drop the appropriate ICD 10 code: Z98.51;
2) Contact your CareOregon QI analyst for instructions on how you can submit chart documentation.

Q: How does a member's pregnancy impact the measure?

A: If member is pregnant during the measurement year, the member is excluded from the denominator. However, if the member has an effective contraceptive method documented after the pregnancy in the measurement year, the member is still excluded from the denominator and is counted in the numerator.

Surveillance Codes for Effective Contraceptive Use

The Effective Contraceptive Use measure looks at women aged 15–50 to determine if they have evidence of an effective contraceptive type during the measurement year. **This measure is based on claims during the calendar year; codes must be submitted on a billable visit to exclude women or count her as having met the measure.** Below are exclusion and numerator diagnosis codes for Effective Contraceptive Use.

Exclusions: Women can be excluded from the denominator if they have evidence of the following diagnoses:

Denominator Exclusion Codes	
Hysterectomy	N99.3, Z90.710, Z90.711
Other reproductive system removal	Z90.722
Natural Menopause	N92.4, N95.0, N95.1, N95.2, N95.8, N95.9, Z78.0
Premature Menopause due to survey, radiation or other factors	E28.310, E28.319, E28.39, E28.8, E28.9, E89.40, E28.9, E89.40, E89.41, N98.1
Congenital Anomalies of female genital organs	Q50.02, Q51.0
Female Infertility	N97.0, N97.1, N97.2, N97.8, N97.9

NOTE: Clinics do not need to document exclusions every measurement year if there is existing Medicaid claims history with evidence of exclusion.

Numerator: Women in the denominator with evidence of one of the following methods of contraception during the measurement period: sterilization, IUD, implant, contraception injection, contraceptive pills, patch, ring, or diaphragm, per the numerator code table below.

Numerator	DX Code
Female Sterilization	Z30.2, Z98.51
Intrauterine Device (IUD)	Z30.014, Z30.430, Z30.431, Z30.433, Z97.5
Hormonal Implant	Z30.016, Z30.017
Injectable	Z30.013
Oral Contraceptive Pills	Z30.011
Patch	Z79.3
Vaginal Ring	Z30.015
Surveillance of a contraceptive method	Z30.41, Z30.42, Z30.44, Z30.45, Z30.46, Z30.49
Unspecified Contraception	Z30.018, Z30.019, Z30.40, Z30.8, Z30.9

Strategies to Improve Rates

The OHA ECU Guidance Document provides a few strategies to improve rates, summarized below:

1. **Screen women for their pregnancy intention on a routine basis.**
    a. Several pregnancy intention screening tools are available for use in clinical and non-clinical settings, with Oregon served as a national leader in this area with the One Key Question® initiative, developed by the Oregon Foundation for Reproductive Health. Click here for more information

2. **Improve Availability and Uptake of long acting reversible contraception (LARCs).**
    a. For clinics that can provide IUDs and implants, it is important to get the care team on board. Effective contraceptive use is not solely the responsibility of the clinician. Administrative and other support staff, health educators, and clinicians all have roles to play in supporting LARC adoption.
        i. Recommended strategies include:
            1. Create a dedicated family planning team or lead staff within the clinic to affect change.
            2. Integrate family planning into staff development initiatives, including new hire orientation.

3. **Create QI process for contraceptive care.**
    a. Quality improvement processes for contraceptive care can be developed at the clinic level. Helping women plan healthy (and avoid mistimed) pregnancies is a core component of primary care.
        i. Clinics can use administrative (claims and encounter) and/or electronic health record (EHR) data to track pregnancy intentions and contraceptive use as a core preventive service in primary care settings, similar to cancer screenings.
        ii. Clinics can ensure providers and clinic staff receive standardized training and develop skills in contraceptive counseling and the provision of contraception services.

4. **Use Telephone Visits to drop surveillance code.**
    a. For organizations who do not implement ECU for the entire calendar or measurement year, a telephone visit is a way to capture information for patients and ensure they have a contraceptive method that works for them.

Telephone Visit Billing

Click here for telephone visit toolkit

Telephone and Telemedicine visits are aimed to increase access and efficiency by utilizing another means for management of chronic diseases. These visits expand the physical reach a care team has with members and reduce or eliminate barriers such as transportation, work time and child care. Below are codes that are reimbursed.

Below are codes that are eligible for payment as telephone calls.

Service by Qualified Healthcare Professional (Link)		Service by Qualified Non-Physician (Link)	
99441	Telephone assessment and mgmt 5-10 min	98966	Telephone assessment and mgmt 5-10 min
99442	Telephone assessment and mgmt 11-20 min	98967	Telephone assessment and mgmt 11-20 min
99443	Telephone assessment and mgmt 21-30 min	98968	Telephone assessment and mgmt 21-30 min
99444	On-line assessment and mgmt	98969	On-line assessment and mgmt

Click the link above for telephone visit toolkit or reach out to Primary Care Innovations Specialist (PCIS), Paula Smith (smithp@careoreon.org) for additional information.

Things to remember when billing:

- Codes are time based and the exact amount of time spent with patient should be documented.
- Phone visit should not originate from a previous visit within the previous seven days nor should it lead to assessment in the next 24 hours.
- Phone call must be patient-initiated or pre-scheduled.
- Visit should involve some medical decision making or care coordination.

What about Private Pay and billing?

Senate Bill 144 requires that health insurance companies cover and pay for a service if a doctor or nurse practitioner offers their care remotely through a secure video conference technology.

Common ECU Surveillance Codes		Common ECU Surveillance Codes
Intrauterine Device (IUD/IUS)	Z30.431	Intrauterine Device (IUD/IUS) Z30.431
Injectable (Depo)	Z30.42	Injectable (Depo) Z30.42
Hormonal Implant (Nexplanon/Implanon)	Z30.46	Hormonal Implant (Nexplanon/Implanon) Z30.46
Oral Contraceptive	Z30.41	Oral Contraceptive Z30.41
Hormonal Patch	Z30.45	Hormonal Patch Z30.45
Hormonal Ring	Z30.44	Hormonal Ring Z30.44
Cervical Cap/Diaphragm	Z30.49	Cervical Cap/Diaphragm Z30.49
Hysterectomy	Z90.710	Hysterectomy Z90.710
Sterilization	Z30.2	Sterilization Z30.2
Tubal Ligation	Z98.51	Tubal Ligation Z98.51
Menopause/Post-menopause (40+)	N95.9	Menopause/Post-menopause (40+) N95.9
Premature Menopause (<40)	E28.319	Premature Menopause (<40) E28.319

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Female Infertility	N97.9	Female Infertility N97.9
Pregnant	Z34.90	Pregnant Z34.90
Other (generic/unspecified)	Z30.49	Other (generic/unspecified) Z30.49

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