PART 5 - BENEFIT PAYMENTS

LIST OF CHAPTERS

5-0100 Introduction

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1. Purpose and Scope. Part 5 of the Procedure Manual describes the policies and procedures which pertain to the financial aspects of the Federal Employees' Compensation program. These aspects include processing bills for medical care and related expenses; payment of compensation to beneficiaries in disability and death cases; health benefits and optional life insurance; financial management; financial reports; and the chargeback process.

2. Bill Processing. Bills are processed through the automated Bill Processing System

(BPS). The procedures for use of the BPS and related issues are described in FECA PM 5-0200 to 5-0208.

3. **Compensation Payments**. Entitlement to compensation benefits is determined by the Claims Examiner (CE). Payments are computed based on the period of compensation, rate of pay, and rate of compensation provided by the CE. The procedures for computing payments and use of the Automated Compensation Payment System (ACPS) are described in FECA PM 5-0300 to 5-0309.

4. **Health Benefits/Optional Life Insurance**. The CE provides the information needed to compute health benefit and optional life insurance deductions under the provisions of the FECA and the regulations of the Bureau of Retirement, Insurance and Occupational Health (BRIOH), Office of Personnel Management. The procedures for computing and making these deductions are described in FECA PM 5-0400.

5. **Financial Management**. Fiscal personnel are responsible for completing various documents with respect to payments and for maintaining proper control over cash and disbursement activities. General considerations are discussed in FECA PM 5-0500 and 5-0501, while preparation of documents, cash control, and maintenance of the Fund Control Register are described in FECA PM 5-0502 through 5-0504. Procedures relating to recovery of overpayments are discussed in FECA PM 5-0505.

6. **Financial Reports**. The record-keeping requirements of the program and the major reports which must be completed on a recurring basis are described in FECA PM 5-0600 through 5-0603.

7. **Chargeback**. The term "chargeback" refers to the process by which OWCP bills employing agencies for their compensation costs, which are calculated on the basis of payments made from the Compensation Fund. By August 15 of each year, OWCP informs each agency of the amount expended on behalf of its employees from the Compensation Fund during the preceding fiscal year (which runs from July to June for chargeback purposes). The agency then either reimburses the Fund in the amount requested or budgets that amount for compensation purposes for the upcoming fiscal year. The process is described in FECA PM 5-0900.

8. **Forms and Reference Materials**. Forms, charts and tables which are identified as exhibits appear at the end of the applicable chapter. Reference materials include:

a. Federal Employees' Compensation Act as amended

(5 U.S.C. 8101 et seq.);

b. Title 20, Code of Federal Regulations (CFR), Chapter 10;

c. Federal Employee Compensation System (FECS) Users Manual, which also includes the Federal Establishment Code Manual (FECM);

d. Office of Personnel Management Benefits Administration Letters, formerly the Federal Personnel Manual, letter number 94-202, issued October 19, 1994;

e. Federal Employees' Health Benefits Act of 1959; and

f. Retired Employees' Health Act of 1960.

5-0101 Security of the Fiscal Operation

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1. Purpose and Scope. This chapter describes procedures with implications for the overall security of financial transactions processed under the Federal Employees' Compensation Act. Procedures specific to the security of one type of financial transaction, such as the payment of bills or compensation, are discussed in the applicable chapter.

2. Management Review. The Fiscal Officer, as manager of the Fiscal Section, is responsible for ensuring the security and proper control of financial transactions.

a. As part of the office-wide management review process, the Fiscal Officer will

conduct a periodic review based on the financial sections of the FECA Accountability Review Manual. One of the purposes of the review is to identify problems related to the security of the financial operation and initiate timely corrective action. If a function covered in the review manual is performed by the Fiscal Officer, management review of that function should be conducted by a higher authority.

b. At the completion of the review, but not later than 10 workdays after the end of the review period, the Fiscal Officer will report the results of the review in writing to the District Director. For each item reviewed, the report should include the sample size (where sampling was involved), a summary of findings, a description of corrective actions taken or planned, and any recommendations for training or other appropriate measures which cannot be taken solely at the unit level.

3. Separation of Functions. Although the size of the Fiscal Section precludes a complete separation of duties in most District Offices, the responsibility for certain fiscal actions should be separated as much as is practical. For reasons of security, the same person should not process payments, receive unidentified cash from the mailroom, record transactions in the automated system, and perform reconciliation procedures. To the extent possible, these duties should be handled by separate persons or rotated among the Fiscal Unit staff.

4. Use and Control of Manual Payments. The use of manual payments must be controlled carefully to eliminate the potential for fraud. Because the automated system is capable of issuing payments in most situations, the use of manual payments should be minimal.

a. Manual payments are permitted in the following situations:

(1) Emergencies. In rare situations where manual payment would be received more quickly than payment through the automated system, and extreme hardship or very unusual circumstances are involved, payment may be made manually using form SF-1166, Voucher and Schedule of Payments. Authorization to issue a manual payment under these circumstances must be provided by the Supervisory Claims Examiner or a higher authority.

(2) Check Recertification. When the disposition of a missing check is unknown (i.e., the confirmed copy of the SF-1184 has not been received from Treasury), the check may be reissued on a manual SF-1166. This should be done only if delay in reissuing the check will cause severe financial hardship. (See FECA PM 5-502.11 concerning procedures for recertification of unavailable checks.)

(3) Erroneous Deposits Unrelated to FECA Cases. When money intended for

another account or Federal program is erroneously deposited into the compensation fund via a lockbox depository, the money must be returned to the sender by a manual payment.

(4) Special Payments in District #50. District #50 is responsible for making several types of payments which cannot be made through the automated system. Included among these transactions are payments in foreign currencies, reimbursement to the Panama Canal Commission, and security case payments.

b. Preparation of the SF-1166 is described in FECA PM 5-502.3. The Fiscal Officer must review and certify all manual payments, and must maintain security over the vouchers.

c. Since all payments must be reflected in the history payment file and in the chargeback file, it is necessary to record manual payments in the automated history (see FECA PM 5-0208 and 5-308.4 concerning history updates to BPS and ACPS, respectively). The history should be updated within five days of receipt of the paid SF-1166.

5. FECS Surveillance Reports. District offices receive quarterly surveillance reports to assist in monitoring case payments and detecting unusual provider activity.

a. UTL001, Daily Roll Utilization, lists cases for which more than seven daily roll payments have been made during the quarter, and provides information on the number and amount of the payments. The report should be reviewed to detect inappropriate use of the daily roll, or cases which warrant further investigation to determine whether payments were correctly made.

b. UTL002, Medical Payments on Death Cases, provides information on medical payments made after the date of death. Such payments would normally be made on a one-time basis to a consultant specialist, or to a physician performing an autopsy. Cases with numerous or questionable payments should be reviewed, and additional investigative action taken as needed.

c. UTL003A, Medical Services Without Compensation, and UTL003B, Medical Services Beyond Compensation, are used to identify cases in which frequent bill payments have been made during periods when no compensation was paid.

d. UTL004, Compensation Without Medical Services, provides information about cases in which compensation, but no bill, was paid during the quarter. Long periods of payment without medical service may raise the question of whether disability is supported by medical evidence, or may simply mean that the employee was treated by

unreimbursed physicians, such as Army physicians.

e. UTL005A and UTL005B, BPS Surveillance Reports, are designed to assist the offices in identifying unusual patterns of medical provider activity. UTL005A gives provider and payment information for EIN numbers to which payment has been made on more than 20 cases during the quarter. UTL005B provides the same type of information for providers who received more than $5000 in payments during the quarter. District office personnel who are familiar with the office's frequent providers should review the reports to see if unexpected features or patterns emerge. A Provider Utilization Report by EIN, listing payments to the provider and case file numbers, should be obtained when questionable provider activity is noted. Where necessary, case files should be pulled to examine medical evidence supporting continued or extensive treatment, or to contact the claimant to verify that the treatment was rendered.

f. UTL006A and UTL006B, BPS Surveillance Reports, provide case and payment information for cases with frequent or high cost bill payment activity during the quarter. UTL006A lists cases in which the dollar amount of the bill payments for the quarter exceeded $5000, and UTL006B lists cases in which more than 20 bill payments were made during the quarter. Appropriate review and investigation should be undertaken in questionable cases.

g. UTL007, BPS Bypass and Override Utilization Report, provides an analysis of the number and percentage of bills processed with bypass codes and authorizing initials for each district office.

h. UTL008, Override Utilization Report, shows the total number and amounts of ACPS transactions for each office, and the number and percentage of transactions which were made with a gross override.

6. Password Protection. Permissions for use of BPS and ACPS Jobs and Programs is controlled by individual user identifications and passwords. The selection and coding of the passwords occur at the district office. Passwords must be kept confidential. The Systems Manager is responsible for updating and maintaining the passwords.

5-0200 Overview of the BPS

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Paragraph Subject Date Trans. No.

1. Purpose and Scope. This chapter and the following chapter provide information regarding medical payments. This chapter describes the flow of bills through the office, outlines the various types of bills that are processed, and provides an overview of actions required in conjunction with bill processing. Chapter 5-0201 discusses Central Bill Processing (CBP) issues.

Medical bills may be sent to OWCP through the DFEC Central Mailroom (CM) at the address provided below, or they may be filed electronically through the Electronic Data Interchange (EDI). The goals of medical bill processing are to ensure that all proper charges are paid promptly and that charges which cannot be paid are denied promptly with an explanation.

2. Authority.

a. 5 U.S.C., section 8103, provides that an "employee who is injured while in the performance of duty shall be furnished the services, appliances, and supplies prescribed or recommended by a qualified physician which the Secretary of Labor considers likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation." This section also provides that the expense of these

services and supplies, as well as necessary and reasonable transportation and other expenses related to obtaining services, shall be paid from the Employees' Compensation Fund.

b. 5 U.S.C., section 8123, provides that an employee "shall submit to examination by a medical officer of the United States, or by a physician designated or approved by the Secretary of Labor, after the injury, and as frequently, and at the times and places as may be reasonably required." If the employee's physician should disagree with the physician making the examination for the United States, section 8123 provides that the United States shall appoint a referee physician to make an examination. This section also provides for payment from the Employees' Compensation Fund of reasonable expenses incident to any such examination required by OWCP, including transportation and loss of wages incurred.

c. 20 CFR 10.801 and 10.802 outline the requirements for submission of bills for medical services, appliances, and supplies, and for reimbursement of claims for medical expenses, transportation costs, loss of wages, and incidental expenses.

d. 20 CFR 10.803 describes the timeframe in which bills will be considered for payment..

3. Affiliated Computer Services (ACS). ACS provides all medical bill payment and medical authorization services. This includes enrolling providers, maintaining the provider file, performing bill resolution, processing adjustments, and issuing payments.

a. Mailing address. Providers and claimants should send all mail for Federal workers' compensation cases to:

U.S. Department of Labor
DFEC Central Mailroom
PO Box 8300
London, KY 40742-8300

Information concerning electronic data imaging (EDI) is available on the web at http://www.acs-gcro.com/ or by calling the EDI Technical Support line at (800) 987-6717.

b. Contact information for billing inquiries. Providers, claimants, and employing agencies may obtain information on billing or reimbursement online at http://owcp.dol.acs-inc.com. Bill status information is also available 24 hours per day, seven days per week, via the Interactive Voice Response System (IVRS). The toll-free phone number for the IVRS is (866) 335-8319. Callers may also choose to speak with an

ACS representative during operating hours (M-F, 8:00 a.m. - 8:00 p.m., EST) by calling (850) 558-1818. This is not a toll-free number. OWCP personnel should direct all billing inquiries to ACS.

c. AQS users. Agency Query System (AQS) users may access the ACS Web Portal to perform queries by selecting the "Bill Inquiry" hyperlink from the AQS Injured Worker Case Query results page.

d. Intranet Help Site. The Central Bill Pay/Medical Authorization Unit intranet help site is available to OWCP personnel as a reference concerning ACS related procedures, status reports, and news. The website is: http://esa/owcp/billpay/MAU/index.htm.

4. Providers of Medical Services.

a. Definitions. The term "physician" is defined at 5 U.S.C. 8101 to include licensed medical doctors, surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law.

(1) "United States Medical Officers and Hospitals" includes medical officers and hospitals of the Army, Navy, Air Force, Department of Veterans Affairs, and United States Public Health Service, and any other medical officer or hospital designated as a United States medical officer or hospital by the Director of OWCP.

(2) "Medical, Surgical, and Hospital Services and Supplies" includes services and supplies provided or prescribed by physicians and medical facilities defined above within the scope of their practice as defined by state law, except that a chiropractor is considered to be a "physician" only when a subluxation of the spine has been diagnosed by x-ray, and treatment is limited to manual manipulation of the spine. However, if chiropractic treatment is prescribed by a qualified physician, treatment other than manipulation of the spine may be authorized.

b. Excluded Providers. 20 CFR Sections 10.815 – 826 state that certain providers may be excluded from participation in the Federal Employees' Compensation Program, and their services may not be reimbursed from the Employees' Compensation Fund during the period of their exclusion. Providers who are convicted of fraud in connection with any "Federal or State program" for which payments are made for medical services, or who were excluded or suspended from participation in a benefit program, such as Medicare, are automatically excluded.

Other providers may be excluded through an administrative process if they make false statements in support of a claim, have a different schedule of fees for FEC cases than their usual and customary charges, fail to submit accurate and full medical reports, or provide excessive or substandard treatment.

c. Provider enrollment. All medical providers must enroll with ACS. All bills submitted by unenrolled providers are returned along with instructions on how to enroll. Providers may contact ACS for an enrollment packet or may enroll online at https://owcp.dol.acs-inc.com through the "Provider" link in the FECA section. All enrolled providers will receive a provider identification (ID) number that is assigned by ACS.

d. Provider file updates and Notification of Change reports. ACS maintains a provider file. Providers should contact ACS for address and account information changes. The Department of Treasury sends Notification of Change reports to the District Office (DO) with information regarding electronic funds transfers (e.g., bank routing numbers or account types). The DO fiscal personnel should fax the reports to ACS at (850) 558-1920.

5. Case actions required. The following case actions are required in conjunction with bill processing.

a. Form CA-1 or CA-2 must be filed and a case number assigned by OWCP before a bill for medical expenses may be processed.

b. Form CA-16 (if issued) must be entered into the iFECS system by OWCP. This generally authorizes medical treatment for 60 days in traumatic cases. The date the form was signed by the authorizing official is the "from" date and the system generates the "to" date (60 days later). A CA-16 should not be entered if it has not been signed.

c. Case status/case adjudication codes. After the case is adjudicated, the combination of the assigned case status and case adjudication codes and dates, as described in Part 2 of this manual, determine if medical services and supplies are payable beyond the 60-day period authorized by the CA-16. Before the case is accepted, the status code must reflect that the case is under development (UD). Medical services and supplies acquired using the CA-16 are payable while the case is in UD status.

d. The ICD-9 code of the accepted condition must be entered into the iFECS system. The code should be four or five digits, as appropriate. The CE should also use the appropriate FECA identifier in the sixth position of the code.

The CE should review and update the ICD-9 codes based on the medical evidence of record when needed. In order to process a bill, the ICD-9 code on the bill must fall within a designated range of similar diagnoses related to the accepted condition.

6. Medical bills. All of the following types of medical bills are processed by ACS and should be sent to the London, KY address provided above or filed electronically via EDI. Bills must be on the correct form and reflect the OWCP case number in order to be considered for payment. The requirement for forms is as follows:

a. HCFA-1500 or OWCP-1500. Providers must use the HCFA-1500, which is also designated OWCP-1500, to bill for the following types of services: physician, psychologist, chiropractor, therapist, audiologist, radiologist, rural health clinics, laboratory, podiatrist, ambulatory surgery center, home nursing service, acupuncturist, ambulance service, and durable medical equipment.

b. UB-92. All hospital, hospice, and nursing home bills must be on this form.

c. OWCP-957 (Travel Voucher). This form should be used for all medical travel reimbursement and replaces the SF-1012.

d. OWCP-915 (Claim for Medical Reimbursement). The claimant should use this form to request reimbursement for out of pocket injury-related medical expenses. The OWCP-915 replaces Form CA-915.

e. ADA Form J515. This form should be used for all dental bills, including those of oral surgeons.

f. Veterans Administration (VA) bills. VA bills are not subject to the fee schedule. These bills are submitted on the UB-92 (in-patient charges) or the HCFA 1500 (outpatient charges).

g. Field nurse and rehabilitation counselor bills are filed electronically through the ACS Medical Bill Processing Portal at https://owcp.dol.acs-inc.com/portal.

h. Pharmacy bills may be filed electronically (via EDI) or by completion of the Universal Billing Form (UBF).

7. Information required on bills. Bills for all services and appliances, whether for direct payment to a provider or reimbursement to the claimant, must include the following information to be considered for payment (number placement on HCFA-1500 is indicated in parentheses):

a. OWCP file number (1a)

b. Patient's name (2)

c. Patient's birth date and sex (3)

d. Patient's address (5)

e. Other health insurance coverage (9a-d)

f. Is patient's condition related to: (10 a-c)

g. Patient's or authorized person's signature (12) "Signature on file" is acceptable.

h. Insured's or authorized person's signature (13) "Signature on file" is acceptable.

i. Diagnosis of nature of illness or injury (21)

j. Dates of service (24a).

k. Place of service (24b)

l. Procedure code (24d). This should be in the form of Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, including a modifier, if appropriate.

m. Diagnosis code (24e). The International Classification of Disease, 9th edition (ICD-9) code should be reflected.

n. Charges (24f)

o. Days or units (24g)

p. Federal Tax ID number (25)

q. Total charge (28)

r. Amount paid (29)

s. Signature of physician (31). "Signature on file" may be used.

t. Name and address of facility where services were rendered (32)

u. Provider's name, address, zip code, telephone number, and provider number (33). The Provider ID number is assigned when the provider enrolls with ACS. Using this number facilitates quicker and more accurate processing. All providers must have an ACS Provider ID number for bills to be paid. The provider number entered in item 33 is where DOL payment is made. It is also used to report DOL payments to the IRS. No provider ID number or Social Security number is required for reimbursement to the claimant for travel, pharmacy, maintenance, or training.

Bills that do not meet the above standards will be returned to the provider by ACS.

8. Near-Bills. Bills received that are not submitted on the correct form (invoices, non-HCFA forms, letterhead, etc.) will be returned to the provider by the Central Mailroom. The original bills will be returned with a transmittal letter that explains proper billing procedures .

9. Unique Bills. Bills requiring unique processing procedures are as follows:

a. Foreign bills. Foreign nationals and U.S. citizens receiving medical services in a foreign country are entitled to full medical benefits, including a choice of qualified physicians.

(1) Particular forms are not necessary for payment of foreign bills. They also do not require a provider tax identification number or procedure codes.

(2) When received in the District Office, the responsible claims staff should review the bills prior to submission to the National Office for payment.

(3) The National Office facilitates payment of all bills for which payment is sent to a foreign address or is billed in a foreign currency.

b. Pharmacy. Pharmacies may bill directly via EDI and are encouraged to do so. They may also bill using the Universal Billing Form (UBF). "Real time" pharmacy processing allows pharmacies, through a clearinghouse intermediary, to electronically enter information concerning a pharmacy bill on their point-of-sale device and receive a rapid response as to whether the bill is payable and the amount payable. If the claim is payable, the claim will be processed by ACS. If the claim is not payable, the claimant should be advised to contact OWCP.

c. Field nurses and vocational rehabilitation counselors should submit bills via the

web portal. The staff nurse and vocational rehabilitation specialists will review and approve the bills and reports. (Field nurses and vocational rehabilitation counselors must enroll as providers and sign a web-billing agreement. Other providers of vocational rehabilitation services and supplies, such as colleges and bookstores, are not required to enroll.)

d. Second Opinion and Impartial Medical Evaluation (SECOP/IMPAR) bills are sent to the District Office for review and approval prior to payment. The DO staff batches the SECOP/IMPAR bills, identifies them as prompt pay bills, and sends them to ACS for processing. The medical reports are imaged in the DO.

e. The District Medical Advisor (DMA) submits bills to the District Office for review prior to payment. These bills are also sent to ACS and are identified as prompt pay bills. The DMA must enroll as a provider with ACS in order to have the bills paid. Note: The medical reports are imaged in the DO.

f. 100% wage loss. Payments for 100% wage loss due to the claimant's attendance at an OWCP directed medical examination are processed through the compensation payment system. If the case is under development or denied, the DO personnel should fax a certification memorandum to the National Office Fiscal Officer for payment.

g. If a third party surplus exists on a case, medical payments will not be made until the surplus is absorbed. The CE should use the adjudication status A0 to indicate that a third party surplus exists.

h. Balance forward bills will not be processed. All bills must be submitted in the manner described above for consideration of payment.

i. Travel voucher (OWCP-957). Claimants may request reimbursement for reasonable and necessary transportation costs and expenses incurred to obtain authorized medical services or supplies. Generally, 25 miles from the claimant's work site, residence, or place of injury is considered reasonable. The claimant must complete and sign the OWCP-957, Medical Travel Refund Request. Mileage expenses will be reimbursed at the GSA rate in effect on the date of travel. There will be no reimbursement for meals or lodging when travel is for less than 12 hours in total or fewer than 500 miles round-trip. Lodging must receive prior authorization. Cab fare or hire of special conveyance in excess of $75 requires prior authorization. Original itemized receipts are required for cabs and other transportation expenses (including parking and tolls), as well as for all lodging and meals for amounts in excess of $75. Additional instructions for completing the OWCP-957, Medical Travel Refund Request, are shown as Exhibit 1.

j. Common carrier payments. Claimants occasionally travel via common carrier to

attend OWCP directed medical examinations due to the geographic dispersion of medical specialists in certain areas. The DO makes the travel arrangements and coordinates payment processing with the NO Fiscal Officer. Once all charges are reconciled, the DO sends the invoice and supporting documents to the NO. The NO issues the payment in accordance with the Debt Collection Improvement Act and the Prompt Pay Act. A confirmation of payment is sent to ACS for updating the computer system.

k. Medical Reimbursements. A claimant may request reimbursement for out-of-pocket expenses paid to a provider for a service performed for an accepted condition. A separate request must be submitted for each provider. The claimant should submit:

(1) The completed Form OWCP-915, Claim for Medical Reimbursement.

(2) HCFA-1500 or UB-92 for services provided by a physician or other healthcare provider. The bill must be completed in its entirety as if it were being submitted for direct payment.

(3) The universal billing form (UBF) for prescription medication. The form must include the following information:

(a) Name, address, and telephone number of the pharmacy;

(b) Pharmacy provider number;

(c) Prescription number;

(d) Claimant's name;

(e) Date of purchase;

(f) National Drug Code (NDC);

(g) New prescription or refill number;

(h) Quantity of medication; and

(i) Amount paid by claimant.

l. Over-the-counter (OTC) drugs and supplies prescribed by a physician and paid for by the claimant may be claimed for reimbursement. Form OWCP-915 should be completed as described above. The prescription and proof of payment must be submitted with the OWCP-915.

m. In occupational disease cases, a claimant may have incurred and paid medical expenses for some time before filing a claim. The claimant may be entitled to reimbursement for these expenses and should follow the procedures for medical reimbursements described above.

n. Insurance carriers may learn after having made payment on a claim that it was a workers' compensation claim. They should submit a completed Form NALC-200, Health Insurance Claim Form, Carrier Reimbursement (FECA Program) to ACS. This form, when signed by the carrier's representative, requires no further verification of payment.

o. Bills for missed appointments (no-shows). Bills submitted for missed medical appointments (other than OWCP-directed examinations) are not payable. Charges for missed appointments are the responsibility of the claimant.

p. Rehabilitation maintenance benefits. Claimants should complete Form OWCP-17 to claim rehabilitation maintenance benefits. This form must be certified by an official at the rehabilitation facility prior to submission. The form is sent to the Rehabilitation Specialist (RS) in the DO who reviews the form and forwards it to ACS for payment.

10. Edit resolution. Most bill resolution is performed by ACS. However, DO personnel are required to review bills suspended for claimant eligibility issues related to short form closures, field nurse or vocational rehabilitation bills exceeding authorization time frames and/or dollar limits, and bills over $50,000.

11. Adjustment requests are used to adjust a previous bill Most bill resolution is performed by ACS. However, DO personnel are required to review bills suspended for claimant eligibility issues related to short form closures, field nurse or vocational rehabilitation bills exceeding authorization time frames and/or dollar limits, and bills over $50,000.

12. Check tracers. Providers may call ACS to obtain the status of checks they have not yet received. ACS will query Treasury's Pacer system to obtain the check's status and print an image of the check if it has been negotiated. If appropriate, ACS will reissue the check.

13. The AchieveHCS System contains five years of bill payment history. It also provides information regarding enrolled providers, claimant eligibility, and medical authorizations.

5-0200 Exhibit 1:

Instructions for Submitting Form OWCP-957, Medical Travel Refund Request (For reimbursement of travel and related expenses under the Federal Employees' Compensation Act)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Note: Any item not in conformity with the following instructions and not legible will be deducted from the voucher. **Form OWCP-957 *MUST* be submitted with a valid case file number**.

1. Claim for necessary and reasonable expense incident to travel authorized in accordance with provisions of the Federal Employees Compensation Act may be submitted for consideration on Form OWCP-957. Travel must be by shortest route and, if practicable, by public conveyance (streetcar, bus, boat, or train). Generally, 25 miles from the place of injury, the work site, or the employee's home, is considered a reasonable distance to travel.

2. The Office will promptly reimburse all bills received on the approved form and submitted in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the calendar year in which the expense was incurred or the service/supply was provided, or more than one year beyond the calendar year in which the claim was first accepted by the Office, whichever is later (20 CFR §10.803)

3. Payment will be made for taxicab fare or the hire of special conveyance where streetcars, buses, or other public and regular means of transportation are not available, except where these cannot be used because of the injured employee's disability. If claim is made for payment of expenses for taxicabs in excess of $75 or hire of special conveyances, prior authorization is required.

4. Reimbursement for transportation by automobile owned by an employee or a member of his/her immediate family or another Government employee may be claimed when no public conveyance is available or where the physical condition of the injured employee requires the use of special conveyance. Mileage expenses will be reimbursed at the GSA rate in effect on the date of travel. Mileage expenses will be reimbursed at the following rates for travel during the following periods:

January 1, 1995 to June 6, 1996	30.0 cents per mile
June 7, 1996 to September 7, 1998	31.0 cents per mile
September 8, 1998 to March 31, 1999	32.5 cents per mile
April 1, 1999 to January 13, 2000	31.0 cents per mile
January 14, 2000 to January 21, 2001	32.5 cents per mile
January 22, 2001 to January 20, 2002	34.5 cents per mile
January 21, 2002 to December 31, 2002	36.5 cents per mile
January 1, 2003 to December 31, 2003	36.0 cents per mile
January 1, 2004 to February 3, 2005	37.5 cents per mile
February 4, 2005 and after	40.5 cents per mile

If mileage expense is claimed prior to January 1, 1995, contact your OWCP district office for rates.

5. Claim may be made for parking fees. If travel must be over a toll route, toll charges may be claimed. The form must show the locations where travel began and ended and mode of travel. List each item of expense separately, showing the date incurred, place and cost of the travel.

6. ***There will be no reimbursement for meals or lodging when travel is for less than 12 hours in total or fewer than 500 miles round trip.*** If the authorized travel was for longer than 12 hours or greater than 500 miles, and a claim for meals or lodging is made, the dates and hours must be shown on the form. Lodging must receive prior authorization. All charges must be reasonable, and will be reimbursed at the per diem rate for the locality of travel. Any stopover or delay en route must receive prior authorization.

7. If several trips are covered by the same form, list each separately in the spaces provided on the form. Original itemized receipts for amounts in excess of $75 claimed in 5f, 6f and 7f must be furnished.

8. After a Form OWCP-957 has been completed, it must be signed in ink or indelible pencil in the space provided for the payee.

9. The completed form should be mailed to: U.S. Department of Labor, DFEC Central Mailroom, PO Box 8300, London, KY 40742-8300.

10. The form should not be submitted if there is no expense claimed.

5-0201 BPS FECS001 Programs

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1. Purpose and Scope. This chapter summarizes and gives special instructions for certain FECS Sequent BPS programs which are accessed by multiple users through the FECS001 menu.

a. Payment Input, BILL051. The Payment Input job is used to enter all new bills which have been received in the Office.

b. Adjustment Input, BILL052. The Adjustment Input job is used occasionally to enter an adjustment to the payment history file so that canceled checks, cash deposits, fund transfers, or manual payments will be reflected appropriately.

c. Adjustment Correction Input, BILL053. This job is used now and then to correct payment histories for data entry errors made in BILL052 for check cancellations, manual payments, cash receipts and fund transfers.

d. Suspense Resolution, BILL054. Suspense Resolution is used by bill resolvers to make decisions on bills which have been suspended for review.

e. Resubmit Duplicate Bills, BILL002. This job allows the user to access bill records which have previously been rejected by the Central system as duplicate, for the purpose of adding bypass codes and eventual retransmitting.

f. Payee/Case Number Correction Input, BILL004. This job is used infrequently to correct an erroneous Payee EIN/SSN or case file number on a bill record which was previously entered and processed by the system.

g. Provider Update, BILL005. This job is used to add records to the Provider Master File (v46), or to modify or delete those records.

h. On-line Payment History, BILL006. This function allows users to obtain on-line information concerning paid and denied bills.

i. Central Payment History Request, BILL007. The Central Payment History job is used to obtain a report of the Central bill payment history for a specific case. The Central bill payment history contains more information on paid bills than the on-line history, and covers a longer period of time. The Central history does not contain information on denied bills or bills rejected by Central.

j. Central Provider History Request, BILL008. This job is used to request a Central bill payment history for a specific provider.

k. Provider Inquiry, BILL010. Provider Inquiry is used to determine whether a particular provider is on the Provider Master File (v46).

l. Batch Locator, BILL055. Batch locator is used to determine which batches are open and closed, and shows batches transmitted during the billing cycle. Closed batches which have been edited through the batch edit program are not displayed.

m. Batch Open/Close/Delete. This option is used to open, close, or delete specified

batches. The option will not allow these actions to be performed on batches which have already been edited by the BILL552 program.

n. Provider Labels. This option allows the user to print mailing labels for providers.

o. Suspended Bill Query. This option allows the user to view bills on the system which have not been finalized, included suspended, recycled, and newly keyed bills.

p. Zip Code Search. Zip code search is used to determine what state is considered valid by the system for a given zip code.

q. ICD-9 Description. This option allows the user to view ICD-9 codes and descriptions through four different query options.

r. Excluded Provider Query. Queries may be performed by tax identification number or name to determine whether the medical provider has been excluded from participation in the FECA program.

2. Payment Input, BILL051.

a. BILL051 is used to enter information from new bills into the system for processing by BILL552. As each bill is keyed into the system, the data entered is edited for validity, selected data is matched against the corresponding Case Management Record, and data is either extracted from the Case Management Record or the Provider Master File and automatically inserted into the bill payment record. An output file of records is created which will subsequently be edited at the Sequent level by the BILL552 program.

The BILL552 editing will result in bills being approved for payment, denied, partially approved/partially denied, or suspended for manual review. The approved bills are transmitted to the Central computer site, edited further, and checked for possible duplication of payment. If the bill is accepted, a check is issued to the provider or claimant. A explanation of benefits letter (EOB) is produced at the Sequent level by BILL654 to inform the provider or claimant concerning bills which have been denied. The suspended bills are reviewed and resolved by appropriate office personnel using BILL054, Suspended Bill Resolution.

b. Because keying a bill into BILL051 may result in a payment or denial of a payment being made without a manual review, accuracy of keying is critical.

c. For security reasons, individuals who use BILL051 should not have access to either BILL054 (Suspense Resolution), or BILL005 (Provider Update). Generally,

contract data entry clerks use BILL051.

d. The mechanics of BILL051 data entry are outlined in detail in the FECS Users' Manual. The following general guidelines supplement that information.

(1) BILL051 is menu item 1 on the Bill Payment Menu.

(2) Bills are entered in groups called batches. A batch will generally consist of 20 to 30 bills, but can consist of as few as one to as many as 999 bills. Batch sizes are determined at each district office.

(3) Each batch is assigned a batch identification number which must remain unique until the payment cycle after the payment cycle in which every bill in the batch is adjudicated. Batch identification numbers are assigned according to the individual office's organizational scheme (see Chapter 5-0200.10), and usually consist of six characters, alpha and/or numeric. Batch numbers may be assigned by mail room, fiscal, or data entry personnel. The batch number should be noted on the CA-D-9, BPS Batch Form, in item 1C. The number of bills in the batch should be shown in item 2A.

(4) To enter bills in BILL051, first enter the batch identification number from item 1C of the CA-D-9.

(5) Next entry is the number of bills in the batch, from item 2A of the CA-D-9.

(6) Enter the case file number. A bill may not be entered in BILL051 without a valid case file number. In addition, if the case has been transferred, loaned, retired, or destroyed, data entry is blocked.

(7) Key the first three letters of the claimant's last name. If the claimant's name does not agree with the name on the data base, further data entry is blocked. Sometimes first and last names are reversed on a bill. If the bill cannot be keyed because of case file number/name disagreement, pull it from the batch and make a note under item 4 on the CA-D-9 that a bill was pulled from the batch because of case file number/name disagreement.

(8) Enter the Direct Payment flag. Direct payment is a payment made directly to a provider or other non-claimant. Payments made to claimants are categorized as reimbursements or non-direct payment. If the bill is for direct payment, key "Y"; if for reimbursement to the claimant, key "N".

Most of bills received in the office are for direct payment. However, travel

vouchers, pharmacy receipts, and maintenance reimbursements are usually non-direct payments. The presence of paid receipts or "paid in full" on the bill are also indications of non-direct payment. If the bill is a HCFA-1500, and an "amount paid" is shown in item 29, the bill should be keyed as a non-direct payment. If unable to determine whether the bill is for direct or non-direct payment, key as non-direct, as this will prompt manual review by a bill resolver.5-0201-2 Payment Input, BILL051

(9) If non-direct payment, enter flag for pharmacy/travel/maintenance/training reimbursement. If the bill is for one of these four types of reimbursement, enter "Y". If not, enter "N". Pharmacy reimbursements usually consist of one or more receipts from the pharmacy. Travel reimbursements are usually submitted on form SF-1012. Maintenance reimbursements are always on form OWCP-17. Training reimbursements should already be marked up with provider type VR on the bill.

If "Y" is entered, the next entry will be provider type. The only provider type codes that should be entered are FR for pharmacy reimbursement, KR for travel reimbursement, QR for maintenance reimbursement, and VR for training reimbursement.

(10) Enter the nine-digit tax identification number of the provider, if bill is for direct payment, or if bill is for claimant reimbursement of anything except pharmacy, travel, maintenance, or training. This number is found at item 25 on the HCFA-1500, or item 6 on the UB-82. This number is not required for reimbursement of pharmacy, travel, maintenance, or training. If that particular identification number is not on the provider file, an error message will be produced. Double check the number keyed and continue if keyed correctly.

(11) Enter provider five-digit zip code. This is required only if a tax identification number has been entered.

(12) Enter provider address sequence number if known. Most of the time, the sequence number will not be known, so press <ENTER> to continue, and the first sequence for that provider tax identification number/zip code combination will be displayed on the screen.

(13) Check the provider name and address on the screen against the one present on the bill. If it matches, respond "Y" to the "Address OK?" prompt. If it does not match, respond "N" to the "Address OK?" prompt, and the next sequence for that tax identification number/zip code combination will be displayed. Continue until a match is found.

(14) If no match is found, it means that the provider is not on the provider file. Keying may continue, or offices may choose to pull a bill from the batch at this point and send for security provider file update. If the bill is pulled from the batch because the provider is not on file, an appropriate notation should be made on the CA-D-9 under item 4.

(15) Enter service state and zip. This data is used to apply the fee schedule. Usually it will be the same as the provider state and zip. However, this is not always true, so if services were rendered at a location other than the provider address state and zip (see item 32 on the HCFA-1500), that information should be entered.

(16) Verify that the claimant address is correct if the bill is for non-direct payment by comparing the claimant name and address on the screen with the name and address on the bill. If they match, respond "Y" to the "Address OK?" prompt. If not, respond "N".

(17) Enter provider type. This entry will be required only on bills which are for reimbursement of pharmacy (FR), travel (KR), maintenance (QR), and training (VR) expenses. For other bills, the provider type is written to the bill record from the provider file record.

(18) Enter the prompt payment flag. Most bills are not subject to prompt payment rules. If the bill is not for prompt payment, enter "N". If it is for prompt payment, press <ENTER> ("Y" already shows on the screen). Prompt payment bills will have already been screened by someone else in the office, and are usually placed in separate batches from the other bills. The following types of bills are always prompt payment:

(a) Bills for direct payment to Rehabilitation Counselors (provider types U, V, and W);

(b) Bills which are stamped "Prompt Payment" and are for direct payment of second opinion (procedure code SECOP), impartial (procedure code IMPAR), consultation (procedure code CNSLT), or medical advisor reviews.

(c) Bills for direct payment to field nurses who are under contract to the office. Their services will be coded using a variety of codes starting with the letter N.

(19) Enter bill number. Entry of a bill number is allowed only if the response to the "prompt payment" question was "Y", or if the payment is for a U.S.

Government Transportation Request (GTR), provider type A. For rehabilitation bills, enter the counselor number. For medical and nurse prompt payment bills, enter the prompt payment number which appears on the bill. If there is no prompt payment number on the bill, make an entry consistent with individual district office policy. The system will accept one to 12 digits. For GTR payments, key the Carrier Bill Number.

(20) Enter invoice number or invoice date. The system will ask whether an invoice number (N) or invoice date (D) will be entered. If the response is "N", then an invoice number consisting of up to eight numeric and alpha characters must be entered. If the response is "D", then an invoice date in mm/dd/yyyy format must be entered.

(21) Enter bill receive date. Enter the date the bill was received in mm/dd/yyyy format, from the date stamp that is on the bill. If more than one valid district office date stamp appears on the bill, the oldest date should be used. A date stamp which has been crossed out and marked as returned is invalid. If there is no date stamp on the bill, look for a notation on the bill as to when it was received in the office, and enter that date. If there is no indication on the bill as to date of receipt, enter today's date. (Note: if there is more than a very occasional bill without a date of receipt, notify your supervisor.)

(22) Enter bill total. Key total amount of the bill. No amount in excess of $999,999.99 may be keyed. If the amount is an even dollar amount, enter the number of dollars and press <ENTER>. If the amount includes cents, use the decimal point, enter cents, and then press <ENTER>.

(23) Key authorizing initials. These will not always be requested, and should be entered only if present on the bill. The authorizing initials will be those of an individual in the office who has reviewed the bill and has authorized the dollar amount. If there are no initials present on the bill, press <ENTER> to continue.

(24) Enter Line Item Data. The following information must be entered for each line item on the bill. A bill may contain from one to 9999 line items. Continue keying line items until all line items for that bill are entered.

(a) MO: Key the two-digit month treatment or service started for the charge item being keyed.

(b) DA: Key the two-digit day treatment or service started for the charge item being keyed.

(c) YEAR: Key the four-digit year treatment or service started for the

charge item being keyed.

(d) The month, day, and year keyed in (a) - (c) above will appear as the to date. If the date is correct, press <ENTER>. If the date is incorrect, type over it.

(e) PROC-CODE: The procedure code is the next entry. Not all bills require procedure codes. Up to eight characters may be entered. The first five characters are for the base procedure code, the next two are for the procedure code modifier, and the final character is for the fee schedule appeals code. Enter five-digit CPT4 code, three-digit RCC code, five-digit HCPCS code, five-digit special DOL code, or five-digit dental code if present on the bill. If a five-digit CPT4 code is followed by a one- or two-digit modifier (this will not occur on a majority of the bills), that should be entered next, followed by a one-digit fee schedule appeals code (this will be present only rarely and will have been written on the bill by other office personnel). If eight characters are entered there is no need to press <ENTER>. RCC, HCPCS, DOL and dental codes should not have modifiers or fee schedule appeal codes.

(f) Unit: If a procedure code is required, the number of units "001" will be automatically generated. If no procedure code is required, no units are required. Key the number of units on the bill for the particular procedure (up to three digits). The user should ensure that the number of units keyed is correct, because errors in the number of units result in misapplication of the fee schedule.

(g) Charge: Key the total amount of the charge item, including the decimal point, and press <ENTER>. The maximum which may be keyed in is $99,999.99.

(h) BYP-CD: Key the single-digit Bypass Code shown on the bill, if present (it would be written in by other office personnel). If a Bypass Code is not present, press <ENTER>. Valid codes are 1, 2, and 3 for BILL051. Bypass Code 1 may be keyed without being present on the bill if a multi-page bill is keyed as separate bills, and line items appearing on separate pages would be considered as duplicate input by the system (but they are not).

(i) INEL: If an ineligible amount is present, key the ineligible amount, including the decimal point, and press <ENTER>. If an ineligible amount is not present, press <ENTER>.

(j) EXP: If an eligible amount has been keyed, key the one-letter explanation code which is next to the ineligible amount on the bill. Valid codes are A through N.

(25) As line item charges are entered, the bill balance which appears at the bottom of the screen will decrease proportionately. Most of the time, the balance at the bottom of the screen will be 0 when the entire bill has been keyed. If the bill is out of balance, that is, the sum of the line item charges less ineligible amounts does not equal the bill total, a negative or positive amount will appear as the bill balance.

(26) When the entire bill has been keyed, press <F10>. If the bill is in balance, an "OK? (Y/N)" prompt will appear. If the bill is not in balance, the system will produce this message and ask whether or not to continue. After checking to ensure accurate data entry, respond "Y" or "N". If the response is "Y", the system will give a final OK? prompt and then will prompt for the case file number of the next bill. If the response is "N", the cursor returns to the AUTH field of the bill, and the user may <ENTER> through fields or make corrections. At the final "OK" prompt, if the response is "N", the cursor returns to the case file number of the bill being keyed.

3. Adjustment Input, BILL052.

a. Purpose. BILL052 is used to enter data concerning manual bill payments, and to enter adjustments to bills previously paid. There are four types of "adjustments" which may be made using BILL052: Manual Payments (Code "M"), Canceled Checks (Code "C"), Cash Deposits (Code "D"), and Fund Transfers (Code "F"). BILL052 data entry is very similar to BILL051. Detailed data entry instructions may be found in the FECS User's Manual. The following information supplements the User's Manual.

b. Data Entry Procedure.

(1) BILL052 is menu item 2 on the Bill Payment Menu.

(2) Enter batch number. As with BILL051, bills are entered into BILL052 in batches. There may be as few as one bill in a batch. The bill batch identification number must remain unique within the weekly cycle.

(3) Enter case number.

(4) Enter first three letters of the claimant's last name.

(5) Enter direct payment flag. If payment is/was directly to a provider, enter "Y"; if reimbursement to a claimant, enter "N".

(6) If not direct payment, is/was payment reimbursement to the claimant for pharmacy, travel, maintenance or training expenses?

(7) Enter provider information - direct payment bill and non-direct payment for something other than reimbursement of pharmacy, travel, training or maintenance.

(a) EIN: Key the nine-digit tax identification number of the provider.

(b) Zip: Key the provider's zip code.

(c) Bill: Key the Carrier Bill Number if the bill is for payment of a U.S. Government Transportation Request. If the field is not filled completely, press <ENTER>.

(d) Invoice No./Date (N,D): Enter an N followed by the invoice number or a D followed by the invoice date. The invoice date, if present, will be entered as mm/dd/yyyy. If there is no number or date, or if the number does not fill the field completely, press ENTER.

(8) Enter provider information - pharmacy, travel, training, or maintenance reimbursement.

(a) Type: Key the provider code, then an "R".

(b) Invoice No./Date (N,D): Enter an N followed by the invoice number or a D followed by the invoice date. If there is no number or date, or if the number does not fill the field completely, depress <ENTER>.

(9) Enter date received.

(10) Enter authorizing initials present on the bill, if any (not required).

(11) Enter Adjustment/Maintenance Information. (a)Adj Date: For manual payments, the adjustment date is the date of the check. For other adjustment transactions, the adjustment date is the date of the action by Treasury (check deposit, check cancellation, or fund transfer). Key month, day and year as shown underneath Provider information on bill.

(b) Maint Type: Key maintenance code (M, C, F, or D) as shown underneath Provider information on bill.

(12) Enter Charge Data - All Bills.

(a) MO: Key the two-digit month of the treatment or service for the charge item being keyed.

(b) DA: Key the two-digit day treatment or service started for the charge item being keyed.

(c) YR: Key the four-digit year treatment or service started for the charge item being keyed. If authorization initials are required due to the service date being prior to the history purge date, cursor up to AUTH field.

(d) Charge: Key the total amount of the charge item. If the charge is an even dollar amount, enter the whole dollar amount and press <ENTER>. If cents are involved, enter decimal point and cents and press <ENTER> if the field is not full.

(e) CODE: Key the Bypass Code shown on the bill, to the left of the charge item being keyed. If a Bypass Code is not present, press the space bar or press <ENTER>.

(f) If there is more than one charge item to be keyed, repeat steps b(12)(a) through b(12)(e) for each charge item. (The system will allow up to four charge items per screen format.) The charges must balance with the total.

(g) When all charge lines have been entered for the screen format being keyed, depress <ENTER>.

(h) If the record being keyed is out of balance, review all amounts which have been keyed to determine if there has been a keying error. If there is an entry error, use the up cursor to move to the erroneous amount and make the correction.

(i) There will be a final "OK? Y/N" prompt.

(j) When all adjustments for the batch have been entered, press <esc-esc>, and respond to the prompt concerning batch closure.

4. **Adjustment Correction Input, BILL053**. To adjust an entry to correct payment histories for data entry errors made when entering check cancellations, manual payments, fund transfers and cash receipts, use BILL053. For example, if when entering a cash receipt into BILL052, $500.00 is entered instead of $50.00, and the error is not discovered until the records have been transmitted to the central system, BILL053 should be used to enter a transaction which will back out or balance the incorrect transaction. A BILL053 transaction for $450.00 could be entered, or a BILL053 transaction for $500.00 and a BILL052 for $50.00 could be entered. The first entry after the batch number is the adjustment type of the record that is being corrected (manual payment, fund transfer to agency, cash receipt, and check cancellation). After that, data entry is identical to BILL052.

5. **Suspense Resolution, BILL054**, is covered in detail in PM Chapter 5-0204. Explicit guidance concerning the mechanics of using BILL054 is found in the FECS Users' Guide. BILL054 is used by bill resolvers (either fiscal or claims staff or a combination of the two) to bring bills which have suspended for review from BILL552 to a final disposition.

6. **Resubmit Duplicate Bills, BILL002**.

a. Description. After approved bills are transmitted to the Central system, they are subjected to a variety of processes. One of these is a check against the Central bill history and against bill input for possible duplicate payments. Even though the BILL552 edit process checks for duplicate payments, because the data file BILL552 uses is less complete than the Central bill record file, and because BILL552 does not check against same-day input, it is possible for bills to pass through BILL552 but be rejected by the Central system because of possible duplication. The purpose of BILL002, Resubmit Duplicate Bills, is to allow an office to review records rejected by Central, determine whether the bill is in fact a duplicate of a previously paid item, and if not, enter a bypass code (as appropriate) and retransmit the bill. BILL002 allows the offices to save time by eliminating the need to rekey and re-resolve rejected bills.

b. The time frame for using BILL002 is limited to 12 days from the date of transmission of the original bill. Bills which have not been corrected within 12 days may no longer be accessible using BILL002, unless another bill in the same batch remains suspended. Thus if a bill has been rejected by Central as a duplicate and it is in fact a duplicate, the office does not need to take any action. If a bill is payable but is not corrected through using BILL002 before the full record is deleted, it must be completely rekeyed.

c. To use BILL002, choose option 16 from the FECS001 Bill Payment Menu, then enter the batch identification number (up to six characters), bill identification number (up

to three numbers), and line item number (up to four numbers) of the record which is to be reprocessed. This information is to be obtained from the BP060W report of "Related History and Possible Duplicate Bills Unpaid on yy/mm/dd". If the significant digits for the bill identification number or line item number do not fill up the field, press <ENTER>. For example, if the bill ID number is 002, press 2 and <ENTER>. After entering the batch ID, bill ID, and line item number, if the record is available for resubmission, the bill information will appear on the screen. The user can then enter and verify a blank, or bypass codes 1, 2 or 3.

7. Payee/Case Number Correction Input, BILL004.

a. This job will be used infrequently for purposes of correcting an erroneous Payee EIN/SSN or case file number which was previously entered and processed by the system. Its most frequent use is to transfer bill payments made on a duplicate case to the file number of the case which is to be retained. The payee number correction could be used if a payee was entered in the provider file with an incorrect tax identification number, and a payment was made using the incorrect information. Once the provider file record is corrected, the erroneous bill record can be corrected using BILL004.

b. Using BILL004.

(1) BILL004 is menu item 4 on the FECS001 Bill Payment menu.
(2) Enter batch number.
(3) Indicate whether payee (p) or case (c) number correction is desired.
(4) Enter authorizing initials (required).
(5) Enter case file number and do name check (first three initials of last name).
(6) Enter payee number, service dates, payment date, and payment amount.
(7) Enter payment type (B, C, M, F, or D).
(8) Enter new payee (or case) number, then rekey.
(9) Respond to final "OK? Y/N" prompt.

8. Provider Update, BILL005. This job is used to add, modify, or delete records from the Provider Master File (v46). The Provider Master File contains information on each provider who has submitted bills for payment under the FECA. For each provider, the following information is present in the file:name, address, including state and zip code, provider type code (see PM Chapter 5-203), an exclusion flag, a payment flag, tax identification number (either Employer Identification Number [EIN] or Social Security Number), sequence number, frequency of payment number, date of last payment, district office information, and date of last change. Payment or denial of payment through the BPS cannot be made unless the provider is on the provider file, except by manual payment.

a. Changes to the provider file may only be made by an individual or individuals who have been authorized to perform this function. The individual who performs the updates must be an employee of the Department of Labor (as opposed to a contract employee) and must not have any other association with processing bills through the BPS. In other words, individuals who key, resolve, authorize, or audit bills should not be given permission to perform updates to the provider file.

b. To perform provider file updates, select option 5 from the FECS001 Bill Payment menu. Detailed instructions for using this option may be found in the FECS Users' Manual.

c. After entering the nine-digit provider identification number, and the zip code, and pressing <ENTER>, the system will display the first provider with that ID number/zip code combination. The user can then modify or delete that record, or may go on to the next record with that ID number/zip code combination.

d. If the particular ID number/zip code combination is not already on the system, or if a new address is to be added for an ID number/zip code combination which is already on the system, the user can add a record.

e. To add a record, in addition to the provider identification number and zip code, the user must enter the full name, street address and city, the two-letter abbreviation for the state, a provider type code (see Chapter 5-203), a payment flag (Y or N - see below), and district office information (optional). The system assigns a sequence number.

f. Special characters, such as "." "," "#" and "&" may not be entered in the name, address, or city fields. A "/" is allowed in the name or address fields, but not the city field.

g. The payment flag should be "Y" for "yes", unless the district office has excluded the provider from payment under the provisions of 20 C.F.R. 10.450-457, or for some other reason, and the exclusion flag has not been updated by National Office yet. The individual performing provider file updates is responsible for checking the excluded providers report or on-line query before entering a "Y" payment flag for any provider. On occasion, the district office may wish to set the payment flag to "N" for "no" for some other reason, such as the need to manually review all of a provider's bills.

h. When adding providers to the provider file, the user must be careful not to make an addition which varies only insignificantly from a record which is already on the file. For instance, if a record for J H Jones MD, 100 Main Street already exists, another entry for John Howard Jones MD, 100 Main St should not be made.

i. Provider type codes determine the type of editing that will be done on a bill, including application of the fee schedule. The user must therefore be certain to enter a correct provider type code.

9. On-line Payment History, BILL006. This function allows users to obtain immediate information concerning paid and denied bills. The information is displayed for individual case file numbers. The user may narrow the selection of records to be viewed by specifying a provider identification number, provider type, payee zip code, check/EOB date range, and/or service date range. The records are displayed in order of date of service, with the most recent first. The "TOTAL" field just above the "PROVIDER" column shows how many records are in the system for the provider/type/dates combination requested, and the number of the record on which the cursor is presently positioned. Each record displayed represents an individual line item on a bill, rather than the entire bill. If a bill contains several line items, these will not necessarily be displayed sequentially on the screen. The up and down cursors may be used to move from one record to another. As the cursor moves, the display at the bottom of the screen changes. <Page Up> and <Page Down> may be used to move from screen to screen. The following information is displayed on the screen for each record:

a. Provider/payee ID. This is the tax identification number of the payee. If the payee was a provider, the number will be either the provider's Employer Identification Number (EIN) or Social Security Number. If the payee was a claimant, and the provider type is FR, KR, QR, or VR, the number will be the claimant's Social Security Number. For other types of claimant reimbursements, the provider number is shown. If a provider/payee ID was specified in the selection process, only records which have a matching provider/payee ID will be displayed.

b. Provider type code. If a provider type code is followed by an "R", the record was processed as a reimbursement to the claimant. If a particular provider type code was specified in the selection process, only 9. records containing that particular provider type code will be displayed. For instance, if "P" is selected, all records with provider type codes of P and PR will be displayed. If "<space>R" is selected, all records processed as reimbursements to the claimant will be displayed.

c. Dates of service. The "from" and "to" dates of service are displayed in mm/dd/yyyy format. If a date range for the search was specified in the selection process, only the records which contain "from" or "to" dates within that range will be displayed.

d. Procedure code. The procedure code, including modifier and fee schedule appeals code (if applicable) is shown. If the provider type is one which does not require a procedure code, the space will be blank.

e. Charge amount. The amount billed for the particular dates of service and

procedure is shown.

f. Paid amount. This is the amount paid for the particular dates of service and procedure code. If this amount is equal to the charge amount, and the check date (see paragraph g below) is blank, the bill has been processed during the current cycle, and the amount of the eventual payment is not yet known. Once payment has been processed by the Central system, the amount will be updated. If the amount is $0.00, the bill was denied by the Office, or was rejected by the Central system (see paragraphs g and h below). If the amount is greater than $0.00, but less than the billed amount, there was either a fee schedule reduction or an ineligible amount.

g. Check date/EOB date. If the bill was paid (paid amount does not equal zero), the date of the check by which it was paid will appear here. If the bill was denied at the Sequent level, the date of the denial will be displayed. If the bill was rejected by Central, a rejection code will be displayed. These codes and their definitions are as follows:

REJDLY - BP010 edit failures
REJWKP - BP020 negative pay amount
REJWKR - Record matched input
REJWKS - Record matched history
REJWKT - Record matched input and history
REJWKU - Record matched input and not history
REJWKV - No match to history

h. Reject date/EOB message. If payment was made, this will be blank. If the bill was denied at the Sequent level, the two highest priority EOB message code numbers will appear (code numbers consist of three numbers). If the record was rejected by the Central system, the date of the rejection will be shown.

i. Record type. The record type reflects the type of record displayed. Bill type B is assigned to all bills created using BILL051 and BILL002. Record types M (manual), C (check cancellation), and D (cash deposit) are for maintenance adjustments keyed using BILL052 or BILL053.

j. A window at the bottom of the screen shows the Provider Zip Code, Sequence Number, District Office issuing Payment, Batch ID, IRS offset flag, and resolver ID for the currently highlighted record. A sequence number of ZZ means that the record was processed as a reimbursement to the claimant.

10. Central Payment History Request, BILL007.

a. Purpose. BILL007 is used to request an overnight Central bill payment history

for a particular case. When a history is requested, a report is printed the following work day, if the request was made before history requests were transmitted to the Central system. The history report contains information on bills which have been transmitted and accepted by Central only, including adjustments. Denied bills will not appear on the Central history report, since they are not transmitted to Central. Bills rejected by Central will not appear on the report.

A request can be made on a case by case basis for the bill payment history for a specific provider, a specific provider type, specific dates of treatment, or the complete bill payment history. If the history is requested during the week, bills paid since the Central history purge date (usually two years) will be shown on the history report. If the history is requested on a Friday, all bills on the BPS, both active and purged, will be shown on the report.

b. Suggested Usage. BILL007 may be used whenever a complete bill payment history is required for a particular case. The information contained in the report is more detailed than the information found in the on-line bill payment history, and covers a longer period of time. The report is particularly useful for determining third party disbursements, for determining actual payments when the on-line history is inaccurate, or for obtaining history which predates the on-line history.

c. Instructions for using BILL007 may be found in the FECS Users' Manual.

11. Central Provider History Request, BILL008. This job is used to request a Central bill payment history for a specific provider. To use this function, both a provider identification number and a provider zip code must be entered, and the entry must be done on a Friday.

12. Provider Inquiry, BILL010. Provider Inquiry is used to determine whether a particular provider is on the Provider Master File. Since it is a query only function, it may be used by individuals who do not have access to the provider file via BILL005. Provider inquiry is option 08 under the FECS001 Query menu.

13. Batch Locator, BILL055. Batch locator, option 09 under the bill payment menu, is used to determine the current status of bill batches. It shows all open, closed (unedited), and transmitted batches. It is often accessed just prior to running the bill batch edits to determine whether all completely keyed bill batches have been closed.

14. Batch Open/Close/Delete. This function, option 11 under the bill payment menu, shows open batches, and unedited closed batches, and allows the user to enter a batch identification

number for opening, closing, or deletion. Access to this option should be very limited. Once a closed batch has been subjected to the edit program (BILL552), it cannot be reopened or deleted using Batch Open/Close/Delete.

15. **Provider Labels**. Provider Labels, option 12 under the Bill Payment Menu, allows the user to generate a mailing label for a specific tax identification number. The user can generate a label for a particular sequence, all sequences under one zip code, or all sequences and all zip codes.

16. **Suspended Bill Query**. This option, which is item 13 under the Bill Payment menu, provides a variety of means to view bills which have not been finalized. Bills with the following status codes may be viewed:

K - keyed, but the batch in which it was keyed has not been closed;
N - keyed, but not yet edited by the BILL552 program;
S - suspended for resolution;
R - set to recycle through the BILL552 program by a bill resolver;
I - internally denied bill;
D - bill has been denied (as soon as daily transmission takes place, bill is not accessible through suspended bill query, but instead appears in the on-line history); and
C - bill has been approved or partially approved for payment (as soon as daily transmission takes place, bill is not accessible through suspended bill query, but instead appears in the on-line history).Users may specify the query by case file number, batch identification number, provider number, or bill status code. After specifying the parameters of the search, a list appears of all bills fitting the search criteria, with a count. The user may then select a bill for viewing. The screens are very similar in appearance and function to those in the suspense resolution program, except that no updates are possible.

17. **Zip Code Search**. A data file on the Sequent contains a list of zip codes and the associated state codes. This data file is updated periodically. Various Sequent and Central programs edit for the validity of the zip code/state combination in a given record. Zip code search may be used to determine what state is considered valid by the system for a given zip code. If a zip code/state combination is known to be valid, but is not on the system, National Office should be notified.

18. **ICD-9 Description**. ICD-9 codes are frequently found on medical bills, and are also used to designate accepted conditions in cases. The ICD-9 Description option allows the user to view ICD-9 codes and descriptions through four different query options:

a. Locate ICD-9 Code - the user enters a specific code, and the screen displays the code and the correlating description;

b. Locate ICD-9 Codes by IC Code Range - the user enters beginning and ending ICD-9 codes, and the screen displays those codes and all the valid codes that fall in between, with the corresponding descriptions;

c. Locate ICD-9 Codes by IC Code Prefix - the user enters the beginning digits of an ICD-9 code (one to five characters), and the screen displays all of the ICD-9 codes that start with those characters, along with the descriptions; and

d. Locate ICD-9 Code by Description Prefix - the user enters the first word of a condition description, and the screen displays all descriptions which start with that word, with their ICD-9 codes. This option is particularly useful to claims examiners who know what condition they want to accept, but don't recall the ICD-9 code for the condition.

19. Excluded Provider Query. This program enables the user to query the excluded provider file by name or by tax identification number. After entering the data, the screen displays the full name and mailing address of the provider, the sanction and notification dates, and the source of the exclusion. If more than one record meets the search criteria, the user is asked to indicate whether he/she wishes to view the next record. When the name query is used, all records with names beginning with whatever is entered will be displayed. For example, if "BROWN" is entered, all records with a last name of "Brown" will be displayed, but in addition, records with names such as "Brownlee" and "Browns Medical Supply" will be displayed as well.

5-0202 Fee Schedule Appeals, Bill Adjustments, District Director Exceptions and Cases/Providers on Review

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1. Purpose and Scope. This chapter provides guidance and instructions for processing appeals of medical fee schedule determinations and adjustments to erroneous bill payments. It also contains information on Return to Provider Letters (RTPs) and Remittance Vouchers (RVs). The chapter also contains information on District Director exceptions and cases/providers on review.

2. Fee Schedule Appeals. Under 20 C.F.R 10.812, a medical provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set under the Office of Workers' Compensation Programs (OWCP) fee schedule may, within 30 days of payment, request reconsideration of the fee determination. Only three circumstances will justify reevaluation of the paid amount. These are:

a. The actual procedure performed was incorrectly identified by Current Procedural Terminology (CPT) code;

b. The presence of a severe or concomitant medical condition made treatment especially difficult; or

c. The provider possesses unusual qualifications, beyond Board-certification, in a medical specialty.

The provider must submit evidence to support the request for reconsideration of the paid amount. Under 20 C.F.R. 10.813, the provider may not seek any additional amount from the claimant in excess of the charge allowed under the fee schedule.

3. Timeliness. The Federal Employees' Compensation (FEC) district office (DO) servicing the claimant's case is responsible for processing the provider's request for reconsideration of the fee determination. Under 20 C.F.R. 10.812 (a)(2), the DO is to respond, in writing, within 30 days of receiving the request stating whether or not an additional amount will be allowed as reasonable.

4. Authority.

a. District Director (DD). The reconsideration decision is to be prepared for the signature of the DD.

b. Regional Director (RD). If an appealed amount continues to be disallowed by the DO, the provider may seek further review. A decision from this further review, stating whether or not an additional amount is to be allowed as reasonable, is to be made within 60 days of receipt of the request for review. This decision is to be prepared for the signature of the RD.

5. Processing Fee Appeal Requests from Providers. In order to appeal a payment, the provider may, within 30 days of the date of payment, make written request for reconsideration of the fee determination; identify the procedure(s) in question; attach documentary evidence relevant to the circumstances upon which the appeal is based (Paragraph 2, above); attach a copy of the RV; submit the request to the Central Mail Facility (CMF). All appeals are logged and linked to the bill that prompted the appeal. They are tracked by Affiliated Computer Services (ACS) through the appeal process.

Once a fee appeal request has been received in the CMF, it is forwarded to the DO via Omnitrack thread. The Claims Examiner (CE) who receives the thread should notify the DD that a new fee schedule appeal has been received on a case. The designated person(s) in the DO reviews the appeal request and either approves or denies the appeal or requests more information; this person should also reply to the thread. Any additional information that is requested should be sent to the CMF for imaging into the case record.

The appeal status is entered into AchieveHCS by ACS staff. When a bill is in an open appeal status, duplicate bills for the same service are denied.

a. The Fee Schedule Appeal Reviewer. The person(s) to be charged with the responsibility of processing fee schedule appeals is left to the discretion of the DD and RD. However, when an appeal is made to the regional level, the person handling the appeal must be someone other than the person who processed the earlier appeal.

6. Evaluating a Fee Appeal Request. The reviewer should consider the following:

a. Incorrect Procedure/Service Code. In addition to the evidence submitted on appeal, review any medical reports of record pertinent to the service or procedure in question. If it is not furnished by the provider, the reviewer may wish to review the original bill in the SIR system for the description of the service provided. If technical assistance is needed, the reviewer

should obtain the opinion of the District Medical Director (DMD)/District Medical Advisor (DMA) or appropriate Office consultant as to the appropriateness of the coding of the service or procedure in question.

b. Severe or Concomitant Medical Condition. The evidence submitted, along with pertinent medical evidence which may already be on file, must establish the presence of a severe or concomitant medical condition and show that this condition made the billed treatment especially difficult. As examples, cardio-pulmonary problems or severe diabetes may make treatment (e.g., surgery) of the injury-related medical condition especially difficult. However, the mere fact that a severe or concomitant condition was present should not result in additional payment without regard to the service or procedure in question. For example, it would not be expected that difficulty in treatment would warrant an additional payment for an office visit or the taking of x-rays.

Review and opinion may be obtained from the DMD/DMA or Office consultant concerning the presence of a severe or concomitant condition, its effect upon treatment and the amount of the additional fee requested given the added difficulty, if any. Any evidence used as a basis for finding that a severe or concomitant medical condition was not present or did not make the billed treatment more difficult must clearly and convincingly represent the weight of the evidence. Where the DMD/DMA or Office consultant's opinion is in disagreement with, but of nearly equal weight to, the evidence submitted by the provider, payment of an additional amount in excess of the fee schedule should be authorized. Such "conflicts" of opinion as to whether or not a severe or concomitant medical condition made treatment especially difficult are not subject to resolution by the use of an impartial third physician.

c. Unusual Provider Qualifications. The evidence upon which such a decision is based is the provider's curriculum vitae. Board certification in a medical specialty is not, by itself, sufficient evidence of unusual qualifications. Professorial rank or the publication of articles authored or co-authored by the provider which are pertinent to the medical condition or procedure in question are considered evidence of unusual qualifications. The DMD/DMA or Office consultant in the appropriate specialty may also be requested to provide an opinion as to the qualifications of the provider and the amount of the additional fee requested given those qualifications and the procedure or service in question.

7. **Additional Amount Payable**. Where it is determined that an additional amount is payable, the DO is generates a letter informing the submitter of the approval. The reviewer must prepare a memorandum for the file stating the findings and the basis for the approval of the additional amount. Second review and approval of this memorandum by a higher authority is not required, but may be implemented by the DO if desired. Where additional payment is denied, the provider must be furnished with a letter decision concerning the findings and the reason for the denial.

8. **Denial of Appeal Payment**. Where additional payment is denied at the DO level, the letter decision must contain a notice of the right to further review similar to the following: If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence and should be addressed to the Regional Director, District ___, Office of Workers' Compensation Programs, U.S. Department of Labor, P.O. Box 8300, London, KY 40742-8300. Where additional payment is denied at the regional level, the letter decision should advise the provider that this decision is final and is not subject to further review.

9. **Payment**. If an additional amount is approved, the DO staff will complete the DO Adjustment Request form (Exhibit 1) and the form will be forwarded to ACS via the District Office Troubleshooter (DOT). ACS will then make the adjustment, issue a remittance voucher and update the AchieveHCS system with the new data.

10. **Additional Payment Based on Unusual Provider Qualifications**. Where an additional amount is found to be payable based on unusual provider qualifications, the DD should determine whether future bills for the same or similar service from that provider should be exempt from the fee schedule. If so, procedures for "Provider on Review" should be followed. (See paragraph 18, below.)

11. **Adjustments: Correcting Errors Without an Appeal**. Obvious errors warranting additional payment, identified internally or by contact from the claimant or provider, may be adjusted by ACS without following the formal appeal procedures.

a. Submission of Adjustment Requests. If a claimant feels a payment should be adjusted, he/she should submit a copy of the original bill containing the original Transaction Control Number (TCN) and an explanation of what needs to be adjusted. The claimant should write "Corrected Bill" or "Adjustment" at the top of the form. The claimant may also submit a copy of the Explanation of Benefits (EOB) or a letter to ACS at the CMF requesting adjustment of a bill. If either of these is submitted, a written explanation as to what needs correction must be included.

A provider who requests an adjustment should submit a copy of the original bill with the original TCN, an explanation of what needs to be adjusted and a copy of the RV. At the

top of the original bill, the words "Corrected Bill" or "Adjustment" should be written. A letter sent to ACS at the CMF will also be accepted for adjustment as long as the information described above is included in the letter.

If a DO requests that a payment be adjusted, the DO should complete an Adjustment Request Form (Exhibit 1) with the original TCN and a description of the charges to be processed. These may be forwarded to ACS via the DOT.

b. Adjustments Based Upon Eligibility. If the adjustment is for an eligibility reason, iFECS should be updated to reflect the current case status and accepted condition(s). Once case eligibility has been updated, an adjustment request form should be completed and forwarded. The adjustment will be processed at that time.

c. Authorization Issues. If the adjustment is related to an authorization issue, the treatment suite will be reviewed to determine the authorization level. If an authorization is required for the service, ACS will review the authorization subsystem to see if an authorization has been created. If not, the CE will be notified via the Omnitrack system.

d. Types of Adjustments. There are several types of adjustments.

(1) Single bill voids/credits. A bill credit (void) is a reversal or offsetting of a previously paid bill.

(2) Single bill adjustment. An adjustment is a net change to a previously paid bill as opposed to a complete reversal or credit. Adjustments may be necessary for a variety of reasons, although they usually involve some error in provider reimbursement.

(3) Gross adjustments. Gross adjustments are those paid to a provider and may include multiple claim numbers. An example of a gross adjustment would be if a provider was incorrectly enrolled as a chiropractor. All of his bills have denied for that reason. Once the enrollment status was corrected, ACS would make a one-time payment to the provider for all bills denied due to the incorrect enrollment status. Gross adjustments are special cases and it is preferable to adjust specific bills when possible.

(4) Mass adjustments. Mass adjustments and credit transactions are submitted online. An example of a mass adjustment is the correction of bills paid based on an error in the fee schedule. The mass adjustment process should be used cautiously due to the potential impact on the processing system since large numbers of bills may be affected.

12. Provider Billing Claimant for Full Payment. A claimant may contact the DO and advise that he/she paid the medical provider in full and was only partially reimbursed by the Office as a result of the application of the fee schedule, or that a provider who was only partially reimbursed by the Office is demanding payment of the balance of the full charge, either directly or by referral to a collection agency or by legal action.

a. The claimant does not have the right to appeal the fee determination per se. However, under 20 C.F.R. 10.337(b), the DO should advise the claimant that he/she may:

(1) Request that the provider make appropriate refund or credit for the amount the claimant paid in excess of the fee schedule;

(2) Request that the provider submit, on the claimant's behalf, and at no additional cost, a request for reconsideration of the fee determination as discussed above; and

b. Where the claimant has made payment to the provider and is only partially reimbursed due to the application of the fee schedule, the DO should release a letter to the provider, with a copy to the claimant, which:

(1) Identifies the specific charges at issue;

(2) Notifies the provider of the provisions of the pertinent regulations;

(3) Requests that appropriate refund or credit be made within 60 days;

(4) Offers the provider the opportunity to appeal the allowable fee; and

(5) Advises the provider of the possible consequences of failure to make appropriate refund or credit.

A sample letter is shown as Exhibit 2. If, after receipt of the above letter, the provider appeals the fee determination and it is found that no additional amount is payable, the letter decision should again request that appropriate refund or credit be made within 60 days.

c. Where the provider has initiated collection action, or has actually collected from the claimant, an amount in excess of the maximum allowable charge paid by the Office, the DO should release a letter similar to Exhibit 3 to the provider, with a copy to the claimant, requesting that the amounts in excess of the maximum allowable fee which have been collected, be refunded to the claimant or credited to the claimant's account, or that the provider cease attempts to collect such additional amounts. The provider should be given 60 days to comply.

13. Sanctions for Provider Noncompliance.

a. If the provider does not comply with the written request of the Office within 60 days, the DO should contact the provider to make appropriate refund or credit, or to cease collection action. If this contact does not satisfactorily resolve the problem, action should be taken to exclude the provider from participation and payment under the Federal Employees' Compensation Act (FECA). See PM 3-0800. (20 C.F.R. 10.815[h]

b. Where all efforts to have the provider credit or refund to the claimant an amount the claimant paid the provider in excess of the maximum allowable have failed, the DO should reimburse the claimant for the amount paid in excess of the maximum allowable fee. (See 20 C.F.R. 10.337[c].)

14. Return to Provider Letter and Remittance Vouchers. ACS issues automated Return to Provider Letters (RTPs) and Remittance Vouchers (RVs) to explain benefits paid or to provide the reason for non-payment of the charges.

a. Return to Provider Letter (RTP). This letter contains specific information explaining why a bill was returned. It is most commonly sent to the provider, but may be sent to a claimant if a request for reimbursement has been submitted improperly. The reason for the returned bill is noted on the letter.

Reasons for RTPs include missing claimant information, missing/invalid billing information, missing provider information, the need for attachments, inability to image the claim form and/or the submission of an incorrect form. The erroneous bill is attached to the RTP letter. All information cited must be corrected before the bill can be processed. The claimant/provider is advised to make the necessary changes and resubmit the bill for processing. This is not a formal decision and no appeal rights are issued with this letter.

b. Remittance Voucher (RV). A remittance voucher is created for every processed bill, showing the amount paid and/or the reasons for line item/bill denial. ACS produces and mails RVs on a weekly basis. They are issued separate from the actual payment. An electronic RV (ANSI 835) can be issued to authorized providers. Appeal rights are included on RVs where bill(s) have been reduced or denied.

(1) Each RV has its own unique number that will appear on the corresponding check that is issued.

(2) Each check has its own reference number. This number is different from the RV number; the check reference number will appear on the RV. This number should be referenced when inquiring about a specific payment.

(3) The RV shows the date the bills were paid and the ACS number of the "pay-to" provider.

(4) The Transaction Control Number (TCN) for each bill processed will appear on the RV. Adjustments will always result in two TCNs, one crediting the original bill and the second processing the adjustment.

(5) Bills are grouped by payment status, paid or denied.

(6) The treating provider's name is listed on the RV, along with the claimant's name and case file number.

(7) Detail is provided for each line item of the bill.

(8) EOB codes are shown for each line item or total bill that is denied.

(9) An explanation of each EOB code is provided.

(10) The RV will stipulate whether the bill is an original or an adjustment.

(11) The remittance summary totals all bills covered under the RV with the total amount billed and the total amount paid for each category.

15. DO Edits The majority of edits are handled by the DOT and ACS Liaison process. However, two situations may require direct intervention by the CE or the DD.

a. Edit 391. This edit describes reimbursements that exceed $50,000. The National Office (NO) will regularly forward a list of these high cost bills to the DD. These bills suspend for resolution of entitlement issues, if any, and DD authorization. Once the DD authorizes the payment, the bill is sent to the DOT who enters the data required to resolve the edit into the AchieveHCS system. The DD is required to keep a high-cost bill log in the DO for audit and accountability purposes.

(1) DD Designate. The DD may designate the Assistant District Director

(ADD) or a Supervisory Claims Examiner (SCE) to authorize payments for reimbursement requests that exceed $50,000. The DD Designate should also maintain the high-cost bill log for audit purposes.

b. Edit 487. Edit 487 is for short form closure (SFC) cases in which bills exceed the $1500 limit and therefore suspend. iFECS generates a task for the responsible CE for each SFC case which has bills exceeding $1500; the OQS2 reports can also generate a list of all such cases. CEs then have five (5) workdays to review the cases and either adjudicate or develop them before bills begin to deny. If a case is accepted within that time-frame, the bills recycle through ACS and pay or deny as appropriate. If the CE develops or denies a case, the bills are automatically denied. If no action is taken on a case within five (5) workdays, the case status "flips" to a UD status and the bills deny.

16. Exceptional Case Processing. Exceptional Case Processing is used when the DO decides that, although a service is not in the treatment suite for a specific case, they wish to have the service paid; or if the DO decides that a service/procedure should be paid in full and not reduced under the fee schedule. Exceptions in both instances must be authorized by the DD.

As with the Edit 391 cases described above, the DD may designate the ADD or a SCE to review and authorize the DD exceptions described below.

a. DD Exceptions: Treatment Suite Issues. If the DO needs to authorize a procedure/service that does not fall within the treatment suite for the accepted conditions in a specific case, the DO will do the following:

(1) The CE, through the SCE, will complete the DD Exception Memo, Treatment Suite (Exhibit 4). This memo must contain the case number, claimant's name, description of the procedure/service being authorized and procedure code(s), date or date range of service(s) to be covered, provider's name, provider number and provider contact information. It must also contain rationale for authorizing the procedure/service. The memo must contain an ending date for the exception (60 days from the date of the memo). The memo is then forwarded to the DD (or designate).

(2) The DD (or designate) reviews the request and either agrees with the proposed exception or requests additional rationale from the CE.

(3) If the DD (or designate) agrees with the proposed exception, he/she then e-mails the memo to NO staff, Myra Kingsland, Frances Ingram and Cheryl Bullock, with a copy to Peter Krah. The e-mail subject must be titled, "DD

Exception Request - Treatment Suite - DO ___".

(4) NO staff will review the exception request, the accepted International Classification of Diseases (ICD) code(s) and the procedure/service code(s). If the ICD code is not consistent with the diagnosed condition shown in the medical evidence submitted with the requested procedure/service, NO staff will attempt to locate a more consistent ICD code. If another ICD code is found that will permit payment of the service, the exception request showing the recommended code will be returned to the DO. Before changing or adding an accepted condition and ICD code, the CE must review the case file to make certain that the recommended condition is supported by medical evidence. If the CE determines that an ICD code should be added or changed, the bill should be processed in the usual manner. NO staff will also review the billed CPT code to verify that it properly describes the procedure/service provided. If NO staff cannot locate an ICD code permitting payment of the procedure/service (and appropriate for the case) and the procedure/service code billed is appropriate, they will forward the DD exception to ACS (with a copy to the initiating DO) for payment.

(5) ACS will enter the authorization into AchieveHCS and place the case on review along with appropriate notes in the AchieveHCS case file. ACS will issue an authorization letter for the procedure/service. They will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information to ensure that no denial statements for these authorizations are made and that bills for these procedures/services are not denied unless they are true duplicates. They will ensure the payment of these bills through the bill processing system. When actions are complete, ACS will send an e-mail response to all parties, including the DO that initiated the request.

b. DD Exceptions: Fee Schedule Issues. The fee schedule exception is used for specific procedure(s) or service(s) that require a DD override as full payment is being authorized with no reduction under the fee schedule. For fee schedule issues, the DO should do the following:

(1) The CE, through the SCE, will complete the DD Exception Memo, Fee Schedule (Exhibit 5). This memo must contain the case number, claimant's name, description of the procedure/service for which full payment is requested, procedure/service code(s), date or date range of service(s) to be covered, provider's name, provider number and provider contact information. It must also contain rationale for payment in full and must show an ending date for the exception (60 days from the date of the memo).

(2) The DD (or designate) reviews the request and either agrees with the

proposed exception or requests additional rationale from the CE.

(3) If the DD (or designate) agrees with the exception, he/she then e-mails the memo directly to ACS with a copy to NO staff, Myra Kingsland, Frances Ingram, Cheryl Bullock and Peter Krah. The e-mail subject title must be "DD Exception Request - Fee Schedule - DO ___".

(4) ACS will enter the authorization into AchieveHCS, place the case on review for the listed procedure/service code(s) and enter Notes into the AchieveHCS system (including the authorization number for the services in question).

(5) ACS will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information and advise that payment will be made in full. ACS will ensure proper processing of the bills through the bill processing system. When actions are completed, ACS will send a response to all parties including the DO that initiated the request.

c. DD Exceptions: Authorizing Diagnostic Testing in UD Cases. On rare occasions, authorization for diagnostic testing may be needed before a case has been adjudicated. If the CE believes that a requested diagnostic procedure is necessary for adjudication of the claim, he/she may request that the DD approve the authorization.

(1) The CE, through the SCE, will complete the DD Exception Memo, UD Diagnostic Authorization Request (Exhibit 6). This memo must contain the name and the provider number of the provider requesting the procedure; the name/description and CPT code of the requested procedure and the date or date range of the requested procedure. Additionally, the CE must include rationale for authorizing a diagnostic procedure for a case that has not yet been accepted. The memo is then forwarded to the DD (or designate).

(2) The DD (or designate) reviews the request and either agrees with the proposed authorization or requests additional rationale from the CE.

(3) If the DD (or designate) agrees with the proposed authorization, he/she then e-mails the memo to NO staff, Myra Kingsland, Frances Ingram, Cheryl Bullock and Peter Krah. The e-mail subject must be titled, "DD Exception Request - UD Diagnostic Authorization - DO ___".

(4) NO staff will review the CPT code to verify that it properly describes the diagnostic procedure requested and is supported by the rationale provided. If the requested CPT is a valid diagnostic procedure, the exception request will be forwarded to ACS (with a copy to the initiating DO) for payment.

(5) ACS will place the case on review, with appropriate notes in the AchieveHCS case file. ACS will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information to ensure that no denial statement for this authorization is made and that the bill for this diagnostic procedure is not denied unless it is a true duplicate. They will ensure the payment of the bill through the bill processing system. When actions are complete, ACS will send an e-mail response to all parties, including the DO who initiated the request.

(6) Because ACS cannot issue an authorization letter in UD cases, the DO will issue the authorization letter for the requested diagnostic procedure, if necessary, after receiving the e-mail response from ACS.

17. Exceptional Case Processing. "Case on Review" is used only for catastrophic cases. Catastrophic cases are defined as those that are life-threatening or have extensive functional deficits (such as head or spinal cord injuries or severe burns) where the medical recovery is expected to extend over long or indefinite periods of time. Those cases with multiple (more than 12) accepted conditions are also often catastrophic. Catastrophic cases should be rare and must be authorized by the DD or designate.

The procedures for placing a catastrophic case on review are as follows:

a. The CE, through the SCE, should complete the DD Exception Memo, Catastrophic Case (Exhibit 7). This memo must contain the case number, claimant's name, accepted condition(s) and rationale for placing a case in catastrophic status. The memo must state specifically how bills are to be handled for the case. i.e. "force all treatment suite edits" or "pay all non-duplicates". There is no ending date for review with a catastrophic case but these cases must be regularly monitored by the CE for improvement and consideration of return to regular bill processing.

b. The DD (or designate) reviews the request and either agrees with the proposed exception or requests additional rationale from the CE.

c. If the DD (or designate) agrees to place the case on review, he/she then e-mails the memo to NO staff, Myra Kingsland, Frances Ingram and Cheryl Bullock, with a copy to Peter Krah. The e-mail subject must be "DD Exception Request - Catastrophic Case - DO ___".

d. NO staff will forward the exception memo to ACS for processing. A copy of this e-mail will be sent to the DO that initiated the request.

e. ACS will place the case on review and update the AchieveHCS system information by placing instructions on Screen 6. They will issue all authorization letters. ACS will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information and to ensure that no inappropriate denial statements are made for these cases and that bills for these cases are handled exactly as the DO instructs.
ceptional

18. Exceptional Case Processing. A provider may be placed on review to ensure proper coding and/or billing. Examples of appropriate situations for "provider on review" would be if the provider has been consistently submitting bills with questionable coding, in cases where there is round-the-clock nursing care requiring complex billing or if the provider has unusual provider qualifications that would exempt him/her from the fee schedule (see paragraph 10, above). All of a provider's services may be placed on review or just specific procedure codes billed by that provider. If specific procedure codes are on review, all bills containing those codes will suspend.

Procedures for placing a provider on review are:

a. The CE, through the SCE, completes the DD Exception Memo, Provider on Review (Exhibit 8). The memo must contain the case number, claimant name, description of the procedure code(s) on review (if for specific procedures or services), dates of services or service range (if any), provider name, provider number and provider contact information. Rationale for placing a provider on review must be included in the memo. An ending date is optional for provider on review. The memo must state that this request is "FECA specific".

b. The DD (or designate) reviews the request and either agrees with the proposed exception or requests additional rationale from the CE.

c. If the DD (or designate) agrees with the proposed exception, he/she e-mails the memo to NO staff, Myra Kingsland, Frances Ingram and Cheryl Bullock, with a copy to Peter Krah. The e-mail subject must be "DD Exception Request - Provider on Review - DO ___".

d. NO may approve or deny the requested exception. If the request is denied, the form will be returned to the DD with the reason for the denial. If the request is approved, NO staff will forward the exception memo to ACS for processing. A copy of the e-mail will be sent to the DO that initiates the request.

e. ACS will place the provider on review. ACS will place all services or specific procedure codes billed by the provider on review, as specified by the DO. ACS will add Notes to the Achieve Provider File on screen 7 with the proper instructions. When actions are complete, ACS will send a response to all parties, including the DO that initiated the request.

Exhibit 1 - DO Adjustment Request Form:

ADJUSTMENT REQUEST FORM

Date:
To: ACS Liaison
From: DO _____ Troubleshooter
Case Number:
Claimant:

TCN:
Description of Charges to be processed:

Date(s) of Service:
Provider Name:
Provider Number:
Provider Contact Information:

Exhibit 2 - Letter to Provider Requesting Refund to Claimant:

File No.:
Claimant:
Date of Injury:

PROVIDER NAME
ADDRESS
CITY, STATE ZIP CODE

Dear

The Office of Workers' Compensation Programs (OWCP) administers the Federal Employees'

Compensation Act (FECA) which provides workers' compensation coverage for civil employees of the United States. Under the provisions of the FECA, this Office authorizes payment to physicians and other persons for medical services to injured Federal employees. In cases where the injured employee has made payment directly to the medical provider, reimbursement for those medical services is made to the employee. In connection with payment for these services, this Office uses a schedule of maximum allowable medical charges.

Under current Federal regulations (Part 20, Sections 10.811, 10.813, and 10.815 of the Code of Federal Regulations), a provider whose fee for service is only partially paid because it exceeds the maximum allowable fee set under the schedule may not request reimbursement from the injured employee for any amount in excess of the maximum allowable charge. A provider who collects or attempts to collect from the injured employee, an amount in excess of the maximum allowable fee may be subject to exclusion from participation and payment under the Federal Employees' Compensation program. Such exclusion is reportable to all Federal employing agencies, the Health Care Financing Administration, and the state or local authority responsible for licensing or certifying the excluded provider.

The claimant identified above has made direct payment to you for the services described below in an amount in excess of the maximum allowable charge for those services.

CPT Code	Service Dates	Amount Paid	Maximum Fee	Amount Over Maximum Fee

In view of existing Federal regulations, and in order that the claimant not bear an expense which would not have otherwise occurred had payment been made to you directly by this Office, it is requested that you make refund to the claimant (or credit the claimant's account) in an amount equal to the amount over the maximum fees as shown above. It is also requested that such refund or credit be made within 60 days of the date of this letter.

If you choose, you may, within 30 days of the date of this letter, request a reevaluation of the allowable fee for the above services. The request should be made at no additional cost to the employee. The only circumstances which will justify reevaluation are (1) the procedure was incorrectly identified by CPT code, (2) the presence of a severe or concomitant medical condition made treatment especially difficult, or (3) the provider possesses unusual qualifications (Board certification in a medical specialty is not sufficient evidence in itself of unusual qualifications).

Any request for reevaluation of the allowable fee should be in writing and be accompanied by a copy of this letter and documentary evidence relevant to one or more of the circumstances described above (e.g., evidence of use of an incorrect CPT procedure code, a report showing a severe or concomitant medical condition and how that condition made treatment especially difficult or a copy of your curriculum vitae). The request should be sent to this office with the notation ATTENTION: FEE SCHEDULE APPEAL.

If it is determined that an additional amount is payable, such amount will be reimbursed directly to the employee.

If you wish to receive additional information concerning the schedule of maximum allowable medical charges, please do not hesitate to contact this office.

Your cooperation and prompt attention to this matter will be appreciated.

Sincerely,

NOTICE TO EMPLOYEE: Please advise this office if appropriate refund or credit is not made within 60 days. If we do not hear from you, we will assume the matter has been satisfactorily resolved.

Exhibit 3 - Letter to Provider Requesting Termination of Collection Action/Refund of Excess Payment:

File No.:
Claimant:
Date of Injury:

PROVIDER NAME
ADDRESS
CITY, STATE ZIP CODE

Dear

The Office of Workers' Compensation Programs (OWCP) administers the Federal Employees' Compensation Act (FECA) which provides workers' compensation coverage for civil employees of the United States. Under the provisions of the FECA, this Office authorizes payment to physicians and other persons for medical services to injured Federal employees. In connection with payment for these services, this Office uses a schedule of maximum allowable medical charges.

The claimant identified above has notified this Office that you have initiated collection action or have collected an amount in excess of the maximum allowable charge paid by this Office. Under

current Federal regulations (Part 20, Sections 10.811, 10.813, and 10.815 of the Code of Federal Regulations), a provider whose fee for service is only partially paid because it exceeds the maximum allowable fee set under the schedule may not request reimbursement from the injured employee for any amount in excess of the maximum allowable charge. A provider who collects or attempts to collect from the injured employee an amount in excess of the maximum allowable fee may be subject to exclusion from participation and payment under the Federal Employees' Compensation program. Such exclusion is reportable to all Federal employing agencies, the Health Care Financing Administration, and the state or local authority responsible for licensing or certifying the excluded provider.

In view of existing Federal regulations, it is requested that you cease all collection actions initiated or make refund to the claimant (or credit the claimant's account) the excess amount already collected. It is also requested that you cease collection action or refund/credit be made within 60 days of the date of this letter.

If you choose, you may, within 30 days of the date of this letter, request a reevaluation of the allowable fee for the above services. The request should be made at no additional cost to the employee. The only circumstances which will justify reevaluation are (1) the procedure was incorrectly identified by CPT code, (2) the presence of a severe or concomitant medical condition made treatment especially difficult, or (3) the provider possesses unusual qualifications (Board certification in a medical specialty is not sufficient evidence in itself of unusual qualifications).

Any request for reevaluation of the allowable fee should be in writing, and be accompanied by a copy of this letter and documentary evidence relevant to one or more of the circumstances described above (e.g., evidence of use of an incorrect CPT procedure code, a report showing a severe or concomitant medical condition and how that condition made treatment especially difficult, or a copy of your curriculum vitae). The request should be sent to this office with the notation ATTENTION: FEE SCHEDULE APPEAL.

If you wish to receive additional information concerning the schedule of maximum allowable medical charges, please do not hesitate to contact this office.

Your cooperation and prompt attention to this matter will be appreciated.

Sincerely,

NOTICE TO EMPLOYEE: Please advise this office if appropriate refund or credit is not made or collection activity has not ceased within 60 days. If we do not hear from you, we will assume the matter has been satisfactorily resolved.

Exhibit 4 - DD Exception Memo, Treatment Suite:

Date:

To:
District Director

From:
Supervisory Claims Examiner

RE: District Director Exception, Treatment Suite Issues

Case Number:

Claimant:

_____

Accepted Condition(s) and ICD-9 codes:

The following procedure(s) or service(s) require District Director override as they are not included in the treatment suite for the accepted conditions:

Description:

Date(s) of Service:

Provider Name:

Provider Number:

Provider Contact Information:

Ending date for exception (required):

Rationale for Acceptance (required):

FOR DISTRICT DIRECTOR (or DD Designate) USE ONLY

0 I agree with the proposed exception. Memo attached to email sent to National Office.

0 I do not agree with the proposed exception, please provide additional rationale.

_____

District Director

Exhibit 5 - DD Exception Memo, Fee Schedule:

Date:

To:
District Director

From:
Supervisory Claims Examiner

RE: District Director Exception, Fee Schedule

Case Number:

Claimant:

_____

_____

Accepted Condition(s) and ICD-9 codes:

The following procedure(s) or service(s) require District Director override to pay bill in full (no reduction under the fee schedule):

Description:

Date(s) of Service:

Provider Name:

Provider Number:

Provider Contact Information:

Ending date for exception (required):

Rationale for Acceptance (required):

FOR DISTRICT DIRECTOR (or DD Designate) USE ONLY

0 I agree with the proposed exception. Memo attached to email sent to National Office.

0 I do not agree with the proposed exception, please provide additional rationale.

_____

District Director

Exhibit 6 - DD Exception Memo, UD Diagnostic Authorization Request

Date:

To: District Director

From: Supervisory Claims Examiner

RE: District Director Exception, UD Diagnostic Authorization Request

Case Number:

Claimant:_____

Name / Description of Requested Procedure:

CPT Code of Requested Procedure:

Date(s) of Service:

Provider Name:

Provider Number:

Provider Contact Information:

Rationale for authorization:

FOR DISTRICT DIRECTOR (or DD Designate) USE ONLY

0 I agree with the proposed authorization. Memo attached to email sent to National Office.

0 I do not agree with the proposed authorization; please provide additional rationale.

_____

District Director

Exhibit 7 - DD Exception Memo, Catastrophic Case:

Date:

Memo To:
District Director

From:

Supervisory Claims Examiner

RE: District Director Exception, Catastrophic Case

Case Number:

Claimant:

_____
_____

Accepted Condition(s) and ICD-9 codes:

Reason(s) case is catastrophic:

Special bill processing instructions:

FOR DISTRICT DIRECTOR USE ONLY

0 I agree with the proposed exception. Memo attached to email sent to National Office.

0 I do not agree with the proposed exception, please provide additional rationale.

_____

District Director

Exhibit 8- DD Exception Memo, Provider on Review:

Date:

Memo To:
District Director

From:
Supervisory Claims Examiner

RE: District Director Exception, Provider on Review

Case Number:

Claimant:

_____

Provider name:

Provider number:

Provider contact information:

THIS IS FECA SPECIFIC.

0 All services/procedures to be manually reviewed.
OR
0 Specific services/procedures to be manually reviewed. (If this option is checked, only the following procedure code(s) submitted for payment will suspend.)

Procedure code(s) at issue:

Description:

Date(s) of Service:

Rationale (required):

Ending date of exception:

FOR DISTRICT DIRECTOR USE ONLY

0 I agree with the proposed exception. Memo attached to email sent to National Office.

0 I do not agree with the proposed exception, please provide additional rationale.

_____

District Director

5-0203 BPS Codes

TABLE OF CONTENTS

1. Purpose and Scope. The purpose of this Chapter is to provide a comprehensive guide to the various coding schemes which are relevant to the Bill Processing System.

2. Provider Types.

a. A Provider Type Code is assigned to each provider entered into the medical provider file (v46). The provider type codes are defined as follows:

A	Transportation (GTR)
B	Physician, not M.D. or D.O., or nurse under contract to the Office
C	Tuition
D	Dentist
F	Pharmacy
H	Hospital
I	Nursing Service
J	Assisted Reemployment
K	Transportation (not GTR)
L	Laboratory
M	Homemaker
N	Nursing Home
O	Other
P	Physician (M.D. or D.O.)
Q	Rehabilitation Maintenance
R	Chiropractor
S	Supplies
T	Therapist
U	Rehabilitation, Plan Development
V	Rehabilitation, Training
W	Rehabilitation, Placement
X	X-RayYRelocation

b. If a provider code on the provider file is incorrect the person designated as having responsibility for the provider file should be asked to make a change in the Provider Master File.

c. Bills for providers of types B, L, P, R, T and X must have procedure codes keyed for each line item. The procedure codes are used by the BPS to determine whether a particular service is payable for a certain accepted condition. In addition, charges for services coded with CPT-4 codes and some HCPCS codes are compared to the FEC medical fee schedule (see paragraph 4, below, for details on CPT-4 coding and the FECA PM 5-205 concerning the FEC medical fee schedule).

d. Outpatient hospital bills (provider type H) require itemized coding of services on both the bill and on the BPS. Outpatient hospital charges for physician's professional

charges, physical therapy, laboratory, radiology, and pathology must be coded with CPT-4 codes. The FEC fee schedule is applied to these charges. All other outpatient services should be coded using RCCs (Revenue Center Codes). Inpatient hospital bills are coded with RCC 001 only.

e. Bills for other provider types are not subjected to the fee schedule, and therefore do not require medical coding on the BPS. If codes were supplied by the provider, they need not be keyed into BILL051. However, various types of procedure codes are valid for these other providers, and if present on the bill, they should be keyed in accordance with paragraph 5-201.d(24)(e).

f. An R after a provider type (such as PR, HR) is an indication that the record is for claimant reimbursement. The first character indicates the type of reimbursement. For example, provider type PR indicates a reimbursement to the claimant for a physician bill.

g. For provider types FR, KR, QR, and VR, there does not have to be a provider file record for the bill record, and no specific provider information is retained in the bill record.

h. Provider type Q (without an R) does not exist, because rehabilitation maintenance is by definition always reimbursement to the claimant.

i. Provider type AR does not exist, because GTR transportation is by definition a payment made directly to a transportation provider.

j. A single provider should not have multiple records on the provider file with different provider types. For instance, a radiologist should not be entered as both provider type P and provider type X.

3. Locator 4 Codes. The UB-82 and UB-92 forms have different areas on the form, which are known as locators. The fourth locator area (locator-4) designates the type of services performed, whether inpatient or outpatient. The BPS requires entry of a locator-4 code for all bills for the "H" provider type (hospital). The locator-4 code allows the system to determine whether the bill is for inpatient or outpatient services, and whether itemized procedure codes are required. A description of the locator-4 coding scheme is shown as Exhibit 1.

4. Procedure Codes.

a. Procedure codes should not generally be changed or added if invalid or missing. The BR has a certain amount of discretion in situations where it is obvious that an incorrect code has been used. However, the procedure code determines the amount

payable for the service under the fee schedule. Using an incorrect procedure code can result in significant under- or overpayment. If it is necessary to change a code, the correct code should be written in colored pen and should be clearly recognizable as a change to the form by OWCP.

b. CPT Codes. The American Medical Association publishes a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians in its Physicians' Current Procedure Terminology, Fourth Edition. The identifying codes are generally referred to as "CPT codes" or "CPT-4 codes". This coding scheme is updated on a yearly basis. CPT codes consist of five numerics, and can be further modified by the addition of a modifier (see item i below).

c. HCPCS Codes. HCPCS is a coding system that describes physician and non-physician services and supplies. These codes supplement the CPT codes and contain physicians' services not included in CPT and non-physician services, such as ambulance, audiology, speech pathology, and such supplies as drugs, durable medical equipment, orthotics, prosthetics and others. The codes consist of five characters, the first being a letter, which is followed by four numbers.

d. Codes for medical examinations or case reviews requested by the district office should be as follows:

Case file review (by district medical adviser or consultant): CNSLT

Second opinion examination, or other specially requested examination:
SECOP

Referee examination to resolve conflict:
IMPAR

Case file review (by district medical adviser or consultant) for back surgery:
SURB1

Second opinion clinical examination for back surgery:
SURB2

Case file review (by district medical adviser or consultant)
for carpal tunnel surgery: SURC1

Second opinion clinical examination for carpal tunnel surgery
:SURC2

Since all these services are covered under Prompt Payment, it is advisable for the district office to have the appropriate code entered on the numbered "Prompt Pay" HCFA-1500 which is sent to the physician. Consistent use of these codes enables the district office and the National Office to collect statistical information about the use of consultants and the cost of such services. The single code encompasses the entire exam, even if several line items would have been required if the bill had been CPT-4 coded.

e. Codes for chiropractic services should generally be limited to the following:

(1) Spinal manipulation (one area) - Use CPT code 97260. For additional areas (up to a maximum of two additional areas during visit), use CPT code 97261. HCPCS code A2000.

Note that cervical, thoracic, lumbosacral, etc., each represent one area.

(2) X-rays - Use the appropriate CPT code for radio- logic examination for the area of the spine and pelvis (see the 72000 CPT series).

(3) Office visits - Given the relatively narrow scope of coverage of reimbursable chiropractic services, some levels of service for office visits as defined by CPT are not reasonably applicable to chiropractic services. Therefore, the coding of office visits for chiropractic services should be limited to the following CPT codes:99201 - New Patient, Brief Service99202 - New Patient, Limited Service99211 - Established Patient, Brief Service99212 - Established Patient, Limited Service

If services other than those shown above have been prescribed by a qualified physician (an M.D. or D.O.), consideration must be given to whether the services are likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation. These additional services are usually physical therapy types of treatment.

f. RCC Codes. Revenue Cost Center (RCC) Codes are used by hospitals and other providers which bill on the UB-92 form. These codes consist of three numbers, and vary as to their specificity. A listing of RCC codes may be found in the OWCP Medical Fee Schedule. Certain RCC codes for outpatient laboratory, pathology, physician professional, radiology and physical therapy services are not valid in the BPS. These services must be coded using CPT or HCPCS codes. A listing of the invalid RCC codes is also found in the OWCP medical fee schedule. In DFEC, the RCC code of 001 (total) is always keyed for bills for inpatient services. Outpatient services must be keyed using itemized codes.

g. Dental Codes. The American Dental Association (ADA) has developed its own

coding scheme. ADA codes resemble CPT codes, in that they consist of five numbers, however, the codes all begin with the number 0, and range from 00110 to 09999. Very few ADA codes are identical to CPT codes. Although dental codes are not required on the DFEC system, and dental services are not subjected to the fee schedule, if the codes are present on a bill, they should be keyed.

h. Nurse and Other DOL Codes. DFEC has developed a series of codes to be used for various specially authorized services. These services are generally subject to the provisions of the Prompt Payment Act. In addition, a few other codes were developed for administrative purposes, and are not subject to the Prompt Payment Act. The DFEC-developed codes are shown in Exhibit 2.

i. Procedure code modifiers. CPT codes may be modified under certain circumstances. The modifiers generally consist of two numerics, or an alpha and a numeric. Different modifiers are valid for different groupings of CPT codes. Modifiers valid for specific groups of CPT codes are listed and described in the "Guidelines" section which precedes each grouping in the CPT coding book. In addition to the modifiers recognized by the AMA, DFEC has designated the following modifiers:

(1) A - appended to a surgical procedure code when used to bill anaesthesia for the surgery;

(2) B - used to denote a combination of modifiers 50 (bilateral procedure) and either 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (assistant surgeon when qualified resident surgeon not available); and

(3) TC - appended to a procedure which involves both a technical and professional component; indicates that the charges are for the technical component only.

5. Bypass Codes.

a. The Central bill processing system and the BPS edit program (BILL552) contain various checks to prevent duplicate payments or incorrect adjustments.

b. A record type B line item is considered to be a duplicate or possible duplicate of another line item when the case file number, payee identification number (9-digit EIN or SSN), and procedure codes (all 8 digits, including base code, modifiers, and fee schedule appeal code) are the same, and the dates of service are the same or overlap. With respect to procedure codes, a blank procedure code acts as a "wild card"; that is, it matches both an actual procedure and a blank procedure code. Thus two B records with matching payee identification numbers, case file numbers, dates of service, and with a procedure

code on one record and no procedure code on the other will be considered duplicate. Two records with matching case file numbers, payee identification number, dates of service, and no procedure code on either record will also be considered duplicate.

c. If the potential duplicates are contained within the same bill, in other words, two separate charges for the same procedure code and dates of service are on one bill, the system does not consider them to be duplicates.

d. Duplicate checking on bills being processed for payment (record type B) is done at the district office Sequent level as part of the BILL552 edit program. These duplicate checks are done using the same table of information which is used to display on-line BPS history. The edit program does not perform duplicate checking against same-day input. However, the Central System duplicate checking is performed on a weekly basis, and takes both weekly bill input and history into consideration. For provider types FR, KR, and QR, Sequent (district office) and Central System duplicate checking is done against history only.

e. Record type B line items which are considered to be potential duplicates will either fail BILL552 edits, or be rejected by the Central processing system. If a record which appears to be a duplicate is to be paid, an appropriate bypass code must be used.

f. Bypass codes for record type B are:

1 - required whenever a B record type line item appears to be a duplicate or a possible duplicate when compared to other bill input of any record type. Input is considered by the Central system to be any line processed in the same weekly billing cycle (usually Tuesday through Monday). If two "duplicate input" lines are to be processed through to payment by Central, at least one of the lines must have a bypass code 1. If three "duplicate input" lines are being processed for payment, and only one line is given a bypass code 1, only that line will be paid, and the other two lines will drop in Central processing. If any number of "duplicate input" lines exist, and none of the lines have bypass codes, all the lines will drop in Central processing.

2 - required whenever a B record type line item appears to be a duplicate or possible duplicate when compared to other bill history. History is considered by the Central system to be any line processed in a previous weekly billing cycle. In the district offices, paid history will appear in the on-line history as a payment with a check date. Paid history which predates the d10 purge date on the system and postdates the Central System purge date is available from Central by requesting an overnight or Friday history. To obtain history that predates the Central System purge date, a Friday history must be requested. To pay a line which is a duplicate against history, a bypass code 2 is needed. Without the

bypass code, the payment will drop in weekly processing.

3 - required whenever a B record type line item appears to be a duplicate or possible duplicate when compared to both input and history, as defined above.

g. BILL002, Resubmit Duplicate Bill, is an option on the FECS001 Bill Payment menu which may be used to enter bypass codes on records which have dropped from the weekly processing because a bypass code is needed.

h. For maintenance adjustments, bypass codes have a different meaning. No maintenance adjustments use procedure codes. For manual payments (record type M), bypass codes 1, 2, and 3 are used in the same circumstances as for B record types, where the case file number and payee identification number match and the dates of service match or overlap another record.

However, for other maintenance adjustments (record types C and D), bypass codes 4, 5, and 6 are used. Record types C and D are used to cancel out previous payments. If a record type C or D line is being entered which has the same case file number, payee identification number, and dates of service (including year) as a previously paid item, and there is no duplicate input within the current processing cycle, no bypass code is needed. For record types C and D, bypass codes are used under the following circumstances:

4 - required when entering a record type C or D line which has the same case file number, payee identification number, and service year (but not service dates) as a previously paid item, and there is no duplicate input within the current processing cycle.

5 - required to enter a record type C or D line if the case file number, payee identification number, and service year (not dates) match an item already paid AND an item being processed in the same weekly billing cycle.

6 - required to enter a code C or D line if the previously paid item has been purged from the active Central history. No duplicate input within the same weekly cycle is allowed.

i. To avoid overpayments, bypass codes 1, 2, and 3 should be used correctly and only when appropriate.

j. Bypass code 9 may appear on Central BPS histories. Bypass code 9 is assigned by the system under certain circumstances involving same-bill duplicate input. A bypass code 9 cannot be entered by the district offices. If a bypass code 9 appears on a bill payment report, the bill record was processed by the district office without a bypass code.

6. **Ineligible Amount Codes**. Ineligible amounts are portions of line item charges which are not payable. The difference between the charge amount and the ineligible amount must be more than $1.00. If a portion of a line item charge is not payable, the ineligible dollar amount and the ineligible code should be written next to the charge amount. The bill total must be adjusted to deduct the ineligible amount. For example, if a travel voucher for a total of $50.00 includes $10.00 worth of charges which are not payable, the bill could be processed with line charge of $50.00, ineligible amount of $10.00, ineligible amount code of H, and bill total of $40.00. The ineligible amount codes are as follows:

Drugs not identified	A
Non-reimbursable drugs	B
Partial payment previously made	C
Charges for other than claimant	D
Private room differential	E
Personal comfort charges deducted	F
Previous balance not itemized	G
Disallowed travel expenses	H
Allowable fee exceeded	I
Services unrelated to injury	J
Explanatory letter to follow	K
State tax disallowed	L
Drug charge reduced by contractor	M
Previously paid based on fee schedule limit	N

Ineligible amounts and messages associated with the ineligible amount code will appear on the payment statement issued with the bill payment check.

7. **Maintenance Type Codes**. Maintenance transactions must be performed using BILL052 or BILL053 for manual payments, check cancellations, cash deposits, and fund transfers. The maintenance programs require entry of a maintenance type code, which are as follows:

Manual Payment	M
Cancelled Check	C
Cash Deposit	D

Fund TransferFIf a maintenance adjustment is used to correct an error in a previous adjustment, the address field should be used to refer to the erroneous entry by type and date.

8. Fee Schedule Appeal Codes. Mark the appeal reason code on the bill immediately after the CPT-4 code. The appeal reason codes are entered as the eighth character of the procedure code field. The codes and their definitions are as follows:

B - Use where the fee schedule function is to be bypassed in connection with the payment of a given line item. This code would be used, for example, to make continuing payment for certain services to a provider who the district office has determined should not be subject to the fee schedule because of his or her unusual qualifications. This code is not to be confused with and does not in any way replace existing duplicate edit bypass codes.

1 - Use this code in cases where the appeal was based on the use of an incorrect CPT code. Appeal decision level: District Director [DD] (or Assistant District Director [ADD]).

2 - Use this code in cases where the appeal was based on the presence of a severe or concomitant medical condition making medical treatment especially difficult. Appeal decision level: DD (or ADD).

3 - Use this code in cases where the appeal was based on unusual provider qualifications. Appeal decision level: DD (or ADD). (This code would be used in connection with a specific appeal. If the district office determines that the unusual qualifications of the provider warrant nonapplication of the fee schedule on a continuing basis for a certain service or procedure, code "B" would be appropriate for subsequent billings.)

4 - Same as 1, except the appeal decision level is the Regional Director [RD] (or DD).

5 - Same as 2, except the appeal decision level is the RD (or DD).

6 - Same as 3, except the appeal decision level is the RD (or DD).

7 - Error identified and corrected without formal appeal.

9. Bill Status Codes. The BPS uses several one-letter codes. These codes may be viewed in either the suspense resolution or suspended bill query programs, at either the bill header or line item level. Note that header status takes precedence over line status. The codes and their meanings are as follows:

C - Continue; bill or line item has been allowed for payment.

S - Suspend; bill or line item has suspended for manual review.

D - Deny; bill or line item has been denied.

N - New; bill or line item has been keyed, and the bill batch in which it was keyed has been closed, but the bill has not yet been edited by the BILL552 program.

K - Keyed; bill or line item has been keyed, but the batch in which it was keyed has not been closed, and the bill has not yet been edited by the BILL552 program.

R - Recycled; bill has been worked and set to recycle through the BILL552 edit program, or has been automatically set to recycle by BILL505.

I - Internal Denial; bill has been marked for deletion because it is to be rekeyed, or should never have been keyed in the first place.

10. ICD-9 Codes. Claims Examiners are required to enter ICD-9 (International Classification of Diseases, 9th Revision) codes on the system for all accepted conditions. The BPS relies on the accepted ICD-9 codes on the system to determine which services are payable. As accepted conditions are amended or additional conditions are accepted on a case, the ICD-9 codes are supposed to be updated. Up to six ICD-9 codes may be entered on an individual case. Special one-character identifiers are used to give more specificity to a particular ICD-9 code. These identifiers are unique to the FECA system and are as follows:

R Right
L Left
B Both
A Aggravation
D Denied

The identifiers are entered in the sixth position of the six-character ICD-9 code field. In addition, ICD-9 code procedures may also be entered on the system. These are found in Volume 3 of the ICD-9 coding manual. On the system, the ICD-9 procedure codes will have a P in the first position.

11. EOB/Edit Codes. Explanation of Benefits (EOB) Codes correlate with the Edit Number Codes, except that not every edit has a related EOB message. Exhibit 1 in Chapter 5-0205 shows all of the EOB messages. All EOB/Edit Code numbers consist of three numbers. Any code of 900 and above is referred to as an "alternate EOB". Edit Codes may be seen in the suspense resolution and suspended bill query programs. EOB codes are seen in the On-line BPS History program. A separate job aid gives detailed edit information.

5-0203 Exhibit 1: Locator 4 Codes

LOCATOR 4 CODES

Locator 4 codes are used by several Federal programs. Locator 4 codes consist of three numeric digits. Each digit has its own significance. The first digit indicates the type of facility:

1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science (Hospital)
5	Christian Science (Extended Care)
6	Intermediate Care
7	Clinic
8	Special Facility
9	Reserved for National Assignment

The second digit indicates the bill classification. The classification codes are as follows (except for clinics and special facilities):

1	Inpatient (Including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
5	Intermediate Care - Level I
6	Intermediate Care - Level II
7	Intermediate Care - Level III
8	Swing Beds
9	Reserved for National Assignment

The second digits for clinics are:

1	Rural Health
2	Hospital Based or Independent Renal Dialysis Center
3	Free Standing
4	Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facility (CORF)
6-8	Reserved for National Assignment
9	OtherThe second digits for special facilities are:
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center

5 Rural Primary Care Hospital
6-8 Reserved for National Assignment
9 Other

The third digit indicates frequency, as follows:

0 Non-Payment/Zero Claim
1 Admit through Discharge Claim
2 Interim - First Claim
3 Interim - Continuing Claim
4 Interim - Last Claim
5 Late Charge(s) Only Claim
6 Adjustment of Prior Claim
7 Replacement of Prior Claim
8 Void/Cancel of Prior Claim
9 Reserved for National Assignment

The definitions for frequency are as follows:

Non-Payment/Zero Claim (0) - This code is to be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill; but needs to inform the payer of the non-reimbursable periods of confinement or termination of care.

Admit Through Discharge Claim (1) - This code is to be used for a bill which is expected to be the only bill to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or a course of treatment, and bills which represent an entire benefit period of the primary third party payer.

Interim - First Claim (2) - This code is to be used for the first of a series of bills to the same third party payer for the same confinement or course of treatment.

Interim - Continuing Claim (3) - This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted.

Interim - Last Claim (4) - This code is to be used for the last of a series of bills, for which payment is expected, to the same third party payer for the same confinement or course of treatment. It is not intended to be used in lieu of a code for Late Charges, Adjustments, or Zero/Non-Payment Claims.

Late Charge(s) Only (5) - This code is to be used for submitting charges to the payer which were received by the provider after the Admit Through Discharge or the Last Interim Claim has been submitted. It is not intended to be used in lieu of an Adjustment Claim or a Replacement Claim.

Adjustment of Prior Claim (6) - This code is to be used when a specific bill has been issued for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" date and the reimbursement amount is to be recalculated through an increase or decrease in charges, per diem calculations, deductibles, co-insurance, and/or prior third party payments. To properly adjust a prior bill, the respective plus or minus adjustment must be provided, along with the net overall change and the new reimbursement amount.

Replacement of Prior Claim (7) - This code is to be used when a specific bill has been issued for a Provider, Patient, Payer, Insured and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. This code is not intended to be used in lieu of a Late Charge(s) Only claim.

Void/Cancel of Prior Claim (8) - This code reflects the elimination in its entirety of a previously submitted bill for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" dates. The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.

5-0203 Exhibit 2: DFEC-Developed Procedure Codes

CODE	DEFINITION	PROMPT PAY?
ACUPU	Acupuncture	No
ATTMD	Attending Physician Medical Report Request	No
AUTHO	Payment Authorized (No fee schedule)	No
NCAA1	Nurse Intervention; Claimant Advocate (Administrative Services or Working/Not Working Call) -15 minutes	Yes
NCAA2	Nurse Intervention; Claimant Advocate (Administrative Services or Working/Not Working Call) -30 minutes	Yes
NCA00	Nurse Intervention; Claimant Advocate (Professional Services) -30 minutes	Yes
NCA01	Nurse Intervention; Claimant Advocate (Professional Services) -1 hour	Yes
NCA02	Nurse Intervention; Claimant Advocate	

	(Professional Services) -2 hours	Yes
NIA00	Nurse Intervention; Administrative Services - less than 1 hour	Yes
NIA01	Nurse Intervention; Administrative Services - 1 hour	Yes
NIP00	Nurse Intervention; Professional Services - less than 1 hour	Yes
NIP01	Nurse Intervention; Professional Services - 1 hour	Yes
NITRA	Nurse Intervention; Travel	Yes
NIPTC	Nurse Intervention; Phone Calls	Yes
SURB1	Case File Review by DMA or Office Consultant (Back Surgery)	Yes
SURB2	Second Opinion Clinical Examination (Back Surgery)	Yes
SURC1	Case File Review by DMA (Carpal Tunnel Surgery)	Yes
SURC2	Second Opinion Clinical Examination (Carpal Tunnel Surgery)	Yes
TAXES	Hawaii Excise Tax	No
SECOP	Second Opinion Medical Examination	Yes
IMPAR	Impartial Medical Examination	Yes
CNSLT	Case File Review by District Medical Consultant	Yes

5-0204 Principles of Bill Adjudication

TABLE OF CONTENTS

Paragraph Subject Date Trans. No.

1. **Purpose and Scope**. This chapter describes the rules and principles which underlie bill adjudication.

2. **Reviewing Medical Evidence**. The BR may need to determine whether the diagnosis on the bill matches the condition which OWCP accepts, and the diagnosis on the medical report; whether the treatment is reasonably related to the diagnosis; whether the dates of treatment in the medical report match the dates of service on the billing form; and whether the amount and period of treatment are within reason.

a. A completed form CA-16 obligates OWCP to pay for any injury-related treatment performed by the physician or medical facility identified in Part A. The BR should look at the reported condition in the system or on the CA-1, Notice of Injury, to determine whether the treatment is reasonably related to the accident for which the CA-16 was issued. A description of the injury may also be found in Box 5, Part A of CA-16.

b. If the treatment occurred more than 60 days from the date of injury, and authorization was not explicitly extended in a letter or telephone message to the provider,

the bill should be treated as if no CA-16 had been issued, and reviewed in connection with the accepted condition and information in the medical reports.

3. Hospital Treatment. No inpatient hospital bill should be paid unless the hospital discharge summary, or hospital record if the claimant is not yet discharged, is present in the case file. Alternate EOB 901 may be used to request these. The discharge summary will give a final diagnosis, dates of hospitalization, and will describe the course of treatment while in the hospital. It may be necessary to refer to the treating physician's report as well to evaluate the bill. The BR should be alert for any pre-existing conditions which may be treated while the claimant is hospitalized for the work injury. If the hospital record or physician's summary show that a personal condition was treated, the BR should ask the hospital to separate out the charges for this treatment and refer them to the claimant for payment. The BR should approve only charges related to the accepted condition.

4. Discounts on Hospital Bills.

a. Some hospitals offer discounts for prompt payment of their medical bills. Since a fee schedule is applied to most outpatient hospital bills, no discount will be applied to outpatient bills. However, for inpatient bills, if a discount is offered on the bill itself or an attachment, a discount should be considered.

b. All inpatient hospital bills fail BILL552 edit 002. When a bill fails this edit, in addition to considering other pertinent issues, the resolver should determine whether a discount is offered.

c. If a discount is offered, the amount is specified, and the bill will be paid within the period of time indicated by the provider, the resolver should:

(1) Calculate the amount of the discounted bill;

(2) Note the discounted amount on the bill itself;

(3) Adjust the bill total and line item charge through bill resolution to equal the discounted amount.

d. When considering whether a bill will be paid timely, the resolver must take the bill payment cycles and check dates into consideration.

e. If the amount of the discount is not specified, the office will pursue the matter further.

f. If a provider whose payment has been discounted later objects to the reduction, a written explanation of the reduction should be provided. If the provider continues to object to the discount, an additional payment equal to the amount of the reduction should be processed.

g. Discounts should be applied only to those charges which would have been reimbursable under the FECA. For example, charges for a private room are usually reduced to the amount for a semi-private room unless the attending physician prescribes a private room. Charges for television are generally not reimbursable.

h. If the method of computing a discount is not obvious from reviewing the bill, a short memorandum should be placed in the case file or attached to the bill, explaining the computation. This would include situations in which the amount of the discount was negotiated with the provider.

5. Prescription Drugs. Physicians should list in their reports the names of drugs prescribed for the patient. Bills for prescription drugs should contain the names and amounts of the drugs, and the name of the prescribing physician. The BR may consult the Physicians' Desk Reference to determine whether a specific drug is being prescribed for the accepted condition. If drugs cannot be verified in this manner, the BR should prepare a brief memorandum to the District Medical Adviser asking for an opinion as to whether the drugs are appropriate for the accepted condition.

6. Submission of Bills for Reimbursement and Third Party Payment.

a. When the claimant has paid a provider for a service performed for a work-related injury, the claimant may request reimbursement by submitting a completed HCFA-1500 signed by the physician, with the amount of payment entered in Block 28, and a statement as to who made the payment. The claimant must sign the bill at item 12 and all information must be present. Hospital bills must be stamped "paid" or otherwise certified to show that payment has been received. A copy of the canceled check should be submitted to support reimbursement of amounts over $500.

b. Bills and receipts which do not appear on printed stationery or billhead must show the full signature of the person issuing the receipt and indicate the capacity in which the payee was represented. Bills that have been prepared on bookkeeping machines (not typewriters) showing debits and credits will be acceptable if the charges may be properly identified and if the cash credits are shown. Such billings, of course, must identify the injured employee as the person for whom the service or supply was furnished. (Billings of this sort prepared on a typewriter are not acceptable as they are obviously only copies of the original billings.)

c. Cash sales receipts that bear imprints of mechanical cash registers may also be accepted if the nature of sale can be identified and the record supports the purchase of an item which may be paid for by OWCP.

d. Photocopies of the canceled checks may also be accepted in lieu of receipts but must be accompanied by itemized bills or other acceptable evidence of the charge for which payment was made.

e. Prescription receipts must include the name of the drug, the prescribing physician, the amount of medication, and the date.

f. In occupational disease cases, a claimant may have incurred and paid medical expenses for some time before filing a claim and being notified that HCFA-1500 or OWCP-1500a is required. The claimant may thus be entitled to reimbursement for these expenses but not have adequate information to support the request. In such cases the office should assist the claimant to obtain completed standard billing forms or, where this is extremely difficult, to obtain adequate information to support payment.

g. Insurance carriers may learn after having made payment on a claim that it was a workers' compensation claim. They should submit a completed HCFA-1500 or facsimile listing procedures, charges, and paid amounts for each individual provider (including tax identification number), and should attach signed certification of the payments made by the insurance company. The National Association of Letter Carriers Health Benefit Plan uses Form NALC-200 to request reimbursement, which when signed by the carrier's representative, requires no further verification of payment. Any third party payee, such as a health insurance company, must be entered in the Provider Master File, using the corporate Tax Identification Number for payment to be made.

Since the BPS edits do not block duplicate payments to two different "providers," the bill payment history must be checked carefully before the BR authorizes payment. Insurance carriers are generally entered as provider type O on the system, so that their claims are not subjected to the fee schedule. However, insurance companies should not be confused with third party billers, such as managed care groups. These providers should be entered as a provider type which is appropriate for the type of services being provided.

7. Appliances, Supplies, and Dental Treatment.

a. Major Appliances. Prior authority is to be obtained from the OWCP for the purchase of major orthopedic or prosthetic appliances. A claim for payment of such an item should be approved without question if the claim is submitted on the AMA standard form and if the item was supplied in accordance with the terms of a prior authorization.

If the item was supplied without the OWCP's prior authorization, the BR shall determine whether the appliance was necessary for the proper management of the injury and whether the charges are reasonable. (Assistance from the District Medical Adviser may be indicated in some cases.)

b. Minor Appliances. Prior authorization from the OWCP is not expected in the case of minor appliances such as a truss, a sacroiliac belt, an ankle strap, or items such as crutches and canes. Reasonable charges for these items may be approved if they were prescribed by the attending physician or the injury was such that the items were necessary for its proper management.

c. Dental work should be performed only if authorized by OWCP unless the work is rendered by or upon order of a United States dental officer or United States medical establishment. A claim for payment of such services should be approved if the claim is in proper form and if the services were performed in accordance with the terms of the prior authorization.

Charges for unauthorized dental work may be approved for payment if the work performed was in the nature of emergency care or it is shown that the injured employee and attending physician were unaware of the need for prior authorization from the OWCP. In this case, the BR should determine whether the work performed was needed because of the injury and whether the charges are reasonable. In some instances the advice of a District Medical Adviser will be necessary. The same procedure is to be followed with respect to furnishing artificial dentures.

d. The FECA 1974 Amendments allowed the destruction or damage of certain appliances to be considered as an injury under the Act. Therefore, if a medical brace, artificial limb, or other prosthetic device is damaged or destroyed on the job, the employee may file a CA-1 for a traumatic injury. The injured employee will be entitled to have the appliance replaced or repaired and will be entitled to continuation of pay (COP) during repair or replacement.

e. Eyeglasses and hearing aids may be repaired or replaced if they were damaged or lost incident to a personal injury for which the claimant required medical treatment. Thus, if the claimant stumbles and breaks his or her glasses but is not otherwise injured and requires no other treatment, replacement of glasses may not be authorized under FECA.

f. It is the responsibility of OWCP to maintain and replace orthopedic or prosthetic appliances that are initially furnished to an injured employee as part of the medical care of a compensable injury. Such repairs and replacements should be rendered upon recommendation of a qualified physician, and OWCP must give prior authorization unless the amount is under $500. However, there may be certain exceptions, notably if

the artificial appliance is essential for the employee to work without interruption.

8. Travel.

a. 20 C.F.R. 10.412 provides in part as follows:

> Where the means of transportation is not furnished by the Government, a claim for reimbursement of the cost of necessary transportation and of necessary incidental expenses incurred by an injured employee who has been authorized to travel for the purpose of securing medical or hospital treatment, appliances or supplies or for medical examinations, may be submitted promptly to the OWCP for consideration. Standard Form 1012 properly executed shall be used for this purpose. Where transportation by automobile is furnished by an employee of the United States or by a relative of the injured employee, reimbursement may be made at the rate per mile fixed by law, Executive, administrative, or other order for employees of the United States authorized to travel at Government expense.

b. Rates fixed by law and payable for the use of privately-owned vehicles are periodically announced by means of FECA Bulletins. Consult the latest FECA Bulletin to determine the currently prevailing authorized rate. The latest FECA Bulletin is to be filed in front of this chapter.

c. The BRs should be familiar with the contents of Form CA-77, "Instructions for Submitting Travel Voucher." This form carries the OWCP's instructions for claiming reimbursement of travel expense and should accompany any Standard Form 1012 that may be sent to a beneficiary. Most questions about travel expense will be answered in the Form CA-77. Other questions that may arise may be disposed of by consulting the applicable provisions of the Standardized Government Travel Regulations.

d. Travel expense incurred to secure treatment as defined by 5 U.S.C. 8103 is reimbursable irrespective of prior authority. Generally, the injured person may be reimbursed for travel expense if the OWCP approves payment of the medical treatment which necessitated the travel. The one exception to this rule is where the OWCP pays for medical care but not for travel expense. This would occur in situations where the employee, for personal reasons, did not obtain medical care at the nearest available source consistent with the requirements of the FECA and regulations. In the case of examinations provided by 5 U.S.C. 8123 travel expense may be allowed if the examinations were authorized by an official superior with full expectation that such examination would have otherwise been authorized by the OWCP.

e. Injured employees are expected to travel by public transportation wherever its use is practical. When examination or treatment is authorized outside the injured employee's

home city, taxi service may be used:

(1) From the employee's home to the place where public transportation is obtained to travel to the distant city;

(2) From that place to the hospital or doctor's office;

(3) From the hospital or doctor's office to the place where public transportation is obtained to return to the home city; and

(4) From that place to the employee's home.

The actual taxi fares may be allowed plus tips of 15 percent; if the 15 percent is not a multiple of 5, it may be allowed for the next multiple of 5. No receipts are necessary for these charges, unless the fare exceeds $20. However, the BR may insist upon the submission of proper receipts if the amounts claimed appear to be excessive.

f. Reimbursement for the hire of special transportation (including taxis) may be approved only:

(1) If no other means of transportation is available or its use is impractical; or

(2) Where the injured employee has a disability which prevents the use of public transportation.

Charges for special transportation which are necessary because of the traveler's disability may be justified by this statement: "Special conveyance necessary due to physical condition of injured employee." The BR should write this statement on the voucher and sign it.

To be approved, charges for special transportation used under other circumstances must be supported by an appropriate statement. This may be added by the BR and the charge may be approved by the BR if satisfied from the evidence that the use of the special conveyance was necessary or in the best interest of the Government.5-0204-8 Travel

g. Transportation Requests. When treatment or examination is authorized by the OWCP it is sometimes necessary to furnish the injured employee with Government Requests for Transportation so that the necessary travel may be made by common carrier at no expense to the traveler.

When considering a travel voucher which includes items of transportation (not travel in the nearby area), the BR must first determine whether Transportation Requests (TRs) were issued and, if so, what disposition has been made of them. If they have been

returned with the travel bill, they should be marked "Canceled" and routed for proper disposition. The copy of letter forwarding the TRs to the beneficiary should be annotated to show that the TRs have been returned and canceled. The BR should then proceed with the audit of the bill.

If the TRs have not been returned and canceled, the BR must request their return or determine what happened to them. Consideration of such a bill must be held in abeyance pending clarification as to the use or disposition of the Transportation Requests. This is of utmost importance because the OWCP is responsible for the payment of the transportation furnished even though the travel may have been made by unauthorized persons or for unauthorized purposes.

h. Actual expenses. All other items incident to the travel will be reimbursed on actual expense basis. There may be no per diem allowance in lieu of subsistence expenses. Receipts are required, whenever it is practicable to obtain them, in support of a claim for any incidental item (such as meals, lodging, hiring of special conveyance, etc.) where the amount exceeds $25 and for the purchase of gas and oil when reimbursement is claimed on an actual expense basis in lieu of a mileage basis. Inasmuch as most injured employees have little occasion to travel at Government expense it is to be expected that there will be no available receipts. In such cases the BR should use discretion and give the employee benefit of doubt.

i. Government travel regulations state that employees traveling on official business "are expected to exercise the same care in incurring expenses that a prudent person would exercise if traveling on personal business." The BR should not approve claims for amounts which appear to be excessive. This is particularly true when the amounts claimed are not supported by proper receipts. The traveler may or may not be requested to submit an explanation for charges that appear excessive.

In some cases it will be proper for the BR to reduce the charges and allow such sums as appear reasonable under the circumstances. The BR's action in any particular case will be guided by the existing facts. No maximum allowable amounts have been established for meals and lodging because of the variety of conditions involved. Such costs will in some measure be controlled by geographical location.

j. Time Frame for Meals. With respect to allowance for meals, a traveler may be allowed reimbursement for breakfast when the time of departure is prior to 8:00 A.M. Reimbursement for dinner may be allowed when the time of return is after 6:00 P.M.

k. Unnecessary Items. Amounts claimed for items which are not necessary or not incidental to the travel should be disallowed. Inquiry should be made of the traveler when the record fails to clearly show whether an item of expense was necessary or incidental to the travel.

l. Time on Bill. The travel voucher should show the hour and date of departure from the traveler's home as well as arrival at and departure from the designated place of treatment or examination and arrival at home. The hour of arrival and departure are unnecessary if claim has not been made for meals or lodging. Likewise the actual elapsed time of travel is unnecessary when no claim for subsistence expense has been made.

m. Verification. No travel expense shall be allowed until the evidence shows that travel was performed for the purpose authorized. This is usually established by reviewing the on-line BPS history to determine whether there was medical treatment on that date, or a report from the attending or examining physician.

In the case of repeated trips the medical report will, in many cases, show the dates when the injured employee reported to the physician. If not, and if the BR has reason to believe trips were not made as claimed, a signed statement should be obtained from the physician showing the dates the traveler reported. This statement may appear on the travel voucher or may be in the form of a supplemental report. The desired confirmation as to actual dates of travel will in some cases appear on the voucher or bill received from the physician or may be taken from any other evidence in the file. In some cases the BR may approve reimbursement of repetitive trips without definite confirmation from the physician as to the dates of travel. The BRs are expected to use good judgment and base their action on the evidence appearing in the record. The nature and extent of injury will furnish some guidance in determining whether the number of trips is reasonable.

n. Attendant. The cost of hire and travel of an attendant to accompany an injured employee may be approved if the injured employee's condition is such that travel cannot be performed without an attendant. Generally speaking, the medical evidence on file will show whether an attendant was necessary. Where there is doubt as to such necessity the BR should seek advice from the District Medical Adviser.

The attendant's travel expenses may be included in the injured employee's travel voucher if such expenses were paid from the injured employee's own funds. Otherwise, the attendant should submit a separate travel voucher. Per diem in lieu of actual expenses may not be allowed for an attendant.

o. Claim for the attendant's salary, if unpaid, may be made on the attendant's travel voucher. A salaried employee of the United States may not be paid a wage in addition to salary for acting as an attendant for one of the OWCP's beneficiaries. A member of the injured employee's immediate family or household may not be allowed a salary or wage to act as the employee's attendant unless it is shown this person gave up gainful employment to do so. The face of a travel bill from an attendant should bear a notation that the person claiming payment was an attendant for the injured employee.

p. Delays in Travel. All travel is to be performed with reasonable dispatch. There are to be no unnecessary or unreasonable delays. In other words, the injured employee and attendant should proceed promptly to the hospital or doctor's office upon arrival in the city where the hospital or office is situated. The employee and attendant should also return home promptly after discharge by the hospital or physician unless it is impractical to do so. It is particularly important that the BR give careful consideration to this question when travel vouchers include charges for meals and lodging. When the BE determines that there has been an unnecessary or unreasonable delay, the charges for meals and lodging that resulted from such delay should be deducted from payment.

9. Itemization of Medical Expense Claims.

a. All medical expense claims must be itemized. There must be sufficient itemization on all vouchers and bills so that the charges may be properly evaluated by the BR. As a general rule the BR should insist upon a further breakdown of charges if unable to determine with reasonable certainty whether:

(1) The charges are excessive in rate; and

(2) Services have been rendered to justify the charges.

b. The A.M.A. Current Procedural Terminology code (CPT-4) or HCPCS code for each medical, surgical, X-ray, or laboratory service should be shown in Block 24c of the OWCP-1500. Outpatient hospital services for physicians' professional, radiology, pathology, laboratory, and physical therapy must also be CPT-4 or HCPCS-coded on the UB-82 or UB-92 form. If charges are not itemized in such a way that the BR can determine what code applies, the bill should be denied.

Bills should show the dates when the respective services or supplies were furnished. Individual dates are not necessary if the billing is for repeated charges over a period of time. In such cases the billing should show the inclusive period covered by the billing, the number (units) and nature of repeated charges, the rate of each charge, and the total charge.

For example, if a physician rendered 10 office visits to an injured employee during June and his regular charge for each office visit is $50.00, it would be acceptable for the physician's billing to show: June 1 to 30, with the appropriate year -- 10 office visits at $50 each, $500.

The BR should be certain that evidence justifies the need for the number of repeated items during the period claimed. (Charges for items at a rate in excess of one per day

should generally not be allowed unless the voucher or bill bears an explanation showing that the greater number is necessary.)

c. Bills from hospitals for inpatient services are frequently submitted in a summarized manner. Charges for the room may be accepted if so shown. Charges for a private room are acceptable only if necessary for treatment of the approved disability. The supplemental charges on such a billing (meaning X-ray, drugs, supplies, anesthesia, operating room) need not show the dates when the individual services were rendered. The BR must ascertain from the evidence, however, whether all of the miscellaneous services during that period are proper charges against the Compensation Fund.

d. Billings need not be itemized on a day-to-day basis. They may be itemized on any other specified basis, such as a weekly or monthly basis. This is frequently applicable in the case of practical nursing services, nursing homes, and sanatoriums.

e. When nursing services (not contract nurse) are employed on critical cases on a shift basis, the charges for such services must carry the inclusive hours of duty. This is a practical necessity for the BR because, without such information, it soon becomes impossible to determine whether there has been any duplication of charges.

10. Disallowance of Part of a Bill.

a. Bills or line items may deny automatically through the application of the BILL552 edits, without intervention by the BR.

b. When a bill suspends for review, if the bill is approved in part only, it is the responsibility of the BR to inform the potential payee of the reasons for non-payment. If the existing EOB messages or an alternate EOB message do not adequately explain the reason for denial, a narrative letter should be used (in addition to the EOB message).

c. Portions of line items may be disallowed by using the ineligible amount codes and amounts.

d. It is not necessary to give a payee prior notice of a denial or reduction of bill. The EOB letter (BILL654) tells payees what to do if they disagree with the decision. At times, if requested by the claimant, a formal decision may be needed. This would generally be done by a claims examiner rather than a BR.

e. Sometimes it is better to approve a bill for a reduced amount (those charges which are clearly allowable) and give the payee an opportunity to resubmit a claim for the items in controversy. This method of handling the bill is preferable when the greater portion of a bill may be approved immediately or when the questionable item apparently may be

approved when placed in proper order.

For example, payment of an entire inpatient hospital bill should not be withheld merely because the drug charges are not itemized adequately while the other charges are in order for approval. The drug charge should be entered as an ineligible amount and the bill approved for the remaining items. The payee should be advised of such action and asked to submit an itemization for the drug charge on another bill. If the itemization is submitted later and found to be acceptable, the remaining charges should be approved.

11. Adjustment Because of Mistake in Bill.

a. Various decisions of the Comptroller General of the United States have established the rule that administrative or accounting officers or employees may not increase the amount of a voucher representing a claim against the Government. The underlying principle of that rule is that no change in a claimant's account should be made by other than the claimant so as to increase the amount claimed to be due from the Government. This is founded upon the policy of the courts where no greater amount than is claimed can ordinarily be recovered without an amendment of the pleading.

b. However, in Comptroller General decision B-131105, dated May 13, 1957, it was stated in part that:

in furtherance of our policy of continuously reviewing our practices and procedures with the view of developing improvements in the fiscal transaction of the Government, we have recognized that strict application of this rule to claims by employees and Government creditors involving minor errors of computation or extension in the stating of a bill, can only be costly in administration and productive of many small claims for the additional amount due. Thus, we have sanctioned the administrative adjustment upward or downward of claims involving such errors in amounts not in excess of $10, without amendment of the claims by claimants. To the extent that this adjustment procedure may be inconsistent with the cited decisions, they may be regarded as modified.

c. Bills which are out of balance (sum of the line item charges does not equal bill total) will fail BILL552 edit 019. In keeping with the above-cited decision, if the imbalance is due to an undercharge or overcharge of $10 or less, the amounts may be adjusted without notice to the payee.

This practice will apply only if the undercharge or overcharge is one of computation or extension and where the payee has clearly made claim for the full quantity of material or service and at the proper unit price. If the undercharge or overcharge is in excess of $10, appropriate notification (deny with EOB 019) should be furnished the payee in order that

the error may be corrected.

d. This will not change established procedure for decreases and partial disallowance of claims.

e. The Comptroller General has ruled that when payment of a bill has been accepted without protest, the payee may not at a later date be paid an additional sum because of an error in the first bill. In the case of a claim for an additional amount because of an alleged mistake in the original bill, the Comptroller General stated:

> It is well settled that the submission of a claim to a disbursing officer of the United States and certification of the bill, therefore, as correct and just, and acceptance of payment without protest, precludes a claimant from receiving any additional amount on account of the alleged mistake.

f. In view of the foregoing, the BR should disapprove any claim for an additional amount resulting from an alleged mistake in the original bill if payment of the first bill was accepted without protest.

g. If the payee refuses to accept payment because of an alleged mistake in the original bill, the payee should be instructed to return the check and to submit a corrected bill. If the charges on the new bill are found to be reasonable and otherwise in order for payment, the returned check should be canceled and the new bill approved for payment in the usual manner.

12. Loss of Wages.

a. 5 U.S.C. 8123 provides an employee shall be paid for any loss of wages incurred in order to submit to any examination required by the OWCP. The CE will make the decision whether the claim will be paid for actual wage loss or as compensation for temporary total disability.

b. If a claimant has returned to work following an accepted injury or the onset of an occupational disease, and must leave work and lose pay or use leave to undergo treatment, examination or testing, compensation should be paid for wage loss under 5 U.S.C. 8105 while undergoing the medical services and for a reasonable time spent traveling to and from the location where services were rendered. Of course, any leave used cannot be compensated until it is converted to leave without pay. (See Myrtle B. Carlson, 17 ECAB 644, and Jeffrey R. Davis, 35 ECAB 950.)

Absence from work for the purpose of medical evaluation or treatment does not constitute a recurrence of disability. Therefore, such absence will not qualify the

claimant for a higher pay rate under 5 U.S.C. 8101(4). In Andrew W. Eickbolt, 30 ECAB 360,the Board stated that in the definition of monthly pay at section 8101(4), the word "disability" means "incapacity because of injury." An absence to obtain medical services while otherwise capable of working does not reflect an incapacity for work and therefore does not establish "disability" in the context of section 8101(4), for purposes of changing the pay rate.

If a claimant loses wages to obtain medical services during the period of a schedule award, the additional hours of wage loss compensation due may be paid at the end of the award, rather than interrupt the schedule award for payment of wage loss compensation.

c. Temporary Total Disability. A claim for loss of wages may not be approved during any period when an injured employee is receiving continuation of pay, compensation for temporary total disability as provided by 5 U.S.C. 8105, or leave pay. Likewise, such claim may not be approved unless the record clearly shows the desired examination took the injured employee away from a remunerative position in which the employee would have otherwise been present for duty. In other words, loss of wages should not be allowed if the injured employee would have otherwise not been present for duty because of disability or some personal reason.

It may generally be assumed that an absence of duty was necessitated because of an examination if the absence is for a period no longer than that required to report for such examination (including necessary travel time). Where the absence is for a longer period, the claim should be given careful consideration in the light of the available evidence. Additional evidence or appropriate explanations should be requested wherever the information is insufficient to make a proper determination.

d. Partial Disability/Schedule Award. The receipt of compensation for partial disability as provided by 5 U.S.C. 8106 or a schedule award as provided by 5 U.S.C. 8107 is no bar to the receipt of a payment for loss of wages if the employee was gainfully employed and lost wages while reporting for an examination in accordance with the provisions of 5 U.S.C. 8123 or treatment in accordance with paragraphs 2 or 3 above. The case record will reveal whether the compensation being paid is for total or partial disability.

e. An allowable claim for loss of wages should be approved for a sum equal to the actual loss resulting from the examination. The claim may be submitted on CA-7 or CA-8, or in the form of a signed statement from the employer indicating the rate of pay and the number of hours or days lost from work for examination or treatment. The CE should prepare a brief memorandum to the Fiscal Officer authorizing payment for wage loss under 5 U.S.C. 8123 or 5 U.S.C. 8103 through the BPS, indicating the dates covered and the amount to be paid. The CE should also ensure that the case status will allow

payment through the BPS.

f. When an employee hires someone to work while reporting for an examination, the employee is entitled to payment for loss of wages. The amount to be allowed will equal the sum the employee paid to the individual who worked in the employee's place if such sum is reasonable and represents a fair wage for the service performed. In these instances it is required that the injured employee submit a receipt in duplicate, from the person who worked in the employee's place. The receipt must be so prepared that the purpose for which payment was made, including necessary dates and rates, is clearly shown.

g. Payment is keyed using provider type KR.

13. Recurrent Disabilities.

a. The official superior may issue authorization for further treatment of an injured employee when the employee complains of recurrent disability if there is reason to believe the alleged disability is due to the injury, and not more than six months have elapsed since final action was taken by the OWCP. The official superior should not issue an authorization if there is doubt that the disability is due to the injury, or more than six months have elapsed since final action by the OWCP. Instead, the employer should communicate with the OWCP and ask for instructions. If the claim is otherwise in order, a bill based upon authorizations issued more than six months after final action by the OWCP may be approved for payment. However, the issuance of such authorization should be brought to the attention of the employee responsible for communication with employing agencies (usually the technical assistant).

b. Form CA-16, Authorization for Medical Treatment, is the proper form to authorize medical treatment for a recurrence. CA-16 authorizations for recurrences should be entered on the system upon receipt in the mail room, as any other CA-16 would be.

c. Generally, no unauthorized medical expense for a major recurrent disability should be approved for payment until the CE has taken action on the original injury and the alleged recurrence. Bills for examinations may be approved without action by the CE if supported by an authorization and medical report. The BR may approve bills for small sums covering examinations and brief periods of treatment without requiring action by the CE if:

(1) The disability is such that no loss of pay is involved and no permanent disability or further recurrences are anticipated;

(2) The BR is satisfied that the recurrent disability is due to an injury sustained while in the performance of duty; and

(3) The bill is supported by an authorization and medical report.

The BR should require action by the CE before approving bills on cases not falling within these three categories.

14. Third-Party Recoveries.

a. When an injury occurs under circumstances creating a legal liability in some person other than the United States to pay damages, the injured person is required, after deducting the costs of suit and a reasonable attorney's fee, to refund the amount of compensation paid by the United States from any money or property received in satisfaction of such liability. This refund is made after the claimant receives a percentage of the recovery as indicated in 5 U.S.C. 8132 of the Act.

b. Whenever there has been a recovery from the third party, the Office of the Solicitor will obtain a refund for the amounts paid by the OWCP and will provide a brief accounting showing the total recovery, the court costs and attorney's fees, the amount refunded to cover the OWCP's payments, and the amount of the surplus to be credited against the future payments. The CE will also record an entry on the Summary Sheet (Form CA-800) showing the third party credit. Similar entries will be recorded at subsequent intervals when there is accrued compensation or paid medical expense which is allowable as a charge against the third party credit.

c. Usually medical expense should not be approved for payment while there is a third party credit except if the expense involves an examination authorized by the OWCP. Such examinations are not frequently authorized while there is a third party credit but such expenses, if reasonable, must be paid in view of the contractual obligation arising from the authorization, and since the examination is for the benefit of the OWCP.

d. Where proper authorization has been issued for medical care, the OWCP has a contractual obligation to see that reasonable medical expenses for treatment rendered under the authorization are paid. Where bills for such services are outstanding at the time of settlement, and they are otherwise correct, payment may be made. If the amount of the bills was not included as a refund to the OWCP, the case should be referred for collection of the medical expense from the injured employee if credit against future payments exists. Such refund will, of course, reduce those credits.

e. The injured employee having a third-party credit may submit receipted bills to be applied as charges against the third-party credit. Such receipted bills will be keyed in the

usual manner. Cases in which a third-party credit remains should have a case status of A0, which will cause edit 111 to fail. When the bill suspends, if payable except for the third-party credit, the resolver will post the amount of the bill as a charge against the third-party credit balance, and deny the bill with EOB 922. Interested parties should be informed by separate letter that the amount of the bill has been applied against the third-party credit. If aside from the third-party credit the bill is not payable, it should be denied using an appropriate EOB message.

15. Hospitalization Required Because of Injury While in Travel Status.

a. The Government Travel Regulations provide for continuing per diem allowance to an employee in travel status who becomes incapacitated due to illness or injury, not due to the employee's own misconduct, for periods not to exceed 14 calendar days in any one period of absence.

b. The regulations also provide that a refund of the per diem allowance shall be required from the employee in any case where the employee received hospitalization under any Federal statute or receives reimbursement under such statute for hospitalization expenses paid by the employee.

c. In those cases where beneficiaries were in a travel status at the time of injury or illness requiring hospitalization, and the OWCP pays the bills for such hospitalization (direct or reimbursement), the BR should notify the employee's official superior (by letter) of the approval of the hospital bill. The letter should show the inclusive dates of hospitalization for which we have paid the expenses and refer to the requirements of section 6.5(a) of the Government Travel Regulations and decision 32 Comptroller General 113 dated August 28, 1952.

16. Payment for Medical Reports by OWCP. On occasion, it is necessary to request an attending physician to supplement medical reports for reasons other than the physician's previous laxity in submitting timely reports or poor reporting. This is usually, but not limited to, requests for rationale to support a prior opinion on causal relation, the history of injury, work limitations, etc. Most of these requests do not require further examination of the claimant. However, it may be a routine expense in addition to the examination. A charge for such report is a proper expense to the Compensation Fund and may be paid. If any question arises as to the propriety of a charge for a medical report, authorization should be obtained from the responsible claims examiner.

5-0205 Bill Resolution

TABLE OF CONTENTS

1. Purpose and Scope. This chapter provides detailed procedures and instructions for resolving bills which have suspended for resolution as a result of the BILL552 process. BILL054, Suspense Resolution, is the program used to resolve suspended bills.

2. Responsibility for Bill Resolution. In some offices, fiscal or bill processing personnel are responsible for resolving suspended bills, while in other offices, claims personnel have this task. In most offices, bill resolution is a shared responsibility between claims and fiscal staff. District office managers decide the staffing structure and responsibilities within an office. Authorization and decision-making functions which have been within the purview of claims examiners, such as authorizing specific medical treatment or surgery, should remain with claims examiners.

3. Responsibility for Monitoring Bill Resolution.

a. After bills have been data-entered and the batch edits (BILL552) run, the intact bill batches should be forwarded to the bill processing unit supervisor along with the BILL552 Suspense Worksheets. The worksheet lists each bill which has been suspended in the batch, along with the error code numbers of the edits which have failed, by line. Line 000 is the header, and line 001 corresponds with the first detail line on the bill, line

002 with the second, etc.

b. Upon receipt of the bill batches, the bill processing unit supervisor will assign batches to resolvers. A record of the assignments should be kept, if assignments are not made according to an organizational scheme.

c. At least once a week, the bill processing unit supervisor will be provided with report BILL652, Suspense Aging Report, or an equivalent report. The report will be reviewed to determine what suspended bills are aging, and to direct resolution of aging bills.

d. The bill processing unit supervisor will also be responsible for auditing and storing batches of bills in which all bills have been finalized (see Chapter 5-0208).

4. Initial Actions. Generally, if any of the edit failures require action which involve other office functions, those edits should be dealt with first. For example, edit failures 023 or 024 result when the provider is not on the Provider Master File. Before the bill is edited through the bill resolution screens, the individuals responsible for security input on the provider file should enter the provider on the provider file. As noted above, this may be done before the batch goes to the bill resolvers.

5. Using BILL054 (Suspense Resolution).

a. To view and potentially modify data on a suspended bill, the bill resolver chooses option 10 from the FECS001 bill payment menu.

b. A job aid which gives details of the individual edits has been published under separate cover. It includes the error description, the edit description, whether the edit denies or suspends when it fails, whether an edit may be overridden or not, the EOB message which goes out if the bill or line is denied based on that edit failure, the edit priority, and detailed bill resolution instructions for that edit. Exhibit 1 lists the EOB messages only.

c. Data on bills may be accessed by batch number, case file number, provider number, or bill identification number. For persons performing suspended bill resolution, the most frequently used means of access will be by batch number.

d. When the user accesses bills by batch number, case file number, or provider, a list of all suspended bills which fit that particular selection criterion will be displayed. From the list, the user may select an individual bill to work on. If the user specifies a bill identification number, the header information for that bill is displayed.

e. The FECS User's Guide provides detailed step-by-step data entry instructions for all of the means of access.

f. Once a bill has been selected for suspense resolution, the first screen which appears relates to header level data. Header level data such as the payee, provider type, receive date, etc., applies to the entire bill, rather than just an individual line item. The information on the left of the screen shows the header data which is currently in the bill record for that bill. The box on the right of the screen shows all of the header level edit failures. At the bottom of the screen, a message describes the purpose of several function keys. By using the function keys, one may move the cursor from the data area to the edit area, move to the line item screen, view case file information, view and modify provider information, or exit the bill (saving any changes that were made). Esc-Esc allows one to exit the bill without saving the changes.

g. The line item screens show data and edit failures for individual line items. There is a separate detail screen for each line item on a bill. The detail screen shows the status of the line, which line item is being viewed, and has bill data on the left, and edit failures in the box on the right. A message at the bottom shows what the function keys do: exit the line, move the cursor to the data or edit area, view case information, view bill payment history data, access provider information, or exit the bill. To view a different line item, one must enter N (for next) or P (for previous). To resolve a suspended line, one must enter U (for update). After a line has been worked, the F1 key must be pressed to exit the line, whether the changes are to be saved or not.

h. The case information screen contains the claimant's name, Social Security Number, case type, date of injury, date of death, responsible examiner, case location, adjudication status, current and previous and case status, form received, the accepted/reported condition(s) (and ICD-9 codes, if present), CA-16 authorizations, physical therapy authorizations, general suspense flag, and all of the case notes. This information may be useful in making decisions on some of the suspended edits.

i. The provider information screen allows one to view provider file information for the provider selected during data entry of the bill, and also allows one to update the bill record if the wrong provider was selected. This screen does not allow any provider file updates. One may also correct the provider from the header screen, except for claimant reimbursements. For claimant reimbursements (other than provider types FR [pharmacy], KR [travel], QR [maintenance allowance], or VR [training reimbursement]), the provider screen must be used to change provider information. For provider types FR, KR, QR, and VR, the provider screen does not function, because no provider data is entered for these reimbursements.

j. Edit failures may be resolved in two different ways: either by correcting bill data,

or by setting override or deny flags on the individual edit failures. Which type of action is appropriate depends on the nature of the edit. The edit-by-edit instructions provided under separate cover describe which type of action should be taken for the particular edit failure. Not all edits may be overridden, and not all edits may be set to deny. In addition, Chapter 5-204 describes general principles of bill adjudication.

k. If a header level edit is set to deny, usually the entire bill will be denied, even if there are other header or detail level edits which failed and suspended. The two exceptions to this general rule are:

(1) If a payee address error is present (edits 020, 023, 024); and

(2) If the case has a general suspense flag (edit 112).

The system requires that edit failures 020, 023 and 024 be corrected before a bill is denied, so that the denial letter will go to a correct address. The general suspense edit must be either overridden or set to deny in order to deny the bill for another header edit failure.

l. In all other instances, when a header level edit is set to deny, the explanation which will go out on the EOB letter is the one associated with that edit number, unless an alternate (900 series) explanation is specified (see subparagraph m, below).5-0205-5 Using BILL054 (Suspense Resolution)- CONTINUED

m. Edits or EOBs 900 through 998 are "alternate" EOBs, which may be used if the usual EOB message is not appropriate. It is not necessary to enter the EOB number when setting an edit to deny, unless an alternate EOB is desired. The alternate EOB number is entered in the "alt EOB" column next to the particular edit failure, inside the box on either the header or line item screens. A complete listing of the "alternate" EOBs is found at the end of Exhibit 1.

n. EOB 999 is assigned by the system to lines which are approved for payment, if other lines are being denied, and may not be entered as an alternative EOB.

o. EOB 920 is "Explanation to follow," which may be used if none of the other EOBs are appropriate. If EOB 920 is used, the user must make certain to follow up with an appropriate letter.

p. If a line edit is set to deny, the line will be denied if there is not a header level suspension, even if there are other edit failures for the same line which have not been addressed. Note, however, that if any individual line suspends, the entire bill suspends. Thus, when resolving a suspended bill, each suspended line item must be worked, or the entire bill will suspend.

q. To approve a bill with multiple edit failures, each edit failure must be addressed either by modifying data on the bill record, or by overriding the edit. Certain edit failures are linked, and correction of the data for one edit failure will also resolve the other edit failure. An attempt has been made to identify these linked edits in the detailed bill resolution instructions.

r. Once a suspended bill has been completely worked, the bill must be recycled by pressing <F10> and responding "Y" to the "Changes made are about to be saved -- has bill been completely updated, and is it ready for recycling? Y/N" prompt. Recycling the bill will allow all of the batch edits to be reapplied when the daily run of batch edits is made. If the bill has been completely worked, recycling the bill will in most instances result in the bill being approved for payment (and transmitted to Central) or denied (and an EOB generated). Some bills will suspend more than once.

s. It is not necessary to resolve all suspended bills in a batch before any of them will be paid. After the initial processing by BILL552, each bill is handled individually, while still retaining its batch identification number. However, all suspended bills in a batch must be resolved before the batch identification number may be reused.

t. If a bill is only partially worked, but is not yet ready for recycling, the revised data may be retained without recycling by pressing <F10>, then responding "N" to the "Is bill ready for recycling? Y/N" prompt.

u. The CTRL-B function may be used to dispose of bills which should never have been keyed, or which must be rekeyed. After pressing CTRL-B, the system asks, "Are you sure that you want to do this? (Y/N)." The bill is then tagged as an "internal denial", and after being listed on a report of internally denied bills, will be deleted from the system. Use of CTRL-B should not be frequent. The reports which list internally denied bills are to be reviewed by bill resolution supervisors to ensure that the option is not misused.

An example of a bill which should never have been keyed is one which is an exact duplicate of another bill in the same batch, or another bill in a different batch which was keyed the same day. An example of a bill which must be rekeyed is one which was keyed with an incorrect case file number, or one in which the number or types of edit failures are such that rekeying the bill is preferable to trying to resolve it.

v. A bill resolution referral sheet (see Exhibit 2 (Link to Image)) may be used if resolving a bill requires input from other office personnel. An effort should be made to keep the original bill in the batch. If a bill must be removed, a copy of the bill or referral form should be kept in the batch or a "placeholder sheet" (see Exhibit 3 (Link to Image)) may be used. The disposition of the referral sheet is up to the office: the sheets may be

associated with the physical bill batch; or supervisors may wish to retain the sheets for various purposes.

w. A bill batch should be kept in an accessible location until all suspended bills have been resolved. The BILL651 summary report identifies batches which contain suspended or internally denied bills. After all bills have been resolved the batch may be audited and stored in the usual manner.

x. When changes are made to a record using BILL054 and the changes are kept, the login ID of the person who made the changes is also recorded on the bill record. This ID is overlaid if subsequent changes are made.

6. Actions Related to Bill Resolution.

a. Prompt action should be taken when bills are referred to other office personnel by the bill resolver.

b. Claims examiners must update accepted conditions on the system whenever appropriate, and enter notes concerning authorization of surgeries, supplies, or other medical services on the system. Failure to make updates may result in erroneous bill adjudications.

c. Cases in which no compensation is being paid, but in which medical treatment continues, should not be closed prematurely.

d. When denying a case which was previously unadjudicated, CEs should check for a CA-16 authorization, and if such an authorization exists on the system, revise the "to date" to coincide with the denial date, if the "to date" is later than the denial date.

e. If a CA-16 authorization is terminated before 60 days has elapsed, the "to date" should be revised on the system.

f. To manually review every bill which comes in on a case, enter a bill suspension flag for that case record. A suspense flag could be used in a case where the claimant has a history of submitting unauthorized medical expenses, or in a case in which, because of unusual circumstances, bills which are payable are erroneously rejected.

g. If physical therapy services are authorized beyond 120 days from date of injury, the periods of authorization should be entered on the system via Case Management option 34. Up to two date ranges may be specified. Physical therapy services which have service dates which fall outside of an authorized date range are automatically denied.

h. CA-16 Authorizations.

(1) CA-16s which do not come in with a CA-1 or CA-2 should be separated from the rest of the mail, so that they may be data-entered under case management menu option 32, "CA-16 Authorization."

(2) If the case has been denied, the claims examiner should enter the CA-16, because the ending date of the authorization will have to be specified. If the case is unadjudicated or accepted, the office may have data entry or mail room personnel enter the CA-16.

(3) If a CA-16 comes in with a CA-1 or CA-2, the forms should be kept together, and the CA-16 should be entered by case create or other personnel after the case has been created.

(4) For a CA-16 authorization to be valid, it must be signed by an appropriate individual from the employing agency. If the CA-16 is not signed, it should not be entered on the system.

(5) When entering a CA-16 on the system, the "from" date is the date the form was signed. A "to" date 60 days after the "from" date is generated automatically, and may be changed if the authorization is terminated earlier (such as when the case is denied). Up to two CA-16s may be entered.

i. Each bill which is data-entered is assigned a bill identification number by the system, which consists of the batch identification number and the sequence the bill was keyed within the batch. For example, the first bill keyed in batch XXX111 will have the number XXX111.001, the second bill XXX111.002, and so on. To aid in bill resolution, the office may wish to have the data entry or other office personnel number the keyed bills in a batch.

5-0205 Exhibit 1: Explanation of Benefits (EOB) Messages (October 2, 1995)

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001   Please submit itemized bill for outpatient services.  Physician
      professional services, radiology, clinical laboratory/pathology, and
      physical therapy should be AMA CPT-4 codes; other services should be RCC
      codes.

002   Hospital stay not related to the accepted work injury/illness.

003   We are unable to determine whether this is inpatient or outpatient from
      a review of the services provided and the Locator 4 code.  Please
      resubmit the bill with correct codes.
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004 A valid Locator 4 code is not present. Please supply the correct code and resubmit.

005 Eligible charges for dates of service have been previously paid.

006 From/to-dates-of-service greater than processing date. Resubmit with correct dates if appropriate.

007 The dates of service appear to be in error or excessive. Please correct or submit explanation for the lengthy service period.

008 To-date-of-service prior to from-date-of-service. Resubmit with correct dates of service.

009 Services not payable because bill was submitted more than one year after the calendar year in which services were provided, or in which claim was first accepted, whichever is later.

010 Date of service from/to dates are after the date of death. Resubmit with justification if warranted.

011 From and/or to-date-of-service is prior to recorded date-of-injury. Resubmit with justification if warranted.

012 Case inactive more than 120 days. Services not authorized. For further consideration, send a medical report to support the need for continuing work-related medical care, and resubmit the bill with a copy of this notice.

013 The date of receipt is prior to the date of injury. Resubmit with correct dates or justification if warranted.

014 Valid AMA CPT-4 or other procedure code is not present. Resubmit with valid procedure code. If bill is hospital outpatient, physician professional, radiology, laboratory/pathology, and physical therapy services should be AMA CPT-4 coded on the UB-82 or UB-92.

017 Line item quantity is equal to zero. Please correct and resubmit if warranted.

018 The line item amount is equal to zero or was left blank. If there are charges for these services, please correct and resubmit.

019 The sum of the line item charges does not equal the total amount billed. Please correct and resubmit.

025 Your address as shown on the bill is different from the address this letter is being sent to, which is the address in our records. Please verify your correct address in writing and resubmit.

027 Date of service is missing. "Balance due" bills are not payable. Please resubmit an itemized billing for this service.

029 Billed service denied. Case has been inactive more than 180 days.

030 Eligible charges for dates of service have been previously paid.

031 Dates of service are after the date bill was received in the office. Future charges are not payable. Rebill after services have been rendered.

101 This case has been denied. If authorization for services was given, resubmit bill with authorization. You may wish to seek reimbursement from another insurance carrier.

102 This case has been denied. If authorization for treatment was given, resubmit bill with authorization. You may wish to seek reimbursement from another insurance carrier.

103 The case has been denied. No valid treatment authorization has been received for these dates of service.

104 This case is denied for these dates of service.

105 A work-related injury has not yet been accepted in this case and there is no valid authorization for the dates of service. Please resubmit if the patient notifies you that the case has been accepted.

106 A work-related injury has not yet been accepted in this case and there is no valid authorization for the dates of service. Please resubmit if the patient notifies you that the case has been accepted.

109 A work-related injury has not yet been accepted in this case. Please resubmit if the patient notifies you that the case has been accepted.

110 A work-related injury has not yet been accepted in this case. Please resubmit if the patient notifies you that the case has been accepted.

111 Benefits are not payable in this case. Contact the patient for further information.

112 Bill is not payable. Explanation to follow.

113 Bill is not payable. Explanation to follow.

201 Payments to this provider are excluded under Federal Regulations 20 C.F.R. Part 10, Subpart F.

202 Payments to this provider are excluded under Federal Regulations 20 C.F.R. Part 10, Subpart F.

210 Please resubmit bill with proof of payment, such as a cancelled check or paid receipt.

211 Reimbursable chiropractic services are limited to manual manipulation for spinal subluxation demonstrated by x-ray. Subluxation not accepted in this case.

301 Billed service(s) not related to the accepted condition(s) in this claim.

302 Billed service(s) not related to the accepted condition(s) in this claim.

303 Billed service(s) not considered payable for a job injury/illness.

306 Billed service(s) not related to the accepted condition(s) in this claim.

309 Procedure requires second opinion evaluation prior to payment; no second opinion evaluation has been obtained. Further information concerning authorization for this procedure will be provided to the patient.

311 Billed service(s) not related to the accepted condition(s) in this claim.

313 Procedure code is invalid for services rendered. Please resubmit with an appropriate code or with justification for the use of this code.

315 Billed service(s) not related to the accepted condition(s) in this claim.

317 Service(s) not related to the accepted condition(s) in this claim.

318 The AMA CPT-4 modifier code used is not valid for this procedure. Please resubmit bill with a valid modifier code.

320 Number of units billed per day exceeds the authorized limit. Please resubmit bill with full explanation for the number of units billed.

321 This procedure code appears to be an obsolete AMA CPT-4 or California RVS code. Please resubmit using a currently valid AMA CPT-4 code.

402 Payable amount for this bill is less than $1.00. No checks are issued for less than $1.00.

500 Rebilled service denied.

501 Charges for this service appear to be excessive. Please resubmit with written explanation/itemization.

502 Procedure codes are missing or invalid for this type of provider. Resubmit bill with AMA CPT-4, HCPCS, RCC codes as appropriate.

601 Case has not been approved. Resubmit bill upon notification of case approval. You may wish to seek reimbursement from another insurance

source.

602 This case is under development and there is no valid authorization on file for these services. If authorization was issued, resubmit bill with a copy. Otherwise, resubmit upon notice of case approval.

704 Billed service(s) not related to the accepted condition(s) in this claim.

705 Billed service(s) not related to the accepted condition(s) in this claim.

707 Billed service(s) not related to the accepted condition(s) in this claim.

708 Billed service(s) not related to the accepted condition(s) in this claim.

710 Further physical therapy treatments require authorization by OWCP. For further consideration, send medical justification along with a copy of this notice and your resubmitted billing.

713 Billed service(s) not related to the accepted condition(s) in this claim.

714 Billed service(s) not related to the accepted condition(s) in this claim.

716 Billed service(s) not related to the accepted condition(s) in this claim.

720 These physical therapy services were not authorized by OWCP.

721 These physical therapy services were not authorized by OWCP. For further consideration, send medical justification, a copy of this notice, and a resubmitted billing.

801 Billed service denied. Duplicate of a service previously paid.

802 Billed service denied. Duplicate of a service previously paid.

803 Billed service denied. Duplicate of a service previously paid.

804 Billed service denied. Duplicate of a service previously paid.

805 Billed service denied. Duplicate of a service previously paid.

901 The UB-82 (or UB-92) admission history and physical examination, and discharge summary should be submitted along with your itemized rebilling.

902 Services were provided after the case (including medical payments) was

denied.

903 The GTR travel was not authorized by this office.

904 Procedure codes (AMA CPT-4 or HCPCS) are missing. Resubmit with all services coded.

905 This tuition bill is not for training authorized under an OWCP rehabilitation plan.

906 These dental services are not related to the work injury/illness.

907 These medications are not for treatment of the accepted condition.

908 Hospital services must have AMA CPT-4, RCC or HCPCS codes. Resubmit with services coded. If bill is hospital outpatient, physician professional, radiology, laboratory/pathology, and physical therapy services should be AMA CPT-4 coded on the UB-92.

909 Nursing services have not been authorized in this case.

910 Travel dates do not correspond with known treatment dates. Medical reports for the dates of travel must be submitted if the travel voucher is resubmitted.

911 Laboratory charges must be coded using AMA CPT-4 codes. Resubmit bill with appropriate coding.

912 Homemaker services have not been recommended by a qualified physician for the work-related condition.

913 Nursing home services do not appear to be warranted for the work-related condition. Seek reimbursement from another insurance carrier.

914 Physician services must be coded with AMA CPT-4 or HCPCS codes. Resubmit bill with codes complete.

915 Maintenance allowance is not payable for the period claimed.

916 Bills for therapy services must contain AMA CPT-4 or HCPCS codes.

917 These rehabilitation services were not authorized.

918 A report is required to pay for these rehabilitation services. Resubmit bill with your report.

919 X-ray services must be coded using AMA CPT-4 or HCPCS codes. Resubmit bill with codes complete.

920 Explanation to follow.

921 Provider was not authorized to provide services to this claimant.

922 There is a third party credit balance remaining in this case. This bill is therefore not payable. Contact patient for further information.

923 Benefits have been suspended for failure to submit to a medical examination required by the office. Bill is therefore not payable. Contact patient for further information.

924 This line will be combined with another billed line for payment purposes.

925 These dates of service overlap a previously paid bill. Please resubmit bill identifying each date of service.

926 Services not related to accepted condition.

927 Send medical report for services performed, along with your resubmitted billing and a copy of this notice. 928Charges appear to be duplicate of previous charges which were reduced under the fee schedule. If you disagree with the fee schedule reduction, you must follow the instructions given at time of reduction.

929 These services are not payable under the Federal Employees' Compensation Act.

930 Please resubmit these pharmacy charges with the names of the medication(s) and the prescribing physician, along with a copy of this notice.

931 Please submit your original pharmacy receipts, along with a copy of this notice.

932 Payment for billed service is denied, as charges appear to have already been paid by another source.

933 Billed service denied. Duplicate of a service previously paid.

934 Reimbursable chiropractic services are limited to spinal manipulation, x-ray of the spine and pelvis, and limited office visits.

935 Services not authorized.

936 Case inactive more than 120 days. Services not authorized. For further consideration, send medical report to support need for continuing work-related medical care, and resubmit bill with copy of this notice.

937 Case denied. Please seek payment from another source.

938 "Balance due" bills are not payable. Please submit an itemized bill for these services.

939 Bills for reimbursement of provider services must be itemized. Please submit a completely itemized bill for reimbursement, including the provider's employer identification number.

940 This procedure code appears to be an obsolete AMA CPT-4 code. Please resubmit using a currently valid AMA CPT-4 code.

941 Missed or cancelled appointments are not payable.

999 Still in process.

5-0205 Exhibit 2: Bill Resolution Referral Sheet (Link to Image)

5-0205 Exhibit 3: Placeholder Sheet (Link to Image)

5-0206 Appeals of Fee Schedule Determinations and EOB Denials

TABLE OF CONTENTS

1. Purpose and Scope. This chapter provides guidance and instruction for processing appeals of medical schedule determinations, and for coding and keying additional payments resulting from such appeals. In addition, this chapter provides guidelines for handling and processing EOB returns in the district offices.

2. Introduction. Under 20 C.F.R. 10.411 a medical provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set under the OWCP fee schedule may, within 30 days of payment, request reconsideration of the fee determination. Only three circumstances will justify reevaluation of the paid amount. These are:

a. The actual procedure performed was incorrectly identified by CPT code;

b. The presence of a severe or concomitant medical condition made treatment especially difficult; or

c. The provider possessed unusual qualifications beyond Board-certification in a medical specialty.

The provider must submit evidence to support the request for reconsideration of the paid amount. The provider may not seek any additional amount in excess of the charge allowed under the fee schedule from the claimant.

3. Fee Schedule Advice to Payees.

a. When a charge for service is reduced by the fee schedule, the provider will receive, in addition to the description of payment which accompanies the check, a separate statement (Form CA-98 shown as Exhibit 1 (Link to Image)) which lists by procedure code those charges which were reduced as a result of the fee schedule. The CA-98 also advises the provider of the right to appeal the fee determination and provides instructions for doing so.

b. In reimbursement situations where the claimant is only partially reimbursed as a result of the application of the fee schedule, a CA-98 will be sent to the claimant (who is the payee in a reimbursement situation). The CA-98 advises the claimant of the actions he or she may take with respect to the amount paid in excess of the fee schedule. The claimant does not have the right to appeal the fee determination per se. However, the claimant is advised that he or she may:

(1) Request that the provider make appropriate refund or credit for the amount the claimant paid in excess of the fee schedule;

(2) Request the provider to submit on the claimant's behalf, and at no additional cost, a request for reconsideration of the fee determination as discussed above; and

(3) Request in writing that the OWCP district office contact the provider with respect to the amount paid in excess of the maximum fee schedule amount.

4. Timeliness. The FEC district office servicing the claimant's case is responsible for processing the provider's request for reconsideration of the fee determination. Under 20 C.F.R. 10.411(g)(2), the district office is to respond in writing within 30 days of receiving the request stating whether or not an additional amount will be allowed as reasonable.

5. Authority.

a. District Director. The reconsideration decision is to be prepared for the signature of the District Director, except in the Kansas City and Washington, D.C. District Offices. In Kansas City, the decision is to be prepared for the signature of the unit Claims Manager; in Washington, D.C., for the Assistant District Director.

b. Regional Director. If an appealed amount continues to be disallowed by the district office, the provider may seek further review. A decision from this further review, stating whether or not an additional amount is to be allowed as reasonable, is to be made within 60 days of receipt of the request for review. This decision is to be prepared for the signature of the Regional Director, except in the Washington, D.C. District Office, where the decision will be prepared for the signature of the District Director.

6. Processing Appeal Requests from Providers.

a. To facilitate identification of appeals, the CA-98 instructs the provider to address

the request for reconsideration of the fee determination with the notation "ATTENTION: FEE SCHEDULE APPEAL." Mail and File personnel should be made aware of the significance of this notation on incoming mail, and of the need to attach this mail to the case file and forward it promptly to the control point.

b. The district office should establish a control point through which all appeals of fee determinations should be routed.

(1) The individual designated as the control point should log the receipt of the appeal showing case number, name of the provider making the appeal, the date received, the date the decision is due (i.e., 30 days after the date of receipt), and the date the decision is issued. This log should be used to track and monitor the adjudication of the schedule appeals.

(2) Following the logging of an appeal request, the control point should forward the case to the person responsible for processing the appeal.

c. The Fee Schedule Appeal Reviewer. The person(s) to be charged with the responsibility of processing fee schedule appeals (hereafter referred to as reviewer) is left to the discretion of the DD and RD. However, where an appeal is made to the regional level, the person handling the appeal must be someone other than the person who processed the earlier appeal.

7. Evaluating an Appeal Request. The reviewer should consider the following:

a. Incorrect CPT Code. In addition to the evidence submitted on appeal, review any medical reports of record pertinent to the service or procedure in question. If it is not furnished by the provider, the reviewer may wish to obtain a copy of the originally submitted bill for the description of the service provided. (It is important that the original bill be returned to the appropriate bill batch immediately after copying.) If technical assistance is needed, the reviewer should obtain the opinion of the DMA or appropriate Office consultant as to the appropriateness of the coding of the service or procedure in question.

It must be remembered that where an additional amount is being paid as a result of a fee schedule appeal (i.e., an appeal reason code is being keyed in the eighth character of the procedure code field), the fee schedule function of BPS does not operate, that is, the system does not compare the keyed charge amount against the fee schedule. To prevent excessive payment as a result of a fee schedule appeal, it may be necessary for the reviewer to manually calculate the correct maximum fee using the fee schedule provided by National Office and to mark the bill with the correct charge amount to enter into the system. This will most frequently occur where an additional amount is being paid

because an incorrect CPT code was originally used.

It may be necessary to review the appropriate BP050 or bill pay history to obtain needed information. As an example, a provider submitted a bill for $200 and it was reduced by the fee schedule to $150. Based on a fee schedule appeal, it is determined that the CPT code originally used was incorrect. The correct code has a maximum allowable charge of $185. If the original charge of $200 is again entered, BPS will not make the appropriate fee schedule reduction. Therefore, the reviewer must advise the revise the charge amount to $185 for the line item, with the $150 previously paid entered as an ineligible amount using "N" as the ineligible amount code. The bill total should also be adjusted to reflect the deduction for the ineligible amount. This will produce a correct additional payment of $35 for the line item.

b. Severe or Concomitant Medical Condition. The evidence submitted, along with pertinent medical evidence which may already be on file, must establish the presence of a severe or concomitant medical condition and show that this condition made the billed treatment especially difficult. As examples, cardio-pulmonary problems or severe diabetes may make treatment (e.g., surgery) of the injury-related medical condition especially difficult. However, the mere fact that a severe or concomitant condition was present should not result in additional payment without regard to the service or procedure in question. For example, it would not be expected that difficulty in treatment would warrant an additional payment for an office visit or the taking of X-rays.

Review and opinion may be obtained from the DMA or office consultant concerning the presence of a severe or concomitant condition, its effect upon treatment, and the amount of the additional fee requested given the added difficulty, if any. Any evidence used as a basis for finding that a severe or concomitant medical condition was not present or did not make the billed treatment more difficult must clearly and convincingly represent the weight of the evidence. Where the DMA or Office consultant's opinion is in disagreement with, but of nearly equal weight to, the evidence submitted by the provider, payment of an additional amount in excess of the fee schedule should be authorized, if appropriate. Such "conflicts" of opinion as to whether or not a severe or concomitant medical condition made treatment especially difficult are not subject to resolution by the use of an impartial third physician.

c. Unusual Provider Qualifications. The evidence upon which such a decision is based is the provider's curriculum vitae. Board certification in a medical specialty is not by itself sufficient evidence of unusual qualifications. Professorial rank or the publication of articles authored or co-authored by the provider which are pertinent to the medical condition or procedure in question are considered evidence of unusual qualifications. The DMA or Office consultant in the appropriate specialty may also be requested to provide an opinion as to the qualifications of the provider and the amount of

the additional fee requested given those qualifications and the procedure or service in question.

8. **Additional Amount Payable**. Where it is determined that an additional amount is payable, payment may be made without issuance of a letter of explanation. The check for the additional amount and accompanying statement of disbursements is considered sufficient notification. However, the reviewer must prepare a memorandum for the file stating the findings and the basis for the approval of an additional amount. Review and approval of this memorandum by a higher authority is not required, but may be implemented by the district office if desired. Where additional payment is denied, the provider must be furnished with a letter decision containing the findings and the reason for the denial.

9. **Denial of Appeal**. Where additional payment is denied at the district office level (i.e., the first level of review), the letter decision must contain a notice of the right to further review similar to the following: If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence, and should be addressed to the Regional Director (except in District Office No. 25), Office of Workers' Compensation Programs, U.S. Department of Labor, (furnish complete address). Where additional payment is denied at the regional level (i.e., the second level of review), the letter decision should advise the provider that this decision is final, and is not subject to further review.

10. **Bill Markup**. In making additional payment as a result of a fee schedule appeal by the provider, the following actions should be taken:

a. Make a copy of the original bill (or use the resubmitted bill, if applicable) and make the notation "FEE SCHEDULE APPEAL" on that copy. This copy will serve as the "bill" for the additional payment.

b. Mark the new CPT code on the bill, if appropriate. Note that if a different CPT code is used, or if the accepted conditions or case status have changed since the original bill was processed, there could be a different result in the bill editing process (BILL552).

c. Mark the appeal reason code on the bill immediately after the CPT code. The appeal reason codes are entered as the eighth character of the procedure code field. The codes and their definitions are as follows:

B - Use where the fee schedule function is to be bypassed in connection with the payment of a given line item. This code would be used, for example, to make continuing payment for certain services to a provider who the

district office has determined should not be subject to the fee schedule because of his or her unusual qualifications. This code is not to be confused with and does not in any way replace existing duplicate edit bypass codes.

1 - Use this code in cases where the appeal was based on the use of an incorrect CPT code. Appeal decision level: DD (or ADD).

2 - Use this code in cases where the appeal was based on the presence of a severe or concomitant medical condition making medical treatment especially difficult. Appeal decision level: DD (or ADD).

3 - Use this code in cases where the appeal was based on unusual provider qualifications. Appeal decision level: DD (or ADD). (This code would be used in connection with a specific appeal. If the district office determines that the unusual qualifications of the provider warrant nonapplication of the fee schedule on a continuing basis for a certain service or procedure, code "B" would be appropriate for subsequent billings.)

4 - Same as 1, except the appeal decision level is the RD (or DD).

5 - Same as 2, except the appeal decision level is the RD (or DD).

6 - Same as 3, except the appeal decision level is the RD (or DD).

7 - Error identified and corrected without formal appeal.

d. Show any revised line charge on the bill which results from the manual application of the fee schedule (see paragraph 7a above). This should be necessary only where the appeal reason code is 1 or 4. The previously paid amount should be shown as an ineligible amount, with an ineligible amount code of "N". The bill total should equal the applicable line charges less the ineligible amounts.

11. Keying an Additional Amount.

a. In keying payment, the appeal reason code as marked on the bill is keyed as the eighth character of the procedure code field. The total amount for the line item rather than just the additional amount payable is to be keyed. The amount previously paid is then keyed as an ineligible amount with ineligible amount code "N." The bill total should be less the ineligible amount(s).

b. After keying has been completed, the bill should be forwarded to a resolver. It

should be noted that bills entered because of a fee schedule appeal are subject to the same editing process as any other bill.

c. If the additional payment was approved on the basis of unusual provider qualifications (appeal reason code 3 or 6), a copy of the memorandum approving additional payment should be referred to the District Director.

12. Additional Payment Based on Unusual Provider Qualifications. Where an additional amount is found to be payable based on unusual provider qualifications, the District Director should determine whether future bills for the same or similar service from that provider should be exempt from the fee schedule. The office should then establish a list of providers with exempted CPT codes or code ranges, and distribute it to all bill examiners and keyers for ready reference. For any provider who is exempt from the fee schedule, the provider payment flag in the provider file should be "N" for "no".

For future bills from these providers, the non-payment flag will cause edit 202 to suspend the bill for review. The bill resolver will determine whether the bill is otherwise payable. If the bill is payable, the resolver will determine from the list provided by the District Director, whether the particular service is one which should be exempted from the fee schedule. If yes, the resolver should enter a "B" as the eighth character of the procedure code in the line item screen.

13. Correcting Errors Without An Appeal. Obvious errors warranting additional payment identified internally or by contact from the provider may be corrected by the district office without following all appeal procedures. Correction of these errors need not be logged by the control point or tracked using the Fee Schedule Appeal Report. However, appeal reason code "7" should be assigned and keyed when the bill is again keyed for payment. This will permit identification of additional payments related to the fee schedule. In keying the payment, the total amount (rather than just the additional amount) should be keyed as the line charge, and the amount previously paid should be shown as an ineligible amount with code "N." Examples of such situations include, but are not necessarily limited to, the following:

a. Transposition of numbers within the CPT code resulted in an inappropriate reduction in fee, and the CPT code without transposition is the appropriate code for the service provided.

b. The provider's bill represented a roll-up of services over a period of time. If the provider advises that his single line item bill for $200 actually represented five office visits, the office may make additional payment for the four visits (with the initial reduced payment being viewed as payment for one office visit).

c. Through internal review, the district office finds that the CPT code used in keying

the payment (even if furnished by the provider) is clearly inappropriate given the procedure performed, and the correct CPT is readily identifiable. An obvious example would be the use of CPT code 99245 rather than IMPAR for an OWCP-requested impartial examination.

14. Provider Billing Claimant for Full Payment. A claimant may contact the district office and advise that he or she paid the medical provider in full and was only partially reimbursed by the office as a result of the application of the fee schedule, or that a provider who was only partially reimbursed by the Office is demanding payment of the balance of the full charge, either directly or by referral to a collection agency or by legal action. Upon such contact, the office should take the following actions:

a. Where the claimant has made payment to the provider and is only partially reimbursed due to the application of the fee schedule, the district office should release a letter to the provider, with a copy to the claimant, which:

(1) Identifies the specific charges at issue;

(2) Notifies the provider of the provisions of the pertinent regulations;

(3) Requests that appropriate refund or credit be made within 60 days;

(4) Provides the provider with the opportunity to appeal the allowable fee; and

(5) Advises the provider of the possible consequences of failure to make appropriate refund or credit.

A sample letter is shown as Exhibit 2. If after receipt of the above letter, the provider appeals the fee determination and it is found that no additional amount is payable, the letter decision should again request that appropriate refund or credit be made within 60 days.

b. Where the provider has initiated collection action or has actually collected from the claimant an amount in excess of the maximum allowable charge paid by the office, the district office should release a letter similar to Exhibit 2 to the provider, with a copy to the claimant, requesting that the amounts in excess of the maximum allowable fee which have been collected be refunded to the claimant or credited to the claimant's account, or that the provider cease the attempts to collect such additional amounts. The provider should be given 60 days to comply.

Since these situations assume that the office made payment to the provider in accordance

with the fee schedule, it is also assumed that he or she received the CA-98 which advises of the right to appeal the fee determination. Therefore, unless otherwise indicated by the evidence of record, the letter to the provider need not contain such advice.

15. Sanctions for Provider Noncompliance.

a. If the provider does not comply with the written request of the Office within 60 days, the district office should contact the provider by telephone in an attempt to persuade the provider to make appropriate refund or credit, or to cease collection action. If this action does not satisfactorily resolve the problem, action should be taken to exclude the provider from participation and payment under the FECA. See PM Chapter 3-0800. (Exclusion based on collection or attempts to collect from the claimant an amount in excess of the maximum fee was added to the regulations as paragraph 10.450(h).)

Before initiating such action, the office must ensure that it has documentary evidence that the provider has collected an amount in excess of the maximum fee, is attempting to collect an additional amount from the claimant directly or through a collection agent, or has initiated legal action against the claimant.

b. Where all efforts to have the provider credit or refund to the claimant the amount the claimant paid the provider in excess of the maximum allowable have failed, the district office should reimburse the claimant for the amount paid in excess of the maximum allowable fee (see 20 C.F.R. 10.412(d)).

16. Processing EOB Returns: Background. One of the features of the enhanced Bill Processing System is the capacity to issue automated remittance advice or explanation of benefits letters (EOBs). These letters are issued to the potential payee when a bill is not being paid, either wholly or in part. These letters are not to be construed as formal decisions with formal appeal rights. Many of the EOB letters are requests for corrected procedure codes or other data. The letter contains instructions to be followed if the receiver disagrees with the non-payment of the bill. The receiver is instructed to place a copy of the EOB on top of any materials submitted in response to the EOB.

17. Processing EOB Returns: Actions. When EOBs are received in the office, special handling is required. Often resubmitted bills are attached to a returned EOB letter. If these bills do not receive special handling prior to keying, and are keyed in the usual manner, the same EOB messages may be reissued. The type of handling required depends upon why the bill was originally rejected.

a. Each office should designate an individual or individuals to be responsible for reviewing EOB returns.

b. EOB returns should be separated from other mail (including bills) after date stamping. The EOB returns should be easily identifiable because the EOB letter should be placed on top. Bills attached to returned EOB letters should not be detatched. The separated EOB returns will then be given to the individual(s) designated to handle EOB returns.

c. The responsible reviewer should review the EOB return and determine whether the bill should be paid. If the bill is still deniable for the reasons stated in the EOB letter, and none of the data upon which the original decision was made has changed, the bill will be batched, keyed and resolved as it was previously. An additional narrative explanation may be needed if the original EOB explanation was not detailed enough, in which case alternate EOB 920 would be used instead of the assigned EOB for any edit failure.

For example, if the bill was originally denied because information was lacking, and that information is still lacking, set any appropriate suspended edit failures to deny with alternate EOB 920, and send a more detailed narrative explanation of what information is needed. If the bill was originally denied because of eligibility issues (such as case denied, or services not related to the accepted condition), and the eligibility issue has not changed, an appropriate edit failure should be set to deny with alternate EOB 920, and the biller should be informed that the EOB letter does not comprise a formal decision, and that the case claimant (employee) may request a formal decision in writing. If another alternate EOB message is appropriate, that may be used instead of the 920 EOB.

d. If after review the bill is still deniable, but for a reason or reasons other than those contained in the original EOB, the bill should be batched, keyed, and resolved to deny with EOB 920 (and inform the biller separately in writing of the reason for denial of the bill) or another appropriate message.

e. If the bill is payable, but was denied automatically by the system, either data on the bill (such as the procedure code or bypass codes) or in the case management record (such as accepted conditions or physical therapy authorization) must change if the bill is to be paid. What data must change depends upon the reason for the original denial. Paragraph 18 (below) describes data which must potentially change for each of the bill batch edits that currently denies automatically. Once the data has been changed, the bill may be batched, keyed and resolved.

f. If the original bill suspended for review, but then was set to deny by the resolver, changing data may remove some of the original edit failures (as when bill is resubmitted with valid procedure codes, or the accepted conditions are updated). More often, what is

needed is a note on the system (authorizing particular services) or a bypass code (for charges which appear to be potential duplicates but are not). The edit-by-edit bill resolution instructions (see Chapter 5-0205) provide guidance to reprocess bills of this nature.

18. Actions Required for Specific Edit Failures.

a. Edit 029. This edit fails when the case closure date is more than 180 days prior to the line item dates of service. To pay the bill, the closed case status must either be made more current, or the case must be in an open, accepted status. If further bills are anticipated, and continuing medical treatment is authorized, the case should be in an open status and an appropriate intervention point and call-up established.

b. Edit 101. This edit fails when the bill is from a non-fee schedule provider type, the case is currently in a denied status, and the prior status was UN or UD. To pay a bill, change case status (and adjudication status) to an acceptance, then change it back to the denied status. Having a prior status other than UN or UD will cause edit 104 to fail rather than edit 101, and edit 104 is an overridable suspense. Note that when the "acceptance" is entered, ICD-9 codes will be needed as well, but these may be deleted when the status is changed back. The bill may be processed with the denied status in place.

c. Edit 102. This edit fails when the bill is from a fee schedule provider type, the case has been denied, the prior status is UN or UD, and there is no CA-16 authorization. To pay a bill, enter a CA-16 authorization (via Case Management Option 32) for the dates of service. The case status does not need to be changed. Note that with the CA-16 authorization, any fee schedule provider type bills with service dates that fall in the CA-16 authorization date range may be paid. The range entered, therefore, should be restricted to the dates which have been determined to be payable.

d. Edit 105. This edit fails when the bill is from a fee schedule provider type, the case status is UN or UD and the adjudication status is blank, and there is no CA-16 authorization entered on the system. To pay the bill, enter a CA-16 authorization covering the dates of service (via Case Management Option 32).

e. Edit 303. This edit fails when the procedure code is one which has been determined never to be payable under FECA. This should occur very rarely. To pay a bill which has failed edit 303, another procedure code must be used. If the original procedure code was incorrect, and the provider has rebilled with a corrected code, use that revised code. However, if the original code was correct, and has been determined to be payable, use AUTHO instead. National Office should also be informed if AUTHO is used under these circumstances, especially if the code will continue to be used.

f. Edit 321. This edit fails if the procedure code used is 72999, 73999, 90026, 90625, 90720, 90730, 90803, 97000, 97050, 97100, 97101, 97200, 97201, 97740, or 97741. These codes are obsolete CPT-4 codes and are commonly used in California, where they are still valid in the state RVS system. To pay, a different procedure code must be used, preferably the correct currently valid CPT-4 code. Requiring the provider to recode rather than recoding by OWCP is strongly urged, to prevent a recurring problem.

g. Edit 704. This edit fails if procedure code/ICD-9 code relationship is one which the v17 table (a reference table on Sequent) says should be denied (range indicator is D). If there is more than one accepted condition on the system, all procedure code/ICD-9 code relationships must have D range indicators on the v17 table for edit 704 to fail. To pay a service which has denied with edit 704, at least one accepted condition should be added for which the service is payable or suspendable.

Sometimes, what code is needed is identified by common sense: if the service is psychiatric, and there is no psychiatric diagnosis entered in the system, then a psychiatric diagnosis should be added to pay the bill; if the service is for back surgery, and the only condition accepted on the system is a back strain, then a condition for which the surgery could be payable (herniated disc) is needed. Intelligent Query may be used to query the v17 table, to determine prior to processing whether a particular diagnosis will be adequate to ensure payment or at least suspension of a bill.

In the absence of a valid (and legitimately acceptable) numeric ICD-9 code which will allow the bill to be paid or at least suspended rather than denied, a P-ICD-9 code may be added for the service for which payment is desired. If the service would usually be denied for all of the other accepted conditions, but a P-code is present, edit 716 will fail, which is overridable. For example, if limited behavior modification was being authorized in an orthopedic case, addition of an accepted condition of P94.33 (individual behavior therapy) would be appropriate. However, the P-codes should not be used as a means to delay making a decision on the relatedness of a condition to the work injury.

Another option would be to put a general suspense indicator on the case (via option Case Management option 33) prior to keying the bill, then make adjustments as needed after the bill suspends for edit 112. AUTHO may be used instead of the original procedure code, but this is not strongly encouraged because the fee schedule will be bypassed, and the possibility of duplicate payment increases.

h. Edit 705. This edit applies to certain diagnostic services, primarily radiology codes, which would not ordinarily be related to the accepted condition, but which might be performed within a short period of time after an injury as part of a general screening. For certain procedure code/ICD-9 code combinations, if the procedure is performed

within seven calendar days of the date of injury, it is paid; if more than seven days after the date of injury, edit 705 fails. To pay for a service which has been denied with EOB 705, the accepted conditions may be modified - see instructions for edit 704. Use of P-codes may be more prevalent, since many of these procedures will be authorized on a one-time basis for diagnostic purposes, and it would not be appropriate to accept a condition which is more clearly related to the procedure.

i. Edit 710. This edit fails when the date of injury is on or after 8/1/90, the dates of service are more than 120 days after the date of injury, the procedure code/ICD-9 code relationship is one which has been coded in v17 as requiring authorization, and there are no physical therapy authorization dates on the system. To pay a bill which has failed this edit, a date range for physical therapy authorization which encompasses the dates of service should be entered on the system via Case Management option 34 prior to keying the bill. A written authorization should be provided to the provider, with a copy to the claimant.

j. Edit 721. This edit fails when the date of injury is on or after 8/1/90, the dates of service are more than 120 days after the date of injury, the procedure code/ICD-9 code relationship is one which has been coded in v17 as requiring authorization, and there are physical therapy authorization dates on the system, but the authorization dates do not include any portion of the service dates on the line item. To pay a bill which has failed this edit, the physical therapy authorization date range must be modified or another range entered to include the dates of service in the bill. As with edit 710, a written authorization should also be released.

k. Edit 801. This edit fails when the line being processed is for the same provider EIN, case file number, procedure code, and dates of service as another paid bill, according to the on-line bill payment history. To pay a bill which has been rejected because of edit 801, a bypass code 1, 2, or 3, as appropriate, is required.

5-0206 Exhibit 2: Letter to Provider Requesting Refund to Claimant

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File No.:

Claimant:

Date of Injury:

PROVIDER NAME
ADDRESS
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CITY, STATE ZIP CODE

Dear

The Office of Workers' Compensation Programs administers the Federal Employees' Compensation Act (FECA) which provides workers' compensation coverage for civil employees of the United States. Under the provisions of the FECA, this Office authorizes payment to physicians and other persons for medical services to injured Federal employees. In cases where the injured employee has made payment directly to the medical provider, reimbursement for those medical services is made to the employee. In connection with payment for these services, this Office uses a schedule of maximum allowable medical charges.

Under current Federal regulations (Part 20, Sections 10.411, 10.412 and 10.450 of the Code of Federal Regulations), a provider whose fee for service is only partially paid because it exceeds the maximum allowable fee set under the schedule may not request reimbursement from the injured employee for any amount in excess of the maximum allowable charge. A provider who collects or attempts to collect from the injured employee an amount in excess of the maximum allowable fee may be subject to exclusion from participation and payment under the Federal Employees' Compensation program. Such exclusion is reportable to all Federal employing agencies, the Health Care Financing Administration, and the state or local authority responsible for licensing or certifying the excluded provider.

The claimant identified above has made direct payment to you for the services described below in an amount in excess of the maximum allowable charge for those services.

CPT Code	Service Dates	Amount Paid	Maximum Fee	Amount Over Maximum Fee

In view of existing Federal regulations, and in order that the claimant not bear an expense which would not have otherwise occurred had payment been made to you directly by this Office, it is requested that you make refund to the claimant (or credit the claimant's account) in an amount equal to the amount over the maximum fees as shown above. It is also requested that such refund or credit be made within 60 days of the date of this letter.

If you choose, you may, within 30 days of the date of this letter, request a reevaluation of the allowable fee for the above services. The request should be made at no additional cost to the employee. The only circumstances which will justify reevaluation are (1) the procedure was incorrectly identified by CPT code, (2) the presence of a severe or concomitant medical condition made treatment especially difficult, or (3) the provider possesses unusual qualifications (Board certification in a medical specialty is not sufficient evidence in itself of unusual qualifications).

Any request for reevaluation of the allowable fee should be in writing, and be accompanied by a copy of this letter and documentary evidence relevant to one or more of the circumstances described above (e.g.,

evidence of use of an incorrect CPT procedure code, a report showing a severe or concomitant medical condition and how that condition made treatment especially difficult, or a copy of your curriculum vitae). The request should be sent to this office with the notation ATTENTION: FEE SCHEDULE APPEAL.

If it is determined that an additional amount is payable, such amount will be reimbursed directly to the employee.

If you wish to receive additional information concerning the schedule of maximum allowable medical charges, please do not hesitate to contact this office.

Your cooperation and prompt attention to this matter will be appreciated.

Sincerely,

NOTICE TO EMPLOYEE: Please advise this office if appropriate refund or credit is not made within 60 days. If we do not hear from you, we will assume the matter has been satisfactorily resolved.

5-0400 Health Benefits Insurance

TABLE OF CONTENTS

1. Purpose and Scope. To describe procedures for handling health benefits insurance (HBI) under the provisions of the Federal Employees' Compensation Act (FECA) and instructions of the Center for Retirement and Insurance, Office of Personnel Management (OPM). The Correspondence Library includes appropriate letter that can be used to make necessary notification to OPM, employing agencies and health benefits insurance carriers.

2. Legislative Authority and Directives. Public Law 86-382, September 28, 1959, the Federal Employees' Health Benefits Act of 1959; the Retired Employees' Health Benefits Act of 1960; PL 100-654; 5 USC 8905(a), Spouse Equity Act and Temporary Continuation of Coverage; and

Federal Personnel Manual, Appendix B, Part 890-1, S-17, Federal Employees' Health Benefits Regulations.

3. Enrollment Requirements in Disability Cases. A claimant who is already enrolled in a health benefits program is entitled to continued coverage during a leave without pay status.

a. The claimant's enrollment continues when compensation begins, so long as the claimant was enrolled in a Federal Employees' Health Benefits (FEHB) plan at the time of injury. In order to maintain the coverage, the claimant must be receiving compensation through daily or periodic roll payments for disability or schedule award.

b. Dependent Status. To qualify for enrollment in an FEHB plan, the individual in question must be either a spouse or a dependent child of the claimant:

(1) Spouse. An individual of the opposite sex who is married to the claimant qualifies for coverage as a spouse. For separated spouses, coverage continues until the separation is legally finalized by divorce. Upon divorce coverage is terminated but may be continued at the ex-spouse's discretion under the Spouse Equity or Temporary Continuation of Coverage (TCC) provisions. See PM 5-400(10)(1) and (2).

(a) Common Law Spouse. In states where common-law marriage is recognized, a common-law spouse is eligible for FEHB coverage.

(b) Same Sex Marriage. The Defense of Marriage Act specifically bars individuals in a same sex marriage from qualifying as a spouse for any federal entitlement, including FEHB coverage.

(2) Dependent Child. An unmarried dependent child of a claimant, either biological or adopted, is eligible for coverage as a dependent until the child reaches age 22. The claimant is not required to provide proof of either dependency or student status to keep this coverage in effect. Coverage may be extended beyond age 22 under several exceptions:

(a) Disabled Child. A disabled child may continue coverage as a dependent if totally disabled from gainful employment. The condition causing the child's disability must have been present prior to age 22, while the child was the claimant's legal dependent. If the proper documentation is received, the OWCP may grant dependency status to a disabled child. The district office must then contact the FEHB carrier, indicating that documentation is on file to support the child's disability from gainful employment. The decision to grant disabled child status is made by

OWCP, and not the FEHB carrier. See PM 5-400(10)(d) for a detailed explanation.

(b) Foster Child. In order to have a foster child considered an eligible dependent for FEHB purposes, it must be established that a parent-child relationship exists between the claimant and the foster child. The foster parent-child relationship is recognized when the claimant is the primary source of financial support for an unmarried child under the age of 22. Also, the foster child must live with the claimant and the claimant must expect to raise the child to adulthood. The claimant does not need to be related to the child, nor do they need to legally adopt him/her. There is no requirement for any type of legal action or documentation to formalize the foster parent-child relationship for FEHB purposes. The foster parent-child relationship can be recognized when the child's natural parents are alive, when the child's natural parent lives with the claimant, or when the child receives some support from sources other than the claimant (such as social security payments or support payments from a parent).

(c) Adopted Child. An adopted child is considered a dependent once the adoption process has been formally completed. In a death claim, the adoption must have been legally formalized prior to the claimant's death.

(d) Posthumous Child. A posthumous child will be considered the "dependent" of the deceased claimant so long as the child was conceived during the lifetime of the employee.

(e) Grandchildren. Grandchildren are not considered eligible dependents under the FEHB Plan. However, a grandchild can qualify for dependency status as a foster child, so long as all of those requirements are met.

(f) Tennessee Valley Authority (TVA) Employees. Employees of the TVA are specifically excluded from FEHB coverage.

c. Schedule Award Claim. In most claims where schedule awards are being paid, the claimant is either working or receiving an annuity from OPM. Therefore, although OWCP is paying compensation, the health benefits withholdings are the responsibility of the employing agency or OPM. Coverage is also possible in certain cases where lump sum payments have been granted. See PM 5-400(6)(d).

d. Part-Time Employees. Part-time career employees are defined as those whose regular working schedule is between 16 and 32 hours per week. Those federal employees that began working on a part-time basis on or after April 8, 1979 are only entitled to a partial Agency Share contribution, made by the Government towards their health benefits insurance. For OWCP's purposes, this rule applies only to those claimants that were considered part-time employees prior to their work-related disability. This pro-rated Agency Share is in direct proportion to the number of hours the claimant was scheduled to work in a pay period. The balance of the Agency Share must be paid by these claimants, and included in their periodic premium deduction.

(1) Calculating the Agency Share for Part-Time Employees. The amount of the Agency Share contribution is determined by dividing the number of hours the claimant works during the pay period by the number of hours worked by a full-time employee serving in the same or comparable position (normally 80 hours per bi-weekly pay period). That percentage is then applied to the Agency Share contribution made for full-time employees enrolled in that plan. The amount of the Government's contribution to the Agency Share is then deducted from the total premium (Agency plus Employee Shares), and the remaining amount is withheld from the employee's pay.

(2) Part-Time Employees Prior to April 8, 1979. Employees who served on a part-time basis before April 8, 1979, and who have continued to serve on a part-time basis without a break in service (in that or any other position) are eligible for the full Agency Share contribution. Part-time employees, who work less than 16 hours or more than 32 hours, per week, are also entitled to the full Agency Share.

e. Temporary Employees. Federal employees with an appointment that is limited to one year or less are not eligible to enroll in the FEHB. If the appointment is renewed at the end of the year, even as a temporary appointment for another single year or less, the employee is then eligible to enroll in the FEHBP and the employing agency may create a new enrollment at that time. However, temporary employees receiving benefits from the OWCP are not eligible for a new enrollment at any time.

f. Peace Corps. Volunteers for the Peace Corps are not entitled to FEHB coverage. Only regular employees of the Peace Corps may be enrolled in an FEHB plan.

g. Plans Sponsored by Unions and Employee Organizations. Plans sponsored by unions or employee organizations require that the claimant be a member of that organization in order to participate in the plan. That membership must be paid for by the claimant in order to continue enrollment while receiving benefits from OWCP. OWCP does not make membership deductions from compensation benefits; the claimant must pay the membership dues directly.

h. Denials of Eligibility. If a claimant is ineligible for coverage, the district office should issue the denial, not OPM. Since the decision is made under the FEGLI (and not FECA), the usual FECA appeal rights, which include reconsideration, hearing, and appeal to ECAB, do not apply. The denial letter should include the following address for review of the decision:

U.S. Department of Labor

Office of Workers' Compensation Programs
ATTN: HB/LI Reconsideration
200 Constitution Ave., N.W., Room S-3229
Washington, D.C. 20210

4. Enrollment Requirements in Death Cases. The enrollment of the deceased employee continues for the surviving family members if all of the following requirements are met:

a. The deceased employee must have been enrolled for self and family at time of death.

b. At least one of the covered family members must receive compensation as a surviving beneficiary of the FECA.

c. The decedent must have met all the conditions noted under subparagraph 3(a) above.

d. Denials of Eligibility. Just as in disability cases (described in 3.h., above), the district office should issue the denial when a claimant is ineligible for coverage, and not OPM. The decision is made under the FEGLI, not the FECA. Therefore, the usual FECA appeal rights, which include reconsideration, hearing, or ECAB appeal, do not apply. The letter should instruct the claimant to use the following address in order to request review of the decision:

U.S. Department of Labor
Office of Workers' Compensation Programs
ATTN: HB/LI Reconsideration
200 Constitution Ave., N.W., Room S-3229
Washington, D.C. 20210

5. Information from Employing Agency.

a. Coverage of Beneficiary. If the agency completed Section 10 on the Claim for Compensation (Form CA-7) in the affirmative, and shows a valid health benefits code, the requirements listed in subparagraph 3(a) above will be deemed satisfied. When received, Form SF-2809-1 must be reviewed to support the continuance of health benefits coverage. The agency's negative reply to these items will notify OWCP not to make deductions for health benefits.

b. Enrollment Transfer. OPM has ruled that the “transfer-out” of health benefits is no longer a recognized process (see Benefits Administration Letter (BAL) 94-202, dated October 19, 1994). From that point forward, only a “transfer-in” action will be required to change the controlling office of the claimant’s health benefits enrollment. If

OWCP completes a transfer-in of the claimant's enrollment it must then request the original enrollment packet from the employing agency. This serves to complete OWCP's records, as well as notify the employing agency that OWCP has assumed control of the health benefits enrollment. If the enrollment is terminated by the employing agency while the health benefits are being deducted by OWCP, the agency must reinstate the claimant's coverage by rescinding the termination action. The agency must also notify the insurance carrier that the claimant's coverage has been reinstated.

6. Procedures in Disability Cases.

a. Deductions. Premiums are withheld from compensation payments based on data entered into the automated system. The CE is responsible for confirming the accuracy of the information entered prior to processing the compensation payment.

(1) Periodic and Death Roll Deductions. For claimants receiving benefits on the automatic 28-day payment cycle, deductions will be routinely made at the appropriate rate from the claimant's gross compensation. This amount is equal to twice the bi-weekly rate for a given plan, as established by OPM at the start of each health benefits year. These rates are programmed into the system by the National Office to take effect at the start of each health benefits year. In order to create this deduction, the appropriate health benefits code must be entered into the ACPS when processing the payment.

(2) Daily Roll Deductions. Health benefits deductions for this type of payment will not be for an exact period, as found in the automatic 28-day cycle. The keyer will be required to enter a date range in addition to the health benefits code, and should enter the exact period covered by the daily roll payment. The system will then make the appropriate withholding, based on the number of days entered when keying the payment.

(3) Deduction Periods. No deduction will be made if compensation is paid for less than 02/229 days. However, if later payments bring the total period to 29 days or more, retroactive withholdings are made to the first day of the compensation period for which no deductions were made. From that point onward, deductions should be made for the exact days of compensation claimed.

b. Transfers In. If the claimant is expected to be on the OWCP rolls for 90 days or more, the district office must transfer-in the health benefits enrollment. This action makes the district office the controlling office for all future health benefits actions associated with the claim. When it is determined that OWCP should have the enrollment, the CE should release the appropriate notice from the Correspondence Library (Form CA-2217), requesting that the employing agency send the enrollment packet to OWCP.

c. Termination. If a claimant elects to terminate coverage while in receipt of compensation benefits, that termination is irrevocable and should be promptly reported to the carrier. OWCP must return the enrollment to the agency promptly. If the claimant elects to terminate coverage, the enrollment is maintained in the case record.

(1) Termination of OWCP Benefits. If compensation benefits are terminated and the claimant has not returned to duty with a federal agency, the enrollment should remain on file in the district office. This may be accomplished by imaging the SF-2809 enrollment form signed by the claimant into the case file. The district office must complete Form SF-2811 (see subparagraph 13(d) below), notifying the carrier of the termination.

(2) Election of OPM Benefits. If the employee elects an annuity from OPM over benefits from DFEC, the CE will advise OPM via Form CA-1107 of the appropriate enrollment code and date of last deduction. The enrollment packet, or a printout of the imaged enrollment documents, should then be mailed to OPM. This will allow OPM to pick up the health benefits enrollment promptly, and avoid a lapse in coverage.

(3) Election of Medicare, TRICARE, or CHAMPVA. When claimants elect to terminate their coverage in favor of one of these health insurance options, they do not irrevocably lose all future FEHB entitlement. The termination of FEHB benefits is treated as a suspension of coverage and allows claimants to re-enroll in the FEHB in the future. See PM 5-400(16) and (17).

d. Lump Sum. If a lump sum has been paid and the claimant asks to continue HBI coverage, the office will obtain the premiums from the claimant for the period of the lump sum.

(1) Collection of Premiums. In order to have the claimant maintain coverage, the district office should collect the necessary premiums on either a quarterly or annual basis, and at the beginning of the specified period. When the premium is received, it will be deposited into the Compensation Fund Account and recorded in the ACPS history file as a credit.

(2) Reporting to OPM. The district office will report premiums via the RITS/OPM Monthly HBI/LI Adjustment (ARMAPAS) monthly, as though the claimant were actually receiving compensation. The National Office will report to the OPM on Form SF-2812 and SF-2812A. The funds must also be charged under the Create History Record function. The two ACPS transactions cancel one another in the chargeback process.

e. Loss of Wage-Earning Capacity (WEC). Claimants receiving compensation benefits for partial disability remain entitled to FEHB coverage. If the compensation payments being made do not cover the amount of the FEHB premiums, the office should continue to carry the claimant on the rolls and offer the claimant a plan that will cost less than the amount of compensation payable.

If the claimant insists on retaining the same HBI plan, the office may ask the claimant to submit premiums in advance on either a quarterly or yearly basis to continue coverage. Fiscal actions as noted in 6(d) will be completed when the premium is received.

(1) Retention of Enrollment. As noted in subparagraph 3(e) above, part-time Federal employees who elect FEHB coverage are entitled to only a pro-rated share of the government's contribution for the cost of the insurance. Thus, claimants that return to part-time federal employment due to a WEC would be required to pay this partial share of the government contribution, in addition to the full employee share. In order to prevent the disincentive for returning partially disabled WEC claimants to part-time duty, the enrollment should be retained by the district office and not transferred to the employing agency.

(a) Premiums. The premiums for FEHB coverage will remain the same for claimants receiving compensation for partial wage loss as those claimants receiving compensation for total disability. The Agency Contribution of the total premium will also remain unchanged.

(b) Returning the Enrollment to the Employing Agency. When the claimant returns to full-time duty (more than 32 hours per week), DFEC should return the enrollment back to the employing agency. If compensation is terminated without a return to federal employment, the enrollment is to be imaged into the case record.

(2) Postal Service Employees. For all employees that return to duty with the U.S. Postal Service with a LWEC, OWCP will transfer the enrollment back to the Postal Service to make the health benefits deductions.

f. Third Party Credits. If settlement is made and funds are received by a claimant who is entitled to compensation, the third party settlement check must be applied to the compensation previously paid and/or future payments due until the credit is absorbed. In this situation, the claimant is entitled to compensation, and health benefits coverage may remain in effect.

(1) Crediting Accounts Receivable. The district office should maintain an accounts payable on the third party credit, charge the credit during each payment cycle for the amount of the HB deduction, and transmit the funds to OPM, as described in 5-400(6)(d) above.

(2) Payment by the Claimant. The claimant may wish to pay the premium. If so, instead of crediting the surplus as described above, the district office may continue the coverage by obtaining the premiums directly from the claimant. This is accomplished in the same manner described above in subparagraph 6(d).

(3) Severance Pay. Claimants remain eligible for FEHB coverage, even though they are not receiving regular compensation benefits due to the receipt of severance pay. Once the period of the severance pay has been completed, regular FEHB deductions can be made from ensuing compensation benefits. FEHB premium deductions for the entire severance pay period should be made from the initial payment made by the OWCP.

g. Change in Dependency Status. If a non-Open Season change occurs in the claimant's dependency status, the claimant is entitled to change from "self" to "self and family" (or vice-versa). Claimant may elect to make this change under their current plan, or to any other FEHB plan. This change may be requested from 31 days before a change in family status, and up to 60 days after.

h. Postal Rates. Claimants originally employed by the U.S. Postal Service are entitled to reduced FEHB premiums for one year from their pay rate effective date. After one year the ACPS will automatically adjust the HBI deduction to the standard FEHB rate. If the pay rate effective date is changed in a claim, then the Postal rate will apply for one year from the new effective pay rate date. Postal employees may contact their Injury Compensation Office for a specific USPS form to request reimbursement of any extra FEHB premiums paid after the Postal rate was dropped by OWCP.

i. Suspension of Compensation. If the claimant's benefits have been suspended due to non-cooperation, the FEHB benefits should be terminated. If the claimant is still on the employing agency's rolls (i.e. not separated from the agency), the enrollment may be sent back to the employing agency instead of being terminated. If the enrollment packet is to be returned to the employing agency, a cover letter should be attached explaining the reason for the return. A copy of that letter should also be sent to the claimant for notification purposes. Once the reason for the suspension has been resolved, the claimant may be offered a prospective enrollment rather than reinstating the benefits.

7. Procedures in Death Cases.

a. Deductions. Premiums are withheld from compensation payments by the system in accordance with data entered from compensation payment documents. Procedures for the payroll cycle are outlined in Chapter 5-307, subparagraph 4(b).

b. Transfers In. In most instances, the employing agency or OPM will have the deceased's enrollment and will send it to OWCP on advice that OWCP benefits have been elected.

c. Adjustments. FEHB coverage may be adjusted to account for changes in

beneficiary status in a death claim.

(1) Changes in Dependency. If the children of a deceased employee are no longer covered, the coverage should be adjusted from "self and family" to "self only" for the surviving spouse. OWCP must complete an SF-2809-1 form on behalf of the surviving spouse in order to change the enrollment code. In lieu of the surviving spouse's signature on the SF-2809-1, the office may write "Per annuitant request" and type an explanation in the remarks portion of the form.

(2) Re-Marriage of Surviving Spouse. If the surviving spouse remarries prior to age 55, FEHB coverage may continue for surviving children. If the surviving spouse remarries, the enrollment should be placed in the name of the youngest child. If the surviving spouse remarries after age 55, FEHB coverage may continue for the surviving spouse, but the new spouse may not be included in the enrollment. Since FEHB entitlement is based on the decedent's work-related injury, not the death claim of the surviving spouse, a new spouse is ineligible for coverage. See PM 2-700(7)(b) for details regarding former spouses in death claims.

d. Termination. OWCP must return the enrollment promptly to OPM or process a termination when no dependents remain on the OWCP rolls. If benefits are payable to the beneficiary by OPM, the HBI should be transferred to OPM. However, if there are no entitlements to annuity benefits, the HBI enrollment should be terminated.

8. Open Season Changes. Each year OPM announces changes in rates and coverage in health benefit plans. Annuitants and FECA beneficiaries may change plans but may not enroll in the FEHB Plan during Open Season (P.L. 86-382, 9/28/59, Section 2(c)(3)). The effective date of all Open Season changes is the first day of the first full compensation cycle in the new year. Instructions regarding rates, plans available, forms, and procedures to be utilized in recording changes are distributed by OPM in FPM Supplements to the 890-1 series and are detailed further in FECA bulletins.

a. Reporting Changes. Changes are processed into ACPS from SF-2809-1 enrollment forms completed by the recipients of compensation. Copies of the forms should then be sent to the appropriate insurance carrier.

b. Change in FEHB Plan Participants. Claimants enrolled in a plan that drops out of the FEHB Plan must enroll in a new plan to continue coverage. This applies to plans that drop out of the FEHB during Open Season, as well as the plans that drop out during the course of the year.

(1) The district office should immediately inform the claimant of the change required, and supply the claimant with a Form SF-2809-1 and current FEHB guide.

(2) In order to avoid a lapse in coverage should the claimant fail to respond in a timely manner, the district office should change the claimant's coverage. In order to minimize the chance of overpayment to the claimant while awaiting the new plan selection, the health benefits coverage should be changed to Blue Cross Standard Option (self or family, as applicable). However, this action is only carried out to ensure that premiums continue to be deducted from the claimant's compensation benefits. Do not inform the carrier of this enrollment change until the claimant makes a formal election.

(3) Once notification from the claimant is received, the district office should make the necessary adjustment, and promptly notify the carriers of the change. In addition, the compensation payment history should be reviewed for any possible over or under payment to the claimant for the period in question.

9. Overpayments

a. Temporary Loss of Coverage. If the claimant was denied use of coverage for a period of three months or more, then they are not required to pay for FEHB coverage during that period. If the claimant is returning to the benefit rolls after a period of compensation being denied, they should be provided with a prospective enrollment, if they had no use of or access to the benefits during the period their compensation was terminated. If premiums are withheld for periods when the claimant had no use of the coverage, those premiums should be refunded once it is confirmed that the claimant did not use the coverage. All refunds must be reported via the ARMAPAS process.

b. Underwithholding of Premiums. If it is discovered that there has been an underwithholding of premiums, the entire amount is deemed to be an overpayment of compensation.

(1) Declaring an Overpayment. Any overpayment declared in connection with an underwithholding should be treated in the same manner as all other overpayments of compensation. This includes the waiver provisions in 5 USC 8129, as well as all other regulations and statutes relative to overpayments and debt collection.

(2) Reporting to OPM. An underwithholding of premiums results in a two-tiered liability. The claimant owes the agency the underwithheld funds, and similarly the agency owes the insurance fund/OPM. If this occurs OWCP must make OPM whole, and must remit the entire amount of the underwithholding, even if the debt is eventually waived. This should be accomplished immediately upon discovery via the ARMAPAS process.

10. Continuation of Coverage for a Former Spouse. There are two forms of health benefits coverage available to a claimant's ex-spouse, subsequent to a change in marital status such as divorce or annulment.

a. Temporary Continuation of Coverage (TCC). This plan is administered and regulated solely by the U.S. Department of Agriculture (USDA), National Finance Center (NFC). TCC, established by Public Law 100-654, is similar to the COBRA coverage offered in the private sector. The plan allows a new enrollment to be created for individuals that would ordinarily lose their FEHB entitlement when they lose their dependency status. The entitlement is limited to thirty-six (36) months of coverage. However, former claimants and OPM annuitants are specifically excluded from coverage.

(1) All TCC elections by a claimant's ex-spouse must be submitted in writing to the National Office. The request must include a signed Form SF-2809-1 and a copy of the divorce decree. Since the new enrollment is in the ex-spouse's name, that individual must complete and sign all the necessary paperwork. The NFC is responsible for collecting the necessary premiums and administrating the enrollment. Any changes in coverage, such as Open Season or a change in the number of dependents, is processed by the NFC.

(2) If a claimant elects TCC coverage via OPM during a period where his or her compensation benefits have been terminated, he or she may have that money reimbursed by the NFC. Specifically, if the claimant is later deemed entitled to compensation for that period his or her FEHB coverage would be deducted under

OWCP benefits, rather than by NFC.

This only applies if the entire period of TCC coverage should have been covered by OWCP. NFC will not grant refunds of premiums paid for partial periods. The claimant's enrollment should be transferred into OWCP effective the date that the coverage was originally terminated. FEHB premiums should be deducted effective that date, and the premiums reported to the carrier via the ARMAPAS process (see PM 5-400-13). Once complete, TCC should be informed of the effective date in writing, so that they may refund any premiums paid by the claimant.

b. Spouse Equity Act: This plan is administered and regulated by OPM for any ex-spouse of an OWCP claimant. A claimant's ex-spouse may elect HBI coverage under the Spouse Equity Act only if the divorce agreement entitles the ex-spouse to a portion of the claimant's Civil Service annuity benefits. If the ex-spouse is not entitled to any portion of the annuity, then he or she must elect coverage under TCC. If the ex-spouse is electing benefits under the Spouse Equity Act, he or she must provide a certified copy of the divorce decree, along with the SF-2809-1 form. The certified copy is distinguished by the raised seal of the court of jurisdiction embossed on the cover page. Unlike TCC coverage, there is no time limitation as to the length of the coverage under the Spouse Equity Act.

c. Premiums and Costs. Both TCC and Spouse Equity coverage require the beneficiary to pay 102% of the total health benefits premium cost. This encompasses the employee and employer costs, as well as a 2% administrative fee. The beneficiary will receive a payment booklet from the appropriate administrative agency, and is responsible for making the monthly payment. The coverage becomes effective 30 days from the qualifying event, i.e. the date of divorce.

11. Continuation of Coverage for a Dependent Child.

a. TCC Coverage. Public Law 100-654 also provides for coverage to be continued under the same TCC regulations that apply to ex-spouses for dependent children when they reach age 22.

(1) Coverage Requirements. Unlike OWCP coverage for dependent children, there is no requirement that the child be unmarried or a full-time student. Also, as with the regulations for ex-spouses, the TCC coverage for a dependent child is a new enrollment and considered separate from the claimant's enrollment.

(2) Premiums and Costs. TCC coverage requires the beneficiary to pay 102% of the total health benefits premium cost. This encompasses the employee and employer costs, as well as a 2% administrative fee. The beneficiary will receive a payment booklet from the appropriate administrative agency, and is responsible for making the monthly payment. The coverage becomes effective 30 days from the 'qualifying event', which is the date of the dependent child's 22nd birthday.

b. Federal Employees Health Benefits Children's Equity Act of 2000. This law (Public Law 106-394), enacted October 30, 2000 requires mandatory self and family coverage for employees who do not comply with a court or administrative order to provide health benefits for their children. An employee subject to such an order must enroll in self and family coverage in a plan that provides full benefits to his or her child(ren) in the area where they live, or provide documentation that he or she has other health coverage for the children. If the order does not specify a time limit on the coverage, the employee must keep the self and family enrollment until the last child marries or reaches age 22. This coverage is limited to the claimant's dependent child(ren), and is not extended to the former spouse since the former spouse is no longer considered a dependent.

NOTE: If the claimant has already separated from his or her employing agency at the time of the order, he or she is NOT considered an employee for purposes of the Child Equity Act and it is not applicable to them.

(1) Enrollment. If the employee already has self and family plan coverage that provides full benefits in the location where the children live, written notification should be sent to the entity that issued the order. A copy of the enrollee's SF 2809-1 must be sent to the carrier, along with a copy of the order to notify the carrier of the additional family members being covered under the self and family enrollment.

If the employee is eligible for FEHB but does not have the appropriate coverage, notify the employee that the order has been received, and send him/her a SF-2809-1 form and a plan comparison booklet in order to select appropriate coverage. Allow the employee until **the end of the pay period following the one in which notice was given** to enroll in an appropriate health plan or provide documentation that he/she has other health benefits for the children.

(2) Involuntary Enrollment. If the employee does not enroll in an appropriate

plan or provide documentation of other coverage for the children, you must enroll him or her as follows:

(a) If the Employee Is Not Currently Enrolled in FEHB. If the employee is not enrolled for any FEHB coverage, enroll him or her for self and family coverage in the Standard Option of the Blue Cross and Blue Shield Service Benefit Plan (enrollment code 105).

(b) If the Employee Has Self Only Coverage. If the employee has a self-only enrollment, and the plan serves the area where the children live, change the enrollment to self and family in the same option of the same plan. If the plan does not serve the area where the children live, change the enrollment to self and family in the Blue Cross and Blue Shield Standard Option.

(c) Carrier Notification. If a claimant must be enrolled involuntarily, complete a SF 2809-1 with the employee's identifying information. Use Event Code 1C (Change in family status). In the Part G signature block write "See Remarks." **In Part H remarks block note "Involuntary enrollment for self and family coverage under Pub. L. 106-394."** Attach a copy of the order to the SF 2809-1 sent to the carrier.

(3) Effective Date. For the order to be valid, it must be received in the office no earlier than October 30, 2000. The order can be issued before October 30, 2000; but if originally submitted before October 30, 2000 it must be resubmitted. The effective date of the coverage will be the first day of the pay period following the one in which the SF 2809-1 was completed. However, if the order specifies an effective date, the enrollment would be retroactive to that date.

(4) Open Season Changes. During open season (or when there is an event allowing an enrollment change), an employee who is subject to a court order can change to a plan that provides full benefits where the children live. However, such an employee **cannot** cancel the enrollment, change to self only, or change to an HMO that doesn't provide coverage in the area where the children live, as long as the order remains in effect and the children are eligible under the FEHB Program.

d. Continued Coverage for Disabled Dependent Child. FEHB coverage may also continue beyond the age of 22 if the dependent child is physically or mentally incapable of self-support. OPM has defined the specific list of medical conditions that qualify a child as a disabled dependent.

(1) Determination of Entitlement. The determination of disability is made by

DFEC, not the health benefits carrier, and is not dependent on any other outside finding of the child's disability. The district office must first determine that the child possesses a medical condition that has been identified on OPM's "List of Medical Conditions That Would Cause Children to be Incapable of Self-Support During Adulthood." This list may be found on OPM's web site at www.opm.gov. To support this determination, the claimant must provide medical documentation of disability. This should include medical evidence that the condition existed prior to age 22, and continues to be disabling. The expected duration of the disability must also be specified and supported.

(2) Notification. Once the determination has been made, a letter must be sent to the health benefits carrier, notifying them of the determination that coverage may be continued beyond age 22. The letter should indicate that medical documentation is on file to support the mental or physical disability for gainful employment. Also, inform the carrier of the approximate expected duration of the disability.

d. Release of Information to Spouse and Children. OPM allows the release of information concerning FEHB coverage to family members who may be affected by a claimant's change from a self-and-family to a self-only enrollment. If the claimant changes to a self-only enrollment without informing his or her family member(s), they do not know that they are without coverage until they file a claim that is denied by the carrier. A family member has only 31 days from the date coverage is terminated in which to convert to a private plan. However, the family member has 6 months to convert if the individual failed to make the request because of a reason beyond his or her control. They are not eligible for TCC.

12. Other Plan Changes. There are also a limited number of events that allow a compensation recipient to change his or her HBI coverage or plan, such as relocation from the health benefits carrier's service area. All of the permissible reasons for change (and the appropriate FEHB codes) are included in the instructions to Form SF-2809-1. Note that these reasons are more limited than those options allowed to regular federal employees on the SF-2809. Only the allowable changes stated on the SF-2809-1 are available to OWCP claimants. All non Open Season plan change requests should be sent to the district office within 30 days of the described event that allows the change.

13. Health Benefits Reconciliation. All health benefits reconciliation must be processed on the National Finance Center's Centralized Enrollment Clearinghouse (CLER) site. The CLER system, a secure website, receives electronic enrollment information from all health insurance carriers, federal government payroll offices, and OWCP on a quarterly basis. That information is processed by the NFC, who compares the data from the various sources and conducts basic

discrepancy resolution. Any health benefits discrepancies that cannot be resolved by the NFC are reported as "errors" on the CLER site, and must be resolved by both the carrier and the appropriate payroll office. For claimants receiving benefits from OWCP, the enrollment is flagged to indicate that OWCP, not the original employing agency, is making the health benefits deductions.

a. Access to CLER. In order to add or remove a user from CLER, the district office must complete the NFC's Access Request form (Exhibit XX). The CLER Security Officer for OWCP is responsible for assigning user reference numbers for each new user request. All other fields should be completed by the district office. Once completed, the Security Officer will forward the form to NFC for processing. The NFC will then complete the new enrollment within five working days and inform the Security Officer of the initial sign-on procedures. The Security Officer must then forward this information to the appropriate user.

b. Identification Numbers. In order to make full use of the CLER site, certain identification numbers should be referenced. These numbers will refine the CLER site query, and allow easier processing of enrollment discrepancies:

(1) Payroll Office Identification Number. This number corresponds to the particular health benefits Agency Location Code (ALC) assigned to the district office.

(2) Agency Identification. The identifier for OWCP is DL00 for all district offices.

(3) Personnel Office Identification. This number is composed of the last four digits of the district office ALC number.

c. Transmission of CLER Data.

(1) National Office Transmissions. The National Office will transmit quarterly all data received from the compensation rolls for each district office. The quarterly transmission will separate the CLER data into individual reports, by the district office ALC number.

(2) District Office Transmission of Data. The local district office will also have the capability to transmit CLER data. This is limited to those cases where the claimant's health benefits deductions are not being made from the automated compensation rolls. This would include cases being paid on a gross override, or claimants not being paid compensation due to a third party surplus.

d. Contact Information. For more detailed information on the policies and procedures of CLER, the user may download a copy of the procedure manual from the NFC's Publications and forms web page (http://dab.nfc.usda.gov/pubs/na-pubsmain.html). In addition, the CLER Help Desk can be reached by telephone at (504) 255-3270, or by e-mail at NFC.CLER@usda.gov.

14. Certification to OPM of HBI Entitlement. As noted above, claimants' entitlement to the FEHB only continues so long as they are unable to "return to duty" as defined above. DFEC may be required periodically to provide OPM with documentation regarding this entitlement for continuing OLI eligibility.

a. Completing Form RI 20-8. If certification by DFEC is necessary, OPM will forward Form RI 20-8 with the front side of the form already completed. The CE need only be concerned with the period after the date requested by OPM on the front side of Form RI 20-8 when completing the back of the form. All relevant items on Form RI 20-8 should be completed, as follows:

(1) Item 2 - Is an application pending? Complete this item if the individual applying for OPM benefits has filed a claim with the Office but it has not yet been adjudicated.

(2) Item 3 - Receipt of OWCP Benefit. Complete this item if the claimant has received or is receiving compensation for disability within the last two years.

(3) Item 4a - Health Benefits Premiums Withheld.
If premiums were withheld then list the period of withholding.

(4) Items 4b & 4c - Transfer of Health Benefits. If the answer to 4b is yes, then complete 4c by providing the name and address of the agency where the HBI information was transferred.

(5) Item 5 - Basic and Optional Life Insurance. The CE should complete this item if the claimant had life insurance withheld from compensation payments.

(6) Item 6a - Possible Third Party Settlement. If the answer is yes, then provide the "Ending" and "Commencing" dates of the third party credit. Item 6b should also be answered.

(7) Item 7 - Last Known Address for Deceased Claimant. This item should be completed if OPM is inquiring about a deceased claimant.

(8) Item 9 - Certification. The CE should print and sign his or her name. The CE should also provide a phone number for OPM and date the form.

Once completed, the original copy of the form should be returned to OPM and a copy imaged into the case record.

b. Schedule Awards. The inability to return to duty is not a condition of receiving compensation for schedule awards. Therefore, it must be determined whether the claimant is or was unable to "return to duty" during the period of the schedule award in order to have health insurance eligibility to continue. In order to certify continuing eligibility while the claimant receives a schedule award, the case record should contain the following:

(1) Medical evidence showing the physical restrictions caused by the impairment in terms of standing, walking, bending, lifting, hours of duty, etc., and a medical opinion showing whether the impairment would bar the claimant from returning to the work performed at the time of the injury. If this information does not already appear, the CE should ask the attending physician to provide it in a report.

(2) The position description and a statement from the employing agency showing the physical requirements of the job if they are not already in the record.

Once all needed information has been received the CE should compare the requirements of the job to the medical evidence of record. If necessary, the District Medical Advisor (DMA) should be consulted to supply an opinion on the claimant's ability to "return to duty". The CE should prepare a recommendation to the SCE as to whether the claimant could perform the job held at the time of injury. The SCE or higher-level authority must make this determination; it may not be delegated to anyone subordinate to the SCE.

15. Forms and Use.

a. Automated RITS/OPM Monthly HBI Adjustment (ARMAPAS). This electronic form is used to record supplemental health benefits withholdings made from manual or direct payments. The data is then included in the monthly RITS adjustment process conducted by the National Office to transmit the funds to OPM for all DFEC health benefits coverage.

(1) Form Elements.

(a) Case File Number. Nine digits must be entered for the case number, without a dash or letters. Space(s) or "X" can be used as the first two positions for old case file numbers.

(b) Health Plan Code. All three characters for the specific health plan code must be entered in the field.

(c) Employee Share/Agency Contribution. Enter the dollar amounts for each respective field. A dash (-) should be used as the first position for negative amounts.

(d) Total Employee Share and Agency Contribution. This dollar amount is automatically calculated and updated when the form is saved.

(2) Entering Data in PrHealth.

(a) Adding Data. To add new data go to the first blank row and click on the "Case File Number" field. Enter the file number and use the "Enter" key to move one field to the right. Repeat for each field until the entire row is filled. Data must be entered in every field of the row.

(b) Editing Existing Data. To edit a previously entered data field, go to the "Case File Number" field of the appropriate row. Use the "Enter" key to move across the row and enter any new value(s).

(c) Deleting Existing Entries. To delete an entry the entire row must be highlighted, and the "delete" key must be used. Click on the "Save" button to make the delete permanent and remove the blank row.

(3) End of Month Processing. The Month End Processing must be completed on the first workday after the 20th of the month. Clicking on the "Month Clear" button on the form will create the monthly file ("hbmon") that needs to be sent to the National Office. This also clears the data from the form so that new data can be entered during the course of the next month.

(a) Transmission of Data. Once the monthly file has been created, it should be sent as an e-mail attachment to the National Office. The National Office will complete the transmission to OPM for each individual district office.

(b) Multiple Files. If there is more than one "hbmon" file for the district office, they must be combined on a single master file in order to transmit the data to the National Office. To copy individual files to the master file, open the file and highlight all the rows to be copied. Once copied, paste the file on the first blank row of the master file. Repeat this process until all the individual files are copied to the master file. Once all

have been copied to the master file, save the contents and transmit to the National Office as described above.

(4) Month Recover. This action restores the monthly file to a daily file, which can be edited. The Month Recover button should be used after the end of month processing is done, and before any data for the current period is entered. When restoring an old month any new data that has been entered will be lost.

b. Health Benefits Registration Form, SF-2809-1. This form must be used to enroll for health benefits, or to make an adjustment in existing coverage, and will be requested on transfer as indicated in subparagraph 7(b) above.

Instructions for its completion and distribution are provided on the form itself. All health benefits actions must be requested on the SF-2809-1 form, which must bear the signature of the claimant. Photocopies of the original SF-2809-1 are acceptable for processing health benefits actions, as OPM has stated that the original forms are no longer mandatory.

c. Notice of Change in Health Benefits Enrollment, SF-2810. This form is used to transfer enrollment. If OWCP is receiving enrollment, the sender will complete the form. Instructions for its completion and distribution are provided on the form itself. Although some agencies may continue to use Form SF-2810, its use is no longer mandatory to transfer-out an enrollment.

d. Transmittal and Summary Report to Carrier, SF-2811. This form was used to transmit the enrollment data to the carrier. OPM has since discontinued the form, stating that it is no longer mandatory (OPM BAL 01-315; April 9, 2001) due to the advent of the CLER system. Thus, the district offices will no longer be required to complete the form. However, it is the responsibility of each district office to create a similar tracking mechanism, in order to maintain a record of all health benefits changes sent to the carriers.

e. Report of Withholding and Contribution, SF-2812. The report is completed and electronically submitted to OPM by the National Office. It is generated with each payment cycle (weekly or 28-day) and details all deductions made during the period.

16. Retired Federal Employees Health Benefits (RFEHB). The RFEHB covers employees who were not eligible for coverage under the FEHB when that law became effective in 1960, and consists of two options.

a. Uniform Plan. This plan is an enrollment in coverage by a Government-wide plan sponsored by AETNA. No change in plan is possible, as the Uniform Plan enrollees are ineligible for FEHB coverage.

b. Private Plan. This plan consists of Government contribution toward payment for any qualified plan the claimant may have. The Private Plan's government contribution is added to the claimant's periodic benefit payment, as opposed to monies deducted from the periodic benefit payment for FEHB coverage. Only enrollees covered under the Private Plan have the right to convert to FEHB coverage at any time they wish.

c. Reporting Deductions. Two forms are used in reporting deductions under the RFEHB:

(1). Notice of Change in Enrollment Status, BRI-41-100. This form is used to record and formulate any allowable changes in the Uniform Plan coverage. The proper distribution of copies is noted on the bottom of the form. The control must be changed whenever a BRI-41-100 is completed by the National Office.

(2). Report of Withholdings and Contributions, BRI-41-101. This form is used both to account for the various codes and to transmit the withholdings to OPM. Private Plan contributions are charged to OPM using this form, as well. Each district is allotted funds for Private Plan expenses each year and charges are reported on the monthly SF-224 against appropriation 16-24x8445(15) by the National Office.

(a) The amount listed in Uniform Plan Total, Withholdings and Government Contributions, for both "Annuitants" (disability) and "Survivors" (death) will agree with the totals of the CP-113 and any manual deductions made.

(b) The amount listed in Private Plan Total for both "Annuitants" and "Survivors" will agree with the totals of the CP-113 and any manual deductions made.

17. Federal Long Term Care Insurance Program (FLTCIP). FLTCIP, or "Long Term Care" is an insurance program sponsored by OPM and administered by Long Term Care Partners, a private sector partnership between the John Hancock Life Insurance Company and the Metropolitan Life Insurance Company.

a. Coverage Basics. FLTCIP provides reimbursement for costs of care when the individual is unable to perform at least two activities of daily living for an expected period of at least 90 days, such as eating, bathing or getting dressed. Also included are situations when the individual needs constant supervision due to a severe cognitive impairment, such as Alzheimer's disease. Care can be received in a variety of settings, including the home, assisted living facilities, adult day care centers or hospice facilities. However, long term care is not the type of medical care needed to get well from a sickness or an injury, nor is it intended as short-term rehabilitation from an accident or recuperation from surgery.

b. Benefit Options. Long term care can be covered completely or in part by the long term care insurance offered by FLTCIP. Reimbursement will be based on the benefit options elected by the claimants, and for the amounts that he or she is approved for. Most plans allow the individual to choose the amount of the coverage desired, as well as how and where to use the benefits. There is also a comprehensive plan that includes benefits for all levels of care, custodial to skilled.

c. Eligibility. Long Term Care is available to all current Federal employees that are eligible for FEHB coverage, whether or not they are currently enrolled in a plan. Individuals receiving compensation who are separated from Federal service remain eligible to elect long term care. In addition, surviving spouses of deceased Federal or Postal employees are eligible. D.C. Government employees are not eligible to apply for coverage in the Federal Program, even if they may be eligible for FEHB coverage.

18. FEHB Coverage and Medicare. The Balanced Budget Act of 1997 (Public Law 105-33) expanded Medicare's health plan options with the creation of Medicare+Choice. Beginning in

1999, Medicare beneficiaries may remain in original Medicare or choose to get their Medicare benefits from an array of Medicare+Choice managed care plan options, depending on where the claimant lives. Generally, everyone is eligible for Medicare if they are age 65 or over. Also, certain younger disabled persons and persons with permanent kidney failure (or End Stage Renal Disease) are eligible. For more specific questions on coverage options, the claimant should contact Medicare directly at (800) 633-4227 or on the web at www.medicare.gov.

a. Electing Medicare Coverage Instead of FEHB Coverage. If the claimant elects to drop FEHB coverage in favor of Medicare coverage, they must inform the office in writing. The notice should advise OWCP that the claimant is suspending their FEHB coverage to enroll in a Medicare managed care plan. The claimant must also complete a SF-2809-1 form (or OPM election form) terminating their current enrollment and provide proof of medicare coverage. However, for purposes of this Medicare coverage, the termination of benefits is treated as a "suspension" of coverage, instead of a total loss of future coverage. Unlike the usual termination of FEHB benefits, this "suspension" of FEHB coverage allows claimants to reenroll in FEHB if they later lose or cancel their Medicare managed care plan coverage.

(1) Voluntary Re-Enrollment in FEHB. If the claimant has previously informed OWCP that they are voluntarily suspending FEHB benefits to enroll in a Medicare managed care plan, he or she has the option to later re-enroll in the FEHB. However, they must wait until the next Open Season to reenroll in FEHB.

(2) Involuntary Re-Enrollment in FEHB. "Involuntary loss of coverage" may occur when a Medicare managed care plan is discontinued or when the claimant moves outside the service area of the Medicare provider. Claimants that opt for Medicare over the FEHB have the right to re-enroll if they involuntarily lose their coverage. They do not have to wait until Open Season to re-enroll in the FEHB. The re-enrollment can be made from 31 days before, to 60 days after, the loss of the Medicare managed care plan coverage. The re-enrollment in FEHB should be made effective the day after the Medicare managed care plan coverage ends.

(3) OPM Election: If the claimant completes the OPM election form, the Form SF-2810 should be used to terminate the current enrollment. The "Remarks" section of the form should indicate that coverage is being suspended due to the claimant's election of Medicare benefits.

b. Medigap. This is a Medicare supplemental health insurance policy sold by private companies to fill "gaps" in Medicare plan coverage. For claimants that seek to drop their FEHB plan in favor of Medicare coverage, one of the ten standardized Medigap policies may be necessary to mirror their current coverage. As with all Medicare options, the claimant should contact Medicare directly for more detailed information.

c. Dual Medicare and FEHB Coverage. When a claimant opts to enroll in a Medicare managed care plan, they may not need FEHB coverage since the Medicare managed care plan provides them with many of the same benefits. Typically, for claimants that opt to keep their FEHB coverage while being covered under Medicare, Medicare is considered the "primary payer" for all medical costs not related to their work-related condition(s). This means that Medicare must pay benefits before the FEHB coverage when the claimant is receiving compensation and OWCP has determined that the claimant is either partially or totally disabled.

19. TRICARE and CHAMPVA Coverage. There are two additional programs available to claimants outside the usual FEHB coverage:

a. TRICARE. TRICARE is a Department of Defense (DoD) health care program for active duty and retired uniformed services members (formerly known as CHAMPUS). Eligible retired members of the military receiving compensation benefits and coverage under the FEHB may elect coverage under TRICARE, as it allows many of the same benefits at a much lower cost. Standard TRICARE coverage has no annual enrollment fees or forms, and the claimant is only responsible for annual deductibles and cost-shares. There are additional TRICARE programs to choose from, including TRICARE Extra, TRICARE Prime, TRICARE Plus, and TRICARE for Life (a combined TRICARE and Medicare program). For details on options and requirements of the TRICARE program, claimants should contact their DoD personnel office, or TRICARE on the internet at www.tricare.osd.mil.

b. CHAMPVA. Public Law 107-14 provides beneficiaries over age 65 of the Department of Veterans Affairs (VA) with coverage secondary to Medicare under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA provides similar benefits to VA eligible beneficiaries as those benefits provided to uniformed services beneficiaries under the TRICARE programs. CHAMPVA, though separate and distinct from TRICARE, operates in a similar fashion by sharing the costs of medical care with the claimant, reducing the overall health benefits costs. However, any claimant that is eligible for TRICARE is not eligible for CHAMPVA. For additional information on the program, claimants should contact the VA by telephone at (800) 733-8387, or on the web at www.va.gov\hac.

c. Electing TriCare or CHAMPVA Coverage. If the claimant makes the election to drop FEHB coverage in favor of TriCare or CHAMPVA coverage, he or she must inform the office in writing. Similar to Section 16(a) (above) the claimant must complete a SF-2809-1 form, terminating the current enrollment and submit proof of TRICARE/CHAMPVA coverage. As with Medicare coverage, the termination of benefits is treated as a "suspension" instead of a total loss of future coverage.

5-0401 Life Insurance

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5-0401-x1	Optional Life Insurance Coding Structure
5-0401-x2	Life Insurance Rates

1. Purpose and Scope. This chapter addresses Life Insurance (LI) coverage for recipients of compensation under the Federal Employees' Compensation Act (FECA). It describes eligibility for Basic, Post-Retirement, and Optional Life Insurance (OLI); processing life insurance actions; coordinating with employing agencies and the Office of Personnel Management (OPM); and maintaining life insurance records.

2. Authority and Directives. The law governing life insurance for federal employees is found at 5 U.S.C. §§ 8701-8716.

a. Basic Coverage. Section 5 U.S.C. § 8706(b)(2) provides that Federal Employees' Government Life Insurance (FEGLI) coverage may continue while a claimant is in receipt of compensation, when the coverage would otherwise cease. OPM sometimes requires OWCP to certify the periods that compensation is paid and the claimant's inability to return to duty.

b. Optional Coverage. Since OWCP does not enroll claimants in LI, any inquiries about enrollment should be referred to the claimant's employing agency or OPM.

3. Responsibilities. Fiscal and claims staff share responsibility for ensuring that premiums for life insurance are deducted when appropriate and that such deductions are accurate. In most offices, the fiscal staff is responsible for keying life insurance data into ACPS, and claims staff is responsible for making determinations of eligibility when so requested by OPM. See paragraphs 5b and 5c.

4. Coverage Options. Before 1981 only one optional life insurance plan was available to Federal employees. Currently there are three optional life insurance options available, in

addition to the basic life insurance options.

a. Basic Life Insurance. In order to be eligible for Optional Life Insurance (OLI), the claimant must also be enrolled in Basic Life insurance coverage. Although a claimant may be enrolled in only Basic Life coverage, he or she must elect Basic Life in order to qualify for OLI coverage. Federal employees are automatically enrolled in Basic Life Insurance as of the first day of their employment, unless they specifically waive the coverage. Premiums are only withheld until the claimant reaches age 65, and deductions from compensation payments should cease during the first full periodic roll payment after the claimant's 65th birthday.

The Basic Life insurance benefit will reduce at a rate of 2% per month until it reaches 25% of its original value, unless the Post Retirement option has been elected.

(1) Claims With Date of Injury Prior to January 1, 1990: For all claims with a date of injury prior to January 1, 1990, Basic Life Insurance coverage is free of charge, and no premiums for Basic Life need be deducted from the claimant's compensation payments.

(2) Claims With Date of Injury January 1, 1990 and Later. For all claims with a date of injury of January 1, 1990 and later, Basic Life insurance premiums are deducted from the claimant's compensation payments. This is based on the original date of injury, and not a date of recurrence. Bi-weekly premium rates are found in Exhibit 1.

b. Post-Retirement Basic Life Insurance. This premium is being paid to prevent the reduction of the life insurance benefit at age 65. Federal employees who retired or separated from Federal employment and continue to receive benefits from either DFEC or OPM on or after December 9, 1980, have the option of paying the extra premium for No Reduction or a 50% reduction in Basic Life insurance. The claimant must elect the coverage when he or she separates from federal employment, usually after twelve months of Leave Without Pay (LWOP). The coverage takes effect immediately, regardless of age, and premiums are paid until time of death. The election of Post-Retirement Basic Life Insurance at the time of retirement determines the amount that Basic Life insurance will decline or reduce to after the claimant reaches age 65.

(1) Coverage Effects. The claimant may elect to continue Basic Life insurance under this provision at the 75% reduction, 50% reduction, or no reduction of the original value of the policy (No reduction guarantees full value of the Basic Life policy at death). A recipient of compensation is entitled to elect the benefit at the time of separation or retirement, if this occurs at age 65 or later. If Post-Retirement is elected prior to age 65, premiums for both Post-Retirement and Basic Life insurance are paid until age 65, at which time Basic Life Insurance

premiums stop.

(a) 75% Reduction. Basic Life insurance will automatically reduce at the rate of 2% per month after age 65, until it reaches 25% of its original value. All claimants receive this "75% reduction" unless they specifically elect a different Post-Retirement option. There is no charge for the 75% reduction coverage.

(b) 50% Reduction. A premium is charged for this option, which reduces the Basic Life insurance coverage at a rate of 1% per month after age 65, until it reaches 50% of its original value. The claimant must pay a premium for this coverage from the date of the election.

(c) No Reduction. A premium is charged for this option, which retains the full value of the Basic Life insurance coverage after age 65, without reduction. The claimant must pay a premium for this coverage from the date of the election.

(2) Notification. OPM will notify OWCP of this coverage if it applies, and OWCP is responsible for deducting premiums when advised to do so by OPM. As with Basic Life insurance, the amount of the bi-weekly deduction must be manually entered in ACPS. The rates for Post-Retirement Basic Life Insurance are shown in Exhibit 1.

c. Option A - Standard Life Insurance. This option provides $10,000 life insurance in addition to the basic policy. Its coverage is the sole option available before April 1, 1981, and claimants on the compensation rolls prior to that date who never returned to duty thereafter are still covered under this option. Withholdings from compensation payments will cease at age 65, though FEGLI coverage continues at a reduced rate. At age 65 the Option A benefit reduces at a rate of 2% per month, until it reaches 25% of its original value.

d. Option B - Additional Life Insurance. This option is based on multiples of the claimant's annual salary. The claimant may elect coverage from one to five times their salary, and the premiums charged are based on the total amount of coverage.

(1) Premium Calculations. For example, a 40 year old claimant with a salary of $25,000.00 who elects Option B coverage for three times his salary would pay $9.00 in premiums every 28 days. ($25,000.00 X 3 times salary = $75,000.00 in coverage. 75 X $0.06 bi-weekly for a 40 year old = $4.50 bi-weekly or $9.00 every 28-days). The premiums listed in Exhibit 1 detail the specific costs per $1,000.00 in coverage, based on the claimant's age band.

(2) Limitations. All deductions for Option B coverage automatically stop when the claimant reaches age 65. This change in compensation benefit deduction takes effect during the first full roll cycle after the claimant's 65th birthday. Although the deductions have stopped, the claimant's Option B eligibility for FEGLI purposes actually continues at a declining rate. Unless the claimant elects to "freeze" the coverage, the eligibility reduces at the rate of 2% per month for 50 months, until it reduces to zero. See Paragraph 8d for further details on continuing OLI beyond age 65.

e. Option C - Family Life Insurance. This option provides insurance coverage for the claimant's spouse and eligible dependent children.

(1) Coverage Effects. All eligible family members are automatically covered and claimants may elect up to five multiples of coverage. Each multiple is equal to $5,000 for the spouse and $2,500 for each eligible dependent child. For example, if the claimant elects three multiples, he or she would receive $15,000 (3 X $5,000) upon the death of the spouse. If one eligible dependent child dies, the claimant would receive $7,500 (3 X $2,500). The claimant is always the beneficiary of the Option C benefits, and may not designate a beneficiary.

(2) Eligible Dependents. The claimant's current spouse, unless legally separated, is covered by Option C coverage. Eligible dependent children are those that are unmarried and under age 22. If age 22 or over, the child must be incapable of self-support because of a mental or physical disability that existed before he or she reached age 22.

(3) Limitations. All deductions for Option C coverage automatically stop when the claimant reaches age 65. This change in compensation benefit deduction should take effect during the first full roll cycle after the claimant's 65th birthday. Although the deductions have stopped, the claimant's Option C eligibility for FEGLI purposes actually continues at a declining rate. Unless the claimant elects to "freeze" the coverage, the eligibility reduces at the rate of 2% per month for 50 months, until it reduces to zero. See Paragraph 8d for further details on continuing OLI beyond age 65.

5. Requirements for Coverage. The employing agency determines the claimant's eligibility for LI. Therefore, when Box 28 of Form CA-7 indicates coverage, OWCP automatically considers the claimant eligible for continued coverage for the first 12 months of non-pay status, or separation from federal service.

a. Notification of Eligibility by Employing Agency. DFEC must be informed by the employing agency if the claimant does not meet OPM's eligibility requirements for life insurance. The employing agency must make this initial eligibility determination, and it is their responsibility to notify both OPM and DFEC of any change in the claimant's entitlement to FEGLI coverage.

(1) Reporting Non-Eligibility. For those claimants where it is clear that they will not meet OPM's "Five-Year/All-Opportunity" requirement, the employing agency must notify DFEC. This notification is necessary to ensure that life insurance withholdings can be appropriately stopped at the end of 12 months in non-pay status or separation. In order to notify DFEC, the agency must complete the Notice of Life Insurance Ineligibility, and submit it along with the Form CA-7. A copy of the form will be sent by the employing agency to notify the claimant that FEGLI coverage will terminate upon separation or completion of 12 months in non-pay, whichever comes first.

(2) CE Responsibility. The CE is responsible for monitoring the claim to ensure that life insurance premiums are stopped at the end of 12 months of non-pay or separation.

b. Continuing Enrollment While Disabled. An employee receiving disability benefits may retain LI coverage while receiving compensation, if the claimant would have been eligible to continue the insurance as an employee. Specifically, the claimant must satisfy the requirements of the "Five Year/First Opportunity" rule and has had LI as an employee for no less than:

(1) The five years of service immediately preceding the disability; or

(2) The full period or periods of service during which OLI was available to the employee, if less than five years.

c. Ability to Return to Partial Duty. The term "return to duty" as used in 5 U.S.C. § 8706(c) means “return to duty or occupation or work which the employee was doing at the time of injury.” Thus, claimants who continue to receive compensation for even a minor Loss in Wage Earning Capacity (LWEC) do not lose FEGLI coverage, even though they are able to work part-time or to perform light-duty work. Coverage may continue in the presence of a reduced level of compensation under the following circumstances:

(1) Return to Federal Service. If the claimant returns to federal service, the life insurance as a compensation recipient stops, and he or she becomes insured as an employee. NOTE: The amount of OLI coverage for claimants in this group will be based on their return to work federal salary.

(2) Private Sector Employment. For those claimants employed outside of federal service, LI may be continued so long as some compensation payments for the LWEC continue. The LI salary for these claimants will be based on the total salary used to compute the LWEC. Claimants that return to work in the private sector without receiving any type of compensation from DFEC lose their FEGLI entitlement.

(3) Constructed LWEC. If the claimant’s constructed LWEC results in no continuing compensation benefits, then the claimant loses entitlement to LI benefits.

d. Denials of Eligibility. If a claimant is ineligible for coverage, the district office should issue the denial which is a decision under the FEGLI, not the FECA. Thus, the usual FECA appeal rights (reconsideration, hearing, or appeal to ECAB) do not apply. The letter should include the following address for review of the decision should the claimant request it:

U.S. Department of Labor
Office of Workers' Compensation Programs
ATTN: HB/LI Reconsideration
200 Constitution Ave., N.W., Room S-3229
Washington, D.C. 20210

6. Certification to OPM of LI Entitlement. As noted above, claimants' entitlement to LI only continues so long as they are unable to "return to duty" as defined above. DFEC may be required periodically to provide OPM with documentation regarding this entitlement for continuing OLI eligibility.

a. Completing Form RI 20-8. If certification by DFEC is necessary, OPM will forward Form RI 20-8 with the front side of the form already completed. In completing the back of the form, the CE need only be concerned only with the period after the date requested by OPM on the front side of Form RI 20-8. The CE should then complete all relevant items on the back side of Form RI 20-8, as follows:

(1) Item 2 - Is an application pending? Complete this item if the individual applying for OPM benefits has filed a claim with the Office but it has not yet been adjudicated.

(2) Item 3 - Receipt of OWCP Benefit. Complete this item if the claimant has received or is receiving compensation for disability within the last two years.

(3) Item 4a - Health Benefits Premiums Withheld. If premiums were withheld then list the period of withholding.

(4) Items 4b & 4c - Transfer of Health Benefits. If the answer to 4b is yes, then complete 4c by providing the name and address of the agency where the HBI information was transferred.

(5) Item 5 - Basic and Optional Life Insurance. The CE should complete this item if the claimant had life insurance withheld from compensation payments.

(6) Item 6a - Possible Third Party Settlement. If the answer is yes, then provide the "Ending" and "Commencing" dates of the third party credit. Item 6b should also be answered.

(7) Item 7 - Last Known Address for Deceased Claimant. This item should be completed if OPM is inquiring about a deceased claimant.

(8) Item 9 - Certification. The CE should print and sign his or her name. The CE should also provide a phone number for OPM and date the form.

Once completed, the original copy of the form should be returned to OPM and a copy imaged into the case record.

b. Schedule Awards. The inability to return to duty is not a condition of receiving compensation for schedule awards. Therefore, it must be determined whether the claimant is or was unable to "return to duty" during the period of the schedule award in order for life insurance eligibility to continue. In order to certify continuing eligibility while the claimant receives a schedule award, the case record should contain the following:

(1) Medical evidence showing the physical restrictions caused by the impairment in terms of standing, walking, bending, lifting, hours of duty, etc., and a medical opinion showing whether the impairment would bar the claimant from returning to the work performed at the time of the injury. If this information does not already appear, the CE should ask the attending physician to provide it in a report.

(2) The position description and a statement from the employing agency showing the physical requirements of the job if they are not already in the record.

Once all needed information has been received the CE should compare the requirements of the job to the medical evidence of record. If necessary, the District Medical Advisor (DMA) should be consulted to supply an opinion on the claimant's ability to "return to duty". The CE should prepare a recommendation to the SCE as to whether the claimant could perform the job held at the time of injury. The SCE or higher-level authority must make this determination; it may not be delegated to anyone subordinate to the SCE.

7. Establishing Annual Pay for Life Insurance. Annual pay for life insurance purposes is the annual rate of pay as fixed by law or regulation. However, this does include all of the elements that may comprise basic pay for compensation purposes.

a. Elements Included in Basic Pay:

(1) Locality-based comparability payment (locality pay) and interim geographic adjustments.

(2) Premium pay for overtime inspectional service for customs officers.

(3) Law enforcement officers' premium pay for standby duty and administratively uncontrollable overtime.

(4) Night differential pay for wage-grade (WG) employees.

(5) Environmental differential pay for employees exposed to danger or physical hardship.

(6) Tropical differential pay for citizen employees in Panama.

(7) Special pay adjustments for law enforcement officers.

(8) Availability pay for criminal investigators.

(9) Bonuses for physicians and dentists of the Department of Veterans Affairs.

(10) Straight-time pay for regular overtime hours for firefighters.

b. Elements *Not* Included in Basic Pay:

(1) Foreign post differential for WG employees. *Exception*: those wage employees in Guam who were recruited from outside Guam and are paid a recruitment and retention incentive.

(2) Night differential or premium pay not listed in paragraph 7a.

(3) Foreign and non-foreign post differential pay of GS employees.

(4) Bonus, allowances, overtime, holiday, and military pay not listed in paragraph 7a.

(5) Premium pay for certain air traffic controllers.

(6) Lump-sum payments for accrued leave.

(7) Supervisory differentials.

(8) Retention allowances.

(9) Physicians' comparability allowances.

8. Making Deductions. This paragraph describes enrollment codes, rates, beginning and ending dates, as well as how to make deductions in various situations. ACPS withholds LI premiums based on data entered into the payment processing system.

a. Basic Life Insurance: Basic Life premiums are based on the annual "base salary" of the claimant used to calculate disability compensation. The base salary should then be rounded up to the nearest $1,000, and an additional $2,000 added to that figure, to arrive at the claimant's annual salary for basic life insurance purposes.

(1) The U.S. Postal Service (USPS) pays the entire cost of Basic life insurance for their employees. If a claimant remains an employee of the USPS, they are eligible for basic life insurance at no charge. USPS employees are automatically enrolled in Basic unless they waive the coverage.

(2) As of 1999, OPM regulation changes removed the cap on the value of Basic Life Insurance. There is no longer a "maximum" amount of basic pay.

(3) Premiums for basic life insurance must be manually calculated, and that

dollar amount keyed into the ACPS. Although the calculation is for a bi-weekly premium, ACPS will automatically double the amount for the amount for the four-week/28 day deduction. To enter the premium in ACPS, the record ***MUST*** be deleted and re-entered in ACPS. There is no adjustment capability for Basic Life Insurance in ACPS.

b. Post-Retirement Basic Life Insurance: Premiums for Post-Retirement must be manually calculated, and that dollar amount keyed into the ACPS. Although the calculation is for a bi-weekly premium, ACPS will automatically double the amount to arrive at the four-week or 28 day deduction amount. At the payment system prompt, the claims examiner should key in the Post-Retirement code ("C"), and then enter the appropriate dollar amount.

c. Optional Life Insurance. In addition to the Basic Life Insurance described above, claimants are also entitled to Optional Life Insurance (OLI).

(1) Processing Optional Life Insurance. Exhibit 1 lists the codes corresponding to various kinds of LI coverage. The codes should be provided by the employing agency when certifying a Claim for Compensation (Form CA-7) submitted by the claimant, and used in entering data into the payment processing system. If the code is missing from the CA-7 form, the claims examiner should contact the employing agency directly to determine what LI coverage may apply. The employing agency should be requested to provide a copy of the claimant's most recent SF-50 form, where the FEGLI code can be found (in Box 27).

(2) Employee Eligibility Beyond Age 65. If the claimant begins receiving compensation benefits *after* his or her 65th birthday, he or she remains entitled to the life insurance eligibility held during employment. Claimants are not required to "freeze" their coverage or elect Post-Retirement coverage until they have either retired or been separated by the employing agency. In essence, the "age 65" limitations or reductions do not begin to take effect until the claimant is no longer an employee for life insurance purposes.

d. "Freezing" Optional Life Insurance Coverage: OLI coverage reduces in value for Options B and C, once the enrollee reaches age 65. Benefits reduce 2% per month, until they are reduced to zero after 50 months (four years and two months). Although DFEC withholdings for LI stop at age 65, coverage does continue, on a decreasing scale. However, under new OPM regulations, claimants are presented with the option to continue coverage beyond the usual limits after age 65. Claimants are now allowed to continue (or "freeze") their Option "B" and Option "C" coverage indefinitely, without further reduction.

(1) Election. To notify claimants of their entitlement to the "freeze", the National Office will issue letters two months before their 65th birthday, advising them of this option. The claimants will then have 30 days from their 65th birthday in which to send their election directly to OPM. Once certified, OPM will inform the National Office of the election, and the National Office will make the necessary calculations to determine the claimant's 28-day premium deductions. Once calculated, the National Office will then inform the appropriate District Office of the necessary deductions that must be made from the claimant's compensation payments.

(2) Keying Freeze Deductions. In order to deduct the premiums for the coverage, an Accounts Receivable (A/R) entry must be established in ACPS to deduct the premiums from the claimant's compensation payments. Each A/R should contain the following information in the address field, so that the deductions can be identified as Option B premiums rather than another type of A/R deduction:

(2)Line 1 - Claimant Name
(3)Line 2 - "Option B/C Freeze"
(4)Line 3 - Number of Multiples Elected for Each
(5)Line 4 - Effective Date of Election (the date of the claimant's 65th birthday)

(3) Ongoing Deductions. The term “freeze” regarding Option B and C life insurance applies only to principle of maintaining the rate of coverage, by not allowing it to reduce after age 65. However, the premiums charged for this coverage are NOT “frozen”, and are subject to the applicable age band rates. See Exhibit 1.

e. Life Insurance Rates. The premiums deducted from compensation benefits are based on the claimant’s age and salary, and what various multiples of life insurance have been elected. Rates will increase as the claimant ages, even though the actual coverage does not increase. This is due to the fact that the claimant moves into a higher “age band” as they age. The increased premiums for a new age band will begin during the first pay period following the pay period in which the birthday occurs. When the LI rates or age bands change, OPM notifies the National Office. In turn, the National Office advises OWCP district offices of the changes via FECA bulletin. Current and previous rates are shown in Exhibit 1.

f. Beginning Dates. OWCP starts to deduct LI premiums on the 29th day of compensation. At that time withholdings are made retroactive to the date compensation began. The amounts of the withholdings are determined by the compensation period:

(1) Up to 3 days: no withholdings.

(2) 3 - 14 days: bi-weekly rate.

(3) Over 14 days: twice bi-weekly (28-day) rate.

g. Ending Dates. When compensation stops, LI also stops. If the claimant was paid on the periodic roll, DFEC deducts for insurance from the last four-weekly check. The period of compensation is not a factor in determining LI withholdings. If compensation

and the LI enrollment do not end at the same time, the LI enrollment must be retroactive to the date compensation ended.

ACPS automatically stops all life insurance deductions once the claimant reaches age 65 unless the claimant has elected either Post-Retirement Basic Life Insurance or an Option B/Option C freeze of benefits. This increase in net compensation is realized on the first full payment cycle after the claimant's 65th birthday.

h. Schedule Awards. Where a schedule award is being paid, the claimant is usually working or receiving an OPM annuity. If the claimant is receiving payment from either of those sources, the agency or OPM will withhold premiums.

i. Lump Sum Payment. If a lump sum has been paid and the claimant asks to continue LI coverage, OWCP will obtain the premium from the claimant for the forthcoming year of coverage at the beginning of the year. When the premium is received, it will be deposited into the Compensation Fund Account and recorded into the ACPS history file. The funds will be reported to OPM on **the Automated RITS/OPM Monthly LI Adjustment (ARMAPAS). The National Office will transmit the data to OPM via** Form SF-2812 and SF-2812A as though the claimant was actually receiving compensation and the funds were being reported to the carrier. The two ACPS actions will cancel one another in the chargeback process.

j. Benefits Insufficient to Make Deductions. Sometimes compensation payments do not cover the amount of the deduction for LI because the amount of compensation is very small. OWCP should continue to carry the claimant on the rolls and arrange for the claimant to submit premiums at the beginning of each year to continue coverage. The payment should be received from the claimant and credited as described in paragraph 8i.

9. Changes in Existing Coverage. Claimants do not have the ability to increase their LI coverage while DFEC is making the withholdings. However, they may cancel or reduce coverage at any time, unless the coverage is subject to an assignment. OPM must be notified directly of any changes that effect life insurance eligibility. Any such cancellation or reduction of life insurance coverage must be sent to OPM in writing and have an original signature by the insured claimant. The request should be sent to: OPM, Retirement Operations Center, P.O. Box 45, Attn: Life Insurance, Boyers, PA 16017-0045. The claimant must specify what action he or she wishes to take concerning his or her coverage. OPM determines the effective date of the change, and will notify DFEC of the change to withholdings and sends DFEC verification of the new level of insurance. NOTE: Once coverage has been voluntarily canceled or reduced, it cannot be reinstated while the claimant receives compensation benefits.

10. Third Party Credits. This paragraph describes the LI actions needed when a third party credit exists. If the claimant is entitled to compensation, LI coverage may remain in effect, using either of two methods to obtain the premiums.

a. The beneficiary may pay the premiums for each year of coverage at the beginning of the calendar year. See Paragraph 8i concerning ACPS transactions.

b. The beneficiary may be placed on the periodic roll, with the expiration date equal to the date the surplus should be depleted. Withholdings for LI should be entered, along with the third party "A/R" entry. The "total amount due" should be the amount of the surplus, and the "periodic deduction" should be the net amount of the benefits payable plus an extra $500 to cover future cost-of-living increases (CPIs). This method allows for electronic reporting of LI coverage and premiums to OPM.

11. Overpayment and Underpayments. This paragraph describes LI actions needed when either an overpayment or underpayment exists. LI withholdings can be credited to the overpayment, thus reducing the total amount due. The payment confirmation should show the status of LI withholdings and whether a credit can be applied. The following examples address various possibilities:

a. Return to Work.

(1) If the employee returned to work with no LWEC, the amount deducted for LI should be applied to the overpayment.

(2) If the employee returned to work with an LWEC, the course of action will depend on whether reemployment is with the federal government or in the private sector:

(a) If federal employment, LI deductions should be terminated as these withholdings are now based on the actual salary being paid to the enrollee.

(b) If private employment, LI deductions should not be applied to an overpayment period after the LWEC determination was made.

(3) If forfeiture is involved, and entitlement ceased on the first day of the overpayment period, and no eligibility for further compensation exists, LI for the overpayment period should be credited to the compensation and manually reported to OPM. At the same time, the LI enrollment must be canceled effective the same date that entitlement ceased.

(a) If it is later determined that the claimant is entitled to ongoing compensation from the ending date of the forfeiture period, retroactive LI deductions must be made from the beginning date of the overpayment period. This may occur in cases where the Employees' Compensation Appeals Board reverses a prior decision denying ongoing entitlement to compensation.

(b) If compensation continues beyond the forfeiture period, LI is not credited to the overpayment of compensation. The overpayment is computed on the gross amount paid.

b. Underwithholding of Premiums. If it is discovered that there has been an underwithholding of premiums, the entire amount is deemed an overpayment of compensation.

(1) Declaring an Overpayment. Any overpayment declared in connection with an underwithholding should be treated in the same manner as all other overpayments of compensation. This includes the waiver provisions in 5 USC 8129, as well as all other statutes and regulations relative to overpayments and collection of debts.

(2) Reporting to OPM. An underwithholding of premiums results in a two-tiered liability. The claimant owes the agency the underwithheld funds, and similarly the agency owes the insurance fund/OPM. If this occurs OWCP must make OPM whole, and remit the entire amount of the underwithholding, even if the debt is eventually waived. This is to be accomplished immediately upon discovery via ARMAPAS process.

c. Underpayment. In the event that a claimant is owed a refund due to an excess deduction of life insurance premiums, the claims examiner must compute the amount owed. The refund should be issued via the ACPS Payment Option 03 screen, in order to insure that the agency chargeback is not adversely affected.

12. Reporting Premiums to OPM. The reporting of premium deductions is accomplished by the Automated RITS/OPM Monthly LI Adjustment (ARMAPAS). This electronic form is used to record supplemental LI withholdings made from manual or direct payments. This data is then included in the monthly RITS adjustment process conducted by the National Office to transmit the appropriate funds to OPM for all DFEC LI coverage.

a. Form Elements.

(1) Case File Number. Nine digits must be entered for the case number, without a dash or letters. Space(s) or "X" can be used as the first two positions for old case file numbers.

(2) Employee Premiums. There is a separate field for each type of life insurance coverage. Enter the dollar amounts for each type of coverage in the respective field(s). A dash (-) should be used for negative amounts.

b. Entering Data in PrHealth.

(1) Adding Data. To add new data go to the first blank row and click on the "Case File Number" field. Enter the file number and use the "Enter" key to move one field to the right. Repeat for each field until the entire row is filled. Data must be entered in every field of the row.

(2) Editing Existing Data. To edit a previously entered data field, go to the "Case File Number" field of the appropriate row. Use the "Enter" key to move across the row and enter any new value(s).

(3) Deleting Existing Entries. To delete an entry the entire row must be highlighted, and the "delete" key must be used. Click on the "Save" button to make the delete permanent and remove the blank row.

c. End of Month Processing. The Month End Processing must be completed on the first workday after the 20th of the month. Clicking on the "Month Clear" button on the form will create the monthly file ("limon") that needs to be sent to the National Office. This also clears the data from the form so that new data can be entered during the course of the next month.

(1) Once the monthly file has been created, it should be sent as an e-mail attachment to the National Office. The National Office will complete the transmission to OPM for each district office.

(2) If there is more than one "limon" file for the district office, they must be combined on a single master file in order to transmit the data to the National Office. To copy individual files to the master file, open the file and highlight all the rows to be copied. Once copied, paste the file on the first blank row of the master file. Repeat this process until all the individual files are copied to the master file. Once all have been copied to the master file, save the contents and transmit to the National Office as described above.

d. Month Recover. This action restores the monthly file to a daily file, which can be edited. The Month Recover button should be used after the end of month processing is done, and before any data for the current period is entered. When restoring an old month any new data that has been entered will be lost.

OPTIONAL LIFE INSURANCE CODING STRUCTURE

OPTION A - STANDARD - $10,000 in coverage
OPTION B - ADDITIONAL - Up to 5 times the annual salary
OPTION C - FAMILY COVERAGE

CLASS	EXPLANATION OF CODE	
A	A0	Ineligible
B	B0	Basic
C	C0	Post - Retirement Basic Life Insurance
D	D0	Basic + Option A
E	E1	Basic + Option C (1X)
	E2	Basic + Option C (2X)
	E3	Basic + Option C (3X)
	E4	Basic + Option C (4X)
	E5	Basic + Option C (5X)
F	F1	Basic + Option A + Option C (1X)
	F2	Basic + Option A + Option C (2X)
	F3	Basic + Option A + Option C (3X)
	F4	Basic + Option A + Option C (4X)
	F5	Basic + Option A + Option C (5X)
G	G0	Basic + Option B (1X)
H	H0	Basic + Option A + Option B (1X)
I	I1	Basic + Option B (1X) + Option C (1X)
	I2	Basic + Option B (1X) + Option C (2X)
	I3	Basic + Option B (1X) + Option C (3X)
	I4	Basic + Option B (1X) + Option C (4X)
	I5	Basic + Option B (1X) + Option C (5X)
J	J1	Basic + Option A + Option B (1X) + Option C (1X)
	J2	Basic + Option A + Option B (1X) + Option C (2X)
	J3	Basic + Option A + Option B (1X) + Option C (3X)
	J4	Basic + Option A + Option B (1X) + Option C (4X)

	J5	Basic + Option A + Option B (1X) + Option C (5X)
K	K0	Basic + Option B (2X)
L	L0	Basic + Option A + Option B (2X)
M	M1	Basic + Option B (2X) + Option C (1X)
	M2	Basic + Option B (2X) + Option C (2X)
	M3	Basic + Option B (2X) + Option C (3X)
	M4	Basic + Option B (2X) + Option C (4X)
	M5	Basic + Option B (2X) + Option C (5X)
N	N1	Basic + Option A + Option B (2X) + Option C (1X)
	N2	Basic + Option A + Option B (2X) + Option C (2X)
	N3	Basic + Option A + Option B (2X) + Option C (3X)
	N4	Basic + Option A + Option B (2X) + Option C (4X)
	N5	Basic + Option A + Option B (2X) + Option C (5X)
O	90	Basic + Option B (3X)
P	P0	Basic + Option A + Option B (3X)
Q	Q1	Basic + Option B (3X) + Option C (1X)
	Q2	Basic + Option B (3X) + Option C (2X)
	Q3	Basic + Option B (3X) + Option C (3X)
	Q4	Basic + Option B (3X) + Option C (4X)
	Q5	Basic + Option B (3X) + Option C (5X)
R	R1	Basic + Option A + Option B (3X) + Option C (1X)
	R2	Basic + Option A + Option B (3X) + Option C (2X)
	R3	Basic + Option A + Option B (3X) + Option C (3X)
	R4	Basic + Option A + Option B (3X) + Option C (4X)
	R5	Basic + Option A + Option B (3X) + Option C (5X)
S	S0	Basic + Option B (4X)
T	T0	Basic + Option A + Option B (4X)
U	U1	Basic + Option B (4X) + Option C (1X)
	U2	Basic + Option B (4X) + Option C (2X)
	U3	Basic + Option B (4X) + Option C (3X)
	U4	Basic + Option B (4X) + Option C (4X)
	U5	Basic + Option B (4X) + Option C (5X)

V	V1	Basic + Option A + Option B (4X) + Option C (1X)
	V2	Basic + Option A + Option B (4X) + Option C (2X)
	V3	Basic + Option A + Option B (4X) + Option C (3X)
	V4	Basic + Option A + Option B (4X) + Option C (4X)
	V5	Basic + Option A + Option B (4X) + Option C (5X)
W	W0	Basic + Option B (5X)
X	X0	Basic + Option A + Option B (5X)
Y	Y1	Basic + Option B (5X) + Option C (1X)
	Y2	Basic + Option B (5X) + Option C (2X)
	Y3	Basic + Option B (5X) + Option C (3X)
	Y4	Basic + Option B (5X) + Option C (4X)
	Y5	Basic + Option B (5X) + Option C (5X)
Z	Z1	Basic + Option A + Option B (5X) + Option C (1X)
	Z2	Basic + Option A + Option B (5X) + Option C (2X)
	Z3	Basic + Option A + Option B (5X) + Option C (3X)
	Z4	Basic + Option A + Option B (5X) + Option C (4X)
	Z5	Basic + Option A + Option B (5X) + Option C (5X)

BASIC LIFE INSURANCE

BI-WEEKLY RATES

Effective January 1, 1990: $ 0.185 for each $1,000 of coverage

Effective January 10, 1993: $ 0.165 for each $1,000 of coverage

Effective april 25, 1999: $ 0.155 for each $1,000 of coverage

Bi-Weekly Rates Effective January 12, 2003: $ 0.150 for each $1,000 of coverage

PLEASE NOTE: To enter Basic Life Insurance in ACPS, the record ***must*** be deleted and re-entered in ACPS, since there is no adjustment capability for Basic Life Insurance. The premiums must be manually calculated and then the bi-weekly premium is entered.

ACPS will double the amount for the four week deduction.

Premiums are only withheld until age 65. Premiums are calculated using the "BASE" pay on which compensation is computed. This amount is rounded-up to the nearest $1,000 and an additional $2,000 is added.

POST-RETIREMENT BASIC LIFE INSURANCE

Bi-Weekly Rates Prior to December 1988

75% Reduction in Coverage: No Cost

50% Reduction in Coverage: $ 0.30 for each $1,000 of coverage

NO Reduction in Coverage: $ 0.81 for each $1,000 of coverage

Bi-Weely Rates Effective December 1988

75% Reduction in Coverage: No Cost

50% Reduction in Coverage: $ 0.24 for each $1,000 of coverage

NO Reduction in Coverage: $ 0.78 for each $1,000 of coverage

Bi-Weekly Rates Effective April 25, 1999

75% Reduction in Coverage: No Cost

50% Reduction in Coverage: $ 0.27 for each $1,000 of coverage

NO Reduction in Coverage: $ 0.94 for each $1,000 of coverage

Bi-Weekly Rates Effective January 12, 2003

75% Reduction in Coverage: No Cost

50% Reduction in Coverage: $ 0.60 for each $1,000 of coverage

NO Reduction in Coverage: $ 1.83 for each $1,000 of coverage

PLEASE NOTE: Premiums are based on the per annum salary of the claimant at retirement. OPM must advise OWCP of the coverage, and will provide the effective date and the per annum salary. Calculation of the premiums is a manual process. The bi-weekly amount is entered in ACPS, and the premiums continue for life.

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE JANUARY 12, 2003

OPTION A: Standard - $10,000

Under 35	$	0.30
35 - 39		0.40
40 - 44		0.60
45 - 49		0.90
50 - 54		1.40
55 - 59		2.70
60 - 65		6.00

OPTION B: Additional up to 5x salary; per $1,000 of coverage

Under 35	$	0.03
35 - 39		0.04
40 - 44		0.06
45 - 49		0.09
50 - 54		0.14
55 - 59		0.28
60 - 64		0.60
65 - 69		0.71
70 - 74		1.03
75 - 79		1.43
80 - over		1.83

OPTION C: Family - premium per contract

Under 35	$	0.27
35 - 39		0.34
40 - 44		0.46
45 - 49		0.60
50 - 54		0.90
55 - 59		1.45
60 - 64		2.60
65 - 69		3.00
70 - 74		3.40
75 - 79		4.50
80 - over		6.00

Rates for deduction past age 65 are only applicable in the iFECS system, but can be used for manual calculations.

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE APRIL 25, 1999

OPTION A: Standard - $10,000

Under 35	$	0.30
35 - 39		0.40
40 - 44		0.60
45 - 49		0.90
50 - 54		1.40
55 - 59		2.70
60 and over		6.00

OPTION B: Additional up to 5x salary; per $1,000 of coverage

Under 35	$	0.03
35 - 39		0.04
40 - 44		0.06
45 - 49		0.10
50 - 54		0.15
55 - 59		0.31

60 and over		0.70

OPTION C: Family - premium per contract

Under 35	$	0.27
35 - 39		0.34
40 - 44		0.46
45 - 49		0.60
50 - 54		0.90
55 - 59		1.40
60 - and over		2.60

In ACPS, premiums will change pay cycle following the age event (i.e. the claimant's birthday when they move into a new age bracket for life insurance). If the enrollee elects to "freeze" coverage after age 65, premiums will continue for life. ACPS has not yet been modified to accommodate this requirement, but an A/R should be entered into DMS to account for the deductions from compensation benefit payments..

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE JANUARY, 1993

OPTION A: Standard - $10,000

Under 35	$	0.40
35 - 39		0.50
40 - 44		0.70
45 - 49		1.10
50 - 54		1.80
55 - 59		3.00
60 and over		7.00

OPTION B: Additional up to 5x salary; per $1,000 of coverage

Under 35	$	0.04
35 - 39		0.05
40 - 44		0.07
45 - 49		0.11
50 - 54		0.18
55 - 59		0.30
60 and over		0.70

OPTION C: Family - premium per contract

Under 35	$	0.30
35 - 39		0.31
40 - 44		0.52
45 - 49		0.70
50 - 54		1.00
55 - 59		1.50
60 - and over		2.60

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE AUGUST 3, 1986

OPTION A: Standard - $10,000

Under 35	$	0.40
35 - 39		0.50
40 - 44		0.80
45 - 49		1.30
50 - 54		2.20

55 - 59		4.50
60 and over		7.00

OPTION B: Additional up to 5x salary; per $1,000 of coverage

Under 35	$	0.04
35 - 39		0.05
40 - 44		0.08
45 - 49		0.13
50 - 54		0.22
55 - 59		0.45
60 and over		0.85

OPTION C: Family - premium per contract

Under 35	$	0.30
35 - 39		0.31
40 - 44		0.52
45 - 49		0.70
50 - 54		1.10
55 - 59		1.75
60 - and over		2.80

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE MAY 17, 1984

OPTION A: Standard - $10,000

Under 35	$	0.55
35 - 39		0.70
40 - 44		1.00
45 - 49		1.60
50 - 54		2.70
55 - 59		6.00
60 and over		7.50

OPTION B: Additional up to 5x salary; per $1,000 of coverage

Under 35	$	0.04
35 - 39		0.05
40 - 44		0.08
45 - 49		0.16
50 - 54		0.27
55 - 59		0.60
60 and over		0.95

OPTION C: Family - premium per contract

Under 35	$	0.30
35 - 39		0.31
40 - 44		0.52
45 - 49		0.72
50 - 54		1.10
55 - 59		2.00
60 - and over		3.00

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE APRIL 23, 1981

OPTION A: Standard - $10,000

Under 35	$	0.60
35 - 39		0.80
40 - 44		1.40
45 - 49		2.20
50 - 54		3.20
55 - 59		7.50
60 and over		9.00

OPTION B: Additional up to 5x salary; per $1,000 of coverage

Under 35	$	0.05
35 - 39		0.07
40 - 44		0.12
45 - 49		0.20
50 - 54		0.30
55 - 59		0.60
60 and over		0.95

OPTION C: Family - premium per contract

Under 35	$	0.50
35 - 39		0.60
40 - 44		0.70
45 - 49		0.90
50 - 54		1.30
55 - 59		2.00
60 - and over		3.00

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a

claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

5-0207 BPS Reports

TABLE OF CONTENTS

1. Purpose and Scope. This chapter describes the composition, content, and purpose of the several series of ADP reports generated by the BPS at the District Office (DO) level, and as part of the Central system transmission and processing. These reports serve several operational and managerial needs.

2. General Categories.

a. Some BPS reports are generated at the District Office level when various programs are run, and as requested using the FECS002 reports or reports reprint menus. Portions of some of these reports are transmitted to the National Office (NO) for compilation, reprinting, and program management.

b. Other BPS reports are generated as part of the Central system processing on a daily basis or as part of the weekly processing cycle. They are generated to inform the DO systems managers and fiscal staff and the NO production control unit as to the results of each transmission, and the weekly processing. Reports may be received by both the NO and the DO (paragraph 4 below), the DO only (paragraph 5 below), or the NO only (paragraph 6 below).

c. A few reports are provided on microfiche.

3. District Office Reports. The following reports are generated from data on the local system and are available at the District Office. If a report or a portion of the report is also available at the National Office, it is marked with an asterisk (*). All of these reports may be reprinted from the FECS002 Reports Reprint menu, for a limited time after the initial generation.

a. BILL552.SUM* and BILL552.NEW - reports which are automatically generated each time the bill batch edit program (BILL552) is run. BILL552.SUM provides a summary of the number and amount of bills approved, denied and suspended for both recycled and newly processed bills. This report is useful for office managers to monitor the processing of bills in the office. BILL552.NEW provides the same information for the newly processed bills, and also includes suspense work sheets for each batch in which bills were suspended. The suspense work sheets should be separated and associated with their respective bill batches. The suspense work sheets show all of the edit failures at both the header and individual line item levels for the bills that have suspended for manual review. The work

sheets may be used by individuals performing bill resolution, to aid in prioritizing and organizing their work.

b. BILL505 - Suspended Bill Recycling - a report that is produced automatically whenever BILL505 is run from the FECS004 menu. The report shows the total number of bills recycled.

c. BILL507 – EDI Pharmacy Data Processing – a report that is produced automatically whenever BILL507 (Load EDI Pharmacy Bills) is run. The report shows the date, the operator, the identification number of the load file, the number of records, number of bills, number of line items, and the total dollar amount. If more than one day's worth of data is being loaded, there will be a separate report for each load file.

d. BILL511 – EDI Hospital Data Processing – a report that is produced automatically whenever BILL511 (Load EDI Hospital Bills) is run. The report shows the same information as the BILL507 report, except that it includes the inpatient hospital bills (instead of pharmacy bills). To further define any errors encountered when running BILL511, BILL514 (Edit EDI Hospital Bills) is run. Errors may be corrected through BILL515 (Modify EDI Hospital Bills).

e. BILL554 - History Update Errors - a report generated whenever there are errors in the process that updates the on-line BPS history table (d10).

f. BILL605 – Report of Bills Assembled for Transmission - a report generated whenever bill data is assembled for transmission. It shows detailed information for each line item assembled for transmission, and totals for each bill, and for each batch. The final page is a summary of bills assembled, and shows total number of bills, line entries, and dollar amounts for bills, cancelled checks and cash deposits, and manual payments. The report is used for reconciling BPS transmissions. [See paragraph 4.a(1)(a)]

g. BILL610 – Excluded Provider Report – a report produced upon request that lists medical providers excluded from participation in the Federal Employees' Compensation Program. The report can be sorted by last name, tax identification number, or state. The report supplements the on-line query capability available for excluded providers.

h. BILL649 - Specific Edit Failures Report - a report produced upon request, lists all suspended bills that contain failures of a specified edit. The report shows all of the edit failures for those bills, the procedure codes, and the ICD-9 accepted condition codes. When edit 301 is specified, the report may be used to monitor accuracy of procedure codes and to make suggestions to National Office concerning procedure codes which should be added to the relationship table (v17). Other edits may be specified for various reasons, such as a desire for an office to work off all of one particular type of edit.

i. BILL650 – Purged Internally Denied Bills Report - a report that is automatically generated when the system performs a purge of the internally denied bills. Internally denied bills (see Chapter 5-205) are purged from the system automatically each day. The report may be used to monitor appropriate follow-up action on internally denied bills.

j. BILL651 - Suspended/Internally Denied Bills - a report that is run upon request, which lists all batches currently on the system which contain suspended or internally denied bills. The report also lists each of those bills individually by batch. The report may be used to monitor and organize bill batches with suspended bills.

k. BILL652* - Error Summary - a report which is run upon request, summarizes how many times each edit has failed. All complete bills still on the system are incorporated in the report, including bills that have already been paid or denied (the data remains on the system for a short period of time after the bill has been finalized). The report may be used to analyze trends in edit failures, identify high-frequency edit failures, and possibly high-frequency keying errors. For example, a high rate of edit 014 failure may indicate a need to educate providers about use of procedure codes. A high rate of edit 105 failure could indicate that CA-16 forms are not being keyed into the system properly, or that employers in the area are not issuing CA-16s. A high rate of edit 112 failures could indicate that claims examiners are putting too many general suspense flags on cases, or that prompt action is not being taken when bills with this edit failure are referred to the claims examiner.

l. BILL653 - CPT4/ICD9 Edit Failures - a report which is run upon request, shows all of the edit failures that have occurred because of the relationship of the procedure code to the accepted condition (700 series edits). The report may be used to identify problems due to non-specificity of accepted conditions, or to errors in the CPTTOICD edit table (v17) itself.

m. BILL654 - Explanation of Benefits Letters - letters that are generated on the main laser printer for denied and partially denied bills. This report must be run daily. Running this report also populates the table (b23) that is used to measure timeliness of processing denied bills, thus it is critical that the report be run each day. The user will be asked to enter the dates for processing. If the report is run daily after BILL552 is run, then today's date should be entered.

Each individual letter contains a sequential reference number. When this report is reprinted, the user may specify a particular letter or range of letters that should be reprinted by specifying the reference numbers.

n. BILL655* - Suspense Aging - a report which is run upon request, lists all currently suspended bills, sorted according to batch number (and bill number), age of bill, case file number (triple terminal digit) or responsible claims examiner. The report may be used to monitor and organize pending suspended bill workloads.

o. BILL656 - New Batch Summary - may be run upon request, usually immediately prior to running batch edits (BILL552) to determine the numbers and dollar amounts of newly keyed batches. The user will be prompted to enter the key date, which should be today's date.

p. BILL657 - Error Override - a report which is run upon request, summarizes the number of each type of edit failure (by edit number) which have been overridden, and also shows identifying information for each edit override. The report may be used to monitor edit overrides, to ensure that overrides are appropriate.

q. BILL658 - Pending Internal Denials - a report that is run upon request, lists internally denied bills currently present on the system. The report is to be used to ensure that appropriate action is taken on internally denied bills, and that there is not an excessive number of such bills.

r. BILL661* - Denied Bills Performance - a report which is run upon request, shows timeliness of office action on denied bills, for a specified period of time. The user is prompted for the beginning and end dates of the period for which data is desired. Data is not routinely retained after 5 months. The report shows how many bills were denied during the period, and the numbers and percentages denied within 28 days and 60 days of receipt in the office.

Most office managers will want to receive this report monthly. In addition, since quarterly data is used to measure performance for purposes of the Quarterly Review and Analysis (QR&A), a quarterly report should be run.

s. BILL662 – Returned Bill Letters – generates letters for bills entered on the returned bill log. The letters may be printed for all letters that have not yet been generated, or letters for a specific print date can be regenerated.

4. Central Reports Available at both National Office and the District Office.

a. Daily Transmission Reports include three major types and several subtypes that cover Bill Payments, Inquiries, and EIN changes.

(1) Bill Payment Reports.

(a) BP010 - Transmission Log Report. This report is generated as the result of each successful transmission and furnishes an accounting of the data that has been transmitted successfully and has either been accepted or dropped. This report is useful to the Systems Manager, fiscal personnel, and the National Office production control unit as it confirms performance in both system terms and operational terms. If the report is not received shortly after transmission of the bills, it should be assumed that transmission has

failed and a retransmit is necessary. This report is important as it is the basis for the reconciliation of the daily transmission and the weekly processing; therefore it should be routed to the appropriate office location as soon as possible after receipt. For transmission reconciliation purposes, the total count and net amount, plus the count and amounts dropped (as noted on the Report of Unacceptable Bills/Line Entries) should equal the BILL605 Summary line entries and amount.

(b) Report of Unacceptable Bills/Line Entries (BP010). This report is generated as the result of each transmission if the Central edit program identifies any erroneous data. Messages are printed to identify the errors encountered. The data that is printed on this report is dropped from the BPS and will require re-entry; therefore, it should be routed to the appropriate office location as soon as possible after receipt.

(c) BP015 – Accumulation of Transmitted Bill Records. This report is generated the day following a successful transmission and furnishes totals for the accepted records. For transmission reconciliation purposes, the total charges and amounts should equal the total count and net disbursement amount found on the BP010 Transmission Log Report.

(d) The Duplicate Transmission Report will be generated if more than one transmission of data is made within the same day, or if data from a previous day has not yet been processed by the central site daily processing cycle and the district office is transmitting new data.

(e) The Data Deletion Report will be generated whenever the procedure for deleting data previously transmitted, but not yet processed by the central site daily processing cycle, is executed by the district office.

(2) Inquiry Reports.

(a) The Inquiry Transmission Log Report is generated as the result of each successful transmission of inquiry data and furnishes an accounting of the data that has been transmitted successfully.

(b) The Inquiry Duplicate Transmission Report will be generated if more than one transmission of inquiry data is made within the same day, or if data from a previous day has not yet been processed by the central site daily processing cycle and the district office is transmitting new data.

(c) The Inquiry Data Deletion Report will be generated whenever the procedure for deleting inquiry data transmitted previously, but not yet processed by the central site daily processing cycle, is executed by the district office.

(3) EIN/SSN Change Reports.

(a) The Transmission Log Report is generated as the result of each successful transmission of EIN/SSN Change Data and furnishes an accounting of the data that has been transmitted successfully.

(b) The Report of Unacceptable Change Records is generated as the result of each transmission if the edit program identifies erroneous data. Each record that contains erroneous data will be listed on the report and will be followed by appropriate error messages. The records listed on this report are dropped from the system and will require re-entry.

(c) The Duplicate Transmission Report will be generated if more than one transmission of EIN/SSN Change Data is made within the same day, or if data from a previous day has not yet been processed by the central site and the DO is transmitting new data.

(d) The Data Deletion Report will be generated whenever the procedure for deleting EIN/SSN change data transmitted previously, but not yet processed by the central site daily processing cycle, is executed by the DO.

b. Weekly Reports. The weekly processing cycles, aside from producing the payment file which is used by the Treasury Department to produce the payment checks, identify possible duplicate bills, and maintain a history of disbursements. They also produce three series of ADP reports that are transmitted to both the NO and the DO. The purpose of these reports is to furnish information, allow auditing and control, and to determine performance levels.

(1) Summarization of Bill Payment Data (BP030). This report reflects the resulting bill payment data after complete processing has been effected, including updating the Central bill payment history and identifying unpaid bills due to possible duplication. As this is the "final" report after editing and updating has been completed, it reflects totals for all DOs as well as combined totals. Due to its contents this report is extremely valuable, as it can be used to reconcile all BPS transmissions effected for the current processing cycle and to reconcile all reports produced by the weekly processing cycle.

(2) Manual/Cancelled Checks and Cash Deposits Paid (BP050). This report reflects manual checks, cancelled checks, and cash deposits that have been processed via BILL052 and accepted by the weekly processing cycle.

(3) Analysis of Payment Performance (BP050). This report furnishes an analysis of the services rendered by each DO, as well as for all DOs collectively, in the payment of bills. Payment performance is determined by calculating the time span from the date that a bill is received in the mail room until the check for payment has been issued. For purposes of this report, all payment records in which the submitting district office code, case number, payee EIN/SSN, payee name, provider code, and date received are identical are considered to have emanated from the same bill.

(4) Analysis of Provider Performance (BP050). This report furnishes an analysis of the timeliness of providers' submissions of bills. Time is measured from the latest date of service to the date received in the office. A summary for each office is included.

(5) IRS Levy Report. This report lists bill payments that have been applied to a registered IRS lien against the provider.

c. As Requested Reports. The BPS daily processing cycle, in addition to combining the daily DO inputs for subsequent processing by the weekly processing cycle, produces information relative to previously processed data that is available in special request. Typical of such a request is the "Formatted Bill Payment History Requested" report (BP060D), which contains formatted bill payment history records for a particular case or cases, for use at a particular location within a DO and is produced in response to inquiry data which has been input via BILL007. The information listed may be the complete payment history for a case, or a partial history if a provider type, EIN, or service dates were entered on the inquiry record at the time of keying. This report is generated on an overnight turnaround basis and should be routed to the DO location indicated upon the report. If requested on Monday through Thursday, only history on the active file is provided. If a Friday request is made, active, purged, and archived history data is available.

5. Central Reports Available at the District Office Only. The weekly processing cycle produces various reports for the use of the DO only. These reports are received in each DO and only reflect the data that has been input by or is relative to the receiving DO's operation. The purpose of these reports is to furnish information, allow auditing and control, and to determine performance levels.

a. Register of Miscellaneous Checks Paid (BP040). This report is a master listing of all checks written in payment of bills for the DO during a single payment cycle. This report reflects the identification number assigned to each check by the BPS, the net amount paid, the name and address of the recipient, as well as the positional location of each check on the check tape which is forwarded to the Treasury for check issuance.

b. Detail of Bills Paid (BP050). This report is the record of those bills that have been accepted by the weekly processing cycle for purposes of producing payments to providers or reimbursements to claimants. This report provides information as to which cases there were payments made in behalf of, to whom the payments were made, in what amounts and for what dates of service.

c. Payee Number to Case Number Cross Reference (BP050). This report furnishes the means to identify to whom payments were made during the current processing cycle and for which cases the payments were made.

d. Related History and Possible Duplicate Bills Unpaid (BP060W). This report is the record of those bills and their associated bill history which the BPS has not processed for payment due to suspected duplication and, in the case of cash deposits or cancelled checks, failure to match against the BPS payment history. After appropriate research into the original bill, the bills, if to be paid, can be accessed via BILL002 for entry of an appropriate bypass code (or not) and retransmission. BILL002 must be used within the weekly cycle following the one in which the bills were rejected. If a bill is not deemed to be appropriate for payment because it is a duplicate, and the original payment was made within 60 days of the receive date of the rejected bill, no further action need be taken. If the original payment was made more than 60 days prior to receipt of the duplicate bill, the provider should be informed that the bill is not payable because it was previously paid, and the date of the previous payment should be stated.

e. Payee/Case No Records Not Processed (BP060C) is a listing of the EIN/SSN change records which were not processed by the BPS as they did not match a record contained in the BPS payment history. The records on this report should be researched to determine the reason for their being mismatched and, if appropriate, be reentered for subsequent processing.

f. Payee/Case No Change Records and Related History (BP060C) is a listing of those EIN/SSN change records which were accepted for processing by the BPS and the original and resulting payment history for each case which has had an EIN/SSN change processed against it during the current processing cycle.

6. Central Reports Available at the National Office Only. BPS, in the normal process of operation, generates reports that are received as output at the National Office only.

a. Weekly Reports. The BPS weekly processing cycle (1) produces the payment file which is used by the Treasury Department to produce the payment checks, (2) identifies possible duplicate bills, (3) maintains a history of disbursements, and (4) produces a series of reports. The purpose of these weekly reports is to furnish information, allow auditing and control, and to determine performance levels.

(1) Consolidation of District Office Bill Payment Data (BP020). This report is a summary of all data transmitted by all DOs subsequent to the previous weekly processing cycle. As this report is primarily a summarization of the Accumulation of Transmitted Bill Records Reports which are produced by each daily processing cycle, it is used to verify that all data transmitted by the DOs and combined by the daily processing cycle is subsequently accounted for in the weekly processing cycle.

(2) The Register of Miscellaneous Checks Paid summary report (BP040) is a summary checks written in payment of bills for all DOs during a single payment cycle.

(3) The Detail of Funds Disbursed report is the record of those bills which have been accepted by the weekly processing cycle for purposes of producing payments to providers or reimbursements to claimants and as such is an elaboration of the Register of Miscellaneous Checks Paid Report. This report reflects the identification number assigned to each check by the BPS, the cases for which there were payments made, the dates of service, and amounts covered by the issued check.

b. Periodic Reports. When the bill purge program runs, it produces the "Purge of Bill History" report, which summarizes all data processed.

7. Reports on Microfiche. The Detail of Funds Dispersed report and the Register of Miscellaneous Checks Paid report are provided to the District Offices and the National Office on microfiche.

5-0700 - CHARGEBACK

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1. Purpose and Scope. Costs incurred under the Federal Employees' Compensation Act

(FECA) for most injuries and deaths are billed to the agencies on an annual basis through a mechanism known as chargeback. The purpose of this chapter is to describe how the chargeback system works.

2. Statutory Provisions. The authority for the chargeback process is found in Section 8147 of the FECA.

a. Coverage. Each employing agency is responsible for the total cost of benefits paid from the Employees' Compensation Fund during the previous fiscal year for injuries or deaths occurring after December 1, 1960. Costs for injuries and deaths which occurred before then are not billed back to the employing agencies; rather, Congress appropriates them directly. Costs for certain other kinds of cases (e.g., non-Federal law enforcement officers, or LEO cases) are also appropriated directly by Congress.

b. Administrative Expenses. Each agency which is not funded (or only partly funded) from Congressional appropriations is required to pay an additional amount to the OWCP as its "fair share" of administrative expenses each year. Examples of such agencies are the U.S. Postal Service and the Tennessee Valley Authority.

c. Billing. By August 15 of each year, the OWCP is required to send each agency a statement and bill which summarizes its total costs for the prior chargeback year. The FECA chargeback year begins on July 1 and ends on June 30, and all checks issued by the U.S. Treasury between those dates will be shown on the chargeback listing. The agency must include the amount shown on the chargeback billing in its budget for the following fiscal year.

3. Agency Codes. The OWCP assigns each agency one or more four-digit agency codes which are used for chargeback purposes. The agency decides which of its departments or facilities are to be assigned separate codes. National Office (NO) staff assign these codes, which are listed in the Sequent System Case Management Users' Guide. NO staff also prepare FECA Circulars as changes or additions occur.

A two-digit suffix identifier is appended to the four-digit code. This two-digit code identifies the geographical location of the reporting office. The district offices assign these two-digit codes for all agencies except Department of Defense. The code will be either two letters of the alphabet (such as DC) or the numbers 00. Cases created prior to 1978 may only have the four-digit code, as the suffix code was not listed on the case summary until that time.

4. Transfer to Another Agency. If an agency (in whole or in part) or any of its functions is transferred to another agency, the costs of benefits paid for employees of the transferred agency or function are transferred to the receiving agency. The agency should advise the NO of the reorganization and provide a list of the employees affected and the OWCP agency code applicable to the gaining organization. The NO will furnish this information to district offices as soon as it is available.

Generally, such organizational changes affect only the codes for new injury cases. The codes for cases created before the transfer or reorganization remain unchanged in the data base and are adjusted by group change in the automated system.

By contrast, the chargeback code does not change when an employee transfers from one agency to another, but the function does not transfer. When an employee files a Notice of Recurrence with an agency other than the one at the time of injury, the chargeback code for that case should generally not be changed.

5. Determining Amounts Charged. The amount charged for any case is the sum of compensation and medical payments made over the course of the chargeback year.

a. Compensation Payments. When a payment is made through the Automated Compensation Payment System (ACPS), the system records the payment automatically using agency codes maintained in the Case Management File (CMF).

Adjustments to these payments such as check cancellations, cash receipts, CPI increases, and third party settlements (compensation portion) must be made through the ACPS using screen 02, Adjustment Input. The part of any third party

settlement to be applied against compensation payments made must be entered as a Cash Receipt adjustment in the ACPS.

However, there are certain adjustments which, though they must be made part of the ACPS history, should be entered using screen 03, Payment/Cash Receipt Refund/Offset, so they
do not affect the amount to be charged back. Examples of these adjustments include health benefits refunds and excess accounts receivable.

b. Medical and Other Bills. When a payment is made through the Bill Processing Subsystem (BPS), the system records the payment automatically using agency codes maintained in the CMF.

Adjustments to these payments, as well as bills paid manually or through fund transfers, must be entered into the BPS using screen 02, Adjustment Input. The part of any third party settlement to be applied to bill payments must be entered as a Cash Receipt adjustment into the BPS.

6. Agency Requests for Adjustment. In addition to funding the compensation program, the chargeback system serves as a management tool for agencies. The agencies actively monitor chargeback information provided by OWCP to control compensation costs and evaluate the effectiveness of their compensation programs. Because accurate chargeback data is crucial to their interests, an agency will sometimes request that a case believed to belong to another agency be removed from its report or bill.

a. Advice to Agencies. After the case is created, the OWCP sends a notice (Form CA-801) showing the case number generated by the ADP system to the claimant and the agency. Also, each agency receives a quarterly report showing a breakdown of cases and costs for which charges will appear on that year's chargeback bill.

b. Identification of Potential Errors. To ensure accurate chargeback data, OWCP encourages agencies to identify potential errors at the earliest possible time. No documentation is required for an agency to bring an error to the attention of the district office within 60 days of receipt of Form CA-801.

Requests for changes based on review of the quarterly chargeback report should be made to the district office within 90 days of receipt of the report. The request should be accompanied by appropriate documentation, such as copies of an SF-50, job record card, or response from the Federal Records Center.

c. Action by District Office. Upon request by the agency, the district office will review the disputed case and any supporting evidence to determine whether a keying or coding error occurred.

(1) If the evidence does not support the agency's request, the district office must send the agency a copy of Form CA-1 or CA-2 from the case file with an explanation of why a change is not justified.

(2) If the evidence shows that the disputed case belongs on another agency's account, the district office must notify the new agency and forward a copy of Form CA-1 or CA-2 from the case file. A copy of this letter should be sent to the agency that brought the error to the office's attention.

(3) Before changing the agency code in the CMF, the district office should allow the new agency 60 days to respond in the event that it disputes ownership of the case. If at the end of that period no evidence has been received to alter the district office's finding, the Systems Manager should be asked to change the agency code for the case.

d. Intra-Agency Changes. Occasionally an agency will request that the chargeback code for a case be changed to reflect a different section of the same agency. If such a change is requested, the district office should ask the agency to send a representative to the office to review the disputed case and resolve the matter. No letter to the agency or 60-day waiting period is required before making an intra-agency correction of a chargeback code.

f. Adjustments to Bills. A request for an adjustment to the yearly chargeback bill must be forwarded to the NO for response. The request should be accompanied by documentation that the disputed charge was not for an employee of the agency, or by a complete explanation of the basis for the agency's objection.

Requests for adjustments of the chargeback bill will be considered only when the request involves a transfer of costs from one agency to another. A transfer of charges from one organization to another on the same bill will not be made.

7. Error Reports. Several kinds of reports are available to verify chargeback information and detect errors and omissions.

a. Case Not in CMF. Each time the disability and death roll programs are executed, a report is generated which lists cases having invalid CMF pay/adjudication status codes. Occasionally a case appears on this list with an indication that it is not contained in the CMF. When this happens, the case is not captured for chargeback purposes and thus is erroneously included with nonchargeable cases. The case must be reviewed for correction of erroneous codes and addition of the case to the CMF.

b. Payments and Agency Codes. The NO frequently provides district offices with lists of cases containing errors which affect chargeback. The error lists include cases for which payments were made in the chargeback period but which do not appear on the CMF, and cases that require correction of erroneous or nonexistent agency codes. District offices are required to take prompt corrective action to ensure that the costs associated with these cases are charged to the appropriate agency.

c. High-Cost Cases. District offices receive quarterly listings of cases with particularly high medical or compensation costs. The lists of high-cost cases are to be used for review of possible payment discrepancies, and to ensure that the payment and cost transactions are correct when they appear in the final chargeback listings. The district office will review the lists and take any actions necessary to correct payment history records.

8. End-of-Year Adjustments. The steps required to ensure the accuracy of the chargeback bill are described below.

a. Preliminary Bill and Error Reports. At the end of June, the NO produces a preliminary chargeback bill. The NO also produces error reports as described in paragraph 7 above and sends them to the district offices with instructions to make corrections by a specified date. Unless the corrections are made by that date, they will not appear on the final chargeback bill run at the end of July.

b. Updates. The cutoff date for taking action on error reports also applies to updates to history for transactions occurring before July 1. Updates to reflect manual payments, check cancellations and cash receipts for the recently ended chargeback year must be processed prior to the cutoff date. When the final bill is produced at the end of July, it will reflect any updates entered during the "window" period for transactions occurring prior to July 1.