Doula Claims Submission

Please use IEHP's Portal to bill for all Doula services.

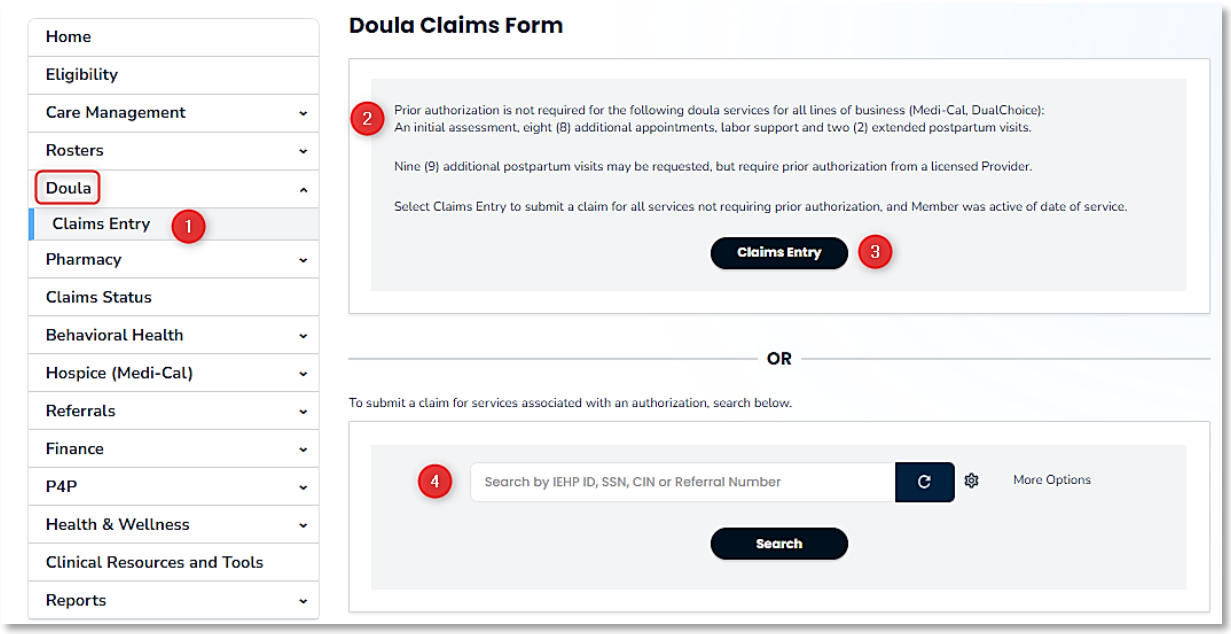
Log into the Provider Portal.

1. On the left-hand navigation, select "**Doula**" and then click on "**Claims Entry.**"

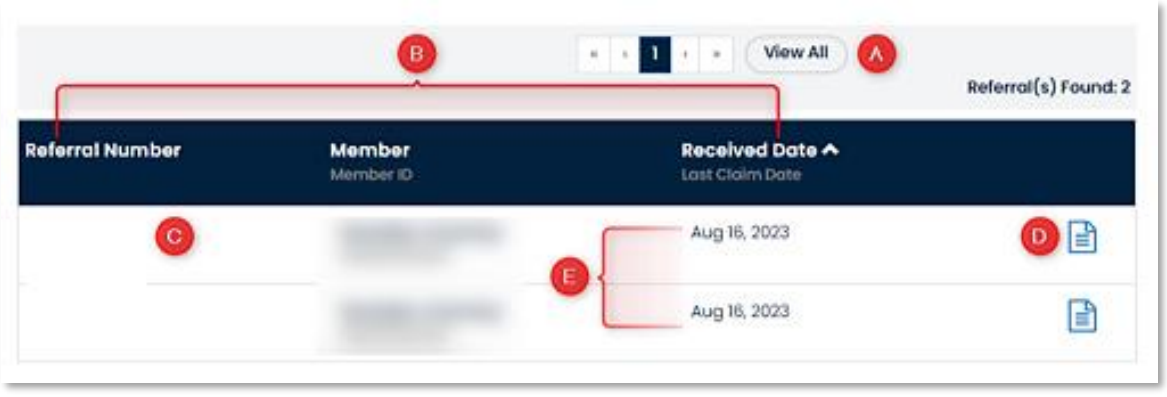
2. Prior authorization is not required for the following doula services for all lines of business (Medi-Cal, DualChoice):
    a. An initial assessment, eight (8) additional appointments, labor support and two (2) extended postpartum visits.
    b. Nine (9) additional postpartum visits may be requested but require prior authorization from a licensed Provider.

3. Select Claims Entry to submit a claim for all services not quiring prior authorization, and member was active on date of service.

4. To submit a claim for services associated an authorization, search below by IEHP ID, SSN, CIN or referral number.



5. If prior authorization was received, locate the referral in the list.



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a. The default display is twenty-five (25) per page. Providers may change the view to View All.

b. Columns are sortable.

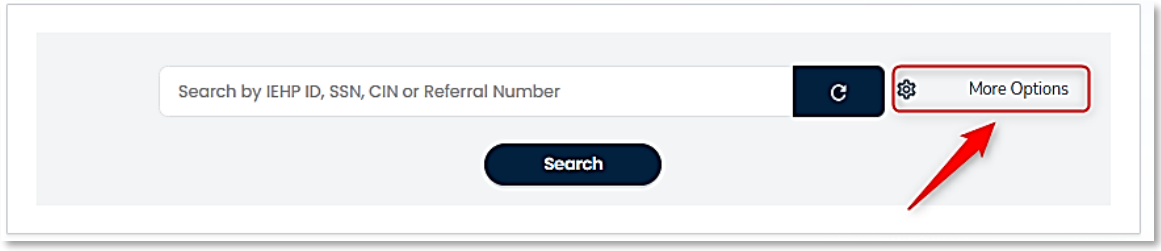
c. Click on the blue Referral Number link to view full Referral details.

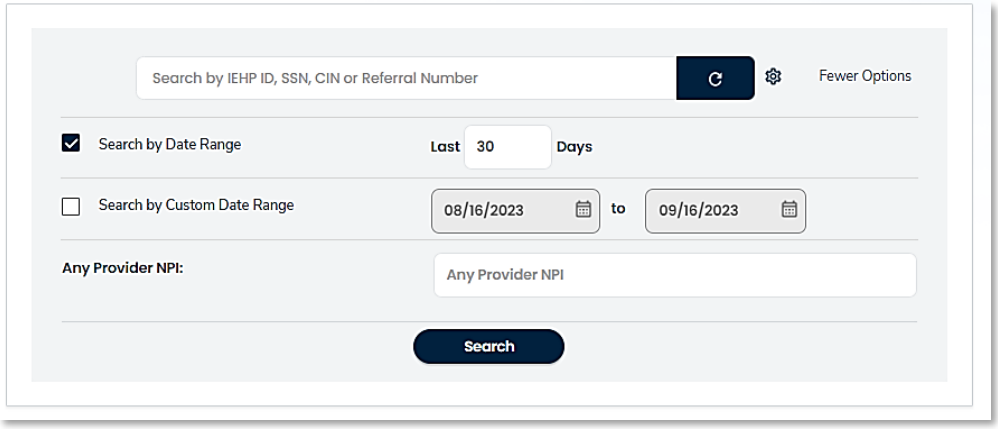
NOTE: If a claim has already been submitted, clicking on the blue Referral Number link will display the previously submitted claim CMS 1500 form.

d. Click on the "**Blue Icon**" to submit a claim for that specific referral.

e. When a claim has already been submitted for that Referral, the date and time of submission will be displayed at the top of the BH Claims Form.

6. To expand search options by clicking "More Options" to select a date range.





7. The **Member Information** section will be prefilled with what was entered in the **Member ID**. The **Servicing Provider** can be chosen from the "Servicing Provider" box. Please bill separately should there be another Doula Provider with a different NPI who has provided services on the same referral.

NOTE: Only Providers within the same TIN will display in the search pop-up box.

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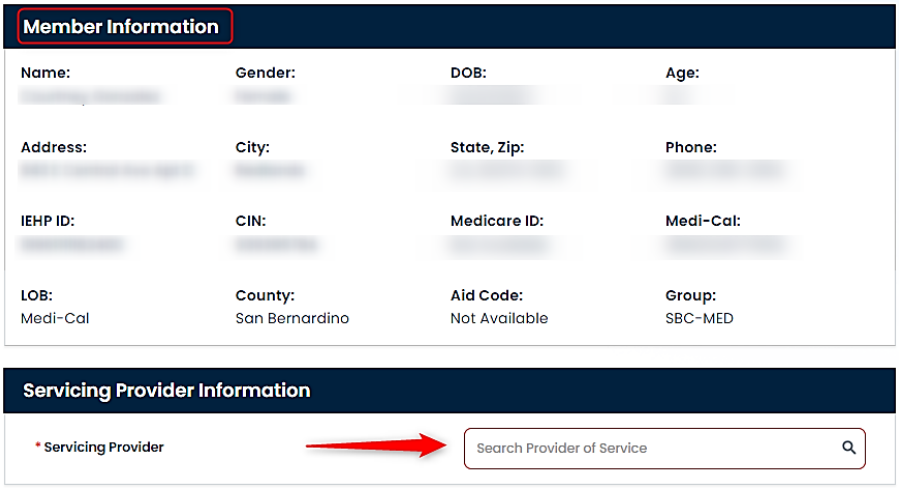


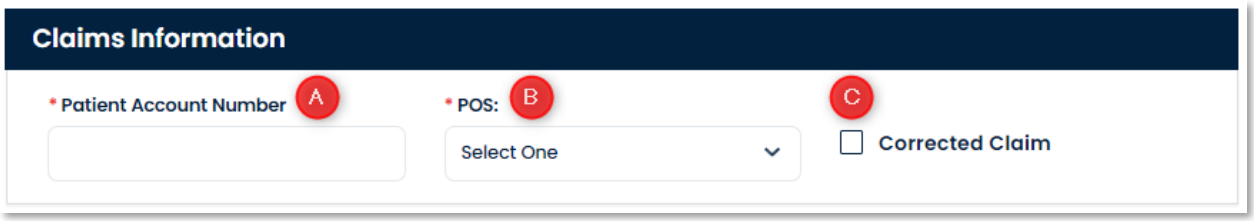
8. **Claims Information**

   a. Claims Information requires the Patient Account Number. The Patient Account Number is the specific alpha-numeric number that is assigned to the Member by the Provider's office.

   b. Select a Place of Service (POS). The list of locations will appear in a dropdown list.

      NOTE: Providers must submit one Place of Service (POS) per claim.

   c. If a Corrected Claim is being submitted, please click on the "Corrected Claim" check box.



9. Select the **Diagnosis Codes** from the search pop-up box. The ICD Code will justify the procedure codes.

   a. When entering a valid diagnosis, the diagnosis description will automatically display under the corresponding box.
   b. To remove a diagnosis code(s), click on the "**X**".
   c. To add additional diagnosis code(s), click "**Add +**".
   d. **NOTE**: A total of twelve (12) ICD Codes may be entered

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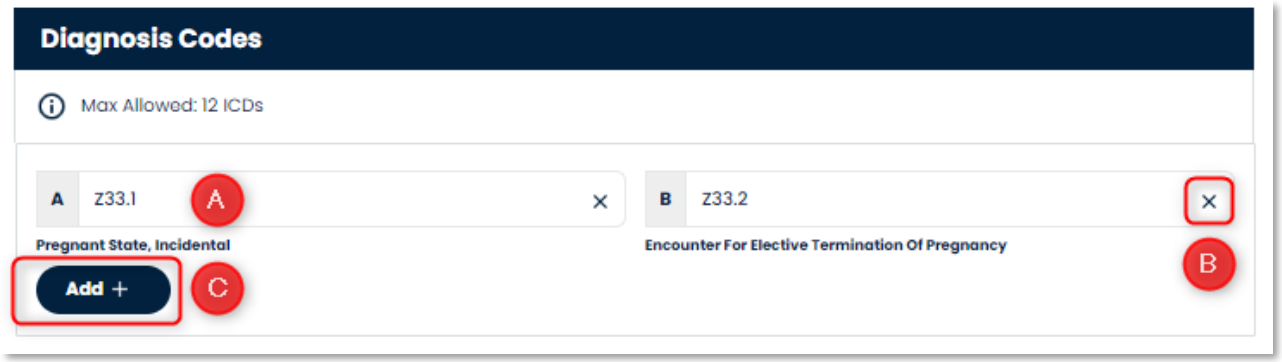


Diagnosis codes:

Z33.1 Pregnant state, incidental (use for prenatal visits and birth)

Z33.2 Encounter for elective termination of pregnancy (use for abortion)

Z39.2 Encounter for routine postpartum follow-up (use for all postpartum visits)

O02.1 Missed abortion (use for miscarriage)

O03.4 Incomplete spontaneous abortion without complication (use for support during D&C procedure/delivery of non-viable pregnancy)

Prenatal and Postpartum Visits:

Z1032 – Extended initial visit 90 minutes

Z1034 – Prenatal visit (8 visits either prenatal or postpartum)

Z1038 – Postpartum visit (8 visits either prenatal or postpartum)

HCPCS T1032 – 2 Extended (3hr) postpartum support, per 15 minutes, max 12 units per visit

Z1038 - 9 additional postpartum visits. *Recommendation by licensed clinician required*

The extended initial visit must be for 90 minutes to bill with Z1032.

All visits are limited to one per day, per Member

- ✓ Only one doula may bill for a visit provided to the same Member on the same day, excluding labor and delivery.
- ✓ One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support.

- ✓ The prenatal visit or postpartum visit billed on the same calendar day as birth may be billed by a different doula.

- ✓ For extended postpartum visits lasting up to three hours, doulas may bill HCPCS code T1032 (15 minutes per unit) for 12 units per visit, up to two visits (24 units) per pregnancy, per Member, provided on separate days.

Labor and Delivery Support

- CPT 59409 – Doula support during vaginal delivery only.
- CPT 59612 – Doula support during vaginal delivery after previous cesarean section.
- CPT 59620 – Doula support during cesarean section.

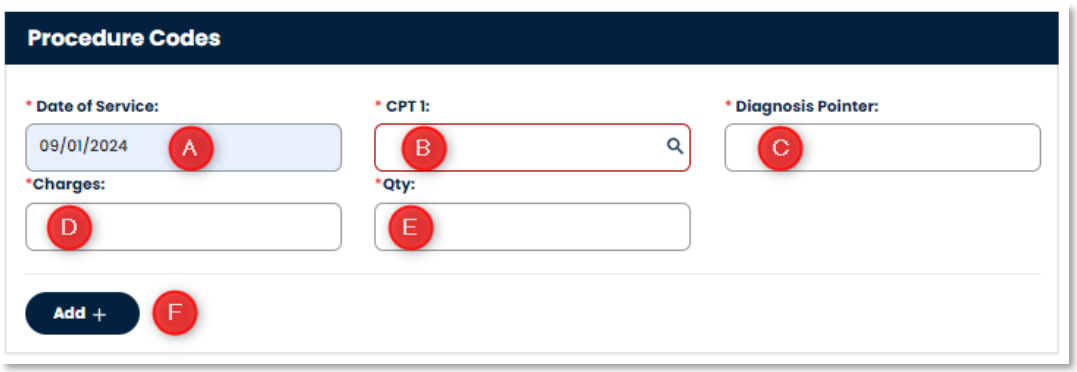
Billing codes for support during labor and deliver are limited to once per pregnancy. Support during labor and delivery can be billed if this service is provided by a doula, whether or not the delivery results in a live birth.

Abortion or Miscarriage Support

- HCPCS T1033 – Doula support during or after miscarriage.
- CPT 59840 – Doula support during or after abortion.

Billing codes HCPCS code T1033 for miscarriage support and CPT code 59840 for abortion are each limited to once per pregnancy.

10. Enter the **Procedure Codes** of the services rendered with the Date of Service for the Referral.



a. Select a Date of Service on the pop-up calendar or manually using the format of (MM/DD/YYYY).

b. When clicking in the CPT 1 field, a pop-up box will display with billable codes.
NOTE: To remove CPT Code(s), click on the "**X**" next to the CPT Code.

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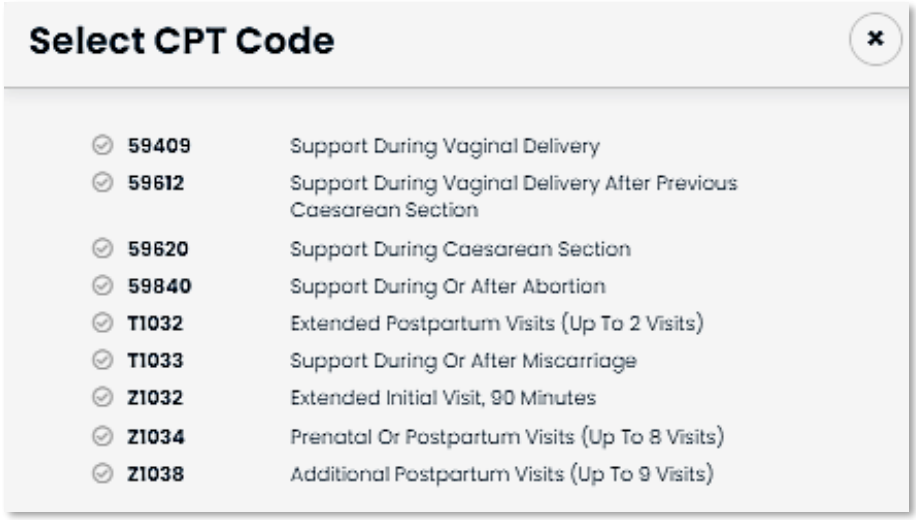

c. Select a Diagnosis Pointer for the CPT Code. The pop-up box displays Diagnosis Pointers from the Diagnosis Codes section.
   NOTE: Providers must submit one Place of Service (POS) per claim.

d. Enter the charge amount for the selected CPT Code.

e. Enter the Quantity (Qty) amount for the CPT Code.

f. If services were rendered because of an Emergency, please check the "**Yes**" check box.

g. Enter Modifier if required. Click Add + to include an additional modifier.

Telehealth:

- Doulas may bill for telehealth services with modifiers **93 or 95 as the secondary modifier.** 'XP' must be submitted as the primary modifier.

- Modifier **93** – Synchronous telehealth services rendered via telephone or other real-time interactive audio-only telecommunication system.

- Modifier **95** – Synchronous telehealth service rendered via a real-time interactive audio and video telecommunication system.

- The following codes can be billed with either modifier 93 or 95.

59409	**59612**	**59620**
T1032	**T1033**	**59840**
Z1032	**Z1034**	**Z1038**

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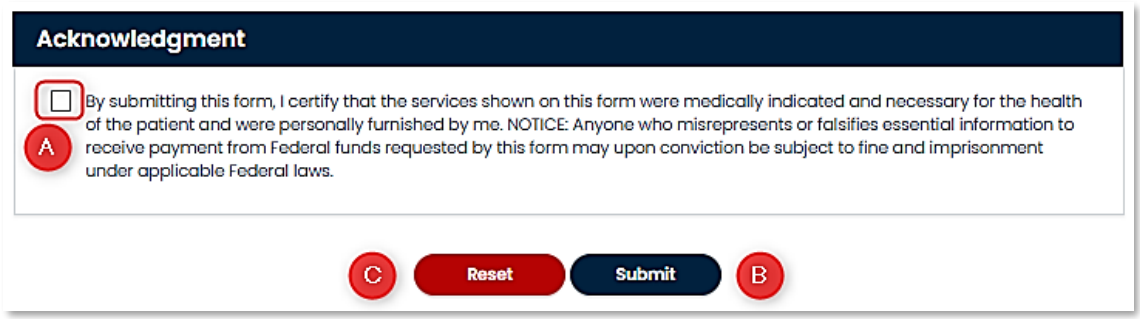
h. To add additional Procedure Code(s), click "**Add +**"

NOTE: Providers are unable to bill twice for the same Procedure Code in one Claim Submission.
NOTE: A maximum of twenty-five (25) Procedure Code(s) may be billed at once.

11. Before submission, an **Acknowledgement** must be verified by the Provider by clicking on the check box.
    a. "By submitting this form, I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me. NOTICE: Anyone who misrepresents of falsifies essential information to receive payment from Federal funds requested by this form may upon conviction by subject to fine and imprisonment under applicable Federal laws."

    b. After reviewing the form, click on the "**Submit**" button to submit claim for referral.

    c. To start over and clear the form, click on the "**Reset**" button.



12. After Claim is submitted, a copy of a completed CMS 1500 form is available to be printed.