

## Family Planning Services

### PURPOSE

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Family planning services consist of health services or supplies for the voluntary planning of conception and pregnancy for individuals of childbearing age.

### APPLICABILITY

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#### ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll in ND Medicaid and be listed on the claim form. Please refer to [provider enrollment](#) for additional details on enrollment eligibility and supporting documentation requirements

The family planning services can be provided by the following enrolled providers as allowed by their scope of licensure:

- Ambulatory surgical centers
- Anesthesiologists and CRNAs
- Clinical Nurse Specialists
- Federally Qualified Health Centers (FQHC)
- Indian Health Service facilities (IHS)
- Laboratories
- Local Public Health Units
- Nurse Midwives
- Nurse Practitioners
- Outpatient and inpatient hospital departments
- Pharmacies
- Physician Assistants
- Physicians
- Rural Health Clinics (RHCs)
- Tribal 638 facilities

#### ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the [ND Medicaid MMIS Portal](#) or through the Automated Voice Response System by dialing 1.877.328.7098.

Refer to the Member Eligibility manual for additional information regarding eligibility including information regarding limited coverage categories.

## **COVERED SERVICES AND LIMITS**

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### **GENERAL PROVIDER POLICIES**

The [General Provider Policies](#) details basic coverage requirements for all services.

Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

Medicaid covers family planning services and supplies for members of childbearing age, including minors. Members must be free of coercion or mental pressure, free to choose the method of family planning they will use and must have full knowledge of the service and consent to it freely. The provider may not require that an unmarried minor's parent or guardian consent to family planning services for the minor.

The following family planning services and supplies are covered with an order or prescription from an enrolled Physician or Other Licensed Provider(OLP):

- Contraceptive counseling;
- Hormonal methods (pills, patches, rings and injectables);
- Emergency contraceptives;
- Long-acting reversible contraception (LARCs)
- Distribution of information and patient education;
- Consultation, examination, and medical treatment;
- Genetic counseling;
- Laboratory examinations and tests; and
- Elective sterilization. Refer to the [Sterilization and Hysterectomy](#) policy for complete coverage details and requirements.

## **SERVICE AUTHORIZATION REQUIREMENTS**

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No service authorization is required.

## **NON-COVERED SERVICES**

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### **GENERAL NON-COVERED SERVICES**

The [Noncovered Services Policy](#) contains a general list of services that are not covered by North Dakota Medicaid.

Non-covered family planning services include:

- Fertility preservation for iatrogenic infertility, such as cryopreservation of eggs, embryos, sperm, or ovarian/testicular tissue, and other procedures like radiation shielding and ovarian transposition
- Hysterectomy for the purpose of sterilization
- Reversal of a previous sterilization
- Treatment related to infertility

## **DOCUMENTATION REQUIREMENTS**

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### **GENERAL REQUIREMENTS**

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the [Provider Requirements Policy](#).

## **REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS**

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### **TIMELY FILING**

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The [Timely Filing Policy](#) contains additional information.

### **THIRD-PARTY LIABILITY**

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The [Third Party Liability Policy](#) contains additional information.

## **CLIENT SHARE (RECIPIENT LIABILITY)**

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The [Client Share Policy](#) contains additional information.

## **REIMBURSEMENT**

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

Long-Acting Reversible Contraceptives (LARCs) will be reimbursed outside of a DRG payment to in-state Prospective Payment System (PPS) hospitals when the device is inserted prior to discharge from the delivery stay.

- The hospital must bill the LARC device on an Outpatient claim with type of bill (TOB) 0131.
- Report revenue code 0636 with one of the following HCPCS codes and their associated National Drug Code (NDC);
  - J7296
  - J7297
  - J7300
  - J7301
  - J7307
- The date of service on the claim must be the date the LARC was placed.
- Payment for the device will be reimbursed at the lesser of the published fee schedule amount or NDC pricing.
- The facility charges related to the insertion of the device are part of the DRG payment.
- Do not include the charges for the LARC device on the inpatient claim.

## **CLAIM FORM**

Professional Family Planning services must be billed using the CMS 1500 claim form or 837p. Institutional, FQHC, and RHC Family Planning services must be billed using the CMS UB-04 claim form or 837p. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual [webpage](#).

## CLAIM REQUIREMENTS

Physician-administered drugs, laboratory tests, and diagnostic imaging performed during a family planning visit require the ordering, referring, or prescribing providers' National Provider Identifier (NPI) to be submitted on the claim.

## DEFINITIONS

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*Family planning* – encompassing services and supplies to prevent or delay pregnancy, including contraception, sterilization, and related medical diagnosis and treatment

## REFERENCES

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- [North Dakota Administrative Code](#)
- [North Dakota Century Code](#)
- [Code of Federal Regulations](#)

## RELATED POLICIES

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- [Physician Administered Drugs](#)
- [Professional Medical and Surgical Services](#)
- [Sterilization and Hysterectomy](#)

## FREQUENTLY ASKED QUESTIONS

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Q: Does Medicaid cover the removal of a LARC?

A: Yes, per [42 CFR 441.20](#), recipients must be free to choose their method of family planning to be used. Recipients do not have to start a new form of contraception to have a LARC removed.

## POLICY UPDATES

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July 2025

Section	Summary
	Format updates and clarifications added throughout