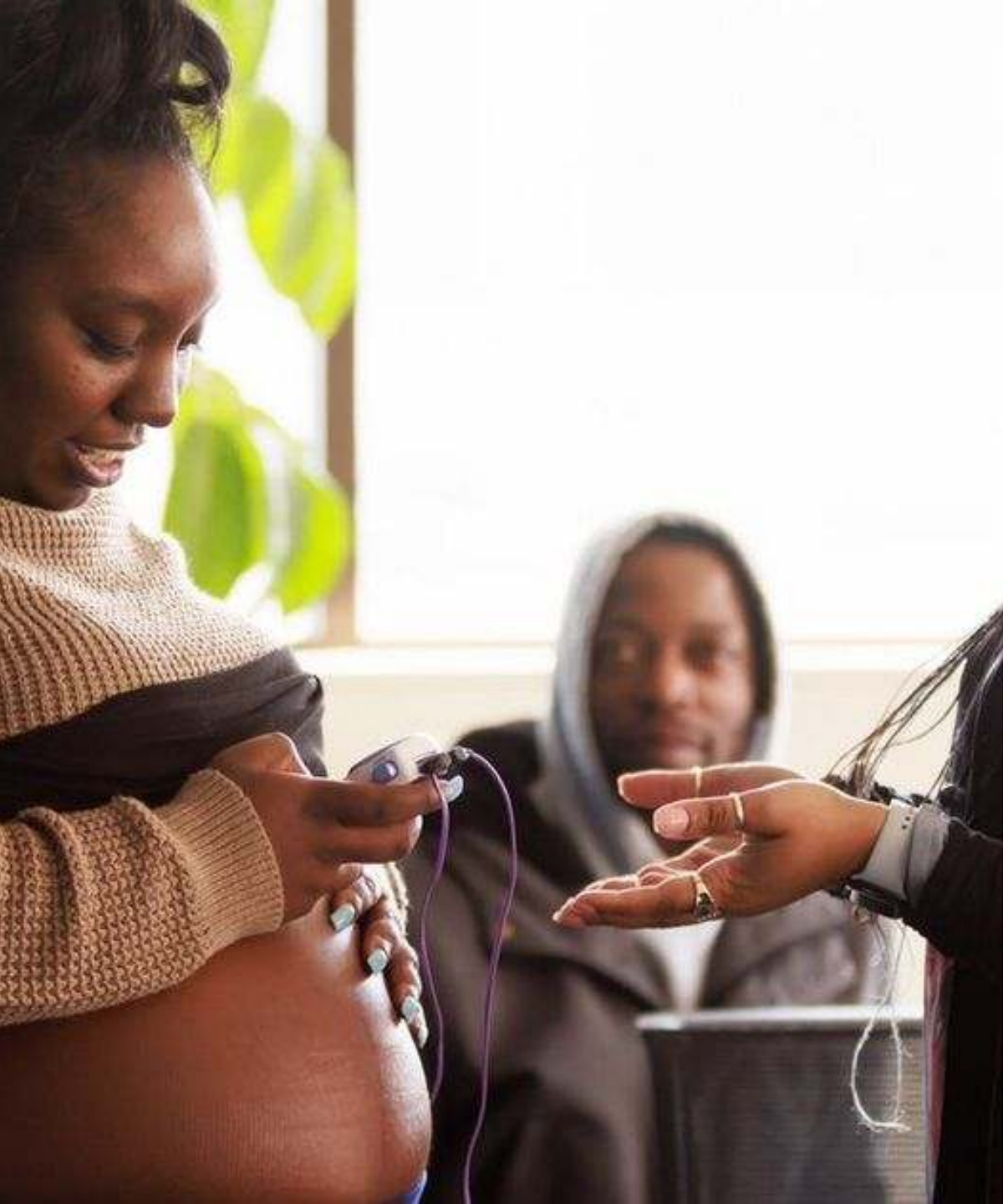


DENVER PUBLIC HEALTH & ENVIRONMENT

DANIELLE PETERS CONSULTING

Billing for Doula Providers

A step-by-step guide for claim submission

Objectives

Billing

Understand key considerations for doulas (groups and individuals) to effectively bill Medicaid in Colorado

Claim Submission

Understand how to submit a claim to Colorado Medicaid

Reimbursement

Navigate Medicaid reimbursement for individual doulas and groups

Billing Standards

**Must be included on your claim*

- **Member Name**
- **Medicaid ID**
- **Doula visits including:**
  - Dates of appointments (service)
  - Length of appointments (duration)
  - Services provided
  - Location of appointment (in patient's home, office, telehealth) (modality)
- **Provider NPI**

Billing Overview

Referring Provider NPI

Referring provider's NPI must be indicated on all claims

Accurate Service Times

Document exact start and end times for each service for proper unit billing

Billing in 15-Minute Increments

Use HCPCS code T1032 and bill services in 15-minute units

Documentation to Support Billing

Maintain documentation that supports the number of units billed

Claim forms necessitate the inclusion of specified elements, such as time and precision. Additionally, the submitted documentation must align with the billed services.

Group Billing Mechanics

- **Group vs. Individual Claims Submission**
  Group claims use Type 2 (organizational) NPI as billing provider, while individual doula identified as rendering provider with Type 1 NPI. Some states restrict which group types can bill for doula services.

- **NPI Placement on Claims**
  Both provider and doula NPIs must be included and accurately placed on claims.

- **Non-Physician Practitioner Billing**
  State-specific models for doula billing (group, collective, or supervised). Proper enrollment and certification required for all billing models. Each state establishes specialized doula billing codes and rules.

- **Reassignment of Benefits**
  Formal authorization required for payment to go to group. Typically requires completion of specific forms (like CMS-855R). Legal exceptions to direct payment rule allow for group billing.

- **Required Billing Modifiers**
  Procedure-specific modifiers vary by state (e.g., T1032, T1033 in Colorado). Special modifiers for telehealth/telemedicine delivery when applicable. Unlike physician services, no special group-based billing modifiers.

Financial Implications

- **Group vs. Individual Payment Rates**
  Rates typically standardized regardless of billing model; same procedure codes and fee schedules apply to both; group billing doesn't usually alter base payment amounts; some states expressly support collective models with specialized billing codes.

- **Payment Distribution in Group Practices**
  Group entity receives payment and manages internal distribution; internal compensation agreements determine individual payment; administrative fees or overhead often deducted before distribution; clear policies needed for handling shared revenue.

- **Financial Advantage for Doula Groups**
  Shared administrative staff and billing expertise; centralized credentialing and enrollment; collective negotiating power with managed care plans; reduced per-provider costs for liability insurance; more efficient participation in innovative payment models. This is an advantage to working within a doula group.

- **Group-Specific Incentives**
  Enhanced tracking of quality incentive payments; better positioned for geographic rate adjustments (e.g., rural bonuses); more capacity to document outcome-based incentives; easier integration with value-based payment structures.

- **Managing Denials and Recoupments**
  Specialized billing expertise to prevent denials; established processes for appealing incorrect denials; risk spread across multiple providers; more efficient tracking of documentation for potential audits; improved cash flow management during disputes.

Vital Claim Components

Claim Requirements

Provider Type Differences

Individual providers (PT 79) must use their individual credentials and type 1 NPI, whereas group practices (PT 72) bill under the group affiliation using the type 2 NPI.

Additional Record-Keeping Requirements

Colorado group practices must maintain 7-year record retention, documentation of recommending providers, organizational structure changes, and eligibility verification protocols.

Colorado's documentation requirements for doula group practices focus on maintaining comprehensive, compliant records to support Medicaid reimbursement, including detailed affiliation and medical records management.

Claim Requirements Cont.

Referring Provider NPI

Doulas must document written or electronic recommendations from licensed practitioners (e.g.: OBGYN, PCP, Mental Health Clinician), including the NPI of the recommending provider.

Medical Records Management Across Providers

Secure documentation system, standardized protocols, and full substantiation of claims required. Telehealth services need additional documentation with specific modifiers.

Claim Submission Process

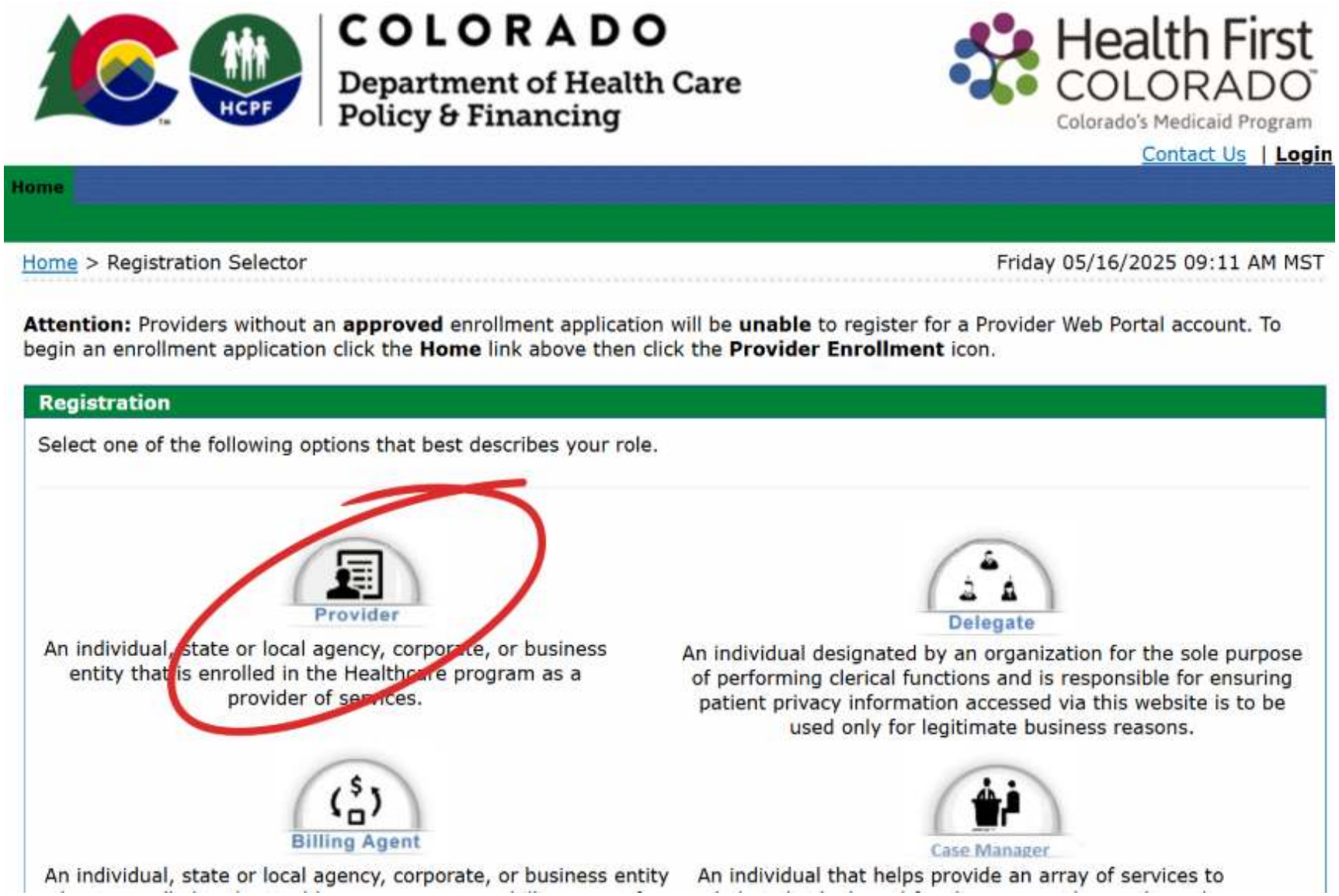
STEP 1

Portal Set Up

1) Go to the CO HCPF provider website

2) Click *Register Now*

3) Click provider



4) Enter YOUR NPI number

5) Enter YOUR nine digit zip code

6) Enter the doula taxonomy which is reflected in the slide – 374J00000X

7) Create a username

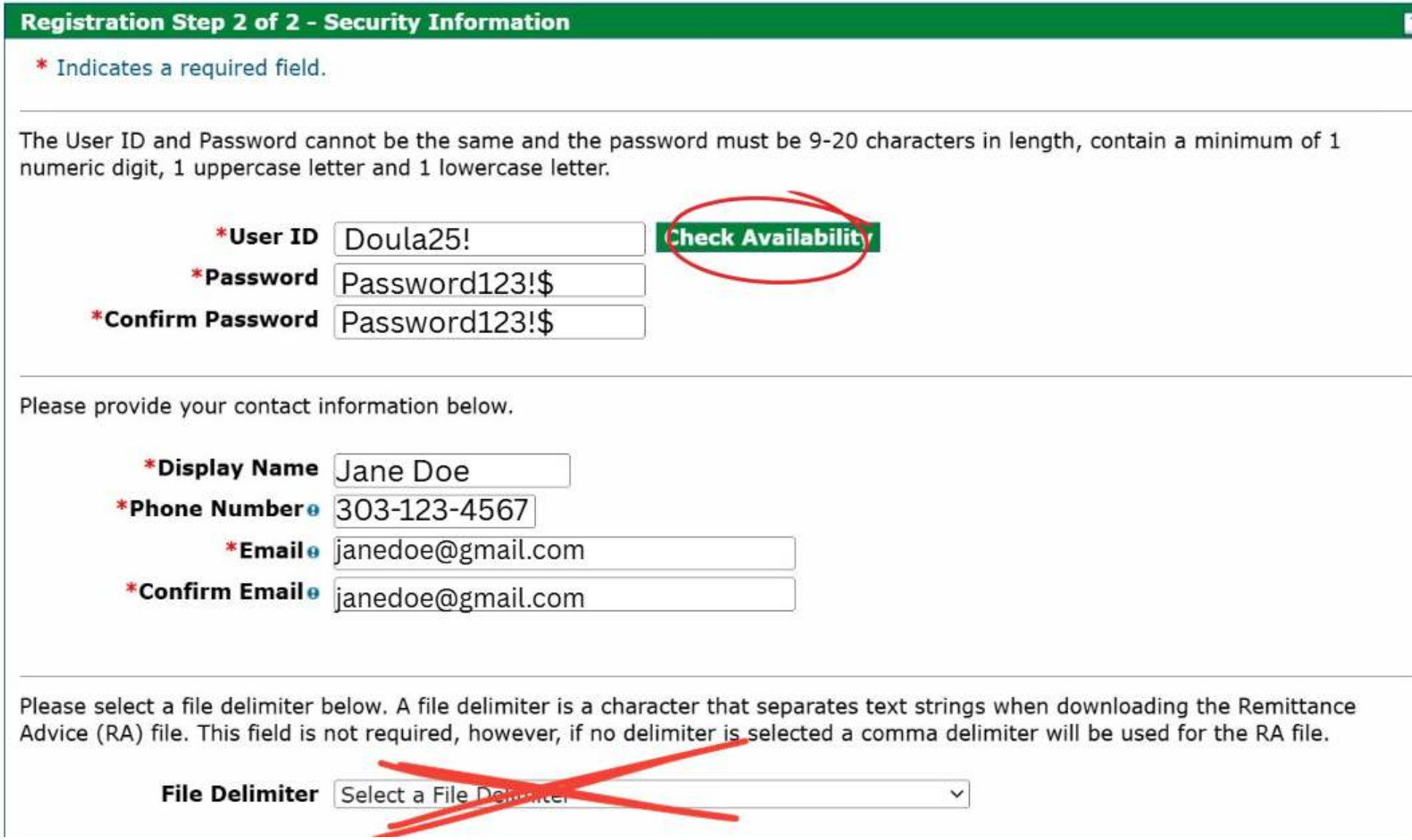
8) click *Check Availability* to make sure the username works

9) Create a password

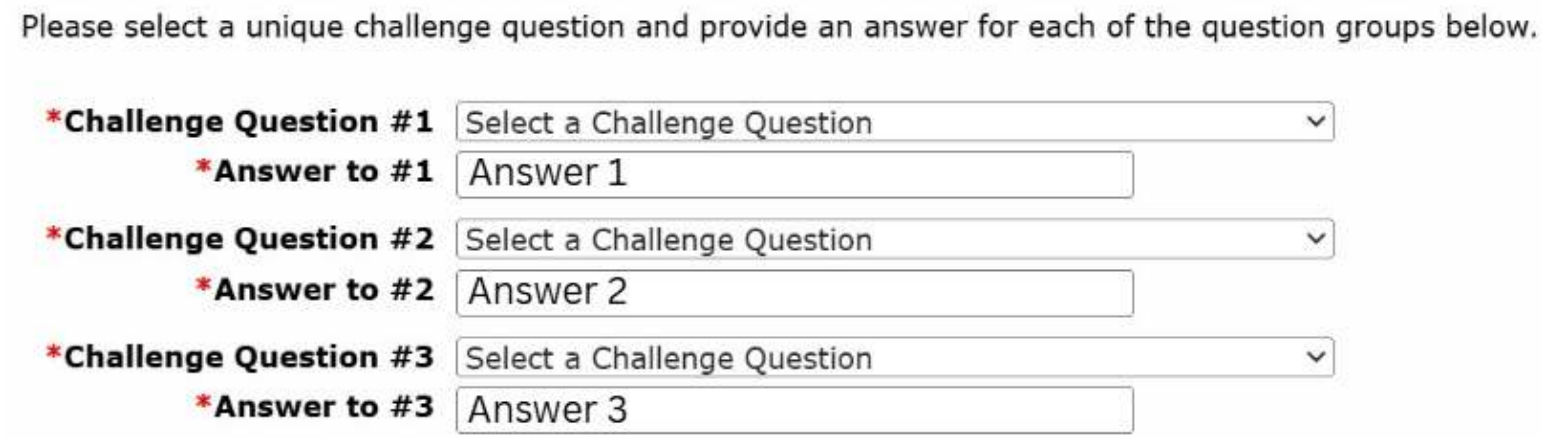
10) Put your full name under *Display Name*

11) Enter your phone number and email

12) Disregard choosing a file delimiter and scroll down



13) Choose your Challenge Questions and put your answers

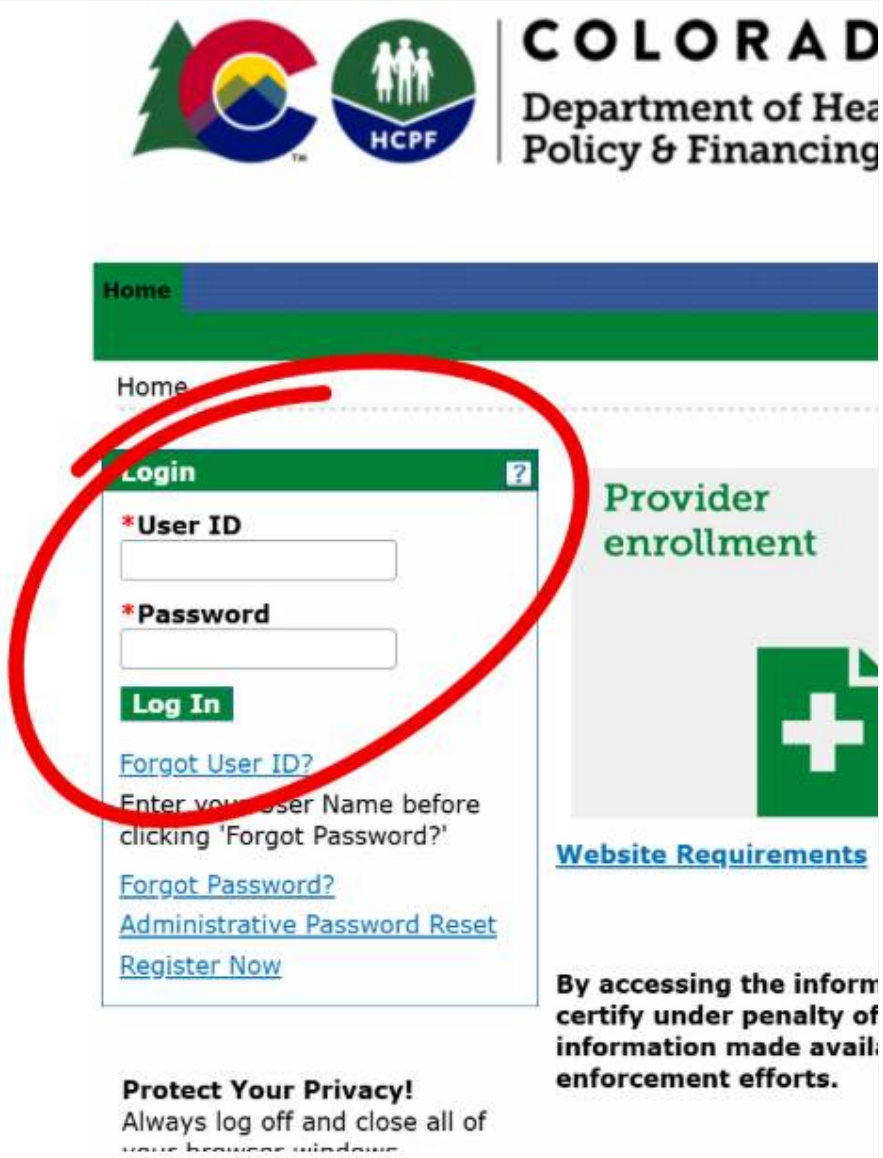


14) Read & scroll through the Web Portal User Agreement

15) Sign by typing your full name

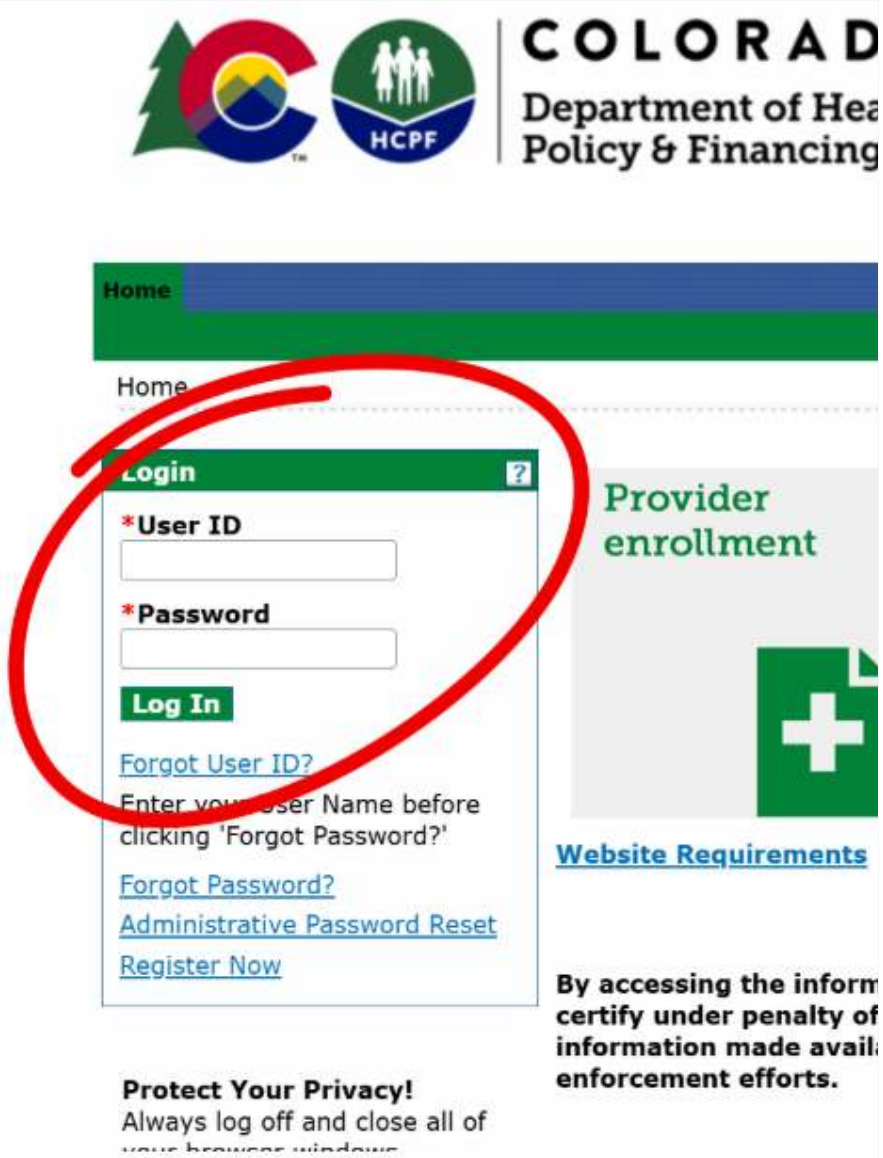
16) Hit Submit

- Once you hit submit wait 15-30 minutes to receive a confirmation email
- Click the link at the bottom of the email
- The email will send you to the website. Reenter your password and confirm your username and password
- Once confirmed, go back to the HCPF Provider Website and enter your username and password to login



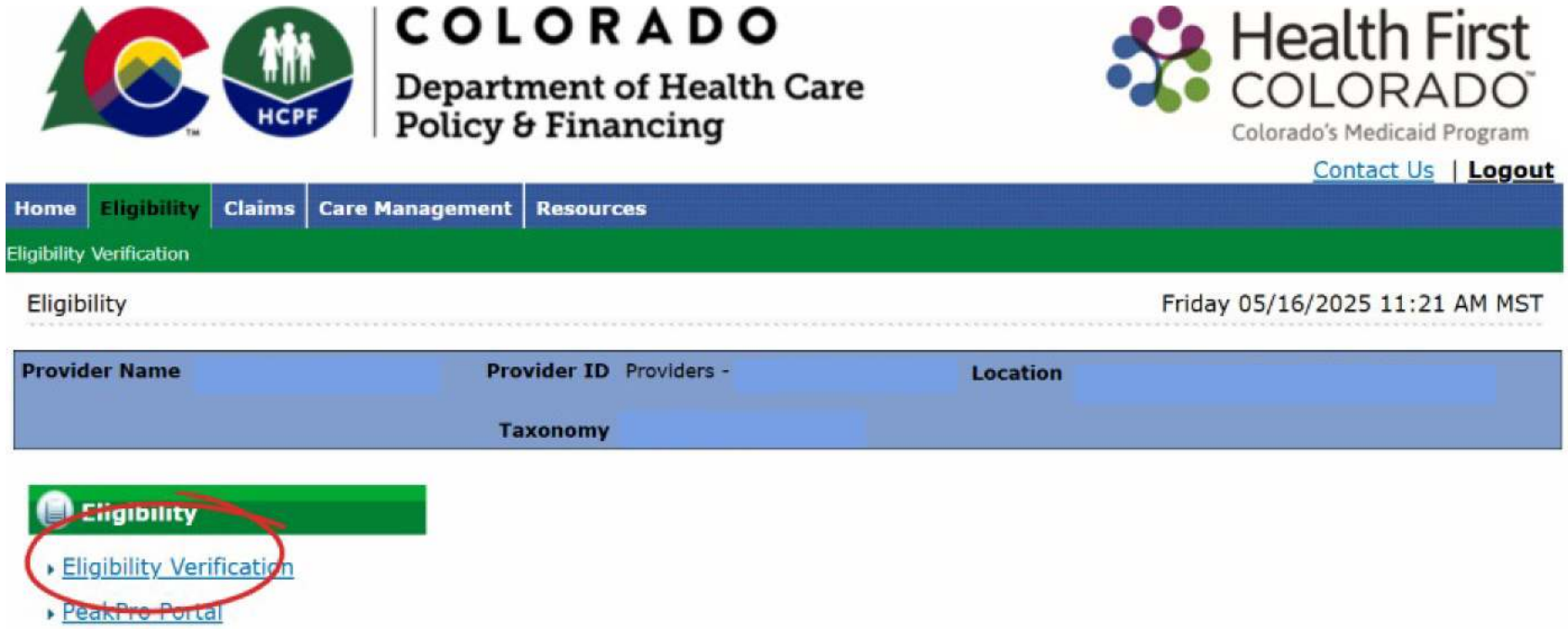
Verifying Medicaid Member Eligibility

- Use your username and password to login to your Health First Colorado Portal



2) Click Eligibility in the top Blue bar

3) Click Eligibility Verification



Verification Tool

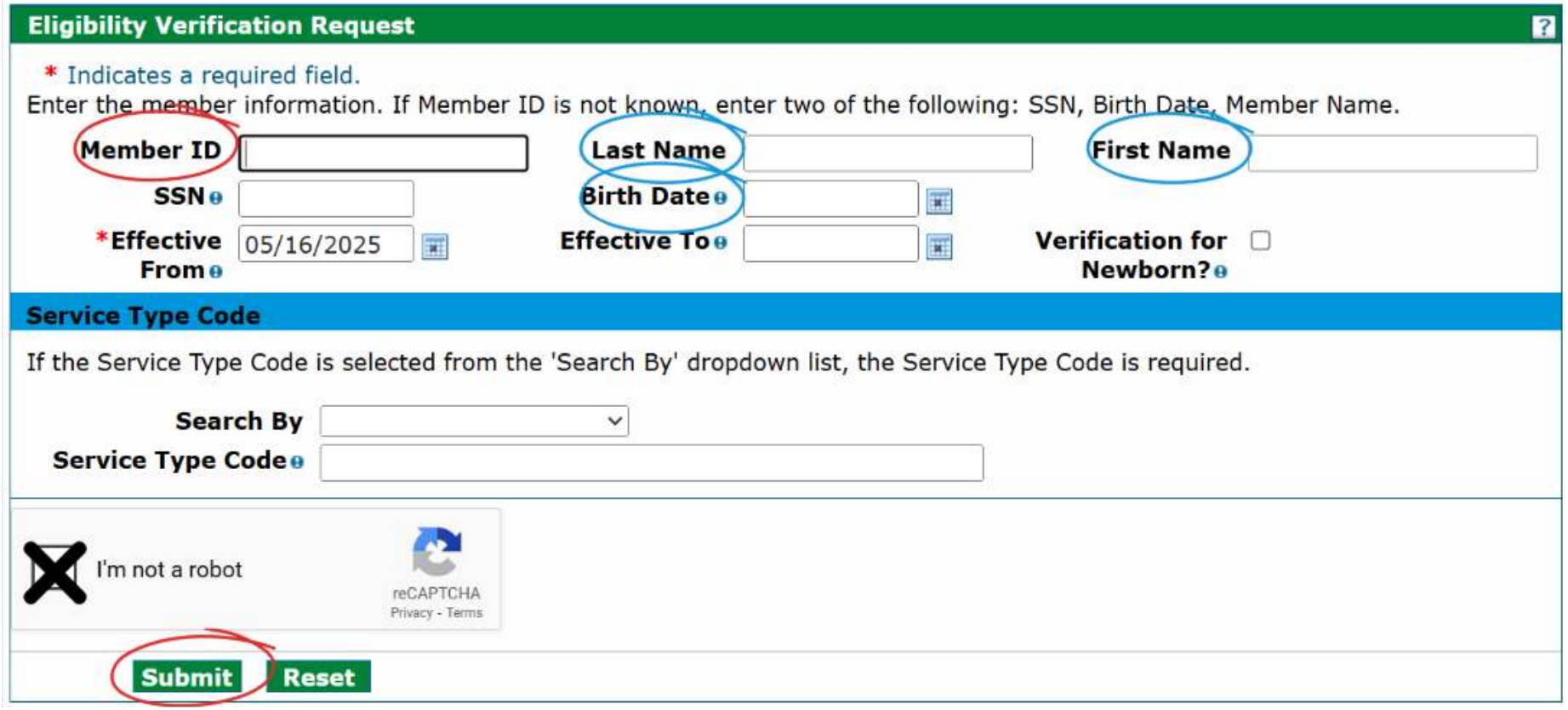
- Enter the Member ID
- Click *I am not a robot*
- Click Submit

OR

- Enter the Last Name
- Enter the First Name
- Enter the Birth Date
- Click *I am not a robot*
- Click Submit

The results of the member's insurance status will be listed below

NOTE: click on "Other Insurance Detail Information" and insure they don't have primary insurance that is active. If so, skip to the Billing Primary Insurance and CHP+ slide



Submitting a Claim

STEP 1:

From your Home Screen click on Claims in the top blue bar

STEP 2:

2) Click *Submit Claim Prof*

**Doulas always submit professional claims. You can disregard Dental and Institutional claims*

STEP 3:

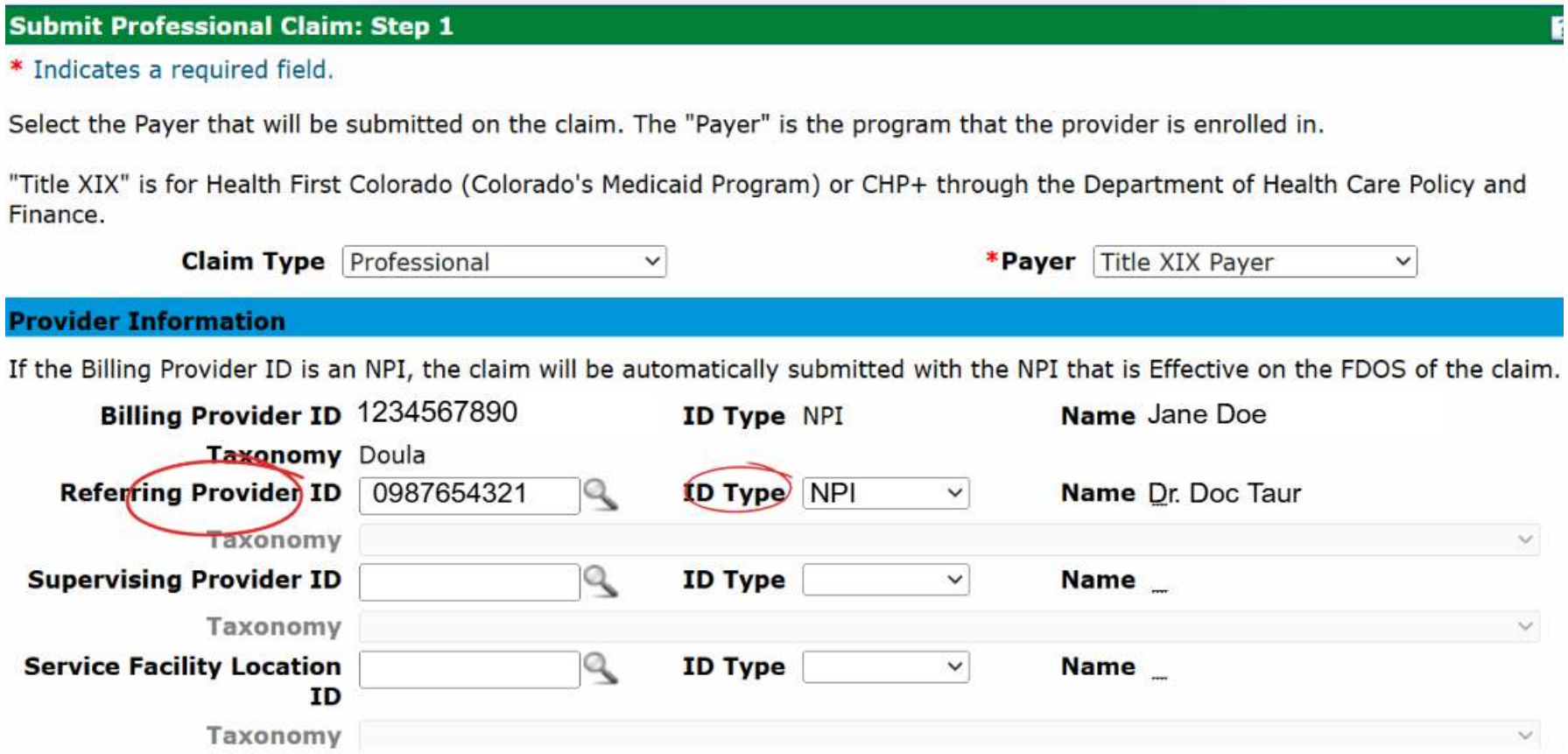
Your provider ID, ID Type, and Name will auto populate to your information every new claim

1) Enter the Referring Provider's ID number (Can be found at the NPI Registry Website)

2) Click *NPI* in the *ID Type* drop down menu

- After entering these two fields the provider's name will auto populate to the right. Please confirm the name is correct

- Leave Supervising Provider ID and Service Facility location ID BLANK



STEP 4:

1) Enter the Member ID number (this ID should begin with 1 letter followed by 6 numbers)

- After entering the Member ID, the Last name, first name, and birth date should auto populate - please confirm this is correct

- You do not have to enter the Address

STEP 5:

1) Date Type - click *Pregnancy* from the drop down menu

2) Enter todays date in *Date of Current*

- *Disregard Accident related reason*

3) Enter YOUR OWN patient number in *Patient Number* (this cannot be duplicated in the future)

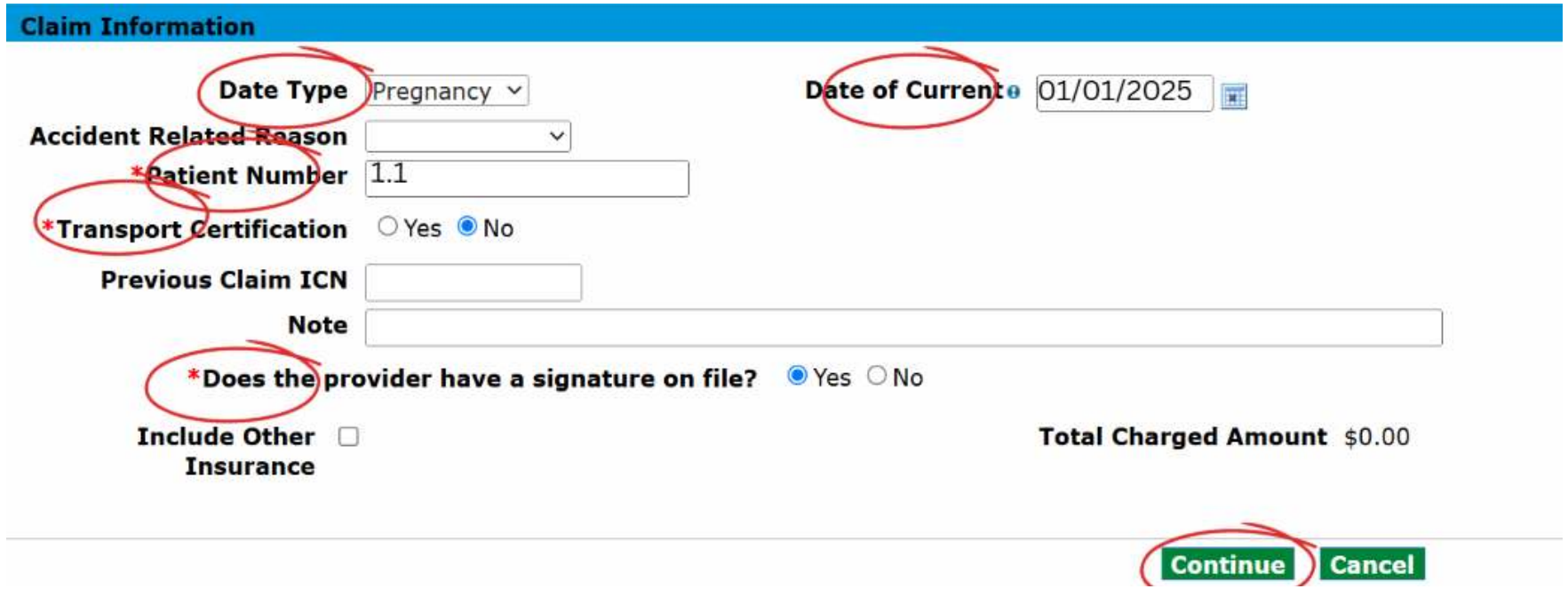
4) Click NO in *Transport Certification*

- Disregard *Previous Claim ICN*

- *Disregard Note*

5) Click Yes for "*Does the provider have a signature on file?*"

6) Click *Continue*



STEP 6:

1) Diagnosis Type should auto populate to ICD-10-CM (keep this as such)

2) Enter the Diagnosis Code

- once entered click what pops up

3) Click *ADD*

- if you have multiple line items repeat these steps. IF YOU ARE BILLING PRENATAL AND BIRTH TOGETHER YOU ONLY HAVE TO PUT THE DIAGNOSIS CODE ONCE.

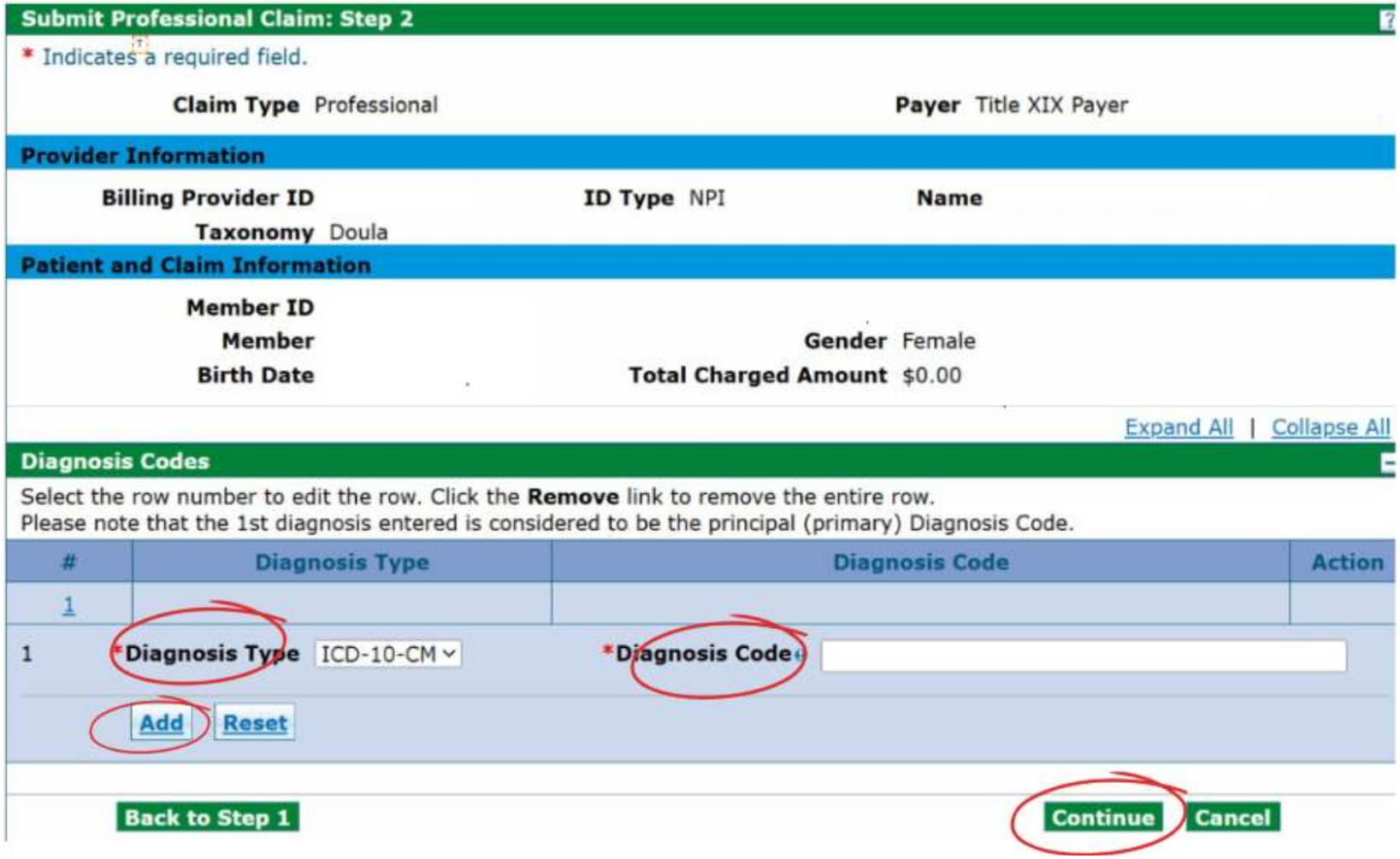
4) Press *Continue* when all diagnosis codes are listed for your bill

DIAGNOSIS CODES

- Prenatal = Z331

- Birth = Z331

- Postpartum = Z392



STEP 7:

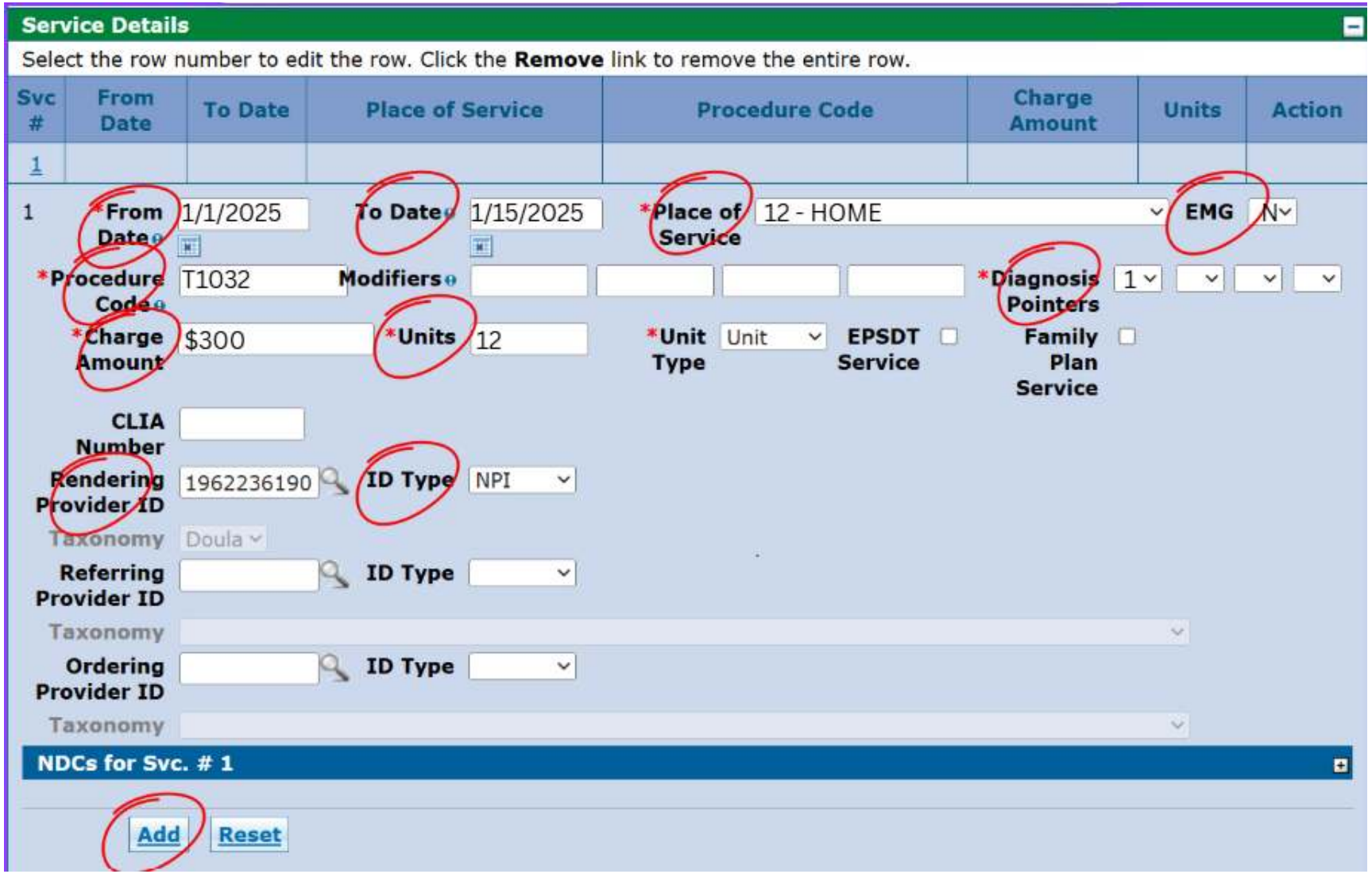
1) Put the first date of the prenatal, birth or postpartum visit in *From Date*

2) Put the last date of the prenatal, birth or postpartum visit in *To Date*

3) Put Place of Service of where service was rendered

- Common places for doulas are #12 – HOME, #21 – INPATIENT HOSPITAL, #25 – BIRTHING CENTER

4) Click N (no) for *EMG* (emergency)



STEP 8:

5) Enter the procedure code for the service rendered, click the pop up when you enter the code

- Doula Procedure Codes
Prenatal - T1032
Birth - T1033
Postpartum - T1032

6) Click #1 or #2 in the Diagnosis pointers to match the diagnosis code line from Step 2

7) Enter the Charge amount (i.e. $300 for 3 hours of prenatal or pp visits OR $900 for the birth)

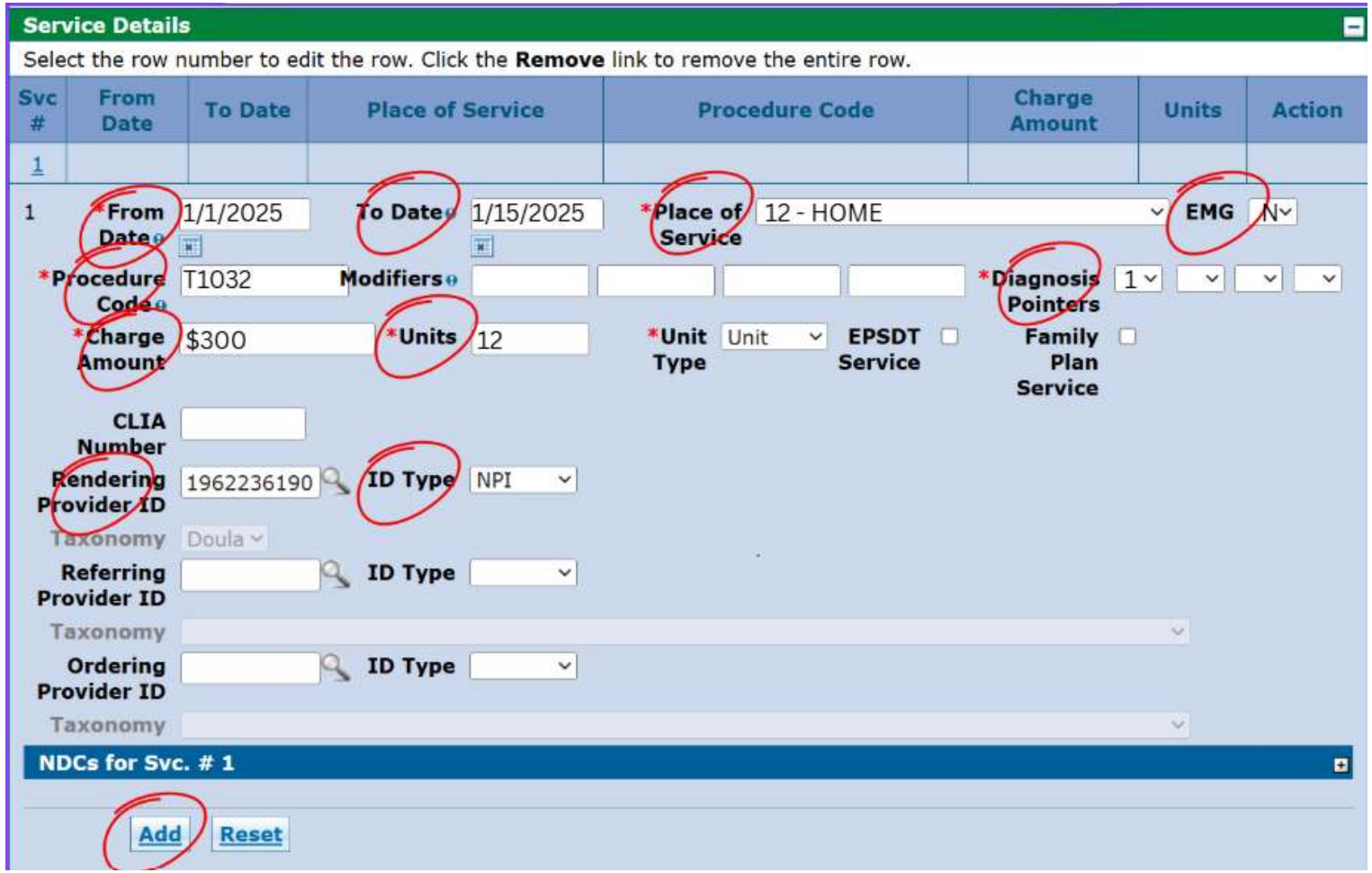
8) Enter the number of units reflected in the Charge amount (i.e. 1 unit for birth OR 12 units for 3 hours of prenatal or PP) ($25 per one 15 min unit)

9) Enter your NPI in *Rendering Provider ID*

10) Click NPI from drop down in ID type

11) Click *ADD*

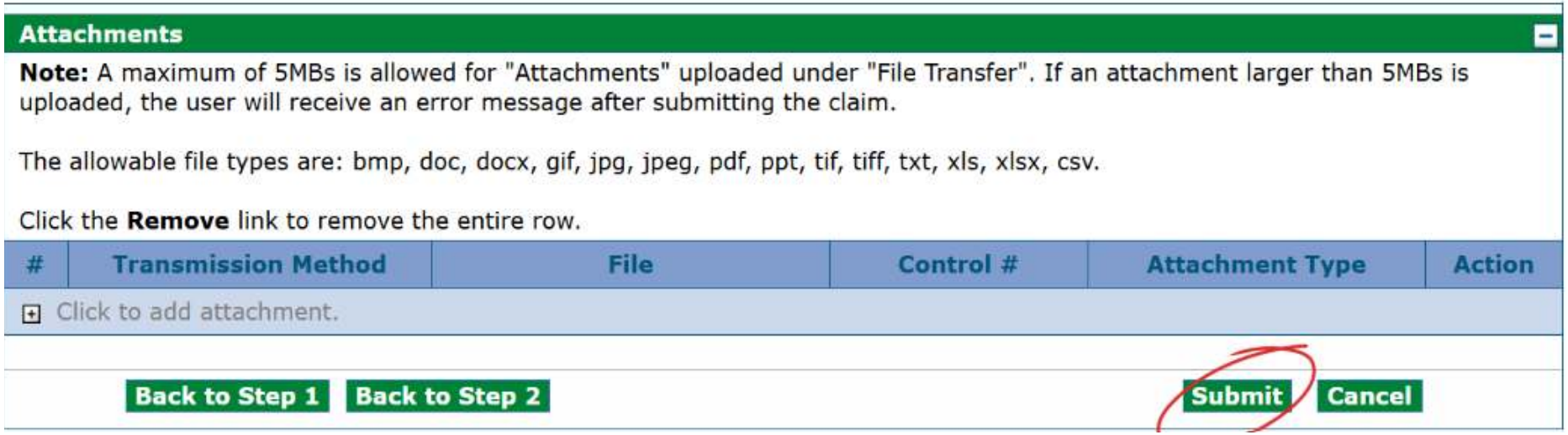
- if you have multiple line items repeat these steps



STEP 9:

– You do not need to add attachments

– Click Submit



- Confirm all the information is correct
- Click Confirm

Confirm Professional Claim

Select Print Preview **before** you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.

Claim Type Professional **Payer** Title XIX Payer

Provider Information

Billing Provider ID	1234567890	**ID Type**	NPI	**Name**	Jane Doe
Taxonomy	Doula				
Referring Provider ID	0987654321	**ID Type**	NPI	**Name**	Doc Taur
Taxonomy	OBGYN				
Supervising Provider ID		**ID Type**		**Name**	
Taxonomy					
Service Facility Location ID		**ID Type**		**Name**	
Taxonomy					

Member Information

Member ID A123456 **Gender** Female
Member Ellie Phant
Birth Date 1/1/1999
Address
City
State **Zip Code**

Claim Information

Date Type Pregnancy **Date of Current** 05/16/2025
Accident Related Reason
Patient Number 5.16
Transport Certification No
Previous Claim ICN
Note
Does the provider have a signature on file? Yes
Total Charged Amount $900.00

Expand All | Collapse All

Diagnosis Codes

Service Details

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT Service	Family Plan Service	Charge Amount
1	05/10/2025	05/10/2025	21	N	T1033		1	1.000 Unit			$900.00

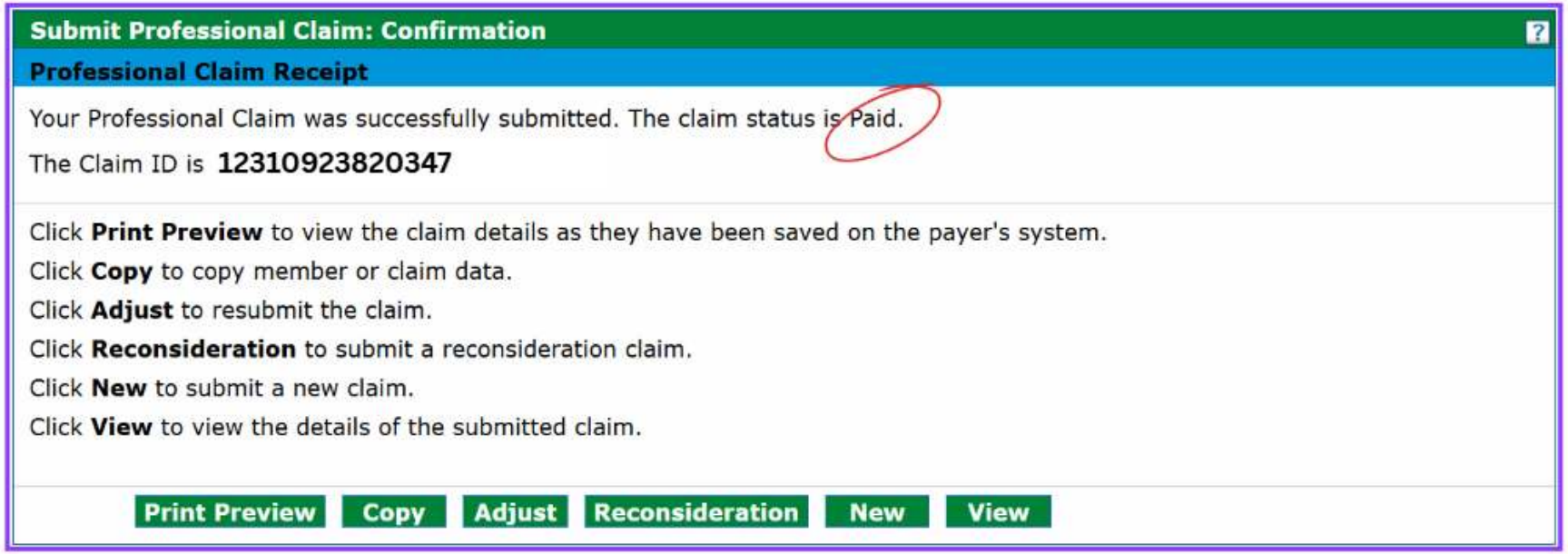
No Other Insurance Details exist for this claim

No Attachments exist for this claim

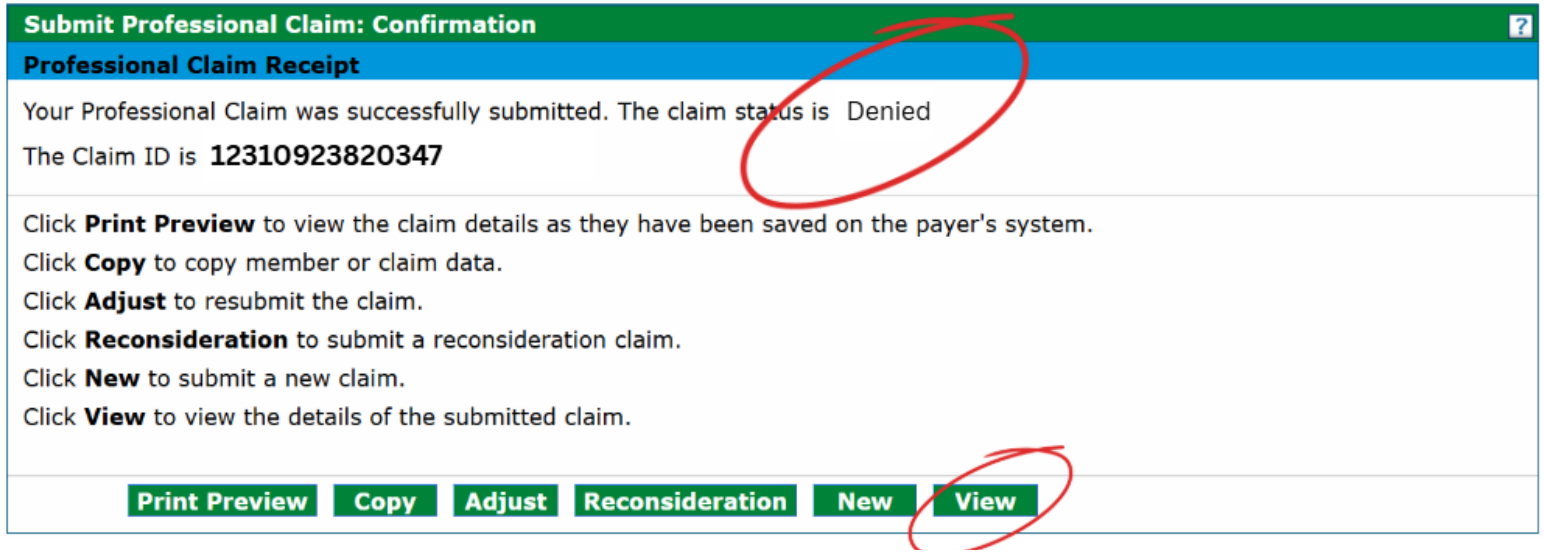
Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview | Confirm | Cancel

Confirmation

- If the claim status says PAID this claim is successful and you will receive payment within 2 weeks through electronic funds transfer (EFT)



- If the payment status is DENIED click VIEW



- Once you click view, scroll down and find ADJUDICATION ERRORS and click the + sign on the right of the green bar

- The bar will expand and tell you exactly why your claim was denied

- If it was an error on your part do not edit the claim, create a new one and submit

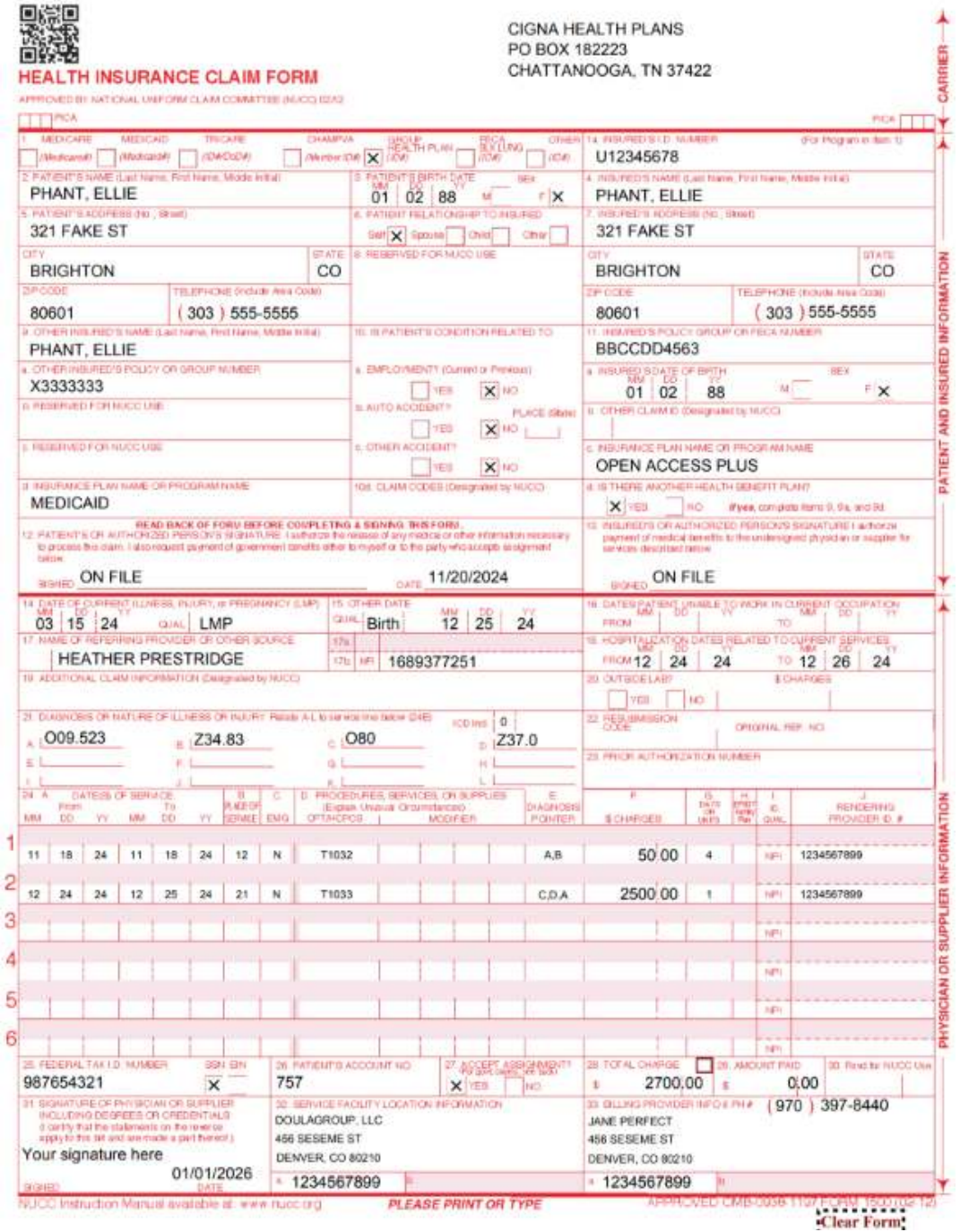
- If the client has primary private insurance see following slides

Billing Primary Insurance or CHP+

Only used when a client has primary private insurance (i.e.: Cigna) and Medicaid as secondary. The primary insurance must be billed first.

HCFA 1500 (CMS 1500)

CLICK



HEALTH INSURANCE CLAIM FORM

CIGNA HEALTH PLANS
PO BOX 182223
CHATTANOOGA, TN 37422

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN (X) / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: U12345678
2. PATIENT'S NAME: PHANT, ELLIE	3. PATIENT'S BIRTH DATE: 01 02 88 SEX: F X
5. PATIENT'S ADDRESS: 321 FAKE ST	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
CITY: BRIGHTON STATE: CO	8. RESERVED FOR NUCC USE
ZIP CODE: 80601 TELEPHONE: (303) 555-5555	
9. OTHER INSURED'S NAME: PHANT, ELLIE	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER: X3333333	a. EMPLOYMENT? (Current or Previous) NO X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? NO X PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAID	10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: BBCCDD4563	
a. INSURED'S DATE OF BIRTH: 01 02 88 SEX: F X	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME: OPEN ACCESS PLUS	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: ON FILE DATE: 11/20/2024

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 03 15 24 QUAL: LMP	15. OTHER DATE QUAL: Birth 12 25 24
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: HEATHER PRESTRIDGE	17a. 17b. NPI: 1689377251
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM 12 24 24 TO 12 26 24	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD Ind. 0 A. O09.523 B. Z34.83 C. O80 D. Z37.0 E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE: ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

#	24A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11 18 24	11 18 24	12	N	T1032		A,B	50 00	4		NPI	1234567899
2	12 24 24	12 25 24	21	N	T1033		C,D,A	2500 00	1		NPI	1234567899
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 987654321 SSN EIN: X	26. PATIENT'S ACCOUNT NO.: 757	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES: X NO	28. TOTAL CHARGE: $ 2700,00	29. AMOUNT PAID: $ 0,00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): Your signature here DATE: 01/01/2026	32. SERVICE FACILITY LOCATION INFORMATION: DOULAGROUP, LLC 456 SESEME ST DENVER, CO 80210 a. 1234567899 b.	33. BILLING PROVIDER INFO & PH #: (970) 397-8440 JANE PERFECT 456 SESEME ST DENVER, CO 80210 a. 1234567899 b.		

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500(02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Clear Form

Submitting an HCFA 1500 (CMS 1500) Form

Top right corner – These lines are where you enter the insurance company's name and billing address.

In sections 1-3 and 5 are self-explanatory which is your client's (patient) information. Be sure to double and triple check the "Insured's ID Number" in section 1a. If it is wrong at all, the claim will be rejected. (that's why it is important to get a copy of the client's insurance card).

Sections 4, 6, and 7 are information about the "insured". This is highly likely to be the same as the client's information, but not always. An example would be the spouse or parent of the client is the insured and the client is on their health insurance policy.

Section 9 – Medicaid information goes here.

Section 10 – answered "No" for most health claims.

Section 11– is where you enter any Group Number if there is one. If not, either leave blank or enter in "none."

Section 11a – is self-explanatory, insured's date of birth and sex.

Section 12 & 13– you would simply put in "Signature on file" and the date they signed the agreement with you – your agreement should have an assignment of benefits statement (example at the end of these instructions) You can also have them sign the printed form here.

Section 14 – LMP for pregnancy/postpartum AND birth claims – indicate LMP in the QUAL box.

Section 15 – Use this box for birth claims, leave blank for prenatal/postpartum.

Section 17 – enter the provider who you are using for your Medicaid referral. You have my permission to use my name and NPI for Doula claims.

Section 18 – use for inpatient birth only. All other claims leave blank

Section 21– enter the primary diagnosis using the ICD-10 code on line A. If there is more than one diagnosis, you can fill them in on lines B-L. (You only need one diagnosis though). In the top right of this section there is a space labeled "ICD Ind.;" just use 0 (zero) to let them know you are using ICD-10 (Most all the insurance companies are now using this anyway).

Section 23 sometimes if services require a prior authorization, you will enter the authorization number here. If no pre-authorization is needed, just leave this section blank.

Section 24a enter the date of service; same date in both "From" and "To". Be sure to put the date in both.

Section 24b The most common place of service codes that Doulas would use are:

- 02-Telehealth if the client is NOT at their home
- 04-Homeless shelter
- 09- Correctional facility/prison
- 10-Telehealth in client's home
- 11-Office
- 12-Home

- 16-Temporary lodging
- 18-Place of employment
- 21-Inpatient hospital
- 25-Birth Center
- 99-Other place of service

Section 24C is asking if you are billing for an emergency, Doula's will always answer N

Section 24d is the CPT Code for the session. CPT means, "Current Procedural Terminology" or simply the type of session you had. For Doula care the most typical codes uses are:

- T1032 – prenatal or postpartum visit 15min increments
- T1033- Labor and delivery

Submitting an HCFA 1500 Form

Section 24d also has a section for "Modifiers". Most of the time these are not used. But when required, they usually are two letters and might be specific to the insurance company.

Section 24E is matching the diagnosis code line from Section 21 to the CPT codes in 24D. Always list the most specific diagnosis codes first in this section. Claims will usually only accept a maximum of 3 codes, so only 3 letters should go in this box.

Section 24F enter your charges for the session. Tip: double or triple the amount you expect to get paid. The insurance company will discount the price regardless of the contracted rate. Also, plans can vary within insurance companies, and you might get more for a particular type of session or plan.

Section 24G for billing prenatal and postpartum, put in how many 15 min increments there were. Example – 1-hour long session = 4 units. Labor and delivery would be 1 unit.

Section 24J your NPI number

Section 25 your tax ID number – indicate if it is an EIN or your social security number.

Section 27 check "Yes" to have payment of the claim to come to you. (WARNING) Blue Cross/Blue Shield will almost always send the payment to the client no matter what box you check. This would mean you have to collect the money from the client. Denials and EOB (explanation of benefits) should come to you either way.

Section 28 total charge from section 24F (if charging $60 per 15min, 4 units = $240)

Section 29 any co-pays or payments the client made – most likely 0.00.

Section 31 your signature and date

Section 32 & 32a; your office location and address; the NPI number will depend on how you are contracted with the insurance company. If you are in a group practice, be sure and put the group name and address here, or the name of your solo practice. If your practice does not have a name, you would simply put your name and address here.

Section 33 & 33a enter the name of your practice. Again, the NPI number will depend on how you are contracted with the insurance company. If you are in a group practice and the payments need to come to the group, be sure and put the group name and address here. If you are a solo practitioner, you would simply put your name and address here.

Once you have the above information entered, the claim is ready to file. Do go back and check to make sure you have entered your information correctly. It is quite easy to leave out a digit in one or more of the numbers asked for. Keep a copy of your claim form, then mail or fax it to the insurance company claims office. After 2-3 weeks, you should call to make sure they have received your claim. If not resend it via fax and call to follow up. Call to check the status of your claim weekly until you receive a payment or a denial. Always get the name of the agent you speak with and ask for a call confirmation number.

Assignment of benefits example

ASSIGNMENT OF BENEFITS AND AGREEMTN FOR PAYMENT: I authorize medical benefits to the named provider. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all noncovered fees incurred within 30 days or my account may incur interest at the rate of 18% Annual Percentage Rate. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

Claim Status & Receipts

To view claim receipts

- Click Claims

- Click *Search Payment History*

- click search

- below will populate all paid claims and the dates they were paid

- please note that the receipt will not pop up immediately after submitting the claim. The receipt will show after the claim has been sent to your bank account