Sentara® Health Plans

Doula Program Guide

Table of Contents

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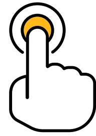


Purpose of the Guide

Definitions

Initiating Doula Services

Medicaid-Funded Community Doula Benefit

Community Doula and Care Management

Provider Commitments

Health Plan Commitments

Provider Services Solution (PRSS)

Confidentiality

Compensation and Billing: *Critical Elements*

Compensation and Billing: *Covered Doula Services*

Compensation and Billing: *Doula Service Codes*

Compensation and Billing: *Incentive Payments*

Completing Paper Claim Forms

Claims Pathway: *Clean Claim/Auto Adjudication*

Claims Pathway: *Clean Claim Criteria NOT Met* (Manually Processed)

Appointment Timeliness Standards

Purpose of the Guide

This guide is designed to orient doulas as well as other providers seeking to integrate the Sentara Health Plan Doula program into their practice.

Definitions

1. **Billed Charge:** the actual amount charged by the provider for any covered service furnished to a member.
2. **Clean Claim:** a claim that has no material defect (including any lack of required documentation).
3. **Covered Services:** those services, drugs, supply, and equipment for which coverage benefits are available under the health care plans. Covered services beneficiaries are given benefits according to the terms and conditions of the health plan.
4. **Copayment:** charges for covered services collected directly by provider from member as payment in addition to the fees paid to Provider by the health plan.
5. **Deductible**: a dollar amount which a member is responsible to pay before the covered service.
6. **Electronic Health Record or EHR:** an electronic record of clinical services rendered by a participating provider to a member.
7. **Fee Schedule:** a list of the maximum amounts allowed per unit for covered services.
8. **Taxonomy Code:** A unique 10-character code that designates a health care providers classification and specialization.
9. **Medically Necessary:** those covered services as provided by a participating provider which are:
    - required to identify, evaluate, or treat the member's condition, disease, ailment, or injury, including pregnancy related conditions
    - in accordance with recognized standards of care for the member's condition, disease, ailment or injury
    - appropriate with regard to standards of good medical practice
    - not solely for the convenience of the member, or a participating provider
    - the most appropriate supply or level of service which can be safely provided to the member
10. **Noncovered Services:** those health care services that are not covered services.
11. **Provider Network:** a group of participating providers that, through a contractual relationship, supports some or all products in which members are enrolled.
12. **Quality Improvement or Utilization Management:** the processes established and operated by the health plan, or its designee, to evaluate and promote the quality and cost-effective delivery of covered services.

Initiating Doula Services

- Members must choose a community doula who has completed a Virginia Department of Health approved certification program.
- Doulas are then responsible for ensuring that the Doula Care Form has been completed and signed by the member's licensed healthcare provider prior to initiating services.
- Doulas must retain a copy of the signed Doula Care Form with the member's medical records

Fax the Doula Care Form to the Maternity Biscom line at **757-352-2694** or toll-free at **1-833-666-0706 (TTY: 711).**

CardinalCare Virginia's Medicaid Program

Virginia Medicaid Department of Medical Assistance Services

VIRGINIA'S MEDICAID PROGRAM DMAS

DOULA CARE FORM

1) *If a member is enrolled in Fee-For-Service, please fax forms to 804-452-5447.*
2) *If a member is enrolled in a managed care organization, please refer to that Health Care Plan (MCO) for detailed form submission or return the completed form to the Medicaid member or doula (if known).*

If you are a Virginia Medicaid member and are pregnant or have given birth within the last six months ….

You are eligible to receive community doula care to provide you physical, emotional, and informational support before, during and after you give birth. You or your doula must get a licensed practitioner's signature to provide this care under the VA Medicaid program. You can access the doula care form at: **dmas.virginia.gov/doula** or request a doula care form from your doctor/midwife/nurse[1] and give it to your doula. You can ask for a doula care form even if you don't know who your doula will be yet.

If you are a doula….

You must secure and retain a licensed practitioner's recommendation for each member prior to initiation of their doula care and store the record in a manner consistent with HIPAA requirements. A copy of this form must be provided to the Managed Care Organization in which the member is enrolled (for managed care members) or the Department of Medical Assistance Services (for Fee-for-Service members) prior to initiating services.

If you are a licensed practitioner[1]….

By completing this doula care form, you are enabling this individual to access **non-clinical** community doula services[2].
A doula care form is not the same as a prescription/medical order.

Licensed Practitioner's Support for Doula Care	
VA Medicaid member's full legal name (first, middle, last) – (please print):	
VA Medicaid member's DOB or ID #:	
Licensed Practitioner's Signature:	
Licensed Practitioner's full legal name (first, middle, last) – (please print):	
Licensed Practitioner's NPI number:	
Address and phone number of Licensed Practitioner (please print):	
Date of recommendation (MM-DD-YYYY):	
Name of doula or doula organization (if known):	
Name & address of member's OB/GYN provider (if known):	
Name of member's Health Care Plan (MCO) - (check one):	Anthem☐ Aetna☐ Molina☐ Sentara Health☐ United Healthcare☐ Fee For Service (no MCO)☐

[1] 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.

[2] VA Medicaid's doula services are provided as a preventive service. Federal Medicaid law (42 C.F.R. Section 440.130(c)) indicates: "Preventive services" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to - (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency.

Medicaid-Funded Community Doula Benefit

- Pregnant and postpartum members are eligible for:
  - eight prenatal or postpartum visits
  - one doula attendance at the delivery visit
- Members can be approved for additional visits after completion of the eight visits if it is deemed medically necessary.
- Members are not allowed multiple visits in the same day except when:
  - a prenatal visit occurs early in the day and the attendance at delivery is later
  - attendance at delivery occurs early in the day and a postpartum visit is later

Community Doula and Care Management

- Members will receive communication and education regarding the new benefit.
- The Welcoming Baby Case Management Team (WBCMT) will conduct outreach to pregnant members.
- WBCMT will complete the necessary documentation in our internal systems.
- If no provider recommendation form has been received:
  - The member will be contacted to verify doula contact information and provided education on the need for a completed provider form.
  - The doula will be contacted to request that the completed form is faxed to the maternity Biscom line.

Provider Commitments

- **Provide Services:** Provide covered doula services to Sentara Health Plan members
- **Maintenance of Credentials:** Maintain and submit to Sentara Health Plan upon request, evidence of licensure, accreditation, registration, certification, and all other credentials sufficient to meet all applicable federal and state law and regulations.
- **Provider Locations:** Provide covered services only at locations permitted under the contract.
- **Notifications:** Provide prior written notice to Sentara Health Plan as soon as possible, but at least 90 days before, any change to the information about provider included in the provider network directory.
- **Compliance with SHP and Payor Programs, Policies, and Procedures:** Provider complies fully with all programs, policies, and procedures, as applicable.
- **Quality Improvement:** Provider agrees that quality improvement decisions may result in the denial of payment for those covered services provided to a member which are determined to be not medically necessary or of substandard medical quality.
- **Cooperation with Medical Directors:** Provider agrees to cooperate with reviews of the quality of care administered to members as such reviews are conducted by SHP's medical director, or the SHP Medical Director's designee.
- **Report Critical Incidents:** Provider agrees to report critical incidents in a timely manner. A critical incident is defined as any actual, or alleged, event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member.
- **Waiver of Copayments, Coinsurance and Deductibles:** Collects all applicable coinsurance, copayments and deductibles from Members, and shall not waive the collection of such coinsurance, copayments and deductibles without the written consent of SHP.
- **Non-Covered Services:** Provider agrees not to bill, charge, or seek compensation or reimbursement of any kind from any Member, SHP, or any Payor for health care services and/or supplies provided determined not medically necessary or covered services.
- **Access to and Inspection of Records:** Upon reasonable notice and during regular business hours, provide access by the health plan or its designee, to inspect, audit, review and makes copies of records related to covered services rendered to Sentara Health Plan members.

Health Plan Commitments

- **Program Information:** The health plan will provide a Provider Manual, accessible online, containing current information concerning Policies and Procedures. The health plan agrees to update as changes in requirements are made by law or otherwise.
- **Provider Education:** The health plan communicates important updates and other information through various methods, including, but not limited to a quarterly newsletter, webinars, and e-mail announcements. The purpose is to convey best practices so you can do business with us successfully. Provider Network: SHP will include a provider in the General Network of Participating Providers.
- **Member Eligibility Verification:** SHP agrees to provide a mechanism that allows providers to verify member eligibility before rendering services, based on current information held by SHP.
- Prior Authorization request forms, policies and procedures will be made available on the health plan's website.
- **Timely Notification:** Provide notice of policy and procedure changes with no fewer than 60 days prior notice.

Provider Services Solution (PRSS)

All providers must enroll in Provider Services Solution (PRSS) to participate with one or more Managed Care Organizations (MCOs). The platform will be used to:

- update licenses and certifications
- submit required attachments.
- request participation with MCO health plans during the enrollment/revalidation process

Register for PRSS training:
vamedicaid.dmas.virginia.gov/training/providers.

Course List:

- PRSS-111 Provider Enrollment Application
- PRSS-118 Introduction to Provider and MCO Portal Delegate Management
- PRSS-120- Introduction to the Provider Portal

Confidentiality

- Provider agrees that all medical records, Protected Health Information (PHI) and any other personal information about a member will be maintained within the United States and treated as confidential.
- Additionally, the provider will maintain all medical records and financial, administrative, and other billing records and documents concerning services provided to members for 10 years or as required by applicable laws and according to industry standards.

Compensation and Billing: Critical Elements

1. Doula Taxonomy Code: 374J00000X
2. Rates and Compensation: Provider will collect payments for covered services
3. Provision of Covered Services: Provider will not limit the provision of covered services to a member because of or based on any compensation arrangement between SHP and provider.
4. Billing: Provider will bill for covered services according to billing and claims submission policies as outlined in the provider manual.
5. Timely Filing is not more than 365 days after the date on which those services are rendered. Claims received by SHP after the 365-day period may be denied for payment. The provider shall not seek any payment from members for claims denied by SHP under this section.
6. Clean Claims: Provider shall make its best effort to submit claims correctly.

Compensation and Billing: Covered Doula Services

Coverage includes:

1. Initial prenatal visit
2. Standard care prenatal visit
3. Labor support (vaginal birth), labor support (C-section)
4. Postpartum care postpartum visit within six (6) weeks of delivery, incentive mother postpartum
5. Incentive newborn postpartum; a pediatric clinician visit must occur within six (6) weeks of delivery
    - A standard case will be composed of nine touchpoints:
        - Eight prenatal/postpartum visits (additional visits may be authorized as member needs are identified).
        - Attendance during labor and delivery
        - Two linkage-to-care incentive payments for postpartum and newborn care

Important Note: Linkage to care incentive payments may be delayed as payment is contingent upon all requirements being met, including the OB/GYN's claim submission. OB/GYNs globally bill, sometime resulting in delays in submissions.

- Doula services, rendered from date of conception through 180 days (six months) after delivery, may be reimbursed contingent on individual maintaining Medicaid eligibility.
- Doula services can only be provided in the community, in clinician offices (if a doula is accompanying the member to a clinician visit) or in the hospital.
- Rendered doula care must be documented in the member's medical record.

Compensation and Billing: Doula Service Codes

Code	Description	Maximum Units Allowed Per Visit	Rate	Notes
99600-HD	Initial Prenatal Visit	90 min	$14.99	Max 6 units of 15 min each (total of 90 min) One date of service.
59425-HD	Standard Care, Prenatal Visit	60 min	$14.99	Max three visits (initial prenatal and three prenatal visits) - bill in 15-minute increments, total of 60 minutes per visit
59409-HD	Labor Support, Vaginal Birth	1 unit (flat rate)	$350.00	
59514-HD	Labor Support, C-section	1 unit (flat rate)	$350.00	
59430-HD	Postpartum Care, Postpartum Visit	60 min	$14.99	Max four visits - bill in 15-minute increments, total of 60 minutes per visit
99199-HD	Incentive Mother Postpartum	1 unit (flat rate)	$50.00	
99199-HD	Incentive Newborn* Postpartum	1 unit (flat rate)	$50.00	*Must be billed under the newborn Medicaid ID

Fax recommendation forms to **757-352-2694** or **1-833-666-0706**

Compensation and Billing: Incentive Payments

To receive the incentive payments, doulas need to have performed at least one postpartum visit. A $50 value-based incentive payment can be received by the doula if the client is seen by an obstetric clinician for one postpartum visit. A $50 value-based incentive payment can be received if the newborn is seen by a pediatric clinician for one visit after birth

Completing Paper Forms

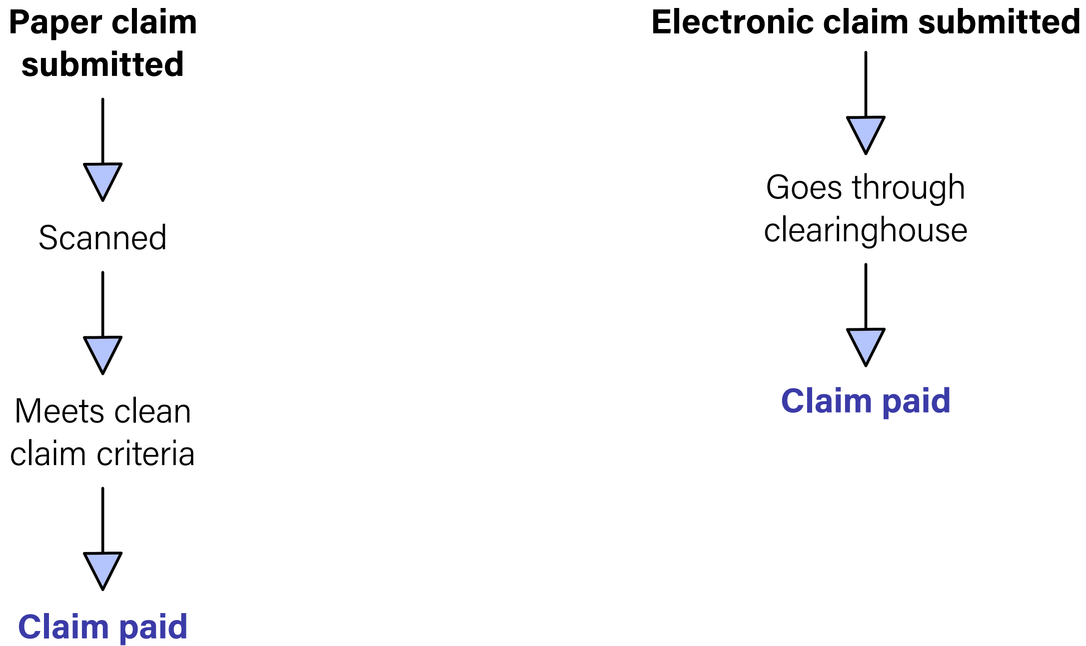
Sentara Health Plan requires the CMS 1500 Claim form version 02-12. For directions on filling out a paper form, we refer to NUCC guidelines.

- To expedite payment and avoid re-submission of claims, fill out the CMS-1500 claim form as completely and accurately as possible.
    - Submit claims containing all data elements and industry-standard coding conventions.

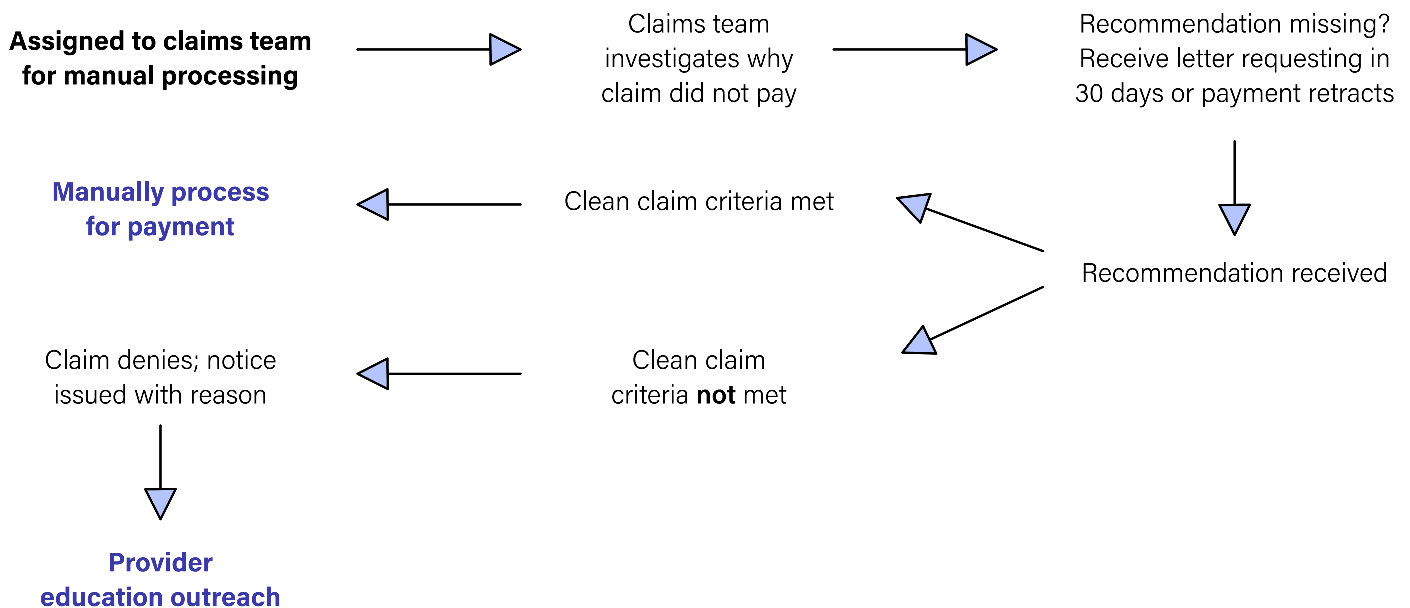
Common Reasons for Claims Denials:

- Errors in member name. Hyphenated last names must be submitted correctly.
- The birth date submitted must match the birth date associated with the member ID number.
- For a complete list of the most common errors in completing the CMS 1500 see page 81 in the provider manual or download Avoiding Common Claim Submission Errors from the provider toolkit on our website.

Claims Pathway: Clean Claim/Auto Adjudication



Claims Pathway: Clean Claim Criteria NOT Met (Manually Processed)



Appointment Timeliness Standards–Medicaid

Please follow these appointment timeliness standards for Sentara Health Plan members

Service	Sentara Health Plans Medicaid Standard
Emergency appointments, including Crisis Services	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request. Follow up to crisis services must be made within 24 hours of Sentara Health Plans being notified of the crisis services utilization.
Urgent Appointments	Within 24 hours of the member's request
Routine Primary Care	Routine, primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.).
Maternity Care – First Trimester	Within 7 calendar days of request
Maternity Care – Second Trimester	Within 7 calendar days of request
Maternity Care – Third Trimester	Within 3 business days of requests
Maternity Care – High Risk Pregnancy	Within 3 business days of high-risk identification to Sentara Health Plans or a maternity provider, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery
Mental Health Services	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met.
LTSS	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met.