OWCP AUTHORIZATION TIPS

This document provides tips for authorization request submission along with understanding authorization outcomes and corrections. Providers are encouraged to submit authorization requests via the Workers' Compensation Medical Bill Processing (WCMBP) secured Provider Portal.

Authorization Request Submission

Question	Answer
What authorization submission methods are available?	Division of Federal Employees' Compensation (DFEC) and Division of Energy Employees Occupational Illness Compensation (DEEOIC) Providers have multiple authorization submission options: ▪ **Direct Data Entry:** All providers are encouraged to submit authorization requests via Direct Data Entry on the WCMBP Medical Bill Processing Portal. By utilizing this method of submission, the provider will be immediately notified if authorization is not required. If authorization is required, the request will route to the appropriate approver. Utilizing Direct Data Entry allows the request to be received more quickly and begins the authorization review process faster. ▪ **Fax:** When submitting authorization requests via fax, it could take up to 24 hours for the fax to upload into the WCMBP System. The fax could be returned to the provider if mandatory information is missing on the authorization request form or template. Notification of missing mandatory information is mailed via USPS to the requestor. Once the letter is received, the provider will have to make necessary corrections and resubmit the authorization request. **Note**: All faxes must be on the appropriate template to be ingested into the system. If the correct authorization request form or template is not received, the sender will receive a fax alerting them that the faxed authorization was submitted on the incorrect request form or template and must be resubmitted using the correct authorization request form or template. **Mail:** All paper submissions must be on the appropriate authorization request form or template to be ingested into the system. If the correct authorization request form or template is not received, the provider will receive a Return to Provider (RTP) letter informing the provider that the authorization request was submitted on the incorrect form or template and must be resubmitted using the correct authorization request form or template.

Question	Answer
	For DCMWC Providers, refer to the DCMWC Certificate of Medical Necessity FAQs for instructions on how to complete and submit Certificate of Medical Necessity (CMN) form when requesting authorization for Durable Medical Equipment (DME), oxygen supplies, and home nursing services.
Do I need to be enrolled as a provider to submit an authorization?	Providers must be actively enrolled in the OWCP program associated with the ill or injured worker before submitting an authorization. For example, if enrolled as a DFEC provider, the provider would not be able to submit an authorization for the DEEOIC program until enrolled with the DEEOIC program. Active status means that the provider can submit authorization requests and submit bills for payment consideration. For an inactive provider number, visit the WCMBP Portal Tutorial section for instructions on how to enroll. Once a provider submits the enrollment via the portal, it can take up to seven business days to process. Providers can track the status of their enrollment application by visiting the WCMBP Portal Provider Enrollment page. Select **Resume** or **Track an Enrollment Application** to view the status.
How do I know if authorization is required?	Providers can inquire about eligibility by logging in to the WCMBP Portal. Refer to the Verify Claimant Eligibility tutorial for instructions on how to check claimant eligibility.
How do I know what fields are required on the authorization request paper form?	When submitting an authorization request form via fax or mail, be certain to fill out the authorization request form or template in its entirety. If any mandatory fields are left blank, the request will be returned to the submitter for correction. The following are examples of some fields commonly missed: ▪ OWCP Provider ID (Section C) ▪ Code Type ▪ Is this an implant? If selecting yes, the provider must provide Implant Cost. ▪ Is the requested therapy related to post-operative treatment within 60 days of surgery? ▪ Providing care for a family member? If selecting yes, the provider must provide the relationship. ▪ Specific Body Part to be treated. ▪ Is this a second surgery on the same body part?

Question	Answer
	The following are examples of fields commonly missed on DFEC Surgical Package Authorization requests: ■ Where will the surgery be performed? (Section D2) ■ All locations and professions requiring authorization for the surgery (Section D3) ■ Has this surgery been performed previously on the same anatomical site? (Section E3) ■ Will this claimant require Home Health Services after surgery? (Section E4) ■ Will this claimant require Physical or Occupation Therapy Services after surgery? (Section E5)
Is supporting documentation mandatory for all authorization requests?	Supporting documentation may be required based on the selected authorization type. Choose the appropriate authorization type and select the appropriate procedure codes based on the type of services to be performed. The Provider's OWCP provider type must also be appropriate for the type of authorization request. Be sure to submit the authorization to the correct program as each program has unique requirements. **DEEOIC Authorizations:** ■ Durable Medical Equipment (Letter of medical necessity, prescription and information regarding the requested equipment and how it meets the physician's prescription.) ■ General Medical (Documents for supporting the need for the service as it relates to the accepted condition(s), such as letter of medical necessity, medical records, treatment plan, etc.) ■ Rehabilitative Therapies (Therapy Evaluation, Letter of Medical Necessity (LMN). Evidence of Face-to-Face exam, and any medical documentation supporting the need for therapy as it relates to the accepted condition(s). If services will be provided in the home, LMN must indicate whether or not claimant is homebound.) ■ Medical Transportation (Transportation invoice and supporting transportation documentation) ■ Home Health (Letter of medical necessity, evidence of face-to-face exam, plan of care, and any medical documentation supporting the need for care as it relates to the accepted condition(s).) ■ Transplant (Include letter of medical necessity, recent clinical evaluation, and a copy of the treatment protocol)

Question	Answer
	DFEC Authorizations: ■ Durable Medical Equipment (Include the prescription from the prescribing doctor, which must be signed by a MD, DO, PhD, or DPM) ■ General Medical (While supporting documentation is not required, it is recommended) ■ Physical Therapy and Occupational Therapy (include the prescription from the prescribing doctor, which must be signed by an MD, DO, PhD, or DPM) ■ Transportation and Travel (Include receipts and invoices to confirm the estimated total charge) ■ HCPCS J-Code Unspecified and Unclassified (Include the prescription from the prescribing doctor, which must be signed by an MD, DO, PhD, or DPM) ■ Surgical Package (Supporting documentation is recommended but not required) ■ Home Health (Include the prescription from the prescribing doctor, which must be signed by an MD, DO, PhD, or DPM, as well as a letter of medical necessity)
What is the importance of using the appropriate diagnosis?	It is important to submit the diagnosis code(s) on the authorization template that is related to the claimant treatment. Why is it important? ■ Submitting the appropriate diagnosis codes can ensure the treatment is directly related to the claimant's accepted conditions. **Note:** Providers must log into the WCMBP Portal to check eligibility and view a claimant's accepted conditions. Along with the diagnosis codes, use the appropriate diagnosis code pointer for each line item on the authorization request to correlate the injury or condition with the service being requested.

Understanding Authorization Outcomes and Corrections

Question	Answer
How can I inquire about the outcome of an authorization request?	Providers can use the WCMBP Portal to inquire on authorizations under the Online Authorization Submission feature. Authorization inquiry will include fields such as but not limited to case number. Providers can also use the Interactive Voice Response (IVR) System through the toll-free numbers for each OWCP program. Please visit the Contact Us page for more information.
How do I read and understand an authorization status?	The responsible Claims Examiner (CE) or Medical Benefits Examiner (MBE) reviews authorizations. Based on the information provided on the authorization request and any supporting documentation, the CE or MBE can make one of the following determinations: ▪ **Approved:** The requested services have been approved after review. ▪ **Approved or Denied:** Certain services on the authorization request have been approved while other services within the request have been denied. ▪ **Denied:** The CE or MBE has denied the authorization request. The CE or MBE issues a denial letter to the claimant that includes the reason for the denial and requests any additional information needed for further consideration. ▪ **Pending Further Development:** The CE or MBE has pended the authorization request to obtain additional information needed for a final determination. Supporting documentation may be added to the authorization request. ▪ **Corrected**: A correction request has been submitted and approved by the CE or MBE. The correction request will change to Corrected status and approved changes are applied to the original approved authorization. ▪ **Auth Not Required:** The requested services do not require prior authorization to perform or bill for the services. ▪ **Entering:** The provider has entered data for the authorization request but has not yet submitted the request for review. Authorization requests must be submitted to trigger the review process. ▪ **In Review:** The provider has submitted the authorization request for review. Supporting documentation may be added to the authorization request.

Question	Answer
	▪ **Processed Awaiting Decision (DEEOIC):** This status is associated with authorization requests submitted for Division of Energy Employees Occupational Illness Compensation (DEEOIC) claimants. The authorization request is under Medical Benefits Examiner (MBE) review. Supporting documentation may be added to the authorization request. ▪ **Returned to Provider (RTP):** The request contains missing or invalid required information or supporting documentation. ▪ **Cancelled:** The authorization request has been cancelled.
What action can be taken after receiving an authorization Return to Provider (RTP) letter?	Any required information missing on the authorization form will be returned to the provider (RTPd) listing all the reasons the authorization request could not be processed. The provider may submit a new request after addressing the reasons the request was returned.
Why has an authorization request been denied?	When an authorization request is denied by the claimant's Claims Examiner (CE) or Medical Benefits Examiner (MBE), the CE or MBE will send a denial letter to the claimant that details the reasons for the denial. In addition, DFEC denial reasons will appear on the WCMBP portal authorization details page by selecting the line number, which is hyperlinked to additional information. ▪ **DEEOIC program:** Providers will also receive a copy of the denial letter. ▪ **DFEC Program:** Providers are encouraged to communicate with the claimant to obtain information about the denial. Providers can also connect with the DFEC Medical Treatment Adjudicator (MTA) for assistance. Refer to the OWCP Provider Manual for details. **Note:** Acentra Health neither denies requests nor sends denial letters.
What action can be taken if an authorization request is Pending Further Development?	Providers can upload supporting documentation to an authorization where at least one service line is in "Pended Further Development" status. The status of the request will change to "In Review" and the CE or MBE will be alerted to the new documentation. Refer to the Quick Reference Guide (QRG): Uploading Attachments to a Previously Submitted Authorization Request for additional information.

Question	Answer
I have mistakenly entered an authorization request on the portal with a keying error. Can I cancel the request?	Providers can cancel authorization requests that are "In-Review" or "Processed Awaiting Decision" status. Providers can select the checkbox for the authorization request and then select **Cancel Authorization** to complete the cancellation.
What does the Cancellation Source mean when I inquire on an authorization request?	Providers can refer to the **Cancellation Source** field on the **Authorization Detail** page on the portal to help understand the entity who cancelled the authorization request. ▪ **Provider:** Provider initiated cancellation ▪ **CE/MBE:** OWCP Claims Examiner or Medical Benefits Examiner initiated cancellation ▪ **Operations User:** Medical Bill Processing user-initiated cancellation ▪ **System:** Cancellation was initiated based on a system process. For example, authorization requests that are in "Entering" status for more than 14 days and have not been Submitted are systematically cancelled.
How do I submit an authorization correction?	Providers may need to request corrections to their previously approved Prior Authorizations, in many cases to request a date extension or to add units. Get more information about submitting an authorization correction by viewing the Authorization Correction Resources Guide. The system will auto-populate all the required information from the original authorization for the submitter to view and edit the correction authorization. Select the line item for the authorization to be updated and select **Initiate Correction** (the new button). The approved authorization details will appear on the page, and providers can edit fields such as end date, units, and dollar amounts. DFEC will allow corrections for all authorization types (General Medical, Durable Medical Equipment, and so on). DEEOIC will allow corrections for Rehabilitative Therapies and Home Health Care authorizations. The following errors will be displayed when an authorization cannot be corrected:

Question	Answer
	▪ When multiple authorizations are selected for correction ▪ When an authorization is either In-Review or Entering status ▪ When a selected authorization does not have a service line with an Approved status ▪ When a correction is initiated for the DEEOIC program authorization types: General Medical, Transportation, Durable Medical Equipment, and Transplant If a provider receives an error message and it is not related to one of the issues listed above, the provider should verify their data entry or refresh their page.
What is the Copy Authorization button?	Effective September 20, 2025, providers can select an existing authorization and select the **Copy Authorization** button, to create a new request that mirrors the previous authorization. Providers can then update service details and submit the new request. Authorization requests in any status can be copied. When copying a previous authorization request, please note that the following fields cannot be changed: Program, Authorization Type, Claimant information, and Provider information. Additionally, attachments from the original request will not carry over and must be uploaded again.
Who can I contact if I need further Authorization Submission assistance?	For further assistance, contact the Medical Bill Processing Call Center: ▪ **Division of Federal Employees' Compensation (DFEC):** 1-844-493-1966 ▪ **Division of Energy Employees Occupational Illness Compensation (DEEOIC):** 1-866-272-2682 ▪ **Division of Coal Mine Workers' Compensation (DCMWC):** 1-800-638-7072