Maryland Department of Health - Frequently Asked Questions and Answers for Medicaid's Doula/Birth Worker Coverage Implementation for Providers

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Description: This document represents a compilation of questions received from doulas and other stakeholders around Medicaid's Doula/Birth Worker Coverage implementation, and the Department's responses in a frequently asked questions format. The questions are grouped by subject, and a key terms list is defined to assist with readability. You can find more resources on our Doula Provider Information webpage.

Comments and/or questions may be directed to the Department's dedicated mailbox: mdh.medicaidmch@maryland.gov.

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Key Terms

Beneficiaries - A beneficiary is someone who receives services from Maryland Medicaid.

Claims - A claim is submitted by approved Maryland Medicaid providers in order to get paid for the services they give to clients.

Electronic Provider Revalidation and Enrollment Portal (ePREP) - ePREP is Maryland Medicaid's online provider enrollment website. ePREP is where new providers can sign up to become an approved Maryland Medicaid FFS provider. All Maryland Medicaid providers must enroll and be approved by ePREP before being reimbursed for services provided to Maryland Medicaid beneficiaries. In order to sign up in ePREP, a provider needs their NPI (defined below).

Eligibility Verification System - EVS is a telephone inquiry system that enables health care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status. It will tell you if the beneficiary is enrolled with a Managed Care Organization (MCO), in fee-for-service, or if they have third party insurance.

Fee schedule - A fee schedule shows the details about the services a provider can submit a claim for, like unit of service, cost, and what code to use.

Fee-for-Service (FFS) beneficiaries - About 15% of Maryland Medicaid's beneficiaries are 'Fee-for-Service,' meaning their services are paid for directly from Maryland Medicaid.

HealthChoice beneficiaries - About 85% of Maryland Medicaid beneficiaries are enrolled in the HealthChoice program. This means that their care is coordinated by an MCO.

Managed Care Organizations (MCOs) - Managed Care Organizations are responsible for coordinating the care of their members. MCOs contract with enrolled Maryland Medicaid FFS providers, and pay contracted providers for the services given to HealthChoice beneficiaries. There are nine MCOs in Maryland: Aetna Better Health, AMERIGROUP Community Care, CareFirst BlueCross Blue Shield Community Health Plan Maryland, Jai Medical Systems, Kaiser Permanente, Maryland Physicians Care, MedStar Family Choice, Priority Partners, and UnitedHealthcare Community Plan.

Maryland Department of Health (MDH) - MDH is the state government agency that is in charge of Maryland Medicaid services.

Maryland Medicaid (Medicaid) - Maryland Medicaid provides free healthcare services for eligible Maryland residents. There are two major groups covered by Maryland Medicaid: Fee-for-Service beneficiaries and HealthChoice beneficiaries. Maryland Medicaid is operated by the Maryland Department of Health.

MA ID Number (or Provider Number) - The MA ID Number is a unique 9 digit ID generated by MDH for Medicaid providers. Providers obtain their MA ID when they enroll in ePREP.

Member ID Number - Each Medicaid beneficiary has a unique member ID number that is shown on their Medicaid card they receive when they enroll. This number can be used to identify their MCO with the EVS system, explained above.

National Provider Identifier (NPI) - An NPI is an ID number issued by the National Plan and Provider Enumeration System (NPPES), run by the Department of Health and Human Services (HHS), which gives unique identifiers to providers across the country. All doulas applying to become Medicaid enrolled providers need a Type 1 NPI; group doula practices can obtain a Type 2 NPI, and enroll as a group and then enroll individual doulas as rendering providers.

Place of Service codes - In order for claims to be processed, codes that correspond to where the service was provided must be entered based on a list developed by CMS. Reference the place of service codes from the code and modifier table published in this document.

Prior Authorization - Some MCOs and health insurance organizations require approval for certain procedures before they will pay for those services. When this happens, that service needs 'prior authorization' from the MCO.

Benefit Information

1. **How many visits are covered?**
   It will be an 8:1 model, meaning that a total of eight visits before (prenatal) or after birth (postpartum) are covered per pregnancy, as well as attendance at labor and delivery. The prenatal/postpartum visits can be divided up however the doula and client wish. All 8 visits could happen in the prenatal period or the postpartum period or a combination of both. Many doulas will choose to have 4 visits in the prenatal period and 4 visits in the postpartum period, but this is the decision of the doula and client.

2. **When is the start date?**
   Beginning January 1, 2022, doulas will be able to enroll in ePREP. Now that regulations are finalized, as of February 21, 2022, enrolled doulas may contract with MCOs, submit claims and be reimbursed for services rendered to HealthChoice and FFS beneficiaries.

3. **Is this a pilot program or is it available throughout the state?**
   The benefit is available statewide.

4. **Could people with high risk pregnancies have more doula visits covered?**
   There is currently a maximum of 8 visits per pregnancy. The Department is exploring having extra services for high risk populations in the future.

5. **What information, if any, do clients need to know/ be aware of as far as their benefits?**
   The doula benefit is effective February 21, 2022. More details about the benefit are available through COMAR Regulations. Please refer to the program manual that can be found on our provider resources website.

Doula Eligibility/Enrollment

6. **Are there any requirements to enroll as a doula? If so, what are those requirements?**
   Yes, to participate you must:
   - Be at least 18 years of age;
   - Obtain and maintain liability insurance;
   - Attest to being trained and certified by an MDH approved organization [see question 7];
   - Receive a Type 1 NPI from CMS (if enrolling as a group, also receive a type 2 NPI);
   - Enroll in ePREP as a Fee-for-Service (FFS) Medicaid provider;
   - Pass a background check

Please see the 'Medicaid Enrollment Guide for Doulas' on the Doula Providers Website for more detail on how to enroll.

7. **What are the current doula certification organizations accepted?**

   The following organizations are approved by MDH. For each organization, **ALL** of the listed trainings are required:

Organization	Certification Requirement(s)
Doula Trainings International	- Birth Doula Certification AND - Postpartum Doula Certification
The Childbirth and Postpartum Professional Association (CAPPA)	- Certified Labor Doula Certification AND - Certified Postpartum Doula Certification AND - Certified Community Lactation Educator Certification
Black Doula Training, formerly the International Black Doula Institute	- Pregnancy & Childbirth Doula Certification AND - Postpartum & Newborn Certification AND - Lactation/Breastfeeding Certificate of Completion
Ancient Song Doula Services	- Full Spectrum Labor & Postpartum Certification
Mamatoto Village	- Community Birth Worker Certification
Doulas of North America (DONA)	- Birth Doula Certification AND - Postpartum Doula Certification
International Childbirth Education Association (ICEA)	- Birth Doula Certifications AND - Postpartum Doula Certification
Childbirth International (CBI)	- Birth Doula Certification AND - Postpartum Doula Certification
MaternityWise	- Labor Doula Certification AND - Postpartum Doula Certification

8. **Are you considering more certifying organizations to be added to your list?**
   Yes, we are considering a process for reviewing additional organizations as part of Phase 2.

9. **What kind of insurance is required?**
   Doulas are required to have liability insurance before starting to see Medicaid beneficiaries. If a doula is part of a larger doula collective, the employer may purchase insurance at a group rate; however, it is the doula's responsibility to make sure the liability insurance is kept up to date.

10. **I tried applying in ePREP, but my application was not accepted. Why did that happen?**
    When ePREP applications are denied and Returned To Provider, the providers are given an explanation as to what information is needed to complete the application. Check the

notification you received to learn the specific reason why your application was returned to you.

11. **Do enrolled doulas require a site visit from MDH as a part of enrollment in ePREP?**
    No.

12. **How often is the training/recertification required?**
    MDH is discussing training and recertification requirements and will consider this further in phase 2.

13. **I have been a practicing doula for the past 15 years but have not received formal training from any of the listed organizations. Can that count towards the education requirement?**
    Right now, certification from one of the approved organizations is required. Other paths for enrollment are still being discussed, and more information will be available/discussed during phase 2.

Billing

14. **What is the fee schedule/reimbursement amount?**
    The fee schedule is below. A Medicaid beneficiary is allowed 8 visits before or after birth, as well as attendance at labor and delivery per pregnancy. This means, for example, someone could have 5 prenatal visits and 3 postpartum visits, as well as a labor and delivery service.

    Each perinatal visit is broken up into 15 minute units and can last up to an hour (4 units total). Attendance at delivery is a flat fee. As of July 1, 2023, the reimbursement rate for attendance at labor and delivery (T1033) is $800.

Description	Service Code until 3/31/23	Service Code Starting 4/1/23	Per unit rate as of 7/1/23	Max Units per service
Prenatal service visits (15 min/unit)	W3701	T1032	$16.62	4
Attendance at delivery (flat rate)	W3700	T1033	$800	1
Postpartum service visit (15 min/unit)	W3702	T1032 U9	$19.62	4

Note: Due to the CMS designation of service codes for doulas, MDH transitioned to these new codes effective April 1, 2023. Any services provided before 4/1/23 should be billed using the W codes indicated, and any services provided on or after 4/1/23 should be billed using the T codes.

15. **How do doulas apply for the reimbursement under this program?**
    1. Apply for and receive an individual NPI number from NPPES
    2. Enroll with Medicaid through ePREP, the online provider enrollment portal
    3. Contract with an MCO(s) to bill members enrolled through HealthChoice
    4. Submit a professional claim and be reimbursed by either Medicaid, for fee-for-service beneficiaries, or an MCO for services rendered

    You may find a copy of the most recent Maryland Medicaid Billing Instructions for the CMS 1500 form at https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

16. **By working with the MCOs, would doulas be considered an individual or could they be part of an organization?**
    All doulas will be required to have a Type 1 NPI and TIN to enroll in ePREP to obtain an MA Provider ID. Individuals doulas can then bill MCOs directly for services under their individual Type 1 NPI if they are contracted with that MCO. Group doula practices will be required to have a Type 2 NPI and TIN to enroll in ePREP, and then can enroll doulas as rendering providers using the individual doulas' Type 1 NPI. Group practices can then be reimbursed for services provided by their rendering providers. All doulas or doula group practices will need to submit an addendum attesting to having met the conditions of participation as part of ePREP enrollment.

17. **Do I need to bill through claims submission or is invoicing an option?**
    Doulas will bill only through claims submission, generally using a paper or electronic version of the CMS 1500 form. You may find a copy of the most recent Maryland Medicaid Billing Instructions for the CMS 1500 form at https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

18. **Once I've contracted with an MCO, how do I bill them for services?**
    Once you contract with an MCO, they will advise you on their specific billing practices. All use the CMS 1500 form for claims. You may find a copy of the most recent Maryland Medicaid Billing Instructions for the CMS 1500 form at https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

19. **How will I know whether to bill a client's MCO, or bill fee-for-service?**
    You can use the Eligibility Verification System (EVS). EVS (1-866-710-1447) is a telephone-inquiry system that enables health care providers to quickly and efficiently verify a beneficiary's current eligibility status. It will tell you if the beneficiary is enrolled with an MCO, has fee-for-service coverage, or has third party insurance. You can learn more about it in the most recent Maryland Medicaid Billing Instructions at https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx.

20. **I work in a doula collective and sometimes we will fill in for each other if there is a scheduling conflict. Can multiple doulas work with the same patient?**

Yes, multiple doulas can work with the same patient, as long as the maximum number of visits under the 8:1 model is not exceeded.

21. **What is a diagnosis code, and which one should I use for billing?**
    Diagnosis codes are required when billing for Medicaid services. A diagnosis code indicates the reason why the beneficiary required services. Doulas should use the diagnosis code Z32.2, which stands for 'encounter for childbirth instruction,' when billing for any and all of their services, along with the designated CPT codes.

22. **Would FQHCs be required to bill an Encounter Trigger Code with the Doula or HVS CPT codes on the claim for them to receive the additional payment amount or are the Doula or HVS codes able to be billed on a stand-alone basis for payment?**
    No. FQHCs who are also approved Doula and/or Medicaid HVS providers contracted with an MCO, should bill doula and HVS codes on a stand-alone basis for payment. They would not be required to bill an Encounter Trigger Code for the provision of this benefit.

23. **What are the place of service codes, and how do I use them in billing?**
    When billing Medicaid, you need to indicate where the service took place by using a place of service code. The place of services codes doulas might use are:
    - 02 - Telehealth Provided Outside Patient's Home
    - 04 - Homeless Shelter
    - 11 - Provider's Office
    - 12 - Patient's Home
    - 22 - Outpatient Hospital
    - 50 - Federally Qualified Health Center (FQHC)
    - 99 - Other

    In addition, the code modifier "GT" may indicate a service was delivered via telehealth. The table below shows the situations in which different place of service codes and modifiers can be used when billing for doula services.

    Note: Place of Service 02 will be accepted for FFS dual eligible beneficiaries receiving doula services via telehealth. Providers serving HealthChoice participants should continue to use the GT modifier for telehealth services.

    Detailed explanation of place of service codes are at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

CPT Code and Description until 3/31/23	CPT Code and Description after 4/1/23	Per Unit Rate as of 7/1/23	Place of Service Description	Place of Service code to use	Modifier to use	Limitations
W3701-Prenatal doula visit	T1032 - Prenatal doula visit	$16.62	Doula visit in home	04/12	none	4 15-minute units per service; 8 total services maximum
W3701-Prenatal doula visit	T1032 - Prenatal doula visit	$16.62	Doula visit at doctor's office w/client	11/50/22	none	4 15-minute units per service; 8 total services maximum
W3701-Prenatal doula visit	T1032 - Prenatal doula visit	$16.62	Doula visit in community	11/99	none	4 15-minute units per service; 8 total services maximum
W3701-Prenatal doula visit	T1032 - Prenatal doula visit	$16.62	Doula visit via telehealth	12	GT	4 15-minute units per service; 8 total services maximum
W3700 -Labor & Delivery doula support	T1033 - Labor & Delivery doula support	$800 (flat rate)	Doula visit in hospital/L&D - in-person only	21/25	none	1 unit of service per delivery; Cannot be delivered as a telehealth service and can only be delivered in a hospital or birthing center
W3702-Postpartum doula visit	T1032 U9 - Postpartum doula visit	$19.62	Doula visit in home, in-person	04/12	none	4 15-minute units per service; 8 total services maximum
W3702-Postpartum doula visit	T1032 U9 - Postpartum doula visit	$19.62	Doula visit in community, in-person	11/99	none	4 15-minute units per service; 8 total services maximum
W3702-Postpartum doula visit	T1032 U9 - Postpartum doula visit	$19.62	Doula visit via telehealth	12	GT	4 15-minute units per service; 8 total services maximum

Client eligibility

24. **Do clients need any prior authorization for the doula services?**
    Prior authorization is not required.

Benefit Scope

25. **Where are prenatal and postpartum visits allowed to take place? Am I allowed to accompany clients to medical appointments?**
    The visits should take place at a comfortable, safe location. This could include the client's home or current residence, a doula's office, or place of practice. A doula is allowed to bill for accompanying a client to a medical appointment as a prenatal or postpartum visit.

26. **For pre and post services can we offer them via telehealth exclusively?**
    No, a doula must offer in-person prenatal and postpartum services. Telehealth services may also be provided as an additional option. Medicaid doulas must be able to offer all three services in-person. Labor and delivery services are only permitted to be in-person, however prenatal and postpartum services can be virtual but must have the option of being in-person.

27. **Can pre and post services be offered in a classroom setting with two or more mothers? If yes, can this be done virtually as well?**
    No, a classroom is not an approved place of service. Additionally, a service is only billable for one Medicaid participant at a time.

28. **If we just wanted to offer pre and post services, no Labor and Delivery services is that permissible?**
    No, all doulas must make labor and delivery services available to every client. It would not be permissible for this provider type to only offer prenatal and postpartum services; labor and delivery would also need to be provided. A birthing parent may choose whether or not they wish to receive any of these services.

29. **Is it possible to bill for lactation support?**
    Lactation support is not a separately billable service for the doula provider type. As explained in our program manual, the doula would incorporate into a prenatal or postpartum doula visit (among other services indicated):
    - Provision of evidence-based information on infant feeding to supplement, but not in lieu of, the services of a lactation consultant;
    - Provision of general breastfeeding guidance and resource

Beneficiary Outreach

30. **Will there be outreach to beneficiaries to notify them about the new benefit?**

Yes, MDH is currently working with MCOs to develop implementation and outreach strategies. Additionally, MDH will reach out to stakeholders involved in Maternal and Child Health.

31. **Is there a referral process between beneficiaries (potential clients) and doulas?**
    Medicaid beneficiaries will not require a referral from a licensed provider for doula services.

Further Information

32. **Will there be additional guidance?**
    Yes, this document will be updated and additional information will be provided in the form of a policy transmittal and program manual.

33. **What does "phase 2" refer to? When does it start?**
    To allow the doula benefit to be available to Marylanders as soon as possible, an initial benefit implementation phase was launched in June 2021. Phase 2 means the time period after the initial finalization of regulations (February 21, 2021), where MDH will consider any additional policies or program updates, as raised by stakeholders in Phase 1 or ongoing into Phase 2, to further refine the benefit.