

FECA: 20 C.F.R. § 10.801 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to injured employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 10.800. The physician or provider shall itemize the charges on the standard Health Insurance Claim Form, HCFA 1500 or OWCP 1500, (for professional charges), the UB-92 (for hospitals), the Universal Claim Form (for pharmacies), or other form as warranted, and submit the form promptly to OWCP.

(b) The provider shall identify each service performed using the Physician's Current Procedural Terminology (CPT) code, the Health Care Financing Administration Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC), or the Revenue Center Code (RCC), with a brief narrative description. Where no code is applicable, a detailed description of services performed should be provided.

(c) The provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the "International Classification of Disease, 9th Edition, Clinical Modification" (ICD-9-CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment or monthly, if treatment for the work-related condition is necessary for more than 30 days.

(1)(i) Hospitals shall submit charges for medical and surgical treatment or supplies promptly to OWCP on the Uniform Bill (UB-92). The provider shall identify each outpatient radiology service, outpatient pathology service and physical therapy service performed, using HCPCS/CPT codes with a brief narrative description. The charge for each individual service, or the total charge for all identical services, should also appear in the UB-92.

(ii) Other outpatient hospital services for which HCPCS/CPT codes exist shall also be coded individually using the coding scheme noted in this paragraph. Services for which there are no HCPCS/CPT codes available can be presented using the RCCs described in the "National Uniform Billing Data Elements Specifications", current edition. The provider shall also furnish the diagnostic code using the ICD-9-CM. If the outpatient hospital services include surgical and/or invasive procedures, the provider shall code each procedure using the proper CPT/HCPCS codes and furnishing the corresponding diagnostic codes using the ICD-9-CM.

(2) Pharmacies shall itemize charges for prescription medications, appliances, or supplies on the Universal Claim Form and submit them promptly to OWCP. Bills for prescription medications must include the NDC assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider's billhead stationery and submit them promptly to OWCP.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which reimbursement is sought was performed as described and was necessary. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart concerning the rendering of treatment and/or the process for seeking reimbursement for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: be itemized on the Health Insurance Claim Form (for physicians), the UB-92 (for hospitals), or the Universal Claim Form (for pharmacies); contain the signature or signature stamp of the provider; and identify the procedures using HCPCS/CPT codes, RCCs, or NDCs. Otherwise, OWCP may return the bill to the provider for correction and resubmission.

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EEOICPA: 20 C.F.R. § 30.701 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 30.700. The physician or provider shall itemize the charges on Form OWCP-1500 or CMS-1500 (for professional charges), Form OWCP-92 or UB-92 (for hospitals), Form 79-1A (for pharmacies), or other form as warranted, and submit the form promptly for processing.

(b) The provider shall identify each service performed using the Physician's Current Procedural Terminology (CPT) code, the Centers for Medicare and Medicaid Services Common Procedure Coding System (CCPCS) code, the National Drug Code (NDC), or the Revenue Center Code (RCC), with a brief narrative description. Where no code is applicable, a detailed description of services performed should be provided.

(c) The provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the "International Classification of Disease, 9th Edition, Clinical Modification" (ICD-9-CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment or monthly, if treatment for the occupational illness is necessary for more than 30 days.

(1)(i) Hospitals shall submit charges for medical and surgical treatment or supplies promptly on Form OWCP-92 or UB-92. The provider shall identify each outpatient radiology service, outpatient pathology service and physical therapy service performed, using CCPCS/CPT codes with a brief narrative description. The charge for each individual service, or the total charge for all identical services, should also appear on the form.

(ii) Other outpatient hospital services for which CCPCS/CPT codes exist shall also be coded individually using the coding scheme noted in this section. Services for which there are no CCPCS/CPT codes available can be presented using the RCCs described in the "National Uniform Billing Data Elements Specifications," current edition. The provider shall also furnish the diagnostic code using the ICD-9-CM. If the outpatient hospital services include surgical and/or invasive procedures, the provider shall code each procedure using the proper CCPCS/CPT codes and furnishing the corresponding diagnostic codes using the ICD-9-CM.

(2) Pharmacies shall itemize charges for prescription medications, appliances, or supplies on Form 79-1A and submit them promptly for processing. Bills for prescription medications must include the NDC assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider's billhead stationery and submit them promptly for processing.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which reimbursement is sought was performed as described and was necessary. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart concerning the rendering of treatment and/or the process for seeking reimbursement for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: be itemized on Form OWCP-1500 or CMS-1500 (for physicians), Form OWCP-92 or UB-92 (for hospitals), or Form 79-1A (for pharmacies); contain the signature or signature stamp of the provider; and identify the procedures using CCPCS/CPT codes, RCCs, or NDCs. Otherwise, the bill may be returned to the provider for correction and resubmission.

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BLBA: 20 C.F.R. § 725.405 Development of medical evidence; scheduling of medical examinations and tests.

(a) Upon receipt of a claim, the district director shall ascertain whether the claim was filed by or on account of a miner as defined in Sec. 725.202, and in the case of a claim filed on account of a deceased miner, whether the claim was filed by an eligible survivor of such miner as defined in subpart B of this part.

(b) In the case of a claim filed by or on behalf of a miner, the district director shall, where necessary, schedule the miner for a medical examination and testing under Sec. 725.406.

(c) In the case of a claim filed by or on behalf of a survivor of a miner, the district director shall obtain whatever medical evidence is necessary and available for the development and evaluation of the claim.

(d) The district director shall, where appropriate, collect other evidence necessary to establish:

- (1) The nature and duration of the miner's employment; and
- (2) All other matters relevant to the determination of the claim.

(e) If at any time during the processing of the claim by the district director, the evidence establishes that the claimant is not entitled to benefits under the Act, the district director may terminate evidentiary development of the claim and proceed as appropriate.

BLBA: 20 C.F.R. § 725.406 Medical examinations and tests.

(a) Medical examinations and tests authorized by the deputy commissioner shall be conducted, if possible, in the vicinity of the miner's residence by physicians or in medical facilities selected from a list compiled by the Secretary, or by a physician or medical facility approved by the deputy commissioner at the miner's request.

(b) If any medical examination or test conducted under paragraph (a) of this section is not administered or reported in compliance with the provisions of part 718 of this subchapter, the deputy commissioner shall schedule the miner for further examination and testing where necessary and appropriate.

(c) The cost of any medical examination or test authorized under this section, including the cost of travel to and from the examination, shall be paid by the fund. No reimbursement for overnight accommodations shall be authorized unless the deputy commissioner determines that an adequate testing facility is unavailable within one day's round trip travel by automobile from the miner's residence. The fund shall be reimbursed for such payments by an operator, if any, found liable for the payment of benefits to the claimant.

BLBA: 20 C.F.R. § 725.701 Availability of medical benefits.

(a) A miner who is determined to be eligible for benefits under this part or part 727 of this subchapter (see Sec. 725.4(d)) is entitled to medical benefits as set forth in this subpart as of the date of his or her claim, but in no event before January 1, 1974. No medical benefits shall be provided to the survivor or dependent of a miner under this part.

(b) A responsible operator, other employer, or where there is neither, the fund, shall furnish a miner entitled to benefits under this part with such medical, surgical, and other attendance and treatment, nursing and hospital services, medicine and apparatus, and any other medical service or supply, for such periods as the nature of the miner's pneumoconiosis and disability requires.

(c) The medical benefits referred to in paragraphs (a) and (b) of this section shall include palliative measures useful only to prevent pain or discomfort associated with the miner's pneumoconiosis or attendant disability.

(d) The costs recoverable under this subpart shall include the reasonable cost of travel necessary for medical treatment (to be determined in accordance with prevailing United States government mileage rates) and the reasonable documented cost to the miner or medical provider incurred in communicating with the employer, carrier, or district director on matters connected with medical benefits.

(e) If a miner receives a medical service or supply, as described in this section, for any pulmonary disorder, there shall be a rebuttable presumption that the disorder is caused or aggravated by the miner's pneumoconiosis. The party liable for the payment of benefits may rebut the presumption by producing credible evidence that the medical service or supply provided was for a pulmonary disorder apart from those previously associated with the miner's disability, or was beyond that necessary to effectively treat a covered disorder, or was not for a pulmonary disorder at all.

(f) Evidence that the miner does not have pneumoconiosis or is not totally disabled by pneumoconiosis arising out of coal mine employment is insufficient to defeat a request for

coverage of any medical service or supply under this subpart. In determining whether the treatment is compensable, the opinion of the miner's treating physician may be entitled to controlling weight pursuant to Sec. 718.104(d). A finding that a medical service or supply is not covered under this subpart shall not otherwise affect the miner's entitlement to benefits.

BLBA: 20 C.F.R. § 725.705 Arrangements for medical care.

(a) *Operator liability.* If an operator has been determined liable for the payment of benefits to a miner, the Office shall notify such operator or insurer of the names, addresses, and telephone numbers of the authorized providers of medical benefits chosen by an entitled miner, and shall require the operator or insurer to:

(1) Notify the miner and the providers chosen that such operator will be responsible for the cost of medical services provided to the miner on account of the miner's total disability due to pneumoconiosis;

(2) Designate a person or persons with decision-making authority with whom the Office, the miner and authorized providers may communicate on matters involving medical benefits provided under this subpart and notify the Office, miner and providers of such designation;

(3) Make arrangements for the direct reimbursement of providers for their services.

(b) *Fund liability.* If there is no operator found liable for the payment of benefits, the Office shall make necessary arrangements to provide medical care to the miner, notify the miner and medical care facility selected of the liability of the fund, designate a person or persons with whom the miner or provider may communicate on matters relating to medical care, and make arrangements for the direct reimbursement of the medical provider.