HOW TO SUBMIT OWCP- 1500 BILLS TO

THE FEDERAL BLACK LUNG PROGRAM

OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF COAL MINE WORKERS' COMPENSATION

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

° Physicians (MD, DO)	**° DME Suppliers**	**°Independent Laboratories**
° Ambulatory Surgical Centers	**° Home Nursing Agencies**	**° Ambulance**
° Pulmonary Rehabilitation	**° Pharmacies (Optional)**	**° Nursing Homes (Limited)**

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 1 week from date of payment, describing, if applicable, the payment made, a reason for denial, and a reason why full payment was not approved. 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.

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 Black Lung 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.

USING THE OWCP-1500

Physician services rendered in the treatment of a miner's pulmonary disease are reimbursable under the following categories: office visits, hospital visits, procedures at an outpatient clinic, home visits, pulmonary consultations, immunizations for flu and pneumonia, radiology for the diagnosis and/or treatment of a pulmonary disease, pulmonary therapy, and prescriptions for and administration of drugs on the lists of drugs and laboratory tests covered by the Department of Labor program. When care is rendered for an acute condition causing hospitalization, emergency room, or ambulatory care services, the acute condition must be indicated on the billing form before reimbursement can be considered.

AUTHORIZATION REQUIREMENTS

The Federal Black Lung Program pays for medical services rendered to coal miners disabled from pneumoconiosis (black lung disease). Some services, specifically home nursing services, pulmonary rehabilitation, and durable medical equipment, 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. To request a Certificate of Medical Necessity, you may contact the claimant's district office or download and

print the CMN at http://www.dol.gov/esa/regs/compliance/owcp/cm-893.pdf. See Attachment 1 or go to http://www.dol.gov/esa/contacts/owcp/blcontac.htm) for the appropriate DCMWC District Office address and telephone number.

Nursing homes that provide services requiring pre-approval must also follow these procedures, and bill using the OWCP-1500. The Federal Black Lung Program does not cover room and board for nursing homes, but will pay for covered physicians' services and prescriptions in addition to pre-approved services.

BILLING REQUIREMENTS

1. **All bills must contain the 9-digit Social Security number of your patient and your 9-digit DCMWC provider number. Your patient's SSN is not shown on the Black Lung Benefits Identification Card for privacy reasons.**

2. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).

   The following modifiers must be used for services requiring anesthesia:

Anesthesia	AA

3. For surgical procedures, no modifier is necessary. If an assistant surgeon is needed, services must be coded with modifier 80:

Surgical Assistant	80

4. Drugs dispensed/administered at the physician's office:

Oral medication: Bill using the appropriate NDC and HCPC Code J8499

Injectable medication: Bill using the specific HCPCs injection code and optionally CPT 4 code 90782

5. When billing for services over a period of time, use the "From" and "Through" dates with the appropriate units for each CPT code billed.

The following modifiers must be used for procedures billed as professional or technical components if a full fee is not billed:

Professional	26
Technical	TC

The following modifiers must be used for durable medical equipment billed as purchase or rental:

Purchase	1B
Rental	RR

6. For additional instructions, please refer to Attachment 2, a detailed OWCP-1500 listing with the required fields.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

SS# Required

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Required DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Required

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. Required 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2 Required			Required	Required	Required					
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28 $ Required

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Required

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Required

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Required

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Attachment 1 - 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.

Continued on following page

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.

Attachment 2 – Detailed Instructions for Completion of OWCP-1500

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

OWCP –1500 CLAIM ITEM	TITLE	ACTION
14	**Date of current illness, injury or pregnancy**	No entry required.
15	**Dates of Same or Similar Illness**	No entry required.
16	**Dates Patient Unable to Work**	No entry required.
17 and 17a	**Name of Referring Physician and DOL Provider ID Number**	CCNo entry required.
18	**Hospitalization Dates Related to Current Services**	No entry required.
19	**Reserved for Local Use**	No entry required.
20	**Was Laboratory Work Performed Outside Your Office?**	No  required.
21	**Diagnosis or Nature of Illness or Injury**	**Mandatory field**. Enter the diagnosis code(s). At least one header diagnosis is required.
23	**Prior Authorization Number**	No entry required.
24 A	**Date(s) of Service**	**Mandatory field**. 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."
24 B	**Place of Service**	**Mandatory field**. Enter the two-digit place of service (POS) code for each procedure performed.
24 C	**Type of Service**	No entry required.

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

OWCP –1500 CLAIM ITEM	ITEM	ACTION
28	**Total Charge**	**Mandatory field**. Add together all charges in the column under #24F and enter the total amount in this item.
29	**Amount Paid**	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 **not** enter prior DOL payments here when filing an adjustment invoice.
30	**Balance Due**	No entry required.
31	**Signature of Physician or Supplier and Date**	**Mandatory field**. Sign and date the bill form. Signature stamp is allowed. "Signature on file" may be used.
32	**Name and Address of Facility Where Services Were Rendered**	**Mandatory field.** Enter the complete name and address of hospital, facility or physician's office where services were rendered, including the zip code.
33	**Provider's Name, Address, Zip Code, Telephone Number and DOL Provider Number**	**Mandatory field**. Enter the provider's name, address, zip code and telephone number in the upper portion of the item. **Enter the nine-digit DOL DCMWC 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#."** The provider number entered in item 33 is where DOL payment is made. It is also used to report DOL payments to the IRS.

Attachment 3 – Place of Service Codes

Place of Service Codes (POS)

Code		Description
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
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
60		Mass Immunization Center
71		State or Local Public Health Clinic
72		Rural Health Clinic
81		Independent Laboratory
99		Other Place of Service