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Overview

This manual is designed to help inform and assist those who collect data for the state of Oregon and for the billing system of the Oregon’s family planning Medicaid waiver, OregonContraceptiveCare (CCare).

Background: Title X and Data Collection

Title X is funded by a federal grant from the Department of Health and Human Services–Office of Population Affairs (HHS-OPA). To qualify for Title X grant funds, clinics must follow Title X requirements, which include submitting data of services provided, which is used in required reports to the federal Office of Population Affairs. The Oregon clinic visit record (CVR) was developed to collect the data needed to meet these requirements. The current CVR is located in Exhibit 5 of this section.
CCare and Oregon's CVR

In 1999, Oregon was granted a Medicaid waiver to expand Medicaid coverage for family planning services. The resulting Oregon Contraceptive Care Program or CCare (formerly known as the Family Planning Expansion Project or FPEP) expanded eligibility, established its own enrollment process, and enlarged the provider network. To streamline the billing process for CCare providers, the Oregon CVR was modified to collect the information necessary to bill Medicaid for Oregon clients enrolled in CCare. These additions make the Oregon CVR different from the CVR used in other states.

Purpose of the Oregon CVR

In addition to providing the reports required by OPA for funding purposes and serving as the billing mechanism for services provided to CCare clients, Oregon’s CVR is an important source of data for:

- Describing family planning clients who receive services in Oregon
- Constructing financial and internal reports
- Planning the allocation of resources
- Measuring outcomes
- Analyzing clinic effectiveness and efficiency
- Providing data to the Region X Office of Family Planning, the Centers for Medicare and Medicaid Services (CMS), the Oregon Health Authority Public Health Division, and delegate agencies

CVR Development and Revision

Occasionally changes need to be made to the Oregon CVR. Updates relating to Title X are based on changing data requirements by OPA. Changes in relation to CCare receive input from members of the CCare Workgroup who provide guidance on CVR elements needed for billing or administration. Oregon Reproductive Health Program staff make final decisions about Oregon’s CVR in consultation with the contractor for CVR data processing and billing, Ahlers and Associates. A software patch is
provided by Ahlers for download by agencies using the Ahlers billing software system. Revised paper CVRs are also provided by Ahlers to those agencies that use them.
Q. What exactly is a CVR? And other important questions...

The Oregon CVR (Clinic Visit Record) is a specialized data collection tool for recording required Title X and CCare visit information about a family planning client.

A variety of methods and software can be used to collect CVR data. In most clinics, the CVR is incorporated as a section of a computerized billing/client information system. Your clinic may be using the software developed by the regional data processor, Ahlers and Associates (Ahlers), or any number of other billing and/or client information software packages. A few clinics continue to use a paper CVR.

Whichever format you use, the tool is identical, and the same definitions and guidelines apply. Section D.3 describes how to complete a CVR.

Q. When and for whom do I record a CVR?

Clinics that receive Title X funding and follow Title X guidelines are expected to generate a CVR for every family planning client visit (except a non-CCare supply-only pick-up encounter), regardless of the source of pay. Non-Title X clinics that participate in CCare are expected to submit a CVR for every CCare visit. A CVR must be submitted to generate payment for the visit.

A CVR is required for the following types of visits and services:

- All initial, annual, and other medical visits for clients who are receiving family planning medical and/or counseling services and for whom a client record is established and updated for each visit. This applies to both female and male clients, and to clients who are using abstinence or sterilization as their contraceptive method.

- Off-site services that meet the criteria of a family planning visit, e.g., nurse home visits.

- Pregnancy test visits where testing and professional counseling services related to pregnancy test results are provided and recorded on the client record (Title X).

- Vasectomy visits that include professional counseling services and establishment of a client record.
• Vasectomy medical services provided by a provider or a contracted referral provider.

• Counseling-only visits where the information is placed in the client record.

• Emergency contraceptive visits that include establishment or update of a client record.

• Supply-only pick-up encounters in which an established client receives refills of their birth control method without needing other services (CCare only).

Q. Who should complete the CVR?

As stated above, the purpose of the CVR is to collect required visit information for family planning clients. The CVR helps capture the rational behind clinical decision making and provides the data for the Family Planning Annual Report. Therefore it is best practice for the clinician who performed the visit to complete the medical services portion of the CVR. If completion of the CVR is left to staff who were not present during the visit, there is potential for inaccuracies in data and billing.

Q. What happens to the CVR data?

CVR data are collected at each registered clinic site in the agency and then transmitted via mail (paper CVRs) or electronically through a HIPAA-compliant website to Ahlers. The information is scanned for errors, tallied, and parsed into usable form in tabular region-wide reports. CVR data are reported by project (all clinic sites at the agency included) and by each individual clinic site.

Q. How does information from the CVR help me?

Ahlers provides a wealth of statistical data broken down by date of service: quarterly, calendar year (January – December), fiscal year (July – June), FPAR (December 1 – November 30 of the following year), and special request. These reports are provided at no additional charge.

Q. How can I obtain reports from Ahlers?

We strongly encourage using the on-line reporting section of the Ahlers website at www.ahlerssoftware.com. To gain access, you must have a user
ID and password from Ahlers. See Exhibit 1 for a project/site number request form from the RH Program and Exhibit 2 for a login and password application for the Ahlers system.

Once you enter the secure portion of the website, you can access and print all of your clinic’s or agency’s data for the last three years as standard reports (under the **View Reports** option) or as custom tables that you create (using the **Build a Report** function). Sample reports are also included as Exhibit 3. Raw, visit-level data can be downloaded and manipulated to meet your needs. Exhibit 4 describes the steps to access data.

Agencies and clinics needing access to paper versions of reports should contact Ahlers.

**Q. We use Ahlers’ WINCVR software. Is it the same as the paper CVR?**

Yes. Ahlers built their WINCVR system around a modular client information system geared specifically toward public health, particularly family planning. The Title X and CCare CVR components are integrated into this system.

**Q. We use third-party billing software. How will it capture CVR information?**

Most CVR components are common to client registration systems (super bills) and most standard billing software. Oregon may collect a few items that are not included in your system, such as data on referrals or counseling. To capture the required CVR data correctly, you may need to add elements to your clinic software. To transmit the data, use the standard file format included as Exhibit 6.

**Q. What are the deadlines for transmitting data to Ahlers?**

Because the CVR is used for both billing and data collection, there are two sets of data submission deadlines: one for claims payment and one for report generation.

**Claims Payment:** CCare reimbursements are generated monthly. In order to receive a timely payment, you must submit the CVR data no later than the Thursday before the 15th of the month. (See Section C, Exhibit 9 for current deadlines.) These data typically consist of CVRs from the previous month, but may include CVRs with dates of service up to the deadline date or as old as one year.
**Report Generation:** CVR data should be submitted by the processing deadline for each month to ensure that your agency’s Ahlers reports are accurate and comprehensive.

<table>
<thead>
<tr>
<th>Month</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>Annual Report</td>
</tr>
<tr>
<td>April</td>
<td>Quarter 1 Report</td>
</tr>
<tr>
<td>July</td>
<td>Quarter 2 Report</td>
</tr>
<tr>
<td>August</td>
<td>Fiscal Year Report</td>
</tr>
<tr>
<td>October</td>
<td>Quarter 3 Report</td>
</tr>
<tr>
<td>December</td>
<td>FPAR Report</td>
</tr>
<tr>
<td>January</td>
<td>Quarter 4 Report</td>
</tr>
</tbody>
</table>

**Q. How do we know our data are really reaching Ahlers? Can we run a test batch?**

Yes. In fact, any time the CVR is upgraded or revised or you change your information system, it’s advisable to transmit a monitored test batch of data. This should be done prior to the cutoff for monthly data to resolve any problems. You should also provide Ahlers with a contact e-mail address. Upon request, Ahlers will send back tallies of the number of records received after an electronic transmission. An Ahlers employee can walk you through the process and help you look for data anomalies and incomplete files. See the contact information for Ahlers on the last page of the CCare Eligibility Database Instructions (Section C, Exhibit 1).

**Q. How do we resubmit a CVR that has been rejected?**

Data errors and billing errors can cause your CVR to be rejected. Along with your monthly billing register, your agency will receive a CVR Error Report (See Exhibit 9 for a sample report) that shows CVR rejections and an explanation for each rejection.

You can correct any rejected CVRs and resubmit them with the next month’s batch of CVRs. In some cases, you will need to supply missing...
information and in others, you will need to make a billing error edit correction.

Q. How does HIPAA affect the Family Planning Information System?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, requires that all information transferred via the Internet be encrypted to protect client privacy.

HIPAA information is available on many websites. Two of the more comprehensive are:

http://www.aspe.hhs.gov/ADMNSIMP - subscribe to a HIPAA registration list to receive regular email updates on the law.


For more information, visit www.ahlerssoftware.com and click on HIPAA.
How to Complete a CVR

Here are item-by-item instructions for completing each numbered section of the CVR. The instructions are the same, whether you use a paper form or an electronic version.

Top Section: Client Information

The Client Information section must be completed if you intend to bill CCare for the visit or if your agency or clinic uses the information for administrative purposes. If those situations don’t apply to you, you may leave it blank.

1. Clearly print the client’s last name, first name, and middle initial in items A, B, and C, as indicated.
2. Print the client’s Social Security number in item D. CCare will reject claims without a Social Security number.
3. Print the client’s CCare number in item E. See the Eligibility Database Instructions in the RH Program Manual, Section C, Exhibit 1 for information about accessing the client’s CCare number.

If you submit paper CVRs to Ahlers for data entry, you should send them the top (white) copy. The yellow copy is for local agency use. The CVR is not a charting form and should not be part of the client’s medical record. However, services documented on the CVR must match those documented in the medical chart.

Section 1: Service Site Number

You must fill in all seven boxes. If your service site number is fewer than seven digits, use leading zeros. For example, site number 4321 should be entered as 0004321.

Please use only the service site number assigned by the Oregon Reproductive Health Program (see sidebar at right).
## Section 2: Client Number

| 2. CLIENT NUMBER |   |   |   |   |

The client number is the unique identifier your agency or clinic assigns to the client. It can be found in the client’s medical records or other client information files.

You must fill in all nine boxes in the CVR. If the client number is fewer than nine digits, use leading zeros. For example, client number 1122 should be entered as 000001122. (Ahlers WINCVR automatically fills in leading zeros.)

### Assigning Client Numbers

The client number is an agency-specific identifier used in conjunction with the date of birth field to ensure that the correct data are matched to the client. Each agency may follow its own procedures for assigning numbers, as long as the numbers meet the following requirements:

- There are no duplicate numbers:
- No two clients within a service site (clinic) may have the same number.
- No two clients within a project (agency) may have the same number.
- The client number must not contain alphabetic or non-numeric characters.
- The client number cannot be longer than nine digits.
- Projects with multiple clinic sites may want to use prefixes to better identify clients from each site. This will also help to avoid duplicates. Example:
  - Site A assigns numbers with a 1 prefix: 100000789.
  - Site B assigns numbers with a 2 prefix: 200000789.

If a client has been inactive in the system for 36 months or more, Ahlers will discontinue that client number. If the client returns to the system, that old number can be reactivated, or a new one assigned. Do not assign a previously used number to a different client.
Section 3: Date of Visit

Section 3 requests the actual date on which the client received medical and/or counseling services at the service site. It is not the date you enter the information. Be sure to use the actual visit date, even if you fill out the CVR at a later time.

Enter the date in month/day/year format (mm/dd/yyyy). Convert month and day to two-digit numbers:

- January 01
- February 02
- March 03
- April 04
- May 05
- June 06
- July 07
- August 08
- September 09
- October 10
- November 11
- December 12

For example: if you see a client on July 9, 2012, enter the date as 07/09/2012.

Section 4: Date of Birth

The date of birth is the month, day, and year the client was born. Record as much of this information as the client is able to give. If the birth year is unknown, ask the client, “How old are you?” and calculate the year. If the birth month is unknown, use July 15, a default date used by the processor for unknown data.

Enter the date in month/day/year format (mm/dd/yyyy), using the same two-digit code as in date of visit. For example: If the client’s date of birth is June 3, 1988, enter the date as 06/03/1988.

A client can have only one date of birth. If you’re using Ahlers’ WINCVR software, be sure to always record the same birth date as on the CVR for the client’s first visit. Otherwise, the CVR will be rejected. Clients sometime give different dates at different times, so check the actual records.
Section 5: Gender

5. GENDER □ 1 - Female □ 2 - Male

Determine the client’s gender by observation or from medical records and check the appropriate box.

Section 6: Ethnicity

6. ETHNICITY □ 6 - Hispanic or Latino □ 9 - Not Hispanic or Latino

You must check one and only one box: Hispanic or Latino; or Not-Hispanic or Latino

If ethnicity is not included on the client’s medical record, try asking a clarifying question, such as “Do you consider yourself Hispanic or Non-Hispanic?” Do not make assumptions or rely on observation to complete this box; neither are reliable means of ascertaining ethnicity.

Hispanic origin or descent includes:

1. Mexican-American Mexicana(o)-Americana(o)
2. Puerto Rican Puerto Riqueña(o)
3. Cuban Cubana(o)
4. Central or South American Centro o Sudamericana(o)
5. Other Spanish Speaking Otra Categoria Espanol

Section 6a: Race

6a. RACE (Mark All That Apply) □ 1 - White □ 2 - Black/Afr. Amer □ 3 - American Indian □ 4 - Alaska Native □ 5 - Asian □ 6 - Other □ 7 - Unknown/Not Reported □ 8 - Native Hawaiian/Pac. Isl.

Check all that apply. If race is not indicated on the client’s medical record, try asking a clarifying question, such as “What race or races do you identify with?” Again, do not rely on assumptions or observation; neither are reliable means of ascertaining race. If the client doesn’t know or chooses not to answer, check box 7 – Unknown/Not reported.

Many people assume that Hispanic or Latino is a racial category; however, our funders categorize Hispanic or Latino only as ethnicity and consider race to be a separate category. Funders need to know if Hispanic/Latino clients also identify as White, African American, etc. This data is important to collect because it allows us to provide the most effective and appropriate healthcare services and to better understand the health behaviors/practices of our clients. Please work with clients, particularly those of Hispanic ethnicity, to explain why we need information about ethnicity and race and to help clients identify a racial category that best describes them.
Section 7: Additional Demographic

5 – Limited English Proficiency

Limited English Proficiency describes a client who has limited ability to read, speak, or understand English and may need assistance to optimize his or her use of family planning services. Check this box if the staff must speak in the client’s native language or if a third person is used to communicate with staff/client.

Section 7A: Client Testing Dates

1 - Last Chlamydia (≤24) □ 1 - Never □ 2 - Unk. □ 3 - Date
2 - Last Pap (≥21) □ 1 - Never □ 2 - Unk. □ 3 - Date

This section is intended to capture female clients’ most recent test dates (month and year) prior to today’s visit, as used in clinical decision-making. Test dates may be self-reported by the client or populated from client medical records, when available. If the client has never had one of these tests, 1-Never should be checked. If test dates are unknown or unavailable, 2-Unknown should be checked. Chlamydia test dates should be entered only for female clients age 24 years and younger. Pap test (cervical cytology) dates should be entered only for female clients age 21 years and older. If test dates are entered for clients outside these age ranges, Ahlers will clear out the dates upon receipt of the CVR data.

Section 8: Zip Code

Enter the zip code provided by the client. This item is important for documenting the location of the client’s residence. If the client is homeless, use the zip code of the clinic providing service, or that of the address where the client receives mail.
Section 9: Assigned Source of Payment

9. ASSIGNED SOURCE OF PAYMENT (Check one)

- 01 - No Charge
- 02 - Title XIX (OHP)
- 07 - Other
- 04 - Private Insurance
- 05 - Full Fee
- 10 - Non-CCare
- 08 - CCare*
- 06 - Partial Fee Visi/CCare Supply*
- 03 - WA Take Charge
- 11 – OVP

*Complete top section and 17 for CCare

Use Section 9 to document how your service site expects to be paid for the services provided during the visit. This number-by-number guide will help you determine which single box to check.

01 - No Charge: Client does not qualify for third-party billing (Medicaid or insurance) and is below 100% of the Federal Poverty Level (FPL) based on income/family size assessment.

02 - Title XIX (OHP): Client is currently enrolled in the Oregon Health Plan and the visit is billable to OHP.

03 – WA Take Charge: Client has Take Charge coverage (Washington State’s family planning Medicaid waiver program) and clinic is a Take Charge provider. Take Charge will be billed for the visit.

04 - Private Insurance: Client has private insurance and today’s visit will be billed to that company. Check this box even when the billing outcome is unknown.

05 - Full Fee: Client does not have insurance or Medicaid coverage that will pay for the visit, is over 250% of the poverty level based on income/family size assessment, and will be charged the full fee for the visit. The client may not pay for all/any of the fee on the date of visit.

06 - Partial Fee: Client does not have Medicaid or private insurance for the visit and is between 100% and 250% of poverty level based on income/family size assessment. The client will be charged a partial fee and may not pay all or any of the fee on the date of visit.

07 - Other: Check this box when other, non-specified third-party payers are charged. These may include special federal or state funds for American Indians or male services.

08 - CCare: Client is eligible for CCare and the visit is for contraceptive management.

Box 9 records how your site expects to be paid. It may not be the method that eventually covers the invoice. If you expect any payment from CCare, be sure to check either 08 or 10. Otherwise, if you expect to be paid by a combination of resources (e.g., partial fee and private insurance), check the one that you think will cover the largest portion of the invoice.

Donations are not a source of payment. They are not to be reported on the CVR.
**10 - Non-CCare Billable Visit/CCare Supply:** Client is CCare eligible and receives services that are not for contraceptive management, but also receives contraceptive supplies that are billable to CCare. For example, a CCare eligible client comes in for an STI check and requests a refill of her oral contraceptives at the same visit. This is not considered a contraceptive management visit and therefore does not qualify for CCare billing. However, you **can** check box 10 to bill CCare only for the contraceptive supplies dispensed at the visit.

**11 - OVP:** Client is being seen for a vasectomy counseling or procedure visit under the Oregon Vasectomy Project (OVP). To receive payment for these visits, you must mark the appropriate medical services (box 20 in Section 13A) and/or counseling service (box 03 in Section 14A) on the CVR. This box should also be marked with box 8 - Vasectomy Referral in Section 12 AND box 18 - Vasectomy Referral Fee in Section 13A when billing OVP for administrative and/or referral work for a client receiving vasectomy services from a sub- or state-contracted vasectomy provider.
Section 9A: Diagnosis Code

This section is for CCare-billable visits only. Complete it if you checked box 08 – CCare or 10-Non CCare Visit/CCare Supply in box 9. Otherwise, leave it blank.

Enter the ICD-9 diagnosis code that represents the contraceptive service provided during the client’s visit. To be reimbursed by CCare, you must list a V25 code. You’ll find the CCare-reimbursable codes listed in Section C, Exhibit 7.

Use the highest level of specificity within the V25 series. That means always using five-digit codes where they are available. Assign four-digit codes if there are no five-digit codes; assign three-digit codes if there are no four-digit codes.

Section 9B: Will Insurance Be Billed for This Visit?

This section is only for visits billable to CCare. Clients with insurance coverage for contraceptive management services are also eligible for CCare. Per federal Medicaid regulations, insurance should always be billed first, so that Medicaid (CCare) is the payer of last resort.

- Client’s insurance will be billed for any portion of the visit: check 2 - Yes and enter the insurance amount in Section 17A, item 2. If the insurance company denies payment, remember to enter the appropriate TPR code in Section 17A, item 1.
- Client has insurance but it will not be billed because of special confidentiality needs: check 1 - No and enter the TPR code NC in Section 17A, item 1. (Also see instructions for Section 9C.)
- Client does not have any insurance: check 1 - No.
Section 9C: Special Confidentiality Needs

The special confidentiality option is available to any CCare client who believes she or he would be at risk of physical or emotional harm if a parent/partner or other household member learned the client was seeking family planning services. This section is not limited to teens, nor should it be used for every teen client.

Check 1 - Yes if the client has CCare as a source of pay and indicates that special confidentiality is needed; otherwise, leave the section blank. If you check 1 - Yes, be sure that:

- You also enter the TPR code NC in Section 17A. This is required and provides documentation of why insurance was not billed, which is necessary for audit purposes.
- You notify outside labs of the client’s special confidentiality request (if applicable).
- The client has also indicated her or his request for special confidentiality and staff have marked it on the CCare Enrollment Form (if applicable).

Section 18: Client Insurance Status (Principal Health Insurance Covering Primary Care)

Section 18 assess whether family planning clients have health insurance for “a broad set of primary medical care benefits” (not just family planning services). Clients may have more than one kind of coverage so ask them directly about their primary care insurance. This section should be completed for all clients. Note that the information in Section 9: Assigned Source of Payment is not a reliable indicator of what should go in Section 18.

Here are guidelines on which category to check:

1. **Public Health Insurance**: Check this box if the client is currently enrolled in the Oregon Health Plan (OHP) or has Medicare coverage for primary care. CCare should not be counted as public health insurance in this box because it does not cover primary care.

2. **Private Health Insurance**: Check this box if the client has personal or employer-sponsored primary health care insurance, whether or not the insurance pays for family planning, contraceptive services, or supplies.
3. **Uninsured:** Check this box if the client has no coverage for primary health care services. This includes clients who may receive primary care services from the Indian Health Service, as that is not considered “insurance.”

4. **Unknown:** Check this box only if you are unable to check one of the other three.

**Section 10: Income and Family Size**

Ask the client for this information. An accurate answer requires that both you and the client understand what is included and what is not included in income, and precisely what constitutes a family for the purposes of the CVR.

**Start with Item 10b - Family Size.** Using the definition for family (see sidebar), determine how many people are supported by this income. The answer must be at least one.

Then compute the monthly income of each person and enter the total amount in whole dollars in Item 10a. For example, if the income is $431.41 enter $431. See page D3-11 for the kinds of income that should be included.

Make every attempt to get an actual or estimated figure from the client. For CCare clients, you can use the amount given on the CCare Enrollment Form. Please note that clients are not required to provide proof of income for Title X or CCare eligibility.

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**What Is Family?**

Family is defined as a social unit composed of one person, or two or more persons living together, as a household. Household members do not need to be married to be counted in household income; dependents away at school also are included. The income of all these persons should be counted to calculate the total income of the family. Examples include:

- a married couple, with or without children
- domestic partners, with or without children
- one parent with one or more children
- a married couple sharing the home of a husband’s or wife’s parents
- two related married couples sharing a single household

Roommates living together are not considered a family; each person should be considered a family of one. However, any income received as a result of the arrangement (e.g., rent) is considered income contributed to the client and should be counted.

Foster children or other unrelated children living in a household are not considered part of the family; payments received for caring for foster children is not considered income.
Helpful Guidelines for Determining Income

If the client is a full-time salaried employee, base the average gross monthly income on the client’s most recent month’s income. If the client works part time, on a commission basis, or otherwise has an unsteady income, use the average gross monthly income for the previous 12 months. Some clients may know only their take-home pay, or net income. To calculate gross income, multiply the net income (take-home pay) by 1.15. Do this for all contributing members of the family.

Teens living at home and college students aged 19 and under who are dependent on family income pose special challenges. CCare defines a teen as someone aged 10–19. Title X defines a teen as a minor, which in Oregon is someone aged 10–18.

- **Title X Teens**
  - Teens are considered as a family of one only when confidential services are necessary. In Item 10b, enter the number 1; in Item 10a, enter any personal income derived from allowances or employment.
  - For teens who consider themselves to be supported by their parents (and do not require confidential services), include the parents’ income and the total number of people supported by the parents.

- **CCare Teens**
  - All teens aged 19 and under can qualify for CCare based on their own income.

What Is Income?
The gross average monthly income is all money coming in that contributes to the support of the family. Sources of income that should be included are listed on the following page.
Types of Income

<table>
<thead>
<tr>
<th>These sources of income should be included</th>
<th>These sources of income should NOT be included</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Salaries</td>
<td>• Grants</td>
</tr>
<tr>
<td>• Wages</td>
<td>• Loans</td>
</tr>
<tr>
<td>• Tips</td>
<td>• Withdrawal from savings</td>
</tr>
<tr>
<td>• Help from relatives and non-relatives</td>
<td>• Tax refunds</td>
</tr>
<tr>
<td>• Public assistance</td>
<td>• Receipts from sale of possessions</td>
</tr>
<tr>
<td>• Unemployment compensation</td>
<td>• Inheritance</td>
</tr>
<tr>
<td>• Worker’s compensation</td>
<td>• Lump sum compensation for injury or legal damages</td>
</tr>
<tr>
<td>• Veterans benefits</td>
<td>• Maturity payments on insurance policies</td>
</tr>
<tr>
<td>• Sick pay</td>
<td>• Payments for foster parenting</td>
</tr>
<tr>
<td>• Social Security cash benefits (such as widow’s benefits and children’s allowances)</td>
<td>• Dollar amount of Food Stamps</td>
</tr>
<tr>
<td>• Alimony/child support</td>
<td></td>
</tr>
<tr>
<td>• Net investment income (rent, interest, dividends)</td>
<td></td>
</tr>
<tr>
<td>• Net earnings from self employment</td>
<td></td>
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<tr>
<td>• Pensions</td>
<td></td>
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<tr>
<td>• Annuities</td>
<td></td>
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<tr>
<td>• Royalties and commissions</td>
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<tr>
<td>• Business profits</td>
<td></td>
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<tr>
<td>Also included should be deductions commonly taken out of income before the client receives it. These include:</td>
<td></td>
</tr>
<tr>
<td>• Federal, state and local taxes</td>
<td></td>
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<tr>
<td>• Social Security payments</td>
<td></td>
</tr>
<tr>
<td>• Deductions for savings bonds, other savings plans, or union dues</td>
<td></td>
</tr>
</tbody>
</table>

Section 11: Health Insurance Enrollment Assistance

Section 11 is used to record if health insurance enrollment assistance (not including CCare) was provided to the client. Check **1-Onsite** when provided by a trained enrollment assister at your agency, regardless of when the assistance is provided (e.g., sent to another section of same agency later that day or soon after the original visit). Check **2-Referral** if client is referred for assistance outside of your agency (even if they are located within the same building as your agency).
Section 12: Purpose of Visit

Use Section 12 to record the primary reason for the client visit. Check one box only.

1. **First Annual Exam**: First comprehensive examination at your agency during which physical exam and lab services are provided as clinically indicated (see Section 13A: Medical Services Provided) and contraceptive counseling and education are given. This examination does not necessarily take place during the client’s first visit to the agency.

2. **Return Annual Exam**: Subsequent visit (often provided annually) during which the client receives a comprehensive medical examination. Physical exam and lab services should be provided as clinically indicated during this visit. Other services may also be provided. Return annual exams must occur no sooner than 11 months plus one day after the previous annual exam date. For example, if the first annual exam is 05-10-14, then the return annual exam must be on 04-11-15 or later.

3. **Other Medical**: A visit during which one or more medical services are provided for routine contraceptive, sterilization, infertility, or related care. Counseling may be provided along with the services. These services include:
   - Contraceptive follow-up, such as hormonal method supply, IUD, contraceptive injection, and diaphragm check.
   - Method prescription without complete physical exam and lab services: pill prescription, diaphragm fit, IUD insertion, etc.
   - Follow-up to initial or annual medical exam visit because all services were not provided at that time.
   - Vasectomy or tubal ligation.
   - Infertility consultation if medical or lab services are provided. If not, check box **4 - Counseling Only**.
   - Male physical examination.
   - Contraceptive method change related to method complaints: IUD removal, poor diaphragm fit, pill change, etc.
   - Exam or service related to contraceptive method complaints: pelvic exam because of abdominal pain, excessive bleeding, fatigue, etc.
   - Positive or borderline lab test follow-up: repeat Pap smear, monitoring of blood pressure, repeat gonorrhea culture, etc.
• Post-pregnancy check.
• Sickle cell, blood sugar, or other screening because of high-risk status.
• Gestation check. (Note: Prenatal exams are not included because they are not considered in the definition of family planning services).
• Emergency contraception provided, including history and counseling.

4. **Counseling Only**: A visit during which the client receives specific family planning-related consultation, but no medical services are provided. This consultation is recorded in the medical record. For examples of counseling services, see Section 14A: Counseling Education Provided.

5. **Pregnancy Test Visit**: Primary purpose for the visit is a pregnancy test and counseling. The visit may consist solely of a urine pregnancy test or the urine test plus a pelvic examination. Counseling may be provided at another visit if preferred.

6. **Supply Only-Mailed (CCare Only)**: This box should be used only for returning CCare clients who choose to have their refill of their contraceptive method mailed to their address. Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive supplies. Contraceptive methods that require a written prescription may only be mailed to established clients who have been using the method(s) for at least three months, with no problems or contraindications.

8. **Vasectomy Referral (w/OVP SOP)**: This box should be used to indicate administrative and/or referral work for clients receiving vasectomy services through a sub-contracted or state-contracted vasectomy provider. A new CVR, separate from the CVRs completed for the vasectomy counseling visit or vasectomy procedure, should be completed with a unique date of service in order to receive reimbursement for the administrative and/or referral work. This box must be marked in conjunction with box 11 – OVP in Section 9: Assigned Source of Payment, even if the vasectomy counseling visit or vasectomy procedure are being covered under a different source of payment. Additionally, box 18 – Vasectomy Referral Fee in Section 13A: Medical Services must be checked in order to receive reimbursement. Reimbursement will be reflected in the OVP payment reports generated each month by Ahlers.

9. **Supply Only Visit (CCare Only)**: This box should be used only for established CCare clients who present for a refill of their contraceptive method (more packs of pills, additional Rings and packs of EC, etc.) and receive no or very brief medical (vital stats check) or counseling services. If this visit is the first being billed to CCare, the client must be an established client at the clinic, having had a face-to-face family planning visit with a clinician within the last two years OR the client is new to your agency but has been enrolled in CCare and established on a
birth control method at another agency within the last year. Make sure that this has been indicated at the time of enrollment in the CCare eligibility database. Note that provision of Depo-Provera can be classified under box 3 - **Other Medical**, since the Depo injection requires medically trained staff.
Section 13A: Medical Services

### Medical Services Defined
This list below describes medical services in numerical order. On the CVR, the services are divided into four categories and the services are not in numerical order. The categories are: Exam & Lab Services, Contraceptive Related Services, Pregnancy Related Services, and STD Services.

02. **Blood Pressure**: Use of a stethoscope and blood pressure cuff to measure the force exerted on the walls of arteries as blood is pumped through them.

03. **Height/Weight**: Measurement of client’s height and/or weight are recorded.

04. **Thyroid Palpation**: Manual and physical examination of the thyroid to evaluate size, shape, symmetry, or tenderness.

05. **Heart Lung Auscultation**: Evaluation of heart and lung sounds using a stethoscope.

06. **Breast Exam**: Visual inspection and palpation of the female/male breasts to evaluate the symmetry of shape, color, size, surface characteristics, and for masses.

07. **Abdominal Palpation**: Visual inspection and palpation of the abdomen to evaluate for abnormalities.
08. **Extremities:** Inspection and/or palpation of the arms and legs to evaluate for abnormalities.

09. **Bimanual/Speculum Pelvic Exam:** Visual and/or manual examination of the vulva, vagina, cervix, and pelvic organs to detect any abnormalities and collect specimens/samples for laboratory analysis when indicated.

11. **Vaginitis/Urethritis/Eval/DX:** Evaluation of the vagina, urethra, and male/female or genital area via palpation, visual inspection, and/or laboratory tests to detect infection.

12. **Vaginitis/Urethritis/Eval/Rx:** Treatment of any vaginal/genital or STD infection not specifically identified elsewhere under 13A - Medical Services Provided.

13. **Chlamydia Treatment:** Providing treatment for a laboratory diagnosed case of *Chlamydia trachomatis* (CT).

14. **Chlamydia Presumptive Treatment:** Prescribing medication to treat CT based on history, e.g., contact with a confirmed case, and/or clinical findings. This may be done without performing a CT test or prior to receiving the results of the test.

15. **Wart Treatment:** Treatment of external genital HPV infection with medication or cryotherapy. This may also include giving the client a prescription for self-administered medication.

16. **Herpes Test:** Blood tests or cultures of lesions taken to diagnose Herpes Simplex Virus (HSV).

17. **Diaphragm/Cervical Cap Fit:** Assessment for proper fit and client instruction on use of diaphragm or cervical cap.

18. **Vasectomy Referral Fee:** Administrative and/or referral work for clients receiving vasectomy services through a sub-contracted or state-contracted vasectomy provider. Box 11 – OVP in Section 9: Assigned Source of Payment AND Box 8 – Vasectomy Referral (w/OVP SOP) in Section 12: Purpose of Visit must also be checked. The vasectomy referral fee must be indicated on a unique CVR with its own date of service, separate from those of the vasectomy counseling visit and vasectomy procedure, in order to receive reimbursement.

19. **IUD/IUS Insert:** Insertion of an intrauterine contraceptive device, or system into the uterus.

20. **Sterilization Procedure:** Any procedure on a man or woman intended to provide permanent contraception; e.g., tubal ligation or vasectomy.
21. **Post Pregnancy Exam:** Physical assessment of a woman’s health status with emphasis on uterine involution, presence or absence of infection, and family planning status, following a pregnancy of any gestational age.

22. **IUD/IUS Removal:** The intrauterine contraceptive device or system is removed from the uterus.

23. **Hgb/Hct:** A measurement of the hemoglobin (HgB) content or the solids/serum ratio (Hct) of capillary blood as an indirect assessment for anemia.

24. **Urine Dip Strip/Urinalysis:** A narrow plastic strip containing chemical reagents that is dipped in a small amount of urine as to provide a quick, point-of-service check for sugar (diabetes), protein (kidney problems and dehydration), and white cells (infection). A urinalysis is a sample of urine submitted to a laboratory for a thorough evaluation with special equipment.

25. **Pap Test Conventional:** A sample of cervical cells taken during a speculum exam of the vagina and cervix to detect cervical dysplasia or cancer. The sample is submitted to a clinical laboratory on a dry glass slide.

26. **Pap Test Liquid-Based:** A sample of cervical cells taken during a speculum exam of the vagina and cervix to detect cervical dysplasia or cancer. The sample is submitted to a clinical laboratory in a small vial of liquid preservative.

27. **Colposcopy:** An examination of the cervix, vagina, or vulva with a special microscope called a colposcope, to detect for abnormal cell changes.

28. **Gonorrhea Test:** A laboratory test performed to detect the bacterium Neisseria gonorrhoeae (also called GC). Test specimens may be collected from the urethra, vagina, cervix, rectum, and throat. Tests are also commonly performed on urine samples.

29. **Chlamydia Test:** A laboratory test performed to diagnose *Chlamydia trachomatis* (also called CT). Endocervical and urethral samples are taken during a pelvic exam. Clients may self-collect samples using vaginal swabs. Tests are commonly performed on urine samples. If checked, and the source of pay is CCare, Ahlers will generate an additional reimbursement rate for a combined GC/CT test.

30. **Wet Mount:** A microscopy procedure to detect vaginitis by visually scanning a sample of vaginal discharge on a slide prepared with saline and/or KOH.

31. **Serum Pregnancy Test:** A blood test to detect pregnancy soon after conception and before a missed period; useful for assessing suspected ectopic or molar pregnancy when performed in a series. Also called a quantitative pregnancy test.
32. **Negative Pregnancy Test:** A negative test either by serum or urine HCG as part of the pregnancy diagnosis.

33. **Positive Pregnancy Test:** A positive test either by serum or urine HCG testing as part of a pregnancy diagnosis.

34. **Immunization:** Providing vaccinations for a variety of diseases including, but not limited to, hepatitis B, HPV, and rubella.

35. **Infertility Screening:** A basic Level 1 screening that includes an initial infertility interview, education, physical exam, counseling, and appropriate referral.

36. **Other Lab or Exam:** Medical services provided in conjunction with other reproductive services, and other related services.

37. **No Lab or Exam:** No medical or laboratory services were provided. This is a “counseling only” visit.

38. **Hormone Implant In:** A surgical procedure to insert a flexible, matchstick-sized rod containing small amounts of a contraceptive hormone.

39. **Hormone Implant Out:** A surgical procedure to remove implanted contraceptive hormone rod.

40. **Hormonal Injection:** An intramuscular or subcutaneous injection of the contraceptive hormone progestin.

42. **Male Genitalia Exam:** Examination of the male external genitalia via visual inspection and palpation to detect any abnormalities.

43. **HIV Test-Standard:** A laboratory test performed by a reference laboratory (“outside” lab) by any means (blood, saliva) to detect the presence of human immunodeficiency virus (HIV) antibodies. Results are typically received by the clinic in 5-15 days.

44. **HIV Test-Rapid:** A point-of-care test performed by any means (blood, saliva) to detect the presence of human immunodeficiency virus (HIV) antibodies. Results are typically available in 20 minutes.

46. **EC–Future Need:** Prescription or product given for future use, with instructions to use in the event of unprotected intercourse or birth control failure, e.g., broken condom.

47. **VDRL/RPR:** Venereal Disease Research Laboratory Test/Rapid Plasma Region blood test for syphilis, a sexually transmitted infection.

48. **EC–Immediate Need:** Emergency contraception (EC) prescribed or provided to be used as soon as possible after unprotected intercourse to prevent pregnancy.
49. **Colo-Rectal Cancer**: A fecal sample placed on a card with chemical reagent to screen for blood in the stool.

50. **HPV Test**: A laboratory test using genetic viral typing to detect human papilloma virus (HPV) infection.
Record All Counseling Sessions
Make sure that all counseling segments provided to a client are recorded on a CVR. All counseling logged on a CVR must also be recorded in the client’s medical record.

Use Section 14A to record non-medical services that: (1) inform a client about available family planning and related services and supplies, and/or (2) assist the client to clarify her or his needs and examine alternatives available. The provider should complete this section at the time of service. Alternatively, the information can be transcribed from the client’s medical record at the end of the visit.

01. Contraceptive Counseling/Education: Consultation/Information provided to a client regarding risks, benefits, and correct use of any birth control method being considered by the client. This could also indicate general methods of education where birth control choices are discussed and information provided in pamphlets, etc.

02. Natural Family Planning/Fertility Awareness Method: Consultation/education provided to a client concerning the non-medical or “natural” family planning techniques including using a calendar, mucous ovulation, basal body temperature, CycleBeads, and other related methods of fertility awareness.

03. Sterilization Counseling/Education: Consultation/education provided to a client by trained personnel regarding a permanent birth control method, i.e., tubal ligation or vasectomy.

04. Infertility Counseling/Education: Consultation/education provided to a client or couple by trained personnel concerning the inability of a client or couple to conceive.

05. Tobacco Counseling/Education: Consultation/education provided to a client by trained personnel regarding the assessment of tobacco habit/use, its relationship to birth control and general health, and assistance with resources to promote cessation.

06. Substance Abuse Counseling/Education: Consultation/education and information provided to a client by trained personnel concerning substance use habits and the relationship between
use, abuse, and health. This may include education on self-assessment, risk reduction, goal setting, and behavior change.

07. **Pregnancy Options Counseling/Education**: Consultation/education provided to a client by trained personnel regarding pregnancy testing, its limitations, and all pregnancy options.

08. **Preconception Counseling/Education**: Information and counseling regarding conception, including rubella, genetics, and all other factors that can affect a pregnancy. Identification of possible pre-pregnancy risks and provision of health education are given to help women/couples make informed choices about future childbearing.

09. **STD/HIV Prevention/Education**: Consultation/education provided to a client by trained personnel concerning sexually transmitted disease (including HIV) prevention and education.

10. **HIV Pre Test or Post Test Counseling/Education**: Consultation and information provided to a client by trained personnel concerning HIV during the pre-test or post-test visit.

12. **Nutrition Counseling/Education**: Consultation/information provided to a client regarding nutrition that promotes health and prevents disease.

13. **Abstinence Counseling/Education**: Consultation/information regarding abstinence from sex (not having intercourse) and discussion of positive outcomes of this decision, such as protection from pregnancy and sexually transmitted disease.

15. **Crisis Counseling/Education**: Consultation/education provided to a client by trained personnel regarding a crisis identified by the client.

16. **Abnormal Pap**: Consultation/education between a client and trained personnel regarding an abnormal pap result.

17. **Encourage Parental/Family Involvement**: Consultation/education provided to a client by trained personnel regarding the encouragement of family participation in the decision of minors seeking family planning services.

18. **Relationship Safety**: Consultation/education provided to a client of any age by trained personnel on how to resist attempts from others to engage in unwanted sexual activities. This includes teaching refusal skills to prevent coercion. Relationship safety may also include discussions about intimate partner violence or abuse and assault and steps the client can take to avoid violent situations.

19. **BSE**: Consultation/education provided to a client by trained personnel regarding Breast Self-Exam including encouragement of regular self-breast exams.

20. **TSE**: Consultation/education provided to a client by trained personnel regarding Testicular Self-Exam including the encouragement of regular testicular self-exams.
Section 19A: Pregnancy Intention Screening

19. PREGNANCY INTENTION SCREENING

☐ 1 - Yes, Near Future ☐ 3 - Unsure
☐ 2 - No, Maybe Later ☐ 4 - Never

Use this section to indicate the client’s intentions regarding pregnancy in the near future (e.g. next 6-12 months), regardless of which pregnancy intention screening tool was used. If pregnancy intention screening was not conducted, this section should be left blank. Client pregnancy intentions are expected to align with medical and counseling services provided at that visit, for example, if 1-Yes, Near Future is checked, preconception counseling should occur at the visit and be checked in Section 14A. For clients whose stated intentions change during the visit, the final stated intention should be indicated.

Section 13B.14B: Provider of Medical Services/ Counseling/Education Services

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)

☐ 1 - Physicians
☐ 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
☐ 3 - RNs, LPNs
☐ 4 - Other service providers, health educators, social workers, clinic aides and lab technicians.

Use this section to identify who provided the services in Section 13A and Section 14A. Check all that apply, based on the following provider categories:
1. Physician: a licensed doctor of medicine (M.D.) or osteopathy (D.O.).
2. Physician Assistants (PA), Nurse Practitioner (NP), or Certified Nurse Midwife (CNM).
3. Registered Nurse (RN) or licensed practical nurse (LPN).
4. Other service providers, health educators, social workers, clinic aides, and lab technicians.

A provider is a trained individual whose primary responsibility is to assess the client’s health status and exercise independent judgment regarding which services the client needs.
## Section 15A: Primary Contraceptive Method
### Section 15B: If None at the End of This Visit, Give Reason

### 15A. PRIMARY CONTRACEPTIVE METHOD
(Complete before and after blocks)

<table>
<thead>
<tr>
<th>HIGHLY EFFECTIVE</th>
<th>MODERATELY EFFECTIVE</th>
<th>LESS EFFECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 - Male Sterilization</td>
<td>16 - Hormonal Injection</td>
<td>06 - Male Condom</td>
</tr>
<tr>
<td>01 - Female Sterilization</td>
<td>02 - Oral Contraceptives</td>
<td>19 - Female Condom</td>
</tr>
<tr>
<td>11 - Hormone Implant</td>
<td>17 - Hormonal Patch</td>
<td>21 - Contraceptive Sponge</td>
</tr>
<tr>
<td>15 - IUS</td>
<td>18 - Vaginal Ring</td>
<td>20 - Withdrawal</td>
</tr>
<tr>
<td>03 - IUD</td>
<td>04 - Diaphragm/Cap</td>
<td>08 - NFP/FAM</td>
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<tr>
<td>22 - LAM</td>
<td></td>
<td>07 - Spermicide</td>
</tr>
</tbody>
</table>

### OTHER
- 09 - Other Method
- 13 - Abstinence
- 10 - None

<table>
<thead>
<tr>
<th>BEFORE VISIT</th>
<th>AFTER VISIT</th>
</tr>
</thead>
</table>

### 15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.

- Pregnant
  - 1 - Planned
  - 8 - Unplanned
  - 3 - Seeking Pregnancy
  - 6 - Not Sexually Active
  - 7 - Other

Use Section 15A to record the contraceptive method the client used before the visit and the method the client will use as a result of the visit. It should be noted that agencies’ electronic data collection systems may not reflect the order of methods by effectiveness as shown on the paper CVR. Use Section 15B to record the reason that the client will not use a contraceptive method after the visit. Here are instructions that apply to the coding for both sections:

- In the Section 15A **Before Visit** space, enter the two-digit code of the primary or most effective method even if more than one method is used.
- In the Section 15A **After Visit** space, enter the code of the primary or most effective method to be used after the visit even if more than one method will be used. If the client receives two methods, code the primary method only.
- Clients relying on their partners’ methods should be marked as users of those methods. For example, if a male client relies on his female partner’s Depo-Provera for contraception, use code 16. Similarly, if a female client relies on her male partner’s vasectomy, use code 14.
- If no contraceptive method is continued or initiated at the end of this visit, enter code 10 (None) in Section 15A and the most important reason for this decision in Section 15B. **Please note that code 3-Seeking Pregnancy in Section 15B is unallowable for CVRs with a CCare source of pay.**
- In order to bill CCare for a client requesting an IUD removal for the purposes of seeking pregnancy, mark box 10 (None) in Section 15A and box 7 (Other) in Section 15B.
- For infertility clients, enter code 10 (None) in Section 15A. (Even if a method is being used as treatment, its purpose is not to prevent pregnancy, but to enhance fertility.)
- If any code except 10 is entered in the **After Visit** space in Section 15A, skip Section 15B.
Section 16: Referral Information

Use Section 16 to indicate whether the client was referred to another agency or clinician, or to another program in a multi-service project. Check all that apply for the current visit. All referral information must be documented in the client medical record.

Section 17: Medicaid Billing

Section 17 is used to generate billing for contraceptive supplies provided to clients enrolled in CCare. If the client is not enrolled in CCare or is receiving services not covered by CCare, this section can be ignored. Note that contraceptives are the only supply/medication for which you may receive payment.

Please see Section C, Exhibit 8 for the contraceptive supply codes list, with maximum allowable quantities and reimbursement rates per unit that may be billed on each date of service. Enter the appropriate quantity and CVR code for each method you dispense to the client.

Pay particular attention to the following special instructions for the billing of these methods. The patch and the ring are both billed using the quantity per each. Even though the patch comes in a box of three (one cycle), they are billed as 1/3 of the total price times the quantity of three. For Depo, the unit price is the total acquisition cost. For OHP use quantity 150 and the total unit cost, for CCare use quantity 1 or 150 and the total unit cost. The Ahlers system will convert quantity 150 to quantity 1 for CCare.
You will be reimbursed at your **acquisition cost**, not at the CCare maximum allowable amount. Each agency must document the calculations used to determine the acquisition cost of each supply. That information must be available for audit purposes. See Section C for guidance on how to calculate acquisition costs.

**Section 17A: Third Party Resource (TPR) Codes**

<table>
<thead>
<tr>
<th>TPR Codes: Single Insurance Coverage</th>
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<tbody>
<tr>
<td><strong>Code</strong></td>
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<tr>
<td>UD</td>
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<td>NC</td>
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<td>PP</td>
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<td>NA</td>
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<td>MB</td>
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<tr>
<td>OT</td>
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Use item **2 - Other Insurance Paid** to record the amount paid by the private insurance for the family planning service. CCare will reimburse the balance up to the maximum reimbursement rate.

Clients should be asked about current insurance status at each visit. Unless a client with private insurance also indicates the need for special confidentiality, federal law requires that all reasonable efforts be taken to ensure that CCare or Title X is the payer of last resort.

If a client with insurance requests special confidentiality at the time of enrollment, insurance should not be billed and the Explanation/TPR Code “NC” should be entered in box 17A of the CVR.

If a client reports having insurance on the CCare Enrollment Form but does not bring the card or policy information to the visit, clinic staff are expected to try to contact the insurance company to obtain the information necessary for billing. Otherwise, it is the expectation of the RH Program that clinic staff follow-up with the client to obtain the insurance information and document the attempt. If this follow-up does not yield the necessary information, CCare can be billed using the TPR code “OT”.

**Beginning February 17, 2014** CCare claims will be rejected from the Ahlers system when a client has indicated having private insurance on the CCare Enrollment Form, but no dollar amount paid or explanation code is provided with the claim.

The error message on the CVR Error Report will read as follows: **REJECT: PVT INS FROM WEB IS YES BUT 17A IS BLANK**