U.S. Department of Labor
Office of Workers' Compensation Programs

Read Me First
Fee Schedule Overview

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GENERAL CONTACT INFORMATION

Medical Bill Submission

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CONDUENT

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NOTICE

The document outlines the accepted coding schemes for billing medical procedures, services, equipment, prosthetics, orthotics, and supplies (DMEPOS) under the U. S. Department of Labor's Office of Workers' Compensation Programs. These coding schemes include:

- The American Medical Association (AMA) Current Procedural Terminology (CPT) ©
- U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System Level II (HCPCS) ©
- The American Dental Association's Current Dental Terminology (CDT) ©
- Revenue Center Codes (RCC)
- U.S. Department of Labor's OWCP Unique and Exclusive Codes

Charges and fees for medical services, equipment, and supplies billed using terminated service codes as per the above-listed coding schemes will be denied.

For this document all CPT, HCPCS, RC, CDT, and unique OWCP codes will be broadly referred to as service codes.

1. INTRODUCTION

The U.S. Department of Labor's (DOL) Office of Workers' Compensation Programs (OWCP) administers four major disability compensation programs: the Federal Employees' Compensation Act (FECA) and Longshore and Harbor Workers' Compensation Act (LHWCA) managed by the Division of Federal Employees, Longshore and Harbor Workers' Compensation, the Black Lung Benefits Act (BLBA) managed by the Division of Coal Mine Workers' Compensation (Black Lung), the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) managed by the Division of Energy Employees Occupational Illness Compensation (Energy).

OWCP Fee Schedule Read Me First Document (RMF) provides an overview of billing and fee schedule policies for the agency. It includes information on claims processing, covered services, reimbursement calculations, fee schedules, and specific billing rules across different compensation programs (FECA, Black Lung, and Energy). The document also contains formulas, examples, appendices, and references to enhance understanding of the various fee schedules.

2. CLAIMS PROCESSING

2.1 General Information

This section provides general processing information and guidelines for OWCP medical claims. It offers an overview of components involved in the processing of medical claims. A large segment of OWCP fee schedules is based on a system that assigns relative values to medical services, adjusting for regional cost variations and overall economic factors affecting medical practice. This ensures that payments reflect the cost of resources required to provide medical services considering geographical differences. Fees may increase or decrease based on updates to the relative value of services, regional cost adjustments, and or changes in economic factors affecting the delivery of medical services in a particular locality. Readers should review this document and contact the appropriate bill processing contractors to address any questions or concerns.

The Workers' Compensation Medical Bill Process (WCMBP) web portal, managed by Acentra, is the platform where providers and claimants can submit medical bills for adjudication. This portal offers self-service features for providers, claimants, claimant representatives, DOL staff, and Acentra employees. Providers can access news, helpful resources, and other publicly available information through the portal. Registered users can quickly and securely access billing, claimant eligibility, authorization, and provider enrollment features. Providers must register through OWCP Connect to access the WCMBP self-service portal.

To help providers and claimants determine reimbursement rates, a Fee Schedule Calculator tool is available on the WCMBP web portal. After logging in, providers can use this tool to estimate the

maximum allowable amount for services billed on the OWCP 1500 Professional form or the ADA Dental form. Please note the following:

- The Fee Schedule Calculator provides an estimate of payment but does not guarantee eligibility or coverage for specific services.

- The tool does not assess if services are appropriate for the accepted condition or if authorization is required. For these verifications, use the Claimant Eligibility Inquiry and Authorization Submission features.

For more information, please refer to "Helpful Links – Fee Schedule Calculator Quick Reference Guide".

Optum manages the Pharmacy Benefit Management (PBM) program under the Federal Employees' Compensation Act. Conduent has been contracted to handle pharmacy billing services specifically for the Energy and Black Lung programs. For further details, please refer to, "Helpful Links – Energy & Black Lung Pharmacy (Conduent) and FECA Pharmacy (Optum).

2.1.1 Covered Services

OWCP does not cover every service code, and coverage varies by program. Determinations are based on the specific healthcare needs and guidelines of each program, ensuring that only medically necessary and program-appropriate services are covered. This approach allows for tailored healthcare solutions that meet the unique requirements of each program.

2.1.2 Bill Submission

OWCP recommends electronic submission of bills and attachments via the Secured File Transfer Process (SFTP), Direct Data Entry (DDE), and Electronic Data Interchange (EDI) to streamline processing, reduce errors, and expedite reimbursements. Detailed instructions for submitting claims electronically can be found on the online WCMBP Portal.

2.1.3 Claimant Reimbursements & Travel

Claimants can use the Claimant Medical Reimbursement Form OWCP-915 to request reimbursement for out-of-pocket expenses for accepted conditions, prescription medications, and medical supplies. A separate form should be submitted for each provider where out-of-pocket expenses were incurred.

The Medical Travel Refund Request - Mileage Form (OWCP-957A) and Medical Travel Refund Request - Expenses Form (OWCP-957B) are used to seek expenses for medically related travel. Black Lung does not utilize the OWCP-957-A form.

Each program has specific travel policies that determine reimbursement. Some travel requires prior authorization, and each program has different requirements regarding receipts and mileage. Review the respective program's policy for travel reimbursement guidance.

To access, please refer to the Helpful Links section below – Forms and References.

2.1.4 Utilization Restrictions (UR)

Utilization Restrictions are policies designed to regulate the number of units of medicine or medical services that are reimbursable within a specific time frame to ensure medically necessary care. For example, a utilization restriction might limit a particular procedure to two units per month, contingent upon medical necessity and clinical guidelines. This ensures that resources are used appropriately and that patients receive the necessary care without overutilization.

2.1.5 Revenue Center Codes (RCC)

RCCs are numeric codes that identify a specific accommodation, ancillary service, billing calculation, or arrangement relevant to the claim. It is used by hospitals or health care systems to communicate where the patient was or what type of item or equipment they received.

2.1.6 Bundled Services

Bundled codes are covered procedures that are billable but not separately payable. Payments for bundled codes are included in the payment for the services to which they are incidental.

2.1.7 Cut-Back Logic

Cutback logic refers to a set of rules or algorithms designed to adjust or reduce the units billed for certain services or procedures. This mechanism ensures that billed claims align with policy guidelines. It operates by enforcing limitations on the number of units or frequency of covered services, adjusting payments based on predetermined criteria such as bundling multiple procedures, and ensuring compliance with OWCP policies and medical necessity requirements. Additionally, cutback logic helps control costs by preventing excessive or unnecessary charges and by identifying and correcting errors or inconsistencies in billing. Overall, it aims to manage and optimize reimbursement while adhering to established policies and cost-control measures.

2.1.8 Maximum Allowable Rates

Maximum allowable rates are set amounts that remain constant regardless of where care is provided. It is not calculated through a payment formula but instead represents the maximum allowable that can be reimbursed per unit. The final payment may be adjusted if modifiers or processing rules apply (e.g., cutback logic).

2.2 National Correct Coding Initiative (NCCI)

The purpose of the NCCI is to promote accurate and appropriate coding methodologies and to control improper coding that may lead to inappropriate payments. By implementing coding policies and edits, NCCI helps ensure that claims are billed correctly and that payments are made for services that are medically necessary and adhere to OWCP guidelines.

2.2.1 Procedure to Procedure (PTP) Code Pair Edits

Procedure-to-Procedure (PTP) code pair edits are designed to prevent improper payments by identifying pairs of service codes that should not be reported together for the same patient on the same date of service. These edits are implemented in OWCP claims processing systems to automatically detect and deny improper code pairings. Providers may use specific modifiers to bypass certain edits if clinical circumstances justify separate reporting. OWCP updates these edits quarterly to reflect changes in coding standards and medical practices.

2.2.2 Medically Unlikely Edits (MUE) and Max Units

OWCP utilizes the Centers for Medicare & Medicaid Services' (CMS) Medically Unlikely Edits (MUEs) for service codes. MUEs define the maximum number of units of service that a provider would typically report for a single beneficiary on a single date of service. It is important to note that not all service codes have an associated MUE.

Although CMS publishes most MUE values on its website, some MUE values are confidential and are not releasable. The confidentiality status of these MUE values may change over time.

CMS updates its NCCI public MUE files quarterly, including additions, deletions, and revisions for Practitioner Services, Outpatient Hospital Services, and Durable Medical Equipment (DME) Supplier Services. OWCP policy mandates the use of these MUEs for bill processing, except when statutes, regulations, or policies specify otherwise.

Max Units, similar to MUEs, define the maximum number of units of service that a provider would typically report for a single beneficiary on a single date of service. However, Max Units are determined by the program and are not publicly published.

2.2.3 Modifiers

A modifier is a two-characters alphanumeric code added to a procedure or service code to indicate specific circumstances that may affect reimbursement for that service. Modifiers provide additional information to ensure accurate and clear communication of services rendered. Examples of modifiers include:

- Modifier 25: Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

- Modifier 59: Distinct procedural service, used to indicate that a procedure or service was distinct or independent from other services performed on the same day.
- Modifier 50: Bilateral procedure, indicating that the same procedure was performed on both sides of the body.

Modifiers help to clarify the services provided and ensure that the reimbursement accurately reflects the complexity or unique circumstances of the service rendered.

2.2.4 Add-on Codes

An Add-on Code (AOC) is a service code that describes a procedure typically performed in conjunction with a primary service. An AOC is not eligible for reimbursement if it is billed without the associated primary service code.

2.3 Prior Authorization

Prior authorization (PA) is an internal control requiring claimants, physicians, and other healthcare professionals to obtain advance approval from OWCP before a specific service or item qualifies for payment. PA is used to ensure appropriate patient care and is typically required for higher levels of care. PA requirements for all programs can be found in the Helpful Links section of this document. Providers and claimants may submit authorization requests via the WCMBP Provider Portal (direct data entry), fax, or mail. Providers must be actively enrolled in the program for which they request authorization. Please note that an approved authorization does not guarantee reimbursement for the services provided.

2.4 Implanted Medical Equipment & Prosthetic Implants

Implants are reimbursed through the Outpatient Prospective Payment System (OPPS) for Energy. In some instances, implants may be reimbursed using the Medical Physician Fee Schedule. Implants are not covered for Black Lung.

For FECA, the providers will be reimbursed based on the acquisition cost of the implant. Providers must submit a copy of the original invoice, clearly showing the invoice cost minus any applicable discounts, along with the bill. The acquisition cost is defined as the invoice cost to the provider, including shipping, handling, and sales tax, after all discounts have been applied.

2.5 Billing and Coding

All physician services, regardless of setting, as well as all outpatient professional services—including the technical components of radiology, pathology, and clinical laboratory—must be recorded using the appropriate service codes.

Coding conventions, including the use of modifiers, should be carefully observed. Incorrect coding or failure to accurately indicate the number of units (frequency or time) on bill forms may lead to

inaccurate claim processing. Additionally, OWCP reviews billed services to ensure they are consistent with the procedure descriptions and other common standards for appropriateness.

Non-specific service codes ending in "99," such as unlisted or unspecified codes, are categorized as miscellaneous services that provide inadequate descriptive information about a procedure. These codes are often deemed inappropriate for use due to their lack of specificity and can frequently result in improper reimbursement. As such, they should be used sparingly and only when necessary. Providers are encouraged to use the most specific and accurate codes available to ensure proper reimbursement and to avoid delays or denials in payment.

Listing a single service code multiple times for a single day of service may lead to the denial of all but the initial charge, as the OWCP automated system may interpret these as duplicate charges. If a procedure covered under a single service code is performed more than once on the same day, use the appropriate units or modifiers to indicate the frequency.

Incomplete information may result in claim denials, processing delays, or erroneous reimbursements.

3. OWCP FEE SCHEDULES

OWCP Fee Schedules provide the maximum allowable reimbursement for services and items rendered to OWCP claimants. These include fee schedules for Medical Services (known also as the Physician Fee Schedule), Clinical Laboratory Services (Clin Lab), Physician-Administered Drugs and Biologicals (PADB), also known as the Average Sale Price, ASC, DMEPOS, Outpatient Services, Inpatient Services, Pharmacy, Dental, Home Health Care (HHC) services, and Anesthesia Services. Bills are processed through an automated system where reimbursements are typically made for the lesser of the billed amount, or the maximum allowable amount (MAA). This ensures that payments are capped at the maximum allowable amount specified by the OWCP guidelines, while also accommodating lower billed amounts when applicable.

Inaccurate information submitted on claims may lead to denials, erroneous MAA reductions, or delays in bill processing.

3.1. Medical Physician Fee Schedule

The OWCP Medical Physician Fee Schedule covers the payment rates for a wide range of services provided by physicians and other healthcare professionals. This includes evaluation and management services, surgical procedures, diagnostic tests, and various other medical services. The Medical Physician Fee Schedule determines the reimbursement rates for these services primarily based on the Resource-Based Relative Value Scale (RBRVS), which accounts for the resources required to perform each service, including time, skill, and overhead costs. The Medical Physician Fee Schedule also considers geographic variations in practice costs and updates annually to reflect changes in medical practice and economic conditions.

The Medical Physician Fee Schedule is generally released annually, with routine updates occurring throughout the year as needed. The public is notified of any updates on the webpage where the fees are posted.

Each procedure subject to the maximum allowable amount under the OWCP Medical Physician Fee Schedule is assigned three relative value units (RVU): work expense (W), practice expense (PE), and malpractice expense (MP). These RVUs are adjusted by three geographic practice cost index values (GPCI) that account for regional variations in procedure costs: work (w), practice expense (pe), and malpractice expense (mp). The resulting value is then multiplied by a conversion factor (CF) to determine the final dollar amount. OWCP develops CFs to convert RVUs and GPCIs into maximum allowable dollar amounts for medical services and items. For an example of how RVUs, GPCIs, and CFs are used to calculate the MAA, please refer to Appendix A.

While most rates in the Medical Physician Fee Schedule are calculated using RVUs, GPCIs, and CF, some rates identified in the fee schedule are reimbursed as a maximum allowable rate per unit.

3.2 Clinical Laboratory Services

Clinical Laboratory services are diagnostic tests performed on specimens such as blood, urine, or tissue to help detect, diagnose, or monitor health conditions. These services are typically ordered by a healthcare provider and conducted by a certified lab, often without the need for a face-to-face visit. Each distinct laboratory test is reimbursed at a maximum allowable rate per billing unit.

3.3 Physician-Administered Drugs, Biologicals

Physician-Administered Drugs and Biologicals (PADB) are medications or biological products that must be administered by a healthcare professional, typically by injection or infusion during an in-person visit. These are not self-administered and are commonly used in outpatient settings such as physician offices or clinics. PADBs are reimbursed based on a maximum allowable rate assigned to each drug or biological, calculated per billing unit.

3.4 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

The DMEPOS fee schedule provides rates for medical equipment and supplies including DME items, prosthetic limbs, orthotic devices, and medical supplies such as crutches, wheelchairs, back braces, splints, and wound care materials. The DMEPOS Fee Schedule shows the maximum allowable rate per unit for each applicable service code where a rate is available.

3.5 Outpatient Services

Ancillary charges for hospital outpatient services (such as emergency room, recovery room, and operating room) should be billed using the appropriate Revenue Center Codes (RCC) along with the relevant service codes, when applicable, on the UB-04/OWCP-04 Form. OWCP requires that some RCC codes be billed with the corresponding service codes. To determine which RCCs

require an accompanying service code, please refer to the Helpful Link titled "RCC Codes Requiring an Accompanying Service Code."

OWCP uses two (2) different pricing methodologies for Outpatient billing:

1. **Outpatient Prospective Payment System (OPPS)**

   The OPPS is a method used by OWCP to pay for hospital outpatient services. Under OPPS, payments are based on Ambulatory Payment Classifications (APCs). Black Lung does not utilize OPPS pricing rule for Outpatient Services. Instead, it utilizes OWCP Fee Schedule to make reimbursements. Each APC is a grouping of services that are clinically similar and require comparable resources. Payments for each APC are predetermined and cover the facility costs associated with providing the outpatient services, including equipment, supplies, and labor. Adjustments may be made for geographic variations in costs, and additional payments can be provided for high-cost outlier cases, rural hospitals, and certain cancer hospitals.

   Type of Bills 13x or 14x are typically processed using OPPS. However, OPPS does not apply to Critical Access Hospitals, Maryland Hospitals, ASCs, Dialysis Centers, freestanding clinics, or Federally Qualified Health Centers (FQHC). APC rates and status indicators are updated quarterly. OWCP utilizes 3M Health Information Systems to accurately classify outpatient services. OPPS is utilized by FECA and Energy, though not all outpatient codes are processed under OPPS. The MAA derived from OPPS is multiplied by 1.25 to determine the reimbursement amount.

2. **OWCP Medical Physician Fee Schedule**

   If the Type of Bill is not 13x or 14x, or if the services cannot be priced using OPPS for any reason, the services will be priced using the Medical Physician Fee Schedule methodology.

3.5.1 Outpatient Hospital Facility Charges

Outpatient Facility Charges are costs for care provided in outpatient and physician office settings that are owned or controlled by hospitals. These charges should be identified by the RCC and service codes, if applicable, on the UB-04/OWCP-04 forms for hospital outpatient facilities.

3.5.2 State Waiver

The Maryland Health Services Cost Review Commission sets the rates for hospital-based ambulatory surgery services in Maryland. Since Maryland hospitals are required to bill these rates, reimbursement for ambulatory services is based on the billed charge.

Freestanding, non-hospital-based ambulatory surgery centers in Maryland are not covered under the Maryland state waiver.

3.6 Ambulatory Surgical Center (ASC)

An ASC is a healthcare facility that provides surgical care, including diagnostic and preventive procedures, without requiring an overnight hospital stay. ASCs are designed to deliver surgical services in a safe, efficient, and cost-effective outpatient setting.

OWCP reimburses ASC facility services using the Medical Physician Fee Schedule (MPFS) methodology. When a surgical procedure is performed in an ASC and billed with the SG modifier, OWCP pays 200% of the applicable MPFS rate for that procedure. ASC facility services must be billed on the OWCP-1500 form, and the SG modifier is required on ASC bills for surgical procedure codes.

Certain services or items (such as implants, select supplies, or ancillary services designated as separately payable) may receive additional reimbursement if OWCP policy allows. Standard OWCP billing rules, including multiple procedure rules, bilateral procedure rules, and modifier requirements, apply when determining the final allowable payment.

OWCP determines which surgical procedures are ASC payable by referencing CMS ASC guidelines and using CMS's ASC addenda for clinical alignment and bundling guidance. These resources help identify which procedures are considered surgical, which are packaged, and when separate payment may be appropriate. Providers may consult CMS's publicly available files to identify surgical and ancillary service classifications:

- ASC Covered Surgical Procedures (CMS Addendum AA)
- ASC Covered Ancillary Services (CMS Addendum BB)

These addenda can be accessed through the links provided in the Helpful Links section of this document.

3.7 Inpatient Services

Typically, inpatient care requires an overnight stay in a hospital or other care setting, and is associated with more serious surgeries, procedures, and care that necessitate at least one overnight stay. Inpatient hospital services provided under OWCP are grouped and priced using the 3M Core Grouping Software and follow a reimbursement schedule based on CMS Inpatient Prospective Payment System (IPPS). The IPPS assigns services to diagnostic-related groups (DRGs) and adjusts rates for individual hospitals based on their specific cost index. OWCP uses 3M software in line with CMS payment methodologies. For inpatient services not covered by CMS IPPS, reimbursement is based on a formula using the cost-to-charge ratio (CCR) data tables published annually by CMS for rural and urban hospitals in each state.

Hospital-based inpatient services should be billed on the UB-04 form, including RCCs, International Classification of Diseases (ICD) diagnostic and procedure codes, and the hospital's Medicare number. Physician professional services should be coded and billed separately on Form CMS-1500/OWCP-1500.

Appendix D details the methodology for inpatient reimbursements.

3.8 Home Health Care

The HHC fee schedule provides rates payable for authorized services, deemed necessary and medically appropriate for care within the claimant's home for a covered and accepted medical condition. The HHC Fee Schedule shows the maximum allowable rate per unit for each applicable service code, when a rate is available.

3.9 Anesthesia

OWCP will reimburse anesthesia services provided by a qualified anesthesiologist, physician, Certified Registered Nurse Anesthetist (CRNA), or an Anesthesiologist's Assistant, if they are related to the conditions accepted by OWCP.

Anesthesia involves the administration of a drug or gas to induce partial or complete loss of consciousness. All anesthesia services must be billed using the appropriate CPT five-digit procedure code along with the relevant modifier codes: AA, G8, G9, GC, QS, QY, QK, AD, QX, or QZ. Surgery codes are not appropriate for billing anesthesia services.

Anesthesiologists and CRNAs must bill separately for anesthesia services they personally perform. In cases where medical direction is provided, both the anesthesiologist and the CRNA should bill OWCP for their respective components of the procedure, each using the appropriate anesthesia modifier.

OWCP anesthesia CFs are determined for each locality where services are performed. A single CF is applied to all qualified anesthesia practitioners, including both physicians and non-physicians. When multiple anesthesia practitioners from the same group are involved in a procedure, one practitioner may perform the pre-anesthesia exam while another provides medical direction and post-anesthesia care. Medical records must clearly indicate the name of the practitioner who performed each specific service.

The formula for calculating maximum allowable rate for anesthesia services is:

(Times Units + Base Units) x CF = MAA

Time Units

Anesthesia time begins when the Anesthesiologist starts to prepare the patient for the procedure. Normally, this service takes place in the operating room, but in some cases, preparation may begin in another location (i.e., holding area). Anesthesia time is measured in minutes from the start to the end of anesthesia service. Anesthesia time may include periods before and after an interruption if the practitioner provides continuous anesthesia care throughout these intervals.

This policy requires reporting of actual minutes spent from the time the Anesthesiologist or CRNA begins to prepare the patient for induction and ending when the patient is safely placed under post-

operative supervision and the Anesthesiologist or CRNA is no longer in personal attendance. Time units will be calculated from the number of anesthesia minutes reported in locator 24G of the OWCP-1500 form or electronic equivalent.

Base Units:

The OWCP uses the anesthesia base unit values that CMS assigns to each anesthesia procedure code, including the usual pre-operative, post-operative, and evaluation services. The base unit is used to determine a portion of the reimbursement amount of the anesthesia procedure.

Note: Anesthesia base units are automatically calculated and should not be reported on the claim form.

Conversion Factors

OWCP anesthesia conversion factors are determined for each locality where services are performed. A single conversion factor will be used for all qualified anesthesia practitioners (e.g., physician and non-physician).

When all anesthesia practitioners involved in a procedure are associated in the same group, one practitioner may provide the pre-anesthesia exam, and the other practitioner can perform the medical direction and post-anesthesia care. Medical records must indicate the name of the practitioner who performed the specific service.

For additional information, please refer to the Helpful Link titled "Anesthesia Procedure Codes with Base Units, Zip Code Conversion Factors and Anesthesia Modifiers". Please refer to Appendix F for examples of how to calculate Anesthesia service rates.

3.10 Pharmacy

The scope of pharmacy services encompasses various critical elements that contribute to safe, effective, and cost-conscious medication use.

3.10.1 FECA Pharmacy Reimbursement

Pharmacy providers are reimbursed from the FECA Pharmacy Benefit Manager (PBM). Pharmacy providers may inquire about reimbursement and joining the network by directly reaching out to the FECA PBM listed in the Helpful Links section of this document.

3.10.2 Energy and Black Lung Pharmacy Fee Schedule

Effective August 1, 2024, OWCP began calculating the maximum allowable fee for pharmacy billings of prescription drugs using a formula, which differentiates between brand name drugs, generic drugs, and compounded drugs. The maximum allowable fee for brand name drugs is 85% of the Average Wholesale Price (AWP) plus a $4.00 dispensing fee, the maximum allowable fee

for generic drugs will be 60% of the AWP plus a $4.00 dispensing fee, and the maximum allowable fee for compounded drugs is 30% of the AWP plus a $4.00 dispensing fee.

3.11 Dental

The American Dental Association (ADA) Dental Claim Form should be used for all dental bills, including those of oral surgeons, when submitting paper claims. The ADA Dental Claim Form may also be uploaded as an attachment when billing electronically. The Dental Fee Schedule shows the maximum allowable rate per unit for each applicable service code, when a rate is available.

3.12 Prompt Pay

The Prompt Payment Act (PPA) is a law that requires federal agencies to pay claims in a timely manner. Prompt Pay claims are adjudicated within 21 calendar days of receipt.

3.13 Dialysis Services

Dialysis is a medical treatment that removes waste products and excess fluid from the blood in place of kidney function. As noted in Section 3.5, dialysis centers are excluded from OPPS pricing. Dialysis facility services must be billed on the OWCP-04 form using the appropriate RCC and corresponding service code. Professional services must be billed separately on the OWCP-1500 form.

3.13.1 Unlisted Dialysis Procedure Code (90999)

Effective July 1, 2026, CPT code 90999 (Unlisted Dialysis Procedure), reimbursing at a maximum allowable rate per billing unit. Code 90999 should only be used when no other, more specific dialysis code accurately describes the procedure performed. The following maximum allowable amounts and utilization restrictions apply:

Procedure	Modifier	MAA
Hemodialysis	D8*	$1,408.55
Peritoneal Dialysis (incl. CAPD/CCPD)	-	$603.66

**Modifier D8 is an OWCP internal code and is required when billing for hemodialysis services, to be used with the appropriate RCC and CPT 90999.*

3.14 Appeals

If OWCP reduces a fee or does not reimburse an amount that is satisfactory to the provider or claimant, they may request reconsideration of the reimbursement amount. An appeal can be submitted to request a review of the reimbursement, and it must be filed within 30 calendar days of the initial payment. More information about specific appeal processes is available in the Helpful

Links section. The Fee Schedule Appeal Form (OWCP-FSA) can also be found on the Medical Bill Processing Portal page under the Forms and References link.

3.15 Charges in Excess of the Maximum Allowable

A provider must charge OWCP their lowest fee charged to the public. The OWCP fee schedule is not to be used to establish billing rates. If OWCP partially pays a provider's fee because their rates exceed the MAA, the provider must not seek reimbursement from the claimant. Such actions could lead to the provider's exclusion from participation, with exclusions reported to the Department of Health and Human Services (HHS) National Practitioner Data Bank.

Not all services have an MAA. Those services, if covered, are paid as billed and are subject to review to ensure their appropriateness.

4. APPENDIX

Pricing examples given in this document are for purposes of illustration only and reflect RVU and GPCI values that are subject to change.

A. Medical Physician Fee Schedule Examples

To determine the MAA under the Medical Physician Fee Schedule, determine the service code's RVU's and CF and the Zip Code's GPCI.

The Medical Physician Fee Schedule uses three RVUs:

- Work RVU (Wrvu) - reflecting the relative time, skillset, and intensity associated with providing a service.
- Practice Expense RVU (PErvu) - reflecting the cost, such as renting office space and buying equipment.
- Malpractice RVU (MPrvu) - reflecting the relative costs of malpractice insurance.

The Medical Physician Fee Schedule also uses three GPCIs:

- Work (w gpci)
- Practice Expense (pe gpci),
- Mal-practice Expense (mp gpci).

The Medical Physician Fee Schedule formula for Non-Facility and Facility billing in full is:

Non-Facility Example

$$[(W_{rvu} \times W_{gpci}) + (PE_{rvu} \times PE_{gpci}) + (MP_{rvu} \times MP_{gpci})] \times CF = MAA$$

Wrvu	:	Work relative value units
Wgpci	:	Work geographic practice cost index value
PErvu	:	Non-facility practice expense relative value units
PEgpci	:	Practice expense geographic practice cost index value
MPrvu	:	Mal-practice relative value units
Mpgpci	:	Mal-practice geographic practice cost index value
CF	:	Conversion Factor
MAA	:	Maximum Allowable Amount

EXAMPLE: CPT 11451- Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair

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

CPT 11451 RVU:	Work	4.43
	Non-facility Practice expense	10.41
	Mal-practice expense	0.95

Locality Name: DC+MD/VA Suburbs (Zip code 20002)

Work	1.054
Practice expense	1.178
Mal-practice expense	1.113

Conversion Factor = 64.80417

CALCULATION:
[(4.43×1.054) + (10.41×1.178) + (0.95×1.113)] × 64.80417 = $1,165.03

Facility Example

$$[(W_{rvu} \times W_{gpci}) + (PE_{rvu} \times PE_{gpci}) + (MP_{rvu} \times MP_{gpci})] \times CF = MAA$$

Wrvu	:	Work relative value units
Wgpci	:	Work geographic practice cost index value
PErvu	:	Facility practice expense relative value units
PEgpci	:	Practice expense geographic practice cost index value
MPrvu	:	Mal-practice relative value units
Mpgpci	:	Mal-practice geographic practice cost index value
CF	:	Conversion Factor
MAA	:	Maximum Allowable Amount

EXAMPLE: CPT 11451: Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair

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

CPT 11451 RVU:	Work	4.43
	Facility Practice expense	4.64
	Mal-practice expense	0.95

Locality Name: DC+MD/VA Suburbs (Zip code 20002)

Work	1.057
Practice expense	1.192
Mal-practice expense	1.168

Conversion Factor = 64.80417

CALCULATION:
[(4.43×1.057) + (4.64×1.192) + (0.95×1.168)] × 64.80417 = $733.78

B. Outpatient ASC Fee Example

The formula for Outpatient ASC facility billing is:

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

Wrvu	:	Work relative value units
Wgpci	:	Work geographic practice cost index value
PErvu	:	Facility practice expense relative value units
PEgpci	:	Practice expense geographic practice cost index value
MPrvu	:	Mal-practice relative value units
MPgpci	:	Mal-practice geographic practice cost index value
CF	:	Conversion Factor
MAA	:	Maximum Allowable Amount

EXAMPLE: CPT 11451: Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair

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

CPT 11451 RVU:	Work	4.32
	Facility Practice expense	4.26
	Mal-practice expense	1
Locality Name: DC+MD/VA Suburbs (Zip code 20002)		
	Work	1.054
	Practice expense	1.178
	Mal-practice expense	1.113

Conversion Factor = 64.80417

CALCULATION:
[(4.32×1.054) + (4.26×1.178) + (1×1.113)] × 64.80417 = $692.40 x 200% = $1,384.80

C. Inpatient Services Examples

Cost-To-Charge Ratio

- Cost to Charge (CCR) Ratio Hospitals Services not subject to the Medicare Inpatient Prospective Pay System (IPPS). Ex. Rehabilitation, and Long-Term Care (LTC)

- OWCP applies a CCR ratio formula that is based on CMS case-weighted data for hospital operating and capital costs per state. All IPPS-exempt hospitals in the state are paid at the same ratio.

Facilities Paid as Billed

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

Acute Care Facilities

The payment for acute care hospital services under the CMS Inpatient Prospective Payment System (IPPS) will follow this process:

Medicare allowable amount is derived from the 3M Core Grouping Software and follows a reimbursement schedule based on CMS Inpatient Prospective Payment System (IPPS Although, Medicare beneficiaries are responsible for paying the Part A inpatient hospital deductible and the coinsurance amount, OWCP does not require claimants to pay a deductible or coinsurance.

OWCP Inpatient Payment Formula

- OWCP MAA = OWCP maximum allowable payment.
- Length of Stay (LOS) = The claimant's length of stay.
- MA = Medicare allowable amount, calculated using the latest version of the 3M Pricer software that matches the discharge date.
- OWCP Multiplier = 1.33333
- CMS Part A deductible = $1,676
- CMS Co-Insurance:
    - If 90 days or less = $419
    - If greater than 90 days = $838

Calculation Example 1:

<u>LOS is less than or equal to 60 days use the formula below.</u> For this example, the MA = $12,500.

(MA x 1.33333) + CMS Deductible = OWCP MAA

($12,500 × 1.33333) + $1,676 = **$18,342.63**

Calculation Example 2:
If LOS is greater than 60 days but less than or equal to 90 days use the formula below. For this example, the LOS = 65 and the MA = $12,500.

(MA x 1.33333) + CMS Deductible + [(LOS – 60) x CMS Co-Insurance] = OWCP MAA

($12,500 x 1.33333) + $1,676 + (65-60) x $419 = **$20,437.63**

Calculation Example 3:

If LOS is greater than 90 days use the formula below. For this example, the LOS = 95 and the MA = $12,500.

(MA x 1.33333) + CMS Deductible + (30 x CMS Co-Insurance 90 days or less) + (LOS – 90) x CMS Co-Insurance greater than 90 days = OWCP MAA

($12,500 × 1.33333) + $1,676 + (30 x $419) + [(95-90) × $838] = **$35,102.63**

D. Anesthesia Example

Reimbursement Example:

(Time Units + Base Units) x CF = Allowance

Code: 00830
Modifier: AA
Time: 120 minutes
Locality: Dallas (zip code 75201)
Time: 120 minutes = 120 ÷ 15 = 8 units
Code: 00830, base units + 4 units
12 units

Conversion factor, Dallas = 70.18
Total units = 12 x 70.18 = $842.16
The physician's maximum allowed amount = $842.16

E. Online Fee Schedule Tables

The descriptions below refer to the latest Fee Schedule table formats. For questions about the tables or service codes, see the General Contact Information at the start of this document.

General Fee Schedule Tables Information

Each Fee Schedule has a dedicated webpage displaying all previously released fee schedule tables and the latest one. The information appears as bullet points, with the most current document listed first.

1. Anesthesia Procedure Codes with Base Units, Zip Code Conversion Factors and Anesthesia Modifiers Template

Anesthesia Fee Schedule	
Worksheet Tab	**Column Descriptions**
Base Units	*CPT* – Service Codes *Short Description* – AMA CPT short descriptions *Unit* – Base units
Conversion Factor	*Zip Code* – United States & Territorial zip codes *Locality Name* – Regional name associated with preceding adjacent column zip code *State* – State or Territory abbreviation *Conversion Factor* – Anesthesia conversion factors currently in use by corresponding region
Modifiers	*Modifier* – Anesthesia Modifiers *Description* – Anesthesia Modifier descriptions *Required* – Yes/No indicator for modifier use in accordance with description *Payment Adjustment* – Payment instructions impacting percentage rates based on description

2. List of Surgical Procedures Allowed for Facility Fee Payment to Ambulatory Surgery Center Template

Ambulatory Surgery Center Allowed Procedures	
Worksheet Tab	**Column Descriptions**
Surgical Procedures	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Modifiers* – two-character code added to a HCPCS/CPT service code that adds additional information about a medical procedure, service or supply *Short Description* – AMA HCPCS/CPT short descriptions of the respective service code

	Subject to Multiple Procedure Discounting – This applies when two or more surgical procedures are performed during same operative session. *Separate Payment* – Procedures subject to separate payment to related surgical procedures
Ancillary Procedures	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Modifiers* – two-character code added to a HCPCS/CPT service code that adds additional information about a medical procedure, service or supply *Short Description* – AMA HCPCS/CPT short descriptions of the respective service code *Separate Payment* – Procedures subject to separate payment to related surgical procedures

3. Cost to Charge Ratio Tables for Inpatient Non-PPS Hospital Services Template

Cost to Charge Ratio for Inpatient Hospital Services	
Worksheet Tab	**Column Descriptions**
CCR	*State* – State and/or Territory with available Cost to Charge Ratio *Cost to Charge Ratio* – This is a calculation dividing a hospital's total costs by total charges based on data from healthcare cost reports.

4. Medical Physician Fee Schedule Template

Medical Physician Fee Schedule	
Worksheet Tab	**Column Descriptions**
MPFS	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Maximum Allowable* – Maximum fee for the service code. *Modifier* - two-character code added to a HCPCS/CPT service code that adds additional information about a medical procedure, service or supply. *Work RVU* – Physician's professional work to perform medical service. *Non-Facility PE RVU* – Overhead costs associated with providing medical services in a non-facility setting. *Facility PE RVU* – Overhead costs associated with providing medical services in a facility setting *MPE RVU* – Cost of malpractice insurance for each procedure or service. *Conversion Factor – OWCP's* multiplier used to convert a service's RVU into a final payment. *Global Factor* – The conversion factor used to adjust the payment rates for services provided by healthcare providers

	Short Description – AMA HCPCS/CPT short descriptions of the respective service code

5. Clinical Laboratory Template

Clinical Diagnostic Laboratory Fee Schedule	
Worksheet Tab	**Column Descriptions**
OWCP	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Modifier* - two-character code added to a HCPCS/CPT service code that adds additional information about a medical procedure, service or supply. *Rate* – The established fee rate for a service code. *Short Description* – AMA HCPCS/CPT short descriptions of the respective service code.

6. Physician-Administered Drugs and Biologicals Template

Physician Administered Drugs and Biologicals Fee Schedule	
Worksheet Tab	**Column Descriptions**
OWCP	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Short Description* – AMA HCPCS/CPT short descriptions of the respective service code. *Service Code Dosage* – Medicinal dosage for respective service code. *Payment Limit* – The established fee rate limit for a service code

7. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Template

Durable Medical Equipment and Prosthetics, Orthotics, and Supplies Fee Schedule	
Worksheet Tab	**Column Descriptions**
DMEPOS	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Modifier* - two-character code added to a HCPCS/CPT service code that adds additional information about a medical procedure, service or supply. *Rate* – The established fee rate for a service code. *Short Description* – AMA HCPCS/CPT short descriptions of the respective service code.

8. Home Health Care Template

Home Health Care Fee Schedule

Worksheet Tab	Column Descriptions
Updated HHC List	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Rate* – The established fee rate for a service code. *Short Description* – AMA HCPCS/CPT short descriptions of the respective service code.

9. Dental Fee Schedule Template

Dental Fee Schedule	
Worksheet Tab	**Column Descriptions**
Dental	*Service Code* – HCPCS/CPT Medical Procedural Service Codes *Rate* – The established fee rate for a service code. *Short Description* – AMA HCPCS/CPT short descriptions of the respective service code.

5. ACRONYM GLOSSARY

ACRONYM	DEFINITION
ADA	American Dental Association
AMA	American Medical Association
AOC	Add-on Code
APC	Ambulatory Payment Classifications
ASC	Ambulatory Surgical Centers
AWP	Average Wholesale Price
BLBA	Black Lung Benefits Act
CCR	Cost-to-Charge Ratio
CDT	Current Dental Terminology
CF	Conversion Factor
ClinLab	Clinical Laboratory
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology. It is a medical code set maintained by the American Medical Association (AMA) and is used to describe medical, surgical, and diagnostic services performed by healthcare professionals. CPT codes are numeric and alphanumeric and are used for billing purposes, enabling healthcare providers to communicate standardized information about the services they provide to insurance companies and other payers. CPT codes are widely used in the United States healthcare system for reimbursement, tracking healthcare services, and conducting research.
CRNA	Certified Registered Nurse Anesthetists
DCMWC (Black Lung)	Division of Coal Mine Workers' Compensation
DDE	Direct Data Entry
DEEOIC (Energy)	Division of Energy Employees Occupational Illness Compensation
DFEC (FECA)	Division of Federal Employees' Compensation
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOL	Department of Labor
DRGs	Diagnostic-Related Groups
EDI	Electronic Data Interchange
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
FECA	Federal Employees' Compensation Act
FQHC	Federally Qualified Health Centers
GPCI	Geographic Practice Cost Index

HCPCS	HCPCS Healthcare Common Procedure Coding System. It is a standardized coding system used in the United States for describing and identifying medical services and procedures provided by healthcare professionals. These codes are alphanumeric and cover a wide range of healthcare services, supplies, and equipment.
HHC	Home Health Care
HHS	U.S. Department of Health and Human Services
ICD	International Classification of Diseases
IPPS	Inpatient Prospective Payment System
LHWCA	Longshore and Harbor Workers' Compensation Act
LOS	Length Of Stay
LTC	Long Term Care
MAA	Maximum Allowable Amount
MP	Malpractice Expense
MP GPCI	Mal-practice Geographic Practice Cost Index Value
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative
OPPS	Outpatient Prospective Payment System
OWCP	Office of Workers' Compensation Programs
PA	Prior Authorization
PADB	Physician-Administered Drugs and Biologicals
PBM	Pharmacy Benefit Manager
PE	Practice Expense
PE GPCI	Practice Expense Geographic Practice Cost Index Value
PPA	Prompt Pay Act
PTP	Procedure-to-Procedure
RBRVS	Resource-Based Relative Value Scale
RCC	Revenue Center Code
RVU	Relative Value Units
SFTP	Secured File Transfer Process
UB-04	Universal Billing Form 04
UR	Utilization Restrictions
W	Work Expense
W GPCI	Work Geographic Practice Cost Index Value
WCMBP	Workers’ Compensation Medical Bill Processing

Helpful Links

OWCP Fee Schedules Overview
OWCP Medical Bill Processing Portal
Fee Schedule Calculator Quick Reference Guide
Fee Schedule Frequently Asked Questions
Provider Manual
OWCP Appeals vs. Adjustments Tips
Fee Schedule Appeal Request Form