

**Certification of Medical Necessity**

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



ResetPrint

Completion of this form and prior approval is required when making an initial request for the Department of Labor to authorize reimbursement charges for equipment and home nursing care (30 U.S.C. 901 et seq. and 20 CFR 725.705 and 725.706). If granted, the authorization covers a maximum period of one (1) year, subject to renewal. 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: XX XX  
XXXX

<b>1. Patient's Name and Mailing Address</b> Name: _____ line 1: _____ City: _____ line 2: _____ State: _____ Zip: _____	<b>2. Telephone Number</b> _____	<b>3. DOL's Case ID Number</b> _____
		<b>4. Date of Birth</b> _____
<b>5. (blank)</b> _____		

<b>6a. Date(s) of last hospitalization</b> From: _____ To: _____	<b>6b. Condition(s) treated while in hospital</b> _____
--	--

<b>7. Pulmonary Condition(s) for which this prescription is written:</b> _____	<b>8a. Type of Prescription</b> <input type="checkbox"/> Original (New) <input type="checkbox"/> Recertification (Renewal)	<b>8b. Requested Duration of Prescription for DME or Home Nursing (see 11c.)</b> Beginning Date: _____ Ending Date: _____
---	--	--

**9. EQUIPMENT OR SERVICE PRESCRIBED (SEE ITEM. 11, FOR CORRESPONDING DOL REIMBURSEMENT STANDARDS)**

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

<input type="checkbox"/> Tank O <sub>2</sub> With Flowmeter and Humidifier	<input type="checkbox"/> O <sub>2</sub> Concentrator	<input type="checkbox"/> O <sub>2</sub> Liquid System
<input type="checkbox"/> Portable Unit (Gaseous)	<input type="checkbox"/> O <sub>2</sub> Liquid System With Portable Liquid	

**9b. Other DME**

<input type="checkbox"/> Manual Hospital Bed/Mattress (11b.)	<input type="checkbox"/> Wheelchair (11d.)	<input type="checkbox"/> Home Nursing Care (See 11c.)
<input type="checkbox"/> Semi-electric Hospital Bed (11b.)	<input type="checkbox"/> Other (Explain in Item no. 12.)	

**10. Objective Test Results - 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.

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

<b>A. Pulmonary Function Test (see 11e.)</b> Date of test: _____ Pt.'s condition: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic				<b>B. Check as Miner's Coc</b> Miner _____			
Results (Best Effort) Was equipment calibrated before the test? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain Under Item 12.) Testing Facility Name and Address: _____ Name: _____ line 1: City: _____ line 2: State: Zip: _____				<b>C. Arterial Blood Gas Test (see 11e.)</b> Date of test: _____ Pt.'s condition: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic			
FEV <sub>1</sub> L/BTPS FVC L/BTPS		Predicted PO <sub>2</sub> PCO <sub>2</sub> PH		Before After		Bronchodilation Name: _____ line 1: City: _____ line 2: State: Zip: _____	
<b>D. Air Trapping</b> Was equip _____ Testing Fac _____ line 1: _____ line 2: _____				<b>E. Time Sar</b> _____			

**11. DOL/DCMWC 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 pCO<sub>2</sub> and pH values. *If the ABCs 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.
- If the patient is homebound or non-ambulatory, or if other circumstances related to his/her condition prevent the sample from being analyzed within 30 minutes, the prescribing physician may submit a narrative rationale explaining the circumstances and substantiate the medical necessity for the item or service prescribed.
- 11b. Hospital Bed/Mattress:** must be justified by PFT results indicating a FEV<sub>1</sub> equal to or less than 40% of predicted, or chronic hypoxia (pO<sub>2</sub> of 55 mmHg or less). PFT – Test results with tracings and flow volume loop must be attached. ABG – Test strip must be attached.
- 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, PT) providing care. Use Item 12, below, and/or attach separate sheet.
- 11d. Wheelchair:** 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 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 equipment must be reviewed yearly or at the expiration date. PFT – Test results with tracings and flow volume loop must be attached. ABG – Test strip must be attached.
- 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**

<p><b>a. Prescribing Physician's Name, Address and Phone Number (print or type)</b></p> <p>Name: _____</p> <p>line 1: _____ City: _____</p> <p>line 2: _____ State: _____ Zip: _____</p> <p>Phone: _____</p>	<p><b>b. Are you the patient's regular physician or are you actively treating this patient?</b></p> <p align="right">Yes    No</p> <p>If NO, explain why you are prescribing the equipment or services on this form. <input style="width: 100px;" type="text"/></p>
<p><b>c. Date of Visit (the date you examined the patient and made the decision for this prescription):</b> _____</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 covered pulmonary condition. I also certify that all data accompanying the submission is an accurate representation of the test results. Any statement on my letterhead attached hereto, 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 Signature \_\_\_\_\_ Date \_\_\_\_\_

**TWO FILING OPTIONS:**

1. To file electronically, submit completed form and accompanying medical documentation to the COAL Mine Portal: <https://eclaimant.dol-esa.gov/bl>
2. To file by mail, submit completed form and accompanying medical documentation to:

US Department of Labor OWCP/DCMWC  
 PO Box 8307  
 London, KY 40742-8307  
 For further information call TOLL FREE: 1-800-638-7072.

**f. Name, Address, Phone No., and PROVIDER NO. of provider who is supplying the equipment or service:**

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, 5 U.S.C. 552a. (1) Collection of this information is authorized by the Black Lung Benefits Act (30 U.S.C. 901 et seq) and implementing regulations (20 CFR 725.706 and 725.707). (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. (3) This information may be used by other agencies or persons handling matters relating, directly or indirectly, to processing this form including liable coal mine operators and their insurance carriers; medical professionals in obtaining medical services or evaluations; contractors providing automated data processing or other services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies. (4) Furnishing all requested information will facilitate accurate and timely payment of medical services to the provider. (5) This information is included in a System of Records, DOL/OWCP-2 and DOL/OWCP-9, published at 81 Federal Register 25765, 25858, and 25866 (April 29, 2016), or as updated and republished.

**Public Burden Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 20-40 minutes/hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is to obtain or retain benefit (required to ob 30 U.S.C. 901)). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Division of Coal Mine Workers' Compensation, U.S. Department of Labor, Room N-3464, 200 Constitution Avenue, N.W., Washington, DC 20210. Note: Please do not return the completed CM-893 form to this address.

**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 staff to ask for assistance.