Doula Services, OB 13

Table of Content

Description & Definitions
Criteria
Document History
Coding
Special Notes
References
Keywords

Effective Date	7/1/2026
Next Review Date	3/2027
Coverage Policy	OB 13
Version	8

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Revision: HFCA-PM-91-4 August, 1991 Attachment 3.1- A&B Supplement 1 Page 28.1 OMB No. 0938- STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Doulas support the pregnant individual throughout the pregnancy, childbirth and postpartum experience, with the goal of improving outcomes for birthing parents and infants. Doulas offer support, guidance, evidence-based education, practical support during childbirth, and linkages to community-based resources. Service components include:

- Perinatal support services, including newborn care, to prevent adverse outcomes;
- Labor support; and
- Coordination with community-based services, to improve beneficiary outcomes

Criteria:

Doula Support Services beyond the original allowable 11 visits are considered medically necessary for **all** of the following:

- A physician or other licensed practitioner provides documentation that the individual is experiencing a potential complication, or is at risk for or needs support managing **1 or more** of the following:
  - Excessive anxiety
  - Breastfeeding knowledge, support, and assistance
  - Information about feeding and caring for the baby
  - Helping member or family learn to become comfortable with baby soothing and bonding methods
  - Promoting self-care
  - Postpartum Depression

Document History:

Revised Dates:

- 2025: July – Implementation date of October 1, 2025. Updated to allow for an original 11 visits instead of 9 per update DMAS contact.
- 2024: June – Updated Coverage statement, Authorization Requirements and Description of Service per DMAS State Plan Amendment (SPA) #: 21-00132023: June

Reviewed Dates:

- 2026: March – Implementation date 7.1.2026. No updates to criteria. Updated references.
- 2025: May – Implementation date of August 1, 2025. No changes to criteria. Updated policy to new format.
- 2023: August

Origination Date: August 2022

Coding:

Medically necessary with criteria:

Coding	Description
59409HD	Vaginal delivery only (with or without episiotomy and/or forceps)
59425HD	Antepartum care only; 4-6 visits
59430HD	Postpartum care only (separate procedure)
59514HD	Cesarean delivery only
99600HD	Unlisted home visit service or procedure
99199HD	Unlisted special service, procedure or report

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
    - Revision: HFCA-PM-91-4 August, 1991 Attachment 3.1- A&B Supplement 1 Page 28.1 OMB No. 0938- STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
        - Any service limits may be exceeded based upon medical necessity.
- Application to Products: Policy is applicable to Sentara Health Plan Medicaid products.
- Authorization Requirements: Pre-certification by the Plan is required.
    - Revision: HFCA-PM-91-4 August, 1991 Attachment 3.1- A&B Supplement 1 Page 28.1 OMB No. 0938- STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
    - Department of Medical Assistance Services. Doula Care Form
        - For the doula benefit, VA Medicaid defines a “licensed practitioner” as licensed clinicians, including physicians, licensed midwives, nurse practitioners, physician assistants, and other Licensed Mental Health Professionals (Virginia Administrative Code 12VAC35-105-10 defines a Licensed Mental Health Professional as a: physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist). Recommendations from licensed, non-clinical providers will not be accepted. The recommending clinician need not be a VA Medicaid provider.
    - Qualified Provider Specifications:
        - Doula services shall be provided by qualified individuals who are at least 18 years of age. Doulas must:
            - Complete doula training, which must include core competencies (perinatal support services, labor support), community-based/cultural competency training, and care

coordination. Doula trainings must be approved by the Virginia Department of Health (VDH); and
- Be certified by a state certifying entity designated by VDH.

- Limits:
  - Any service limits may be exceeded based upon medical necessity.
  - Service authorization is required if more than eight prenatal/postpartum visits are required, and if services are required more than twelve months after delivery.

- Special Notes:
  - Medicaid
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.
    - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Commonwealth of Virginia. Department of Medical Assistance Services. Maternal Health Bills and Budget Items Effective July 1, 2025. Issued date July 22, 2025. Retrieved 2.5.2026. https://vamedicaid.dmas.virginia.gov/bulletin/maternal-health-bills-and-budget-items-effective-july-1-2025

Commonwealth of Virginia. Department of Medical Assistance Services. Doula Care Form Overview for Licensed Providers. February 2024. Retrieved 2.5.2026. https://vamedicaid.dmas.virginia.gov/sites/default/files/2024-02/VA%20Medicaid%20Doula%20Care%20Coversheet%20final%20%28ENG%29120623.pdf

Keywords:
Doula Services, Obstetrics 13, OB, Birth Coach, Labor Coach, Post-Birth Supporter, Postpartum, Antepartum, Home visit