OWCP Medical Fee Schedule
Effective: July 1, 2022

U.S. Department of Labor
Martin J. Walsh, Secretary of Labor

Office of Workers' Compensation Programs
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OWCP MEDICAL FEE SCHEDULE – EFFECTIVE: JULY 1, 2022

PART I

PART II -- DATA FILES

Procedure Codes and Revenue Center Codes

CPT*, HCPCS**, CDT*** and OWCP codes, pay status codes, RVU values, conversion factors and short descriptions are contained in the file: ***Effective_July_1_2022_code_rvu_cf.xls***

UB-04 Revenue Center Codes (RCC) that require CPT/HCPCS/OWCP procedure codes are contained in the file: ***Effective_ July_1_2022_rcc_req_cpt.xls***

Geographic Practice Cost Index Values

A listing of geographic practice cost indices by ZIP code is contained in the file: ***Effective_ July_1_2022_gpci-by-zip.xls***

Modifier Adjustments

Listings of Modifier Level Tables with OWCP-designated fee schedule adjustment for each modifier are contained in the file: ***Effective_ July_1_2022_mod_table.xls***.

- American Medical Association, Current Procedural Terminology, 2022 Edition
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, 2022 Edition
- American Dental Association, Current Dental Terminology, 2022 Edition

NOTICE

The following coding schemes are valid for billing medical procedures, services, durable medical equipment, and supplies, under the U. S. Department of Labor's Office of Workers' Compensation Programs:

- The American Medical Association, Current Procedural Terminology (CPT, 2022 edition)
- The U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System Level II, 2022 (HCPCS)
- The American Dental Association, Current Dental Terminology 2022 (CDT)
- Uniform Bill 04 (UB-04, CMS-1450, OWCP-04) Revenue Center Codes (for services and procedures where CPT/HCPCS or OWCP codes are required)
- U. S. Department of Labor's OWCP Program-specific codes

Charges and fees for current services that are billed under codes not current on the above-listed coding schemes, or that are applicable only to state workers' compensation programs, will be denied. Such charges may be submitted again under the above-listed coding schemes.

PART I

INTRODUCTION

The U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP) administers workers' compensation programs under three divisions: Division of Federal Employees', Longshore and Harbor Workers' Compensation (DFELHWC), Division of Coal Mine Workers' Compensation (DCMWC), and Division of Energy Employees Occupational Illness Compensation (DEEOIC). The OWCP Medical Fee Schedule applies to DFELHWC, DCMWC and DEEOIC.

FECA (20 CFR Part 10) provides benefits for work-related injuries sustained by federal employees, employees of the U.S. Postal Service, civilian employees of the Department of Defense, members of the Peace Corps, employees of American Embassies and certain others. Under the provisions of FECA, OWCP authorizes payment for medical services and establishes limits for fees for such services (March 10, 1986, 51 FR 8276- 82, as amended; the most recent amendment was published November 25, 1998, 63 FR 65284-345. The 1998 amendment included authority to establish payment limits for inpatient services and prescription drugs.

LHWCA (33 U.S.C. 901, *et seq*) provides medical benefits, compensation for lost wages, and rehabilitation services to longshoremen, harbor workers, and other maritime workers who are injured during the course of employment. By extension, various other classes of industry workers also receive benefits. These include workers engaged in the extraction of natural resources on the outer continental shelf, employees of defense contractors' overseas, employees at post exchanges on military bases, and others. The amendments to the regulations governing administration of the LHWCA, published October 2, 1995 60 FR 51346-348, clarify that fees by medical care providers covered by the Act shall be limited to that which prevails in the community, and that where a dispute arises, the OWCP Medical Fee Schedule shall be used to determine the prevailing reasonable and customary charge (section 702.413). Where the OWCP schedule does not establish a rate, other state or federal fee schedules, or prevailing community rates may be used. The OWCP medical fee schedule does not apply to the Jones Act.

EEOIC (20 CFR Part 30) provides compensation and medical benefits to covered employees of the United States Department of Energy (DOE), its predecessor agencies, and certain of its contractors and sub-contractors. Under the provisions of EEOIC, OWCP authorizes payment for medical services and establishes limits for fees for such services (20 CFR 30.705-713.)

THE OWCP MEDICAL FEE SCHEDULE

OWCP began to reimburse medical services under a schedule of maxima allowable amounts in 1986. Since June 1, 1994, the schedule has been based on the most recent relative value units (RVU) devised by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) (last published November 9, 2021, 86 FR 64996, pp. 64996 – 66031 and updated quarterly) for services described under the American Medical Association's Physicians' Current Procedural Terminology (CPT), and the Healthcare Current Procedure Coding System (HCPCS). In addition, the OWCP uses program-specific data and the most recent CMS Clinical Diagnostic Laboratory National Limit data, including carrier maxima, national limit, and mid-point values, to establish RVU and conversion factors for clinical laboratory procedures provided under OWCP programs. OWCP also devises its own RVU for durable medical equipment, supplies, and other items or services such as those described under procedure codes unique to the program (OWCP Codes). Such RVU are based on CMS data, state workers' compensation data, other federal entities and OWCP program-specific data.

Effective April 27, 2020, the Office of Workers' Compensation Programs (OWCP) has transferred all medical bill processing services to OWCP's new bill pay contractor CNSI. Please use https://owcpmed.dol.gov for information pertaining to medical bill processing services.

Geographic Adjustment Factors

A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component by the GPCI for that component. Effective, September 27, 2017, OWCP will use the Geographic Practice Cost Indices (GPCI) developed by CMS to calculate the values Medicare program carriers use for carrier-designated locality adjustments. OWCP now uses the Medicare Locality Name instead of the MSA name, to more closely align with CMS practices. MSA's will no longer be used in OWCP's Fee Schedule.

OWCP Conversion Factors

The OWCP devises its own conversion factors (CF) for converting RVU and GPCI into maximum dollar amounts per medical service or item based on program-specific data, and national billing data from other federal programs, state workers' compensation programs and the U. S. Department of Labor's Bureau of Labor Statistics consumer price index (CPI) data.

Covered Services: The fee schedule is applicable to charges for services by medical professionals, including physicians, clinical psychologists, ophthalmologists, chiropractors, osteopaths, podiatrists, physicians' assistants, therapists, and medical technologists/ technicians. OWCP also applies a schedule to certain durable medical equipment, supplies and other items or services covered under the program. Information regarding whether a service may be covered can be found in the file: ***Effective_July_1_2022_code_rvu_cf.xls*** under the column entitled Pay Status. Applicable codes and their definition are as follows:

N - Bundled
C – Covered
D – Not Payable by DOL
S/R – Suspend for Review

****PLEASE NOTE: Pay Status Code equal to "C" is not a guarantee of coverage or payment in any case****

Bundled Services: Effective May 13, 2018, OWCP implemented a change for processing bundled codes for the Division of Federal Employees Longshore Harbor Workers' Compensation (ELHDFWC) and the Division of Energy Employees Occupational Illness Compensation (DEEOIC) programs. This change went into effect for the Division of Coal Mine Workers' Compensation Program (DCMWC) on April 27, 2020. Bundled codes are covered procedures that are billable but not separately payable. Payments for bundled codes are included in the payment for the services to which they are incident.

Medically Unlikely Edits (MUE): Effective March 5, 2022, the OWCP implemented the use of National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUE). The MUE for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®) code is the maximum number of units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Not all HCPCS/CPT® codes have MUE.

Although the CMS publishes most MUE values on its website, some MUE values are confidential. Confidential MUE values are not releasable. The confidentiality of MUE values is subject to change.

The CMS posts changes to each of its NCCI public MUE files on a quarterly basis. This includes additions, deletions, and revisions to public MUE for Practitioner Services, Outpatient Hospital Services, and DME Supplier Services. MUE files can be found at: Medicare NCCI Medically Unlikely Edits | CMS

It is OWCP policy that MUE shall be used for bill processing unless statue, regulation, or written compensation program policy dictate otherwise.

Inpatient Services: Inpatient hospital services provided under OWCP are grouped and priced using the 3M Core Grouping Software and subject to a reimbursement schedule based on the Medicare Inpatient Prospective Payment System (IPPS). That system assigns services to diagnostic-related groups (DRGs) and adjusts rates for individual hospitals according to their specific cost index. OWCP utilizes the 3M software based on Medicare payment methodologies, but has devised its own reimbursement formulae which were derived from national statistics on injuries treated under workers' compensation (data from OWCP and state workers' compensation programs), as well as other data on injuries and illnesses from Medicare, CHAMPUS, and the VA. Inpatient services not covered under the Medicare IPPS are reimbursed under a formula that is based on the cost-to-charge ratio (CCR) data tables published by CMS for rural and urban hospitals in each state. These tables are a portion of the data CMS publishes each year when they update their regulations on payment of inpatient services. For most recent changes to CMS hospital inpatient prospective payment systems, CCR values, see 86 FR 42044, published April 27, 2021. Specific information on OWCP inpatient formulae follows under a section titled "OWCP Inpatient Reimbursement Formulae". Additional information about our inpatient reimbursement schedules may be obtained by contacting the program. (See "Program Information" below.)

Hospital-based inpatient services should be billed on the UB-04 showing revenue center charges, ICD diagnostic and procedure codes and the hospital's Medicare number. Inaccurate coding may cause inappropriate reimbursement, erroneous reductions in allowable amounts and/or delays in bill processing. The physician's professional services should be coded and billed on Form CMS-1500/OWCP-1500.

Outpatient Services: Ancillary charges for hospital outpatient services (for example, emergency room, recovery room, operating room) should be billed under the appropriate Revenue Center Code (RCC) on the UB-04/OWCP-04. All outpatient professional services must be billed under the appropriate CPT/HCPCS/OWCP procedure codes.

Currently, OWCP requires some RCC codes to be billed with appropriate CPT/HCPCS codes. These are listed in file: ***Effective__July_1_2022_rcc_req_cpt.xls.*** (It should be noted that inclusion of a procedure code in an RCC-crosswalk range does not imply authorization and/or coverage for that procedure code.)

On October 1, 2014, the Office of Workers' Compensation Programs (OWCP), Division of Federal Employees Longshore Harbor Workers' Compensation (DFELHWC), implemented a new reimbursement methodology based on the Medicare Outpatient Prospective Payment System (OPPS). On February 22, 2015, the Division of Energy Employees Occupational Illness Compensation (DEEOIC), implemented a new reimbursement methodology which will be based on the Medicare Outpatient Prospective Payment System (OPPS). The payment method will utilize Medicare's Ambulatory Payment Classifications (APC) as well as the OWCP Fee Schedule. DFELHWC Outpatient bills submitted with a date of service before October 1, 2014, will be priced based on the OWCP Fee Schedule. DFELHWC Outpatient bills submitted with a date of service on or after October 1, 2014, will be priced based on the APC rate and/or OWCP Fee Schedule. DEEOIC Outpatient bills submitted with a date of service before February 22, 2015 will be priced based on the OWCP Fee Schedule. DEEOIC Outpatient bills submitted with a date of service on or after February 22, 2015, will be priced based on the APC rate and/or OWCP Fee Schedule. The new method applies to outpatient care in all acute care hospitals, including general hospitals, freestanding rehabilitation hospitals and long-term care hospitals, with the exception of Critical Access Hospitals, Maryland Hospitals, Ambulatory Surgical Centers (ASC), Dialysis Centers, Free-standing Clinics, and Federally Qualified Health Centers (FQHC). When submitting a UB-04/ OWCP-04 form for Outpatient services, providers will be required to enter their Medicare Number in box 51. If the Medicare Number is missing or invalid, the bill will be denied.

The OPPS payment uses Medicare's Ambulatory Payment Classifications (APC) and the OWCP Fee Schedule as well as utilizes the Medicare OPPS payment policies including OPPS quarterly update APC rates, OPPS payment status indicator, Outliers and the geographical wage index adjustment for dates of service on or after October 1, 2014 for the DFELHWC program, dates of service on or after February 22, 2015 for the DEEOIC program.

On April 27, 2020, the Division of Coal Miner Workers' Compensation implemented a new reimbursement methodology, for outpatient bills using the OWCP Fee Schedule. Ancillary charges for hospital outpatient services (for example, emergency room, recovery room, operating room) should be billed under the appropriate Revenue Center Code (RCC) on the UB-04/OWCP-04. All outpatient professional services must be billed under the appropriate CPT/HCPCS/OWCP procedure codes. Outpatient bills with dates of service prior to April 27, 2020 will be processed using the DCMWC Maximum Allowable Fee Schedule.

OWCP Pricing Updated for RCC to CPT Crosswalk

Effective October 1, 2022, Outpatient UB-04 billed lines submitted with both the Revenue Center Code (RCC) and a CPT/HCPCS/OWCP procedure code will be priced based on the procedure code fee schedule. This pricing update will apply to bills submitted for DFEC, DEEOIC, and DCMWC.

Please note that there will be no changes for RCC pricing for lines billed without a procedure code.

In addition, this pricing update will not affect the RCC Codes requiring CPT/HCPCS/OWCP Codes for Outpatient Hospital Services, per the OWCP Fee Schedule.

It also will not affect Outpatient Bills (13x or 14x) that are priced via OPPS for DFEC and DEEOIC Programs, or implant lines billed with RCC 0274 – 0279 that require a manufacturer's invoice for reimbursement (DFEC program only).

Anesthesia Services: Anesthesia is the administration of a drug or gas to induce partial or complete loss of consciousness. All anesthesia services administered ***must*** be billed under the appropriate Current Procedural Terminology (CPT) anesthesia five-digit procedure code plus the appropriate modifier codes: AA, QY, QK, AD, QX, or QZ. Surgery codes are not appropriate. A complete listing of all anesthetic procedures and modifiers which OWCP may cover is included in the file:
Effective_ July_1_2022_anesthesia_tables.xls.

An anesthesiologist, Certified Registered Nurse Anesthetists (CRNA) or an Anesthesia Assistant (AA) can provide anesthesia services. The anesthesiologist and the CRNA can bill separately for anesthesia services they personally perform. In cases of medical direction, both the anesthesiologist and the CRNA would bill OWCP for their component of the procedure. Each provider should use the appropriate anesthesia modifier. An in-depth explanation of the OWCP Anesthesia Services Policy and Reimbursement can be found in the file: ***Effective_ July_1_2022_Anesthesia_Services_Policy.doc***

Formula for calculating maximum allowable: (Times Units + Base Units) x Conversion Factor = Max Allowable

Ambulatory Surgical Center Services: Ambulatory Surgical Centers should bill for facility charges on the CMS-1500/OWCP-1500 using the appropriate AMA CPT® code(s) for the primary, secondary, tertiary, etc. procedures and should use the "**SG**" modifier with each CPT® code. An in-depth explanation of the OWCP Ambulatory Surgery Center Payment Policy and a complete listing of all surgical procedures and ancillary services that OWCP may cover in the ambulatory surgical setting can be found in the following files:
Effective_January_01_2022_asc_pymt_grp.xls. The file is updated quarterly. Note that inclusion in this list does not mean that a procedure is automatically payable. Prior authorization for elective procedures, appropriateness for the accepted condition, and other program requirements must also be met. Outpatient professional services shall be billed separately under the appropriate CPT®/HPCS/OWCP procedure codes.

Implanted Durable Medical Equipment & Prosthetic Implants: Implants are paid under the Grouper/Pricer processing of inpatient acute care hospital bills. For outpatient procedures, implants must be billed on a separate line using the appropriate HCPCS code. Many implant items have maximum fees under the OPPS APC or OWCP fee schedule. If no maximum allowable levels are set by either fee schedule, OWCP will pay acquisition cost for implants, provided a copy of the original invoice clearly showing invoice cost less applicable discounts accompanies the bill.

Exception – Intraocular Lenses: For freestanding ambulatory surgical centers, intraocular lenses, including new technology lenses, are bundled into the fee for the associated procedure. Please include the cost of the lens in the charge for the procedure. It is permissible to include a line on the bill with the HCPCS code for an intraocular lens (e.g., V2630, V2631 and V2632) and its associated cost for information purposes only.

Acquisition Cost Policy for Implanted Devices: Acquisition cost equals the invoice cost to the provider, including shipping, handling and sales tax, net of all discounts. These items must be billed together as one charge. Wholesale invoices for all devices must be retained in the provider's office files for a minimum of three years. A provider must submit a hard copy of the invoice when an individual device or supply costs $150.00 or more, or upon request. Payment of a provider's bill may be delayed if this information is not submitted.

Prescription Drugs:

Federal Employees' Compensation Act (FECA) Pharmacy Reimbursement

Effective March 9, 2021 pharmacy providers will be reimbursed from the FECA Pharmacy Benefit Manager (PBM). Pharmacy providers may inquire about reimbursement and joining the network by directly reaching out to the FECA PBM, at https://feca-pharmacy.dol.gov.

Prior Authorization Requirements for Compounded Products

Beginning December 9, 2021, all compounded products will require prior authorization through the FECA PBM. Prescribers may submit a prior authorization request form for compounded drugs by logging into the FECA PBM prescriber portal, at https://feca-pharmacy.dol.gov.

Prior Authorization Requirements for Opioids

Beginning December 9, 2021, the Division of Federal Employees', Longshore, and Harbor Workers' Compensation (DFELHWC) updated its policy with respect to payment authorization for opioids. Payment authorization for opioids and will now be managed through the FECA PBM (FECA BULLETIN NO. 22-02). Those claimants who had prior authorization requests approved prior to December 9, 2021, will be subject to this policy once their prior authorization periods are completed. Legacy claimants who did not require prior authorization, but who are receiving opioids, will not be subject to this policy; they will be managed through the PBM's retrospective drug utilization review program. The PBM will allow no more than one 7-day supply of an on-formulary, immediate release opioid prescription for new opioid users with non-cancer pain, without prior authorization. The one 7-day supply of opioid may not exceed 90 MME per day. Subsequent fills beyond the initial 7-day supply require prior authorization. Fills are in 30-day maximum supply increments and the PBM will not authorize more than a 60-day treatment period of opioids beyond the first 7-day prescription. If additional opioids are needed, prescribers must continue to seek prior authorization before the end of each prior authorization period. Each prior authorization extension may not exceed a 60-day treatment period unless unique circumstances exist. Prescriber's should review all requirements within FECA BULLETIN NO. 22-02 and may request an opioid prior authorization by logging into the FECA PBM prescriber portal at https://feca-pharmacy.dol.gov and completing a prior authorization request form for opioids.

Prior Authorization Requirements for Non-Formulary Medications

Beginning December 9, 2021, Prescriber's should login to the FECA PBM's Prescriber Portal, at https://feca-pharmacy.dol.gov to view and review the FECA formulary before prescribing medications to FECA claimants. All claimants with a date of injury after December 9, 2021 are immediately subject to the formulary requirements associated with all prescriptions. Claimants with a date of injury on or prior to December 9, 2021 are subject to the formulary requirements for all new prescriptions. A new prescription is defined as a prescription for a medication that has a date of service after December 9, 2021 for a medication that the claimant has not taken in the past six months. Prescriptions for claimants with a date of service after December 9, 2021 for a medication that the claimant has taken in the past six months for their accepted work injury are considered legacy prescriptions. From December 9, 2021 thru December 8, 2022, claims for legacy prescriptions for the work-related injury will continue to be paid regardless of whether the medication is or is not on the formulary. Prescriber's should review all requirements within FECA BULLETIN NO. 22-02 and may request prior authorization for a non-formulary medication by logging into the FECA PBM prescriber portal at https://feca-pharmacy.dol.gov and completing a prior authorization request form for non-formulary medications.

DEEOIC Pharmacy Fee Schedule
Effective May 1, 2014, the Office of Workers' Compensation Programs (OWCP) began calculating the maximum allowable fee for pharmacy billings of prescription drugs using a formula, which differentiates between brand name drugs and generic drugs. The maximum allowable fee for brand name drugs is 90% of the AWP plus a $4.00 dispensing fee, and the maximum allowable fee for generic drugs will be 75% of the AWP plus a $4.00 dispensing fee.

DCMWC Pharmacy Fee Schedule
Effective May 1, 2014, the Office of Workers' Compensation Programs (OWCP) began calculating the maximum allowable fee for pharmacy billings of prescription drugs using a formula, which differentiates between brand name drugs and generic drugs. The maximum allowable fee for brand name drugs is 90% of the AWP plus a $4.00 dispensing fee, and the maximum allowable fee for generic drugs will be 75% of the AWP plus a $4.00 dispensing fee

Prescription drugs should be billed under the correct NDC on the Uniform Claim Form in either hard copy or electronic format; show the trade or generic name, and the quantity provided. Pharmacies may submit bills electronically using the NCPDP 5.1 format to the Department's fiscal agent, Conduent. Contact the Conduent Call Center at (844) 493-1966 for assistance with electronic billing. Claims for reimbursement of pharmacy bills by the injured worker must be submitted on Form CA-915 and accompanied by a Universal Billing Form with a 9-digit employer tax identification code completed by the pharmacy.

Requests to determine if a drug is payable under a claim should be directed to our Medical Authorizations Unit at (844) 493-1966. Callers must have the NDC number of the drug to receive a prior authorization. Eligibility may also be checked via the web at this URL:

https://owcprx.dol.gov
You must have the Case Number, NDC code and the date the prescription was (or is to be) filled.

Further information on electronic billings may be found at the OWCP web site: http://www.dol.gov/owcp/dfec/regs/compliance/infomedprov.htm

Other Services: OWCP will continue to exercise its current authority to establish maxima for certain services, items of durable medical equipment, facility use fees and other charges not currently on the schedule. Providers will be notified of major schedule changes. All fees without an OWCP-established maximum are subject to review based on prevailing reasonable and customary charges in the area where the service was provided.

Procedure Coding: Billings for medical services subject to the OWCP fee schedule must be identified according to the American Medical Association Physicians' Current Procedural Terminology coding scheme (CPT), the Healthcare Common Procedure Coding System (HCPCS), including the American Dental Association Codes (ADA), or designated OWCP generic codes. The applicable coding rules should be followed as appropriate, including the use of correct CPT and HCPCS modifiers. Use of non-specific or "unlisted" codes to identify procedures clearly described by a CPT code will be denied. OWCP now uses a correct coding initiative program that is based on the CMS model, and separately billed components of services also billed under comprehensive codes will be rejected.

Non-physician Providers: NON-PHYSICIAN HEALTH CARE PROFESSIONALS MUST USE THE APPROPRIATE HCPCS MODIFIERS TO IDENTIFY THEIR CREDENTIALS WHEN USING CODES ALSO USED BY PHYSICIANS (MD/DO). Modifiers acceptable to OWCP are listed on the Modifier Level Table: Effective__ *July_1_2022_mod_table.xls*. Non-physician providers who fail to use proper modifiers may not be reimbursed until services are correctly billed.

Home Health Services: Home health services should be billed under the appropriate HCPCS codes or OWCP program-specific codes. For further information on DEEOIC's program specific policy on Home Health may be found at the OWCP web site: http://www.dol.gov/owcp/energy/.

Charges in Excess of the Maxima allowable: A provider is to charge OWCP their lowest fee charged to the general public. The OWCP fee schedule is not to be used to establish billing rates. A provider, whose fee for services is partially paid by OWCP as a result of the application of the schedule of maxima allowable charges, shall not request reimbursement from the injured employee (patient) for any amount in excess of the maximum allowable. A provider who collects or attempts to collect any amount in excess of the maximum allowable fee may be subject to exclusion from payment under the OWCP. Such exclusion of a provider will be reported by OWCP to all Federal employing agencies, the Centers for Medicare and Medicaid Services, and the state or local authority responsible for licensing or certifying the excluded provider.

Appeals:

Provider: A provider whose charge for service is partially paid because it exceeds the maximum allowable amount may, within 30 days of payment, request reconsideration of the fee determination. Such request should be made to the OWCP District Office having jurisdiction over the injured employee's (patient's) case, and must be accompanied by documentary evidence that (1) the actual procedure performed was incorrectly identified by the original code, or (2) the presence of a severe or concomitant medical condition made

treatment especially difficult, or (3) the provider possessed unusual qualification (Board Certification in a specialty is not sufficient evidence in itself of unusual qualifications). These are the only circumstances which will justify reevaluation of the amount paid. If the OWCP district office issues a decision which continues to disallow a contested amount, the provider may apply to the Regional Director of the region with jurisdiction over the OWCP district office. The application must be filed within 30 days of the date of such decision, and it may be accompanied by additional evidence.

Claimant (patient): If an employee is not reimbursed in full for medical expenses because the amount he or she paid to the medical provider exceeds the maximum allowable, the employee may take the following actions in the order presented: (1) request the provider to refund or credit the difference, (2) request the provider to submit at no additional cost a request for reconsideration of the fee determination as described above, (3) request the OWCP District Office with jurisdiction to contact the provider concerning the amount paid in excess of the allowable maximum.

OWCP FEE SCHEDULE PUBLIC USE FILES

Publications: The OWCP medical fee schedule has seven EXCEL® spreadsheets and four WORD® files and is available at the Department of Labor web site. The URL is:
http://www.dol.gov/OWCP/regs/feeschedule/fee.htm

The files contain (1) Public Use File Directory; (2) Read Me First; (3) Anesthesia Services Policy; (4) Anesthesia Tables; (5) Ambulatory Surgery Centers Payment Policy; (6) Ambulatory Surgery Center list of Allowable Procedures – Effective January 1, 2022; (7) Cost To Charge Ratio Table – October 1, 2021; (8) RCC Codes Requiring CPT/HCPCS/OWCP Codes for Outpatient Services; (9) CPT, HCPCS, ADA and OWCP codes with RVU and Conversion Factors; (10) Geographic Practice Cost Indices by Zip codes; (11) Modifier Level Table

Billing Information

Billing Forms: Unless otherwise instructed, all charges should be presented on standard forms - the CMS-1500/OWCP-1500 (formerly HCFA-1500/OWCP-1500) or the UB-04/OWCP-04, and submitted to the U.S. Department of Labor, Office of Workers' Compensation Programs at the appropriate address:

General Bills
DFELHWC-FECA
PO Box 8311
London, KY 40742-8311

General Bills
DEEIOC
PO Box 8306
London, KY 40742-8306

General Bills
DCMWC
PO Box 8307
London, KY 40742-8307

Online Billing: OWCP strongly recommends electronic submission of bills and attachments via Secured File Transfer Process (SFTP), Direct Data Entry (DDE), and Electronic Data Interchange (EDI)

Claimant Identification: The injured employee's social security number must be listed on each bill; as well as the DFELHWC claim number when applicable.

Procedure Coding: For billing purposes, all physician services, regardless of setting, and all outpatient professional services, including the technical components of radiology, pathology, and clinical laboratory must be recorded using CPT/HCPCS codes or those provided by the OWCP.
Coding conventions as described in the CPT 2022© should be carefully observed, including the use of modifiers. Incorrect coding or the failure to indicate the correct number of units (frequency) on the CMS-1500/OWCP-1500 or UB-04/OWCP-04 may result in inappropriate reimbursement. In addition, OWCP reviews services billed under CPT codes for coherence with the AMA's description of the procedure, and other common standards for appropriateness of use. When a procedure has been prior authorized by OWCP, consult the authorizer if there is any question concerning the correct coding, especially for comprehensive functional capacity evaluations, occupational rehabilitation programs (work hardening/work conditioning), and pain management programs. Non-specific CPT/HCPCS codes ending in "99" are usually considered inappropriate coding, and frequently result in improper reimbursement. Listing a single CPT code more than once on a day of service may result in denial of all but one of the charges because it will be interpreted by the OWCP automated system as duplicate charges; if a procedure covered under a singular CPT/HCPCS code was provided more than once on the same day, use appropriate units or appropriate modifier to indicate frequency. **Non-standard coding and incomplete information will result in delayed and/or erroneous reimbursements**.

INSTRUCTIONS FOR CALCULATING THE MAXIMUM ALLOWABLE DOLLAR AMOUNT PER PROCEDURE FOR A SPECIFIC AREA

Each procedure subject to a maximum allowable amount (MAA) under the OWCP medical fee schedule has been assigned three relative values: work (W), practice expense (PE), and mal-practice expense (MP). Each of these three values is multiplied by three related values for geographic variance in procedure costs called geographic practice cost index values (GPCI): work (w), practice expense (pe), and mal-practice expense (mp). The resultant value is multiplied by a conversion factor (CF) to convert it into a dollar amount.

The work (W), practice expense (PE), mal-practice expense (MP) and conversion factor (CF) values are located: Effective July 1, 2022 CPT, HCPCS, ADA & OWCP Codes with RVU and Conversion Factors.
The geographic practice cost index values (GPCI): work (w), practice expense (pe), and mal-practice expense (mp) are located: Effective July 1, 2022 Geographic Practice Cost Indices by Zip Codes

The Formula is:
$[(W_{rvu} \times w_{gpci}) + (PE_{rvu} \times PE_{gpci}) + (MP_{rvu} \times MP_{gpci})] \times CF = MAA$

Where: W_{rvu} = Work relative value units
$_{Wgpci}$ = Work geographic practice cost index value
$_{PErvu}$ = Practice expense relative value units
$_{PEgpci}$ = Practice expense geographic practice cost index value
$_{MPrvu}$ = Mal-practice relative value units
$_{MPgpci}$ = Mal-practice geographic practice cost index value

EXAMPLE: CPT 73562: Radiological examination, knee, minimum of three views, hospital setting.

Place of Service: Washington, DC 20002
Locality Name: DC+MD/VA Suburbs

CPT 73562 RVU:	Work	0.18
	Practice expense	1.02
	Mal-practice expense	0.02
Locality Name: DC+MD/VA Suburbs (Zip code 20019)		
	Work	1.054
	Practice expense	1.236
	Mal-practice expense	1.294

Conversion Factor for Radiology = 54.01

CALCULATION:
$[(0.18\times1.054) + (1.02\times1.236) + (0.02\times1.294)] \times 54.01 = 79.74$

Outpatient Hospital Facility Charges:

For hospital outpatient facilities: facility charges should be identified by Revenue Center Codes (RCC) on the UB-04/OWCP-04.

RCC codes that require appropriate CPT/HCPCS codes are listed in:
Effective_ July_1_2022_rcc_req_cpt.xls. (It should be noted that inclusion of a procedure code in an RCC-crosswalk range does not imply authorization and/or coverage for that procedure code).

On October 1, 2014, the Office of Workers' Compensation Programs (OWCP), Division of Federal Employees Compensation (DFELHWCC), implemented a new reimbursement methodology based on the Medicare Outpatient Prospective Payment System (OPPS). On February 22, 2015, the Division of Energy Employees Occupational Illness Compensation (DEEOIC), implemented a new reimbursement methodology which will be based on the Medicare Outpatient Prospective Payment System (OPPS). The payment method will utilize Medicare's Ambulatory Payment Classifications (APC) as well as the OWCP Fee Schedule. DFELHWC Outpatient bills submitted with a date of service before October 1, 2014, will be priced based on the OWCP Fee Schedule. DFELHWC Outpatient bills submitted with a date of service on or after October 1, 2014, will be priced based on the APC rate and/or OWCP Fee Schedule. DEEOIC Outpatient bills submitted with a date of service before February 22, 2015 will be priced based on the OWCP Fee Schedule. DEEOIC Outpatient bills submitted with a date of service on or after February 22, 2015, will be priced based on the APC rate and/or OWCP Fee Schedule. The new method applies to outpatient care in all acute care hospitals, including general hospitals, freestanding rehabilitation hospitals and long-term care hospitals, with the exception of Critical Access Hospitals, Maryland Hospitals, Ambulatory Surgical Centers (ASC), Dialysis Centers, Free-standing Clinics, and Federally Qualified Health Centers (FQHC). When submitting a UB-04/ OWCP-04 form for Outpatient services, providers will be required to enter their Medicare Number in box 51. If the Medicare Number is missing or invalid, the bill will be denied.

The OPPS payment uses Medicare's Ambulatory Payment Classifications (APC) and the OWCP Fee Schedule as well as utilizes the Medicare OPPS payment policies including OPPS quarterly update APC rates, OPPS payment status indicator, outliers and the geographical wage index adjustment for dates of service on or after October 1, 2014 for the DFELHWC program, dates of service on or after February 22, 2015
for the DEEOIC program.

On April 27, 2020, the Division of Coal Miner Workers' Compensation implemented a new reimbursement methodology, OPPS for outpatient bills using the OWCP Fee Schedule. Ancillary charges for hospital outpatient services (for example, emergency room, recovery room, operating room) should be billed under the appropriate Revenue Center Code (RCC) on the UB-04/OWCP-04. All outpatient professional services must be billed under the appropriate CPT/HCPCS/OWCP procedure codes. Outpatient bills with dates of service prior to April 27, 2020 will be processed using the DCMWC Maximum Allowable Fee Schedule.

Ambulatory Surgery Center Facility Charges:

Facility fees for services provided by freestanding ambulatory surgery centers under the OWCP medical fee schedule.

State waiver: Ambulatory surgery services provided in a hospital-based ambulatory surgical center in Maryland are exempt from this section. The Maryland Health Services Cost Review Commission establishes rates for hospital-based ambulatory surgery services in Maryland. Since Maryland hospitals are required to bill these rates, reimbursement for ambulatory services is to be based on the billed charge. Freestanding ambulatory surgical centers in the state of Maryland are not covered under the Maryland state waiver for hospital inpatient, hospital outpatient and hospital-based ambulatory surgical centers.

Facility fees: Facility fees associated with procedures performed in freestanding ambulatory surgical centers are paid according to calculations based on the CPT code for the surgical procedure(s) performed. Bills are to be submitted on the Form HCFA/OWCP–1500. Each surgical procedure is to be indicated by the appropriate CPT Code with the OWCP modifier SG appended to indicate that the facility fee is being charged. The SG modifier carries a multiplier of 200% of the physicians' professional maximum for dates of service beginning May 12, 2009 forward. For dates of service prior to May 12, 2009, the multiplier is 175%. Payment rates are also adjusted for the performance of multiple surgical procedures. The adjustment criteria calculate payment allowing 100% of the maximum allowable charge for the highest priced procedure and 50% of the maximum allowable charge on secondary, tertiary and all other procedures. Actual payment is based on the calculated payment rate or the billed charge, whichever is less.

These payment rates established under the OWCP medical fee schedule only apply to facility charges. The payment rate does not include physician fees, anesthesiologist fees, or fees of other professional providers authorized to render ambulatory surgery procedures and to bill independently for them. Professional fees must be submitted separately from facility fees. The payment rate does not apply to laboratory, x-rays, or diagnostic procedures other than those directly related to the surgical procedure. Charges for non-surgical diagnostic services must be submitted separately from facility fees. The payment rate does not apply to surgically implant prosthetic devices; ambulance services; leg, arm, and back braces; artificial limbs; or durable medical equipment for use in the patient's home. Charges for DME/POS and implanted devices

must be submitted separately from facility fees, and bills for such items must be accompanied by true copies of the vendor's invoice.

Example: $[(W_{rvu} \times w_{gpci}) + (PE_{rvu} \times PE_{gpci}) + (MP_{rvu} \times MP_{gpci})] \times CF$ = MAA x 200%

CPT 29823: Arthroscopy, shoulder, surgical; debridement, extensive

Place of Service: Washington, DC 20002
Locality Name: DC+MD/VA Suburbs

CPT 29823 RVU:	Work	7.98
	Practice expense	8.09
	Mal-practice expense	1.57
Locality Name: DC+MD/VA Suburbs		
	Work	1.054
	Practice expense	1.236
	Mal-practice expense	1.294

Conversion Factor = 62.11

CALCULATION:
$[(7.98 \times 1.054) + (8.09 \times 1.236) + (1.57 \times 1.294)] \times 62.11$ = $1,269.64 x 200% = **$2,539.27**

Note: a radiology/diagnostic procedure is considered to be directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the CPT code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description. Radiology/diagnostic procedures performed prior to the date of ambulatory surgery are processed separately and are paid under the appropriate sections of the OWCP medical fee schedule.

Covered ASC (Ambulatory Surgery Center) Facility Services include:

• Nursing services, services of technical personnel, and other related services
• Use of the ASC facilities by the patient
• Drugs, including take-home medications, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the surgical procedure
• Diagnostic or therapeutic items and services directly related to the surgical procedure (including simple preoperative laboratory tests, e.g., urinalysis, blood hemoglobin or hematocrit)
• Administrative, record keeping and housekeeping items and services
• Blood, blood plasma, platelets, etc.
• Materials for anesthesia; and

• Intraocular lenses (IOLs).

ASC Approved Procedures include most CPT codes approved by the Medicare program for its ASC list for 2021. A complete listing of all surgical procedures which OWCP may cover in the ambulatory surgical setting is included in file: ***Effective_January_1_2022_asc_pymt_grp.xls***. The file is updated quarterly.

This list does not include procedures that are currently performed on an ambulatory basis in a physician's office and that do not generally require the more elaborate facilities of an ASC. Neither does the list include procedures that are appropriately performed in an inpatient hospital setting or an outpatient hospital setting but would not be safely performed in an ASC. We recognize that there are some procedures that might be appropriately performed in ASC for the younger patient who is generally healthy. But for the larger number of OWCP program beneficiaries whose health is more likely to be compromised by disability and age, an ASC may be a questionable setting for those same procedures. Therefore, we are including in the list only those procedures that can be safely performed in an ASC on the general OWCP program population in at least a significant number of cases. The resulting list of procedures allows ASCs to furnish OWCP program beneficiaries with a broad range of surgical services that reflect the practice of contemporary surgery without compromising patient safety.

OWCP Program Requirements for Prior Authorization: Elective surgery, therapeutic services provided beyond customary time periods (e.g., prolonged physical therapy treatments or therapy initiated long after the injury), comprehensive rehabilitation services such as work hardening/work conditioning programs or pain management programs, home health services, **must be prior-authorized**. All Medical Authorizations are handled by our contractor, CNSI. The fax number for DFELHWC medical authorizations is (800) 215-4901, and the fax number for DEEOIC is (800) 882-6147. Please be sure to put the claimant case number on each page you fax.

Further information, including specific information to include in requests for authorization, and our online tool for Eligibility, Authorization and Bill Payment can be obtained at the DOL web site:

For DFELHWC claims: http://www.dol.gov/owcp/dfec/regs/compliance/CBPOutreach.htm
For DEEOIC claims: http://www.dol.gov/owcp/energy/

Reimbursement Rates: Bills are processed through an automated system and are reimbursed at the billed amounts unless a particular charge exceeds the maximum allowable; such charges are reimbursed at the maximum allowable amount under the OWCP medical fee schedule. Procedures without an assigned maximum allowable (no RVU values have been assigned) are reviewed independently based on prevailing reasonable and customary charges in the area where the service was provided. To determine the maximum allowable amount for a procedure, see the instructions at the end of this document.

PROGRAM INFORMATION

For additional information concerning the OWCP schedule of maximum allowable amounts, or codes for OWCP-ordered services such as occupational rehabilitation, functional capacity evaluations or pain management programs, contact the nearest OWCP District Office. Current addresses and telephone numbers may be obtained at the DOL web site:

For DFELHWC: http://www.dol.gov/owcp/contacts/fecacont.htm
For DEEOIC: http://www.dol.gov/owcp/energy/regs/compliance/law/JurisdictionMap.htm
For DCMWC: http://www.dol.gov/owcp/dcmwc

National Office Contact:

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Planning, Policy and Standards
Room S-3524
200 Constitution Avenue N.W.
Washington, D.C. 20210
(202) 354-9648

OWCP INPATIENT BILL PROCESSING FORMULAE

OWCP INPATIENT BILL PROCESSING FORMULAE

The following describes how OWCP prices reimbursements for payable, inpatient bills.

Cost-To-Charge Ratio

- Cost to Charge (CCR) Ratio (Effective Annually October 1, Dates of Services),
- Hospitals Services not subject to the Medicare Inpatient Prospective Pay System (IPPS). Ex. Rehabilitation, and Long-Term Care (LTC)
- OWCP applies a "cost-to-charge" (CCR) ratio formula that is based on CMS' case-weighted data for hospital operating and capital costs per state. All IPPS-exempt hospitals in a state are paid at the same ratio.
- Formula:

  ((CMS State Operating CCR + CMS State Capital CCR) × Billed Amount)) × 1.26 = OWCP Maximum Allowable

Pay as Billed – the facilities listed below are paid as billed

- Maryland hospitals regulated by the Maryland Health Services Cost Review Commission have negotiated a facility-specific cost-based rate with HHS and they are paid as billed.
- Federal Facilities (Veteran's Administration)
- Residential Facilities
- Boarding Home
- Skilled Nursing Facility

Acute Care Facilities

(Effective October 1 through September 30 with Quarterly updates)
Acute care hospital services covered under the Medicare Inpatient Prospective Pay System (IPPS) are paid under the following formulas based on the following:

- OWCP Inpatient Algorithm (Effective Annually January 1)

  The Part A inpatient hospital deductible and the daily coinsurance amounts are paid "out of pocket" directly to the hospital by the Medicare beneficiaries. OWCP claimants do not pay "out of pocket", so these amounts are applied to the Medicare allowable (MA) (from the Grouper/Pricer output) when calculating the OWCP maximum allowable (A).

  - A = OWCP maximum allowable payment
  - LOS = The claimant's length of stay
  - MA = Medicare allowable amount calculated using the version of the 3M Grouper and Pricer software appropriate to the discharge date.

Effective January 1, 2022, acute care hospital services covered under the Medicare Inpatient Prospective Pay System (IPPS) are paid under the following formula:

- A = OWCP maximum allowable payment
- LOS = the claimant's length of stay
- MA = Medicare allowable amount calculated using the version of the 3M Grouper and Pricer software appropriate to the discharge date.
- If LOS is less than or equal to 60 days,
- A = (MA × 1.33333) + 1,556.00
- If LOS is greater than 60 days but less than or equal to 90 days,
- A = (MA × 1.33333) + 1,556.00 + [(LOS - 60) × 389.00]
- If LOS is greater than 90 days,
- A = (MA × 1.33333) + 13,226.00 + [(LOS - 90) × 778.00]

Effective January 1, 2023, acute care hospital services covered under the Medicare Inpatient Prospective Pay System (IPPS) are paid under the following formula:

- A = OWCP maximum allowable payment
- LOS = the claimant's length of stay
- MA = Medicare allowable amount calculated using the version of the 3M Grouper and Pricer software appropriate to the discharge date.
- If LOS is less than or equal to 60 days,
- A = (MA × 1.33333) + 1,600.00
- If LOS is greater than 60 days but less than or equal to 90 days,
- A = (MA × 1.33333) + 1,600.00 + [(LOS - 60) × 400.00]
- If LOS is greater than 90 days,
- A = (MA × 1.33333) + 13,600.00 + [(LOS - 90) × 800.00]