

HOW TO SUBMIT OWCP-04 BILLS TO ACS

OFFICE OF WORKERS' COMPENSATION PROGRAMS DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION

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

General Hospital

Hospice

Nursing Home

Rehabilitation Centers

BILLS SHOULD BE SENT TO:

US Department of Labor
P O Box 8304
London, KY 40742-8304

ELECTRONIC REMITTANCE VOUCHER RETRIEVAL

Retrieving DOL remittance vouchers via electronic media offers the advantage of speed in retrieval. All providers, including pharmacy 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.

AUTHORIZATION REQUIREMENTS

The DEEOIC Program pays for medical services rendered for employees of the Department of Energy with radiation-related cancer and other illnesses related to radiation, Chronic Beryllium Disease, and Chronic Silicosis. Some services require prior authorization. Listed below are some of the services that require prior authorization:

◦All inpatient admissions

◦Some durable medical equipment

◦Emergency admissions within 48 hours of admission

◦All surgical procedures

◦MRIs and CT scans

◦Home health services

◦Physical therapy services - Physical therapy authorization requests must be accompanied by a physician's prescription and a treatment plan. Authorization will be given for the number of modalities to be done per day and the number of days requested.

◦Anesthesia CPT codes 01995 and 01996

Routine services such as office/clinic visits, plain x-ray films and laboratory service **do not** require prior authorization.

Please call (866) 272-2682 or fax (# TBD) to request an authorization. To request an authorization via fax, use the appropriate template included in this packet.

BILLING REQUIREMENTS

1. **All bills must contain the Division of Energy Employees Occupational Illness Compensation (DEEOIC) 9-digit case number of your patient or client and your 9-digit provider number.**
2. Laboratory, x-ray, physical therapy, and clinical test such as ECGs, etc. must be identified with the correct CPT code.
3. Facility charges for ambulatory surgical center/outpatient surgery billing must be billed using the surgical CPT code. Modifier SG should not be used.
4. **All inpatient bills will pay by Diagnosis Related Groups (DRG), which pays a percentage of hospital bills based on diagnosis, age, gender and complications. Therefore, when billing for inpatient services, the Medicare number must be included. Also it is recommended to include on all Inpatient bills the NPI Number.**
5. Please refer to the attached OWCP- 04 list and the required fields for additional instructions.

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					
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37			
38		39 CODE		VALUE CODES AMOUNT		40 CODE	
		a				41 CODE	
		b				VALUE CODES AMOUNT	
		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.		57 OTHER PRV ID		A	
A		B		C		D		E		F		G	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		A		B		C		C	
A		B		C		D		E		F		G	
66 DX		67		A		B		C		D		E	
68		F		G		H		I		J		K	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73		74		75	
74 PRINCIPAL PROCEDURE DATE		a. OTHER PROCEDURE DATE		b. OTHER PROCEDURE DATE		76 ATTENDING NPI		QUAL		77 OPERATING NPI		QUAL	
c. OTHER PROCEDURE DATE		d. OTHER PROCEDURE DATE		e. OTHER PROCEDURE DATE		LAST		FIRST		LAST		FIRST	
80 REMARKS		81 CC a		b		78 OTHER NPI		QUAL		79 OTHER NPI		QUAL	
		c		d		LAST		FIRST		LAST		FIRST	

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 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.

UB-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. Claimant's 9-digit Claimant ID
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.



**Durable Medical Equipment
Authorization Request Form**
Please fax with supporting medical documentation
800-882-6147



Effective January 3, 2005 all Prior Authorization requests must be submitted through the Web Bill Processing Portal (<http://lowcp.dol.acs-inc.com>), Medical Authorization Entry screen or faxed using the available template. Requests that are not properly coded with CPT or HCPCS codes cannot be processed.

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS) _____

Rental or Purchase and price per item _____

Duration Requested _____

Comments _____

**Please remember to send prescription from attending physician and any
supporting medical documentation for request.**

800-882-6147



**General Medical, Hospital, Radiology and Surgery
Authorization Request Form**
Please fax with supporting medical documentation
800-882-6147



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Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 _____

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS, RCC) _____

Specific body part to be treated _____

Units/Days Requested _____

Is this a second surgery on the same body part? _____

Comments _____

**Please remember to send any supporting medical documentation with request.
Please put Case File # on every page faxed.
800-882-6147**



PT and OT Authorization Request Form
Please fax with supporting medical documentation
800-882-6147



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Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 _____

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS) _____

Specific body part to be treated _____

Frequency and Duration Requested _____

Comments _____

Please remember to send prescription from attending physician and treatment plan with request for physical therapy or occupational therapy. Please put Case File # on every page faxed.
800-882-6147