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

Fee Schedule Read Me First Document

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GENERAL CONTACT INFORMATION

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CONDUENT

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NOTICE

The document outlines the accepted coding schemes for billing medical procedures and services including durable medical 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) ©
- The 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, Current Dental Terminology (CDT) ©
- Revenue Center Codes (RCC)
- U.S. Department of Labor's OWCP unique and exclusive codes

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

For the ease of the reader, CPT, HCPCS, RCCs, CDTs, and OWCP unique and exclusive codes will be referred to as *service codes* in this document.

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 OWCP. 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 examples, appendices, and references to key fee schedule formulas for medical, Ambulatory Surgical Center (ASC), Anesthesia, and Inpatient services.

2. CLAIMS PROCESSING

2.1 General Information

This section provides general claims processing information and guidelines for the OWCP. It offers an overview of components involved in the processing of medical related claims. The OWCP fee schedules are 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 resources required to provide each service, considering geographical differences and economic changes. Fees may increase or decrease based on updates to the relative value of services, regional cost adjustments, and changes in economic factors affecting medical practice. 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 program under the Federal Employees' Compensation Act, which is required for all FECA claimants. 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

The 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) is 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

Utilization Restrictions (UR) are policies designed to regulate the number of units that can be reimbursed 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.

2.2 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 written compensation program 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 are requesting 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 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, Physician-Administered Drugs and Biologicals (also known as Average Sale Price), DMEPOS, Outpatient Services, ASC, Inpatient Services, Pharmacy, Dental, 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 Fee Schedule

The OWCP Medical 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, DME, and various other healthcare services. The Medical Fee Schedule determines the reimbursement rates for these services 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 Fee Schedule also considers geographic variations in practice costs and updates annually to reflect changes in medical practice and economic conditions.

The Medical Fee Schedule is generally released annually, with additional 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 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. The 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.

3.2 Clinical Laboratory Services

Clinical Laboratory (Clin Lab) 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 fixed 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 fixed rate assigned to each drug or biological, calculated per billing unit.

3.4 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 determined based on Ambulatory Payment Classifications (APCs). Black Lung does not utilize OPPS pricing rule for Outpatient Services, instead OWCP Fee Schedule is used. 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 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 Fee Schedule methodology.

3.4.1 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.

3.4.2 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.

3.5 Ambulatory Surgical Center (ASC)

ASCs provide surgery without requiring an overnight stay and are not connected to a hospital. Facility charges should be billed on the CMS-1500/OWCP-1500 using the appropriate service codes for the primary, secondary, tertiary, etc., procedures, with the "SG" modifier applied to each service code.

The maximum reimbursement amount for any covered ASC surgical procedure is 200% of the MAA rate, based on the Medical Fee Schedule methodology, not considering any other system logic that may reduce the MAA (e.g., cut-back logic).

Prior authorization for elective procedures, as well as appropriateness for the accepted condition and other program requirements, must be met. Outpatient professional services should be billed separately using the appropriate service codes.

The list of covered ASC procedures can be found in the “Helpful Links” section. However, inclusion on this list does not guarantee automatic payment. Please refer to Appendices B and C for examples of how to calculate ASC service rates.

3.5.1 ASC Facility Charges

Facility fees for procedures performed in freestanding ambulatory surgical centers are paid based on the service code for the surgical procedure(s) performed. Bills should be submitted on the Form CMS-1500/OWCP–1500, with each surgical procedure indicated by the appropriate service code and the OWCP modifier “SG” to denote that the facility fee is being charged. Payment rates are adjusted when multiple surgical procedures are performed, with the adjustment criteria allowing 100% of the MAA for the highest-priced procedure and 50% of the MAA for secondary, tertiary, and all other procedures. Actual payment is based on the calculated payment rate or the billed charge, whichever is less.

These payment rates, established under the OWCP medical fee schedule, apply only to facility charges. They do not include physician fees, anesthesiologist fees, or fees for other professional providers who render ambulatory surgery procedures and bill independently. Professional fees must be submitted separately from facility fees. The payment rate does not cover laboratory tests, x-rays, or diagnostic procedures not directly related to the surgical procedure. Charges for non-surgical diagnostic services must also be submitted separately from facility fees. Furthermore, the payment rate does not apply to surgically implanted prosthetic devices, ambulance services, leg, arm, and back braces, artificial limbs, or durable medical equipment for home use. Charges for DMEPOS must be submitted separately from facility fees and accompanied by copies of the vendor's invoice.

3.5.2 ASC Services Included in the Facility Payment

Facility payments for ASCs cover several services that are not paid separately, including:

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

3.5.3 ASC Services Not Included in the Facility Payment

Facility payments for ASCs do not cover the following services, which may be paid separately:

- Professional services, including those provided by physicians
- Laboratory services
- X-ray or diagnostic procedures not directly related to the surgical procedure
- Prosthetics and implants, except for intraocular lenses
- Ambulance services
- Leg, arm, back, and neck braces
- DME for use in the patient's home

3.5.4 Spinal Injections

Injection procedures are billed in the same manner as other surgical procedures with the following considerations:

1. For the purpose of multiple procedure discounting, each procedure in a bilateral set is considered a single procedure.

2. For injection procedures that require fluoroscopic localization and guidance, ASCs may no longer bill separately for the technical component of the radiological CPT code (e.g., 77003 –TC). Payment for these codes is bundled into the payment for the primary procedure.

3.6 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 the 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.

3.7 Anesthesia

OWCP will reimburse anesthesia services provided by a qualified anesthesiologist, physician, Certified Registered Nurse Anesthetist (CRNA), or an Anesthesiologist's Assistant (AA) if they are related to the condition(s) 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 anesthesia five-digit procedure code along with the relevant modifier codes: AA, QY, QK, AD, QX, or QZ. Surgery codes are not appropriate for billing anesthesia services.

Anesthesiologists and CRNAs must bill separately for the 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 for anesthesia 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 a continuous time period, in minutes, from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

OWCP will assign one (1) time unit when the total anesthesia time is equal to or less than 15-minutes. When calculating time units beyond the first 15 minutes, OWCP will utilize the rule of significant figures for rounding off to the closest whole number. Tenths of units from zero to four are rounded to zero; tenths from 5 to 9 are rounded up to the next whole number. 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 has adopted the anesthesia base unit values that CMS has assigned to each anesthesia procedure code and reflects the difficulty of the anesthesia services, including the usual pre-operative and post-operative care and evaluation. 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.

- When time units calculate to a number with a decimal time unit of .4 or lower the unit is rounded down to the closest whole number.

- When time units calculate to a number with a decimal time unit of .5 or higher the unit is rounded up to the next whole number.

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.

3.8 Pharmacy

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

3.8.1 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.

3.8.2 Energy and Black Lung Pharmacy Fee Schedule

Effective August 1, 2024, the Office of Workers' Compensation Programs (OWCP) began calculating the maximum allowable fee for pharmacy billings of prescription drugs using a formula, which differentiates between brand name drugs, 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.

3.9 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.

3.10 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.

3.11 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 on the program's webpages 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.

3.12 Charges in Excess of the Maximum Allowable

A provider must charge OWCP their lowest fee charged to the general 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 Fee Schedule Examples

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

The Medical Fee Schedule uses three RVU's:

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

The Medical Fee Schedule also uses three GPCIs:

- Work (w gpci)
- practice expense (pe gpci),
- mal-practice expense (mp gpci).

The Medical 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	10.43
	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 = 64.48

CALCULATION:
$[(4.43 \times 1.057) + (10.43 \times 1.192) + (0.95 \times 1.168)] \times 64.48 = \$1,175.13$

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 = 64.48

CALCULATION:
$[(4.43\times1.057) + (4.64\times1.192) + (0.95\times1.168)] \times 64.48 = \$730.11$

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	4.43
	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 = 64.48

CALCULATION:
[(4.43×1.057) + (4.64×1.192) + (0.95×1.168)] × 64.48 = $730.11 x 200% = $1,460.21

C. ASC Related Modifier Example

OWCP will accept all valid CPT and HCPCS modifiers, however, all modifiers do not affect payment.

Modifier -50, bilateral modifier

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using a single line item for each procedure performed and append modifier -50 to indicate that a procedure was performed bilaterally. The bilateral procedure will be paid at 200% + 50% of the allowed amount for that procedure.

Example: Bilateral Procedure, Modifier -50, Chicago, IL. (zip code 60523)

Line Item on Bill	CPT Code	Maximum Allowable	Bilateral Policy Applied	Max Allowable Amount
1	64721-SG-50	$1,628.87	$2,443.30*	$2,443.30*
**Bilateral Procedure is paid at 150% of maximum allowed amount*				

Modifier -51, multiple surgical procedures modifier, Chicago, IL. (zip code 60523)

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -51 should be applied to the second and subsequent line items. The total payment equals

the sum of 200% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus 50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

Example: Multiple Procedure, Modifier -51, Chicago, IL. (zip code 60523)

Line Item on Bill	CPT Code	Maximum Payment	Multiple Procedures Policy Applied	Allowed Amount
1	29881-SG	$2,020.37		2020.37*
2	64721-SG-51	$1,628.87	$814.43	814.43**
** Highest valued procedure is paid at 200% of maximum allowed amount.*				
*** When applying the multiple procedure payment policy, the secondary procedure billed with a modifier -51 is paid at 50% of the maximum allowed amount for that line item.*				
**** Represents sum of allowed amounts for line 1 + line 2.*				

D. 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 a state are paid at the same ratio.
- Formula:
  $\frac{((\text{CMS State Operating CCR} + \text{CMS State Capital CCR}) \times \text{Billed Amount})}{} \times 1.26 = \text{OWCP Maximum Allowable}$

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

Effective January 1, 2025, 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 follow 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

- A = 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:

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

(MA x 1.33333) + CMS Deductible = A

($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] = A

($12,500x 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 = A

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

E. Anesthesia Example

Reimbursement Example:

(Time Units + Base Units) x CF = Allowance

(This is an example only. Providers should check their current anesthesia conversion factors for correct fee amounts.)

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 = 52.03
Total units = 12 x 52.03 = $624.36
The physician's maximum allowed amount = $624.36

5. ACRONYM GLOSSARY

ACRONYM	DEFINTION
AA	Anesthesia Assistant
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.
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 Program
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

Site Reference	Links
Medical Bill Processing Portal	Medical Bill Processing Portal | Office of Workers' Compensation Programs (dol.gov)
FECA Program Page	Federal Employees' Compensation Program | U.S. Department of Labor (dol.gov)
Black Lung Program Page	Black Lung Program | U.S. Department of Labor (dol.gov)
Energy Program Page	Energy Workers Program | U.S. Department of Labor (dol.gov)
Energy & Black Lung Pharmacy (Conduent)	Pharmacy Bill Processing Portal - Home (dol.gov)
FECA Pharmacy (Optum)	Pharmacy Benefits Management Portal (dol.gov)
Fee Schedule Calculator Quick Reference Guide	CR 174 - Fee Schedule Calculator QRG (dol.gov)
OWCP WCMBP Provider Manual	WCMBP Provider Manual (dol.gov)
Prior Authorizations	WCMBP Provider Manual (dol.gov)
Prior Authorizations for Non Formulary and Opioid Prescriptions	FECA Bulletins (2020-2024) | U.S. Department of Labor (dol.gov)
FECA Information for Providers	Information for Medical Providers | U.S. Department of Labor (dol.gov)
FECA Appeals	Procedure Manual | U.S. Department of Labor (dol.gov)
Energy Appeals	Federal EEOICPA Procedure Manual | U.S. Department of Labor
Black Lung Appeals	General | OFFICE OF WORKERS' COMPENSATION PROGRAMS (dol.gov)
Energy Procedure Manual	Federal EEOICPA Procedure Manual | U.S. Department of Labor
FECA Procedure Manual	DFEC Procedure Manual | U.S. Department of Labor (dol.gov)
Black Lung Procedure Manual	DCMWC Procedure Manual | U.S. Department of Labor (dol.gov)
Forms and References	General | OFFICE OF WORKERS' COMPENSATION PROGRAMS (dol.gov)
Centers for Medicare & Medicaid Services	Home - Centers for Medicare & Medicaid Services | CMS
Anesthesia Procedure Codes with Base Units, Zip Code Conversion Factors and Anesthesia Modifiers	
List of Surgical Procedures Allowed for Facility Fee Payment to Ambulatory Surgery Center	OWCP Fee Schedules | U.S. Department of Labor

Cost to Charge Ratio Tables For Inpatient Non-PPS Hospital Services	
RCC Codes Requiring CPT/HCPCS, ADA & OWCP Codes With RVU and Conversion Factors	
CPT, HCPCS, ADA & OWCP Codes With RVU and Conversion Factors	
Clinical Laboratory Services	
Physician-Administered Drugs and Biologicals	
Geographic Practice Cost Indices by Zip Code	
Modifier Level Table for Quick Reference	