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)**

BLACK LUNG 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 Conduent, the Fiscal Agent for the Office of Worker's Compensation Programs, which includes the Federal Black Lung Program. The Conduent 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 (RTP) letter giving the reason. The bill should be resubmitted with the necessary corrections to the London, Kentucky address noted above.

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 London, Kentucky. At approximately the same time, an electronic funds transfer of the approved amount will be made to your financial institution.

ELECTRONIC SERVICES

Conduent is pleased to offer enhanced services on its web portal (https://owcpmed.dol.gov/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. Conduent'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. 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

Some services, specifically home nursing services, 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. www.dol.gov/owcp/dcmwc/regs/compliance/blforms.htm. Go to http://www.dol.gov/owcp/dcmwc/blcontac.htm for the appropriate DCMWC District Office address and telephone number.

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.

Lung transplant procedures require prior approval.

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:

Assistant Surgeon	80

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

Using procedure codes J3490, J8499, J8999 and J9999 will require a National Drug Code.

5. When billing for services over a period of time, use the "From" and "Through" dates to represent the date range, with the appropriate units for each CPT/HCPCS code billed per the service code description.

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

Professional	26

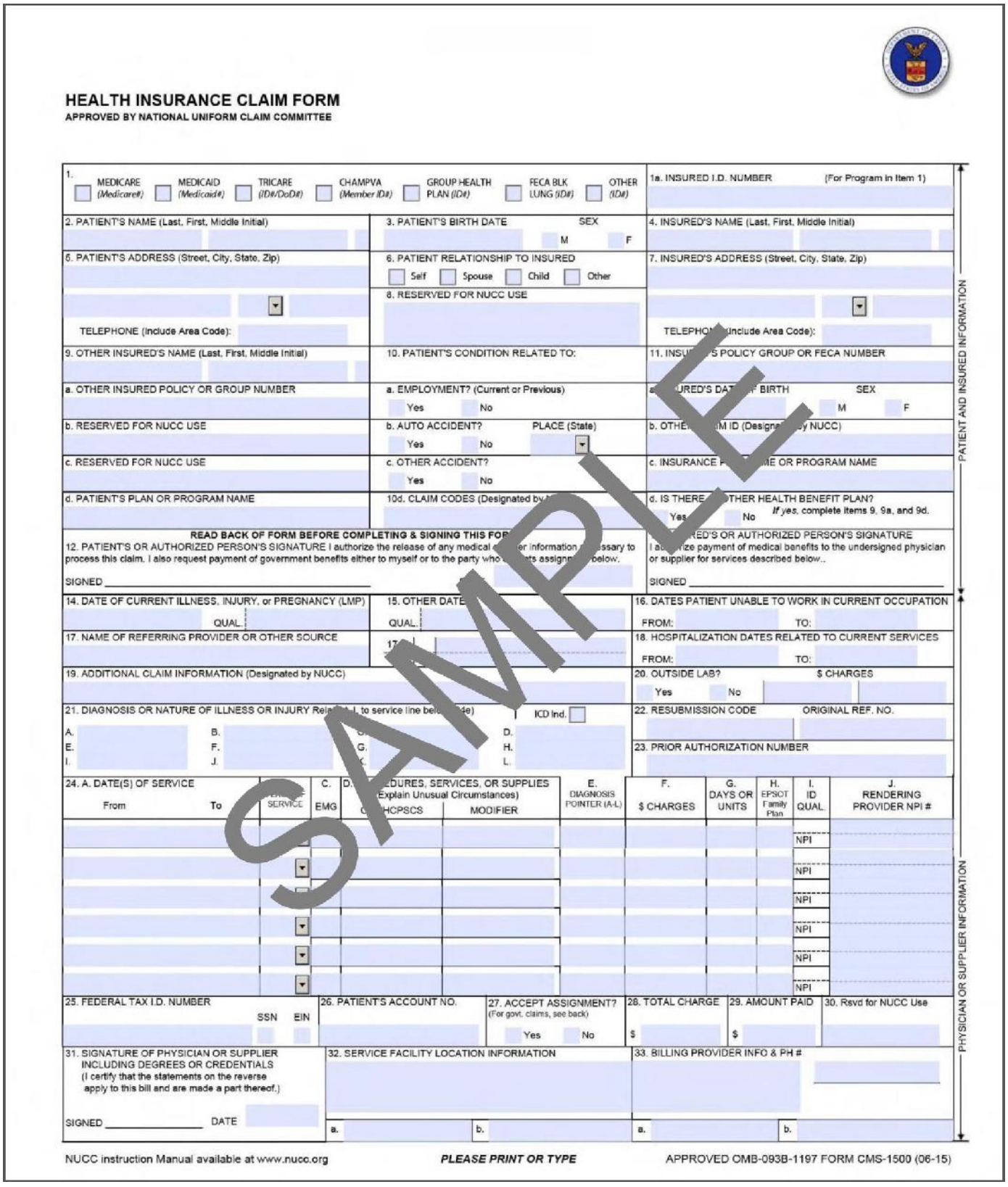
Technical	TC

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

Purchase	NU
Rental	RR

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

Attachment 1 – Detailed Instructions for Completion of OWCP-1500



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE SEX M F

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

5. PATIENT'S ADDRESS (Street, City, State, Zip)

TELEPHONE (Include Area Code):

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

8. RESERVED FOR NUCC USE

7. INSURED'S ADDRESS (Street, City, State, Zip)

TELEPHONE (Include Area Code):

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

10. PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) Yes No

a. INSURED'S DATE OF BIRTH SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) Yes No

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? Yes No

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. PATIENT'S PLAN OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes No *If yes*, complete items 9, 9a, and 9d.

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

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.

15. OTHER DATE QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: TO:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: TO:

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? Yes No $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From	To	PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER (A-L)	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER NPI #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) Yes No

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC instruction Manual available at www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-093B-1197 FORM CMS-1500 (06-15)

OWCP –1500 Claim Item	Title	Action	Required?
1	**Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other**	No Entry Required.	N
1a	**Insured's ID Number**	**Mandatory Field**. Enter the claimant's case number.	Y
2	**Patient's Name**	Enter the claimant's last name, first name, and middle initial.	Y
3	**Patient's Birth Date** **Sex**	Enter the claimant's 8-digit birth date (MM | DD | CCYY). Use an "X" to mark the appropriate box for patient sex.	Y
4	**Insured's Name**	Enter the claimant's last name, first name, and middle initial.	Y
5	**Patient's Address** **Telephone Number**	Enter the claimant's address Enter the claimant's telephone number.	Y
6	**Patient's Relationship to claimant**	No Entry Required.	N
7	**Insured's Address, Telephone Number**	No Entry required unless the claimant is covered by other insurance.	N
8	**Reserved for NUCC Use**	No Entry Required.	N
9a-d	**Other Insured's Name**	If Item Number 11d is marked, complete fields 9 and 9a-d, otherwise leave blank.	N
9a	**Other Insured's Policy or Group Number**	Enter the policy or group number of the claimant.	N
9b	**Reserved For NUCC Use**	No Entry Required	N
9c	**Reserved For NUCC Use**	No Entry Required	N
9d	**Insurance Plan Name or Program Name**	Enter the claimant's insurance plan or program name.	N
10a-c	**Is Patient's Condition Related to:**	When appropriate, enter an X in the correct box.	N
10d	**Claim Codes (Designated By NUCC)**	No Entry Required.	N
11	**Insured's Policy, Group,**	Enter the claimant's policy or group number as it appears on the claimant's health care identification card. If Item Number 4 is completed, then this field should be completed**. NOT APPLICABLE FOR BLACK LUNG**	N
11a	**Insured's Date of Birth** **Sex**	Enter the 8-digit date of birth (MM | DD | CCYY) of the claimant. Enter an X to indicate the sex of the claimant.	N

11b	**Insured's Employer's Name or School Name**	Enter the name of the claimant's employer or school.	N
11c	**Insurance Plan Name or Program Name**	Enter the insurance plan or program name of the claimant.	N
11d	**Is there another Health Benefit Plan?**	When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a–d.	N
12	**Patient's or Authorized Person's Signature**	Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6 digit format (MMDDYY) or 8-digit format (MMDDCCYY). If there is no signature on file, leave blank or enter "No Signature on File."	Y
13	**Insured's or Authorized Person's Signature**	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."	Y
14	**Date of current illness, injury or pregnancy**	No Entry Required.	N
15	**Other Date, Qualifier**	No Entry Required.	N
16	**Dates Patient Unable to Work in Current Occupation**	No Entry Required.	N
17	**Name of Referring Provider or Other Source**	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supply(s) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider	N
17 a	**Other ID#**	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.	N
17 b	**NPI #**	Enter the NPI number of the referring, ordering, or supervising provider.	N
18	**Hospitalization Dates Related to Current Services**	No Entry Required.	N
19	**Additional Claim Information(Designated by NUCC)**	No Entry Required.	N
20	**Outside Lab? $Charges**	Complete this field when billing for purchased services.	N
21	**Diagnosis or Nature of Illness or Injury** **ICD Ind**	Enter the diagnosis/condition. List up to 12 ICD-10-CM diagnosis codes. Enter '9' if using ICD9 codes. Enter '0' if using ICD10 codes.	Y

22	**Resubmission Code, Original Ref No**	No Entry Required.	N
23	**Prior Authorization Number**	Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. (Optional)	N
24a	**Date(s) of Service**	**Mandatory Field.** Enter the beginning date of service in month, day, year format. Services rendered in one calendar month may be billed on one line with a "From Date" and a "To Date."	Y
24b	**Place of Service**	**Mandatory Field.** Enter the two-digit place of service (POS) code for each procedure performed.	Y
24c	**EMG**	No Entry Required.	N
24d	**Procedures, Services, or Supplies**	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service.	Y
24e	**Diagnosis Pointer**	Enter the diagnosis code pointer reference letter as shown in Item Number 21 (A,B,C, etc) to relate the date of service and the procedures performed to the primary diagnosis.	Y
24f	**$ Charges**	Enter number right justified in the dollar area of the field. Do not use commas. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	Y
24g	**Days or Units**	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.	Y
24h	**EPSDT/Family Plan**	No Entry Required.	N
24i	**ID Qualifier**	Enter in the shaded area of 24i the qualifier identifying if the number is a non-NPI.	N
24j	**Rendering Provider ID #**	Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the un-shaded area of the field.	Y
25	**Federal Tax ID Number**	Enter the provider of service or supplier federal tax ID (employer identification number) or Social Security number. Enter an X in the	Y

26	**Patient's Account No.**	If the patient's account number is entered, the account number will appear on the remittance voucher.	N
27	**Accept Assignment**	By billing the Division of Coal Mine Workers' Compensation (DCMWC), the medical provider automatically accepts assignment which does not allow the provider to balance-bill the patient for covered services	N
28	**Total Charge**	Enter total charges for the services (i.e., total of all charges in 24f).	Y
29	**Amount Paid**	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	N
30	**Rsvd For NUCC Use**	No Entry Required.	N
31	**Signature of Physician or Supplier Including Degrees or Credentials** **Bill Date**	Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative. Signature stamp or facsimile signature is allowed. Enter either the 6-digit or 8 digit date, or alphanumeric date (e.g., January 1, 2003) that the form was signed.	Y
32	**Service Facility Location Information**	Enter the name, address, city, state, and zip code of the location where the services were rendered.	Y
32 a	**NPI#**	Enter the NPI number of the service facility location in 32a.	N
32 b	**Other ID#**	Enter the two digit qualifier identifying the non-NPI number followed by the ID number.	N
33	**Billing Provider Info & Ph #**	Enter the provider's or supplier's billing name, address, zip code, and phone number.	Y
33 a	**NPI#**	Enter the NPI number of the billing provider.	N
33 b	**Other ID#**	**Conduent Provider Number is required** *You may also use a two digit qualifier identifying the non-NPI number followed by the ID number.*	Y

Attachment 2 – Place of Service Codes

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
9		Prison/Correctional Facility
11		Office
12		Patient Home
13		Assisted Living Facility
14		Group Home
15		Mobile Unit
16		Temporary Lodging
17		Walk-in Retail Health Clinic
18		Place of Employment – Worksite
19		Off Campus Outpatient Hospital
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
49		Independent Clinic
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
57		Non-residential Substance Abuse Treatment Facility
60		Mass Immunization Center

61		**Comprehensive Inpatient Rehabilitation Facility**
62		**Comprehensive Outpatient Rehabilitation Facility**
65		**End Stage Rental Disease Treatment Facility**
71		**Public Health Clinic**
72		**Rural Health Clinic**
81		**Independent Laboratory**
99		**Other Place of Service**