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. Servicing providers acting as a locum tenen provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirement.

South Dakota Medicaid has 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.

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
- Pharmacies
- 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>
</tbody>
</table>
Medicaid – Pregnancy Related Postpartum Care Only (47) Coverage restricted to family planning and postpartum care only.

Medicaid – Pregnancy Related Coverage Only (77) Coverage restricted to pregnancy related services only including issues that can harm the life of the mother or baby.

Unborn Children Prenatal Care Program (79) Coverage restricted to pregnancy related services 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**

**General Coverage Principles**
Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

**Family Planning Covered Services**
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

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-Covered Family Planning 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

General Requirements
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. Please refer to the Documentation and Record Keeping manual for additional requirements.

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 in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment.
sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

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, 0JHH3HZ, 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>
</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>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>

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99244</td>
<td>Office consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity</td>
</tr>
<tr>
<td>99251</td>
<td>Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor</td>
</tr>
<tr>
<td>99252</td>
<td>Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of low severity</td>
</tr>
<tr>
<td>99253</td>
<td>Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate severity</td>
</tr>
<tr>
<td>99254</td>
<td>Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity</td>
</tr>
<tr>
<td>99255</td>
<td>Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity</td>
</tr>
<tr>
<td>99360</td>
<td>Physician standby service, requiring prolonged physician attendance, each 30 minutes</td>
</tr>
<tr>
<td>99384</td>
<td>Initial comprehensive preventive visit, new patient, age 12-17 years</td>
</tr>
<tr>
<td>99385</td>
<td>Initial comprehensive preventive visit, new patient, age 18-39 years</td>
</tr>
<tr>
<td>99386</td>
<td>Initial comprehensive preventive visit, new patient, age 40-64 years</td>
</tr>
<tr>
<td>99394</td>
<td>Periodic comprehensive preventive visit, established patient, age 12-17 years</td>
</tr>
<tr>
<td>99395</td>
<td>Periodic comprehensive preventive visit, established patient, age 18-39 years</td>
</tr>
<tr>
<td>99396</td>
<td>Periodic comprehensive preventive visit, established patient, age 40-64 years</td>
</tr>
</tbody>
</table>

**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
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.