Doula Services

Overview

A doula is a non-medical trained professional who provides education, emotional and physical support during pregnancy, labor/delivery, and post-partum periods.

Policy

Nevada Medicaid's doula policy can be found on the Division of Health Care Financing and Policy DHCFP website, http://dhcfp.nv.gov, under Medicaid Services Manual (MSM) Chapter 600 – Physician Services.

Covered Services

The following Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes may be billed by provider type (PT) 90 – Doulas:

Procedure Code	Modifier	Procedure Code Description
59409	U1	Vaginal delivery only
59514	U1	Cesarean delivery only
59612	U1	Vaginal delivery only after previous cesarean delivery
59620	U1	Cesarean delivery only after attempted vaginal delivery after previous cesarean delivery
S9445	U1	Patient education not otherwise classified non physician provider, individual per session

These codes should be billed with the U1 modifier. If doula services are provided to recipients in a rural area, providers should bill procedure codes with the TN modifier in addition to the U1 modifier. The rates for the TN modifier include an additional 10%.

Doula services for the same recipient and pregnancy are limited to a maximum of the following:

- Four (4) visits during the prenatal, antepartum, and/or postpartum period up to 90 days postpartum (procedure code S9445). Code S9445 also has a limitation of one (1) visit per day.
- One (1) visit at the time of labor and delivery (procedure codes 59409, 59514, 59612 or 59620).

Prior authorization (PA) may be submitted for additional medically necessary doula visits for code S9445 as outlined in the *Prior Authorization (PA)* section below.

For services rendered via telehealth, refer to MSM Chapter 3400 – Telehealth Services. Please refer to the Telehealth Billing Instructions for additional information.

Non-covered Services

For a list of non-covered services, refer to MSM Chapter 600 – Physician Services.

Claims that reimburse in error are subject to recoupment.

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Prior Authorization (PA)

PAs are not required for (4) four visits during the prenatal, antepartum, and/or postpartum period up to 90 days postpartum and for (1) one visit at the time of labor and delivery. If any other visits are medically necessary for code S9445, prior authorization is required.

Prior authorization requests must be requested at least *three* business days prior to service.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

How to Request Prior Authorization

Submit prior authorization requests through the Nevada Medicaid Provider Web Portal as Outpatient M/S/ Retro Outpatient M/S Process Type. The Outpatient Medical/Surgical Services Prior Authorization Request (form FA-6) must be completed and submitted with your PA request.

Billing Requirements or Instructions

Submit all professional claims electronically using Direct Data Entry (DDE) through the Electronic Verification System (EVS) secure Provider Web Portal or use an approved trading partner. Refer to the EVS User Manual for billing instructions.