OBSTETRICAL 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.

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

- Physicians;
- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists; and
- Nurse midwives.

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 limitations 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.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

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.

Initial Prenatal Visit Reporting
Providers are encouraged to report the initial prenatal visit as it will allow Medicaid and the Department of Health to provide additional educational materials and case management services if necessary to pregnant women. South Dakota Medicaid reimburses the reporting of the initial prenatal visit for pregnant recipients when billed by an eligible provider. Reporting should be billed to Medicaid within 15 days of the initial prenatal visit using CPT code 0500F. As an exception, if the recipient was ineligible for Medicaid on the date of the initial prenatal visit, but coverage is later backdated to include the date of service, 0500F can also be billed. In this scenario, it should be billed prior to delivery. The code is reimbursable once per pregnancy. Providers should include any other services rendered on that date of service on the claim as usual.

For FQHC, RHC, or IHS the code should be listed on the encounter claim and it will be reimbursed at the fee-for-service rate in addition to the encounter.

Billing Flexibilities in Advance of CPT Code Changes
Global obstetric codes remain valid for dates of service through December 31, 2026. However, because some patients will have episodes of care that span the transition into 2027, South Dakota Medicaid is providing flexibility for providers who choose to begin reporting services individually before the sunset of global codes.

Providers may elect to bill obstetrical services individually before January 1, 2027, rather than using global obstetric codes. The following service-level billing is allowed for dates of service through December 31, 2026:

Service	Billing Flexibility
Antepartum Care	• May be billed per encounter using the appropriate E/M procedure codes (CPT 99202–99499). • All claims must include pregnancy-related ICD-10-CM diagnosis codes. • The TH modifier should be applied when billing EM codes for prenatal care.
Labor and Delivery	• May be billed per delivery using the current delivery-only codes (CPT 59409, 59514, 59612, 59620).

	• These delivery-only codes include immediate postpartum care provided on the calendar day of delivery. • Any additional services outside this scope must be billed separately.
Postpartum Care	• May be billed per encounter using appropriate E/M procedure codes (CPT 99202–99499). • Diagnosis code Z39.2 must be used to indicate routine postpartum follow-up care. • The TH modifier should be applied when billing EM codes for postpartum care.

Providers may continue to use global obstetric package codes through December 31, 2026, when all components of care fall within 2026.

For specific scenarios and additional information regarding the billing flexibilities for dates of service through December 31, 2026, please refer to the bulletin released on the topic.

Global Obstetrics Codes

The global obstetrics code can be billed if one practitioner or practitioners within the same physician or group practice provide all components of the recipient's obstetrical care including 4 or more antepartum visits, delivery, and postpartum care. Itemization of obstetric related services may occur in the following situations:

- A recipient transfers into or out of a physician or group practice;
- A recipient is referred to another physician during her pregnancy;
- A recipient has the delivery performed by another physician or health care professional not associated with her physician or group practice;
- A recipient terminates or miscarries her pregnancy; or
- A recipient changes insurers during her pregnancy and the change prevents the billing of all of the services under the global code.

FQHC, RHC, IHS, and Tribal 638 providers

If an FQHC, RHC, IHS, or Tribal 638 provides the prenatal care or postpartum care to a recipient, they should itemize their billing for the service. Prenatal services should be billed using the applicable EM code and pregnancy related diagnosis code. South Dakota Medicaid requires FQHCs, RHCs, IHS, and Tribal 638 providers to append the TH modifier when billing prenatal care EM codes. The modifier should not be applied to the initial visit in which pregnancy was confirmed. Postpartum visits should be billed using 59430. Providers must not bill duplicative services. For example, it is not permissible to bill for prenatal services using an EM code and bill the global delivery code.

If a third-party payer requires billing the services under a different code, the provider should note that on the explanation of benefits that they submit with the claim. The claims should still be billed to Medicaid using the applicable EM code.

Global Period

The global period starts the date of the initial visit in which the pregnancy is confirmed and extends through the end of the postpartum period (56 days after vaginal delivery and 90 days after c-section). If a global code is billed, use the date of delivery as the date of service. A provider may not submit separate claims for the antepartum care, delivery services, or postpartum care when using either of the global delivery codes. Global services should be billed for using the applicable global CPT code 59400, 59510, 59610, or 59618.

Services Included in the Global Obstetrical Package

Per CPT guidelines and the American College of Obstetricians and Gynecologists (ACOG), the following services are included in the global obstetrics package and may not be billed separately if a global procedure code is billed:

- All routine prenatal visits until delivery;
- Initial and subsequent history and physical exams;
- Recording of weight, blood pressures, and fetal heart tones;
- Routine chemical urinalysis (CPT codes 81000 and 81002);
- Admission to the hospital including history and physical;
- Inpatient E/M service provided within 24 hours of delivery;
- Management of uncomplicated labor;
- Vaginal or cesarean section delivery (limited to a single gestation);
- Delivery of placenta (CPT code 59414);
- Administration/induction of intravenous oxytocin (CPT codes 96365-96367);
- Insertion of cervical dilator on same date as delivery (CPT code 59200);
- Repair of first or second degree lacerations;
- Simple removal of cerclage (not under anesthesia);
- Uncomplicated inpatient visits following delivery;
- Routine outpatient E/M services provided within 6 weeks of delivery;
- Postpartum care only (CPT code 59430); and
- Education services such as breastfeeding, lactation, and basic newborn care.

Per ACOG coding guidelines, reporting third or fourth-degree lacerations should be identified by appending modifier 22 to the global obstetrics code or delivery only code.

Services Excluded from the Global Obstetrical Package

Per CPT guidelines and ACOG, the following services are excluded from the global obstetrics package and may be billed separately if medically necessary:

- Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of ICD-10-CM diagnosis code Z32.01 (Encounter for pregnancy test, result positive).
- Laboratory tests (excluding routine chemical urinalysis)
- Maternal or fetal echography procedures (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76820, 76821, 76825, 76826, 76827 and 76828).
- Amniocentesis, any method (CPT codes 59000 or 59001)
- Amnioinfusion (CPT code 59070)

- Chorionic villus sampling (CVS) (CPT code 59015)
- Fetal contraction stress test (CPT code 59020)
- Fetal non-stress test (CPT code 59025)
- External cephalic version (CPT code 59412)
- Insertion of cervical dilator (CPT code 59200) more than 24 hours before delivery
- E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services.
- Additional E/M visits for complications or high-risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.
- Inpatient E/M services provided more than 24 hours before delivery.
- Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).

Costs associated with Long Acting Reversible Contraceptives (LARC) are reimbursable if placed immediately after delivery or prior to discharge from the hospital. Refer to the Family Planning manual for additional guidance.

High Risk/Complications

A recipient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global OB CPT codes of 59400, 59510, 59610 or 59618. Submission of high risk or complication services must occur at the time of delivery, due to the need for an appropriate assessment for the number of antepartum visits at the time of delivery. Per ACOG coding guidelines, if a patient sees an obstetrician for extra visits to monitor a potential problem and no problem actually develops, the physician is not to report the additional visits; only E/M visits related to a current complication can be reported separately. South Dakota Medicaid will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

Antepartum Care Only

An initial evaluation and management (E/M) procedure code may be billed if the antepartum record is not initiated at the confirmatory visit. Antepartum care only codes should only be billed when the practitioner or practitioner of the same group will not be billing all 3 components of global obstetrics care (4 or more antepartum visits, delivery, and postpartum care). If antepartum services do not qualify to be billed in the global code, bill using the following codes:

- 3 or fewer antepartum visits performed – bill the appropriate E/M codes for the visits
- 4-6 antepartum visits – bill CPT code 59425
- 7 or more antepartum visits – bill CPT code 59426

If 4-6 antepartum visits are performed, do not bill for the initial antepartum visits using an E/M code. The initial 3 visits are included in CPT code 59425. If 7 or more antepartum visits are provided, only bill CPT code 59426. Do not bill CPT code 59425. The initial visits are included in 59426.

Anetpartum Care Billing Flexibilities in Advance of CPT Code Changes

South Dakota Medicaid will allow providers to report obstetrical antepartum services individually prior to the January 1, 2027 transition from global obstetric codes. Providers may begin to bill per encounter using applicable E/M codes (CPT 99202–99499). All claims must include pregnancy-related ICD-10-CM diagnosis codes, and the TH modifier should be applied when billing E/M codes for prenatal care.

Delivery Only

Delivery begins on the date of initial hospitalization for delivery and extends through the date in which the birthing mother is released from the hospital. Hospital care related to the delivery is considered part of the delivery charge and is not considered part of the postpartum care. If a c-section is performed, the reimbursement for the delivery only charge includes payment for the surgical procedure as well as the post-surgical care. Use the applicable delivery only code in the CPT manual to bill for this service.

Antepartum Care and Delivery

If both antepartum care and delivery are provided and postpartum care is not provided, the applicable antepartum only and delivery only CPT codes should be billed.

Postpartum Care Only

Postpartum care begins after the patient is discharged from the hospital stay for delivery and extends throughout the postpartum period (56 days for vaginal delivery and 90 days for cesarean delivery). Postpartum care only must be billed using CPT code 59430.

Recipients eligible for Medicaid through the Unborn Children Prenatal Care Program (Aid Category 79) are covered for postpartum care when billed using an appropriate global delivery and postpartum care CPT code (59410, 59515, 59614, 59622). The date of service for the global code must be the date of delivery. Postpartum care only services (CPT code 59430) are not covered as the birthing mother's Medicaid eligibility ends after delivery.

Postpartum Care Billing Flexibilities in Advance of CPT Code Changes

South Dakota Medicaid will allow providers to report obstetrical postpartum services individually prior to the January 1, 2027 transition from global obstetric codes. Providers may begin to bill per encounter using applicable E/M codes (CPT 99202–99499). Diagnosis code Z39.2 must be used to indicate routine postpartum follow-up care and the TH modifier should be applied when billing E/M codes for postpartum care.

Delivery and Postpartum Care

A provider that performs the delivery and postpartum care, but did not provide at least 4 antepartum visits must bill the appropriate delivery and postpartum care CPT code:

- Vaginal delivery including postpartum – bill CPT code 59410.
- C-section delivery including postpartum care – bill CPT code 59515.

- Vaginal birth after cesarean delivery (VBAC) including postpartum care – bill CPT 59614
- C-section after attempted VBAC including postpartum care – bill CPT code 59622

Multiple Deliveries

Providers should bill using the following codes for multiple deliveries:

Delivery	Baby	CPT Code
Vaginal	Baby A	59400 or 59610
	Baby B	59409 or 59612 – Append Modifier 51
Both Cesarean Delivery	Baby A & Baby B	59510 or 59618 – Append Modifier 22 if the delivery was significantly more difficult due to multiple gestations. The medical record must contain supporting documentation.
One Vaginal Delivery and One Cesarean Delivery	Baby A	59510 or 59618
	Baby B	59409 or 59612 – Append Modifier 51

Physician Standby Services

Physician standby services, CPT code 99360, is only covered when there is required prolonged physician attendance awaiting the birth of a newborn via cesarean and/or high-risk delivery. Physician standby services, 99360, is only billable under the birthing mother. The procedure requires the physician's full-time attendance and cannot be providing care to another patient during the reporting period. Physician standby is considered a minimum of 30 minutes total duration of time on a given date. The physician standby procedure code, 99360, is to be billed in 30-minute increments (30 minutes = 1 unit) and must reflect the total duration of time the physician is in attendance, up to a maximum of 4 units (2 hours). Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of services reported. Total duration of less than 30 minutes may not be billed. Physician standby can be reported in addition to the following codes: 99440 and 99465.

Documentation must be maintained by the provider which should include; the medical necessity for the physician's immediate presence, a detailed report of the tasks performed, and the duration of the actual time spent with the patient.

Genetic Screenings

Genetic testing included in the Newborn Metabolic Screening Program as mandated by the South Dakota Department of Health is covered without a prior authorization. Diagnostic testing for genetic abnormalities is a covered service only if the results will affect the treatment decisions for the individual. Noninvasive prenatal testing (CPT codes 81420 or 81507) requires a prior authorization as do many other genetic tests. Please refer to the Laboratory and Pathology Services manual for additional information.

Depression Screenings
South Dakota Medicaid covers up to six depression screenings (CPT code 96127) during a 12 month period.
A maternal depression screening is covered during the postpartum period at 1, 2, 4, and 6 months when performed in conjunction with a well-child visit for an infant. Providers are encouraged to screen birthing mothers who have a South Dakota Medicaid-eligible child under the age of 1. Providers must bill CPT code 96161 for maternal depression screening performed using a standardized screening tool. The service must be billed using the child's South Dakota Medicaid recipient ID number. Providers should refer the birthing mother to follow-up treatment as necessary.

Refer to the Well-Child, Well-Adult, and Other Preventative Services manual for additional information regarding coverage of USPSTF A and B grade recommendations.

Obstetrical Ultrasound
South Dakota Medicaid covers obstetrical ultrasounds during pregnancy when medical necessity is established for one or more of the following conditions:

- Establish date of conception/gestational age
- Standard check on fetal development and screen for major congenital anomalies (anatomy scan)
- Discrepancy in size versus fetal age
- Early diagnosis of ectopic or molar pregnancy
- Fetal Postmaturity Syndrome
- Guide for amniocentesis
- Placental localization associated with abnormal vaginal bleeding (placenta previa)
- Polyhydramnios or Oligohydramnios
- Suspected congenital anomaly
- Suspected multiple births
- Other conditions related directly to the medical diagnosis or treatment of the mother and/or fetus.

An E/M services is only separately reimbursable in addition to an obstetrical ultrasound procedure if the E/M service is separate and distinct and reported with a Modifier 25. South Dakota Medicaid will not reimburse obstetrical ultrasounds during pregnancy for any of the following reasons:

- Determining gender
- Baby pictures
- Elective

Pregnancy Loss
South Dakota Medicaid covers services that may be necessary for the compassionate or palliative care of a child born in a non-viable pregnancy, as well as services related to the end of a pregnancy not resulting in live birth. Covered services include:

- Services and supplies associated with miscarriage, stillbirth, or a non-viable pregnancy, such as a molar pregnancy, ectopic pregnancy, or fetal death in utero; and
- Postpartum services including behavioral health services.

Prenatal Vitamins
Prenatal vitamins are covered for pregnant women with a prescription.
Iron Supplements
Iron supplements for pregnant women are covered under the pharmacy benefit with a prescription .

Aspirin
South Dakota Medicaid covers preventative services with A and B recommendations made by the USPSTF including low-dose Aspirin (81 mg/day) after 12 weeks of gestation in persons who are at high risk for preeclampsia. Low-dose Aspirin is covered with a prescription under the pharmacy benefit.

Refer to the Pharmacy Services manual for additional information regarding over-the-counter (OTC) drug coverage.

Doula Services
Doula services are covered by South Dakota Medicaid as a preventative service under 42 CFR 440.130. Federal regulation requires preventative services be recommended by a physician or other licensed practitioner of the healing arts acting. For doulas services to be covered they must be referred by a physician, physician assistant, certified nurse practitioner, or certified nurse midwife with whom the recipient has had a face-to-face or telemedicine visit within the last 90 days. If the individual is in one of the Medicaid care management programs (BabyReady, Primary Care Provider Program, or Care Connect Program), the services must be referred by their designated provider. At the licensed practitioner's discretion, the referral may be made for services to start up to 60 days prior to the date the provider makes the referral. It is recommended that a referral is obtained as soon as possible to avoid the potential of non-reimbursable services. Refer to the Doula Services manual for additional information.

Home Health Services
Postpartum home health services are covered in limited circumstances. Refer to the Home Health manual for additional information.

PREGNANCY SUPPORT PROGRAMS

BabyReady Care Management Program
The BabyReady Program is designed to enhance maternal health outcomes by providing improved care coordination, ensuring services align with established standards of care, and reducing barriers to care. In addition to standard reimbursement, participating providers receive a monthly case management fee for care coordination along with enhanced reimbursement for meeting prenatal and postpartum care program objectives. Providers are responsible for coordinating care for recipients on their caseload. For providers interested in participating, please refer to the BabyReady manual for additional information.

Bright Start Program
Bright Start home visiting enrolls expectant, first-time moms who are enrolled in Medicaid. Bright Start connects eligible women with a free personal nurse to walk alongside them from pregnancy through their child's second birthday. Bright Start supports families toward improved pregnancy outcomes, improved child health and development, and increased self-sufficiency. For referrals for service, questions, or other information about this program, please call the Bright Start program based on the applicable area of the state:

- Western SD 605-206-1438
- Central SD 605-906-3750
- Eastern SD 605-900-8609

Referrals may be submitted online using the online Referral Form.

Pregnancy Care Program
The Pregnancy Care Program through the Department of Health is available to pregnant women of all income levels. This service offers a Pregnancy Care nurse at no cost to expecting moms. The nurse is available to answer questions and offer support as soon as pregnancy begins. Additional support offered through the program includes:

- Check-ins with a registered nurse for pregnancy education
- Postpartum support for mom and baby after delivery
- Tips for breastfeeding, nutrition, safe sleep, and other practices for a healthy pregnancy and healthy baby
- Referrals to community resources

Providers or pregnant women may call or visit a local Public Health Nursing Office to get connected with a Pregnancy Care nurse.

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.

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.

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. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing manuals when applicable. Providers should refer to the General Claim Guidance manual for additional information.

South Dakota Medicaid recognizes third-party (primary) insurance often limits the codes that may be used when filing a claim. When another insurance requires a code not utilized by South Dakota Medicaid, the billing provider should bill with the EM and document on the EOB “primary insurance requires a different code” in order for the claim to be considered for payment.

Reimbursement

A claim for physician services must be submitted at the provider’s usual and customary charge. Payment for physician services is limited to the lesser of the provider’s usual and customary charge or the fee contained on South Dakota Medicaid’s Physician Services fee schedules.
Non-laboratory procedures including injections and immunization with no established fee are reimbursed at 40 percent of the provider’s usual and customary charge. Laboratory procedures with no established fee are reimbursed at 60 percent of the provider’s usual and customary charge.

Procedure Code Modifiers

Procedure code modifiers must be used if applicable. Some modifier codes increase or reduce payment. Please refer to our Authorized Modifier document for additional information.
When multiple modifiers are needed for the services being provided all percentages will be calculated in the payment. For example, if CPT code 30115 is billed at $236.60 with a modifier 50 and a modifier 80 the following calculation will occur: ($236.60 x 150%)*20% = a payment amount of $70.98.

Claim Instructions

Claims for professional services including inpatient and outpatient professional services must be submitted on a CMS 1500 claim form or 837P. Detailed claim form instructions are available on our website. A claim submitted for the services of a physician or other licensed practitioner must be for services provided by the physician or other licensed practitioner or an employee who is under the direct supervision of the practitioner. A claim submitted by a clinical nurse specialist, a certified nurse midwife, a nurse practitioner, or a physician assistant must contain the clinical nurse specialist's, the certified nurse midwife’s, the nurse practitioner's, or the physician assistant's provider identification number and

may not be submitted under the supervising physician's provider identification number.

Modifiers
Claims must include any relevant modifying circumstance of the services or procedure by adding the applicable modifier code to the procedure code.

Effective April 1, 2024, South Dakota Medicaid will require Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Service (IHS) providers to append the TH modifier when billing prenatal care EM codes.

DEFINITIONS

1. "Clinical nurse specialist," an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87, or an individual licensed or certified in another state to perform those functions;

2. "Nurse anesthetist," an individual who is qualified under SDCL 36-9-30.1 to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions;

3. "Nurse midwife," an individual who is qualified under SDCL Ch. 36-9A to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions;

4. "Nurse practitioner," an individual who is qualified under SDCL Ch. 36-9A to perform the functions contained in SDCL 36-9A-12, or an individual licensed or certified in another state to perform those functions;

5. "Other licensed practitioner" a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title 36.

6. "Physician," a person licensed as a physician in accordance with the provisions of SDCL Ch. 36-4 and qualified to provide medical and other health services under this chapter, or an individual licensed or certified in another state to perform those functions;

7. "Physician assistant," an individual qualified and certified under the provisions of SDCL Ch. 36-4A to perform the functions contained in SDCL 36-4A-26.1, or an individual licensed or certified in another state to perform those functions;

REFERENCES

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

QUICK ANSWERS

1. **Will South Dakota Medicaid cover a D&C for a woman in the Unborn Children Prenatal Care Program?**

   Yes, South Dakota Medicaid will cover a medically necessary Dilation and curettage (D&C) and follow-up care if a woman miscarries while receiving coverage under the Unborn Children Prenatal Care Program. Claims for D&C procedures and follow-up care occurring after 30 days post-miscarriage or pregnancy loss must be submitted with medical records for review and may not be covered.