Introduction to Federal Workers’ Compensation

Marianne Cloeren, MD, MPH
Medical Director
Managed Care Advisors, Inc.

Topics

- Who’s covered
- Claims administration
- Types of claims
- FECA nuances
- How to get paid for providing care to injured federal workers

FECA – Who Is Covered?

- Civilian employees of federal agencies
- Excluded:
  - Non-citizens
  - Contractors
  - Active military
FECA Claims Administration

- Department of Labor
  - Employment Standards Administration
  - Office of Workers’ Compensation Programs
  - 12 District Offices
- Each agency has HR personnel responsible for local claims management

FECA Claims Administration

- District Office Administration
  - District Director
    - Claims Manager
    - Senior Claims Examiner
    - Claims Examiner
    - District Medical Advisor
    - Staff Nurse
    - Contract Nurse Case Managers

Responsibilities in FECA Claim Administration

- DOL Claims Examiner:
  - Adjudication
  - Authorization of care
  - Setting up IMEs
  - Claim expansion
  - Vocational rehabilitation referral
  - Claim closure
**Responsibilities in FECA Claim Administration**

- Agency HR compensation specialist
  - Filing claim within 5 days
  - Notifying CE if plan to controvert/challenge
  - Managing pay for early lost time
  - Oversight of limited duty/RTW process

**Types of Claims**

- **CA-1**: Traumatic Injury (develops over course of one shift)
- **CA-2**: Occupational Illness
  - Develops over more than one shift
  - Includes repetitive trauma
- **CA-2A**: Reoccurrence (symptoms/signs of previous accepted condition come back without specific provocation)
- **CA-7**: Lost time

**FECA System Nuances**

- **CA-16** from the agency can authorize emergency care
  - Only valid for acute injuries (not occupational illness)
  - Authorizes catastrophic care
  - Authorizes care for less severe injuries, including diagnostic testing, PT, and specialist referrals
  - Valid for 60 days, or until $1500 reached, or until claim is denied, whichever comes first
FECA System Nuances

- COP - first 45 lost time days are paid by agency
  - continuation of regular pay
- No agency right to appeal claim acceptance
- Little medical oversight/ involvement in claims adjudication
- Employees unable to RTW are able to receive wage replacement until death
- Pay is 2/3 tax-free; ¾ if dependents

FECA System Nuances

- Adjudication limbo
  - Claim is neither accepted nor denied if employee is still working and care is not costing much
  - Accepted for "medical only"
- Agency must notify CE at time claim is filed of intent to challenge or risk early acceptance (no appeal right for employer)

FECA System Nuances

- Employees getting wage replacement fall under different provisions, depending on age of claim and prognosis:
  - COP
  - DR
  - PR
  - PN
FECA System Nuances

- COP – little scrutiny by DOL during this period - best opportunity for agency case management
- DR – regular medical updates needed to support ongoing disability
- PR – annual update required
- PN – update required just once every 3 years – should correspond clinically to permanently totally disabled

FECA System Nuances

- Occupational illness claims
  - CA-35 is checklist of required information to support illness claims
  - CA-16 cannot be used (no authorization of care prior to claim decision)
  - High risk of denial so best to have personal medical insurance back-up plan.
  - COP does not apply so no compensation for lost time unless claim is accepted
  - Usually takes months to adjudicate

FECA System Nuances

- Exposure evaluations
  - E.g. BBP, TB
  - Not covered by FECA by policy, since no compensable condition has occurred
  - First aid for needle stick covered with CA-16 but testing, prophylactic meds, and follow-up are not
  - If condition as result of exposure is diagnosed, claimed and accepted this would be covered.
FECA System Nuances

- **DOL Contract Nurses**
  - "COP nurses" - Telephonic case management when lost days hits 15
  - Field nurses
    - May be assigned by CE
    - May accompany employee to appointments
    - Should work with employer to facilitate safe RTW
    - Can help provider navigate system
    - Usually assigned for 90 day period
    - Often assigned when surgery is planned

Occupational Medicine Roles

- Agency physician/nurse - working for federal agency:
  - Injury care
  - Case management
  - Agency directed medical examination (FFD)
- DOL Second Opinion/IME provider - private contractor with DOL
- Community injury care provider – need to enroll with DOL ACS - simple online process compared to other insurance systems

How to Become a Provider

- **The best way**: [http://owcp.dol.acs-inc.com](http://owcp.dol.acs-inc.com)
  - Click on "Forms and Links"
- Or call 850-558-1818
  - Select enrollment option
  - Request provider packet
Access is Easy

- Call 1-800-461-7485 - this is the helpdesk number for access to DOL bill processing portal.
- You must have your ACS provider number.
- The call associate will walk you through the registration process. This takes 10 minutes.
- Once you have completed the registration process with our assistance your password will be emailed to you within minutes.
- Information about claimant, authorizations and bill are at your finger tips within 20 minutes.

Technical Helpdesk

For issues related to the ACS Medical Bill Processing Web Portal (i.e. passwords)

(800) 461-7485

How to update your provider information?

- Mail address change to: PO Box 14600
  Tallahassee, FL 32317-4600
- Requesting a Tax ID number change must be mailed in. You must identify your old TIN number to be terminated and your new TIN along with a copy of your license.
The Fastest Way to Receive your Payment

- Select EFT and complete the request on the provider application form
- Always use provider number when submitting HCFA or UB's

Provider Enrollment Form:

- Box 1: If the provider is updating their current provider file, the update box must be checked.
- Box 2: This information is not required.
- Box 3-7: The practice name & address (only a physical address is acceptable as the practice address)
- Box 8: The practice telephone number is required.
- Box 9: The practice fax is not required.
- Box 10: The practice type is required.
- Box 11a: The numerical provider type is required.
- Box 11b: The provider type description is required.
- Box 11c: Explanation of services for provider type 96 & 53

Boxes 12-20:
- Box 12: The tax id or SSN is required.
- Box 13: Medicare number is required for all acute medical hospitals.
- Box 14a,b,c,d,e: The individual provider license/certification information is required for all M.D & DO.
- Box 15: Not required.
- Box 16a,b,c,d: Billing/Remit address is required if applicable.
- Box 17: Is required for DCMWC (Black Lung), DEEIOC (Energy), & FECA (optional).
- Box 18: Is not required this is a request by the provider to submit bills electronically.
- Signature & Date is Required.

Group Provider Enrollment-10C:
- The Name & Provider Type is required.
- All providers must submit a copy of a License/Certification.
- The returned addresses are listed for each Department of Labor Program.
Authorization Levels

- **LEVEL 1:** Procedures do not require authorization (for example, Office Visits, MRIs, Routine Diagnostic Tests). No response will be sent on Fax requests. Please check Web or call 1-866-335-8319.

- **LEVEL 2:** Procedures can be authorized by ACS over the phone with ACS. Hospital Admission must be called in. Currently the Web does not accept facility authorizations.

- **LEVEL 3/4:** Procedures require authorization by a Claims Examiner but initiated via fax from Provider to ACS. Fax requests could take up to 7 work days. Web requests should be monitored via the web.

What requires authorization?

- Whenever you treat a DOL employee, verify on the website if procedure requires authorization.
- Or if you don’t have web access call 1-866-335-8319 for the IVR or the call center for services at 850-558-1818.
- Certain procedures require authorization prior to services being rendered.
- Examples include surgery, physical therapy, occupational therapy, and some DME.

How to Submit an Authorization Request

- **Website:** [http://owcp.dol.acs-inc.com](http://owcp.dol.acs-inc.com)

- Fax to 1-800-215-4901

- Mail to: P.O. Box 8300
  London, KY 40742-8300

- Call: 1-850-558-1818
Info Required for Auth Requests
- Claimant name
- Claimant case number
- CPT or HCPCS code(s)
- Specific body part to be treated
- Requested date of service
- Appropriate supporting documentation
- Provider name
- Provider number

Authorization Request Template

Most Common Reasons for Denial of Authorization or Payment
- ICD-9 code mismatch
- CPT code approved is not the one used on the invoice for care
- Wrong body part
- ACS payment system searches for matches – automatic denial if mismatch
Info Required for Physical Therapy and Occupational Therapy

- Claimant name
- Claimant Case number
- Requested CPT code(s)
- Specific body part to be treated
- Prescription from attending physician
- Treatment Plan
- Frequency and Duration of Services
- Provider name and number

Info Required for DME Auth

- Claimant name and case number
- CPT or HCPCS code(s)
- Prescription from attending physician
- Duration of services
- Rental or purchase price for each item
- Appropriate supporting documentation
- Provider name and number

Auth requests will be returned if:

- The case is closed
- The claimant’s case number is missing or invalid
- Procedures codes are missing or invalid

- Any of the following are missing:
  - Prescription, when required
  - Rental or Purchase Price, when required
  - Frequency and Duration
When Accepted Condition and ICD-9 Don’t Match

- Advise that Provider needs to complete the Authorization Request Process.
- Claims Examiner will determine if claim can be expanded for new condition based on information in file and information submitted with request.
- Claims Examiner will determine if additional development is needed to determine if claim can be expanded to include new condition.

Timelines for Prior Medical Authorizations

- Level 2 procedures that ACS can authorize take an average of 3 days.
- All spinal surgery and many other surgery authorizations require District Medical Advisor (DMA) approval and could take about 30 days or less.
- In some instances, additional development of the claim by the Claims Examiner is needed to approve or deny an authorization request.

Notifications Regarding Authorization Request

- The authorization request is logged into the system, forwarded to the Claims Examiner if necessary, or returned to Provider if incomplete within 3 business days.
- If a request for authorization is approved, the requesting Provider is notified via mail.
- If a request cannot be approved because additional information is needed, requesting Provider is notified via mail.
- If a request is denied, the Claims Examiner issues an official denial letter to claimant.
- Authorization status available via AQS or direct access to ACS web portal (http://owcp.dol.acs-inc.com) or via the ACS IVR at 866-335-8319.
Billing Overview

- Proper forms
- Common fields that cause the most problems
- Provider Number Usage
- How to request an adjustment
- Top 5 reasons a bill will be returned

HCFA 1500

- Also called OWCP-1500 and CMS-1500
- Submitted by:
  - Physicians
  - DME
  - Therapists
  - Rural Health Clinics
  - Chiropractors
  - Other specialized medical providers, excluding dentists

Top Reasons Your Bills Will Get Returned

1. No signature on file box 12 and 13 on HCFA-1500
2. Claimant ID missing
3. Tax ID missing
4. Dr's billing for prescriptions dispensed in office MUST to use J8499 and the NDC code
Provider Number Usage

- Learn it, love it, use it!
- Why is this important?
- Use it when you bill
- Use it on the web portal
- Use it when you call in to get information from our call center

Your provider number is your friend!

Return letter contains specific information about why your bill was returned.

Why will some bills be denied?

- Claimant is ineligible
- Disagreements with accepted condition
- No authorization
- Improper CPT codes
Claimant Eligibility

- Claimants are responsible for providing their treating physicians with the accepted condition.
- Claimants are responsible for contacting the district office if there are questions regarding case status.
- Providers may acquire this information directly from the claimant or via our website at http://owcp.dol.acs-inc.com.

Common Problems in Managing FECA Claimants

- Providing care for occupational illness claims before formally accepted.
  - Claimant will be responsible for paying for care ordered (MRIs, etc.) if claim is denied.
  - Can take months to adjudicate.
  - Best to provide care for these under claimant’s own insurance as back-up plan.

Common Problems in Managing FECA Claimants

- Handling repetitive trauma claims as if they are acute injury claims.
  - Claimant motivation for misfiling and fabricating acute injury:
    - COP
    - CA-36
  - Advise employee that condition is chronic, not acute, at outset, to provide opportunity to file appropriate claim.
Common Problems in Managing FECA Claimants

- Letting care for acute temporary condition drift into chronic care for personal medical condition
- E.g. lumbar strain still being treated 2 years later when condition is facet joint arthritis

Common Problems in Managing FECA Claimants

- Failing to inform CE clearly of need to change or expand diagnoses
- Error in initial diagnosis: e.g. lumbar strain diagnosis is clarified to be herniated disc
- Consequential conditions: e.g. abscess at surgical site for accepted condition
- Don’t assume the CE will get this from your narrative reports; spell it out in a letter

Summary

- Claimant-friendly system
- Rigid billing and authorization system with little room for error – but not hard to navigate once you learn it
- Get to know the HR people at the agencies for whose employees you care – they can help you with billing issues and facilitate RTW planning
Questions?

- Thanks to Pete Krah of DOL for many of the slides used in this presentation
- Screen shots of web portal available - e-mail me if you want these slides too
- Contact info for me:
  - mcleren@mcalinnovations.com
  - 443-466-0033