Claims Guidance for California Doula Services

June 2025

Introduction
This document outlines the Kaiser Foundation Health Plan (Kaiser Permanente) claims and billing policy for California Commercial and Medi-Cal doula services. A doula is a trained, non-medical professional. They provide companionship and give physical, emotional, and informational support during pregnancy, birth, and postpartum recovery. Doulas focus on members' well-being, help patients make informed decisions, and offer consistent care through all stages of pregnancy and birth, including in cases of pregnancy loss or abortion.

The goals of this guide are to:
- Interpret coding options and billing guidance
- Facilitate and incentivize accurate and timely payments

Scope
This guidance is intended for doula providers intending to submit ANSI ASC X12N 837P or 837I claims, and outlines data elements providers must submit.

Covered Doula Services
Doula services are covered for California Commercial members effective January 1, 2025, due to Assembly Bill (AB) 904. They are covered for Medi-Cal members effective January 1, 2023, per State Plan Amendment (SPA) 22-0002.

Applicable plans cover the services of a doula for a pregnancy (including pregnancies that end in miscarriage, abortion, or stillbirth). Covered doula services include the following:
- One initial visit
- Up to eight additional visits which can be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery (including labor and delivery resulting in stillbirth, abortion, or miscarriage)
- Up to two extended three-hour postpartum visits after the end of a pregnancy

Additional Coverage Criteria
- All visits are limited to one per day, per member.
- Only one doula may bill for a visit to the same member on the same day, excluding the day of labor and delivery.
- One prenatal visit or one postpartum visit can 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 can be billed by a different doula.
- The extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation.
- The extended postpartum visits are billed in 15-minute increments for up to three hours, with up to two visits per pregnancy per individual provided on separate days.

Service Modalities
- Doula services may be provided virtually or in-person.
- In-person visits may take place at any location, including the member's home, the doula's office, a Kaiser Permanente medical facility, or an

in-network medical facility.
- During labor and birth, the doula should support the member in person.

Non-Covered Services
The following doula services are excluded from coverage:
- Clinical or medical services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care)
- Assistance with activities of daily living
- Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation)
- Yoga
- Birthing ceremonies (e.g., sealing or closing the bones)
- Over-the-counter supplies or drugs
- Home birth
- Belly binding (traditional or ceremonial)
- Massage (maternal or infant)
- Photography
- Vaginal steams
- Group classes on baby wearing

Member Eligibility Criteria for Doula Services
A member must be enrolled on a Commercial or Medi-Cal health plan on the date of service to be eligible for covered doula services. Doulas must contact Kaiser Permanente to verify the member's enrollment for the month of service.

Provider Enrollment Requirements
- Commercial: The doula must have a National Provider Identifier (NPI) and a Tax Identification Number (TIN) for Kaiser Permanente to consider payment for doula services.
- Medi-Cal: Doulas are required to enroll as Medi-Cal providers, consistent with **APL 22-013, "Provider Credentialing/Re-Credentialing and Screening/Enrollment,"** or subsequent updates or any superseding APL, if there is a state-level enrollment pathway for them to do so.

Claims Submission Options

Professional or institutional
There are two standards for claims submissions: *professional* and *institutional*.

Electronic Claim Submission (EDI)
Kaiser Permanente urges providers to submit all claims via Electronic Data Interchange (EDI). Providers may submit EDI claims via 837I (Institutional) or 837P (Professional) transaction format, following all HIPAA standards and appropriate coding and regulatory requirements.
Benefits of Electronic Data Interchange (EDI) transmission include:

- Reduced overhead expenses
- Improved data accuracy
- Reduced turnaround time for claims processing
- Bypass U.S. mail delivery
- Reduced paper, mail time and postal mail costs

Kaiser Permanente's EDI training partners for Northern California (NCAL) and Southern California (SCAL) are listed in the table below:

Clearinghouse	NCAL Payer ID	SCAL Payer ID
Office Ally	94135	94134
Relay Health	94135/RH009/KS003	94134/KS001
SSI	NKAISERCA	SKAISERCA

Paper Claims
Providers may elect to submit paper claims. Please keep in mind that the paper process is the least efficient claims submission method. We expect that doula providers billing for professional services submit professional claims on a *CMS-1500* form. Instructions for completing the *CMS-1500* can be found at **The National Uniform Claims Committee.**

Claims Submission Policy
Doula providers must submit claims for the provision of services to Kaiser Permanente members after services are rendered, using national standard specifications and code sets. Members may not be asked to pay for services upfront and seek reimbursement from Kaiser Permanente retroactively. This process ensures that Kaiser Permanente can effectively monitor the volume and frequency of doula service provision and shows the actual cost of providing doula services to Kaiser Permanente and applicable regulatory bodies.

Kaiser Permanente will pay 95% of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within the regulatory timeframe (currently 45 working days from receipt). Kaiser pathways for claims submission (in order of preference) are EDI and paper claims. Find the latest Kaiser Permanente provider manuals, policies, and guidelines with additional claims guidance at the **provider portal**.

Clean Claims
Please use the following guidelines when submitting a claim.

- Submit clean claims, making sure that the correct and complete information is submitted on the correct form. A clean claim is a request for payment for a service rendered by a provider that:
  - Is submitted timely
  - Is accurate
  - Is submitted in a *HIPAA*-compliant format or using the standard claim form including a *UB-04*, *CMS-1450* or *CMS-1500* (02-12), or successor forms thereto, or the electronic equivalent of such claim form.

  - Requires no further information, adjustment, or alteration by the provider or by a third party to be processed and paid by us.
- Submit claims as soon as possible after providing service.
- Submit claims within the timely filing limit, which is 180 days from the date of service for non-contracted doulas. Contracted doulas should refer to their fully executed agreement for their respective timely filing limit. If we do not adjudicate the clean claim within the mandated timeframe, we will pay all applicable interest as required by law if the claim is payable. Providers are notified of the disposition of a claim via remittance advice (RA) when the claim is finalized.
- Paper claims that are determined to be unclean will be returned to the billing provider. The RA will state the reason for rejection. Electronic claims that are determined to be unclean will be rejected back to the clearinghouse that submitted the claim. In the event the provider is a direct electronic submitter to Kaiser Permanente, the claim will be returned directly to the provider.

Doula Coding Options

Providers should reference the diagnosis and HCPCS codes listed in the table below to report doula services. The specified HCPCS and diagnosis code combinations define the service as a doula service. As an example, HCPCS code Z1032 by itself does not define the service as a doula extended initial visit. HCPCS code Z1032 must be reported with one of the four corresponding diagnosis codes for the services to be defined and categorized as a doula service.

Doula Service	Associated Diagnosis Codes	Associated Billing Codes
One initial visit, either prenatal or postpartum (at least 90 minutes)	Z32.2 (childbirth instruction) Z32.3 (childcare instruction) Z39.1 (care/examination of lactating mother) Z39.2 (routine postpartum follow-up)	Z1032 (can be used for prenatal or postpartum)
Up to eight one-hour (at least 60 minutes) visits that may be provided in any combination of prenatal and postpartum	Z32.2 (childbirth instruction) Z32.3 (childcare instruction) Z39.0 (care/examination of mother immediately after delivery) Z39.1 (care/examination of lactating mother) Z39.2 (routine postpartum follow-up)	Z1034 (prenatal) Z1038 (postpartum)
Support during labor and delivery (limited to once per pregnancy)	Z33.1 (pregnant state, incremental) Z39.0 (care/examination of mother immediately after delivery)	59409 (vaginal delivery) 59612 (vaginal delivery after cesarean delivery) 59620 (cesarean delivery) 59840 (abortion) T1033 (miscarriage)
Up to two additional postpartum visits that may be available (at least 180 minutes)	Z39.0 (care/examination of mother immediately after delivery) Z39.1 (care/examination of lactating mother) Z39.2 (routine postpartum follow-up)	T1032

Modifiers
Doula services require modifier XP on all claim submissions. This modifier is the only field that differentiates the services of a doula from that of a physician. If doula services are provided through telehealth, additional modifiers (93 or 95) must be included. Please see the following table specifying the required modifiers based on service modality:

Modality	Definition	Required Modifiers
In-person	Face-to-face interaction with a member	XP
Audio-visual	Real-time interaction with a member through a secure audio-visual platform	XP, 95
Audio-only	Real-time interaction with a member through a secure telehealth line	XP, 93

Reimbursement
The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that a provider will be reimbursed. Services must meet guidelines appropriate to the procedure and diagnosis. **Additionally, member eligibility must be confirmed on the date of service. Services for patients who do not have active Kaiser coverage on the date of service will be denied.** This is especially important to avoid denials, inform financial responsibility, and facilitate appropriate care. Providers must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes, and diagnosis codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in patient records and/or office notes.

Reimbursement for doula services will vary based on various factors including:
- Line of business (e.g., Medi-Cal)
- Provider contract status
- Number of services provided
- Type of delivery experienced
- Geographic location where services were received

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Kaiser may:
- Reject or deny the claim
- Recover and/or recoup claim payment

Kaiser reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or state contract language, or by state or federal requirements or mandates. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Kaiser strives to minimize these variations.

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be

paid. Conditions of payment include patient eligibility, benefit coverage, or reimbursement policy stipulations.

Electronic Payment and Remittance Advice Online Enrollment
Kaiser has partnered with Citi Payment Exchange to provide a portal for enrolling in Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA). With this partnership, Kaiser requests that all vendors pursuing EFT/ERA enrollments utilize the Payment Exchange portal for enrollment and changes to existing EFT/ERA. The portal is open 24 hours a day and 7 days a week for new enrollments or changes. Reduce turn-around-time for receipt of payments and remove overhead costs associated with handling paper correspondence by signing up for EFT/ERA today.

Each Kaiser region requires a separate enrollment. Please click the following links to create a new EFT/ERA enrollment: **Southern California (SCAL)**, **Northern California (NCAL)**.

Provider Dispute Resolution Process
Kaiser Permanente actively encourages our contracted providers to utilize Member Services Call Center staff to resolve billing and payment issues. If unable to resolve provider billing and payment issues, Kaiser Permanente makes available to all providers a fast, fair, and cost-effective dispute resolution mechanism for disputes regarding invoices, billing determinations, or other contractual issues. This dispute resolution mechanism is managed in accordance with applicable law and in the contract. Please note that the process described in this section applies to disputes subject to the Knox-Keene Act. While Kaiser Permanente expects to use this process for other types of disputes, there is not a requirement to do so.

The following describes the most common types of disputes:

- Claims Payment Disputes: Challenging, appealing, or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted, or contested by Kaiser Permanente.
- Responding to Requests for Overpayment Reimbursements: Disputing a request initiated by Kaiser Permanente for reimbursement of a claim overpayment
- Other Disputes: Seeking resolution of a contract dispute (or bundled group of contract disputes) between a provider and Kaiser Permanente.

Providers may submit payment disputes online via **Online Affiliate** or as a written notice to Kaiser Permanente by U.S. Mail or other physical delivery.

Please refer to the provider manual at **http://kp.org/providers** for detailed instructions.

Review schedules and updates
Kaiser reserves the right to review and revise its policies periodically when necessary. Reimbursement policies undergo reviews for updates to state, federal, or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Kaiser business decision. When there is an update, the most current policy will be published on the website provided at the beginning of this section.

Helpful Resources
Please see the URLs below for more information on specific claims-related topics:

- **Video Overview of KP Online Tools**
- **Video Overview of Guest Access**
- **Video Overview of EOP Account Summary**
- **Video Overview of EOP Recoupment Detail Report**

Doula FAQs

1. **May doulas charge members prior to doula services being rendered?**
   No. Members may not be asked to pay for services upfront and seek reimbursement from Kaiser Permanente retroactively.

2. **What rates should doulas expect to be paid?**
   Commercial:
   - Contracted providers: Please refer to the fully executed contract for rates.
   - Non-contracted providers: Kaiser will pay the Usual Customary Rate (UCR). As such, payment will vary based on the factors described in the reimbursement section above (e.g., geographic location, type of delivery, etc.).

   Medi-Cal:
   - Claims are paid at the current Medi-Cal rate which is specified in the provider's contract.

3. **What should doulas do if a claim is denied or potentially underpaid?**
   Doulas should utilize the provider dispute resolution process described on page 7 above. Disputes will be resolved within the specified regulatory timeframe (currently up to 45 working days after receipt).

4. **Who should doulas contact to obtain claim status updates or ask claim submission questions?**
   Online Affiliate is Kaiser Permanente's self-service portal. It is the most convenient and preferred method to access claim information, such as:
   - Check the status of submitted claims and view claim details (service date, billed amount, allowed amount, patient responsibility)
   - Confirm payment information (check number, payment date, amount)

   Doulas may also call (800) 390-3510 to speak with a Kaiser Permanente customer service representative.

5. **May members be billed for any unpaid claim amounts?**
   No. Member balance billing is prohibited due to applicable state/federal regulations.

6. **Do members have any cost-share for doula services?**
   No. Members currently pay $0 for covered doula services.