Sentara®
Health Plans

Doula Program Guide

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(this document is interactive)

Purpose of the Guide

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

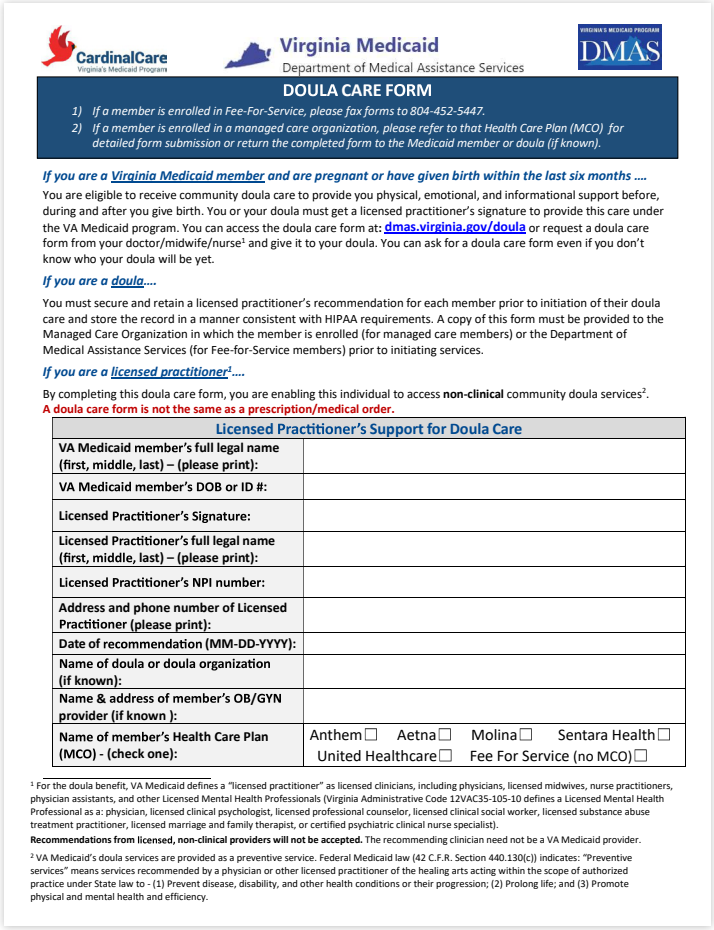
Definitions

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, supplies, 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 a provider from the member as payment in addition to the fees paid to the 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 (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 healthcare provider's 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 that can be safely provided to the member
10. **Noncovered Services:** Healthcare 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

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 Services Solution (PRSS)

All providers must enroll in 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

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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 Sentara Health Plans and the 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 Sentara Health Plans after the 365-day period may be denied for payment. The provider shall not seek any payment from members for claims denied by Sentara Health Plans 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 weeks of delivery; incentive mother postpartum.
5. Incentive newborn postpartum; a pediatric clinician visit must occur within six (6) weeks of delivery.
    - Ten 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, sometimes resulting in delays in submissions.

- Doula services, rendered from the date of conception through 12 months (365 days) after delivery, may be reimbursed contingent on the 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

All doula services must be billed with the HD modifier and the ICD-10-CM code. All claims for doula services must include diagnosis code Z32.2 (Encounter for childbirth instruction).

Procedure Code and Modifier	Description	Maximum Units Allowed Per Visit	Rate	Notes
99600-HD	Initial Prenatal Visit	90 minutes	$14.99	Max six units of 15 minutes each (total of 90 min) One date of service.
59425-HD	Standard Care, Prenatal Visit	60 minutes	$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 minutes	$14.99	Max six 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

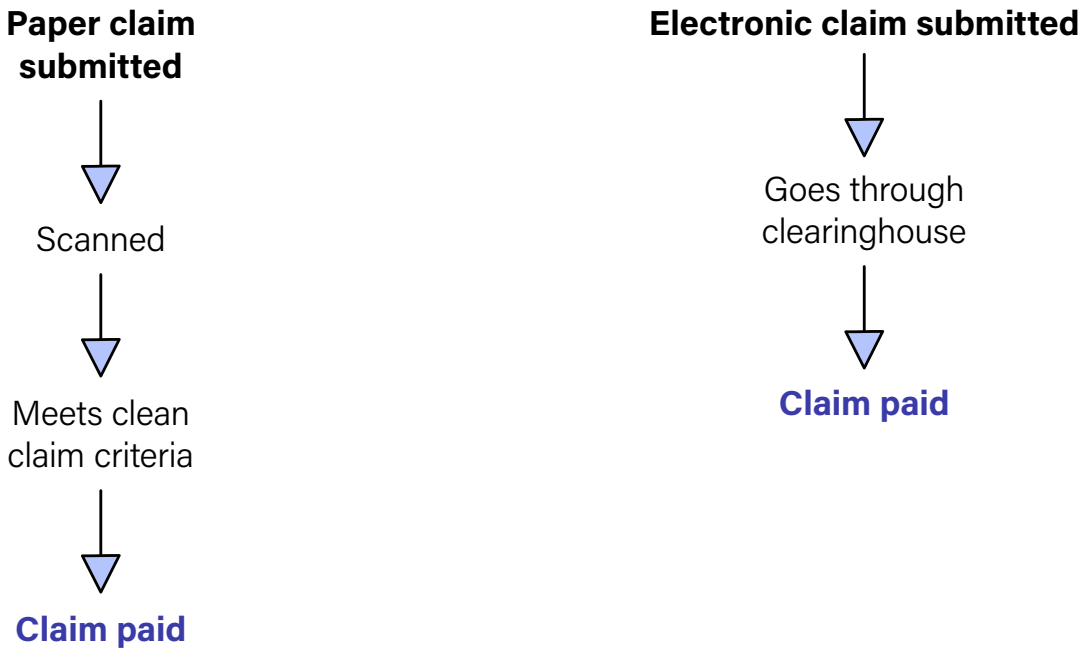
Sentara Health Plans requires the Centers for Medicare & Medicaid Services (CMS) 1500 Claim form version 02-12. For directions on filling out a paper form, we refer to the National Uniform Claim Committee (NUCC) guidelines.

- To expedite payment and avoid resubmission 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.

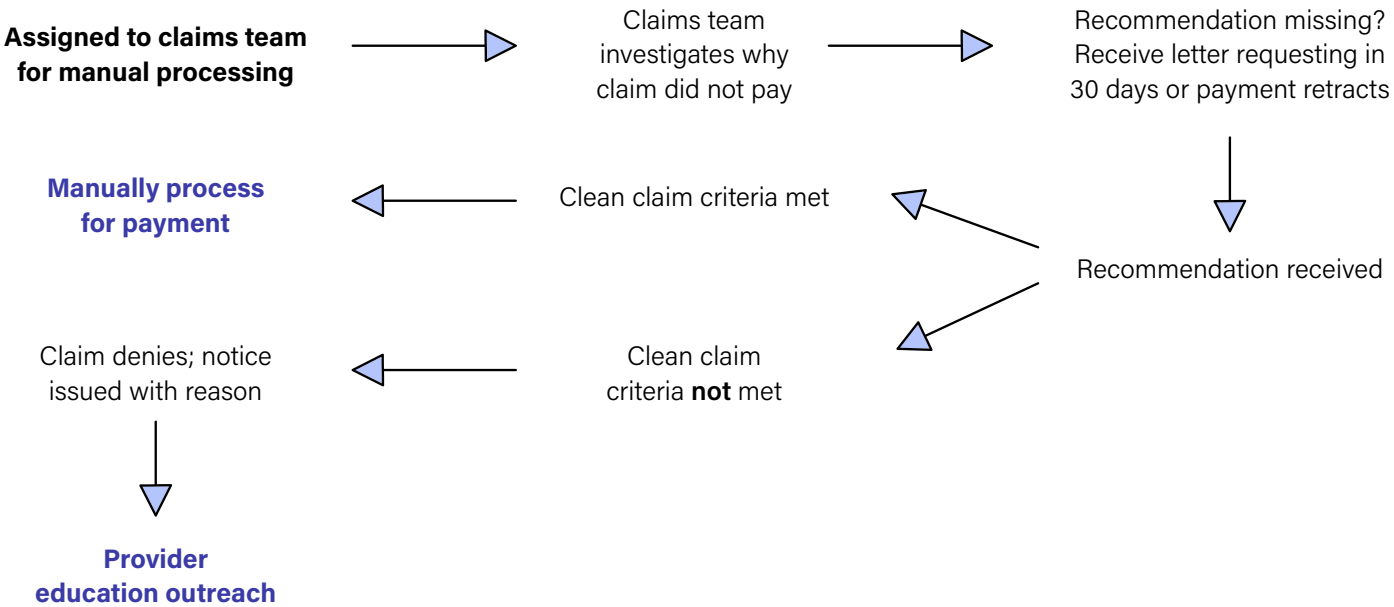
Common Reasons for Claims Denials

- 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.

Claims Pathway: Clean Claim/Auto Adjudication



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



Medicaid Appointment Access Standards

Please follow the following appointment access standards for Sentara Health Plans 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.
Non-life-threatening Behavioral Health Emergency	Within six hours or directed to emergency care.
Urgent Appointments (medical and behavioral health)	Within 24 hours of the member's request.
Regular and Routine Primary Care Services	Regular and 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 seven calendar days of request.
Maternity Care – Second Trimester	Within seven calendar days of request.
Maternity Care – Third Trimester	Within three business days of requests.
Maternity Care – High Risk Pregnancy	Within three business days of high-risk identification to Sentara Health Plans, a maternity provider, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery.
Behavioral Health Services (initial, follow-up, and routine)	Must be made available expeditiously as the member's condition requires and within no more than five business days from Sentara Health Plans' determination that coverage criteria are met.
LTSS	Must be made available expeditiously as the member's condition requires and within no more than five business days from Sentara Health Plans' determination that coverage criteria are met.