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 through Direct Data Entry (DDE) on the WCMBP Medical Bill Processing Portal. The portal immediately notifies providers when authorization is not required. When authorization is required, the portal routes the request to the appropriate approver. DDE speeds up request processing and starts the authorization review process sooner. ▪ **Fax:** The WCMBP System could take up to 24 hours to upload a faxed authorization request. If the authorization request form or template is missing required information, the system may return the request to the provider. The system mails a notification of missing mandatory information to the requester through the United States Postal Service (USPS). After receiving the letter, the provider must correct the request and resubmit it. **Note:** All faxes must be on the appropriate template to be received into the system. If a correct authorization request form or template is not received, the system sends a fax alert to the sender alerting them that the faxed authorization was submitted on the incorrect request form or template and that the sender must resubmit the authorization request using the correct authorization request form or template. ▪ **Mail:** All paper submissions must be on the appropriate authorization request form or template to be received 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 them that the authorization request was submitted on the incorrect form or template and it 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 Office of Workers' Compensation Programs (OWCP) program associated with the ill or injured worker before submitting an authorization. For example, a provider with DFEC cannot submit an authorization for the DEEOIC program until completing DEEOIC enrollment. Active status allows the provider to submit authorization requests and bills for payment consideration. For information about an inactive provider number, see the **Tutorial** section of the WCMBP Portal 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 enrollment application status on the WCMBP Portal Provider Enrollment page. To view the status, select **Resume or Track an Enrollment Application**.
How do I know if authorization is required?	Providers can check 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 by fax or mail, be sure to completely fill out the authorization request form or template. The **Instructions** section identifies mandatory fields. If any mandatory field is left blank, the system returns the request to the submitter for correction. Commonly missed fields include: ▪ OWCP Provider ID (Section C) **Note:** The OWCP Provider ID is a unique 9-digit number assigned during enrollment. This number is **not** the provider NPI or Tax ID. ▪ 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.

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	▪ Is this a second surgery on the same body part? Commonly missed fields 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. Select the appropriate authorization type and 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 or conditions, such as letter of medical necessity, medical records, treatment plan, and so on.) ▪ **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 or conditions. 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 or conditions.) ▪ **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 Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), or Doctor of Podiatric Medicine (DPM).) ▪ **General Medical** (While supporting documentation is not required, it is strongly encouraged.) ▪ **Physical Therapy and Occupational Therapy** (include the prescription from the prescribing doctor, which must be signed by an MD, DO, 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, or DPM.) ▪ **Surgical Package** (Supporting documentation is strongly encouraged.) ▪ **Home Health** (Include the prescription from the prescribing doctor, which must be signed by an MD, DO, or DPM, as well as a letter of medical necessity.)
What is the importance of using the appropriate diagnosis?	It is important to submit diagnosis codes on the authorization template that relate to the claimant's treatment. Appropriate diagnosis codes help show that the treatment relates directly to the claimant's accepted conditions. **Note:** Providers must log in to the WCMBP Portal to check eligibility and view a claimant's accepted conditions. For each line item on the authorization request, also use the appropriate diagnosis code pointer. The pointer links the injury or condition to the requested service.

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 about authorizations through the Online Authorization Submission feature. An authorization inquiry includes fields such as, but not limited to, the case number. Providers can also use the Interactive Voice Response (IVR) System through the toll-free numbers for each OWCP program. Visit the Contact Us page for more information. Beginning April 25, 2026 DFEC and DEEOIC providers will receive an email notification when an authorization request status changes. The system sends the notification to the provider's contact email address on file associated with the authorization request. Providers need to verify that their contact email address is current. If an update is needed, refer to the Updating Provider Information in the Provider Portal Quick Reference Guide.
How do I read and understand an authorization status?	The responsible OWCP employee reviews authorizations. Based on the information provided on the authorization request and any supporting documentation, the OWCP employee 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 authorization request has been denied. The OWCP employee issues a denial letter to the claimant that includes the reason for the denial and requests any additional information needed for further review. The OWCP employee also adds a note on the authorization request specifying reason for the denial. For example, if a development letter was issued and no response was provided, the OWCP employee may note that a response to the development letter was not provided. For DFEC DME requests specifically, the denial letter is typically sent to the requestor and/or treating physician, with a copy to the claimant. ▪ **Pending Further Development:** The OWCP employee has pended the authorization request to obtain additional information needed for a final determination. The requestor may upload supporting documentation to the authorization request. ▪ **Corrected**: A submitted correction request has been approved by the OWCP employee. The correction request will change to Corrected status and approved changes are applied to the original approved authorization.

Question	Answer
	▪ **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. If the authorization is not submitted after 30 days, the request will be automatically cancelled. ▪ **In Review:** The provider has submitted the authorization request for review. Supporting documentation may be added to the authorization request. ▪ **Processed Awaiting Decision (DEEOIC):** This status is associated with authorization requests submitted for the DEEOIC claimants. The authorization request is under OWCP 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. Refer to the Correspondence Tips for information on how to locate copies of available letters on the WCMBP Portal.
What action can be taken after receiving an authorization Return to Provider (RTP) letter?	The system returns an authorization request to the provider when required information is missing. The Return to Provider (RTP) letter lists all reasons the request could not be processed. After addressing those reasons, the provider may submit a new request.
Why has an authorization request been denied?	When an authorization request is denied, the claimant will receive a letter from OWCP detailing the reasons for the denial.. In addition, DFEC denial reasons will appear on the WCMBP Portal's **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.

Question	Answer
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 OWCP employee will be alerted to the new documentation. Refer to Uploading Attachments to a Previously Submitted Authorization Request Quick Reference Guide for additional information.
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:** Responsible OWCP employee 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 30 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. For guidance on submitting an authorization correction refer to 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. ■ To begin a correction, providers can select the line item for the authorization to be updated and then select **Initiate Correction** (the new button). ■ The approved authorization details will be displayed where providers can edit fields such as the end date, units, and dollar amounts. DFEC allows corrections for all authorization types (General Medical, Durable Medical Equipment, and so on).

Question	Answer
	DEEOIC allows corrections to Rehabilitative Therapies and Home Health Care authorizations. The system displays the following errors when an authorization cannot be corrected: ■ 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, the following fields **cannot be changed**: ■ Program ■ Authorization Type ■ Claimant information ■ Provider information. Additionally, attachments from the original request will not carry over and must be uploaded again.
I received an error message stating " Case Number and Procedure Code are Subject to Denial as per Program's Guidelines." What does this mean?	Effective October 10, 2026, designated DFEC claimants may be subject to restrictions when specific physical therapy, occupational therapy, or chiropractic procedure codes are requested or billed. Providers will not be able to submit authorization requests while this restriction is in effect. Additionally, related claims will be denied or rejected.
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

Question	Answer
	▪ **Division of Energy Employees Occupational Illness Compensation (DEEOIC):** 1-866-272-2682 ▪ **Division of Coal Mine Workers' Compensation (DCMWC):** 1-800-638-7072