

# **HOW TO SUBMIT UB-92 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 UB-92 Form:

**General Hospital**

**Inpatient Hospice**

**Ambulatory Care**

## **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, 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 Tallahassee, Florida. 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 UB-92.

## **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 UB-92 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 UB-92 form.
5. Please refer to the attached UB-92 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.

Highlighted fields are required fields.

APPROVED OMB NO. 0938-0270

		2		3 PATIENT CONTROL NO.			4 TYPE OF BILL																												
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 COV D.		8 N-C.D.		9 C-I.D.		10 L-R.D.		11																							
12 PATIENT NAME						13 PATIENT ADDRESS																													
14 BIRTHDATE		15 SEX		16 MS		17 DATE		ADMISSION 18 HR		19 TYPE		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31	
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 CODE		OCCURRENCE SPAN FROM		THROUGH		37		A		B		C															
38		39 CODE		40 VALUE CODES AMOUNT		41 CODE		42 VALUE CODES AMOUNT		43		44		45		46		47		48		49													
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATES		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																					
50 PAYER		51 PROVIDER NO.		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56																							
A		B		C		D		E		F		G																							
57		58 INSURED'S NAME		59 P.REL		60 CERT. - SSN - HIC. - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.																									
A		B		C		D		E		F																									
63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION																													
A		B		C		D																													
67 PRIN. DIAG. CD.		68 CODE		69 CODE		70 CODE		OTHER DIAG. CODES 71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM DIAG. CD.		77 E-CODE		78													
79 P		PRINCIPAL PROCEDURE CODE		DATE		81 OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		82 ATTENDING PHYS. ID		83 OTHER PHYS. ID		OTHER PHYS. ID		85 PROVIDER REPRESENTATIVE		86 DATE													
a		b		c		d		e		f		g		h		i		j		k		l													
84 REMARKS		85 PROVIDER REPRESENTATIVE		86 DATE																															
a		b		c		d																													

For Reference

UB-92 CLAIM ITEM	TITLE	ACTION
1	<b>Provider Name, Address, and Telephone Number</b>	Enter the provider's name and address as well as the telephone number.
2	<b>Claim Reference Number and Financial Classification Code</b>	No entry required.
3	<b>Patient Control Number</b>	Enter the claimant's Patient Control Number. This item is optional.
4	<b>Type of Bill</b>	<b>Mandatory field.</b> Enter the appropriate three-digit code for the Type of Bill.
5	<b>Federal Tax Number</b>	Enter the Federal Tax Number
6	<b>Statement Covers Period</b>	<b>Mandatory field.</b> <b>Inpatient:</b> Enter the beginning and ending service dates for this bill in month, day, and year format: MM/DD/YY.
7	<b>Covered Days</b>	<b>Mandatory for Inpatient</b> Interval must be verified.
8	<b>Non-Covered Days</b>	No entry required.
9	<b>Co-Insurance Days</b>	No entry required.
10	<b>Lifetime Reserve Days</b>	No entry required.
11	<b>Untitled</b>	No entry required.
12	<b>Patient Name</b>	Enter the claimant's last name, first name.
13	<b>Patient's Address</b>	Enter the claimant's address. (Optional)
14	<b>Patient Birth Date</b>	Enter the patient's date of birth in the eight-digit MM/DD/YY format.
15	<b>Patient Sex</b>	Enter the letter "M" if the patient is male or the letter "F" if the patient is female.
16	<b>Patient Marital Status</b>	No entry required.
17	<b>Admission Date</b>	<b>Inpatient:</b> Enter the patient's date of admission in the MM/DD/YY format.

UB-92 CLAIM ITEM	TITLE	ACTION
18	Admission Hour	<b>Inpatient:</b> Enter the code for the hour of admission converted to 24-hour time.
19	Type of Admission	1 Emergency 2 Urgent 3 Elective 4 Newborn
21	Discharge Hour	Not required.
22	Patient Status	<b><u>Patient Status Codes:</u></b> 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 <b>Outpatient:</b> No entry required
23	Medical/Health Record Number	No entry required.
24-30	Condition Codes	Not required.
31	Untitled	No entry required.
32-35 A, B	Occurrence Code and Dates	No entry required.
36 A, B	Occurrence Span Code and Dates	No entry required.



UB-92 CLAIM ITEM	TITLE	ACTION
37	<b>Internal Control Number (ICN)/ Document Control Number (DCN)</b>	No entry required.
38	<b>Responsible Party Name and Address</b>	No entry required.
39-41 A,B,C,D	<b>Value Codes and Amounts</b>	No entry required.
42	<b>Revenue Code</b>	<b>Mandatory field.</b> Enter the appropriate three-digit revenue code(s) itemizing all services and/or items furnished to the patient in your facility.
43	<b>Revenue Description</b>	Enter a written description of the related revenue categories included on this bill.
44	<b>HCPCS/Rates</b>	<b>Inpatient:</b> No entry required. <b>Outpatient:</b> Enter the corresponding five-digit CPT-4 code or HCPCS, if the revenue code requires a CPT code.
45	<b>Service Date</b>	No entry required for inpatient.
46	<b>Service Units</b>	<b>Inpatient:</b> Enter the number of units of service and number of days for accommodations. A late discharge may not be billed as an additional day. <b>Outpatient:</b> Enter the units of service for each revenue code.
47	<b>Total Charges</b>	<b>Mandatory field.</b> 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	<b>Non-Covered Charges</b>	No entry required.
49	<b>Untitled</b>	No entry required.
50 A, B, C	<b>Payer Identification</b>	Enter the name identifying each payer organization from which the provider might expect payment for the bill.
51	<b>Provider Number</b>	Enter the provider's nine-digit DOL DCMWC provider number as found in your Welcome packet.

UB-92 CLAIM ITEM	TITLE	ACTION
52 A, B, C	<b>Release of Information Certification Indicator</b>	No entry required.
53 A, B, C	<b>Assignment of Benefits Certification Indicator</b>	No entry required.
54 A, B, C	<b>Prior Payments</b>	Enter the total amount due from any carrier.
55 A, B, C	<b>Estimated Amount Due</b>	No entry required.
56 A, B, C	<b>Untitled</b>	No entry required.
57	<b>Due From Patient</b>	No entry required.
58 A, B, C	<b>Insured's Name</b>	Enter the insured's last name first.
59 A, B, C	<b>Patient's Relationship to Insured</b>	No entry required.
60 A, B, C	<b>Certificate/Social Security Number/Health Insurance Claim/Identification Number</b>	<b>Mandatory field.</b> Enter the Social Security number.
61 A, B, C	<b>Insurance Group Name</b>	No entry required.
62 A, B, C	<b>Insurance Group Number</b>	No entry required.
63 A, B, C	<b>Treatment Authorization Code</b>	No entry required.
64	<b>Employment Status Code</b>	Not required.
65	<b>Employer Name</b>	No entry required.
66	<b>Employer Location</b>	No entry required.
67	<b>Principal Diagnosis Code</b>	<b>Mandatory field.</b> Enter the ICD-9-CM code describing the principal diagnosis.

UB-92 CLAIM ITEM	TITLE	ACTION
68-75	<b>Other Diagnoses (Other Than Principal)</b>	Enter the ICD-9 codes as appropriate.
76	<b>Admitting Diagnosis</b>	Enter the admitting diagnosis.
77	<b>External Cause of Injury (E-Code)</b>	No entry required.
78	<b>Untitled</b>	No entry required.
79	<b>Procedure Coding Method Used</b>	<b>Mandatory field.</b> Indicator for type of code used in Field 80 and 81.
80	<b>Principal Procedure Code and Date</b>	<b>Inpatient and Outpatient:</b> Enter the code identifying the principal ICD-9-CM surgical procedure and the date on which the principal procedure was performed. Enter the date in MM/DD/YY format.
81 A, B, C, D	<b>Other Procedure Codes and Dates</b>	<b>Inpatient and Outpatient:</b> Enter the codes identifying the procedures, other than the principal procedure, performed during the billing period covered by this bill and the dates on which the procedures (identified by the codes) were performed.
82	<b>Attending Physician ID</b>	No entry required.
83	<b>Other Physician ID</b>	No entry required.
84 A, B, C, D	<b>Remarks</b>	No entry required.
85	<b>Provider Representative Signature</b>	<b>Mandatory field.</b> Signature stamp is acceptable.
86	<b>Date Bill Submitted</b>	Enter the date the bill is submitted in the month, day, and year format.
<b>Multiple Page Bills</b>		On multiple page bills, all required fields must be completed on the final page of the bill. Enter the page number and the total number of pages on the bottom of each bill page. For example, the first page would be numbered Page 1 of 2, the second page, Page 2 of 2.