How to Submit OWCP-04 Bills to DOL

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
PO 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. The 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, fax (800) 882-6147 to request 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 ID 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 THROUGH | 7

8 PATIENT NAME a | 9 PATIENT ADDRESS a

b | b | c | d | e

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

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

a

b

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE 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							
2							
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22							
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						57
B						OTHER
C						PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				
B				
C				

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

I | J | K | L | M | N | O | P | Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 | 76 ATTENDING NPI QUAL

LAST FIRST

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 77 OPERATING NPI QUAL

LAST FIRST

80 REMARKS | 81CC a | 78 OTHER NPI QUAL

b | LAST FIRST

c | 79 OTHER NPI QUAL

d | 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.
3a	**Patient Control Number**	Enter the claimant's Patient Control Number. (Optional)
3b	**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). **Not** Required for Outpatient bills.
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.

OWCP-04 CLAIM ITEM	TITLE	ACTION
17	**Patient Status**	This code indicates the patient's status as of the "Through" date of the billing period (FL 6). **Patient Status Codes:** 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 **Outpatient:** No Entry Required
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**	**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. **Outpatient:** Enter the units of service for each revenue code.
47	**Total Charges – Not Applicable for Electronic Billing**	**Mandatory Field**. Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Decimal Point required (999999.99)
48	**Non-covered Charges**	No Entry Required.
49	**(Untitled)**	No Entry Required.

OWCP-04 CLAIM ITEM	TITLE	ACTION
50 A, B, C	**Payer Identifications**	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**	DOL Provider Number is required. Medicare number is required for inpatient services.
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 Diagnosis Regulated by Federal Statues. 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 – 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.
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 diagnosis code, including all digits.
67A-67Q	**Other Diagnoses (Other than Principal)**	Inpatient Required. The hospital enters the full ICD codes for 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.

OWCP-04 CLAIM ITEM	TITLE	ACTION
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) Codes**	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 NPI)**	Required when a surgical procedure code is listed on this claim.
78 and 79	**Other Provider Name and Identifiers (including NPI)**	Provider Type Qualifier Codes/Definition/Situational Usage Notes: DN – Referring Provider. The provider who send 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. 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. 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. Secondary Identifier Qualifiers: 0B – State License Number 1G – Provider UPIN Number EI – Employer's Identification Number SY – Social Security Number
80	**Remarks**	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).
81	**Code-Code Field**	Situational. To report additional codes.

DURABLE MEDICAL EQUIPMENT(DME)/MEDICAL SUPPLY
PRIOR AUTHORIZATION REQUEST

Please fax with supporting medical documentation to 800-882-6147.

REQUIRED DOCUMENTATION:

☐ DOCUMENTATION OF MEDICAL NECESSITY FROM THE TREATING PHYSICIAN

☐ A COPY OF THE SIGNED PRESCRIPTION

CLAIMANT FILE NUMBER: ___________________________

CLAIMANT NAME: ____

DATE OF REQUEST: _________________ CONTACT PERSON: _________________________

PROVIDER NAME: ____

PROVIDER NUMBER: ___________________ PROVIDER TAX ID: ________________

PROVIDER ADDRESS: ____

PROVIDER FAX: _________________ PROVIDER TELEPHONE: _______________

ICD-9 DIAGNOSIS CODE(S)**(for dates of service 09/30/15 and prior): _________________________**

ICD-10 DIAGNOSIS CODES(S)**(for dates of service 10/1/15 and after): _______________________**

TREATING PHYSICIAN NAME: ___________________________________

Please indicate the cost for each item requested.

ITEM REQUESTED								
							DURATION OF NEED	
DESCRIPTON	HCPCS/CPT CODE	MODIFIER	UNITS	PURCHASE	RENTAL	COST	START DATE	END DATE

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

Effective January 3, 2005 all Prior Authorization requests must either be faxed on this template or submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (https:\\owcpmed.dol.gov).All fields are required and must be complete.Incomplete requests cannot be processed and will be returned.

Date Requested ______________ Requested by _____________________________

Case file # ________________

Claimant Name ____

Claimant Date of Birth (optional) ________________

Provider Name ___________________________________

Conduent Provider Number __________________

Provider Tax ID _____________________________________

Date(s) of Service Requested ________________________________

ICD-9 Diagnosis Code(s)**(for dates of service 09/30/15 and prior)**______________________

ICD-10 Diagnosis Code(s)**(for dates of service 10/01/15 and after)**______________________

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 ____

____

Remember to send any supporting medical documentation with request.
Please put Case File # on every page faxed.

Physical Therapy, Occupational Therapy and Speech Therapy Request Form

Please fax with supporting medical documentation to 800-882-6147.

Effective January 3, 2005 all Prior Authorization requests must either be faxed on this template or submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (https://owcpmed.dol.gov). All fields are required and must be complete. Incomplete requests cannot be processed and will be returned.

New Request Amended Request

Date Requested ______________ Requested by _____________________________

Case file # ________________

Claimant Name ____

Claimant Date of Birth (optional) ________________

Provider Name ___________________________________

Conduent Provider Number __________________

Provider Tax ID _____________________________________

Date(s) of Service Requested ________________________________

ICD-9 Diagnosis Code(s)**(for dates of service 09/30/15 and prior)**_____________________

ICD-10 Diagnosis Code(s)**(for dates of service 10/01/15 and after)**_____________________

Procedure Code(s) and/or Modifier(s) (CPT, HCPCs) _______________________________

____

Specific body part to be treated______ ____

Frequency and Duration Requested ________________________

Comments ____

____

The prescription from the attending physician and treatment plan must be attached.
Please include the claimant's case file number on every page submitted.

DEEOIC Home Health
Authorization Request

Please ensure the prescription signed by the physician and the Case/Subscriber Number is included with this authorization request.

Please submit fax to 1-800-882-6147.

New Request Amended Request

Date Requested ____________________ Requested by ____________________

Case/Subscriber Number _____________________

Claimant Name _________________________________

Claimant Date of Birth (optional) _______________________

Provider Name ______________________________________

Conduent Provider Number ___________________________

Provider Tax ID _______________________________

Date(s) of Service Requested ____________

ICD-9 Diagnosis Code(s)**(for dates of service 09/30/15 and prior)** _______________

ICD-10 Diagnosis Code(s)**(for dates of service 10/01/15 and after)** ______________

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

- ☐ T1001 frequency_______ duration______ total units ________
- ☐ T1017 frequency _______ duration ______ total units ________
- ☐ T1019 frequency _______ duration ______ total units ________
- ☐ T1020 frequency _______ duration ______ total units ________
- ☐ T1030 frequency _______ duration ______ total units ________
- ☐ T1031 frequency _______ duration ______ total units ________
- ☐ S5126 frequency _______ duration ______ total units ________
- ☐ S9122 frequency _______ duration ______ total units ________
- ☐ S9123 frequency _______ duration ______ total units ________
- ☐ S9124 frequency _______ duration ______ total units ________
- ☐ S9126 frequency _______ duration ______ total units ________

All supporting documentation must be faxed to 1-800-882-6147.
Please ensure the Case/Subscriber Number is included on every faxed page.

TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM

Please Fax with Supporting Medical Documentation to:
800-882-6147

Requests for prior authorization must be accompanied by clinical documentation that supports the need for the type of transplant being requested.

REQUIRED DOCUMENTATION:

- ☐ LETTER OF MEDICAL NECESSITY FROM THE TREATING PHYSICIAN DESCRIBING THE NEED FOR THE TRANSPLANT BEING REQUESTED.
- ☐ INITIAL AND RECENT CLINCIAL EVALUATION (I.E., DIAGNOSTIC STUDIES AND LABORATORY TEST)
- ☐ A COPY OF THE TREATMENT PROTOCOL

Please note that the approval of a transplant evaluation does not guarantee the approval of a transplant.

DATE of REQUEST: ______________________________

CLAIMANT FILE NUMBER: ________________

CLAIMANT: ______________________________

CLAIMANT DATE OF BIRTH: ________________

CLAIMANT PHONE: ______________________________

AUTHORIZED REPRESENTATIVE: ______________________________

AUTHORIZED REPRESENTATIVE PHONE: ______________________________

TRANSPLANT SURGEON: ______________________________

CONDUENT PROVIDER NUMBER: ______________

TAX ID: ___________

REFERRING PHYSICIAN: ______________________________

REFERRING PHYSICIAN ADDRESS: ______________________________

PRIMARY DIAGNOSIS DESCRIPTION: ______________________

ICD-9 CODES (**if dates of service are on or before 9/30/2015**): ______________________

ICD-10 CODES (**if dates of service are on or after 10/1/2015**): ______________________

TYPE OF TRANSPLANT: ______________________________

EXPECTED PROCEDURE DATE: ______________________________

PROCEDURE CODE: ______________________

TRANSPLANT FACILITY: ______________________________

TRANSPLANT FACILITY ADDRESS: ______________________________

PHONE: ______________________________

TRANSPLANT COORDINATOR: ______________________________

TRANSPLANT COORDINATOR PHONE: ______________________________