Nurse Home Visitor Program (Targeted Case Management)

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(Targeted Case Management)

The Nurse Home Visitor Program (NHVP) is a program available to first-time pregnant women or women whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level. ("First-time" is defined as no previous live birth; Health First Colorado (Colorado's Medicaid Program) only reimburses for services for Health First Colorado-eligible members.) Participating sites must be certified by the Colorado Department of Human Services (CDHS) as NHVP providers.

Reimbursement for targeted case management (TCM) services is available through this program when provided to Health First Colorado-eligible women who are pregnant with their first child (or have had no previous live birth), and the mother and child up to the child's 2nd birthday.

Nurse Home Visitor Program providers must be enrolled as Health First Colorado providers in order to receive Health First Colorado reimbursement for TCM activities. Reimbursement is provided on a fee-for-service (FFS) basis. Fee-for-service reimbursement for TCM services provided by a NHVP provider is also available for members enrolled in a managed care program. Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10), for specific information regarding NHVP services.

Targeted Case Management Guidance

Targeted Case Management (TCM) includes four core activities:

- Assessment of the first-time pregnant woman and her first child's needs for health, mental health, social services, education, housing, childcare and related services
- Development of care plans to obtain the needed services
- Referral to resources to obtain the needed services, including medical providers who provide care to a first-time pregnant woman and her first child
- Routine monitoring and follow-up visits with the women where progress in obtaining the needed services is monitored, problem-solving assistance is provided and the care plans are revised to reflect the woman's and child's current needs

It is not necessary to provide all four components at every visit. However, in order to bill for TCM, at least one of the components must be provided to or on behalf of the member. The "member," in the context of this billing manual, refers to the Health First Colorado enrollee to whom or on behalf of whom the TCM is being provided. (For example, in the context of this billing manual, if/when the mother becomes ineligible for Health First Colorado, she is no longer a "member.")

Examples of TCM include:

- Discussions with providers, school counselors, etc. about assessments, progress, referrals
- Discussions with member's (mom or baby) family members about progress of the member, etc. (member can be present or not)
- Communication with the mother about meeting the needs of the child
- Time spent finding/researching appropriate referrals for a member based on assessments

Examples of services that are not TCM:

- Direct care/services
- Education
- Driving to visits
- Transporting the member

- Case conferencing with other Nurse Home Visitors/supervisors not directly involved with the member
- Billing activities and data entry
- Time spent charting

When billing TCM for the mother using the mother's Health First Colorado ID, the TCM services provided must be directly related to assessment of the mother's needs, development of the mother's care plan, referrals to resources that will aid in meeting the needs of the mother, or routine monitoring and follow-up of the mother's progress in meeting her needs and achieving her goals.

When billing TCM for the child using the child's ID, the TCM services provided must be directly related to assessment of the child's needs, development of the child's care plan, referrals to resources that will aid in meeting the needs of the child, or routine monitoring and follow-up of the family's progress in meeting the identified needs of the child.

Documentation in Member Records

Every claim for TCM reimbursement must be supported by clear evidence in the member's record/chart. In order for TCM reimbursement to be claimed for any given member, date, or unit amount, corresponding evidence must exist in the member's record.

Elements that should be easily identifiable by an external reviewer include:

- Evidence that at least one component of TCM was provided;
- The Health First Colorado member to whom or on behalf of whom the TCM was provided (If the claim is billed using the child's Health First Colorado ID, the child's name must be evident on the record.);
- The specific dates of service on which the TCM was rendered; and
- The amount of time spent providing TCM (either an actual notation of time or a description of services comprehensive enough that time spent providing TCM could be accurately estimated).

The notations in the chart should support the number of units billed. For instance, if two units of TCM are billed but the only notation in the chart reads, "Referred member to WIC," that notation does not necessarily support the number of units billed. A more complete reference that may more fully support the number of billed units could be, "Spoke with member about quantity and variety of food in household, assessed member for adequate nutrition standards, referred member to WIC to meet nutrition needs."

Targeted Case Management services provided to or on behalf of the mother should be billed using the mother's Health First Colorado ID and the notations in the chart should support that the services were provided to or on behalf of the mother. Targeted Case Management services provided to or on behalf of the child should be billed using the child's Health First Colorado ID and evidence in the chart should support that the services were provided to or on behalf of the child. Services provided to or on behalf of the mother after she is no longer eligible for Health First Colorado are not billable to Health First Colorado and may not be billed using the child's Health First Colorado ID. For every claim submitted using the child's Health First Colorado ID, evidence in the chart supporting this claim and unit amount should specifically describe TCM services provided to or on behalf of the child.

Even if span billing is used (see the *Span Billing* section below), there must be evidence in the member's chart of specific services and specific dates of service.

Billing Information

Refer to the General Provider Information manual for general billing information.

Enrollment and Participation

Participating providers must be certified by the CDHS as NHVP providers. Nurse Home Visitor Program providers must meet established program training requirements, program protocols, program management information systems requirements, and program evaluation requirements for research-based model programs that have demonstrated significant reductions in: infant behavioral impairments, the number of reported incidents of child abuse and neglect, the number of subsequent pregnancies, receipt of public assistance, and criminal activity.

All NHVP services must be provided by a registered nurse. Nurse home visitors must be licensed as professional nurses pursuant to Article 38 of Title 12, C.R.S., or accredited by another state or voluntary agency that the state board of nursing has identified by rule pursuant to Section 12-38-108(1)(a), C.R.S., as one whose accreditation may be accepted in lieu of board approval. Nurse supervisors are required to be nurses with Master's degrees in nursing or public health, unless the implementing entity can demonstrate that such a person is either unavailable within the community or an appropriately qualified nurse without a Master's degree is available.

The rendering nurses must be enrolled as Health First Colorado providers, and the rendering nurses' NPI must be affiliated with the billing provider under which the NHVP claims are submitted.

Procedure / HCPCS Codes Overview

The codes used for submitting claims for services provided to Health First Colorado members represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Health First Colorado provider.

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 four numeric digits, while CPT codes are identified using five numeric digits.

NHVP Procedure / Diagnosis Coding

NHVP Procedure Coding

Target Case Management services may be provided to, or on behalf of, **the woman** during the prenatal period and through the month of the first child's second birthday during any month in which the woman is Health First Colorado-eligible. Targeted Case Management services provided to, or on behalf of, the woman must be billed on a separate claim from TCM services provided to, or on behalf of, the child. The following procedure code may be billed for TCM services provided to, or on behalf of, the woman:

Code	Description	Prior Authorization
G9006	Coordinated care fee, home monitoring	No PA

Targeted Case Management services may be provided to, or on behalf of, **the child** through the month of his/her second birthday during any month in which the child is Health First Colorado-eligible. Targeted Case Management services provided to, or on behalf of, the child must be billed on a separate claim from TCM services provided to, or on behalf of, the woman. The following procedure code may be billed for TCM services provided to, or on behalf of, the child:

Code	Description	Prior Authorization
T1017	Targeted case management, each 15 minutes	No PA

Modifiers

All claims for TCM services provided through NHVP must include one of the procedure codes listed above **plus the HD modifier**, signifying that the services are part of a pregnant/parenting women's program. Claims submitted without this modifier will be denied.

Maximum Allowable Units of Service

Reimbursement for TCM provided through NHVP is made on a per-unit basis, where one (1) unit is equal to fifteen (15) minutes. A **maximum of fifteen (15) units of service** will be reimbursed in any calendar month per mother/child couple. The maximum 15 units per calendar month may be divided between the mother and child if both are Health First Colorado-eligible in the same month.

The maximum 15 units of service may be provided in the home/off-site setting, in the office, or a combination of both home/off-site and office.

Time spent on TCM should be rounded to the nearest whole unit. For example, if 5 minutes of TCM are provided, no units may be billed. If 10 minutes of TCM are provided, 1 unit may be billed. If 23 minutes of TCM are provided, 2 units may be billed.

Place of Service

TCM Services in the Home or Off-Site Setting

Each NHVP provider agency has an agency-specific reimbursement rate for TCM services provided in the member's home or other off-site setting (such as the member's school, work, or any other location to which the nurse home visitor must travel). This agency-specific reimbursement rate includes a calculation to account for mileage costs. **All TCM services provided at a location other than the NHVP provider office must be billed using Place of Service Code 12 (Home).**

TCM Services in the Office Setting

All NHVP provider agencies are reimbursed the same rate for TCM services provided to, or on behalf of, the woman and/or the child when those services take place at the NHVP provider offices. All TCM services that take place at the office **must be billed using a Place of Service Code other than 12**, signifying that the services were rendered in a setting that did not require the nurse home visitor to travel. **Alternative Place of Service Codes include but are not limited to 11 (Office), 50 (Federally Qualified Health Center – FQHC), and 72 (Rural Health Center – RHC).**

Home/Off-Site TCM and Office TCM Provided on the Same Date of Service or Span*

If Home/Off-Site TCM and Office TCM are provided to a member on the same date of service or span, two line items must be used, each with the appropriate Place of Service code. Modifier **HD** should be

used on both line items. Additionally, Modifier **76** ("Repeat procedure or service") must be used as the second modifier on the second line item. If Modifier 76 is not used on the second line item, the second line item will be denied as a duplicate. When the claim is processed, the MMIS suspects that a service is being duplicated when it identifies two line items with the same date of service or span and with the same procedure code, regardless of the difference in the place of service. Modifier 76 must be used on the second line item to signal that it is indeed a separate service from the first line item.

Example:

Home and Office TCM on Same Date	Line 1	Line 2
2 units of Home TCM on 10/6/16 1 unit of Office TCM on 10/6/16	From Date:10/6/16 To Date: 10/6/16 Place of Service: 12 Units: 2 Modifier(s): HD	From Date: 10/6/16 To Date: 10/6/16 Place of Service: 11 Units: 1 Modifier(s): HD + 76

*****See the following for information on span billing.

NHVP Diagnosis Coding

Diagnosis codes that are appropriate for this program include but are not limited to the following:

Member Description and Stage	Diagnosis Code	Diagnosis Code Description
Pregnant Woman	Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
	Z34.01	Encounter for supervision of normal first pregnancy, first trimester
	Z34.02	Encounter for supervision of normal first pregnancy, second trimester
	Z34.03	Encounter for supervision of normal first pregnancy, third trimester
	Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
	Z34.81	Encounter for supervision of other normal pregnancy, first trimester
	Z34.82	Encounter for supervision of other normal pregnancy, second trimester
	Z34.83	Encounter for supervision of other normal pregnancy, third trimester
	Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester

Member Description and Stage	Diagnosis Code	Diagnosis Code Description
	Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
	Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
	Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
	O09.00	Supervision of pregnancy with history of infertility, unspecified trimester
	O09.01	Supervision of pregnancy with history of infertility, first trimester
	O09.02	Supervision of pregnancy with history of infertility, second trimester
	O09.03	Supervision of pregnancy with history of infertility, third trimester
	O09.10	Supervision of pregnancy with history of ectopic or molar pregnancy, unspecified trimester
	O09.11	Supervision of pregnancy with history of ectopic or molar pregnancy, first trimester
	O09.12	Supervision of pregnancy with history of ectopic or molar pregnancy, second trimester
	O09.13	Supervision of pregnancy with history of ectopic or molar pregnancy, third trimester
	O09.291	Supervision of pregnancy with other poor reproductive or obstetric history, first trimester
	O09.40	Supervision of pregnancy with grand multiparity, unspecified trimester
	O09.41	Supervision of pregnancy with grand multiparity, first trimester
	O09.42	Supervision of pregnancy with grand multiparity, second trimester
	O09.43	Supervision of pregnancy with grand multiparity, third trimester

Member Description and Stage	Diagnosis Code	Diagnosis Code Description
Mother from Delivery through ~2-3 Months Postpartum	Z39.2	Encounter for routine postpartum follow-up
Mother After ~2-3 Months Postpartum to Child's 2nd Birthday	Z02.9	Encounter for administrative examinations, unspecified
Child – Infancy through 2nd Birthday	Z76.2	Encounter for health supervision and care of other healthy infant and child

Billing for Members with Commercial Insurance and Health First Colorado

Targeted case management services provided under the NHVP are exempt from commercial billing requirements. This means that when a member has both commercial insurance and Health First Colorado, NHVP providers are not required to submit claims to commercial payers prior to billing Health First Colorado.

Span Billing

Span billing is an alternative method for billing NHVP services. Span billing is a method of billing for one service provided to the same member over a period of time as one line item, rather than billing each encounter separately with individual dates of service. For instance, if TCM was provided to the same member on three different dates of service, a span of dates can be entered in the "From Date" field and the "To Date" field on one line item, rather than billing three line items for each separate date of service.

Examples:

Span Scenario 1	Line 1	Line 2
4 units of Home TCM on 10/2/16 5 units of Home TCM on 10/23/16 No Office TCM provided	From Date: 10/1/16 or 10/2/16 To Date: 10/23/16 or 10/31/16 Place of Service: 12 Units: 9 Modifier(s): HD	
Span Scenario 2	**Line 1**	**Line 2**
2 units of Home TCM on 10/6/16 1 unit of Office TCM on 10/6/16 3 units of Home TCM on 10/16/16 2 units of Office TCM on 10/21/16	From Date:10/1/13 or 10/6/16 To Date: 10/21/13 or 10/31/16 Place of Service: 12 Units: 5 Modifier(s): HD	From Date: 10/1/16 or 10/6/16 To Date: 10/21/16 or 10/31/16 Place of Service: 11 Units: 3 Modifier(s): HD + 76

The span “From Date” and the span “To Date” should be within the same month (10/1/16 – 10/31/16; not 10/15/16 – 11/15/16).

No other claims for that member for that service with dates of service within the span can be processed once the span claim has been submitted. If additional units of the service need to be billed during the span dates after the original span claim has been submitted, the original span claim must be adjusted to add the units. A new claim with the additional units cannot be processed.

CMS 1500 Paper Claim Instructional Reference Table

Nurse Home Visitor Program claims are submitted on the CMS 1500 Claim Form. The following paper claim form reference table shows required, optional, and conditional fields and detailed field completion instructions.

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 Health First Colorado 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 member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. 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	
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.

CMS Field #	Field Label	Field is?	Instructions
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: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the insured.
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.

CMS Field #	Field Label	Field is?	Instructions
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: 070115 for July 1, 2015. 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**	Conditional	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Conditional	Complete if all 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 any laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.

CMS Field #	Field Label	Field is?	Instructions
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. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-10-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, 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**	Not Required	
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **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. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).

CMS Field #	Field Label	Field is?	Instructions
24A	**Dates of Service**	Required	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: 010115 for January 1, 2015 From To **01 01 15** | | | | | | Or From To **01 01 15 01 01 15** Span dates of service From To **01 01 15 01 31 15** Practitioner claims must be consecutive days. 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: permissible if the same service (same procedure code) is provided on consecutive dates.
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. **NHVP** All TCM services that are provided at a location other than the NHVP provider office must be billed with Place of Service Code: 12 Home All TCM services that are provided at the NHVP provider office must be billed with a Place of Service Code other than 12 (Home). Alternative Place of Service Codes include but are not limited to: 11 Office 50 Federally Qualified Health Center 72 Rural Health Clinic

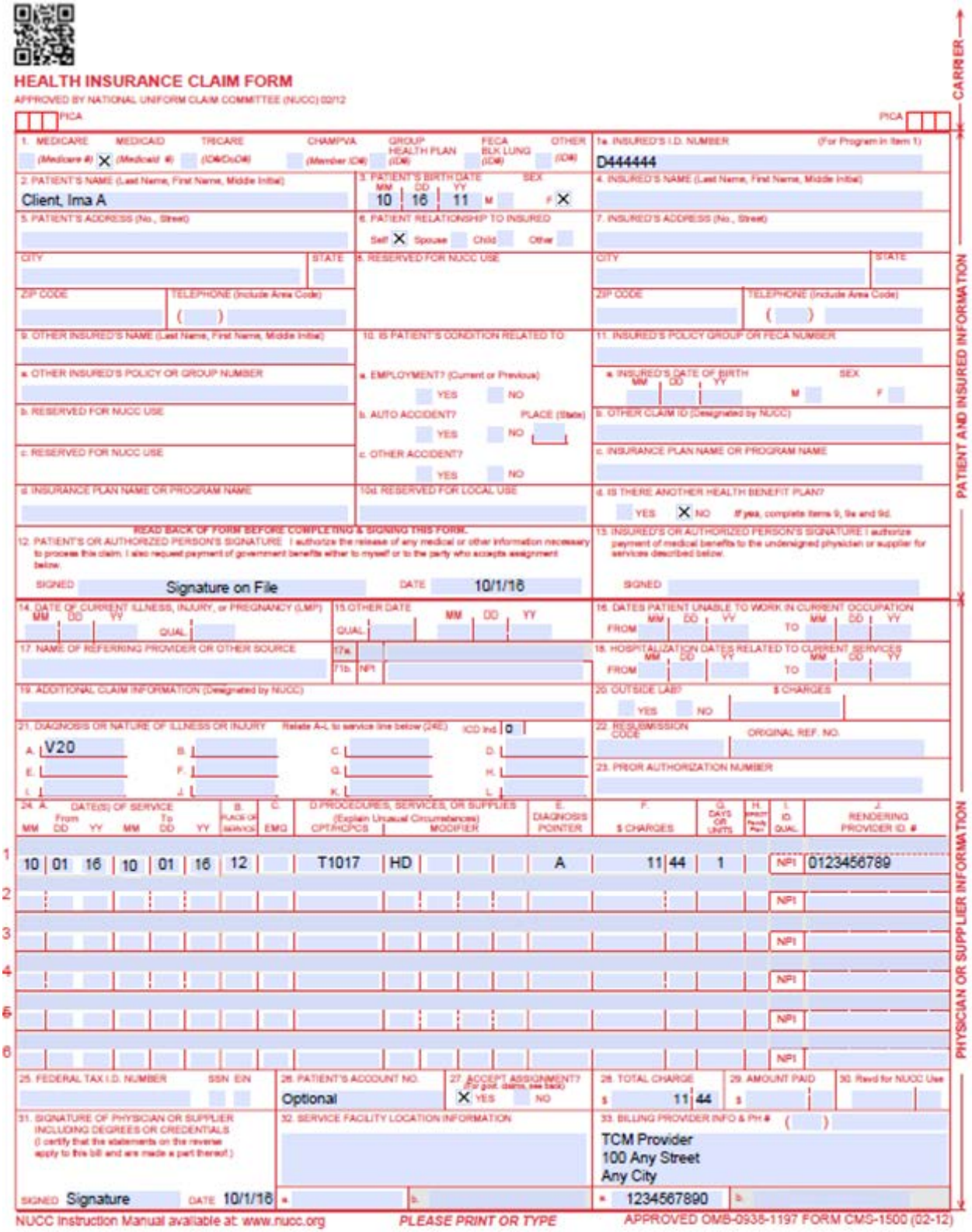
CMS Field #	Field Label	Field is?	Instructions
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians 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. **NHVP** TCM services provided to, or on behalf of the woman: G9006 Coordinated care fee, home monitoring TCM services provided to, or on behalf of the child: T1017 Targeted case management, each 15 minutes
24D	**Modifier**	Required	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. HD **Pregnant/Parenting Women's Program** This signifies that the service is part of a pregnant/parenting women's program.
24E	**Diagnosis Pointer**	Required	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. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.

CMS Field #	Field Label	Field is?	Instructions
			This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	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. 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. 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. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals. **NHVP** One unit equals 15 minutes of TCM. In any given calendar month, the maximum number of reimbursable units is 150 for the mother/child couple. The 15 units may be split between the woman and the child in any given calendar month that both are Medicaid-eligible.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Health First Colorado 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.

CMS Field #	Field Label	Field is?	Instructions
24H	**EPSDT/Family Plan**	Conditional	**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
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
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**		

CMS Field #	Field Label	Field is?	Instructions
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. 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: 070115 for July 1, 2015. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
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: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
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: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

Child - Single Date of Service - Home TCM



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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: 10 | 16 | 11 SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: 10/1/16

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 QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. V20 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16 | 10 01 16	12		T1017	HD	A	11 44	1		NPI	0123456789
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 govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 11 44

29. AMOUNT PAID $

30. Rsvd 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 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

TCM Provider
100 Any Street
Any City

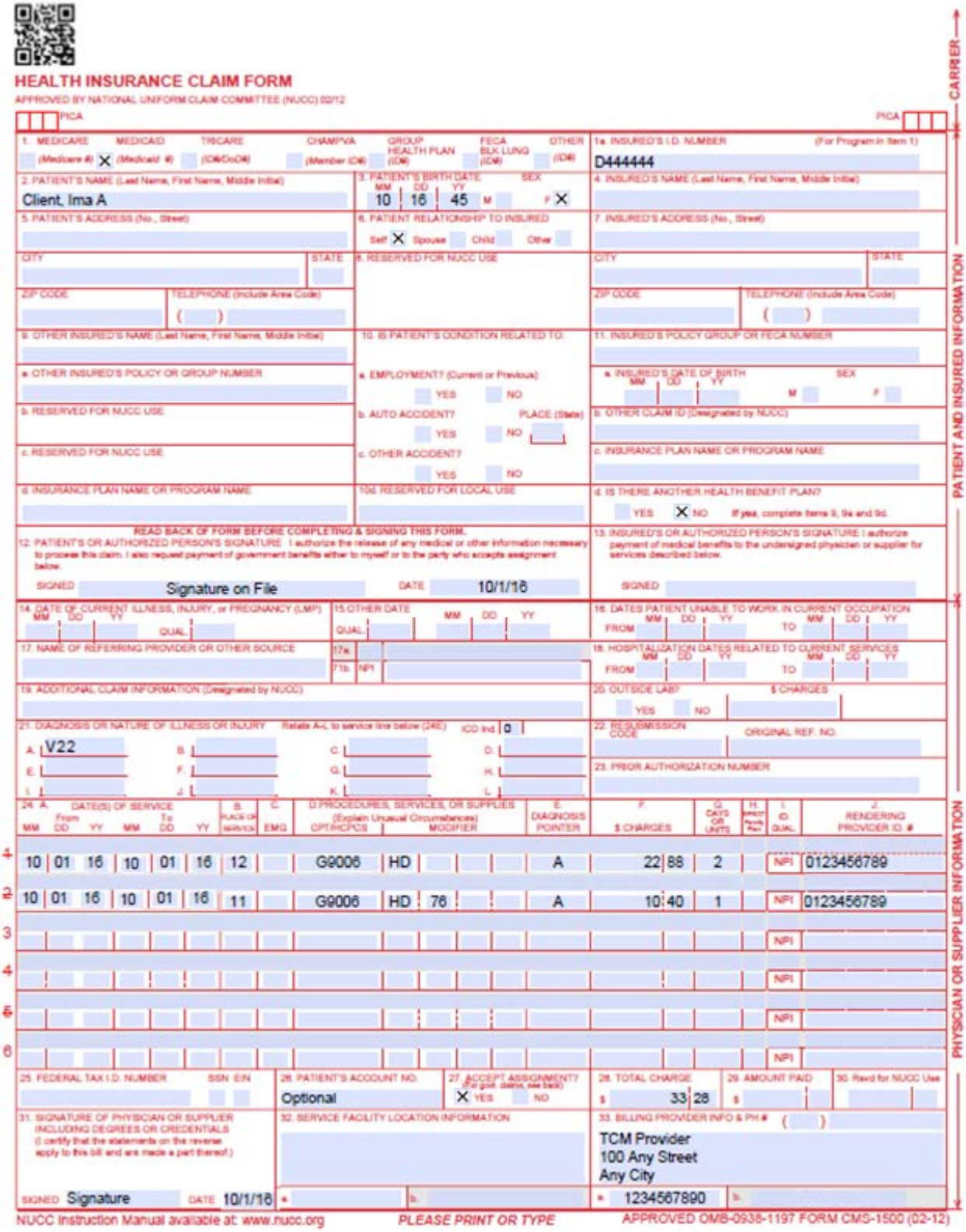
a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Example Only - TCM Rates with Place of Service "12" are provider-specific.

Pregnant Woman - Single Date of Service - Home TCM and Office TCM on Same Date



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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: 10 | 16 | 45 SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: 10/1/16

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 QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. V22 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16 | 10 01 16	12		G9006	HD	A	22 88	2		NPI	0123456789
2	10 01 16 | 10 01 16	11		G9006	HD 76	A	10 40	1		NPI	0123456789
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 govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 33 28

29. AMOUNT PAID $

30. Rsvd 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 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

TCM Provider
100 Any Street
Any City

a. 1234567890 b.

CARRIER

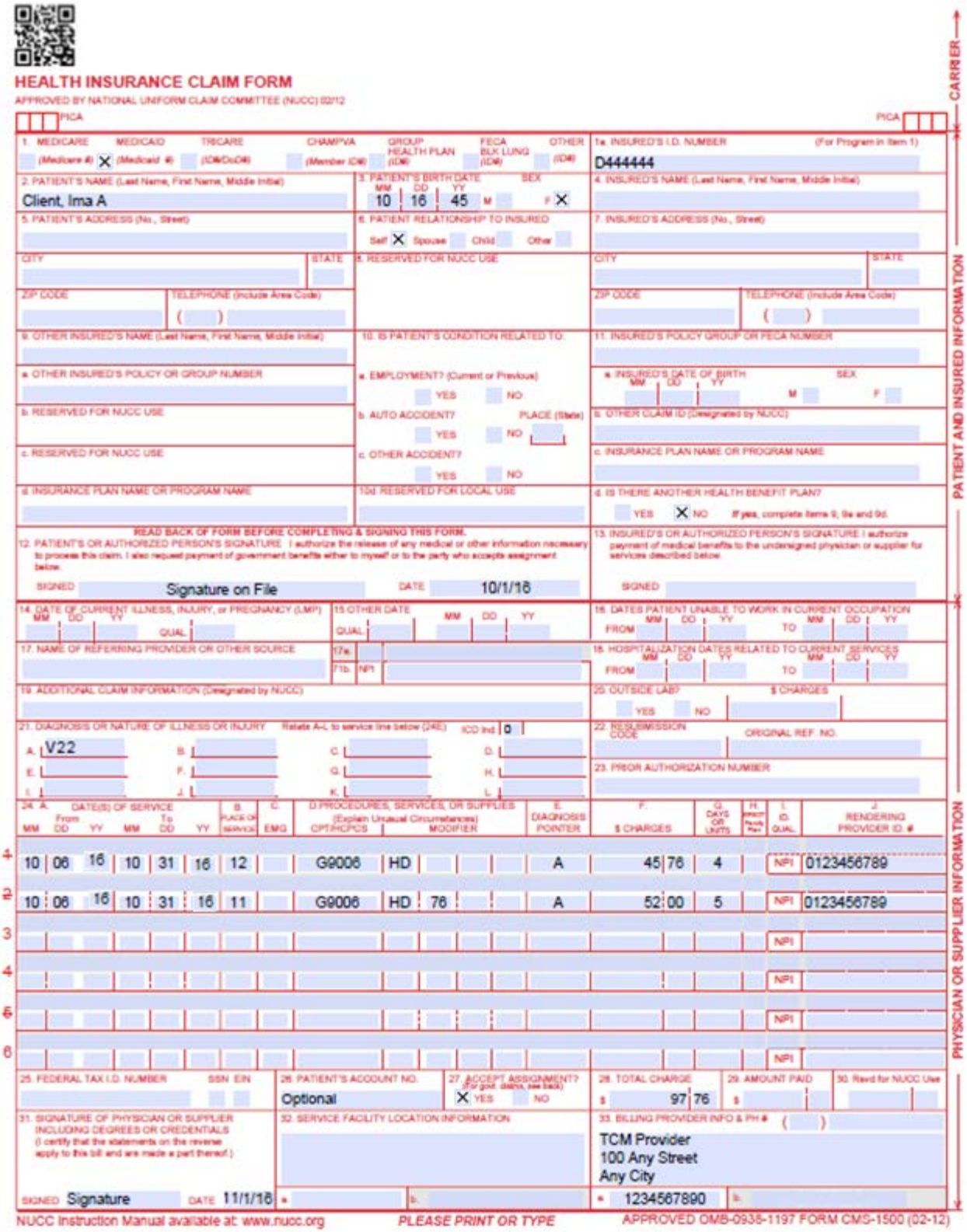
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Example Only - TCM Rates with Place of Service "12" are provider-specific.

Pregnant Woman - Span Dates of Service - Home TCM and Office TCM during Same Span



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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: 10 16 45 | SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO | If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: 10/1/16

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. V22 | B. | C. | D. | E. | F. | G. | H. | I. | J. | K. | L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10 06 16	10 31 16	12		G9006	HD		A	45 76	4		NPI 0123456789
2	10 06 16	10 31 16	11		G9006	HD	76	A	52 00	5		NPI 0123456789
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 govt. claims, see back) X YES | NO

28. TOTAL CHARGE: $ 97 76

29. AMOUNT PAID: $

30. Rsvd 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 11/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH # ( )

TCM Provider
100 Any Street
Any City

a. 1234567890 | b.

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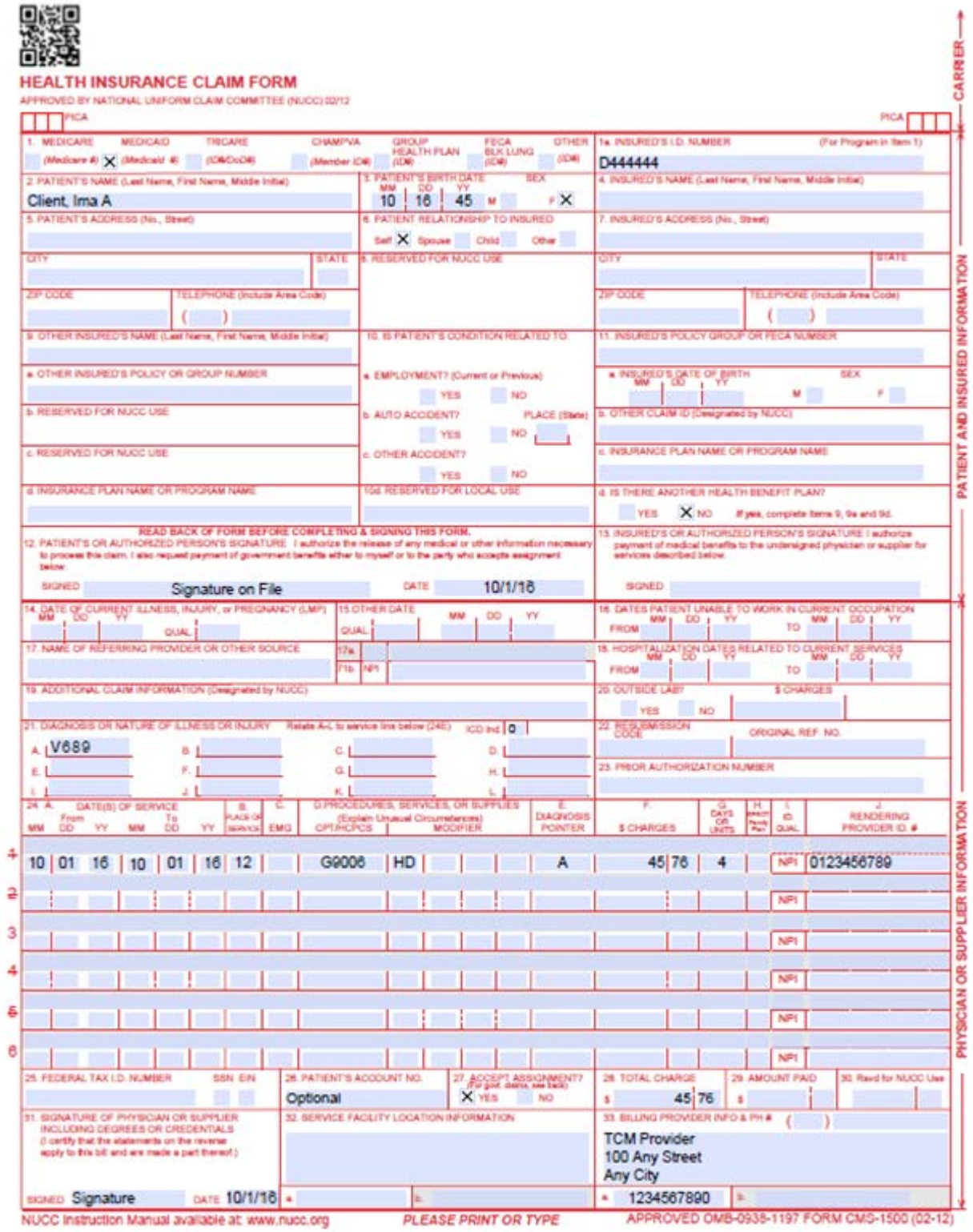
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example Only - TCM Rates with Place of Service "12" are provider-specific.

Mother after 2-3 Months Postpartum - Single Date of Service - Home TCM



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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 | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

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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 QUAL | MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. V689 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16 | 10 01 16	12		G9006	HD	A	45 76	4		NPI	0123456789
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 govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 45 76

29. AMOUNT PAID: $

30. Rsvd 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: 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH #

TCM Provider
100 Any Street
Any City

a. 1234567890 | b.

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PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example Only - TCM Rates with Place of Service "12" are provider-specific.

Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

Nurse Home Visitor Program Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016. Please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*3*	*DXC*
6/22/2018	*Updated billing and timely to point to General Manual*	*3,22*	*HCPF*

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.