

Medicaid Doula Services Billing Guidance

The information below includes information for Medicaid Fee-for-Service (FFS) coverage of doula services. Submit claims for Medicaid Fee-for-Service beneficiaries in CHAMPS. For doula services rendered to individuals enrolled in a Medicaid Health Plan, consult with each Medicaid Health Plan for reimbursement and claims submission information.

Claims must include the required modifier(s) and the *primary* diagnosis identified in the table below. Providers are encouraged to report a *secondary* diagnosis code, as applicable, for reporting social determinants of health (SDOH) that identify factors influencing health status and contact with health services. SDOH codes help the State to identify areas of need and focus efforts accordingly to better support beneficiaries.

Doula Service	HCPCS/CPT Code	Modifier	Primary Diagnosis Code	Limits	May be Delivered via Telemed	Reimbursement Rate*
Prenatal Visit	S9445	HD	Z33.1	Six total visits per pregnancy, prenatal and postpartum services combined	Yes, in addition to modifier HD, report modifier 95	\$100.00 per visit
Postpartum Visit	S9445	HD	Z39.2	Six total visits per pregnancy, prenatal and postpartum services combined	Yes, in addition to modifier HD, report modifier 95	\$100.00 per visit
Labor and Delivery Support	T1033	HD	Z33.1	One per pregnancy. T1033 is covered in the inpatient hospital setting only.	No, services must be in person	\$1500.00 per service

*Refer to the most current fee screen for doula services published at [Billing and Reimbursement \(michigan.gov\)](https://www.michigan.gov/billing-reimbursement)