

HOW TO SUBMIT OWCP-04 BILLS TO THE FEDERAL BLACK LUNG PROGRAM

**OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF COAL MINE WORKERS' COMPENSATION**

The following services should be billed on the OWCP-04 Form:

General Hospital

Inpatient Hospice

Nursing Home

Rehabilitation Centers

BILLS SHOULD BE SENT TO:

US Department of Labor
P O Box 8302
London, KY 40742-8302

HOW WE WILL PROCESS YOUR BILL:

Bills will be processed by Affiliated Computer Services (ACS), the Fiscal Agent for the Office of Worker's Compensation Programs, which includes the Federal Black Lung Program. The ACS facility in London, Kentucky will receive and scan your bill. If the bill must be returned without processing, you will be notified with a Return To Provider letter giving the reason. The bill should be resubmitted with the necessary corrections to London.

After the bill is scanned and entered into the processing system, it will be reviewed to determine if it is payable under the Federal Black Lung Program. You will then be issued a Remittance Voucher (RV), approximately one week from date of payment, describing the payment made, the reason for denial, and the reason why full payment was not approved, if applicable. The RV will be mailed to you from London, Kentucky. At approximately the same time, an electronic funds transfer of the approved amount will be made to your financial institution.

Bills that exceed certain amounts will be suspended briefly for review, and all bills are subject to audit.

ELECTRONIC SERVICES

ACS is pleased to offer enhanced services on its web portal (<http://owcp.dol.acs-inc.com/portal/main.do>). To take advantage of these services, and others that may be added in the future, you will need to know the patient's information, including the claim number and the Medical Benefits Identification Card number, which is a 10-digit number on the reverse side of the card that every eligible beneficiary receives. The claim number is the patient's Social Security number, which does not appear on the card for security reasons.

REMITTANCE VOUCHER RETRIEVAL

Retrieving DOL remittance vouchers via electronic media offers the advantage of speed in retrieval. Providers may access reports online as well as receive paper copies of the remittance vouchers.

The Electronic Data Interchange (EDI) Support Unit assists providers who have questions about electronic bill submission. ACS's EDI Support Unit is available to all providers Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time at 800-987-6717.

EDI Support will:

- Provide information on available services.
- Assist in enrolling users for report retrieval.
- Provide technical assistance on retrieval difficulties.

CLAIMANT ELIGIBILITY INQUIRY

Because the Federal Black Lung Program is limited to coverage of treatment for the patient's pneumoconiosis and related illnesses, the web portal also allows you to help determine if a procedure or diagnosis is covered, or if the patient was covered on a specific date of service.

AUTHORIZATION REQUIREMENTS

Lung transplants may be covered in some cases, but are subject to strict requirements and always require pre-approval by DCMWC. The appropriate District Office should be contacted.

If your facility provides home nursing services, pulmonary rehabilitation, or durable medical equipment, these services require prior authorization in the form of a Certificate of Medical Necessity (CM-893.) Because the Federal Black Lung Program has unique requirements and standards for authorization, the CM-893 is required. Also, these services should be billed on the OWCP-1500, not on the OWCP-04.

BILLING REQUIREMENTS

1. **All bills must contain the 9-digit Social Security number of your patient or client and your 9-digit Federal Black Lung provider number. Your patient's SSN is not shown on the Black Lung Identification Card for privacy reasons.**
2. Both Inpatient and Outpatient services will use the OWCP-04 form for billing since pricing will be based on Revenue Center Codes.
3. Laboratory, x-ray, physical therapy, and clinical tests, such as ECGs, etc. must be identified with the correct CPT code.
3. Use the ICD-9 coding booklet to identify proper surgery codes.
4. Inpatient bills must include the Medicare number in block 51 of the OWCP-04 form.
5. It is recommended that the NPI number is included in block 56 on the OWCP-04 form.
6. Please refer to the attached OWCP-04 list and the required fields for additional instructions.

Black Lung District Office List

JOHNSTOWN, PENNSYLVANIA

**U.S. Department of Labor
ESA/OWCP/DCMWC
319 Washington Street, Second Floor
Johnstown, Pennsylvania 15901
Commercial: (814) 533-4323
Toll-Free: (800) 347-3754**

Virginia

Thirty-seven counties in Pennsylvania: Adams, Bedford, Berks, Blair, Bucks, Cambria, Cameron, Centre, Chester, Clearfield, Clinton, Cumberland, Dauphin, Delaware, Elk, Franklin, Fulton, Huntingdon, Indiana, Jefferson, Juniata, Lancaster, Lebanon, Lycoming, McKean, Mifflin, Montgomery, Montour, Northumberland, Perry, Philadelphia, Potter, Somerset, Snyder, Tioga, Union, and York.

GREENSBURG, PENNSYLVANIA

**U.S. Department of Labor
ESA/OWCP/DCMWC
1225 South Main Street, Suite 405
Greensburg, Pennsylvania 15601
Commercial: (724) 836-7230
Toll-Free: (800) 347-3753**

Maryland

Sixteen counties in Pennsylvania: Allegheny, Armstrong, Beaver, Butler, Clarion, Crawford, Erie, Fayette, Forest, Greene, Lawrence, Mercer, Venango, Warren, Washington, and Westmoreland

WILKES-BARRE, PENNSYLVANIA

**U.S. Department of Labor
ESA/OWCP/DCMWC
100 N. Wilkes-Barre Blvd., Room 300 A
Wilkes-Barre, PA 18702
Commercial: (570) 826- 6457
Toll-Free: (800) 347-3755**

Connecticut, Delaware, District of Columbia, Maine, Massachusetts, New Hampshire, New Jersey, New York, Puerto Rico, Rhode Island, Vermont

The following fourteen counties in Pennsylvania: Bradford, Carbon, Columbia, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Wayne, and Wyoming.

CHARLESTON, WEST VIRGINIA

**U.S. Department of Labor
ESA/OWCP/DCMWC
Charleston Federal Center - Suite 110
500 Quarrier Street
Charleston, West Virginia 25301
Commercial: (304) 347-7100
Toll-Free (800) 347-3749**

Fifteen counties in West Virginia including Boone, Cabell, Fayette, Kanawha, Lincoln, Logan, McDowell, Mercer, Mingo, Monroe, Putnam, Raleigh, Summers, Wayne and Wyoming.

PARKERSBURG, WEST VIRGINIA

**U.S. Department of Labor
ESA/OWCP/DCMWC, Suite 3116
425 Juliana Street
Parkersburg, West Virginia 26101
Commercial: (304) 420-6385
Toll-Free: (800) 347-3751**

All counties in West Virginia not under the jurisdiction of the Charleston Office.

PIKEVILLE, KENTUCKY

**U.S. Department of Labor
ESA/OWCP/DCMWC
164 Main Street, Suite 508
Pikeville, Kentucky 41501
Commercial: (606) 432-0116
Toll-Free: (800) 366-4599**

All claims from Kentucky. This office is part of the Jacksonville Region

MOUNT STERLING, KENTUCKY

**U.S. Department of Labor
ESA/OWCP/DCMWC
402 Campbell Way
Mount Sterling, Kentucky 40353
Commercial: (859) 498-9700
Toll-Free: (800) 366-4628**

Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee. This office is part of the Jacksonville Region.

COLUMBUS, OHIO

**U.S. Department of Labor
ESA/OWCP/DCMWC
1160 Dublin Road Suite 300
Columbus, Ohio 43215
Commercial: (614) 469-5227
Toll-Free: (800) 347-3771**

Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.

DENVER, COLORADO

**U.S. Department of Labor-Black Lung
ESA/OWCP/DCMWC
1999 Broadway, Suite 690
P.O. Box 46550
Denver, Colorado 80201-6550
Commercial: (720) 264-3100
Toll-Free: (800) 366-4612**

Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Guam, Hawaii, Idaho, Iowa, Kansas, Louisiana, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, the North Mariana Islands, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, and Wyoming.

1		2		3a PAT. CNTL. #		4 TYPE OF BILL	
				b. MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
						7 THROUGH	

8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b				c		d	

10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ACCT STATE		30	
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31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		THROUGH		36 OCCURRENCE SPAN FROM		THROUGH		37	
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38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a							
b							
c							
d							

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
PAGE ____ OF ____		CREATION DATE		TOTALS			

50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
A		B		C		D		E		F		G	
58 INSURED'S NAME		59 P/FEL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.					
A		B		C		D		E					

63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
A		B		C	

66 DX		67		A		B		C		D		E		F		G		H		68	
A		B		C		D		E		F		G		H		I		J		K	

69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73			
74 PRINCIPAL PROCEDURE DATE		a. OTHER PROCEDURE DATE		b. OTHER PROCEDURE DATE		75		76 ATTENDING NPI		QUAL	
c. OTHER PROCEDURE DATE		d. OTHER PROCEDURE DATE		e. OTHER PROCEDURE DATE		76 LAST		77 OPERATING NPI		QUAL	
76 LAST		77 LAST		78 OTHER NPI		QUAL		79 OTHER NPI		QUAL	
78 LAST		79 LAST		80 REMARKS		81 CC a		81 CC b		81 CC c	
81 CC c		81 CC d									

OWCP-04 CLAIM ITEM	TITLE	ACTION
1	Provider Name, Address, and Telephone Number	Enter the provider's name and address as well as the telephone number.
2	Pay-to Name, address, and Secondary Identification Fields	Required when the pay-to name and address information is different than the Billing Provider information.
3 a	Patient Control Number	Enter the claimant's Patient Control Number. (Optional)
3 b	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider.
4	Type of Bill	Enter the appropriate three-digit code for the Type of Bill.
5	Federal Tax Number	Enter the Federal Tax Number
6	Statement Covers Period	Mandatory field. Inpatient: Enter the service dates in MM/DD/YY format.
7	Not Used	Reserved
8	Patient's Name	Enter the patient's last name, first name, and, if any, middle initial, along with patient ID (if different than the subscriber/insured's ID).
9	Patient's Address	Enter the claimant's address. (Optional)
10	Patient's Date of Birth	Enter the patient's date of birth in the eight-digit MM/DD/YY format. If full birth date is unknown; indicate zeros for all eight digits.
11	Patient's Sex	No Entry Required.
12	Admission Date	Enter the date the patient was admitted for inpatient care (MMDDYY).
13	Admission Hour	No Entry Required.
14	Type of Admission/Visit	Required on Inpatient bills only. Code Structure: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 6-8 Reserved for National Assignment 9 Information Not Available
15	Source of Admission	The provider enters the code indicating the source of the referral for this admission or visit. (Optional)
16	Discharge Hour	No Entry Required.

17	Patient Status	<p>This code indicates the patient's status as of the "Through" date of the billing period (FL 6). Outpatient no entry required Patient Status Codes:</p> <p>01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to another short-term general hospital for inpatient care 03 Discharged/transferred to skilled nursing facility 04 Discharged/transferred to an intermediate care facility 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution 06 Discharged/transferred to home under care of organized home health service organization 07 Left against medical advice or discontinued care</p> <p>Outpatient: No Entry Required</p>
18 - 28	Condition Codes	No Entry Required
29	Accident State	No Entry Required.
31 – 34	Occurrence Codes and Dates	Required when there is a condition code that applies to this claim. (Optional)
35 and 36	Occurrence Span Code and Dates	Required For Inpatient. The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY. (Optional)
37	(Untitled)	No Entry Required.
38	Responsible Party Name and Address	No Entry Required.
39 – 41	Value Codes and Amounts	No Entry Required.
42	Revenue Code	Mandatory Field. Enter the appropriate three-digit revenue code(s) itemizing all services and/or items furnished to the patient in your facility.
43	Revenue Description	Enter a narrative description or standard abbreviation for each revenue code included on this bill.
44	HCPCS/Rates/HIPPS Rate Codes	When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.
45	Service Date	No Entry Required for Inpatient Services.
46	Units of Service	<p>Inpatient: Enter the number of units of service and number of days for accommodations. A late discharge may not be billed as an additional day.</p> <p>Outpatient: Enter the units of service for each revenue code.</p>

47	Total Charges - Not Applicable for Electronic Billing	<p>Mandatory Field. Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges.</p> <p>Decimal Point required (999999.99)</p>
48	Non-covered Charges	No Entry Required.
49	Untitled	No Entry Required.
50 A, B, C	Payer Identification	If Medicare is the primary payer, the provider must enter Medicare” on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate.
51 A, B, C	Health Plan ID	<p>ACS Provider Number is required.</p> <p>Medicare number is required for inpatient services.</p>
52 A, B, C	Release of Information Certification Indicator	A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An “I” code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.
53 A, B, C	Assignment of Benefits Certification Indicator	No Entry Required.
54 A, B, C	Prior Payments	Situational. For all services other than inpatient hospital or SNF the provider must enter the sum of any amounts collected from the patient toward deductibles (cash and blood) and/or coinsurance on the patient (fourth/last line) of this column.
55 A, B, C	Estimated Amount Due From Patient	No Entry Required.
56	NPI	National Provider Id is recommended for Inpatient Services.
57	Other Provider ID (primary, secondary, and/or tertiary)	Situational. Use this field to report other provider identifiers as assigned by a health plan (as indicated in FL50 lines 1-3) prior to May 23, 2007.

OWCP - 04 CLAIM ITEM	TITLE	ACTION
58 A, B, C	Insured's Name	Enter the insured's last name first.
59 A, B, C	Patient's Relationship to Insured	No Entry Required.
60 A, B, C	Insured's Unique ID (Certificate/Social Security Number/HI Claim/Identification Number (HICN))	Mandatory Field. Social Security Number
61 A, B, C	Insurance Group Name	No Entry Required.
62 A, B, C	Insurance Group Number	No Entry Required.
63	Treatment Authorization Code	No Entry Required.
64	Document Control Number (DCN)	No Entry Required.
65	Employer Name	No Entry Required.
66	Diagnosis and Procedure code Qualifier (ICD Version Indicator)	Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported.
67	Principal Diagnosis Code	The hospital enters the ICD code for the principal diagnosis. The code must be the full ICD-9 diagnosis code, including all five digits where applicable.
67A - 67Q	Other Diagnoses (Other Than Principal)	Inpatient Required. The hospital enters the full ICD codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.
68	(Untitled)	Reserved
69	Admitting Diagnosis	For inpatient hospital claims the admitting diagnosis is required.
70A – 70C	Patient's Reason for Visit	Situational. Patient's Reason for Visit is required for all un-scheduled outpatient visits for outpatient bills.
71	Prospective Payment System (PPS) Code	No Entry Required.
72	External Cause of Injury (ECI) Codes	No Entry Required.
73	Untitled	No Entry Required.
74	Principal Procedure Code and Date	Situational. Required on inpatient claims when a procedure was performed. Not used on outpatient claims.
75	Untitled	No Entry Required.
76	Attending Provider Name and Identifiers (including NPI)	Required when claim contains any services other than nonscheduled transportation services.
77	Operating Provider Name and Identifiers (including	Required when a surgical procedure code is listed on this claim.

78 and 79	NPI) Other Provider Name and Identifiers (including NPI)	<p>The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.</p> <p>Provider Type Qualifier Codes/Definition/Situational Usage Notes: DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.</p> <p>ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send.</p> <p>82 - Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.</p> <p>Secondary Identifier Qualifiers: 0B - State License Number 1G - Provider UPIN Number EI - Employer's Identification Number SY - Social Security Number</p>
80	Remarks	<p>Situational. For DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's FI may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)</p>
81	Code-Code Field	Situational. To report additional codes.