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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 member
- 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 Member's Info tab (header level) will be available soon. Further information on Web Portal functionality for CLIA is available in the February 2011 in the [Provider Bulletin](#) section of the Department's website (B1100296).
- Providers billing on the CMS 1500 paper claim form should enter their valid CLIA number in the REMARKS field (# 23). 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 members 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 procedure 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.

CMS 1500 Paper Claim Reference Table

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

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	Insured's Name	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	Insured's Address	Not Required	

CMS Field #	Field Label	Field is?	Instructions
8	Reserved for NUCC Use		
9	Other Insured's Name	Conditional	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.
9a	Other Insured's Policy or Group Number	Conditional	If field 11d is marked "yes", enter the policy or group number.
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	If field 11d is marked "yes", enter the insurance plan or program name.
10a-c	Is Patient's Condition Related to?	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	Insured's Date of Birth, Sex	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.

CMS Field #	Field Label	Field is?	Instructions
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	Insured's or Authorized Person's Signature	Not Required	
14	Date of Current Illness Injury or Pregnancy	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Not Required	
18	Hospitalization Dates Related to Current Service	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and

CMS Field #	Field Label	Field is?	Instructions
			two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	Additional Claim Information	Conditional	LBOD Use to document the Late Bill Override Date for timely filing.
20	Outside Lab? \$ Charges	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	Diagnosis or Nature of Illness or Injury	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	Medicaid Resubmission Code	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	Prior Authorization	Conditional	CLIA When applicable, enter the word "CLIA" followed by the number. Prior Authorization Enter the six character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent.

CMS Field #	Field Label	Field is?	Instructions																		
24	Claim Line Detail	Information	<p>The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line.</p> <p>Do not enter more than six lines of information on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing.</p> <p>Each claim form must be fully completed (totaled).</p> <p>Do not file continuation claims (e.g., Page 1 of 2).</p>																		
24A	Dates of Service	Required	<p>The field accommodates the entry of two dates: a “From” date of services and a “To” date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014</p> <p style="text-align: center;">From To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td><td style="width: 20px;">01</td><td style="width: 20px;">14</td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table> <p style="text-align: center;">Or</p> <p style="text-align: center;">From To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td><td style="width: 20px;">01</td><td style="width: 20px;">14</td><td style="width: 20px;">01</td><td style="width: 20px;">01</td><td style="width: 20px;">14</td> </tr> </table> <p>Span dates of service</p> <p style="text-align: center;">From To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td><td style="width: 20px;">01</td><td style="width: 20px;">14</td><td style="width: 20px;">01</td><td style="width: 20px;">31</td><td style="width: 20px;">14</td> </tr> </table> <p>Practitioner claims must be consecutive days.</p> <p><u>Single Date of Service:</u> 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.</p> <p><u>Span billing:</u> permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>Supplemental Qualifier</p> <p>To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <p>ZZ Narrative description of unspecified code</p> <p>N4 National Drug Codes</p> <p>VP Vendor Product Number</p> <p>OZ Product Number</p> <p>CTR Contract Rate</p> <p>JP Universal/National Tooth Designation</p>	01	01	14				01	01	14	01	01	14	01	01	14	01	31	14
01	01	14																			
01	01	14	01	01	14																
01	01	14	01	31	14																

CMS Field #	Field Label	Field is?	Instructions
			JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	Place of Service	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. 81 Independent Lab
24C	EMG	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	Procedures, Services, or Supplies	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	Modifier	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. 26 Professional component Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services <u>only</u> if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.

CMS Field #	Field Label	Field is?	Instructions
			<p>TC Technical component Use with diagnostic codes to report technical component services billed separately from professional component services. Report separate technical and professional component services <u>only</u> if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.</p> <p>KX Specific required documentation on file Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test. The KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test", or "I certify that this laboratory is not certified to perform the requested test".</p>
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</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</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>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. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.</p>
24G	Days or Units	General Instructions	<p>A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used Family Planning (unshaded area) Not Required</p>
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Not Required	
25	Federal Tax ID Number	Not Required	

CMS Field #	Field Label	Field is?	Instructions
26	Patient's Account Number	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<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>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014.</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>

CMS Field #	Field Label	Field is?	Instructions
32	32- Service Facility Location Information 32a- NPI Number 32b- Other ID #	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

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>CMS 1500</i>: Indicate “LBOD” and the date in box 19 – Additional Claim Information. ➢ <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>
Denied Paper Claims	<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>

Billing Instruction Detail	Instructions
	<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>
Returned Paper Claims	<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>
Rejected Electronic Claims	<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>
Denied/Rejected Due to Member Eligibility	<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 member and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
Retroactive Member Eligibility	<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>
Delayed Notification of Eligibility	<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 Certification &</p>

Billing Instruction Detail	Instructions
	<p>Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, 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 member, 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 Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). Maintain a copy of the 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 member 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 Standard Paper Remit (SPR) or Electronic Remittance Advice (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>
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance.</p> <p>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.</p> <p>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.</p> <p>LBOD = the date commercial insurance paid or denied.</p>

Billing Instruction Detail	Instructions
<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 member, claim, services, or circumstances.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
<p>Member 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.</p> <p>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.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



CMS 1500 Independent Laboratory Claim Example with CLIA Number



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA <input type="checkbox"/> PICA														
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (ICW/DCW#) (Member ID#) (ID#) (ID#)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A					3. PATIENT'S BIRTH DATE MM DD YY 10 16 45		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>If yes, complete items 9, 9a and 9d.</i>							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE MM DD YY QUAL		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. V7 1X B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER CLIA 01D1000000				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
01 01 15 01 01 15 81		G0307	A		100 00	1	NPI							
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 100 00		29. AMOUNT PAID \$		30. Reserved for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # () ABC Independent Laboratory 100 Any Street Any City a. 1234567890 b. 04567890								

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CMS 1500 Independent Laboratory Crossover Claim Example with CLIA Number



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ICW/DCDR) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A										3. PATIENT'S BIRTH DATE MM DD YY 10 16 45					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>				
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Client, Ima A										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15										11. INSURED'S POLICY GROUP OR FECA NUMBER Medicare Policy Number a. INSURED'S DATE OF BIRTH MM DD YY 10 16 45 M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a and 9d.									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 7/a. 7/b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10 9 A. V71X B. C. D. E. F. G. H. I. J. K. L.										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-10 QUAL. I. ID. QUAL. J. RENDERING PROVIDER ID. #										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER CLIA 01D000000									
1 01 01 15 01 01 15 81 G0307 A 100 00 1 NPI										2 NPI									
3 NPI										4 NPI									
5 NPI										6 NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. Optional									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 100 00									
29. AMOUNT PAID \$ 80 00										30. Rwd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15										32. SERVICE FACILITY LOCATION INFORMATION ABC Independent Laboratory 100 Any Street Any City									
33. BILLING PROVIDER INFO & PH# () a. 1234567890 b. 04567890																			

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PATIENT AND INSURED INFORMATION
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APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Independent Laboratory Revisions Log

Revision Date	Additions/Changes	Pages	Made by
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</i> <i>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</i> <i>Added CLIA claim information</i> <i>Added CLIA instructions to Remarks field 30</i> <i>Updated service dates & added CLIA number on claim examples</i>	1 5 17 22 & 23	<i>jg</i>
06/23/2011	<i>Updated TOC</i> <i>Added CLIA information</i> <i>Changed wording and example in Date of Birth field</i> <i>Updated code in ICD-9-CM field</i> <i>Updated codes in Date of Service field</i> <i>Added CLIA instructions in Remarks field</i> <i>Added "paper" to LBOD "Denied Claims"</i> <i>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</i> <i>Replaced wpc-edi.com/hipaa with wpc-edi.com/</i> <i>Replaced Implementation Guide with Technical Report 3 (TR3))</i>	4 1 1	ss
05/14/2014	<i>Updated to remove references to the Primary Care Physician Program</i>	13	Mm
7/25/14	<i>Replaced all CO 1500 references with CMS 1500</i>	Throughout	ZS
7/25/14	<i>Updated Professional Claim Billing Instructions section with CMS 1500 information.</i>		ZS
7/25/14	<i>Replaced CO 1500 claim examples with CMS 1500 examples</i>		ZS
7/25/14	<i>Changed all references of client to member</i>	Throughout	ZS
7/31/2014	<i>Updated all web links to reflect new web site links</i>	Throughout	mm
12/2/2014	<i>Changed PAR field #30 for CMS-1500 claim form to field #23.</i>	4	mc

12/8/14	<i>Removed Appendix H information, added Timely Filing document information</i>	17, 18	mc
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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.