DCMWC Website Version

Certification of Medical Necessity

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

name: _____

line 1: _____ city: _____

line 2: _____ state: _____ zip: _____

2. Telephone Number _____ Capital I

3. Social Security Number _____

4. Date of Birth _____

5. Case ID _____

6a. Date(s) of last hospitalization

From: _____

To: _____

6b. Condition(s) treated while in hospital

7. Pulmonary Condition(s) for which this prescription is written: Delete

8a. Type of Prescription

☐ Original (New)

☐ Recertification (Renewal)

8b. Requested Duration of Prescription for DME or Home Nursing (see 11c.)

Beginning Date: _____ Ending Date: _____

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

ITEM

9a. Oxygen Delivery Equipment (11a.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

DOL

☐ Tank O2 With Flowmeter and Humidifier ☐ O2 Concentrator ☐ O2 Liquid System

☐ Portable Unit (Gaseous) ☐ O2 Liquid System With Portable Liquid

9b. Other DME

Delete

Capital H

☐ Manual Hospital Bed/Mattress (11b.)

☐ Semi-electric Hospital Bed (11b.) ☐ Wheelchair (11d.)

☐ Nebulizer with Motor (11a.) ☐ Other (Explain in item no. 12.)

9c. Prescription for Medical Services

☐ Pulmonary Rehabilitation Services (See 11d.)

Level: _____

☐ Home Nursing Care (See 11c.)

Delete

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report.

Bold

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

Delete

A. Pulmonary Function Test (see 11e.)

Date of test: _____

Pt.'s condition: ☐ Acute ☐ Chronic

Results (Best Effort)

	Predicted	Bronchodilation	
		Before	After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")

Miner's Cooperation: ☐ Good ☐ Fair ☐ Poor

Miner's ability to understand instructions and follow directions: ☐ Good ☐ Fair ☐ Poor

Item

C. Was equipment calibrated before the test? ☐ Yes ☐ No

D. Testing Facility Name and Address:

name: _____

line 1: _____ city: _____

line 2: _____ state: _____ zip: _____

E. Arterial Blood Gas Test (see 11e.)

Date of test: _____

Pt.'s condition: ☐ Acute ☐ Chronic

Results:

PO2	PCO2	P H

F. Air Intake: ☐ On room air ☐ On 0_2 @ _____ LPM

G. Time Sample Drawn _____ Iced ☐ Yes ☐ No Time Sample Analyzed _____

H. Was equipment calibrated before the test? ☐ Yes ☐ No

I. Testing Facility Name and Address

name: _____

line 1: _____ city: _____

line 2: _____ state: _____ zip: _____

DOL Reimbursement Standards

11a. For Home 0_2 delivery equipment: requires a pO2 value of 60 mmHg or less on room air during a chronic state with corresponding pC02 and pH values. If the ABG is done while the patient is on O2, the pO2 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 FEV1 equal to or less than 40% of predicted, or chronic hypoxia (p02 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: ~~are~~ is 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.

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~~ 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:

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)

name: _____

line 1: _____ city: _____

line 2: _____ state: _____ zip: _____

phone: _____

b. Are you the patient's regular physician or are you actively treating this patient?

☐ Yes ☐ No

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the Patient and made the decision for this prescription): _____

d. Date that the prescribed treatment or service is authorized to begin: _____

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.

Physician's Original Signature (Do not use stamp) (See 11f.) _____ Date _____

Please forward this completed form to: US Dept. of Labor
OWCP/DCMWC/CMR Correspondence
PO Box 8307
London, KY 40742-8307
For further information call TOLL FREE: 1-800-638-7072.

f. Provider's Name, Address, Phone No., and PROVIDER NO.:

name: _____

line 1: _____ city: _____

line 2: _____ state: _____ zip: _____

phone: _____ provider no.: _____

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.