

# HOW TO SUBMIT OWCP- 1500 BILLS TO ACS

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

The services performed by the following providers should be billed on the OWCP-1500 Form:

°Physicians (MD, DO)	°X-Ray	°Independent Laboratories
°Audiologists/Speech Pathologist	°Hearing Aid Specialists	°Therapists
°Community Health Departments	°DME	°Visual Services
°Chiropractors	°Home Health	°Prosthetics/Orthotics
°Ambulatory Surgical Centers	°Home Attendant Services	°Rural Health Clinics
°Ambulance	°Psychologist	°Podiatrist

### **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 pharmacies, 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

◦All surgical procedures

◦MRIs and CT scans

◦Home health services

◦Some durable medical equipment

◦Anesthesia CPT codes 01995 and 01996

**◦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.**

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

Please call (866) 272-2682 or fax (800) 882-6147 to request an authorization.

**To request an authorization via fax, use the appropriate template provided in this packet.**

## **BILLING REQUIREMENTS**

1. **All bills must contain the Division of Energy Employees Occupational Illness Compensation Program (DEEOIC) 9-digit case number of your patient or client and your 9-digit DEEOIC provider number.**
2. All professional services will be paid using the Fee Schedule established by OWCP. This Fee Schedule can be downloaded from **[http://www.dol.gov/esa/owcp\\_org.htm](http://www.dol.gov/esa/owcp_org.htm)**.
3. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).
4. Drugs dispensed at the physician's office, other than injections, require NDC.
5. Facility charges for ambulatory surgical center/outpatient surgery billing must be billed using the surgical CPT code. Please use the SG modifier in addition to the surgical CPT code.
6. When billing for services over a period of time, use the "From" and "Through" dates with the appropriate units for each CPT code billed.
7. Please refer to the attached OWCP-1500 list and the required fields for additional instructions.



<b>OWCP –1500 CLAIM ITEM</b>	<b>TITLE</b>	<b>ACTION</b>
<b>1</b>	<b>Medicare and Medicaid</b>	No entry required.
<b>1a</b>	<b>Insured’s ID Number</b>	<b>Mandatory field.</b> Enter the claimant’s case number.
<b>2</b>	<b>Patient’s Name</b>	Enter the claimant’s last name, first name, and middle initial.
<b>3</b>	<b>Patient’s Birth Date</b> <b>Patient’s Sex</b>	Enter the claimant’s date of birth in month, day, and year format.  Use an “X” to mark the appropriate box, male or female.
<b>4</b>	<b>Insured’s Name</b>	No entry required.
<b>5</b>	<b>Patient’s Address</b>	Enter the claimant’s address.
<b>6</b>	<b>Patient’s Relationship to Insured</b>	No entry required.
<b>7</b>	<b>Insured’s Address</b>	No entry required unless the claimant is covered by other insurance.
<b>8</b>	<b>Patient Status</b>	No entry required.
<b>9a-d</b>	<b>Other Health Insurance Coverage</b>	Enter the requested information if the claimant has other insurance. Enter the word “none” or “not applicable” if there is no other insurance coverage.
<b>10a-c</b>	<b>Is Patient’s Condition Related to:</b>	Use an “X” to indicate the related condition.
<b>10d</b>	<b>Reserved for Local Use</b>	No entry is required.
<b>11a-d</b>	<b>Insured’s Group No.</b>	No entry required.
<b>12</b>	<b>Patient’s or Authorized Person’s Signature</b>	<b>Mandatory field.</b> Have the claimant sign the form. “Signature on file” is acceptable.
<b>13</b>	<b>Insured’s or Authorized Person’s Signature</b>	<b>Mandatory field.</b> “Signature on file” required if payment is assigned to provider.

<b>OWCP –1500 CLAIM ITEM</b>	<b>TITLE</b>	<b>ACTION</b>
14	<b>Date of current illness, injury or pregnancy</b>	No entry required.
15	<b>Dates of Same or Similar Illness</b>	No entry required.
16	<b>Dates Patient Unable to Work</b>	No entry required.
17 and 17a	<b>Name of Referring Physician and DOL Provider ID Number</b>	No entry required.
18	<b>Hospitalization Dates Related to Current Services</b>	No entry required.
19	<b>Reserved for Local Use</b>	No entry required.
20	<b>Was Laboratory Work Performed Outside Your Office?</b>	No entry required.
21	<b>Diagnosis or Nature of Illness or Injury</b>	<b>Mandatory field.</b> Enter the diagnosis code(s). At least one header diagnosis is required.
23	<b>Prior Authorization Number</b>	No entry required.
24 A	<b>Date(s) of Service</b>	<b>Mandatory field.</b> Enter the beginning date of service (From Date) in month, day, and year format.  Services rendered in one calendar month may be billed on one line with a “From Date” and a “To Date.”
B	<b>Place of Service</b>	<b>Mandatory field.</b> Enter the two-digit place of service (POS) code for each procedure performed.
C	<b>Type of Service</b>	No entry required.

<b>OWCP –1500 CLAIM ITEM</b>	<b>TITLE</b>	<b>ACTION</b>
<b>D</b>	<b>Procedures, Services or Supplies: CPT HCPC codes and modifiers</b>	<b>Mandatory field.</b> Enter the procedure code. Enter modifiers if appropriate.
<b>E</b>	<b>Diagnosis Code</b>	<b>Mandatory field.</b> Enter a pointer to correspond to the diagnosis code in block 21. Do not enter the diagnosis codes on the line.
<b>F</b>	<b>Charges</b>	<b>Mandatory field.</b> Enter the usual and customary charge for the procedure performed in dollars and cents format. The decimal must be included. For example: 250.00.
<b>G</b>	<b>Days or Units</b>	<b>Mandatory field.</b> Enter the units of service rendered for each detail line. A unit of service is the number of times a procedure is performed.  <b>Anesthesiologists:</b> Enter the anesthesia time in total minutes. For example, one hour and fifteen minutes should be entered as “75.” <b>Do not convert time to units.</b>
<b>H</b>	<b>EPSDT (Child Health Check-Up) and Family Planning Indicator</b>	No entry required.
<b>I</b>	<b>EMG</b>	No entry required.
<b>J</b>	<b>COB</b>	No entry required.
<b>K</b>	<b>Reserved for Local Use</b>	No entry required.
<b>25</b>	<b>Federal Tax ID Number</b>	Enter the Federal Tax ID Number.
<b>26</b>	<b>Patient’s Account Number</b>	The provider may enter a claimant account number so that it will appear on the remittance voucher.
<b>27</b>	<b>Accept Assignment</b>	No entry required.

OWCP –1500 CLAIM ITEM	ITEM	ACTION
28	<b>Total Charge</b>	<b>Mandatory field.</b> Add together all charges in the column under #24F and enter the total amount in this item.
29	<b>Amount Paid</b>	Enter the amount paid by other health insurance coverage if applicable. This amount must equal the total of the entries in column 24K. The amount must be entered in dollar and cents format, including the decimal. For example: 250.00 Do <b>not</b> enter prior DOL payments here when filing an adjustment invoice.
30	<b>Balance Due</b>	No entry required.
31	<b>Signature of Physician or Supplier and Date</b>	<b>Mandatory field.</b> Sign and date the bill form. Signature stamp is allowed. “Signature on file” may be used.
32	<b>Name and Address of Facility Where Services Were Rendered</b>	<b>Mandatory field.</b> Enter the complete name and address of hospital, facility or physician’s office where services were rendered, including the zip code.
33	<b>Provider’s Name, Address, Zip Code, Telephone Number and DOL Provider Number</b>	<p><b>Mandatory field.</b> Enter the provider’s name, address, zip code and telephone number in the upper portion of the item.</p> <p><b>Enter the nine-digit DOL DEEOIC provider number in the lower portion of the field as found in you Welcome packet. If the provider is an individual provider, the provider number must be entered after the “PIN#.” If the provider is a group provider, the group number must be entered after the “GRP#.”</b></p> <p>The provider number entered in item 33 is where DOL payment is made. It is also used to report DOL payments to the IRS.</p>

**Place of Service Codes (POS)**

Code	Description
3	School
4	Homeless Shelter
5	Indian Health Service Free-Standing Facility
6	Indian Health Service Provider-Based Facility
7	Tribal 638 Free-Standing Facility
8	Tribal 638 Provider-Based Facility
11	Office
12	Patient Home
15	Mobile Unit
20	Urgent Care
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center (CMHC)
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service



General Medical and Surgery  
Authorization Request Form  
Please fax with supporting medical documentation.  
Fax Number: 1-800-882-6147



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 \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please remember to send any supporting medical documentation with request.  
Please put Case File Number on every page faxed.  
Fax Number: 1-800-882-6147**



Durable Medical Equipment  
Authorization Request Form  
Please fax with supporting medical documentation.  
Fax Number: 1-800-882-6147



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, RCC) \_\_\_\_\_  
\_\_\_\_\_

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.**

**Please include Case File Number on every page faxed.**

**Fax Number: 1-800-882-6147**



Physical Therapy/Occupational Therapy  
Authorization Request Form  
Please fax with supporting medical documentation.  
Fax Number 1-800-882-6147



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 \_\_\_\_\_

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 Number on every page faxed.**

**Fax Number: 1-800-882-6147**