PRC Rates

Pricing Information

While all information in these documents are believed to be correct at the time of writing. These documents are for educational purposes only.

Pricing for Physician

Purpose

Determine a fee for Physical, Occupational, Speech, Respiratory Therapies, Psychologists, Sleep Labs and Audiologists. For obligation purposes.

You Need to Know

- PRC rate
- Location of provider
- CPT/HCPCS code(s)
- Service date
- Units billed
- Billed amount

Claim example:

CPT/HCPCS code	Units	Billed Amount	Service Date	Medicare Rate
73564-LT	1	$124.00	07-15-15	$39.95
99213	1	$172.38	07-15-15	$72.72

Step/Action Table Description

Step	Description
1	**Action:** Determine where the provider is located (ex: provider is located in Wenatchee, WA). The carrier/locality code for the outside of King County is, 02402-99; This code is required for all pricing.
2	**Action:** Do you have the CPT/HCPCS codes? If yes, go to the next step. If no, provider will need to provide this information.
3	**Action:** Do you have the service date of when the services were rendered? If yes, go to the next step. If no, provider will need to provide this information.
4	**Action:** Do you have the PRC rate? (for this example, use 100% Medicare). If yes, go to the next step. If no, the IHS Area office or the FI will provide this information.
5	**Action:**

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	Determine the Medicare rate for 73564 and 99213. This information can be found in the online website. In the claim example, the Medicare rate is $39.95 for 73564 and $72.72 for 99213.
6	**Action:** Calculate as follows: 73564 Medicare rate $39.95 x 1= $39.95 99213 Medicare rate $72.72 x 1= $72.72 Total amount to be paid on this claim: **$112.67**

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Pricing for Durable Medical Equipment (DME)

Purpose

Determine a fee for Durable Medical Equipment (DME), for obligation purposes.

You Need to Know

The following information is required to determine a fee:

- PRC rate
- Location of provider/vendor
- Carrier/Locality code(s)
- Medicare rate
- CPT/HCPCS code(s)
- Service date
- Billed amount
- Units

Claim example

CPT/HCPCS code	Units	Billed Amount	Service Date	Medicare rate
E1390-RR	1	$410.00	06/24/2015	$180.92
E0431-RR	1	$64.00	06/24/2015	$30.42

Step/Action Table Description

Step	Description
1	**Action:** Determine where the provider is located (ex: provider is located in Farmington, NM). The carrier/locality code for the state of New Mexico is 04212-05; This code is required for all pricing. For DME pricing, a default locality will be “00”, see *note.
2	**Action:** Do you have the CPT/HCPCS codes? If yes, go to the next step. If no, provider will need to provide this information.
3	**Action:** Do you have the service date of when the services were rendered? If yes, go to the next step. If no, provider will need to provide this information.
4	**Action:** Do you have the PRC rate? (for this example, use Medicare less 10%). If yes, go to the next step. If no, the IHS Area office or the FI will provide this information.
5	**Action:** Determine the Medicare rate for E1390-RR and E0431-RR. This information can be found in the online website.

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	In the example, the Medicare rate is $180.92 for E1390-RR and $30.42 for E0431-RR.
6	**Action:** Calculate as follows: E1390-RR Medicare rate $180.92 x 1= $180.92 x 90% = $162.83 E0431-RR Medicare rate $30.42 x 1= $30.42 x 90% = $27.38 Total amount to be paid on this claim: $190.21

*Note- A default locality code is used to determine pricing, only if the state has a locality code other than “00”. Example: For New Mexico, the carrier and locality code is 04212-05. Since this is DME, we need to use 04212-00.

DME fees are National fees, therefore, the fee for E1390-RR and E0431-RR will be the same for all states, this is why we use “00” locality as the default.

New Mexico (04212-05)

```
 CARRIER: 04212          IHS MEDICARE FEE SCHEDULE LOCATOR
LOCATION: 00                   FUNCTION: INQUIRE
                         PAR          NON-PAR
    PROCEDURE           PRICE          PRICE       EFFECT     CANCEL
   E1390 RR            180.920        171.870     01/01/15   12/31/15
   E1390 RR            178.240        169.330     01/01/14   12/31/14
   E1390 RR            177.360        168.490     01/01/13   12/31/13
   E1391 RR            180.920        171.870     01/01/15   12/31/15
   E1391 RR            178.240        169.330     01/01/14   12/31/14
```

Alaska (02102-01)

```
 CARRIER: 02102          IHS MEDICARE FEE SCHEDULE LOCATOR
LOCATION: 00                   FUNCTION: INQUIRE
                         PAR          NON-PAR
    PROCEDURE           PRICE          PRICE       EFFECT     CANCEL
   E1390 RR            180.920        171.870     01/01/15   12/31/15
   E1390 RR            178.240        169.330     01/01/14   12/31/14
   E1390 RR            177.360        168.490     01/01/13   12/31/13
   E1390 RR            176.060        167.260     01/01/12   12/31/12
```

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Pricing for CRNA/Anesthesia

Purpose
Determine a fee for CRNA/Anesthesia, for obligation purposes.

Anesthesiologists and/or CRNA's bill a professional fee for anesthesia units of service. Always calculate the anesthesia units of service number to determine what the provider charged.

You Need to Know
The following information is required to determine a fee:

- PRC rate
- Location of provider/vendor
- Carrier/Locality code(s)
- Medicare rate(s) / Conversion Factor
- CPT/HCPCS code(s)
- Service date
- Time/units
- Billed amount
- Base units

Claim example: Provider is located in Billings, MT; PRC rate is Medicare less 5%

CPT code	Time/Units	Billed Amount	Service Date	Medicare Rate
00630-AA	13:43-15:10= 87 minutes	$1346.00	07/08/2015	$23.04

Step/Action Table Description

Step	Description
1	**Action:** Determine the number of base units. **Note-** Refer to the Anesthesia Base units, which can be found on the CMS website, listed under Anesthesia.
2	**Action:** Calculate the number of time units. If time is in minutes, divide by 15 minute increments. Ex: 1 hour = 4 fifteen minute increments.
3	**Action:** Determine the number of physical status (CPT) units, if applicable. See table below.
4	**Action**: Add all values together. The total is the number of anesthesia units of service. **Example:** Base units + Time units + Physical Status units (if applicable)= Anesthesia units of service.

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Physical Status CPT

Code	Description	Number of units
99100	Patient is under one year old or over 70 years	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions	2

Calculation

Using the values determined in the Step/Action table (step 4), calculate as follows:

Carrier/Locality – 03202-01 (State of Montana)

8 base units + 6 time units = 14 units total

87 minutes divided by 15 = 5.8, round 6

Medicare rate $23.04 x 14 = $322.56 x 95% (PRC rate) = **$306.43**

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Pricing for Ambulance

Purpose

Determine a fee for Emergency/Non-Emergency Transport (Air and/or Ground). For obligation purposes.

You Need to Know

- PRC rate
- CPT/HCPCS code(s)
- Service date
- Mileage/units billed
- Billed amount
- Zip code of where the patient was picked-up.

Claim example:

1. CPT/HCPCS code *(ground)*	Units/Mileage	Billed Amount	Service Date	Medicare Rate
A0428 (base)	1	$800.00	07-17-15	$207.83
A0425 (mileage)	28	$504.00	07-17-15	$11.02 (1st 17 miles) $7.34 (18+ miles)
2. CPT/HCPCS code *(air)*	**Units/Mileage**	**Billed Amount**	**Service Date**	**Medicare Rate**
A0430 (fixed wing)	1	$21,500.00	06-20-15	
A0435 (nautical miles)	241	$59,577.61	06-20-15	

Step/Action Table Description

Step	Description
1	**Action:** Determine where the transport originated from, using the ground transport claim example #1, above. *Note: For both Air and Ground transports, the zip code is required, because it determines the fee schedule amount. The zip code file is published on the CMS website:
2	**Action:**

STATE	ZIP CODE	CARRIER	LOCALITY	RURAL IND	LAB CB LOCALITY	RURAL IND2
OK	74014	04312	00		Z9	
OK	74015	04312	00		Z9	
OK	74016	04312	00		Z9	
OK	74017	04312	00	R	Z9	R
OK	74018	04312	00	R	Z9	R
OK	74019	04312	00	R	Z9	R

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	Do you have the CPT/HCPCS codes? If yes, go to the next step. If no, provider will need to provide this information.
3	**Action:** Do you have the service date of when the services were rendered? If yes, go to the next step. If no, provider will need to provide this information.
4	**Action:** Do you have the PRC rate? (for this example, use 90% of Medicare). If yes, go to the next step. If no, the IHS Area office or the FI will provide this information.
5	**Action:** Determine the Medicare rate for A0425 and A0428 by using the zip code where the patient was picked-up from. By using the zip code, this will determine if the transport was Urban, Rural or Super Rural and will also determine which fee to use for pricing. This information can be found in the online website. In the claim example, the transport is considered a Rural transport, which determines the Medicare rate as $207.83 for A0428 and $11.02 for the first 17 miles and $7.34 for remaining 11 miles for A0425.
6	**Action:** For Ground transport(s), calculate as follows: A0428 Medicare rate $207.83 x 1= $207.83 x 90%= $187.05 A0425 Medicare rate $11.02 x 17= $187.34 A0425 Medicare rate $7.34 x 11= $80.74 268.08 x 90%= $241.27 Total amount to be paid on this claim: **$428.32**
7	**Action:** For Air transport(s), determine where the transport originated from, using the air transport claim example #2, above. For this example, the transport originated from Chinle, AZ.
8	**Action:** Except for the first 17 miles, air transport is priced the same as ground transports. As with ground, the zip code determines if the transport is Urban, Rural or Super Rural. For this air transport, the “B” indicator means this is considered Super Rural.

STATE	ZIP CODE	CARRIER	LOCALITY	RURAL IND	LAB CB LOCALITY	RURAL IND2
AZ	86502	03102	00	B	Z9	B
AZ	86503	03102	00	B	Z9	B
AZ	86504	03102	00	B	Z9	B
AZ	86505	03102	00	B	Z9	B
AZ	86506	03102	00	B	Z9	B

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Pricing for End Stage Renal Disease (ESRD)

Purpose

Determine a fee for End Stage Renal Disease (ESRD), for obligation purposes.

You Need to Know

- PRC rate
- Location of provider
- Patient's height and weight
- Patient's dialysis start date (onset)
- Revenue code
- Service date
- Units billed
- Billed amount
- Provider Medicare number
- Bill type

Claim example:

SELLS DIALYSIS
HWY-86 MILEPOST 113
SELLS AZ 856343030
5203831701

SELLS DIALYSIS
PO BOX 402946
ATLANTA GA 303842946

CNTL # / b MED REC. #
5 FED. TAX NO 621323090
STATEMENT COVERS PERIOD FROM 050215 THROUGH 053015
1 0721
2

8 PATIENT NAME
9 PATIENT ADDRESS SELLS AZ

10 BIRTHDATE 06031945
11 SEX M
ADMISSION 12 DATE 050215 13 HR 14 TYPE 9 15 SRC 9 16 DHR 17 STAT 01 71
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE 30

31 OCCURRENCE CODE 33 DATE 122200 3
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
5

38 IHS/CHS FISCAL INTERMEDIARY
PO BOX 13509
ALBUQUERQUE NM 871923509

39 VALUE CODES CODE AMOUNT
a 49 33 30 68
b A9 175 26 4
c

40 VALUE CODES 26000 00
41 VALUE CODES CODE A8 AMOUNT 59 20

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Step/Action Table Description

Step	Description
1	**Action:** Determine where the provider is located (ex: provider is located in Sells, AZ). The carrier/locality code for the state of Arizona is 03102-00; *This code is required for all pricing.
2	**Action:** Is the bill type (1), one of the following? • 131 • 721 • 722 • 723

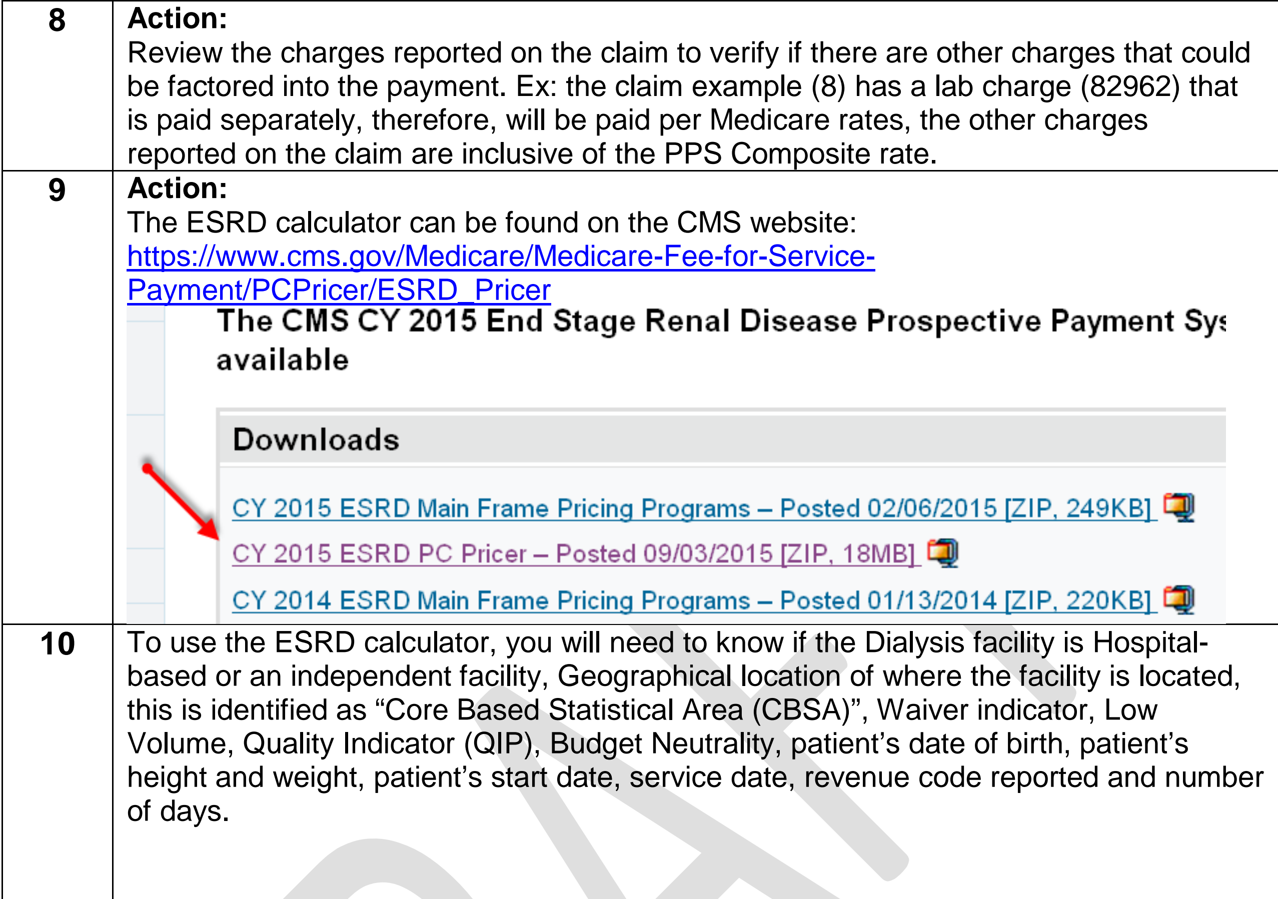
	• 724 • 727 • 728 If yes, go to next step If no, claim is returned to provider for corrections. *Note: Per Medicare guidelines, bill type 141 cannot be reported on a dialysis claim.
3	**Action:** Is the service date listed on the claim (2)? If yes, go to next step If no, return the claim to the provider for corrections *Note: A service date on a claim is usually reported as an entire month, but there may be only 13 days out of the month where the patient was dialyzed.
4	**Action:** Is the patient's start date (3), sometimes known as "onset date" indicated on the claim? If yes, go to next step If no, you can still do the calculation, it just won't be accurate without the start date.
5	**Action:** Is the patient's height and weight reported on the claim (4 & 5)? If yes, go to step 6. If no, call the provider for the information. ***Note:** *An ESRD claim cannot be calculated manually or systematically without the patient's height and weight. Value codes are **A8** = weight (4 digits) and **A9** = height (5 digits).*

The next section is the services rendered:

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED
0821	HEMODIALYSIS	90999		13	46462 00	
0636	VENOFER (IRON SUCROSE IN	J1756		150	1695 00	
0635	EPOGEN	Q4081		260	5967 00	
0305	LAB, RBC	85041		1	40 73	
0270	ADMIN DRUG	A4657		16	1348 80	
0304	BLOOD GLUCOSE TEST	82962		1	54 20	

6 7 8

Step	Description
6	**Action:** Is one of the following revenue codes reported on the claim (6)? • 82x – Hemodialysis • 83x – Peritioneal Dialysis • 84x – Continuous Ambulatory Peritoneal Dialysis (CAPD) • 85x – Continuous Cycling Peritoneal Dialysis (CCPD) • 88x – Miscelleanous Dialysis (this rev code can be used for Pediatric Ultrafiltration) If yes, go to next step. If no, the claim may be billed incorrect.
7	**Action:** How many days was the patient dialyzed (7)?

8	**Action:** Review the charges reported on the claim to verify if there are other charges that could be factored into the payment. Ex: the claim example (8) has a lab charge (82962) that is paid separately, therefore, will be paid per Medicare rates, the other charges reported on the claim are inclusive of the PPS Composite rate.
9	**Action:** The ESRD calculator can be found on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/ESRD_Pricer  **The CMS CY 2015 End Stage Renal Disease Prospective Payment Sys available** **Downloads** CY 2015 ESRD Main Frame Pricing Programs – Posted 02/06/2015 [ZIP, 249KB] CY 2015 ESRD PC Pricer – Posted 09/03/2015 [ZIP, 18MB] CY 2014 ESRD Main Frame Pricing Programs – Posted 01/13/2014 [ZIP, 220KB]
10	To use the ESRD calculator, you will need to know if the Dialysis facility is Hospital-based or an independent facility, Geographical location of where the facility is located, this is identified as “Core Based Statistical Area (CBSA)”, Waiver indicator, Low Volume, Quality Indicator (QIP), Budget Neutrality, patient’s date of birth, patient’s height and weight, patient’s start date, service date, revenue code reported and number of days.

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ESRD PC Pricer v15.1 Data Entry Screen

Provider Information
Provider Type
Hospital-based
Independent
Geographical Location
CBSA 46060
Waive Blended Payment? Yes
Low Volume Provider? No
QIP Reduction? none
Clear Provider

Patient Information
Birthdate 06/03/1945
Weight in kg 059.20
Height in cm 175.26
Is Dialysis Start Date on Form 2728 within 120 days of Line Item Date of Service? No
Unique Patient ID (optional)
Clear Patient

Claim Information
Line Item Date of Service 05/30/20
Condition Code NA
Revenue Code 821
Total Medicare Allowed Payment for Outlier Consideration 0000000.
Number of Dialysis Sessions in this billing period (1-31): 13
Comorbidities
GI Bleed with hemorrhag
Pneumonia
Pericarditis
Myelodysplastic syndrom
Hereditary hemolytic & sickle ce
Monoclonal gammopathy
Clear Claim

This is the amount to be paid for revenue code 821 x 13 days.

Calculate Claim 0000217.55 Detailed Results Clear All Exit the ESRD PC Pricer

For more ESRD information, there are several Transmittals on the CMS website. **Transmittal 2311, CR7460** and **Transmittal 2588, CR7869**; Both of these transmittals have extensive information.

Pricing for Ambulatory Surgery Centers (ASC)

Purpose

Determine a fee for Ambulatory Surgery Centers (ASC), for obligation purposes

You Need To Know

Important Notes:

- Medicare no longer requires the use of the SG modifier, so it may not be on the claim.
- Remember to always apply any PRC rates to the procedures you are pricing.
- **Modifier 59 - modifier 59 does not apply to ASC. They will be reduced accordingly**.
- Provider should bill on a CMS-1500 claim form.

Pricing:

- As of 2008, ASC's will no longer be using the 9 groups for pricing services. There are now over 50 groups. The good news is you don't have to look up each code to find what group it is in.
- Base pricing on where the services were rendered (Box 32 of the CMS-1500), not by the billing address (Box 33 of the CMS-1500). This is how we determine the CBSA for the provider.

Table Description

Follow the table below for additional ASC Pricing procedures.

Services	Procedures
Multiple ASC procedures	If the provider performs multiple ASC procedures in the same operative session, payment is based on fee and ½ for all procedures. The procedure with the **highest dollar allowance** is priced as full all other ASC surgical procedures are paid at 50% (1/2) of their ASC rate. **Example:** 67314 – ASC rate \$804.04 Full = \$804.04 67311 – ASC rate \$777.07 Half = \$388.54 67311 – ASC rate \$777.07 Half = \$388.54 NOTE: If the procedure is on the list for Procedures Exempt from Multiple Procedure Discounting then allow those as full from the CBSA rate list.

Bilateral procedures	Report a procedure performed bilaterally in one operative session as two procedures. Treat payment for a procedure performed bilaterally the same as payment for multiple procedures. Here's what Medicare says: "Bilateral procedures should be reported as a single unit on two separate lines or with "2" in the units field on one line, in order for both procedures to be paid. While use of the -50 modifier is not specifically prohibited according to CMS billing instructions, the modifier will not be recognized for payment purposes and may result in incorrect payment to ASCs. The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure discounting. See the Medicare Learning Network (MLN) Matters article SE0742, available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf for billing examples illustrating this revised payment policy. (FAQ2381)"

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It just full and half for everything it’s really very easy if you don’t over think it.

Example: procedure 31020 is performed bilaterally during one operative session. Report as:
31020 – ASC rate $804.88 Full = $804.77
31020 – ASC rate $804.88 Half = $402.44

Note: Bilateral rule must be applied in conjunction with multiple rule. However, it does not function in the same way as it does for physicians. See the examples below.

Example 1: Provider bills Bilateral procedure on 2 lines with one unit each and no other surgeries, it’s full on one line and half on the other. NOT 150% of any code

DOS	Code	Billed	Units	Price At ASC rate	Priced
41390	31255-SG-50	8660	1	Full	1098.81
41390	31255-SG-50	8660	1	Half	549.41

Example 2: Provider bills bilateral procedure on one line with 2 units, and no other surgeries – it’s150% of ASC rate (that’s the same as full and half)

DOS	Code	Billed	**Units**	Price At ASC rate	Priced
41390	31255-SG-50	8660	**2**	**150%**	(1098.81 x 150%)

Example 3: Provider bills bilateral procedures on separate lines for one unit each and there are no other surgeries. Full for highest paying, half for all others. Nothing is reduced more than once. NOT 150% of any code

DOS	Code	Billed	Units	Price At ASC rate	Priced
4/26/2013	31255-SG-50	8660.00	1	Full	1098.81
4/26/2013	30140-SG-50	3566.00	1	Half	487.60
4/26/2013	30520-SG-50	3311.00	1	Half	549.41
4/26/2013	31288-SG-50	8660.00	1	Half	549.41
4/26/2013	31267-SG-50	8660.00	1	Half	487.86

Example 4: Provider bills bilateral procedures on one line with 2 units plus other surgery. Full for highest and half for all others. If the bilateral procedure is the highest paying, then it’s 150% ASC on that line since there are 2 units. If it’s not the highest paying, then it’s 150% of ASC on that 2 unit line.

DOS	Code	Billed	Units	Price At ASC rate	Priced
4/26/2013	31255-SG-50	8660.00	**2**	150%	**(1098.81 x 150%)**
4/26/2013	30520-SG-59	3311.00	1	50%	487.86
4/26/2013	31288-50-59	8660.00	**2**	150%/2	824.11
4/26/2013	31267-50-59	8660.00	1	50%	549.41
4/26/2013	30140-50-59	8660.00	1	50%	487.86

Covered ASC Facility services

The distinction between covered and non-covered ASC facility services is important, since the facility payment rate includes only the covered ASC facility services. *This means that we do not make additional payment for these services*, *as* they *are part of the rate for the surgery.*

Examples of covered ASC facility services include:

- Nursing services, technical personnel services and other related services

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	• The patient's use of the ASC's facilities • Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances • Equipment (**Example:** OR microscope) • Diagnostic or therapeutic items and services (Examples: ECG, EKG, EEG, x-rays) • Administrative, recordkeeping and housekeeping items and services • Blood, blood plasma, platelets, etc. • Materials for anesthesia Since there is no uniformity among ASC's as to what items and services they include in their facility fee or charge, the Medicare definition of covered facility services is both inclusive and exclusive. The definition specifies what are **not** facility services and what **are** facility services. Generally, facility services are items and services provided in connection with listed covered procedures if provided in a hospital operating suite or hospital outpatient department. (Source: CAR3 2265.2)
Intraocular lenses (IOLs)	**Effective for Q1003:** dates of services **on and after February 27, 2006 through February 26, 2011.** Price at $50.00 for insertion of New Technology Intraocular Lenses (NTIOL) category 3 when billing HCPCS Q1003 - Q1005 along with HCPCS codes 66982, 66983, 66984, 66985, or 66986. **Q1003 may not be paid after date of service 2/26/11.** The following V codes for IOLs are not separately payable in an ASC: Other Intraocular Lens (codes V2630 - V2632) are inclusive to the ACS surgery code and are denied.
Non-ASC Facility services	Part B covers and pays for services provided in an ASC that are not ASC Facility services, and not included in the ASC group payment rate. In addition, an ASC may be part of a medical complex that includes other entities, such as an independent laboratory, supplier of durable medical equipment, or physician's office, which are covered as separate entities under Part B. Examples of items or services that are not part of the ASC group rate and may be paid separately include: • Physician's services (including anesthesiology) • The sale, lease or rental of durable medical equipment to ASC patients for use in their homes • Prosthetic devices, except intraocular lenses (IOLs). See above for handling of IOLs. • Ambulance service • Leg, arm, back and neck braces • Artificial legs, arms, and eyes • Services provided by an independent laboratory. (Source: CAR3 2265.3)
Implants	Some Implants and implantable materials are covered. Look up the codes to determine if the items are implants. The provider should not be billing using **99070** but if they do and an itemized bill is attached, review it to determine if the items are implants including screws and anchors. **99070** – if the billed amount is $300 or more, call the provider and find out if it is an implant. If it is, have them send the invoice and tell them to bill the correct "L" code.

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NOTE: Effective 2010 DOS – most C codes for implant devices are not separately payable.
Follow the steps in the table below when pricing claims for implants.
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Is there a Medicare EOB attached to the claim?
· If yes, use the Medicare rates to price the code.
· If no, go to step 2.</td></tr>
<tr><td>2</td><td>If the provider reported a C-code for implants, and provided a manufactures cost invoice, price at the lesser of billed or the invoice plus 15%.</td></tr>
<tr><td>3</td><td>If it is not a ‘C’ code, request a copy of the invoice and price at the lesser of billed or the invoice rate plus 15%. If no invoice is available, go to Step 4.</td></tr>
<tr><td>4</td><td>Price the procedure at the negotiated rate. If there is no negotiated rate, and no invoice is provided call the provider and request an invoice.</td></tr>
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<tr>
<td>Additional Note</td>
<td>
Note: If there is an invoice attached to the claim, the provider may be paid more than the invoice amount, but not more than billed charges.
Special Instructions for specific Area’s. If the Area already said NO (example Aberdeen) don’t bother calling the SU. Otherwise you can call and if the Service Unit approves it, pay it at billed. That extra 15% added to the cost of the item should be covering the tax and shipping.
If there are multiple items billed on the same invoice that aren’t for the claim we cannot pay the tax and shipping.
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