

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

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Medical Supplies: Billing Examples

The examples in this section are to assist providers in billing for medical supplies on the *CMS-1500* claim form. Refer to the *Medical Supplies* section of this manual for detailed policy information. For incontinence supplies, refer to the *Incontinence Medical Supplies* sections of this manual for more information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in dollar amounts. If requested information does not fit neatly in the *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Note: Only incontinence medical supplies require ICD-9-CM diagnosis code(s) on the claim.

**Ostomy Supplies:
Contracted**

Figure 1. Ostomy supplies, contracted.

This is a sample only. Please adapt to your billing situation

In this example, a Durable Medical Equipment (DME) company is billing for contracted ostomy supplies. Medical supply codes A4399 (cone/catheter), A4367 (ostomy belt), A4363 (replacement clamp) and A4362 (skin barrier) are entered in the *Procedures, Services or Supplies* field (Box 24D).

Because the supplies are being delivered to the patient's home, "12" is entered in the *Place of Service* field (Box 24B).

Claims for contracted medical supplies require a product qualifier/UPN in the shaded area of Box 24A. The unit of measure and numeric quantity in the shaded area of Box 24D are optional. Absence of these two elements will not result in claim denial. These numbers are based

on the product dispensed to the recipient. See the *List of Contracted Ostomy Supplies* spreadsheet for a listing of UPNs and UPN qualifiers. Also see the *CMS-1500 Completion* section for more details about both the qualifier/UPN and the unit of measure/quantity.

Note: This example illustrates billing for contracted medical supplies. An attachment (invoice, manufacturer's catalog page or price list) is not required when billing for contracted medical supplies.

Claims for non-contracted medical supplies with a listed price do not require a qualifier/UPN or an attachment (invoice, manufacturer's catalog page or price list). However, non-contracted supplies without a listed price do require documentation of product cost as an attachment (invoice, manufacturer's catalog page or price list) to the claim.

Enter the usual and customary charges in the *Charges* field (Box 24F). For additional help in calculating charges, providers may refer to upper billing limit information in the *Medical Supplies* section.

Enter the number of units for each medical supply item being billed in the *Days or Units* field (Box 24G).

HEALTH INSURANCE CLAIM FORM												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												
PICA <input type="checkbox"/>					PICA <input type="checkbox"/>							
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 90000000A95001							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN					3. PATIENT'S BIRTH DATE MM DD YY 06 21 62 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY ANYTOWN		STATE CA			8. RESERVED FOR NUCC USE		CITY		STATE			
ZIP CODE 958235555		TELEPHONE (Include Area Code) (916) 555-5555			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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. RESERVED FOR NUCC USE		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		SEX			
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			c. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
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.					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 _____ DATE _____					SIGNED _____							
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					17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					17b. NPI _____		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____					22. RESUBMISSION CODE ORIGINAL REF. NO.							
A. _____ B. _____ C. _____ D. _____					23. PRIOR AUTHORIZATION NUMBER							
E. _____ F. _____ G. _____ H. _____												
I. _____ J. _____ K. _____ L. _____												
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 UK10610075077233		12		UN0000002000			A4399	2300	2		NPI	
2 ON30003175507		12		UN0000002000			A4367	1500	2		NPI	
3 UP762123001493		12		UN0000006000			A4363	1400	6		NPI	
4 EN0762123010327		12		UN0000030000			A4362	9500	30		NPI	
5											NPI	
6											NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 14700	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.) <i>Jane Doe</i>			32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.			33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b.						

Figure 1. Ostomy Supplies: Contracted.

Attachment Invoice Requirements

Figure 2. Attachment Invoice Requirements.

This is a sample only. Please adapt to your billing situation.

In this example, the provider is using an invoice as the attachment for reimbursement of medical supplies. For the claim to be processed, the invoice attachment must contain all of the required elements listed below. The information does not need to be in this order.

Manufacturer/Distributor – The name and address of the manufacturer or distributor from whom the medical supplies were purchased (in this case Fix It Medical at 1569 Main Street).

Bill to – The name and address of the company being billed for the medical supplies.

Ship to – The ship-to address or business Drug Enforcement Agency (DEA) number is not required on medical supply invoices.

Invoice number – The number assigned to the purchase of the supplies from the supplier.

Invoice date – The date of the invoice. This date must be prior to the date of service. The date of the invoice cannot be more than one year prior to the date of service.

Quantity – The total quantity received by the provider.

Item/UPN Number – Manufacturer’s or distributor’s product number or UPN number of the item purchased.

Shipping Units – The unit of measurement that the product is packaged in when received by the provider, such as box, case or each. For the reimbursement process, the shipping unit information will be broken down for each. Providers may hand write the units breakdown on the invoice for clarification purposes. (Example: Case = 1 box of 30 each).

Description – The description of the product purchased by the provider.

Unit Price – The price of the unit size purchased by the provider. This price will be broken down to the each price for reimbursement. (Example: 1 case = \$4.68 (after discount) divided by 30 in each box = \$0.1560 each).

Discounts – Amount of discount, if any, must be reported and applied to the purchase price.

Total amount – The total amount for the number of shipped units purchased by the provider including any discounts given to the provider.

Certification Statement – Invoices with disclaimers and all printouts of electronic invoices and any invoice with words identifying the invoice as a reprint or reproduction of original require the certification statement. See the following “Additional Requirements.”

Additional Invoice
Requirements

Invoices must not be altered.

Any explanatory information added to the invoice by the provider to assist in the reimbursement process may only be handwritten. Typewritten information (other than a certification statement), attached labels or covered information will result in the claim being denied.

Printouts of electronic invoices, reprints or wholesaler reproductions of original invoices require a certification statement. Claims submitted with invoices that contain disclaimers referring to Medicare/Medi-Cal reimbursement, as in the following example, will require a certification statement:

The prices on this invoice may include fees for services that may not be reimbursable under the Medicare/Medi-Cal statutes. You can receive an itemized list of any fees included in the prices upon request.

Providers are required to include the certification statement exactly as shown under “Invoice Certification for Medical Supplies” in the *Medical Supplies* section of this manual.

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FIX IT MEDICAL COMPANY							
1569 Main Street Mytown, CA 90000 Phone: 555-555-5555 Fax: 555-555-5556							
Bill To	Johnson's Medical Supply 690 West 14 th Avenue Johnsonville, CA 98721 555-555-5021		Ship To	The ship-to address or Drug Enforcement Agency (DEA) number are not required on medical supply invoices.		Invoice #	11005
						Invoice Date:	February 13, 2009
						Customer ID:	JMS189
DATE	YOUR ORDER #	OUR ORDER #	SALES REP.	F.O.B.	SHIP VIA	TERMS	TAX ID
2/13/09	567890		Susie		Fed Ex	1% net 30	
QTY	ITEM/UPN #	SHIPPING UNITS	DESCRIPTION	UNIT PRICE	DISCOUNT %	TOTAL	
1	410	CS	410 Catheter (1 Bx. Per CS.- 30 Ea. Bx.)	\$5.20	10%	\$4.68	
						Subtotal	\$4.68
						Tax	\$0.36
						Shipping	\$1.00
						Miscellaneous	
Please return the portion below with your payment.						BALANCE DUE	\$6.04
REMITTANCE							
Invoice #	11005						
Customer ID	JMS189						
Date							
Amount Enclosed							
			Fix It Medical Company	PHONE	(555) 555-5555		
			1569 Main Street	FAX	(555) 555-5556		
			Mytown, CA 90000	WEB SITE	www.fixit.com		

Figure 2. Attachment Invoice Requirements.

Catalog or Price List Requirements

The following are requirements that a catalog or price list must meet to be an acceptable attachment for reimbursement of medical supply claims. Invoice requirements are listed on a previous page in this section.

Medical supply claims requiring a manufacturer catalog or price list attachment for reimbursement must meet the following requirements:

- Catalog or price lists must not be dated more than five years, prior to the date of service.
- The type of catalog or price list must be included in the title of the document. Acceptable types of catalogs or price lists include Manufacturer's Wholesale, Dealer and Distributor.
- Pricing columns found on the catalog or price list page must include one or more of the following types of pricing:
 - Average Wholesale Price (AWP) *
 - Suggested Wholesale Price (SWP)
 - Suggested Wholesale Resale (SWR)
 - Unit Price
 - Net Price
 - Quantity Discount
 - Contracted Price
 - Case Price
- * Catalogs or price lists that contain only an AWP pricing column will not be accepted.
- Catalog and price lists must include the package quantities.
- A copy of the front cover of the catalog or price list must accompany the page(s) submitted with a claim from each source catalog or price list when the individual page(s) does not contain an identification of the type of catalog and a date.