



Chapter 10

Medicaid Provider Manual

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10.1 GENERAL DESCRIPTION

Durable Medical Equipment, Prosthetic and Orthotic Devices and Medical Supplies (DMEPOS) include medically necessary equipment/appliances/items provided either through purchase or rental and prescribed by a physician for the maximum reduction of medical disability and for the restoration or maximum improvement in the patient's functional level

10.1.1 A DME may be provided if it meets the following

- Ordered by the attending physician for medical care of a patient, and
- Is medically necessary for the treatment of a medical condition, and
- Is necessary to assist the client in meeting or improving activities of daily living,
- Suitable for use in the client's place of residence.

All adequate, less expensive alternatives must be considered, and services and materials provided must conform to the currently accepted community standards of the profession involved. DHS retains ultimate authority to review and determine what is considered to be medically necessary and appropriate for payment for Medicaid purposes.

10.2 AMOUNT, DURATION AND SCOPE

a) DMEPOS

- DMEPOS must be medically necessary.
- Applicable DMEPOS must be prescribed by a physician
- DMEPOS must be identified by specific HCPCS Level II and Level III codes. HCPCS Level II codes are national alpha numeric codes published and updated annually by the Centers for Medicare and Medicaid Services (CMS) formerly known as HCFA.
- HCPCS Level III codes are alpha numeric codes that have been assigned by Hawaii Medicaid DHS plans to comply with the HIPAA (Health Insurance Portability and Accountability Act) standard code sets.

b) DME

- DME includes but is not limited to wheelchairs, walkers, canes, crutches and hospital beds.
- DME may be new or used, and either purchased or rented. If used equipment is provided, then it must be billed as used (UE) not new (NU).
- Unless otherwise specified, when DME is rented, rental ceases when the allowable purchase price is reached. At the end of the rental period the recipient will be in possession of equipment that was new at the beginning of the rental period., If used equipment was provided at the beginning of the rental period and the allowable purchase price has been reached, new equipment will be switched out.
- The rental price of rent to purchase DME is based on the price of a new piece of equipment. Therefore, DME distributed as rent to purchase should begin as a new item or can be a used item to be replaced with a new item when the purchase price is met.
- DME generally NOT purchased when used in the home setting are:
 - 1) Oxygen systems including concentrators
 - 2) Apnea monitors
 - 3) Air-fluidized beds
 - 4) Ventilators
- Repairs of DME can only be authorized and reimbursed if the DME is owned by the client. (Repairs of DME owned by facilities, care homes, foster homes, another person, etc. are not covered).

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- Serial numbers on DME (if applicable--hospital beds and wheelchairs) should be submitted with requests for purchase and repairs.

c) Prosthetic and Orthotic Devices

Prosthetic devices include but are not limited to prosthetic eyes, implanted breast prosthesis, artificial limbs, conventional and orthopedic shoes when at least one is attached to a brace or a prosthesis. Orthotic devices include but are not limited to braces and trusses.

- Prosthetic and orthotic devices are almost always purchased new and not rented.
- Medical justification must be provided by the physician and authorization obtained from the Department for certain prosthetic and orthotic devices. Please see Appendix 6 for clarification.

d) Medical Supplies

- Medical supplies are usually disposable items used in the treatment of a medical condition. They include but are not limited to syringes, needles, IV administration sets, urinary catheters, ostomy products and surgical dressings.

1) Ostomy supplies must be requested by a physician's prescription. Providers are encouraged to advise Medicaid clients to obtain ostomy supplies from a single provider. Providers are also encouraged to obtain a patient certification statement, signed by the patient attesting that he/she has not received ostomy products from other suppliers during the same period that he/she is asking for supplies. This will ensure that the provider will not be denied payment when the patient gives false information and receives more than the maximum supplies by using multiple ostomy providers. This certification should be kept in the ostomy provider's files. A blank certification form can be found in Appendix 6.

- Medical supplies are purchased new and not rented.

10.3 EXCLUSIONS

a) The following items are not covered. However, this is not a complete list. Please refer to the Appendix 6 for a more complete list:

- Items not primarily medical in nature
- Items of unproven benefit, experimental items, items not approved by the Food and Drug Administration for the intended use, and/or items that cannot safely be used by the patient
- Books
- Air Conditioners
- Television sets
- Massagers
- Household items and furnishings including standard, orthopedic or water beds
- Fans
- Air purifiers
- Computers
- Telephones
- Toothbrushes (standard and mechanical), water cleansing devices, toothpaste, denture cleaners, and mouth washes
- Baby oil and powder
- Sanitary napkins, unbelted undergarments (pads, shields, guards and liners), belted underpants
- Health food and food supplements
- Non-medicated shampoos
- Soaps including medicated soaps
- Lip balm
- Band aides
- Prepared food formula except when medically necessary for nutrition due to in-born metabolic abnormalities, abnormalities of digestion or absorption, or when persons are being fed by nasogastric, gastrostomy or jejunostomy tubes. The exceptions must be authorized.

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- Bowel and bladder incontinence supplies other than diapers, underpads, gloves and catheters

b) Other items not covered are:

- DMEPOS provided during an inpatient acute hospitalization are covered in the hospital's reimbursement rate.
- DMEPOS provided during surgical procedures performed in the Outpatient Hospital and Facility-Based or freestanding Ambulatory Surgical Center (ASC) are not covered unless the items are not part of the ASC group rate.
- DMEPOS provided during a diagnostic service when the supply is part of the diagnostic service are not covered. Examples are butterfly needles used to inject contrast material for intravenous pyelograms, syringes and needles used to obtain blood samples.
- Standard emergency room supplies and equipment are considered an integral part of the emergency room service and are not separately covered. Examples are blood pressure monitoring devices, nebulizers, sheets, underpads, diapers, Gomco machines, sutures, scissors, oximeters, bedpans, thermometers, etc.
- Coverage of supplies associated with procedures are generally included in the procedure and not separately covered. Examples are clean catch kits when urinalysis and/or cultures are done, electrodes when ECGs are done.
- Usage of updraft, nebulizer and oxygen are respiratory services and should not be coded as DMEPOS, but as a respiratory service.
- Standard DME and medical supplies that are included in the Prospective Payment System (PPS) payment for Acute Waitlisted Long Term Care Level of Care and for Nursing Facilities are not covered.
- Medical supplies used during an office/outpatient visit for the administration of vaccines or in obtaining a blood or urine sample. Examples include syringes, needles, alcohol swabs, and sterile/non-sterile gloves.

10.4 LIMITATIONS

The following are limitations to the provision of DMEPOS that apply to the various health care settings.

10.4.1 Outpatient Hospital Facilities

- a) Items not included in the ASC group rate such as intra-ocular lenses and cochlear implants can be billed. Items not included in the ASC group rate must be itemized with the appropriate HCPCS code and described.
- b) Certain non-standard supplies that are unique to the individual patient's care are covered. They must be separately itemized with the appropriate HCPCS code. Examples are IV tubing intracatheters, gastric tubes and blood administration sets.

10.4.2 Acute Waitlisted Long-Term Care (LTC) Level of Care and Nursing Facilities

- a) See Appendix 1 and Chapter 12 "Long-Term Care" for listing of DME and medical supplies that are separately covered.
- b) Customized prosthetic/orthotic devices are covered with authorization.

10.4.3 Free-Standing Ambulatory Surgical Centers (ASC)

Items not included in the ASC group rate such as intra-ocular lenses and cochlear implants can be billed. Items not included in the ASC group rate must be itemized with the appropriate HCPCS code and medical justification.

10.4.4 Physicians and Other Providers of Professional Medical Services

Supplies used in surgical procedures performed in the office setting should not be separately itemized. They should be coded as a "surgical tray." A4550 is the code for a medium surgical tray; the CPT-4 surgical code followed by a "52" or "XB" modifier is used for a small or large trays, respectively. (Example: 58120-XB is the code for the supplies/surgical tray for a dilatation and curettage). See Section 6.16.2.7.

10.4.5 Home Supplies

Generally, DMEPOS are intended for a patient's use in his/her home. DMEPOS not covered in the home are those items not approved by the Food and Drug Administration (FDA) for use in the home setting or not appropriate for use in the home setting.

10.5 AUTHORIZATION

Specific Authorization Requirements for DMEPOS items include the following items. For specific guidelines, refer to Appendix 6.

10.5.1 Ostomy Supplies

Prior authorization for ostomy supplies is not required unless the amount of ostomy supplies exceeds the maximum units. If the maximum units are exceeded, prior authorization with justification for the additional units must be provided and authorization must be obtained from the Department. Refer to Appendix 6 for specific guidelines and code limitations.

10.5.2 Prepared Food Formula

a) Prepared food formula is covered without authorization when necessary for nutrition due to inborn metabolic abnormalities, abnormalities of digestion or absorption, or when persons are being fed by nasogastric, gastrostomy or jejunostomy tube.

b) Elemental alimentation products (e.g., Vivonex T.E.N. Advera) are covered when patients meet all of the following criteria:

- Extreme weight loss of 20 pounds or 10% of their normal body weight over a short period of time; **and**
- Serious diarrhea/malabsorption problems; **and**
- Otherwise would require total parental nutrition; **and**
- Has one of the diagnoses (shown on each prescription): AIDS/ARC Syndrome, chronic pancreatitis, inflammatory bowel disease, Crohn's Disease, short bowel syndrome.

10.5.3 Incontinence Supplies –Diapers, Underpads, and Gloves

The limits set for incontinence supplies cannot be exceeded through the prior authorization process. Thus, supplies exceeding the limits will not be reimbursed. Although the MQD is setting maximum limits, the quantity provided by Medicaid must still be appropriate and justified by the medical needs of the Medicaid client. Clients that exceed these limits are encouraged to seek coverage of these items through the appropriate waiver program, if eligible. Medicaid will recoup payments in those instances where quantities provided are not necessary. Gloves are for the use of the family caregivers of adults and older children. Employed/contracted caregivers must supply their own gloves.

a) Specific coding and billing requirements apply. Refer to the specific guidelines in Appendix 6.

b) Diapers for clients under the age of 3 yrs are not covered.

10.5.4 DME and Medical Supplies for Patients Being Discharged from an Acute Care Hospital or Nursing Facility (NF) to a Home/Care Home

a) To facilitate the prompt discharge from an acute care hospital or a NF, certain DME and medical supplies can be provided for up to sixty (60) calendar days when provided to a patient upon discharge from an acute care hospital or a NF to his/her home or other noninstitutional setting.

b) A conditional authorization can be given when a physician’s signature is not available, however a medical authorization form must be submitted within 30 days after discharge.

c) If a conditional authorization was not obtained, a Request for Medical Authorization 1144 form listing the item(s) and code(s), signed and dated by the physician must be submitted within ten (10) working days after discharge. Medical justification of the patient’s need for the item(s), the name of the hospital or NF, and the date of discharge must be provided.

d) If the item(s) are needed more than 60 days after discharge, a new authorization form must be submitted.

e) The special authorization process applies only to the following DME:

Item	Comments
Hospital bed	Rental toward purchase
Wheelchair*	Rental toward purchase

10.5.5 Oxygen for Home Use and for Use in Nursing Facilities

a) Prior authorization is not required for oxygen rental

b) Medicare criteria for the need for oxygen for adults must be followed.

c) Oxygen saturations for children must be 95% or lower.

- d)** Oxygen must be prescribed by a physician.
- e)** Regular physician assessments are required for recipients on oxygen
- f)** Portable oxygen is **not** for use within the home as a substitute for an oxygen concentrator or stationary oxygen
- g)** Oxygen systems including concentrators and portable oxygen are rentals. The MQD will follow Medicare's thirty-six (36) month rental payment policy. Rental payments from Medicaid will stop at 36 months and will not resume until the five (5) year equipment replacement occurs
- h)** The MQD will follow Medicare's maintenance policy and will reimburse the maintenance fee (K0740) every six (6) months for the two (2) years after the 36 month rental coverage. K0740 may not begin until the forty second (42nd) month of the rental period.
- i)** The MQD will reimburse oxygen fills at one (1) per month throughout the entire five (5) year period. This is a deviation from Medicare's policy.
- j)** Portable oxygen should be limited to E-tanks only with a maximum of four (4) fills per month and a maximum of four (4) tanks in the client's home at any given time. The portable oxygen fill codes can only be billed as one (1) unit per month regardless of the number of fills provided.
- k)** Rentals toward purchase and guidelines for Medicare capped rentals do not apply for oxygen.
- l)** All supplies associated with the administration of oxygen are included in the global rental allowance for oxygen and are not separately reimbursable.
- m)** Oxygen is not covered in the following situations:
- For use on an "as needed" basis
 - Angina pectoris without hypoxemia
 - Breathlessness without cor pulmonale or evidence of hypoxemia
 - Peripheral vascular disease from desaturation in one or more extremities
 - Terminal illnesses without hypoxemia and/or pulmonary involvement

10.5.6 Wheelchairs

- a)** The rental and/or purchase of standard and companion wheelchairs are covered if medically necessary and authorized. When wheelchairs are rented, all maintenance and repair costs are included in the rental charge.
- b)** Wheelchair evaluations must be submitted with requests for customized wheelchairs, specialized seating systems, and power-operated wheelchairs and scooters. Authoriza-

tions will be given if the equipment is medically necessary and appropriate for the needs of the patient.

- The evaluations for power-operated wheelchairs and scooters must include an assessment of the patient's ability to safely and independently operate the vehicle. Medicaid uses Medicare's criteria for power-operated wheelchair assessments. The most current evaluation criteria is available upon request.
- All wheelchair evaluations must detail the specifications the wheelchair must have to meet the patient's needs.

c) Authorizations for wheelchair rental/purchase must indicate:

- Type of wheelchair (powered, standard, companion, heavy or light weight)
- Brand name and model
- Serial number
- Whether the wheelchair is to be rented or purchased; if purchased, the justification for purchase
- Patient's diagnosis
- Justification for the wheelchair
- If applicable, the wheelchair evaluation should be attached
- Prescribing physician's name, signature and date of signature

d) The approval period for the vendor to provide a customized chair is limited to six months.

10.5.7 Wheelchair Repairs

Authorization for repairs can be faxed in as an urgent request for a wheelchair (power-operated, customized or standard) that is the patient's primary mode of accessing services and community supports.

a) A loaner wheelchair may be provided to the patient while wheelchair repairs are being performed. If repairs are anticipated to take longer than two (2) weeks, an authorization for rental of a wheelchair may be submitted for up to thirty (30) days.

b) Requests for authorization for wheelchair repairs must indicate the following:

- Type of wheelchair (powered, standard, companion, heavy or lightweight, etc.) and brand name (if known).

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- Serial number of the wheelchair; if the serial number cannot be found on the wheelchair, the reason must be given. Example: wheelchair is 7 years old and the numbers cannot be read.
- Description of the repair, including appropriate HCPCS codes and itemized charges for parts and labor.
- Patient's diagnosis.
- Prescribing physician's name, signature and date of signature.

10.5.8 Augmentive/Augmentative Communication Devices (ACD)

All purchases, rentals and repairs of ACDs need prior authorization and must be medically necessary. All authorization for repairs of ACDs can be submitted as urgent.

- ACDs and replacement ACDs should be coded with the appropriate HCPCS code. The same code used on the authorization form must be used when the claim for service is submitted.
- The services of a skilled technician to perform a repair of an ACD should be coded with the appropriate HCPCS code. The same code used on the authorization form must be used when the claim for service is submitted.
- The parts involved in the repair of an ACD performed by a skilled technician should be coded with the appropriate HCPCS code. The same code used on the authorization form must be used when the claim for service is submitted.
- The authorization form must be completed and include the signature of the licensed physician and supplier information from a Medicaid approved vendor. Please reference Appendix 4 of the Medicaid Provider Manual for more information on completing the authorization form.
- Adequate justification for the medical necessity of the ACD, replacement or repair must be included on the authorization form. Adequate justification for the medical necessity of the ACD purchase or repair request will generally include:
 - a diagnosis or other information supporting the new/continued medical need for the ACD,
 - why any existing ACD is no longer appropriate (i.e., if non-functional, a statement of what caused the dysfunction, and why it cannot be repaired or why replacement would be more cost-effective than repairs),
 - information showing the appropriateness of the ACD model requested,
 - the date and source of funding for the purchase of the ACD in issue, and

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- identification of the nature of the ACD problem requiring repairs (i.e., what is not working that needs repair).

- Where such information is not alone sufficient to show medical necessity, additional information should be provided to support the requested repair. If a provider does not know the reason an ACD is inoperable, or whether it is economically repairable, the provider may submit an ACD repair request on an authorization form so the problem can be diagnosed and a repair estimate obtained. If it is not economical to repair an ACD in light of the estimated costs for a new ACD, the provider can submit a request for purchase of a new ACD pursuant to the procedures outlined in this section. If the request is for the same ACD model as previously approved by Medicaid, this should be noted on the authorization form.

- If the request is for a first-time purchase of an ACD, or for a different make or model of ACD than previously approved by Medicaid, then a signed speech pathologist's report and evaluation should be attached to the authorization form to show why the ACD model requested is the most appropriate and least costly in light of the client's condition. This generally requires that there be no equally effective or less costly treatment available.
- The cost of repair, purchase or rental must also be included. If the physician or supplier signing the authorization form provides non-Medicaid patients with rental ACDs (or other durable medical equipment) free of charge, then there should be no charge to Medicaid for the rental.

10.5.8.1 Urgent requests for ACDs

Where an ACD is not working and there is no back-up device, an "Urgent" request may be filed.

- Urgent requests for ACD purchases/rentals/repairs will be accepted by fax to the Fiscal Agent. The completed authorization form must include "Urgent" written on the request and information which verifies that a Medicaid client has an urgent need for the purchase or rental of an ACD or ACD repair (i.e. the ACD is not working and there is no back up ACD device). Refer to Appendix 1 for the Fiscal Agent's fax number.
- A decision (approval, denial or deferral) on an urgent request will be made and faxed or the information conveyed via telephone, to the appropriate provider within two (2) working days of receipt of an "Urgent" request (unless the Fiscal Agent reasonably determines that the request is not "Urgent").
- If there is an approval, it will be sent to the provider (vendor). If there is a denial or deferral, the response will be sent to the client and the client's Attending Physician (the physician indicated on the authorization form).

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- DHS may change a request for an ACD to a less expensive make or model when the basic functions of the desired equipment are met. If this occurs, the response will be deemed to be a partial denial and notice of appeal rights will be provided to the client and the client's attending physician. Medicaid funding may also be denied if the ACD is available from another funding source at the time the claim is filed.

10.5.8.2 Non-urgent requests for ACDs

- A decision (approval, denial or deferral) on non-urgent requests for purchase or rental of an ACD or ACD repair will be made and returned to the appropriate provider within twenty one (21) days of receipt. If there is an approval, it will be sent to the provider (vendor). If there is a denial or deferral, the response will be sent to the client and the client's Attending Physician (the physician indicated on the authorization form).
- DHS may change a request for an ACD to a less expensive make or model when the basic functions of the desired equipment are met. If this occurs, the response will be deemed to be a partial denial and notice of appeal rights will be provided to the client and the client's attending physician. Medicaid funding may also be denied if the ACD is available from another funding source at the time the claim is filed.

10.5.8.3 Deferrals for ACDs

If the request provides insufficient information to determine authorization, within two days of an "Urgent" request and within 21 days of a non-urgent request, the request shall be deemed deferred, and (a) the client and (b) either the provider (vendor) or the Attending Physician, depending on the nature of information needed, shall be sent notice of the deferral, identification of the additional information needed to process the request and where to send the additional information. If the additional requested information is provided within 21 days, a response shall be provided within two working days for Urgent requests, and within 21 days for non-urgent requests, from receipt of the additional information. If the additional information is not provided within 21 days of the Fiscal Agent's request, then the failure to submit the information requested in the deferral will be deemed a denial and a notice of denial and appeal rights will be sent to the client and the client's Attending Physician. If an authorization form received is missing any of the following information, the authorization form will be deemed "incomplete" and will be returned to the sender, without invoking any of the other procedures referred to here:

- a) The identity and ID number of the client,
- b) The attending physician's signature, date, and provider number,
- c) The vendor's name, provider number and signature,

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- d) The diagnostic code or description and
- e) The procedure code.

In the event the missing information is supplied, the newly completed authorization form will be processed in accordance with the procedures in this memo, measured from the date the completed authorization form is received by the Fiscal Agent.

10.6 URGENTLY NEEDED DMEPOS

- a)** If a patient has an urgent medical need for a service, DMEPOS, DME repair, etc., authorizations by fax or a conditional authorization can be given.
- b)** The turn-around time for urgent faxed requests for authorization is two (2) working days.
- c)** The patient's urgent need must be clearly stated on the authorization form.

10.7 REIMBURSEMENT OF DMEPOS

a) Payments for DMEPOS are made at the rate set by the Department and cannot exceed Medicare's payment rate and billed charges.

b) DMEPOS should be coded with the appropriate HCPCS codes. The HCPCS codes for miscellaneous supplies should only be used when an appropriate HCPCS is not available. Generally, items can be defined more precisely with HCPCS Level II and Level III codes rather than with Level I (CPT-4) codes. National Drug Code (NDC) numbers should never be used in the coding of DMEPOS.

c) Applicable modifiers are:

- **NU** New Equipment (purchase)
- **UE** Used Durable Medical Equipment (purchase)
- **MS** Six (6) month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty applicable for Medicare capped rentals
- **NR** New when rented (used when equipment was new when rented and subsequently purchased)
- **RR** Rental

d) If a DME modifier is omitted from a claim, it is assumed that the item is rented. Providers who omit modifiers and are reimbursed for rentals when new or purchase items were dispensed must contact the Medicaid fiscal agent so that appropriate adjustments can be made.

e) When the cumulative rental payments for DME meet the Medicaid allowable for the purchase of the DME, rental payments cease and the DME is considered purchased.

f) On a case by case basis, Medicare's capped rental methodology may be used. Examples of items that may be subject to capped rentals are infusion pumps and enteral pumps that are anticipated to be used on a long-term basis.

g) Medicaid follows Medicare convention in the coding of enteral and parenteral nutrition as DME. Specific HCPCS Level II and Level III have been established for the coding of these items. Conventional modifiers (NU, RR, UE, MS) are not used with all enteral and parenteral items (see Home Pharmacy Services Guidelines in Appendix 6 for specifics on the coding and reimbursement for enteral and parenteral nutrition and associated supplies).

10.7.1 Coding for Prosthetic and Orthotic Devices and Medical Supplies

- a)** Since these are usually purchased new and customized, the DME modifiers UE, MS, RR, and NR are generally not applicable.
- b)** Claims processing is expedited when authorizations for prosthetic and orthotic device include applicable modifiers such as LT (left), RT (right) and claims are submitted with the approved codes and modifiers.
- c)** If no modifier is indicated on the authorization form and/or submitted on the claim, the claim will be processed for the purchase of new prosthetic/orthotic device/medical supply.

10.8 BILLING FOR DURABLE MEDICAL EQUIPMENT PROSTHETIC AND ORTHOTIC DEVICES AND MEDICAL SUPPLIES (DMEPOS)

10.8.1 Coverage Information

- a) For inpatients, DMEPOS are not separately payable to the facility. They are included in the reimbursement rate for the facility. DMEPOS to be used by the patient in the home setting are not payable prior to discharge.
- b) For outpatients, daily rental of infusion pumps medically necessary for infusion is payable. Also, certain DME that is for the patient's use in the home are covered. (Example: crutches dispensed from the emergency room). Appropriate revenue codes and HCPCS must be submitted for all DME provided by the outpatient hospital.
- c) For outpatients, non-implanted and customized prosthetic devices and customized orthotic devices may be payable. Appropriate revenue codes and HCPCS must be submitted for all DME provided by the outpatient hospital.
- d) See Appendix 6 for a listing of supplies that can be billed by the outpatient hospital.

10.8.2 Coding and Claim Submittal

- a) DMEPOS appropriately provided by the outpatient hospital must be billed on the UB-04 claim form.
- b) Appropriate revenue codes must be used. HCPCS code(s) must be used to identify the item(s).
- c) Medicaid will only cover prosthetics up to a Functional Classification level two (2) (community ambulatory). As a result the following HCPCS codes will not be covered:

L5980	L5976	L5722 - L5780
L5979	L5614	L5822 – L5840
L5981	L5814	L5846 – L5848
L5610	L5613	L5400 – L5640
L5987		

If any of the above codes are needed as replacements/repair to already existing lower limb prosthetics, the request for prior authorization will be reviewed on a case by case basis.

10.8.3 Shipping costs for custom items

Medicaid will reimburse the supplier for shipping costs on custom items only, and only if clearly separately charged by the item's distributor/manufacturer. Reimbursement will be based on the most cost effective method of shipment. Express mail, second day air, priority mail, etc., will not be covered. On the 1144 please designate shipping costs using E1399 HX. If the actual cost of shipping is known ahead of time please indicate with MSRP. If the cost of shipping is not known at the time the 1144 is submitted, use E1399 HX and attach the invoice showing actual shipping costs to the claim. Reimbursement for shipping is only allowed if the custom item is obtained from and Out-of – State distributor/manufacturer. No reimbursement for inter-island shipping is allowed. Likewise cost for ground, air travel, or gasoline/mileage incurred when the supplier delivers an item will not be reimbursed.