

FAMILY PLANNING AND STERILIZATION SERVICES

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 tenens 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 requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers 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 and sterilization 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:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.

Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copays, coinsurance, and deductibles for Medicare Part A and Part B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to family planning services provided immediately following the delivery. Sterilization is only covered as part of a bundle when billed with the global delivery codes.

Refer to the [Recipient Eligibility](#) manual 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 childbearing 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 and signed [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.

Pharmacy Coverage

Refer to the [Pharmacy Services](#) manual for information regarding pharmacy coverage and limits.

STERILIZATION

Sterilization services are only covered if:

- The individual is at least 21 years old at the time consent is obtained;
- The individual is not a mentally incompetent individual;
- The individual has voluntarily given informed consent completed in compliance with federal regulation [42 CFR 441, Subpart F](#) .
- The completed and accurate Consent for Sterilization is submitted with the claim.
- The timeframe requirements in the table below are met.

Consent Form Timeframe Requirements

The Consent for Sterilization form must be completed within the timeframes described below. Consent must be obtained according to the general requirement unless one of the exceptions is met.

Type	Timeline
General Requirement	At least 30 days but not more than 180 days must pass between the date the informed consent was signed and the date of the sterilization.
Exception 1: Premature delivery (meaning before 37 weeks of pregnancy have been completed)	The consent form must be signed by the individual to be sterilized at least 30 days prior to expected delivery date. If premature delivery happens prior to the 30 days, at least 72 hours need to pass from the time the recipient gave informed consent for sterilization. The expected delivery date is required to be listed on the form. An individual cannot be in active labor when signing the consent form.
Exception 2: The sterilization is performed during an emergency abdominal surgery	The consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization. The physician must describe the surgery and document the medical necessity of the emergency abdominal surgery. An emergency cesarean section is not applicable for this exception.

Informed Consent Requirements

Informed consent requires the following elements:

- The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the individual to be sterilized:
 - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
 - A description of available alternative methods of family planning and birth control.
 - Advice that the sterilization procedure is considered to be irreversible.
 - A thorough explanation of the specific sterilization procedure to be performed.
 - A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

- A full description of the benefits or advantages that may be expected as a result of the sterilization.
 - Advice that the sterilization will not be performed for at least 30 days, except under the exceptions stated in this manual.
-
- Suitable arrangements must be made to ensure that the information above was effectively communicated to any individual who is blind, deaf, or otherwise handicapped.
 - An interpreter must be provided if the individual to be sterilized does not understand the language used on the consent form or the language used by the person obtaining consent.
 - The individual to be sterilized must be permitted to have a witness of his or her choice present when consent was obtained.
 - The consent form requirements in this manual must be met.

Informed consent may not be obtained while the individual is:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the individual's state of awareness.

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.

Family Planning Non-Covered Services

The following family planning 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.

Sterilization Non-Covered Services

The following sterilization services are not covered by South Dakota Medicaid:

- Sterilization of a mentally incompetent individual;
- Sterilization of an institutionalized individual;
- Sterilization of an individual who has not reached his or her 21st birthday when the sterilization consent form is signed;
- Sterilization is done via hysterectomy solely for the purpose of rendering an individual permanently incapable of reproducing;
- Sterilization is done via hysterectomy and there was more than one purpose for the procedure, but it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing;

- Sterilization when the consent form is not completed, is not accurate, is not signed, or is not legible;
- Sterilization when the consent form was not signed 30 days or more prior to the surgery, unless it qualifies for one of the stated exceptions;
- Sterilization when the consent form was signed more than 180 days prior to surgery;
- Sterilization when the name of the sterilization type listed on the Statement of Person Obtaining Consent section does not match the sterilization type listed on the Physician's Statement section of the sterilization form; or
- Procedures to reverse a previous sterilization.

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.

Sterilization Consent Form

The Consent for Sterilization form must be maintained as part of the medical records.

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.

FQHCs, RHCs, and IHS LARC Reimbursement

Refer to the [FQHC and RHC Services](#) and the [IHS and Tribal 638 Facilities](#) manuals regarding LARC reimbursement for these provider types.

Inpatient Hospital LARC Reimbursement

South Dakota Medicaid covers and separately reimburses an inpatient hospital for LARC when placed immediately after delivery or prior to discharge from the hospital as appropriate.

The maximum allowable reimbursement rate for LARC is limited to the amount on the Physician Services [fee schedule](#). The reimbursement is in addition to the DRG payment. Hospitals must submit a paper UB-04 claim to:

Department of Social Services
Division of Medical Services
Attn: Claims Specialist
700 Governors Drive
Pierre, SD 57501-2291

The claim must include the ICD-10 surgical codes and HCPCS code in the table below and be sent to the attention of the Claims Specialist. The HCPC must be listed next to revenue code 636. The individual provider can bill separately for the insertion of the device as the hospital will be reimbursed for the device.

For non-DRG hospitals, the LARC needs to be a line item on the claim and the appropriate LARC HCPC rate needs to be included in the total charges.

Revenue Code	HCPC	ICD-10 Surgical Codes
636	J7306 - J7307	0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHH3HZ, 0JHL0HZ, 0JHL3HZ, 0JHM0HZ, 0JHM3HZ, 0JHN0HZ
636	J7296– J7301	0UHC7HZ and 0UH97HZ

Claim Instructions

Billing instructions vary by provider type. Please refer to the provider manual section for your provider type for additional information.

LARC Claim Instructions

Claims for LARC services must be submitted on the CMS 1500 claim form or on an 837P and include the appropriate NDC. Detailed CMS 1500 claim form instructions are available on the Medicaid Billing Manual website. Refer to the 837P instructions for electronic claims.

Professional Services Claim Instructions

If family planning professional services are provided (education and counseling in the method of contraception desired or currently in use by the individual, a medical visit to change the method of contraception) the provider must indicate this on the claim form by listing “F” in block 24-H. An “F” may be listed in block 24-H for the following procedure codes:

Service Type	Codes
EM Office Visits	99202 - 99215
EM Initial and Subsequent Hospital Care	99221, 99222, 99223, 99231, 99232, 99233,
EM Hospital Discharge Services	99238, 99239
EM Consultation Services	99242, 99243, 99244, 99251, 99252, 99253, 99254, 99255
Extended Physician Standby Services	99360
Preventative Visits	99384, 99385, 99386, 99394, 99395, 99396

Sterilization Claim Instructions

The completed sterilization consent form must be attached to all sterilization claims submitted to South Dakota Medicaid. South Dakota Medicaid will deny payment to physicians, hospitals, surgical-clinics, anesthesiologists, anesthesiologists, or any provider billing for services involving sterilization unless the Consent Form for Sterilization is completed and submitted with the claim.

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.
2. “Institutionalized Individual,” an individual who is:
 - a. involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or
 - b. confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
3. “Mentally incompetent individual,” an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
4. “Sterilization,” any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
 - [ARSD 67:16:02:04](#)
 - [ARSD 67:16:02:09](#)
 - [ARSD 67:16:03:02](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

- 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.

- 3. Will South Dakota Medicaid still pay for a delivery if a sterilization submitted on the same claim is denied?**

Yes, resubmit the claim without the sterilization procedure if you do not have a valid consent form or the sterilization is otherwise not covered. If the sterilization was denied due to missing consent form and a valid consent form had been completed, resubmit the claim with the consent form.

- 4. Is sterilization covered under retroactive Medicaid coverage for the date of service?**

Yes, if the coverage requirements of this chapter were satisfied including the informed consent requirements.

5. Under what circumstances is there an exception to the 30-day informed consent requirement for sterilization?

In the event of premature delivery (before 37 gestational weeks), the consent form must be signed by the individual to be sterilized at least 30 days prior to the expected delivery date and at least 72 hours prior to the sterilization. The date of the expected delivery must be written on the consent form. This exception does not apply to a scheduled delivery that occurs less than 30 days after the form was signed.

In the event the sterilization is performed during an emergency abdominal surgery the consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization. The physician must describe the surgery and explain the medical necessity of the emergency abdominal surgery.

There are no exceptions to the 72-hour rule.

6. Is a sterilization covered for a woman eligible for under the Unborn Children Prenatal Care Program, aid category 79 coverage group?

Sterilization is only covered as part of a bundle when billed with the global delivery codes. Standard coverage requirements apply.

7. Can errors on the original Sterilization Consent Form be corrected?

Corrections to fields may be made with a strike through the original text (do not use white-out or correction fluid) and the correction must be dated and initialed by the signer of the field section. The recipient's signature or date of signature may not be corrected.