GENERAL FINANCIAL MANAGEMENT

It is expected that all agencies will operate according to the generally accepted government auditing standards (GAGAS) **and Subpart C of 45 CFR Part 74 or Subpart C of 45 CFR Part 92, as applicable**.

All delegate agencies must have written policies and procedures for overall fiscal management of the program. This must be a delegate-, agency- or county-specific policy. (Program Guidelines 6.3, p.7)

All agencies should have an annual audit performed by auditors meeting established criteria for qualifications and independence. (Program Guidelines 6.3, p.8)

Financial records must be maintained for seven years.

FEE COLLECTION POLICY

1. Delegate agencies must have a schedule of discounts **(sliding fee scale)** that is in compliance with the Title X Federal Regulations and provides for the following charges **for family planning services** for non-third party clients:
   a) No charge for a client whose income is at or below 100% of poverty.
   b) A schedule of discounts for clients with incomes between 101% and 250% of poverty.
   c) Full charge for clients whose income is above 250% of poverty.

2. **Covered family planning services include routine family planning visits to initiate, continue or discontinue a contraceptive method. Additional covered family planning services may include, but are not limited to, provision of contraceptive methods and pregnancy testing and counseling. Some labs may also be covered by the family planning program.**

3. The **agency's** fee schedule (sliding fee scale) must be reviewed and updated annually and must be submitted to the CDPHE Women's Health (WH) Unit for approval prior to implementation. The fee schedule must be selected from the models provided by the grantee (page 7 of this Section) and contain sufficient proportional increments so that inability to pay is not a barrier to services. The schedule must be developed using a cost analysis of all services, including clinical and laboratory services and supplies. **The cost analysis must use a relative value system to determine the cost per unit of service (based on CPT codes). Recognized relative values must be used. If the agency treats laboratory and supply/pharmaceutical costs separately from the relative value system, the agency must be able to describe how fees are established for these items.** Costs for laboratory services and supplies may include reasonable estimates for purchase price plus ordering, keeping inventory, storing, and distributing the item. CDPHE reserves the right to request that the delegate agency submit additional documentation to justify the fee schedule, including work papers associated with the cost analysis. Charges should be reasonable, fair, and equitable for all clients. Each agency must perform a cost analysis annually (preferably prior to submitting a fee schedule to CDPHE). The fee schedule must be designed to recover the reasonable cost of providing each service, including clinical and laboratory services and supplies. Agencies must use the most recent Federal Poverty Guidelines to assess income level. The annual revision of the Federal Poverty Guidelines becomes available each spring.

4. Client income and family size must be documented in the client's chart or record. Computer files are considered part of the client's record. Client statements regarding income and family size may be taken at the client's word (self-declaration of income). Written income verification is acceptable but not required. Sites electing to ask for written income verification must complete formal income verification on all clients presenting for family planning services so that the process is fair and equitable for all clients. Client income and family size must be updated at least annually or as appropriate. **Delegates that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on client's self report (OPA Program Instruction Series, OPA 08-1, http://www.hhs.gov/opa/familyplanning/toolsdocs/opa08-1.pdf).**

   If delegate agencies choose to use written income verification, they cannot deny services or charge full fee for services to a client who fails to produce written income verification. In a case

where a client does not have written income documentation, agencies must accept verbal declaration and request that the client bring written documentation of income at their next visit.

5. Client eligibility for third party billing must be updated annually.

6. Adjustments to decrease or waive client charges based on extenuating circumstances are allowed. Collection of fees must be consistent with the client's ability to pay. Clients must not be denied services because of inability to pay current or past due amounts.

7. Agencies must have a methodology for determining whether or not a minor is seeking "confidential" services (i.e., whether or not they are not receiving financial support from their family to pay for their family planning services). Minors presenting for services with parental consent or in the company of a parent/guardian must be queried about whether their parent/guardian is providing financial support for the visit. If so, the client may be charged as all others are: according to their family income and size. **Minors should estimate family income if they are not certain of actual incomes.** However, if a minor seeks "confidential" services, the minor must be income coded on the basis of the minor's income and family size (number of individuals supported by that income). Delegate agencies may not calculate an imputed value of room and board when determining the minor's income.

8. Delegate agencies must provide clients with a statement at the time of service that details the full charges, discounts, amount paid, and the balance, if any, which the client is expected to pay.

9. Reasonable efforts to collect past due amounts, including the mailing of bills, must be undertaken, so long as client confidentiality is not jeopardized. Collections of past due amounts must not be done in a coercive manner. **Delegates must have a system to determine how much money is owed by clients and how long the debt is outstanding and not yet paid.**

10. In cases where a third party is responsible, bills must be submitted to that party. Bills to third parties must show total charges without applying any discount. Projects must bill all third parties legally authorized or legally obligated to pay for services.

    a) If a client with private insurance is willing to bill the insurance company, this is allowable. However, it is preferable for the agency to directly bill the insurance company. If the client is willing to bill the insurance company, the client should be given a copy of the statement showing what services were provided and what the client actually paid (e.g., a super bill).

    b) If a client has private insurance and is not willing to submit the bill, the agency must make efforts to determine if they are a covered provider and if so, submit the bill.

    c) If a client has private insurance and states that her/his plan does not cover family planning services, this must be documented. The agency is then not required to bill the third party.

    d) If the family planning agency is not a covered provider for a given insurance plan, direct billing is not required. However, the agency must have documents on file to show that they are not a covered provider. The agency must verify and document whether or not they are a covered provider with each new insurance plan and annually thereafter.

e) Agencies may elect to submit the bill at full fee to the insurance company and defer the charge to the client at the time of service. If the insurance company refuses all or part of the bill, the agency may charge the balance to the client after applying the discount according to the sliding fee scale.

f) When a contract is in place with an insurance carrier, the terms of the contract (co-pay requirements, acceptance of reimbursement as full payment, fees set by the third party, etc.) must be followed. If a client is in the zero pay category (less than 100% of the federal poverty level), and a co-pay is required, the client may not have money for the co-pay. In that case, the clinic can choose to waive the co-pay.

11. A method for the aging of outstanding accounts must be established. Aging is defined as writing off a client's outstanding balance after a certain defined period of time (CDPHE suggests 12 months). This policy must be in writing and must be agency-specific. **Delegates should develop a methodology to write off overdue accounts either through their existing system or through some other internal mechanisms or software program.**

12. Donations by clients may be accepted under the following circumstances:
    a) There is no schedule of donations.
    b) No bills are sent to clients for donations.
    c) No coercion is involved.
    d) No amount for a donation is suggested.
    e) Requests for donations are equitable. If agencies choose to request donations from clients, they must request them from all Title X clients, regardless of income level.

13. Since the CDPHE Women's Health Unit received special funding in 1988 for Chlamydia testing and treatment, and those funds were subsequently added to the grant award, clinics must offer Chlamydia screening on the Title X fee schedule. The Chlamydia tests must slide from full fee to zero for clients in the required populations **(see Nursing Manual, STD Protocol, page 6).** The Zithromax that delegate agency's receive from The Apothecary in Boulder is funded by the STD program at the CDPHE. The policy of the STD program is that any Zithromax supplied through the grant is free to clients who are positive for Chlamydia, as well as their partners. **Note that the drugs from The Apothecary are purchased through 340B pricing and must only be distributed to partners who have a record established with the clinic. For expedited partner therapy (drugs sent home with the infected client for a partner who is not a client of the clinic), drugs must be purchased at non-340B prices. Please refer to the Nursing Manual, STD protocol for more information about Expedited Partner Therapy and 340B drugs.** Although delegate agencies may not charge for the Zithromax purchased through the STD grant, agencies may apply a sliding fee to any Zithromax purchased with the delegate agency's funds. Screening for gonorrhea is **not** a Title X requirement. **However, if the agency uses a combined Chlamydia/gonorrhea test which provides both results, then the combination test must be charged as one on the sliding fee scale**. Provision of treatment **for gonorrhea** is not **a Title X requirement, therefore,** delegate agencies can offer gonorrhea treatment at either a flat fee or according to the delegate agency's sliding fee scale.

FEDERAL POVERTY LEVELS/GUIDELINES

Federal poverty guidelines are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The table is issued each year and is used to determine financial eligibility/sliding scale charges for certain federal programs, including Family Planning.

The Administrative Consultant will issue the Federal poverty guidelines to delegate agencies each spring (usually in **February or** March when the current year's guidelines are issued) and it is expected that agencies will put the new guidelines into place within two weeks of receiving the information.

The most current guidelines can also be found at:

http://aspe.hhs.gov/poverty/index.shtml

or through the Family Planning website for the Women's Health Unit:

http://www.cdphe.state.co.us/pp/womens/FederalPovertyGuidelines.html?col2=open

SLIDING FEE SCALE

Each program must submit their revised sliding fee scale in the fall of each year. All charges should be based on a cost analysis (see the "Fee Collection Policy" portion of this Section for more information on this).

INFORMING CLIENTS ABOUT SLIDING FEE SCALE POLICIES

The following information must be posted or provided to clients in writing:

- Fees for services are based on the client's income and family size and that the client will be charged according to a fee scale.
- No one is denied services because of an inability to pay.
- Clients whose income is at or below 100% of poverty are not charged or billed for required services.
- Fees for minors requesting confidential services are based on their own income

The following page, "Dear Family Planning Client," summarizes the Title X requirements related to sliding fee scales as stated above and is for delegate agencies to use. The above fiscal information should be posted in agency clinics or given to clients in writing. The "Dear Family Planning Client" information sheets are available for downloading in English and Spanish from the Women's Health Unit website at: http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html. Agencies may also create their own documents to use in providing this information to clients.

Dear Family Planning Client,

We are pleased you have chosen to come to our clinic.

We want to provide you with low-cost, quality care.

A sliding fee scale, based on the cost of providing services, is used to determine your fee. The amount you are charged depends on how much money you earn and how many people you support.

Using a sliding fee scale allows us to provide care at much lower cost to you than other health care offices. No one will be denied birth control because he or she can't pay.

If your income is at or below 100% of the federal poverty level, you will not be charged or billed for covered routine family planning clinic services related to your birth control method.

You may be billed for services that are not covered by the family planning program, and you are responsible for the costs of those services. This could include non-Title X services such as colposcopy, HIV testing, Chlamydia testing for clients not at risk, as well as complications resulting from Title X procedures, side effects from medications, etc.

If you are under 18, your fees are based only on the income available to you, which may or may not include your parent's income.

Family planning clinics receive some state and federal dollars to help pay for your care here. However, government funding has not kept up with our expenses.

Your donations are very important. They help keep our clinic open and this care available. We appreciate your donations, no matter how much you can give.

We will be happy to answer any questions you have about our services and fees.

APPROVED FAMILY PLANNING SLIDING FEE SCALE MODELS

5 Code Model

Poverty Level	Code	% of Full charge
<100%	1	0%
101-150%	2	**25**%
151-200%	3	5**0**%
201-250%	4	**75**%
>250%	5	100%

6 Code Model

Poverty Level	Code	% of Full charge
<100%	1	0%
101-150%	2	20%
151-185%	3	40%
186-220%	4	60%
221-250%	5	80%
>250%	6	100%

CHC (CICP) Model

Poverty Level	Code – CICP Rating	% of Full Charge
<100%	1 **– Z, N, A, B, C**	0%
101-117%	2 - **D**	10%
118-133%	3 - **E**	25%
134-159%	4 - **F**	**4**0%
160-185%	5 - **G**	55%
186-200%	6 - **H**	70%
201-**217**%	7 - **Ia**	85%
218-235%	**8 - Ib**	**90%**
236-250%	**9 - Ic**	**95%**
>250%	**10**	100%

DETERMINING FAMILY SIZE AND INCOME

Family Size

- Count all persons related by blood, marriage, or adoption living in the same household.

Income

- Count the gross income of each person in the family (as described above and in Section I, Definitions)
- The following sources should be included when calculating gross income:
    - Salaries, wages, tips
    - Business profits
    - Royalties or commissions
    - Assistance from relatives or friends
    - Workers' compensation
    - Veterans' payments
    - Social Security cash benefits
    - Public assistance (Aid to Families with Dependent Children, Temporary Assistance for Needy Families (TANF) supplemental security income, non-Federally funded General Assistance or General Relief money payments)
    - Training stipends
    - Alimony
    - Military family allotments or other regular support from an absent family member or someone not living in the household
    - Pensions or annuities (including military retirement pay)

BILLING FOR SERVICES USING CPT AND DIAGNOSIS CODES

Introduction

Current Procedural Terminology (CPT) is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by health care providers. Each procedure or service is identified with a five-digit code.[1] Such coding was devised to assure consistency among providers, standard reporting, and more accurate reimbursement for services (from third party insurers including Medicaid).

All claims submitted to third party insurers for family planning services must also include an appropriate diagnosis code from the *International Classification of Diseases, Clinical Modifications* (ICD-9-CM) coding structure.

In order to be reimbursed by third party insurers, all claims must have (at a minimum) an appropriate CPT and ICD-9-CM code. This can be illustrated using a Patient Encounter Form or super bill *(example is attached).*

It may be challenging initially to appropriately assign and link procedure code (CPT) and diagnosis (ICD-9-CM) code, this guide is intended to assist in this effort. To obtain additional resources other than this guide, including Medicaid maximum allowable rates, please contact the Administrative Consultant in the Women's Health Unit at (303) 692-2493.

*CPT code describes the services provided.	*ICD-9-CM describes the reason for the service.

Payment Guidelines

Upon receipt of appropriate documentation, the Colorado Department of Health Care Policy and Financing will base reimbursement by Medicaid on maximum allowable fees set for family planning services. Payment is subject to conditions, exclusions, and limitations set forth by the department. The payment of services shall be the lower of the following:

1) the amount specified in the department's fee schedule (maximum allowable reimbursement information for specific services available from the WH upon request)
2) the agency's usual and customary fee (in the case of the sliding fee schedule, the 100% charge for the service)

Note: When billing Medicaid for family planning services, CPT codes must include the family planning modifier "-FP" (Example: 99212-FP).

Private third party insurers have similar payment reimbursement policies as well. Please contact the insurance company for more information on its specific policy.

For additional information on Medicaid reimbursement, please visit the Provider Services and Billing Manuals sections of the Colorado Department of Health Care Policy and Financing's website.
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485906

[1] *Current Procedural Terminology, CPT 2008,* Chicago: AMA Press, 2007.

FAMILY PLANNING CPT CODES

Previously, Medicaid only approved the Office Visit codes for family planning billing (99201-99204 for new clients and 99211-99214 for established clients). However, now family planning programs can bill using the Preventive Medicine Services codes. These codes are age-based and are inclusive of the initial or periodic comprehensive exam, counseling, anticipatory guidance, and risk factor reduction interventions.

The actual definition is: "Initial [or periodic] comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of laboratory/diagnostic procedures…"

99384: Initial (new) adolescent 12 – 17 years
99385: Initial (new) 18 – 39 years
99386: Initial (new) 40 – 64 years
99394: Periodic (established) adolescent 12 – 17 years
99395: Periodic (established) 18 – 39 years
99396: Periodic (established) 40 – 64 years

These codes better describe the types of services family planning clinics provide in the form of initial and annual exams.

The family planning service codes listed in the Evaluation and Management (E/M) Services Guidelines **as Office or Other Outpatient Services should be used for those services that are more "medical" in nature, frequently termed "revisits." Visits for STD evaluation, UTIs, Depo reinjections, repeat Pap smears, or other problems would be better described using the Evaluation and Management Office codes (99201-99204 for new or 99211-99214 for established clients).** The descriptions for the levels of these E/M services recognize seven components, six of which are used in defining the level of services.[2] The components are:

- *History**
- *Examination**
- *Medical decision making**
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Please note, when counseling dominates more than 50% of the time spent with the physician or midlevel provider (face-to-face in the office), then time may be the determining factor for the level of E/M services. The extent of the counseling must be documented in the client's record.

*The first three components are considered the *key* components in selecting the level of service.

[2] *Current Procedural Terminology, CPT 2009,* Chicago: AMA Press, 2008.

Definitions

- *New Patient:* A patient who has not yet received any professional services from the **agency's family planning program** within the past three years.

- *Established Patient:* A patient who has received professional services from the **agency's family planning program** within the past three years.

*If a patient is new to the health center **or has been a health center patient but has not received family planning services in the previous three years**, the patient should be considered a new patient for family planning. If the patient is a health center patient **and has received family planning services in the previous three years,** the patient should be considered an established family planning client.*

Preventive Patient Visit Codes

CPT CODE	DESCRIPTION
99384	**Initial comprehensive preventive medicine visit for adolescent for ages 12-17 years** • **Initial family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.**
99385	**Initial comprehensive preventive medicine visit for ages 18 – 39 years.** • **Initial family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.**
99386	**Initial comprehensive preventive medicine visit for ages 40 - 64 years.** • **Initial family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.**
99394	**Periodic comprehensive preventive medicine visit for adolescent (age 12-17 years)** • **Annual family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.**
99395	**Periodic comprehensive preventive medicine visit for ages 18 – 39 years** • **Annual family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.**
99396	**Periodic comprehensive preventive medicine visit for ages 40 – 64 years** • **Annual family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.**

For revisits or visits of a more medical nature consider the following series of codes:

New Patient Visits

CPT CODE	**DESCRIPTION**
99201	New Patient Focused Visit *Presenting problems are self-limited or minor. Physicians typically spend 10 minutes face-to-face with patient.* Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: • A problem focused history; • A problem focused examination; and • Straightforward medical decision making ▪ Example: **Counseling and treatment of male contact to positive Ct/GC**

99202 New Patient Expanded Visit

Presenting problems are low to moderate. Physicians typically spend 20 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Straightforward medical decision making
    - Example: **Initial evaluation of new client with UTI**

99203 New Patient Detailed Visit

Presenting problems are of moderate severity. Physicians typically spend 30 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low complexity
    - Example: **Initial evaluation of female with STD or vaginitis**

99204 New Patient Comprehensive Visit

Presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:

- A comprehensive history
- A comprehensive examination; and
- Medical decision making of moderate complexity
    - Note: It would be very unusual in typical family planning clinic settings to use this code
    - **Example: Initial evaluation of pelvic/testicular pain to rule out PID/epididymitis**

* All visits listed above include counseling and/or coordination of care, including anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.

NOTE: Time spent face-to-face with patients is physician time. It is expected that another healthcare provider (nurse practitioner or registered nurse) may spend more time with patient than time noted above.

Established Patient Visits

CPT CODE DESCRIPTION

99211 Established Patient Minimal Visit

Usually, the presenting problems are minimal ***and may not require the presence of a physician or midlevel provider.*** *Typically, a total of 5 minutes are spent with patient.*

- Example: **Depo injection, blood pressure recheck established client.**

99212 Established Patient Focused Visit

Presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making
  - Example: Brief medical visit with practitioner **for evaluation of vaginitis or STD**

99213 Established Patient Expanded Visit

Presenting problems are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of low complexity
  - Example: **Evaluation of established client with pelvic/testicular pain to rule out PID/epididymitis**

99214 Established Patient Detailed Visit

Presenting problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:

- A detailed history;
- A detailed examination; and
- Medical decision making of moderate complexity
  - Note: It would be **uncommon** in typical family planning clinic settings to use this code
  - **Example: Evaluation of lower quadrant pain to rule out ectopic pregnancy**

* All visits listed above include counseling and/or coordination of care, including anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.

NOTE: Time spent face-to-face with patients is physician time. It is expected that another healthcare provider (nurse practitioner or registered nurse) may spend more time with patient than time noted above.

Preventive Counseling Visits

When a face-to face visit is for the purpose of promoting health, preventing illness or risk factor reduction, it may be more appropriate to use the following counseling codes. This one set of codes is used for both new and established clients. These services can be provided by any qualified health care professional.

CPT CODE	DESCRIPTION
99401	**Preventive Medicine Counseling** ***Provided to an individual; approximately 15 minutes*** • **Example: 3 month method evaluation with no problems and not requiring a physical exam**
99402	**Preventive Medicine Counseling** ***Provided to an individual; approximately 30 minutes*** • **Example: Pregnancy testing and options counseling** • **Example: 'Delayed exam' for initiating a contraceptive method**

Counseling codes include the visit. An additional visit code should not be charged.

Procedure Codes

CPT CODE	DESCRIPTION
11975	Insertion of implantable contraceptive capsules
11976	Removal of implantable contraceptive capsules
11977	Removal and reinsertion of implantable contraceptive capsules
57170	Diaphragm fitting (with instructions)
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)

Procedure codes include the visit. An additional visit code should not be charged.

Contraceptive Supplies

CPT CODE	DESCRIPTION
A4266	Diaphragm
A4267	Condom, male
A4268	Condom, female*
A4269	Spermicide (e.g. foam, gel) - each*
J1055	Contraceptive injectable - per three-month dose (i.e. Depo Provera)
J7300	Intrauterine device, copper T380A (Paragard)
J7302	Intrauterine device, levonorgestrel releasing, LNG-IUS (Mirena)
J7303	Hormone releasing vaginal ring (i.e. Nuvaring) - each
J7304	Hormone containing patch (i.e. Ortho Evra) - each
J7307	Etonogestrel implant, 68 mg. (Implanon)
S4993	Oral contraceptives (per cycle), all brands, including Plan B

For implantable contraceptives, IUDs, Depo-Provera, etc, charge CPT code for procedure and CPT code for device/supply.

*Medicaid does not cover female condoms or spermicide

Other Supplies

CPT CODE	DESCRIPTION
J3490	Medications related to family planning services. *If billing this code to insurance, including Medicaid, the name of the medication must be specified.*
	Including, but not limited to:
	-Metrogel
	-Monistat
	-Monistat Dual Pack
	-Sultrin
	-Terazol 3, Terazol 7, Terazol Cream
J0696	-Rocephin
Q0144	-Zithromax

Lab Codes (for labs typically done in the clinic)

Note: labs that are not performed in the clinic are not billed to third parties by the clinic. The lab performing the test(s) should bill insurance for the test(s).

CPT CODE	DESCRIPTION
81000	Urinalysis, non-automated with microscopy (by dipstick or tablet reagent)
82948	Glucose, blood reagent strip
85013	Spun MicroHematocrit
85018	Hemoglobin (Hgb)
86701	**Rapid HIV 1**
87210	Smear, Wet Mount, or
Q0111	Smear, Wet Mount with preparations
99000	Handling and/or conveyance of specimen for transfer from clinic to a laboratory (e.g., Chlamydia or Pap smear specimens)
36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick)

Other Procedure Codes – Female Genital System

CPT CODE	DESCRIPTION
56501	Destruction of lesion(s) on vulva, **any method**, simple
56605	Biopsy of vulva or perineum, one lesion
+56606	**Each separate additional lesion**
57061	Destruction of vaginal lesions, **any method**, simple
57420	Colposcopy of entire vagina, with cervix if present
57421	Colposcopy of entire vagina, with cervix if present, with biopsy
57452	Colposcopy of the cervix including upper/adjacent vagina
57454	Colposcopy of the cervix including upper/adjacent vagina, with biopsy
57511	**Cryocautery of the cervix, initial or repeat**
58100	**Endometrial sampling, separate from colposcopy procedure**
+58110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy (add on to code for primary procedure - colposcopy)**

Other Procedure Codes – Male Genital System

CPT CODE	DESCRIPTION
00921	Anesthesia for vasectomy, unilateral or bilateral
54050	Destruction of lesion(s) on penis (e.g. condyloma, papilloma) chemical
54056	Destruction of lesion(s) on penis- cryosurgery
55250	Vasectomy, unilateral or bilateral (includes post-op semen examination)

ICD-9-CM DIAGNOSIS CODES

As previously mentioned, ICD-9-CM codes describe the reason for the visit. All claims submitted to third party insurers for family planning services must include an appropriate diagnosis code from the *International Classification of Diseases, Clinical Modifications* (ICD-9-CM) coding structure as well as a CPT code. The codes most likely to be used in family planning clinics, corresponding to the appropriate CPT code include:

Diagnosis Codes

ICD-9-CM CODE	DESCRIPTION
V25	Encounter for contraceptive management
V25.0	General counseling and advice
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive measures
V25.03	Encounter for emergency contraceptive counseling and Prescription
V25.04	Counseling and instruction in natural family planning **to avoid pregnancy**
V25.09	Other counseling and advice for contraceptive management
V25.1	Insertion of intrauterine contraceptive
V25.2	Sterilization (interruption of fallopian tubes or vas deferens)
V25.4	Surveillance of previously prescribed contraceptive method(s)
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill
V25.42	Intrauterine contraceptive device
V25.43	Implantable subdermal contraceptive
V25.49	Other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management (e.g. postvasectomy sperm count)
V25.9	Unspecified contraceptive management

Other Diagnosis Codes

ICD-9-CM CODE	DESCRIPTION
939.2	Foreign body in vagina (e.g. forgotten tampon)

When the reason for the visit (ICD-9-CM code) is other than contraceptive in nature (example – follow up to abnormal Paps, vaginitis, etc.), other ICD-9 codes may need to be used to file insurance claims. The above list is not meant to be an exhaustive list. Please refer to the resource referenced below for more complete coding information.

More information and/or resources on CPT and ICD-9-CM Coding Can be Purchased From:

American Medical Association

Phone: (800) 621-8335

Website: https://catalog.ama-assn.org/Catalog/home.jsp

SUPER BILL

The following is a sample super bill. This type of form can be used to bill third party insurers. For this reason, the form does not include services such as labs which are sent off-site for processing. These labs are usually billed directly to the third party insurer by the laboratory. If agencies wish to use the super bill as a statement of all services provided to the client, they would need to add items such as off-site labs (Pap smear, Chlamydia, gonorrhea, etc.) and other medications and supplies (antibiotics, Cycle Beads, BBT thermometers, etc.) for which the agency cannot bill third parties.

This form can be downloaded from the Women's Health Unit website at:
http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html

INSERT NAME OF AGENCY
COMPLETE ADDRESS, PHONE NUMBER, FAX NUMBER

Date of Service:	**Clinic Presented at:**		
Last Name:	**First Name:**	**Middle Initial:**	**Gender:** ☐ Female ☐ Male
Birth Date:	**Age:**	**Phone Number:**	**Alt. Phone Number:**
Address:	**City:**	**State:**	**Zip:**
Medicaid: ☐ No ☐ Yes	**If yes, enter number:**		
Health Insurance: ☐ No ☐ Yes	**If yes, enter Insurance Company:**	**Insurance Phone Number:**	
Policy Holder's Name:	**Policy Number:**	**Group Number:**	

New Patient Preventive Visit (Initial):		
99384	Age 12 – 17 years - Adolescent	☐
99385	Age 18 – 39 years	☐
99386	Age 40 – 64 years	☐
Established Patient Preventive Visit (Annual):		
99394	Age 12 – 17 years - Adolescent	☐
99395	Age 18 – 39 years	☐
99396	Age 40 – 64 years	☐
New Patient Medical Visit:		
99201	Focused Exam	☐
99202	Expanded Visit	☐
99203	Detailed Visit	☐
Established Patient Medical Visit:		
99211	Minimal Visit	☐
99212	Focused Exam	☐
99213	Expanded Visit	☐
Individual Counseling		
99401	Counseling 15 minutes	☐
99402	Counseling 30 minutes	☐
Procedures:		
11975	Insertion of implantable contraceptive capsules	☐
11976	Removal of implantable contraceptive capsules	☐
11977	Removal/reinsertion of implantable contraceptive capsules	☐
57170	Diaphragm fitting (with instructions)	☐
58300	Insertion of intrauterine device (IUD)	☐
58301	Removal of intrauterine device (IUD)	☐
Contraceptive Supplies:		
A4266	Diaphragm	☐
A4267	Condom, male	☐
A4268	Condom, female	☐
A4269	Spermicide	☐
J1055	Contraceptive injectable	☐
J7300	Intrauterine device, Paragard	☐
J7302	Intrauterine device, Mirena	☐
J7303	Hormone releasing vaginal ring Nuvaring - each)	☐
J7304	Hormone containing patch (Evra - each)	☐
J7307	Etonogestrel Implant, 68 mg. (Implanon)	☐
S4993	Oral contraceptives (per cycle)	☐
Lab Codes:		
81000	Urinalysis, non automated	☐
82270	Fecal Occult Blood Screening	☐
82948	Glucose, blood reagent strip	☐
85013	Spun Microhematocrit	☐
85018	Hemoglobin	☐
86701	Rapid HIV 1	☐
87210	Smear, Wet Mount	☐
Q0111	Smear, Wet Mount with prep	☐
99000	Lab handling	☐
36415	Venipuncture (blood draw)	☐
36416	Collection of capillary blood specimen (finger stick)	☐

Other Codes – Female Genital System:		
56501	Destruction of lesion/s on vulva, simple	☐
56605	Biopsy of vulva or perineum, one lesion	☐
+56606	Each separate additional lesion	☐
57061	Destruction of vaginal lesions, simple	☐
57420	Colposcopy of the entire vagina, with cervix if present	☐
57421	Colposcopy of the entire vagina, with cervix if present, with biopsy	☐
57452	Colposcopy of the cervix, including upper/adjacent vagina	☐
57454	Colposcopy of the cervix, including upper/adjacent vagina, with biopsy	☐
57511	Cryocautery of the cervix, initial or repeat	☐
+58110	Endometrial sampling in conjunction with colposcopy	☐
Other Codes – Male Genital System:		
00921	Anesthesia for vasectomy, unilateral or bilateral	☐
54050	Destruction of lesions on penis, chemical	☐
54060	Destruction of lesion/s on penis, surgical excision	☐
55250	Vasectomy, unilateral or bilateral	☐
Other Supplies:		
	<List all other therapeutics you carry here; These cannot be billed to Medicaid>	☐
Diagnosis Codes:		
	Encounter for contraceptive management:	
V25.0	General counseling and advice	☐
V25.01	Prescription of oral contraceptives	☐
V25.02	Initiation of other contraceptive device	☐
V25.03	Encounter for emergency contraceptive counseling and prescription	☐
V25.04	Counseling/instruction Natural Family Planning	☐
V25.09	Other counseling and advice for contraceptive management	☐
V25.1	Insertion of intrauterine contraceptive	☐
V25.2	Sterilization - Vasectomy	☐
V25.4	Surveillance of previously prescribed contraceptive method/s	☐
V25.40	Contraceptive surveillance, unspecified	☐
V25.41	Contraceptive pill	☐
V25.42	Intrauterine contraceptive device	☐
V24.43	Implantable subdermal contraceptive	☐
V25.49	Other contraceptive method	☐
V25.5	Insertion of implantable subdermal contraceptive	☐
V25.8	Other specified contraceptive management	☐
V25.9	Unspecified contraceptive management	☐
939.2	Tampon Removal	☐

Income Level	1 2 3 4 5
Today's Charges	$
Discounted Charge	$
Amount Paid	$
Balance Due	$
Donation	$

Patient Signature: _____

Form rev. 03/2009

USE OF PROGRAM REVENUE

All dollars received in client fees, cash donations and interest are considered grant-related income and, according to Title X guidelines, can only be expended for Title X efforts. **[42 CFR 59.9]**

The maximum amount of dollars from client fees, donations, and advances retained by a delegate contractor may not exceed the amount required to operate that program for six months. This excludes any local support. Should an agency accumulate more than six months operating expenses, contract payments will be withheld and the agency will be expected to return unspent funds.

DELEGATE AGENCY EXPENDITURE/REVENUE REPORT INSTRUCTIONS

Introduction

This form is required to report expenditures and revenues for your agency's Family Planning Program. Information provided by the delegates is used by the Women's Health (WH) Unit in the completion of reports regarding federal and state funding. This form is available electronically as an Excel spreadsheet from WH. Please email the electronic document to the appropriate person if possible. You may also fax the report. **One report is for the months of July through December; the second report is for the months of January through June. These reports will be due on dates specified by CDPHE.**

All expenditures and revenues are to be reported on an accrual basis (not cash) by reporting all expenses incurred and all revenues earned for the reporting period. All Family Planning Program expenditures and revenues are to be identified and reported. The expenditures and revenues directly related to funds received from CDPHE-Women's Health **(Federal Title X funds, State general funds, Chlamydia funds, and Colorado Family Planning Initiative funds)** are to be reported in Column (A) – CDPHE-WH funding. The expenditures and revenues directly related to funds received from non-CDPHE funding sources are to be reported in Column (B). Column (C) – Combined Total includes all expenditures and funding sources and is the total expended and earned in order to operate the Family Planning Program.

Step 1 - Identification

- *Agency Name* – Enter the name of the agency for which the report is prepared.
- *Period* - This report is required twice a year; one report for the period January 1 through June 30, and a second report for July 1 through December 31. **Check the box to indicate the** dates of the period being reported.
- *Completed By **and Phone #*** – Enter the name and phone number of the person completing the report.
- *Date* – Enter the date the report was completed and submitted to CDPHE.

Step 2 – Expenditures

- *Personal Services*
  - Salary - Show the total salary paid to all family planning (FP) program employees during the period. Do not include time worked in other programs. A total that includes all employees may be reported and individual employees do not need to be listed.
  - Fringe - Show the fringe benefit paid to the FP employees in this period.
  - Subtotal Personal Services - Add and report all salary and fringe. If you are using the electronic document, the subtotal will be provided for you.
- *Contractual Services*
  - Clinician personnel **(physicians, nurse practitioners, etc.)** - Report any dollars paid for non-employee services.
  - Other - Report and identify any other expenditures made via a contractual agreement.
  - Subtotal Contractual Services - Add and report all contractual expenses. If you are using the electronic document, the subtotal will be provided for you.
- *Operating Expenses*
  - **Contraceptive methods – report dollars spent on birth control pills, contraceptive patches or rings, intrauterine devices (IUDs), contraceptive implants, condoms, etc.**
  - **Training – Report dollars spent for staff training, educational programs, etc.**
  - **Travel – Report dollars spent for travel not related to training.**

- **Chlamydia tests – Report dollars spent for Chlamydia tests.**
- **Lab and x-rays – Report the dollars spent for Pap smears and other laboratory tests.**
- **Educational materials – Report dollars spent on brochures, handouts, etc.**
- **Clinical supplies – Report the dollars spent on table paper, gloves, etc.**
- **Office operating supplies – Report the dollars spent on paper, charts, pens, etc.**
- **Office expense – Report the dollars spent on rent, utilities, maintenance, etc.**
- **Other (specify) – Report the dollars spent on other items including description.**
- **Equipment – Show here only those expenditures where the cost of a single item is greater than $5000. Equipment less than $5000 should be reported under "Supplies" or "Other."**
- Subtotal operating expenses - Add and report all operating expenses. If you are using the electronic document, the subtotal will be provided for you.
- *Total Direct Costs* - Record total of personal services, contractual services and operating expenses. If you are using the electronic document, the subtotal will be provided for you.

- *Indirect Costs* **(CDPHE-WH funding)** - Report all "overhead" costs, such as rent, utilities, telephone, administrative staff, payroll, accounting, etc. that are not charged directly to the family planning program **under operating expenses above**.
- ***Administrative Costs (CFPI) – Maximum 10% for CFPI Expansion Grant direct expenses.***
- *TOTAL EXPENDITURES* - Record the grand total of all expenditures for the family planning program. If you are using the electronic document, the subtotal will be provided for you.
- *In-Kind (donations)* - Report the fair market value of donated materials and services. Include in-kind cost of items provided directly to your agency from the Women's Health Unit (this information will be given to you).
- *TOTAL COSTS* - Add In-kind and Total Expenditures. If you are using the electronic document, the subtotal will be provided for you.

Step 3 - Revenues

- CDPHE - Women's Health **Title X Family Planning Contracts** - Report on this line the total revenue **reimbursement your agency received for the six months included in this time period** from WH through your contract for family planning services.
- **CDPHE - Women's Health Colorado Family Planning Initiative Contracts - Report on this line the total revenue reimbursement your agency received for the six months included in this time period from WH through your contract for CFPI family planning services (general and expansion).**
- **CDPHE – Chlamydia Tests – If applicable, report on this line the total revenue reimbursement your agency received for the six months included in this time period from WH through your contract for Chlamydia tests. If your agency was given a credit at the State lab for Chlamydia tests. The amount of the credit that was spent would be listed below under In Kind (other donations). NOTE: Agencies using the CDPHE laboratory may receive credit for Chlamydia tests rather than funding in their family planning contract.**
- Client Fees - Report all fees paid by clients during this period.
- Client Donations - Record all donations received from clients during this period.
- Medicaid - Report actual family planning income received from Medicaid during this period.
- **State Children's Health Insurance (CHP+) – Report actual family planning income received from CHP+ during this period.**
- Local Government - Show income provided by your county or city that supported family planning services during this period (for many programs, this number may be calculated by subtracting all other revenues from the expenditures and showing the balance).

- In Kind (Other Donations) - Report the fair market value of donated materials and services (this amount should match in kind expenses reported above). **If your agency was given a credit at the State lab for Chlamydia tests, the amount of the credit that was spent should be listed here.**
- Other public health insurance – Report revenue from Tricare, Champus, Champva, etc.
- Private Health Insurance – Report revenue from private health insurance.
- Temporary Assistance for Needy Families (TANF) – Report any grants or funds from TANF.
- Other – **Use the lines below to** report and identify any other sources of revenue. Be sure to specify the source.
- *TOTAL* - Add and show totals of all revenues. This total should at least equal the total expenditures for this period. Please note: **CDPHE**-WH funds must be spent according to the timeframes in the contracts and may not be carried over.
- Unspent funds - If you have unexpended funds in a period, list them on the first part of this line in that period. If you have unspent funds carried from another period, show them on the next line. If you use carry over from another period to pay expenditures in this period, indicate a minus on this line.

Step 4 - Equipment

- Answer the question at the bottom of the form to indicate whether or not your agency has used Title X funds to purchase a single piece of equipment valued at more than $5,000 during this time period. If the answer is yes, your agency must have separate documentation of the equipment that was purchased with Title X funding (for more information, see the "Policy on Purchase of Equipment by Delegate Agencies" portion of this Section).

The following is a sample of an Expenditure/Revenue Report. This form can be downloaded from the Women's Health Unit website at:
http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html.

COLORADO DEPARTMENT of PUBLIC HEALTH and ENVIRONMENT
FAMILY PLANNING EXPENDITURE / REVENUE REPORT

AGENCY NAME:

PERIOD: ☐ January 1 - June 30, ☐ July 1 - December 31,

COMPLETED BY AND PHONE#: DATE:

EXPENDITURES

		Column (A)	Column (B)	Column (C)
		CDPHE-WH Funding (Federal Title X, State, & CFPI)	Family Planning Program - (Non-CDPHE funding)	Combined Total
Personal Services				
Salary		$ -	$ -	$ -
Fringe @ %	#DIV/0!	-	-	-
Subtotal Personal Services		$ -	$ -	$ -
Contractual Services				
Clinician personnel (Physician, Nurse Practitioner, etc.)		$ -	$ -	$ -
Other		-	-	-
Subtotal Contractual Services		$ -	$ -	$ -
Operating Expenses				
Contraceptive methods (birth control pills, IUDs, implants, condoms, etc.)		$ -	$ -	$ -
Training (staff training, educational programs)		-	-	-
Travel (dollars spent for travel not related to training)		-	-	-
Chlamydia tests		-	-	-
Lab and x-rays		-	-	-
Educational materials (brochures, etc)		-	-	-
Clinical supplies		-	-	-
Office operating supplies (papers, charts, pens, etc.)		-	-	-
Office expense (rent, utilities, maintenance)		-	-	-
Other (specify)		-	-	-
Equipment (include any single item costing >$5,000)		-	-	-
Subtotal Operating Expenses		$ -	$ -	$ -
Total Direct Costs		$ -	$ -	$ -
Indirect Costs @ % (CDPHE WH funding)		$ -	$ -	$ -
Administrative Costs (CFPI) - (maximum 10% CFPI Expansion)		-	-	-
TOTAL EXPENDITURES		$ -	$ -	$ -
In-kind (donations)		$ -	$ -	$ -
TOTAL COSTS		$ -	$ -	$ -

REVENUES

	CDPHE-WH Funding	Family Planning Program - (Non-CDPHE funding)	Combined Total
CDPHE - Women's Health Title X Family Planning Contracts	$ -	$ -	$ -
CDPHE - Women's Health Colorado Family Planning Initiative Contracts	-	-	-
CDPHE - Chlamydia Tests	-	-	-
Client fees	-	-	-
Client donations	-	-	-
Medicaid	-	-	-
State Children's Health Ins (CHP+)	-	-	-
Local government-County and City grants and contracts	-	-	-
In-kind (Other Donations, Volunteers))	-	-	-
Other public health insurance (TRICARE/CHAMPUS, CHAMPVA)	-	-	-
Private health insurance	-	-	-
Temporary Assistance for Needy Families (TANF)	-	-	-
Other (specify below revenue such as private grants, fundraising, MCH, Social Service Block grant, Medicare, WWC, etc)	-	-	-
Other 1:	-	-	-
Other 2:	-	-	-
Other 3:	-	-	-
TOTAL	$ -	$ -	$ -
Unspent Funds - This Period	$ -	$ -	$ -
Unspent Funds - Prior Periods	-	-	-
Balance Unspent Funds	$ -	$ -	$ -

Has your agency used Title X funds to purchase any single piece of equipment valued at $5,000 during this period? ___ Yes ___ No

TIME AND EFFORT

The U.S. Office of Management and Budget (OMB) Circulars A-87 and A-122 establish standards and principles for determining cost for Federal Awards through grants, cost reimbursement contracts, and other agreements.

Employees that are working only on single Federal Award:

- **charges will be supported by periodic certifications, prepared at least semi-annually, and signed by the employee and supervisor.**

Employees that are working on multiple activities or funding:

- **distribution of salaries and wages will be supported by personnel activity report or equivalent documentation (i.e., timesheet, activity report, time and effort),**
- **or any kind of documentation that will reflect an after the fact distribution of the actual activity of the employee,**
- **must account for the total activity for which employee is compensated**
- **must be prepared at least monthly and must coincide with one or more pay periods**
- **must be signed by the employee and approved by his/her supervisor**

Multiple activities or funding means more than one Federal Award, or one Federal Award and a non-Federal Award. The key is at least one Federal Award is included in the allocation.

FTE INFORMATION-INSTRUCTIONS

The FTE information is required annually for the Family Planning Annual Report (FPAR) and is due **on a date** (**mid-**January) **specified by CDPHE**. **Time and Effort reports should be used to complete this information. Agencies must be able to adequately document the time and effort of staff designated to the Title X program.**

Agencies may also choose to do a time study **to determine client care time,** it is recommended that for a minimum of 2 weeks at least once a year, each FP clinical staff member should complete a time study that **continues to** record **time and effort** spent working in family planning (vs. working in other programs in your agency) and **additionally** records activities so that client care time can be separated from other time. These time study records should not be sent to the WH but should be used in completing this report and kept on file at the local agency.

- Job Title - List by job title the Clinical Services Providers of the family planning program (you may either list each individual separately or you may group them together by title). Use your agency's titles, designating which positions are: Physician, Mid-level (Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant) and Nursing.

- FTE (full time employee) - Determine the percent of FTE that each person (or job type) spends in the family planning program by dividing the hours those employees work per year in the program by 2080 hours (2080 hours per year equals 1 FTE). The calendar year is preferred, but you may use any 12-month period.

    - For example a Nurse who works 1040 hours per year in family planning would be .5 FTE (1040 hrs/2080 hrs = .5 FTE).

    - If your agency has 4 Nurse Practitioners, and one of them works 500 hours, another 1000 hours, another 2000 hours and one full time (2080 hours) you have a total of 5,580 NP hours per year at your agency. When you report them as a group, you will have 2.68 FTE Nurse Practitioners [(500 hrs+ 1000 hrs + 2000 hrs + 2080 hrs)/2080 hrs = 2.68 FTE]

- % Client care/%Other - Record the percent of family planning time each person (or job type) spends providing client care. Client care time should include anything related to direct client services, including not only exams, but also education and counseling, charting, appointment setting, etc. **Multiply the FTE times the Client Care % to get the Client Care FTE (see sample form). Add together the Client Care FTE for each provider type: Physician, Midlevel, and Nursing, and record on the appropriate line at the bottom of the form.**

The following is a sample of a FTE Information Form. This form can be downloaded from the Women's Health Unit website at:
http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html

Family Planning Program

FTE INFORMATION

Agency: _____

JOB TITLE	FTE	% CLIENT CARE	CLIENT CARE FTE (column 2 X column 3

TOTAL FTE: Physician _____ **Midlevel** _____ **Nursing** _____

POLICY ON PURCHASE OF EQUIPMENT BY DELEGATE AGENCIES

Title X program guidelines (6.3, p. 7) require that delegate agencies maintain a financial management system that meets the standards specified in Subpart C of Code of Federal Regulations (CFR), 45 CFR 74 (institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations) or 45 CFR 92 (state and local governments), as applicable. These regulations include the requirements for purchases of equipment.

Equipment is defined as an item having a useful life of more than one year and an acquisition cost of $5000 or more per unit. [45 CFR 74.2 and 45 CFR 92.3]

The requirements are described in 45 CFR 74.34 and 45 CFR 92.32. This includes the obligation to maintain property records that include a description of the property, a serial number or other identification number, the source of property including the award number, who holds the title, the acquisition date and cost of property, the percentage of Federal participation in the cost of the property, the location, use and condition of property, and any ultimate disposition data including the date of disposal and sale price of the property.

Inventory of equipment must be taken and reconciled every two years.

Each delegate agency should review the CFR that is appropriate for their agency type (nonprofit or local government). Copies may be requested from CDPHE.

AGREEMENTS FOR SUBCONTRACTED SERVICES

If a delegate agency provides Title X services by referring clients to another provider (in other words, through a subcontractor), a written agreement (for example, Memorandum of Understanding [MOU] or contract) must be in place with the referral provider. This agreement must incorporate a mechanism for reimbursing the referral provider (Program Guidelines 7.4, p.16). It also must include what can and cannot be charged to the client, including specifying fiscal responsibility for unexpected follow-up/complications. The agency is encouraged to include a follow up appointment with the referral provider following contraceptive procedures as part of the negotiated price in the MOU. Agencies must ensure that the billing and collection of client fees for these services follow Title X requirements. Agreements must be kept on file and closely monitored to ensure deliverables are met.

Use of a subcontractor for provision of Title X services requires prior, express, written consent from the state Family Planning Program. In addition, a copy of the agreement must be sent to the state Family Planning Program for the central files (Program Guidelines 6.1, p.6).

It is each agency's responsibility to ensure that the sub-contracts or MOUs are reviewed by their legal counsel. Submission of these documents to CDPHE is only for verification of compliance with Title X requirements.

Good practice for subcontracting is to ensure that an agreement is signed by both parties, that it outlines the specific roles and responsibilities of each party, any financial obligations are defined and other terms/conditions are included.

Statements of Work (SOW) incorporated in the agreement should include at minimum the following elements:

- **General description of project**
- **Definitions**
- **Deliverables (goods/services)**
- **Personnel**
- **Testing and acceptance criteria**
- **Payment**

In addition, the policies and procedures for referring Title X services must be in writing (Program Guidelines 7.4, p.16).

PURCHASING OF PHARMACEUTICALS

All Title X agencies are considered "covered entities" under the 340B Drug Pricing Program. This Outpatient Discount Drug Pricing was created under Section 340B of the Public Health Service Act, and amended by Section 602 of the Veteran's Health Care Act of 1992. Family Planning is one of the types of entities eligible to participate in the 340B Drug Pricing. For more information on this program, go to: http://www.hrsa.gov/opa/

In addition, all Title X agencies are enrolled in the 340B Prime Vendor Program. This program offers deeper discounts on some pharmaceuticals commonly used in the family planning setting. Access to Prime Vendor pricing is through a participating wholesaler, such as R&S Northeast, Cardinal McKesson, etc. For more information on this program, go to: https://www.340bpvp.com/public/

Title X agencies are not required to purchase from any specific vendor, but should be sure to access the best pricing available. In some instances this will be through the Prime Vendor Program (e.g., purchasing NuvaRing **and Implanon** is least expensive through the Prime Vendor Program), in other instances it may be through the manufacturer (Ortho oral contraceptives are least expensive direct from the manufacturer).

Each agency is eligible for membership in the Family Planning Cooperative Purchasing Program based out of the California Family Health Council in Los Angeles. In the past there was no charge for this membership. However, starting in 2008 they now assess a membership fee. If you need information on how to become a member, please contact the FPCPP staff: The information is also on their web site (www.fpcpp.org).

Louis Linsmeyer, Director: 800-440-3238, Ext. 4582, linsmeyerl@cfhc.org

If you have negotiated better prices, or if you have a vendor source that offers better prices than the prices through any of the above programs, then it is recommended that you access those better prices. The Women's Health Unit of the Colorado Department of Public Health and Environment no longer has state specific agreements with any vendors.

It is also important to note that drugs purchased at 340B or 340B Prime Vendor prices must only be administered/dispensed to clients with whom you have a chart and a provider/patient relationship.

Contact the WHU Family Planning Nursing Consultant for more information.

INVENTORY CONTROLS

It is recommended that all agencies have inventory controls that monitor purchases; track storage and use; and record removal of items from the inventory.

* Refer to Section IX- Pharmaceuticals, pages 1-2 in the Nursing Policy Manual for more information on Pharmaceutical inventory control.