April 1, 2025

Nevada Medicaid Web Announcement 3597

Attention Provider Types 11 (Hospital, Inpatient) and 75 (Critical Access Hospital):

Long-Acting Reversible Contraception Devices Services Now Open For Billing

Update to Web Announcement 3587: During the 82nd Nevada Legislative Session (2023), Senate Bill (SB) 280 was passed which carves out Long-Acting Reversible Contraception (LARC) services for provider types 11 (Hospital, Inpatient) and 75 (Critical Access Hospital) from Managed Care Organizations (MCO) and place them under Fee-for-Service (FFS) Medicaid.

Effective March 31, 2025, hospitals under PTs 11 and 75 may begin billing for LARC services outside of the per diem rate using the procedure codes listed below. Claims for LARC services must be billed as an **outpatient** claim by their PT 12 (Hospital, Outpatient) location and may be billed concurrently with an inpatient stay.

Procedure Code	Description	Service Limit	Notes
58300	Insertion of IUD	2 units allowed per day	
58301	Removal of IUD	2 units allowed per day	
11981	Insertion of a drug delivery implant	2 units allowed per 3 rolling years	Prior authorization (PA) is required to exceed the service limitation
11982	Removal, non-biodegradable drug delivery implant	2 units allowed per day	
11983	Removal and reinsertion of a non-biodegradable drug delivery implant	2 units allowed per 3 rolling years	PA is required to exceed the service limitation
J7296	Kyleena, 19.5 MG - IUD	N/A	Claims must be submitted with the associated National Drug Code (NDC)
J7297	Liletta, 52 MG - IUD	N/A	Claims must be submitted with the associated NDC
J7298	Mirena, 52 MG - IUD	N/A	Claims must be submitted with the associated NDC
J7300	Intrauterine Copper Contraceptive	N/A	Claims must be submitted with the associated NDC
J7301	Skyla, 13.5 MG - IUD	N/A	Claims must be submitted with the associated NDC
J7307	Etonogestrel Implant System	N/A	Claims must be submitted with the associated NDC

Claims submitted by PT 11 and 75 for the procedure codes above with dates of service on or after January 1, 2024, that denied with error code 4801 (No billing rule for procedure) or 757 (Provider not allowed to bill PAD) will be reprocessed automatically. Results of the reprocessed claims will appear on a future remittance advice.

When claims are reprocessed, please be aware that all system and clinical claim editor edits are applicable. As a result, there may be no additional payment, and other claim denials may be received. Providers have the right to appeal denied claims, including those denied upon reprocessing. Please refer to Medicaid Services Manual Chapter 100 and the Billing Manual for information concerning the claim appeal process and time frames.