DFEC Authorization Templates
Introduction

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Overview

When claimants are treated for their work-related injuries and/or occupational diseases, providers are required to secure an approved prior authorization for certain services. DFEC provides the prior authorization request templates for Provider use when requesting prior authorization. These templates were recently updated and on the WCMBP web portal on the References page under the Resources Menu. Providers are able to determine whether a service requires a prior authorization by using the Claimant Eligibility feature available within the WCMBP System’s Provider Portal @ https://owcpmed.dol.gov or you may speak with a customer service representative @ 844-493-1966.
Durable Medical Equipment Template
Requests for Durable Medical Equipment that are a level 2 or 3 will require the completion of a DME Authorization Template.
Completing the Durable Medical Equipment Template

<table>
<thead>
<tr>
<th>PART A: Requestor Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1.</td>
</tr>
<tr>
<td>A2.</td>
</tr>
<tr>
<td>A3.</td>
</tr>
<tr>
<td>A4.</td>
</tr>
</tbody>
</table>

**A1.** Select an option:
- Initial Request (new or first time requesting an authorization for the DME).
- Correction (to update or correct an authorization that is currently on file).

**A2.** If making a correction to an authorization that is on file, list the authorization number that is on file.

**A3.** Type the date the authorization is being completed.

**A4.** Enter the name of the person requesting the authorization.

**A5.** Enter the phone number of the person requesting the authorization. (Not Required)
Completing the Durable Medical Equipment Template

B1. Enter the Claimant’s 9-digit Case ID.
B2. Enter the Claimant’s Date of Birth (mm/dd/yyyy).
B3. Enter the Claimant’s First Name.
B4. Enter the Claimant’s Last Name.
B5. Enter the Claimant’s Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.
Completing the Durable Medical Equipment Template

**C1.** Enter the provider’s 9-digit OWCP Provider Identification Number (PIN).

**C2.** Enter the provider’s Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

**C3.** Enter the Provider’s Name.

**C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider’s profile, it can be left blank. (Not Required)

**C5.** Confirm if you are providing care for a family member or not.

**C6.** If you are providing care, state your relationship to the claimant. **(Only required if “Yes” was selected in C5.)**
D1. Enter the specific body part the DME is for.

D2. Up to four ICD-9 or ICD-10 codes can be entered.
   - ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D3. 
   - Enter the DOS range.
   - Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
   - Enter the Code Type (HCPCS or CPT).
   - Enter the Procedure Code (HCPCS).
   - Select a Body Part Modifier option: LT(Left), RT(Right) or 50(Bilateral). Select 50 if the equipment is for the back, neck or head area.
   - Enter the Units requested.
   - Select RR (for Rental), NU (for Purchased New) or EU (for Purchased Used).
   - Enter the total cost for the full DOS range.
   - Enter duration. **(Required For Rentals Only)**

D4. Enter any additional notes you may have. (Not Required)
A prescription from the prescribing doctor is required, along with the treatment plan.

* Write the Claimant’s Case ID on all additional pages submitted with the template.
General Medical Template
Requests for General Medical Services that are level 2 or 3, will require the completion of a General Medical Authorization Template.
Completing the General Medical Template

A1. Select an option:
   - Initial Request (new or first time requesting an authorization for general medical).
   - Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Enter the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone number of the person requesting the authorization. (Not Required)
Completing the General Medical Template

**B1.** Enter the Claimant’s 9-digit Case ID.

**B2.** Enter the Claimant’s Date of Birth (mm/dd/yyyy).

**B3.** Enter the Claimant’s First Name.

**B4.** Enter the Claimant’s Last Name.

**B5.** Enter the Claimant’s Date of Injury (mm/dd/yyyy).

**Note:** All fields in Part B are required.
Completing the General Medical Template

**C1.** Enter the provider’s 9-digit OWCP Provider Identification Number (PIN).

**C2.** Enter the provider’s Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

**C3.** Enter the Provider’s Name.

**C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider’s profile, it can be left blank. (Not Required)

**C5.** Confirm if you are providing care for a family member or not.

**C6.** If you are providing care, state your relationship to the claimant. (Only required if “Yes” was selected in C5)
Completing the General Medical Template

**D1.** Enter the specific body part to be treated.

**D2.** State if this a second surgery to the same body part.

**D3.** Up to four ICD-9 or ICD-10 codes can be entered.
- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

**D4.** State if this is an implant.

Additional information on Part D is continued on the next slide.
Completing the General Medical Template – Cont.

D5. If this is for an implant, how much does it cost?

D6.
- Enter the DOS range.
- Select the Diagnosis you want to point to from D3, multiple pointers can be selected.
- Select code type (CPT/HCPCS/Revenue Code/NDC Code).
- Enter the code Modifier (if applicable).
- Select a Body Part Modifier option: LT (Left), RT (Right) or 50 (Bilateral). Select 50 if the service is for the back, neck or head area.
- Enter the Units/Days requested.

D7. Enter any additional remarks.
Completing the General Medical Template

Attach any supporting documentation that may help.

* Write the Claimant's Case ID on all additional pages submitted with the template.

**PART E: Supporting Documents**

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.
Home Health Template
Requests for Home Health Services that are level 2 or 3, will require the completion of the Home Health Template.
Completing the Home Health Template

A1. Select an option:
   • Initial Request (new or first time requesting an authorization for home health).
   • Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Enter the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone number of the person requesting the authorization. *(Not Required)*
Completing the Home Health Template

**B1.** Enter the Claimant’s 9-digit Case ID.

**B2.** Enter the Claimant’s Date of Birth (mm/dd/yyyy).

**B3.** Enter the Claimant’s First Name.

**B4.** Enter the Claimant’s Last Name.

**B5.** Enter the Claimant’s Date of Injury (mm/dd/yyyy).

**Note:** All fields in Part B are required.
### Completing the Home Health Template

<table>
<thead>
<tr>
<th>C1.</th>
<th>Enter the provider’s 9-digit OWCP Provider Identification Number (PIN).</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2.</td>
<td>Enter the provider’s Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.</td>
</tr>
<tr>
<td>C3.</td>
<td>Enter the Provider’s Name.</td>
</tr>
<tr>
<td>C4.</td>
<td>Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider’s profile, it can be left blank. (Not Required)</td>
</tr>
<tr>
<td>C5.</td>
<td>Confirm if you are providing care for a family member or not.</td>
</tr>
<tr>
<td>C6.</td>
<td>If you are providing care, state your relationship to the claimant. <strong>(Only required if Yes was selected in C5.)</strong></td>
</tr>
</tbody>
</table>

![PART C: Provider Information](image-url)
Completing the Home Health Template

**D1.** Enter the specific body part to be treated.

**D2.** Up to four ICD-9 or ICD-10 codes can be entered.
- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

Additional information on Part D is continued on the next slide.
D3.
- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select Code Type (CPT/HCPCS).
- Enter the procedure code.
- Select a Body Part Modifier Option: LT (Left), RT (Right), or 50 (Bilateral). Select 50 if the service is for the back, neck, or head area.
- Enter the Frequency (How many times a week will the claimant be seen?)
- Enter the Duration (How many total weeks will the claimant be seen?)
- Enter the total units requested (Frequency x Duration = Total Units Requested).

D4. Enter any additional remarks.
Completing the Home Health Template

Any supporting documentation will need to be attached.

* Write the Claimant’s Case ID on all additional pages submitted with the template.

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**PART E: Supporting Documents**

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.
HCPCS J-Code
Unspecified/Unclassified Template
Requests for Unspecified/Unclassified J-Codes (J3490, J3590, J7999, J8499, J8999, and J9999) require the completion of the HCPCS J-Code Unspecified/Unclassified Template.
Completing the HCPCS J-Code Unspecified/Unclassified Template

**PART A: Requestor Information**

A1. Select an option:
   - Initial Request (new or first time requesting an authorization).
   - Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Enter the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone number of the person requesting the authorization. *(Not Required)*
Completing the HCPCS J-Code Unspecified/Unclassified Template

**B1.** Enter the Claimant’s 9-digit Case ID.
**B2.** Enter the Claimant’s Date of Birth (mm/dd/yyyy).
**B3.** Enter the Claimant’s First Name.
**B4.** Enter the Claimant’s Last Name.
**B5.** Enter the Claimant’s Date of Injury (mm/dd/yyyy).

*Note:* All fields in Part B are required.

<table>
<thead>
<tr>
<th>PART B: Claimant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1. Claimant’s Case ID:</td>
</tr>
<tr>
<td>B3. First Name:</td>
</tr>
<tr>
<td>B5. Date of Injury:</td>
</tr>
<tr>
<td>B2. Date of Birth:</td>
</tr>
<tr>
<td>B4. Last Name:</td>
</tr>
</tbody>
</table>
Completing the HCPCS J-Code Unspecified/Unclassified Template

C1. Enter the provider’s 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider’s Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

C3. Enter the Provider’s Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider’s profile, it can be left blank. (Not Required)

C5. Enter the doctor’s name that prescribed the medication.

C6. Enter the doctor’s NPI that prescribed the medication.
Completing the HCPCS J-Code Unspecified/Unclassified Template

D1. Enter the specific body part to be treated.

D2. Up to four ICD-9 or ICD-10 codes can be entered.
   • ICD-9 code is applicable if date of service is on/prior to 09/30/2015.
     Use ICD-10 code if date of service is on/after 10/01/2015.

D3. • Enter the DOS range.
    • Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
    • Enter the Unspecified/Unclassified J-Code.
    • Enter the National Drug Code (NDC) number.
    • Select a Body Part Modifier option: LT (Left), RT (Right) or 50 (Bilateral). Select 50 if the equipment is for the back, neck or head area.
    • Enter the number of Units requested.

D4. Enter any additional remarks.
A J-code prescription from the prescribing doctor is required.

* Write the Claimant's Case ID on all additional pages submitted with the template.

**PART E: Supporting Documents**

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.
Surgical Package Template
Requests for Surgical procedures that are level 2 or 3 services, will require the completion of a Surgical Package Authorization Template.
Completing the Surgical Package Template

A1. Select an option:
   • Initial Request (new or first time requesting an authorization for a surgical procedure).
   • Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Type the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone number of the person requesting the authorization. (Not Required)
Completing the Surgical Package Template

B1. Enter the Claimant’s 9-digit Case ID.
B2. Enter the Claimant’s Date of Birth (mm/dd/yyyy).
B3. Enter the Claimant’s First Name.
B4. Enter the Claimant’s Last Name.
B5. Enter the Claimant’s Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.
Completing the Surgical Package Template

**PART C: Provider Information**

**C1.** Select the appropriate option (YES or NO), if the primary surgeon is completing this form.

**C2.** Enter the rendering provider’s OWCP ID.

**C3.** Enter the provider’s Tax ID (Social Security Number or Federal Employer Identification Number).

**C4.** Enter the provider’s name.

**C5.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider’s profile, it can be left blank. (Not Required)
Completing the Surgical Package Template

**D1.** Enter the date of the surgery.

**D2.** Select the site where the surgery will take place.
- Inpatient
- Outpatient
- Ambulatory Surgery Center (ASC)
- Office

**D3.** Select all that will require an authorization and include the surgeon requesting the authorization.
- Facility
- Surgeon
- Assistant Surgeon (AS)
- Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Physicians Assistant (PA)

*Note:* One authorization will cover all selected.
Completing the Surgical Package Template

**E1.** Enter the specific body part to be treated.

**E2.** Up to four ICD-9 or ICD-10 codes can be entered.
- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

**E3.** Has there been a previous surgery on the body part you are treating?

**E4.** Will Home Health be required after the surgery?

**E5.** Will Physical/Occupational Therapy be required after the surgery?

Additional information on Part E is continued on the next slide.
E6.
- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select the Code Type (CPT/HCPCS).
- Enter the Procedure Code.
- Enter the procedure Modifier (if applicable).
- Select a Body Part Modifier option: LT(Left), RT(Right) or 50(Bilateral). Select 50 if the equipment is for the back, neck or head area.
- Enter the number of Units/Days requested.

E7. Enter any additional remarks.
Completing the Surgical Package Template

PART F: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Attach any supporting documentation needed.

* Write the Claimant’s Case ID on all additional pages submitted with the template.
Travel Template
Travel Template

Providers rendering the travel services below, will require the completion of a Travel Template:

- **A0100** - Taxi
- **A0110** - Bus, intra/interstate carrier
- **A0120** - Mini-Bus, mountain area transports, and other transports
- **A0130** - Wheelchair Van
- **A0140** – Air Travel
- **A0170** - Transport Parking Fees/Tolls
Completing the Travel Template

A1. Select an option:
   - Initial Request (new or first time requesting an authorization for travel).
   - Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Type the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone number of the person requesting the authorization. (Not Required)
Completing the Travel Template

**B1.** Enter the Claimant’s 9-digit Case ID.

**B2.** Enter the Claimant’s Date of Birth (mm/dd/yyyy).

**B3.** Enter the Claimant’s First Name.

**B4.** Enter the Claimant’s Last Name.

**B5.** Enter the Claimant’s Date of Injury (mm/dd/yyyy).

*Note: All fields in Part B are required.*
Completing the Travel Template

C1. Enter the provider’s 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider’s Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

C3. Enter the Provider’s Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider’s profile, it can be left blank. (Not Required)

C5. Confirm if you are providing care for a family member or not.

C6. If you are providing care, state your relationship to the claimant. **Only required if Yes was selected in C5**
Completing the Travel Template

D1. Select the location where the travel started from.
D2. Select the location where the travel ended.
D3.
- Enter the travel from and to date.
- Enter the travel code(s).
- Enter the estimated total charge of the travel.
- Enter the estimated miles traveled (**For claimant travel reimbursement only**).
D4. Enter any additional remarks.

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Travel Code</th>
<th>Estimated Total Charge</th>
<th>Estimated Miles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D4. Remarks:
Completing the Travel Template

Attach Receipts or Invoices to confirm the estimated total charge.

* Write the Claimant’s Case ID on all additional pages submitted with the template.

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**PART E: Supporting Documents**

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.
Physical Therapy/Occupational Therapy Template
Requests for Physical Therapy (PT) & Occupational Therapy (OT) services that are level 2 or 3 will require the completion of a Physical Therapy/Occupational Therapy Template.
Completing the Physical Therapy/Occupational Therapy Template

A1. Select an option:
   • Initial Request (new or first time requesting an authorization for physical therapy/occupational therapy).
   • Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Type the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone of the person requesting the authorization. (Not Required)
Completing the Physical Therapy/Occupational Therapy Template

| B1. Enter the Claimant’s 9-digit Case ID. |
| B2. Enter the Claimant’s Date of Birth (mm/dd/yyyy). |
| B3. Enter the Claimant’s First Name. |
| B4. Enter the Claimant’s Last Name. |
| B5. Enter the Claimant’s Date of Injury (mm/dd/yyyy). |

**Note:** All fields in Part B are required.
Completing the Physical Therapy/Occupational Therapy Template

C1. Enter the provider’s 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider’s Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

C3. Enter the Provider’s Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider’s profile, it can be left blank. (Not Required)

C5. Confirm if you are providing care for a family member or not.

C6. If you are providing care, state your relationship to the claimant. (Only required if Yes was selected in C5.)
Completing the Physical Therapy/Occupational Therapy Template

**D1.** Enter the specific body part to be treated.

**D2.** Up to four ICD-9 or ICD-10 codes can be entered
- ICD-9 code is applicable if date of service is prior to September 30, 2015. Use ICD-10 code if date of service is after October 1, 2015.

**D3.** Is the therapy related to treatment within 60 days after surgery?

Additional information on Part D is continued on the next slide.
Completing the Physical Therapy/Occupational Therapy Template – Cont.

**D4.**

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select if the Code Type is a HCPCS or CPT.
- Enter a Modifier (if applicable).
- Select a Body Part Modifier option: LT (Left), RT (Right) or 50 (Bilateral). Select 50 if the equipment is for the back, neck or head area.
- Enter the number of units per procedure (1 unit = 15 mins).
- Enter the frequency (How many times a week will the claimant be seen?)
- Enter the duration (How many total weeks will the claimant be seen?)
- Enter the total units requested (# of Units Per Procedure x Frequency x Duration = Total Units Requested).

**D5.** Enter any additional remarks.
Completing the Physical Therapy/Occupational Therapy Template

*A prescription from the prescribing doctor with (MD, PHD, DO or DPM) credentials is required along with the treatment plan.

* Write the Claimant’s Case ID on all additional pages submitted with the template.

**PART E: Supporting Documents**

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.
Authorization Submission Methods
Authorization Submission Methods

Authorization Templates can be submitted via:

- **Direct Data Entry (DDE)** in the Workers’ Compensation Medical Bill Processing (WCMBP) System.
- **Fax** at 800.215.4901.
- **Mail** to P.O. Box 8300 London, KY 40742-8300.

Authorizations are processed within 2 business days of receipt. To check on your Authorization status, visit the Office of Workers' Compensation Programs, Medical Bill Processing Portal at [https://owcpmed.dol.gov](https://owcpmed.dol.gov) or you may speak with a customer service representative at 844-493-1966.
THANK YOU!