

HOW TO SUBMIT OWCP - 1500 BILLS TO CONDUENT

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

| | | |
|----------------------------------|--------------------------|---------------------------|
| °Physicians (MD, DO) | °Radiologists | °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 |

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. 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 electronic bill 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

◦All surgical procedures

◦Some Injections

◦Home health services

◦Some durable medical equipment

◦Anesthesia CPT codes 01996

◦Physical/Occupational therapy services – Physical/Occupational 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, diagnostic tests, and laboratory services do NOT require prior authorization.

Please call (844) 493-1966, fax (800) 215-4901 using the attached authorization forms, or access our website 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, as well as, the 9 digit Conduent Provider Number.**
2. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).
3. Drugs dispensed at the physician’s office, other than injections, require NDC along with the quantity and strength.
4. 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.
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.
6. Please refer to the attached OWCP -1500 list and the required fields for additional instructions.

| 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, or FECA Number | Enter the claimant's policy or group number as it appears on the claimant's Healthcare Identification Card. If Item Number 4 is completed, then this field should be completed. | Y |
| 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 reference number (pointer) as shown in Item Number 21 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 appropriate box to indicate which number is being reported. | Y |
| 26 | Patient's Account No. | Enter the patient's account number assigned by the provider of services or supplier's accounting system. | N |
| 27 | Accept Assignment | No Entry Required. | 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. | Y |
| 30 | Rsvd for NUCC Use | No Entry Required | Y |
| 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 on File," or "SOF." 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. | Y |
| 32 b | Other ID# | Enter the two digit qualifier identifying the non-NPI number followed by the ID number. | Y |
| 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. | Y |

| | | | |
|------|-----------|--|---|
| 33 b | Other ID# | CONDUENT Provider Number Is Required. <i>You may also use two digit qualifier identifying the non-NPI number followed by the ID number.</i> | Y |
|------|-----------|--|---|

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 |
| 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 Renal Disease Treatment Facility |
| 71 | | Public Health Clinic |
| 72 | | Rural Health Clinic |
| 81 | | Independent Laboratory |
| 99 | | Other Place of Service |

**General Medical and Surgical
Authorization Request
Fax # 1-800-215-4901**

All Prior Authorization requests must be faxed on this template or submitted via the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting medical documentation, including the case file number on all pages. All fields are required and must be complete. Incomplete requests cannot be processed and will be returned.

Date Requested _____ Requested by _____ Phone _____

Case file # _____ Claimant's Name _____
 Claimant Date of Birth _____ Date of injury _____
 Provider Name _____
 Conduent Provider Number _____ Provider Tax ID _____
 Are you in the process of enrolling? Yes No

NOTE: Up to five procedure (CPT/HCPCS/RCC) codes may be entered. (An additional form can be completed if extra space is required.)

| | Date of Service | | Procedure CPT/HCPC/RCC | | Unit/Days Requested |
|----|-----------------|---------|---------------------------|----------|------------------------|
| | From Date | To Date | Code | Modifier | Units or Days |
| 1: | | | | | |
| 2: | | | | | |
| 3: | | | | | |
| 4: | | | | | |
| 5: | | | | | |

Treatment Plan Information:

- Specific body part to be treated _____
- Right___ Left_____ Bilateral___
- ICD-9 Diagnosis Code(s)(Apply if date of services Prior to 09/30/2015)_____
- ICD-10 Diagnosis Code(s) (Apply if date of services After to 10/01/2015) _____
- For Home health requests, frequency_____ duration_____
- Is this a second surgery on the same body part? _____
- Comments: _____

**Durable Medical Equipment
Authorization Request
Fax # 1-800-215-4901**

All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting documentation, including the case file number on all pages. All fields are required and must be complete. Incomplete requests cannot be processed and will be returned.

Date Requested _____ Requested by _____ Phone _____

Case file # _____ Claimant Name _____

Claimant Date of Birth _____ Date of Injury _____

Provider Name _____

Conduent Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? Yes No

NOTE: Up to five procedure (CPT/HCPCS) codes may be entered. (An additional form can be completed if extra space is required.)

| | Date of Service | | Procedure Code | Rental or Purchase Modifier | Total Requested Price Per Item |
|---|-----------------|---------|----------------|-----------------------------|--------------------------------|
| | From Date | To Date | | RR or NU | |
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

Treatment Plan Information:

Specific body part(s) to be treated _____

Right___ Left___ Bilateral___

ICD-9 Diagnosis Code(s) (Apply if date of services Prior to 09/30/2015) _____

ICD-10 Diagnosis Code(s) (Apply if date of services **After** to 10/01/2015) _____

Duration Requested, if rental _____

Is this an implant (Y/N)_____ Total Cost of implant_____ Units Requested _____

Comments: _____

Please send prescription from attending physician and treatment plan with requests for DME.

**Physical Therapy/Occupational Therapy
Authorization Request
Fax # 1-800-215-4901**

All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting medical documentation, including the case file number on all pages. All fields are required and must be complete. Incomplete requests cannot be processed and will be returned.

Date Requested _____ Requested by _____ Phone _____

Case file # _____ Claimant's Name _____

Claimant Date of Birth _____ Date of injury _____

Provider Name _____

Conduent Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? Yes No

NOTE: Up to five procedure (CPT/HCPCS) codes may be entered. (An additional form can be completed if extra space is required.)

| | Date(s) of Service | | Procedure CPT/HCPCS | | # of Units (per procedure) | Fre-quency | Du-ration | Total Units Requested |
|---|--------------------|----|---------------------|----------|----------------------------|------------|-----------|-----------------------|
| | From | To | Code | Modifier | | | | |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |

| Treatment Plan Information : | | | |
|-------------------------------------|--------------|--|---|
| Body part to be treated | Side of body | ICD-9 code (Apply if date of services Prior to 09/30/2015) | ICD-10 code (Apply if date of services After to 10/01/2015) |
| | | | |
| | | | |

* Is the requested therapy related to post-operative treatment ? yes no

Treatment Frequency Calculation

* To calculate Total Units/Days Requested, use the following formula for each procedure code requested:

of Units Requested (per procedure) x Frequency Requested x Duration Requested

Comments: _____

Please remember to send prescription from attending physician and treatment plan with requests for physical or occupational therapy. Please put Case File # on every page faxed.