Instructions for Completing OWCP-92 Uniform Billing Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)

GENERAL INFORMATION—FECA AND EEOICPA CLAIMANTS: Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for occupational illnesses defined under that Act. Benefits provided under these statutes include Inpatient/outpatient hospital services, ambulatory surgical care, chemotherapy treatment services, and other non-professional medical services for covered injuries or occupational illnesses. Services provided by skilled nursing facilities, nursing homes and hospices (including medications and other services such as oxygen and respiratory services), as well as personal care services provided by a home health aide, licensed practical nurse or similarly trained individual, may also be provided.

FEES: The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a condition-specific fee schedule based on the Prospective Payment System devised by the Centers for Medicare and Medicaid Services (CMS) and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT), Revenue Center codes and Diagnosis-Related Group (DRG) codes; therefore, use of correct codes and modifier(s) is required. Incorrect coding will result in inappropriate or delayed payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

ITEMIZED BILLS AND TREATMENT PLANS: All forms submitted for inpatient hospital services must be accompanied by an itemized billing statement and an admission/discharge summary. Forms submitted for hospice services or for personal care services provided in the home must be accompanied by a plan of care and treatment.

GENERAL INFORMATION—BLBA CLAIMANTS: The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION
(PRIVACY ACT STATEMENT)

OWCP is authorized by 5 USC 8101 et seq., 30 USC 901 et seq., and 42 USC 7384d to collect information needed to administer the FECA, BLBA and EEOICPA. The information collected is used to identify the eligibility of the claimant for benefits, and to determine coverage of services provided. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. Failure to supply the claim number or required codes will delay payment or may result in rejection of the bill because of incomplete information.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

SIGNATURE OF PROVIDER: Your signature in Block 85 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Block 85 also indicates that the services shown on this form were provided, and that the billing information submitted is both complete and accurate. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FORM SUBMISSION

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742, unless otherwise instructed.
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828, unless otherwise instructed.
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 727, Lanham-Seabrook, MD 20703-0727, unless otherwise instructed.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

INSTRUCTIONS FOR COMPLETING THE FORM: A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

Block 1   Type or print complete provider name, street address, city, state and zip code. Also include area code and phone number.
Block 2   Blank field.
Block 3   Not required.
Block 4   Type of bill classification using appropriate three-digit code: 1st position indicates type of facility, 2nd position indicates type of care, 3rd position indicates billing sequence..
Block 5   Type or print Federal tax I.D. assigned for tax reporting purposes.
Block 6   Type or print dates for the full ranges of services being invoiced (period from/through using MM/DD/YY).
Block 7   Type or print number of covered days.
Block 8   Not required.
Block 9   Not required.
Block 10   Not required.
Block 11   Blank field.
Block 12   Type or print patient's name. Use a comma or space to separate the last and first names, do not use titles such as Mr. or Mrs., and do not leave a space before a prefix to a last name. If last name is hyphenated, both names should be capitalized, and a space should separate a last name and any suffix. For EEOICPA, type or print name as it appears on the Medical Benefits Identification Card.
Block 13   Type or print complete mailing address of patient.
Block 14   Type or print month, year, and day of patient's birth (MM/DD/YY).
Block 15   Type or print sex of patient, using M or F only.
Block 16   Not required.
Block 17   Type or print month, day, and year (MM/DD/YY) of admission.
Block 18   Enter the code for admission hour.
Block 19   Not required.

Block 20 Not required.
Block 21 Not required.
Block 22 Type or print patient's two-digit status code on the last day of the billing period.
Block 23 Not required.
Block 24 Not required.
Block 25 Not required.
Block 26 Not required.
Block 27 Not required.
Block 28 Not required.
Block 29 Not required.
Block 30 Not required.
Block 31 Blank field.
Block 32 Not required.
Block 33 Not required.
Block 34 Not required.
Block 35 Not required.
Block 36 Not required.
Block 37 Blank field.
Block 38 Not required.
Block 39 Not required.
Block 40 Not required.
Block 41 Not required.
Block 42 Type or print Revenue Center Code(s).
Block 43 Type or print Revenue Center Code description(s).
Block 44 Type or print applicable private/semi-private room rate, and the CPT or HCPCS codes and modifiers based on bill type (inpatient or outpatient).
Block 45 Not required.
Block 46 Type or print units of service for inpatient. For outpatient, enter units of service for each RCC.
Block 47 Type or print total charges by RCC and procedure code.
Block 48 Not required.
Block 49 Blank field.
Block 50 Type or print program payer: U.S. DOL-OWCP-FECA, -BLBA or -EEOICPA, as appropriate, and Medicare number (on B) for inpatient services.
Block 51 Type or print Provider I.D. Number provided by the program being billed, and Medicare number for inpatient services.
Block 52 Not required.
Block 53 Not required.
Block 54 Type or print the amount of any prior payments made.
Block 55 Not required.
Block 56 Not required.
Block 57 Blank field.
Block 58 Type or print insured's last name, first name.
Block 59 Not required.
Block 60 For EEOICPA: type or print patient's SSN. For FECA and BLBA: type or print patient's claim number.
Block 61 Not required.
Block 62 Not required.
Block 63 Not required.
Block 64 Not required.
Block 65 Not required.
Block 66 Not required.
Block 67 Type or print complete ICD-9-CM diagnosis code for principal diagnosis. Enter the 4th and 5th digits if applicable. Each diagnosis must be valid for the date of service.
Block 68 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 69 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 70 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 71 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 72 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 73 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 74 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 75 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 76 Type or print complete ICD-9-CM diagnosis code for admission diagnosis. Enter the 4th and 5th digits if applicable. Each diagnosis must be valid for the date of service.
Block 77 Not required.
Block 78 Blank field.
Block 79 Type or print indicator for type of code used in Blocks 80 and 81.
Block 80 Type or print principal procedure using ICD-9-CM and date of occurrence (MM/DD/YY) during hospitalization. Inpatient claims and all surgical procedures require ICD-9-CM codes. Outpatient claims require CPT/HCPCS codes.
Block 81 Type or print any other procedure using ICD-9-CM and date of occurrence (MM/DD/YY) during hospitalization. Inpatient claims and all surgical procedures require ICD-9-CM codes. Outpatient claims require CPT/HCPCS codes.
Block 82 Not required.
Block 83 Not required.
Block 84 Not required.
Block 85 Signature block for provider representative. Attests to conformance with certifications on the form.
Block 86 Type or print date bill is submitted (MM/DD/YY).

HOW TO SUBMIT UB-92 BILLS TO ACS

The following services should be billed on the UB-92 Form:

General Hospital
Hospice
Nursing Home

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
P O 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. 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 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:

∘**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) 335-8319 or fax (800) 215-4901 to request an authorization.

BILLING REQUIREMENTS

1. **All bills must contain the Federal Employees' Compensation (FECA) 9-digit case number of your patient or client.**

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. Please refer to the attached UB-92 list and the required fields for additional instructions.

APPROVED OMB NO. 0938-0279

| 2 | | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL |

| 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM / THROUGH | 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 | ADMISSION 17 DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | 24 | CONDITION CODES 25 26 27 28 29 30 | 31 |

| 32 CODE OCCURRENCE DATE | 33 CODE OCCURRENCE DATE | 34 CODE OCCURRENCE DATE | 35 CODE OCCURRENCE DATE | 36 CODE OCCURRENCE SPAN FROM / THROUGH | 37 A B C | | A B C |

a
b

38

| 39 CODE VALUE CODES AMOUNT | 40 CODE VALUE CODES AMOUNT | 41 CODE VALUE CODES AMOUNT |

a
b
c
d

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |

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| 50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 |

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C

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DUE FROM PATIENT ▶

| 58 INSURED'S NAME | 59 P.REL | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO. |

A
B
C

| 63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION |

A
B
C

| 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.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | 82 ATTENDING PHYS. ID |
| OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | 83 OTHER PHYS. ID |

a
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84 REMARKS

OTHER PHYS. ID

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85 PROVIDER REPRESENTATIVE

X

86 DATE

UB-92 HCFA-1450   OCR/Original   I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 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	**Claim Reference Number and Financial Classification Code**	No entry required.
3	**Patient Control Number**	Enter the claimant's Patient Control Number. This item is optional.
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**	**Inpatient**: Enter the beginning and ending service dates for this bill in month, day, and year format: MM/DD/YY.
7	**Covered Days**	Mandatory for Inpatient Interval must be verified.
8	**Non-Covered Days**	No entry required.
9	**Co-Insurance Days**	No entry required.
10	**Lifetime Reserve Days**	No entry required.
11	**Untitled**	No entry required.
12	**Patient Name**	Enter the claimant's last name, first name.
13	**Patient's Address**	Enter the claimant's address. (Optional)
14	**Patient Birth Date**	Enter the patient's date of birth in MM/DD/YY format.
15	**Patient Sex**	Enter the letter "M" if the patient is male or the letter "F" if the patient is female.
16	**Patient Marital Status**	No entry required.
17	**Admission Date**	**Inpatient**: Enter the patient's date of admission in MM/DD/YY format.

UB-92 CLAIM ITEM	TITLE	ACTION
18	**Admission Hour**	**Inpatient:** 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**	<u>**Patient Status Codes**</u>: 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
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	**Internal Control Number (ICN)/** **Document Control Number (DCN)**	No entry required.
38	**Responsible Party Name and Address**	No entry required.
39-41 A, B, C, D	**Value Codes and Amounts**	No entry required.
42	**Revenue Code**	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 written description of the related revenue categories included on this bill.
44	**HCPCS/Rates**	**Inpatient**: No entry required. **Outpatient**: Enter the corresponding five-digit CPT-4 code or HCPCS, if the revenue code requires a CPT code.
45	**Service Date**	No entry required for inpatient.
46	**Service Units**	**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**	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.
50 A, B, C	**Payer Identification**	Enter the name and, if required, number identifying each payer organization from which the provider might expect payment for the bill. **Medicare provider number must be submitted on B when billing for inpatient services.**

UB-92 CLAIM ITEM	TITLE	ACTION
51	Provider Number	Enter the provider's nine-digit DOL provider number as found in your Welcome packet. **Inpatient**: Must include the DOL ID number and the Medicare number.
52 A, B, C	Release of Information Certification Indicator	No entry required.
53 A, B, C	Assignment of Benefits Certification Indicator	No entry required.
54 A, B, C	Prior Payments	Enter the total amount due from any carrier.
55 A, B, C	Estimated Amount Due	No entry required.
56 A, B, C	Untitled	No entry required.
57	Due From Patient	No entry required.
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	Certificate/Social Security Number/ Health Insurance Claim/Identification Number	Enter the FECA case number.
61 A, B, C	Insurance Group Name	No entry required.
62 A, B, C	Insurance Group Number	No entry required.
63 A, B, C	Treatment Authorization Code	No entry required.
64	Employment Status Code	Not required.
65	Employer Name	No entry required.
66	Employer Location	No entry required.

UB-92 CLAIM ITEM	TITLE	ACTION
67	**Principal Diagnosis Code**	Enter the ICD-9-CM code describing the principal diagnosis.
68-75	**Other Diagnoses (Other Than Principal)**	Enter the ICD-9 codes as appropriate.
76	**Admitting Diagnosis**	Enter the admitting diagnosis.
77	**External Cause of Injury (E-Code)**	No entry required.
78	**Untitled**	No entry required.
79	**Procedure Coding Method Used**	Indicator for type of code used in Field 80 and 81.
80	**Principal Procedure Code and Date**	**Inpatient and Outpatient**: 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	**Other Procedure Codes and Dates**	**Inpatient and Outpatient**: 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	**Attending Physician ID**	No entry required.
83	**Other Physician ID**	No entry required.
84 A, B, C, D	**Remarks**	No entry required.
85	**Provider Representative Signature**	Signature stamp is acceptable.
86	**Date Bill Submitted**	Enter the date the bill is submitted in month, day, and year format.
Multiple Page Bills		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.