FAMILY PLANNING

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider’s National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid.

South Dakota Medicaid uses a streamlined enrollment process for ordering, referring, and attending physicians that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement. Providers acting as a locum tenen provider must enroll in South Dakota Medicaid and be listed on the claim form.

Family planning services may be provided by the following providers:
- Ambulatory surgical centers
- Anesthesiologists and CRNAs
- Clinical nurse specialists
- Federally qualified health centers (FQHCs)
- Health department clinics
- Indian Health Services facilities (IHS)
- Laboratories
- Nurse midwives
- Nurse practitioners
- Outpatient and inpatient hospital departments
- Pharmacists
- Physician assistants
- Physicians
- Rural health clinics (RHCs)
- Tribal 638 facilities

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient’s Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid’s online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitation described in this chapter:

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Coverage Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/CHIP Full Coverage</td>
<td>Medically necessary services covered in accordance with the limitations described in this chapter.</td>
</tr>
<tr>
<td>Medicaid – Pregnancy Related Postpartum Care Only (47)</td>
<td>Coverage restricted to family planning and postpartum care only.</td>
</tr>
<tr>
<td>Medicaid – Pregnancy Related Coverage Only (77)</td>
<td>Coverage restricted to pregnancy related services only including issues that can harm the life of the mother or baby.</td>
</tr>
<tr>
<td>Unborn Children Prenatal Care Program (79)</td>
<td>Coverage restricted to pregnancy related services</td>
</tr>
</tbody>
</table>
only including issues that can harm the life of the mother or baby.

Refer to the Recipient Eligibility Chapter for additional information regarding eligibility including information regarding limited coverage aid categories.

**Covered Services and Limits**

South Dakota Medicaid covers the following family planning services for recipients of child bearing age:

- Initial and annual physical examination for reproductive health/family planning purposes;
- Necessary family planning/reproductive health-related laboratory procedures and diagnostic tests;
- Contraceptive management including drugs and supplies;
- Insertion, implant or injection of contraceptive drugs or devices;
- Sterilization service with a properly completed sterilization form; and
- Related family planning counseling under the supervision of a physician or other licensed practitioner.

**Long Acting Reversible Contraceptive (LARC)**

South Dakota Medicaid covers one insertion of LARC every 18 months. Prior to insertion of LARC the provider must counsel the recipient about the side effects and long-term nature of LARC. Additionally, providers must counsel the recipient about LARC side effect treatment options prior to removal of LARC. Counseling is not required for emergency removal of LARC due to a medical condition.

South Dakota Medicaid reimburses a hospital in an inpatient setting for the cost of the device when placed immediately after delivery or prior to discharge from the hospital, as appropriate.

**Sterilization**

Refer to the Sterilization chapter for information regarding sterilization coverage.

**Non-Covered Services**

The following services are not covered by South Dakota Medicaid:

- Agents to promote fertility;
- Procedures to reverse a previous sterilization;
- Fertility counseling;
- Artificial insemination; and
- Genetic counseling and lab services.

**Documentation Requirements**

**Record Retention**

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Records must not be destroyed when an audit or
investigation is pending. Providers must grant access to these records to agencies involved in a Medicaid review or investigation.

**Required Medical Records**

Per [ARSD 67:16:01:08](#) health services that are not documented are not covered. A provider must maintain a medical record on each recipient which discloses the extent of services furnished. Each page of the record must name or otherwise identify the recipient and each entry in the record must be signed and dated by the individual providing the care. If care is provided by one individual who is working under the supervision of another who is a participating provider, the supervising individual must countersign each entry. If the care is provided in an institution by one of its employees, the entry need not be countersigned unless the institutional provider is responsible for monitoring the provision of such health care. The individual's medical record must include the following additional items as applicable:

- Diagnoses, assessments, or evaluations;
- Case history and results of examinations;
- Plan of treatment or patient care plan;
- Quantities and dosages of drugs prescribed or administered;
- Results of diagnostic tests and examinations;
- Progress notes detailing the recipient's treatment responses, changes in treatment, and changes in diagnosis;
- Copies of any consultation reports;
- Dates of hospitalization relating to the services provided; and
- A copy of the summary of surgical procedures billed to the medical services program.

**LARC Documentation**

Providers must document that the recipient was counseled regarding the side effects and long term nature of LARC prior to insertion. Additionally, providers must document that the recipient was counseled about LARC side effect treatment options prior to removal of LARC. Counseling is not required for emergency removal of LARC due to a medical condition.

**Reimbursement and Claim Instructions**

**Timely Filing**

South Dakota Medicaid must receive a provider’s completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid if one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
• The claim is received within 3 months after a previously denied claim;
• The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
• To correct an error made by the department.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. There are a few exceptions to this rule, such as services provided by Indian Health Services.

Providers must pursue the availability of third-party payment sources. Third-party liability (TPL) is the legal obligation of a third party to pay for all or part of a recipient’s medical cost. Third-party payers include private health insurance, worker’s compensation, disability insurance, and automobile insurance. Medicare is primary to South Dakota Medicaid and must be billed first. Any balance after Medicare payment should be billed to other TPL payers prior to billing Medicaid.

Providers should use the Medicare Crossover billing instructions if the recipient has Medicare coverage and the Third-Party Liability billing instructions for all other instances of third party liability.

Reimbursement
A claim must be submitted at a provider’s usual and customary charge. The reimbursement methodology varies by provider type. Please refer to the provider manual for your provider type for additional information.

FQHC/RHC LARC Reimbursement
South Dakota Medicaid reimburses FQHCs/RHCs according to the Physician fee schedule for codes J7297, J7298, J7300, and J7307 in addition to the received per diem rate. Facilities must bill the appropriate HCPCS code with the associated NDC.

Hospital LARC Reimbursement
South Dakota Medicaid reimburses a hospital in an inpatient setting for the cost of the device when placed immediately after delivery or prior to discharge from the hospital, as appropriate.

LARC is reimbursed a fee according to the Physician fee schedule. The reimbursement is in addition to the DRG. Hospitals must bill on paper with the following ICD10 surgical codes and HCPCS code. The HCPC must be listed next to revenue code 636.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPC</th>
<th>Surgical Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>636</td>
<td>J7307</td>
<td>0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHL0HZ, 0JHL3HZ, 0JHM0HZ, 0JHM3HZ, 0JHN0HZ</td>
</tr>
<tr>
<td>636</td>
<td>J7297 – J7301</td>
<td>0UHC7HZ and 0UH97HZ</td>
</tr>
</tbody>
</table>

Claim Instructions
The following covered family planning services and NDC codes must be billed on the pharmacy claim form.

<table>
<thead>
<tr>
<th>Service</th>
<th>NDC Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diaphragm</td>
<td>02510002001 EA</td>
</tr>
<tr>
<td>Foam – Cream Jellies</td>
<td>02510003001 EA</td>
</tr>
<tr>
<td>Male Condoms</td>
<td>02510004001 EA</td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td>02510005001 EA</td>
</tr>
<tr>
<td>Suppositories</td>
<td>02510006001 EA</td>
</tr>
<tr>
<td>Sponges</td>
<td>02510008001 EA</td>
</tr>
<tr>
<td>Thermometer – Basal</td>
<td>02510009001 EA</td>
</tr>
<tr>
<td>Depo-Provera</td>
<td>02510010001 per ML</td>
</tr>
<tr>
<td>Vaginal Contraceptive Film</td>
<td>02510011001 EA</td>
</tr>
<tr>
<td>Female Condom</td>
<td>02510012001 EA</td>
</tr>
<tr>
<td>Lunelle</td>
<td>02510013001 Vial</td>
</tr>
<tr>
<td>Ortho Evra</td>
<td>02510014001 EA</td>
</tr>
<tr>
<td>Nuvaring</td>
<td>02510015001 EA</td>
</tr>
<tr>
<td>Seasonale</td>
<td>02510016001 EA</td>
</tr>
</tbody>
</table>

When billing South Dakota Medicaid for family planning contraceptives, use only the NDC codes listed above.

The following services must be billed on the CMS 1500 claim form.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD – Copper</td>
<td>J7300</td>
</tr>
<tr>
<td>IUD – Progestacert</td>
<td>S4989</td>
</tr>
<tr>
<td>IUD – Insertion</td>
<td>58300</td>
</tr>
<tr>
<td>IUD - Removal</td>
<td>58301</td>
</tr>
<tr>
<td>Norplant Kit</td>
<td>J7306</td>
</tr>
<tr>
<td>Removal Norplant</td>
<td>11976</td>
</tr>
</tbody>
</table>

If provided for a family planning service, the following procedure codes, , must be indicated on the claim form in block 24-H with an “F”.

99201 Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are minor

99202 Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of low to moderate severity
99203 Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate severity

99204 Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate to high severity

99205 Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate to high severity

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician, presenting problems are minimal

99212 Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are self limited or minor

99213 Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of low to moderate severity

99214 Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of moderate to high severity

99215 Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of moderate to high severity

99221 Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of low severity

99222 Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of moderate severity

99223 Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of high severity

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, requires three components; patient is stable, recovering, or improving

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, requires three components; patient is responding inadequately to therapy or has developed a minor complication
99233 Subsequent hospital care, per day, for the evaluation and management of a patient, requires two key components; patient is unstable or has developed a significant complication or a significant new problem

99238 Hospital discharge day management; 30 minutes or less

99239 Hospital discharge day management; more than 30 minutes

99241 Office consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor

99242 Office consultation for a new or established patient, which requires three key components, presenting problems are of low severity

99243 Office consultation for a new or established patient, requires three key components, presenting problems are of moderate severity

99244 Office consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity

99251 Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor

99252 Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of low severity

99253 Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate severity

99254 Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity

99255 Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity

99360 Physician standby service, requiring prolonged physician attendance, each 30 minutes

99384 Initial comprehensive preventive visit, new patient, age 12-17 years

99385 Initial comprehensive preventive visit, new patient, age 18-39 years

99386 Initial comprehensive preventive visit, new patient, age 40-64 years

99394 Periodic comprehensive preventive visit, established patient, age 12-17 years
**DEFINITIONS**

1. **Family planning services** — medically approved services and supplies which are available for individuals of childbearing age for the purpose of providing freedom of choice to determine, in advance, the number and spacing of children.

**REFERENCES**

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

**FREQUENTLY ASKED QUESTIONS**

1. If a recipient has Medicare and Medicaid coverage and Medicare denies the claim for contraceptive services as not medically necessary, will South Dakota Medicaid pay for the contraceptive service?

   Yes, if the recipient meets the eligibility requirements and the service is covered by South Dakota Medicaid.

2. Does South Dakota Medicaid cover removal of LARC?

   Yes, per 42 CFR 441.20 recipients must be free to choose their method of family planning to be used. Prior to insertion of LARC the provider must counsel the recipient about the side effects and long-term nature of LARC. Additionally, providers must counsel the recipient about LARC side effect treatment options prior to removal of LARC. Counseling is not required for emergency removal of LARC due to a medical condition. Recipients do not have to start a new form of contraception to have a LARC removed. Only one insertion of LARC is covered every 18 months.