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Independent Laboratory

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program client
- Submit claims for payment to the Colorado Medical Assistance Program

An independent laboratory is a certified laboratory that performs diagnostic tests and is independent both of the attending or consulting physician's office and of a hospital. All clinical laboratory providers must furnish their Clinical Laboratory Improvement Amendment (CLIA) certification numbers to the Colorado Medical Assistance Program fiscal agent at the time of enrollment.

Medically necessary, physician-ordered laboratory services are a benefit of the Colorado Medical Assistance Program.

Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10), for specific information when providing independent laboratory services.

Important: All lab tests performed for non-citizens must be emergencies. Claims that are not marked with the "92 - Emergency" code will not be paid.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests may be sent to Affiliated Computer Services (ACS), P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims



Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D wpc-edi.com/ (HIPAA EDI Technical Report 3 (TR3))
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's Web site.
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time.



These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).



The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for “dialing up” when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Provider Claim Report to providers. The Web Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. The reports and transactions include:

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the [Web Portal](#) located at colorado.gov/hcpf, Secured Site. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide in the Provider Services [Specifications](#) section.



Batch Electronic Claim Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Colorado Medical Assistance Program fiscal agent.



Any entity sending electronic claims to ACS Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an EDI enrollment package by contacting the Medical Assistance Program fiscal agent or by downloading it from the Provider Services [EDI Support](#) section.

The X12N 837 Professional, Institutional, or Dental transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the ACS State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the ACS SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the ACS SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to ACS EDI Gateway. Assistance from ACS EDI business analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, ACS EDI Gateway requires providers to submit all X12N test transactions to Edifecs prior to submitting them to ACS EDI Gateway. The Edifecs service is free to providers to certify X12N readiness. Edifecs offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to edifecs.com (Edifecs).



Laboratory Services

Clinical Laboratory Improvement Amendments (CLIA) Claims



Laboratory providers submitting procedures covered by CLIA must have a CLIA number of the laboratory where the procedure was done on the claim or claim line.

- Providers billing on the 837P format should refer to the updated [837P Companion Guide](#) which is posted in the Provider Services [Specifications](#) section of the [Department's Web site](#). Providers billing on the 837P format and billing agents should update their billing systems for 837P transactions.
- Providers billing an 837P through the Colorado Medical Assistance Program Web Portal (Web Portal) are able to enter CLIA numbers on the Detail Line Item tab (claim line). Entry on the Client's Info tab (header level) will be available soon. Further information on Web Portal functionality for CLIA is available in the February 2011 provider bulletin ([B1100296](#)).
- Providers billing on the Colorado 1500 paper claim form should enter their valid CLIA number in the REMARKS field (# 30). Enter "CLIA" before the CLIA number.

Please note: Only one CLIA number can be included on each paper claim form. It is applied to all CLIA covered procedures on the claim. Procedures covered by different CLIA numbers need to be submitted on separate claims. Enter the CLIA number in the REMARKS field only.

The tax ID (TID) on record with the Centers for Medicare and Medicaid Services (CMS) for the CLIA number must correspond to the TID on record with the Department. Questions regarding claims processing or responses should be directed to ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

Handling, Collection and Conveyance Charges

Specimen collection (including venipuncture) is considered to be an integral part of the laboratory testing procedure when performed by an independent/hospital laboratory and is not reimbursable as a separate or additional charge.

Transfer of a specimen from one independent clinical laboratory to another is a benefit only if the first laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered tests. Modifier -KX used with procedure code 99001 verifies that the lab's equipment is not functioning or that the laboratory is not certified to perform the ordered test.



Specimen collection, handling, and conveyance from the patient's home, a nursing facility, or a facility other than the physician's office or place of service is a benefit only if the patient is homebound, bedfast, or otherwise non ambulatory **and** the specimen cannot reasonably be conveyed by mail. A physician's statement explaining the circumstances and medical necessity is required.

Each independent laboratory will be reimbursed only for those tests performed in the specialties or subspecialties for which it is certified.

Papanicolaou (Pap) smears

Colorado Medical Assistance Program allows one pap smear screening/examination per 12-month period in women under 40 years of age. Benefit for more than one Pap smear in a 12-month period is allowed for women ages 40 and over; women with a history of diethylstilbestrol exposure in utero; women with malignancy of the cervix, vagina, uterus, fallopian tubes or ovaries; women with cervical polyps, cervicitis, neoplastic disease of the pelvic organs, vaginal discharge or bleeding of unknown origin, postmenopausal bleeding, or vaginitis; or if the physician determines that more frequent testing is needed and is medically necessary. Claims will deny if the diagnosis code entered on the claim does not support the testing frequency.



General Requirements

- Fees for blood drawing, specimen collection, or handling are not reimbursable to laboratories.
- Claims for non-payable procedure codes are rejected. Do not submit detail lines for procedure codes that are not payable to laboratory providers. If any detail line on the submitted electronic claim is not payable, the entire claim will be rejected.
- The provider who actually performs the laboratory procedure is the only one who is eligible to bill and receive payment. Physicians may only bill for tests actually performed in their office or clinic. Tests performed by independent laboratories or hospital outpatient laboratories must be billed by the performing laboratory.
- CPT identifies tests that can be and are frequently done as groups and combinations (“profiles”) on automated multi-channel equipment. For any combination of tests among those listed, use the appropriate Level 1 or Level 2 CMS codes.
- For organ or disease oriented panels (check CPT narrative), use the appropriate Level 1 CMS codes. These tests are not to be performed or billed separately when ordered in a group/combination and must be billed with one unit of service.

Procedure/HCPCS Codes Overview

The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program clients and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services [Provider Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the (MMIS) *Provider Data Maintenance* area or by completing and submitting a [Publication Email Preference Form](#) in the Provider Services [Forms](#) section. Bulletins include updates on approved procedures codes as well as the maximum allowable units billed per procedure.

Procedure Codes

Services must be reported using HCPCS procedure codes. Use procedure codes listed in the most recent Practitioner HCPCS bulletin located in the Provider Services [Provider Bulletins](#) section.

The fiscal agent updates and revises CMS codes through Colorado Medical Assistance Program bulletins.



Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the Colorado 1500 claim form.

Field Label	Completion Format	Instructions
Invoice/Pat Acct Number	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
Special Program Code	N/A	N/A
1. Client Name	Up to 25 characters: letters & spaces	Required Enter the client's last name, first name, and middle initial.
2. Client Date of Birth	Date of Birth 8 digits MMDDCCYY	Required Enter the patient's birth date using two digits for the month, two digits for the date, two digits for the century, and two digits for the year. Example: 07012010 for July 1, 2010
3. Medicaid ID Number (Client ID Number)	7 characters: a letter prefix followed by six numbers	Required Enter the client's Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
4. Client Address	Not required	Submitted information is not entered into the claim processing system.
5. Client Sex	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required

Field Label	Completion Format	Instructions
6. Medicare ID Number (HIC or SSN)	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number. The term "dually eligible" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.
7. Client Relationship to Insured	Check box Self Spouse <input type="checkbox"/> <input type="checkbox"/> Child Other <input type="checkbox"/> <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an "x" in the box that identifies the person's relationship to the policyholder.
8. Client Is Covered By Employer Health Plan	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder's name and group number. Also complete fields 9 and 9A.
9. Other Health Insurance Coverage	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
9A. Policyholder Name and Address	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.
10. Was Condition Related To	Check box A. Client Employment Yes <input type="checkbox"/> B. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/> C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter a check mark or an "x" in the appropriate box. Enter the date of the accident in the marked boxes.

Field Label	Completion Format	Instructions
11. CHAMPUS Sponsors Service/SSN	Up to 10 characters	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor's service number or SSN.
Durable Medical Equipment Model/serial number (unlabeled field)	N/A	N/A
12. Pregnancy HMO NF	Check box <input type="checkbox"/>	Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum). Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO. Conditional Complete if the client is a nursing facility resident.
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	Optional Complete if information is known. Enter the following information as appropriate to the client's condition: Illness Date of first symptoms Injury Date of accident Pregnancy Date of Last Menstrual Period (LMP)
14. Medicare Denial	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.
14A. Other Coverage Denied	Check box No <input type="checkbox"/> Yes <input type="checkbox"/> Pay/Deny Date 6 digits: MMDDYY	Conditional Complete if the client has commercial health care insurance coverage. Enter the date that the other coverage paid or denied the services.

Field Label	Completion Format	Instructions									
<p>18. ICD-9-CM</p> <p>Diagnosis or nature of illness or injury. In column F, relate diagnosis to procedure by Reference numbers 1, 2, 3, or 4</p>	<p>1 <input type="text"/></p> <p>2 <input type="text"/></p> <p>3 <input type="text"/></p> <p>4 <input type="text"/></p> <p>Codes: 3, 4, or 5 characters. 1st character may be a letter.</p> <p>Text</p>	<p>Required</p> <p>At least one diagnosis code must be entered.</p> <p>Enter up to four ICD-9-CM diagnosis codes starting at the far left side of the coding area.</p> <p>Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits.</p> <p>Example:(May require 4th or 5th digits)</p> <table border="0"> <tr> <td>ICD-9-CM</td> <td></td> <td>Claim</td> </tr> <tr> <td><u>description</u></td> <td><u>Code</u></td> <td><u>Entry</u></td> </tr> <tr> <td>Laboratory Dx</td> <td>V71.01</td> <td>V7101</td> </tr> </table> <p>Optional</p> <p>If entered, the written description must match the code(s).</p>	ICD-9-CM		Claim	<u>description</u>	<u>Code</u>	<u>Entry</u>	Laboratory Dx	V71.01	V7101
ICD-9-CM		Claim									
<u>description</u>	<u>Code</u>	<u>Entry</u>									
Laboratory Dx	V71.01	V7101									
<p>Transportation Certification attached</p>	<p>N/A</p>	<p>N/A</p>									
<p>Durable Medical Equipment</p> <p>Line #</p> <p>Make</p> <p>Model</p> <p>Serial Number</p>	<p>N/A</p>	<p>N/A</p>									
<p>Prior Authorization #:</p>	<p>N/A</p>	<p>N/A</p>									
<p>19A. Date of Service</p>	<p>From: 6 digits MMDDYY</p> <p>To: 6 digits MMDDYY</p>	<p>Required</p> <p>Enter two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service.</p> <p>Single date of service</p> <p>From To</p> <p>06/06/2011</p> <p>Or</p> <p>From To</p> <p>06/06/2011 06/06/2011</p> <p>Span dates of service</p> <p>From To</p> <p>06/06/2011 06/20/2011</p> <p>Practitioner claims must be consecutive days.</p>									

Field Label	Completion Format	Instructions
19A. Date of Service (continued)	From: 6 digits MMDDYY To: 6 digits MMDDYY	Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two fields. Span billing: Span billing is permitted if the same service (same procedure code) is provided on consecutive dates.
19B. Place of Service	2 digits	Required Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. Enter Place Of Service (POS) code 81.
19C. Procedure Code (HCPCS)	5 digits	Required Enter the laboratory procedure code that specifically describes the laboratory for which payment is requested.
Mod(ifier)	2 characters	Conditional Complete if the procedure related modifier relates to the billed service. Pricing modifiers are identified below by the notation **.
	<p style="text-align: center;">-TC**</p> <p style="text-align: center;">-KX</p>	<p>Technical Component, anatomical laboratory services. Use when only the technical component is performed.</p> <p>Specimen handling and conveyance from one laboratory to another, independent laboratories only. Used with procedure code 99001 for specimen handling and conveyance from one laboratory to another. Verifies that the lab's equipment is not functioning or that the laboratory is not certified to perform the ordered test.</p>

Field Label	Completion Format	Instructions
<p>19G. Charges</p>	<p>7 digits: Currency 99999.99</p>	<p>Required</p> <p>Enter the usual and customary charge for the service represented by the procedure code on the detail line.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>
<p>19H. Days or Units</p>	<p>4 digits</p>	<p>Required</p> <p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only.</p> <p>Do not enter fractions or decimals.</p> <p>Do not enter a decimal point followed by a 0 for whole numbers.</p>
<p>19I. Co-pay</p>	<p>1 digit</p>	<p>Conditional</p> <p>Complete if co-payment is required of this client for this service.</p> <p>1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested</p>
<p>19J. Emergency</p>	<p>1 character</p>	<p>Conditional</p> <p>Enter a check mark or an “x” in the column to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention.</p> <p>If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.</p>

Field Label	Completion Format	Instructions
19K. Family Planning	N/A	N/A
19L. EPSDT	1 character	Conditional Enter a check mark or an “x” in the column to indicate the service is provided as a follow-up to or referral from an EPSDT screening examination.
Medicare SPR Date (unlabeled field)	6 digits: MMDDYY	Conditional Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). <ul style="list-style-type: none"> ▪ Do not complete this field if Medicare denied all benefits. ▪ Do not combine items from several SPRs/ERAs on a single claim form. ▪ Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA. ▪ Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.
20. Total Charges	7 digits: Currency 99999.99	Required Enter the sum of all charges listed in field 19G (Charges). Each claim form must be completed as a full document. Do not use the claim form as a continuation billing (e.g., Page 1 or 2, etc.).
21. Medicare Paid	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.
22. Third Party Paid	7 digits: Currency 99999.99	Conditional Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher.

Field Label	Completion Format	Instructions
<p>22. Third Party Paid (continued)</p>	<p>7 digits: Currency 99999.99</p>	<p>Do not enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.</p>
<p>23. Net Charge</p>	<p>7 digits: Currency 99999.99</p>	<p>Required Colorado Medical Assistance Program claims (Not Medicare Crossover) Claims without third party payment. Net charge equals the total charge (field 20). Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount. Medicare Crossover claims Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount. Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>
<p>24. Medicare Deductible</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete for Medicare crossover claims. Enter the Medicare deductible amount shown on the Medicare payment voucher.</p>
<p>25. Medicare Coinsurance</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete for Medicare crossover claims. Enter the Medicare coinsurance amount shown on the Medicare payment voucher.</p>
<p>26. Medicare Disallowed</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.</p>

Field Label	Completion Format	Instructions
<p>27. Signature (Subject to Certification on reverse) and Date</p>	<p>Text</p>	<p>Required</p> <p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
<p>28. Billing Provider Name</p>	<p>Text</p>	<p>Required</p> <p>Enter the name of the individual or organization that will receive payment for the billed services.</p>
<p>29. Billing Provider Number</p>	<p>8 digits</p>	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
<p>30. Remarks</p>	<p>Text</p>	<p>Conditional</p> <p>Use to document the Late Bill Override Date for timely filing.</p> <p>Enter the word “CLIA” followed by the number in this field.</p>



Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the “Claim Notes/LBOD” field.

Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services [Billing Manuals](#) section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>Colorado 1500</i>: Indicate “LBOD” and the date in box 30 - Remarks. ➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks.
Adjusting Paid Claims	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

Billing Instruction Detail	Instructions
<p>Denied Paper Claims</p>	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p>Correct the claim errors and refile within 60 days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
<p>Returned Paper Claims</p>	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p>Correct the claim errors and re-file within 60 days of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
<p>Rejected Electronic Claims</p>	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p>Correct claim errors and refile within 60 days of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p>LBOD = the date shown on the claim rejection report.</p>
<p>Denied/Rejected Due to Client Eligibility</p>	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p>File the claim within 60 days of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
<p>Retroactive Client Eligibility</p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

Billing Instruction Detail	Instructions
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p>Electronic Medicare Crossover Claims</p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR /ERA.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>

Billing Instruction Detail	Instructions
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance. File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. LBOD = the date commercial insurance paid or denied.</p>
<p>Correspondence LBOD Authorization</p>	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific client, claim, services, or circumstances. File the claim within 60 days of the date on the authorization letter. Retain the authorization letter. LBOD = the date on the authorization letter.</p>
<p>Client Changes Providers during Obstetrical Care</p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. LBOD = the last date of OB care by the billing provider.</p>



Independent Laboratory Claim Example with CLIA Number

**STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND
FINANCING**

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ian	2. CLIENT DATE OF BIRTH 12/05/1940	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) M222222
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input style="width: 50px; height: 15px;" type="text"/>	11. CHAMPUS SPONSORS SERVICE/SSN _____
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF ILLNESS (FIRST SYMPTON) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP) 03/10/2005	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAYIDENY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. V71X	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	
3. _____	
4. _____	PRIOR AUTHORIZATION #: _____

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (ICPCS)	D. MODIFIERS	E. RENDERING PROVIDER NUMBER	F. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
05/02/2011 05/03/2011	81	G0307				1	\$100.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</p> <p>27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> 06/27/2011</p> <p>28. BILLING PROVIDER NAME City Labs</p> <p>29. BILLING PROVIDER NUMBER 04444444</p> <p>COL-101 FORM NO. 94320 (REV. 02/99) ELECTRONIC APPLICATION</p>	<p>20. TOTAL CHARGES → \$100.00</p> <p>30. REMARKS CLIA 01D1000000</p> <p>21. MEDICARE PAID <input style="width: 50px;" type="text"/></p> <p>22. THIRD PARTY PAID <input style="width: 50px;" type="text"/></p> <p>23. NET CHARGE <input style="width: 50px;" type="text"/></p> <p>24. MEDICARE DEDUCTIBLE <input style="width: 50px;" type="text"/></p> <p>25. MEDICARE COINSURANCE <input style="width: 50px;" type="text"/></p> <p>26. MEDICARE DISALLOWED <input style="width: 50px;" type="text"/></p>
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COLORADO 1500

Independent Laboratory Crossover Claim Example with CLIA Number

**STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND
FINANCING**

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ian	2. CLIENT DATE OF BIRTH 12/05/1940	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) M222222
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 50px; height: 15px; margin: 0 auto;"></div>	POLICYHOLDER NAME: _____ GROUP: _____
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: 03/10/2005	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SRR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAYIDENY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN		PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)		PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIAN'S OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. V71X	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	
3. _____	
4. _____	PRIOR AUTHORIZATION #:

19A. DATE OF SERVICE FROM	19B. DATE OF SERVICE TO	19C. PLACE OF SERVICE	19D. PROCEDURE CODE (HCPCS)	19E. MODIFIERS	19F. RENDERING PROVIDER NUMBER	19G. REFERRING PROVIDER NUMBER	19H. DIAGNOSIS P I S T	19I. CHARGES	19J. DAYS OR UNITS	19K. COPAY	19L. EMERGENCY	19M. FAMILY PLANNING	19N. EPSDT
05/02/2011	05/03/2011	81	G0307				1	\$100.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p><small>THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</small></p> <p>27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> 06/27/2011</p> <p>28. BILLING PROVIDER NAME City Labs</p> <p>29. BILLING PROVIDER NUMBER 04444444</p> <p>COL-101 FORM NO. 94320 (REV. 02/99) ELECTRONIC APPLICATION</p>	<p>20. TOTAL CHARGES → \$100.00</p> <p>30. REMARKS CLIA 01D1000000</p>	<p>LESS ↓</p> <p>21. MEDICARE PAID \$80.00</p> <p>22. THIRD PARTY PAID \$0.00</p> <p>NET CHARGE \$20.00</p> <p>24. MEDICARE DEDUCTIBLE \$0.00</p> <p>25. MEDICARE COINSURANCE \$20.00</p> <p>26. MEDICARE DISALLOWED</p> <p>MEDICARE SPR DATE 04/25/2011</p> <p style="text-align: right;">COLORADO 1500</p>
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Independent Laboratory Revisions Log

04/21/2009	<i>Drafted Manual</i>	All	<i>jg</i>
07/06/2009	<i>Accepted changes and verified TOC</i>	Throughout	<i>jg</i>
10/19/2009	<i>LBOD</i>	17	<i>jg</i>
01/12/2010	<i>Updated Web site links</i>	Throughout	<i>jg</i>
02/10/2010	<i>Changed EOMB to SPR</i>	14 & 19	<i>jg</i>
03/04/2010	<i>Added link to Program Rules</i>	2	<i>jg</i>
07/12/2010	<i>Updated date examples for field 19A Updated claim examples</i>	11 21 & 22	<i>jg</i>
07/14/2010	<i>Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field and to Electronic Medicare Crossover Claims & to Medicare Denied Services in Late Bill Override Date section.</i>	14 19	<i>jg</i>
05/13/2011	<i>Updated TOC Added CLIA claim information Added CLIA instructions to Remarks field 30 Updated service dates & added CLIA number on claim examples</i>	1 5 17 22 & 23	<i>jg</i>
06/23/2011	<i>Updated TOC Added CLIA information Changed wording and example in Date of Birth field Updated code in ICD-9-CM field Updated codes in Date of Service field Added CLIA instructions in Remarks field Added "paper" to LBOD "Denied Claims" Changed wording for Electronic Medicare Crossover Claims</i>	1 5 7 11 11 17 19 20	<i>Jg</i>
12/06/2011	<i>Replaced 997 with 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3))</i>	4 1 1	<i>ss</i>

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occur.