

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).

Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0176. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0176), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

HOW TO SUBMIT UB-92 BILLS TO ACS

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

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

General Hospital

Hospice

Nursing Home

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 pharmacy 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.

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

◦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) 272-2682 or fax (800) 882-6147 to request an authorization.

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

BILLING REQUIREMENTS

1. **All bills must contain the Division of Energy Employees Occupational Illness Compensation (DEEOIC) 9-digit case number of your patient or client and your 9-digit provider 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 ambulatory surgical center/outpatient surgery billing must be billed using the surgical CPT code. Modifier SG should not be used.
4. All inpatient bills will pay by DRG. Therefore, when billing for inpatient services, the Medicare number must be included.
5. Please refer to the attached UB-92 list and the required fields for additional instructions.

Highlighted fields are required fields.

		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	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 PAYE		51 PROVIDER NO.				52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56															
A		DEEOIC Provider Number				099999 99		99999		DUE FROM PATIENT																			
B		Medicare Number																											
C																													
57		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		81 OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		82 ATTENDING PHYS. ID		83 OTHER PHYS. ID		OTHER PHYS. ID		85 PROVIDER REPRESENTATIVE		86 DATE							
a																													
b																													
c																													
d																													

For Reference

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	Mandatory field. 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 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 the eight-digit 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	Mandatory field for Inpatient. Enter the patient's date of admission in the 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	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 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	Mandatory field. 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 identifying each payer organization from which the provider might expect payment for the bill. Medicare provider name must be submitted on B and correspond with Medicare number in 51B when billing for inpatient services.

UB-92 CLAIM ITEM	TITLE	ACTION
51	Provider Number	Enter the provider's nine-digit DOL DEEOIC provider number as found in your Welcome packet. Inpatient: Must include the DOL DEEOIC 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	Mandatory field. Enter the DEEOIC 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	Mandatory field. 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	Mandatory field. 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	Mandatory field. Signature stamp is acceptable.
86	Date Bill Submitted	Enter the date the bill is submitted in the 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.



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 put Case File Number on every page faxed.

FAX NUMBER: 1-800-882-6147



Physical Therapy and 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