

Certification of Medical Necessity

DCMWC Website Version

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation



Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment and home nursing care (30 U.S.C. 901 at seq. and 20 CFR 725.705 and 725.706). Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician. Collection of this information is required to obtain a benefit. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1240-0024
Expires: 02-28-2018

1. Patient's Name and Mailing Address
2. Telephone Number
3. Social Security Number
4. Date of Birth
5. Case ID

6a. Date(s) of last hospitalization
6b. Condition(s) treated while in hospital

7. Pulmonary Condition(s) for which this prescription is written:
8a. Type of Prescription
8b. Requested Duration of Prescription for DME or Home Nursing

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE) FOR CORRESPONDING REIMBURSEMENT STANDARDS
9a. Oxygen Delivery Equipment (11a.)
9b. Other DME

9c. Prescription for Medical Services
10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT

(Note: Patient's condition is considered ACUTE if test was taken during a hospitalization for a covered pulmonary condition.)

A. Pulmonary Function Test (see 11e.)
Date of test:
Pt.'s condition:
Results (Best Effort)

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation:
Miner's ability to understand instructions and follow directions:

C. Was equipment calibrated before the test?

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test (see 11e.)
Date of test:
Pt.'s condition:
Results:

F. Air Intake:

G. Time Sample Drawn
Iced
Time Sample Analyzed

H. Was equipment calibrated before the test?

I. Testing Facility Name and Address

**DOL Reimbursement Standards**

- 11a. For Home O<sub>2</sub> delivery equipment:** requires a pO<sub>2</sub> value of 60 mmHg or less on room air during a chronic state with corresponding pC<sub>02</sub> and pH values. If the ABG is done while the patient is on O<sub>2</sub>, the pO<sub>2</sub> standard = 80 mmHg for all oxygen equipment (See 11e.). All medical evidence to support your request will be considered.
- 11b. Hospital Bed/Mattress:** must be justified by PFT results indicating an FEV<sub>1</sub> equal to or less than 40% of predicted, or chronic hypoxia (pO<sub>2</sub> of 55 mmHg or less).
- 11c. Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.
- 11d. Wheelchairs:** <sup>1/15</sup> ~~are~~ not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment. *Item*
- 11e. ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services for home nursing care and ~~pulmonary rehabilitation services~~ <sup>equipment</sup> must be reviewed yearly or at the expiration date.
- 11f. Faxes CAN NOT be accepted.**

**NOTE:** Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards, you may submit other medical evidence to support your prescription request. All evidence will be considered.

**12. Comments:**

*remove space, type as one word*

**13. PHYSICIAN/PROVIDER INFORMATION**

|  |  |
|--|--|
| <p><b>a. Physician's Name, Address and Phone Number (print or type)</b><br/>                 name: _____<br/>                 line 1: _____ city: _____<br/>                 line 2: _____ state: _____ zip: _____<br/>                 phone: _____</p> | <p><b>b. Are you the patient's regular physician or are you actively treating this patient?</b><br/> <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 If NO, explain why <u>you</u> are prescribing the equipment or services on this form.</p> |
| <p><b>c. Date of Visit (the date you examined the Patient and made the decision for this prescription):</b> _____ <i>small P</i></p>   | <p><b>d. Date that the prescribed treatment or service is authorized to begin:</b> _____</p>   |

**e. I certify that I am the current treating physician (or have provided an explanation in 13b. above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. Any statement on my letterhead attached here to, has been reviewed and signed by me. I understand that any falsification, omission, or concealment of medical fact may subject me to civil or criminal liability.**

*covered pulmonary*

|   |  |
|---|--|
| <p>Physician's Original Signature (Do not use stamp) (See 11f.) _____</p> <p>Please forward this completed form to: US Dept. of Labor<br/>                 OWCP/DCMWC/CMR Correspondence<br/>                 PO Box 8307<br/>                 London, KY 40742-8307<br/>                 For further information call TOLL FREE: 1-800-638-7072.</p> | <p>Date _____</p> <p><b>f. Provider's Name, Address, Phone No., and PROVIDER NO.:</b><br/>                 name: _____<br/>                 line 1: _____ city: _____<br/>                 line 2: _____ state: _____ zip: _____<br/>                 phone: _____ provider no.: _____</p> |
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**PRIVACY ACT**

The following information is provided in accordance with the Privacy Act of 1974. (1) Collection of this information is authorized by the Black Lung Benefits Act (30 USC 901 et seq.) (2) The information in this form will be used to ensure that the program covers the medical treatment prescribed and to ensure accurate medical provider information for payment of medical bills. Disclosure of beneficiary's social security number and completion of this form are voluntary. Failure to provide the requested information and documentation may result in bill payment delays or denial. (3) Information may be used by other agencies, government contractors or persons in handling matters related, directly or indirectly, to processing this form. (4) Furnishing all requested information will facilitate accurate and timely payment of medical services to the provider.

**Public Burden Statement**

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Division of Coal Mine Workers' Compensation, U.S. Department of Labor, Room N-3464, 200 Constitution Avenue, N.W., Washington, DC. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

**Notice**

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.