

How to Submit OWCP-04 Bills to DOL

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

General Hospital

Hospice

Nursing Home

Rehabilitation Centers

As a provider you have the option of sending your bills either electronically or by paper.

PAPER BILLS SHOULD BE SENT TO:

US Department of Labor
PO Box 8300
DFEC Central Mailroom
London, KY 40742-8300

ELECTRONIC BILL SUBMISSION

Submitting DOL bills via electronic media offers the advantage of speed in processing. Providers may submit electronic bills or choose a billing agent that offers electronic bill submission services. Billing agents must enroll as DOL providers.

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 electronic bills submission and report retrieval.
- Process test transmissions.
- Provide technical assistance on transmission difficulties

AUTHORIZATION REQUIREMENTS

The FECA Program pays for medical services rendered for work-related injury or disease. Some services require prior authorization. Listed below are some of the services that require prior authorization.

- Emergency admissions within 48 hours of admission
- All surgical procedures
- Some injections
- Home Health Services
- Physical/Occupational Therapy services –Physical/Occupational 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, diagnostic tests and laboratory service do not require prior authorization.

Please call (844) 493-1966, fax (800) 215-4901 using the authorization forms available at our website owcp.dol.acs-inc.com to request authorization.

BILLING REQUIREMENTS

1. **All bills must contain the Federal Employees' Compensation Act (FECA) 9-digit case number of your patient or client as well as the 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 outpatient surgery billing must be billed using the surgical CPT code.
4. Inpatient bills must include the 9-digit Provider ID Number in block 51a of the OWCP-04 form.
5. Inpatient bills must include the Medicare Number in block 51b of the OWCP-04 form.
6. It is recommended that the NPI Number is included in block 56 on the OWCP-04 form
7. Please refer to the attached OWCP-04 list and the required fields for additional instructions.

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	<p>This code indicates the patient's status as of the "Through" date of the billing period (FL 6).</p> <p><u>Patient Status Codes:</u></p> <p>01 Discharged to home or self-care (routine discharge)</p> <p>02 Discharged/transferred to another short-term general hospital for inpatient care</p> <p>03 Discharged/Transferred to skilled nursing facility</p> <p>04 Discharged/transferred to an intermediate care facility</p> <p>05 Discharged/Transferred to another type of institution for inpatient care or referred for outpatient services to another institution</p> <p>06 Discharged/transferred to home under care of organized home health service organization</p> <p>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.

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 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 – 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 <u>must</u> 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)	<p>Provider Type Qualifier Codes/Definition/Situational Usage Notes:</p> <p>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.</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	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.