ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND CARRIER'S RESPONSE

State of New York - Workers' Compensation Board

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case Number:	Carrier Case Number:	Date of Injury:

A. Patient's Name: ..... (First / MI / Last) .....Social Security No.: .....

Patient's Address:.....

Employer's Name & Address:.....

Insurance Carrier's Name & Address:.....

B. Attending Doctor's Name & Address:.....

Individual Provider's WCB Authorization No.: ☐☐☐☐☐☐☐-☐☐ Telephone No.: ..... Fax No.: .....

C. **DATE VARIANCE REQUEST SUBMITTED AND METHOD OF TRANSMISSION: on ...../...../..... by.....**

The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:

Guideline Reference: ☐ - ☐☐☐☐ *(In first box, indicate body part: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck*
In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)

Approval Requested for: (one request type per form)

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CARRIER'S / EMPLOYER'S RESPONSE
If service is denied, explain on reverse.

❑ Granted
❑ Granted without Prejudice
❑ Denied

STATEMENT OF MEDICAL NECESSITY -- See item 4 on instruction page for requirements.

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Date of Service of Supporting Medical in WCB Case File: .....

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care. I ❑did / ❑did not contact the carrier by telephone to discuss this variance request before making the request. I contacted the carrier by telephone on (date)..... and spoke to (person spoke to or was not able to speak to anyone).....

❑ A copy of this form was sent to the carrier/employer/self-insured employer/Special Fund by (fax, email) ....., a copy was sent (see addresses on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal counsel, if any, to the claimant if not represented, and to any other parties of interest on the date below.

❑ I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on .....

Provider's Signature: ..... Date: .....

D. **CARRIER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW**

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

By: (print name)..... Title: .....

Signature: ..... Date: .....

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

E. **CARRIER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST**

Carrier's response to the variance request is indicated in the checkboxes on the front side of this form. If request is denied, give reason(s) for denial. Carrier denial must be reviewed by a health professional. (Attach written report of medical professional as explained above.)

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Name of the Medical Professional who Reviewed the Denial:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board (see mail, fax and email addresses on instruction page), the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/self-insured employer/Special Fund attached, on the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally within 8 business days of receipt of the denial, I opt for the decision to be made by the ❑ Medical Arbitrator designated by the Chair or ❑ at a WCB Hearing. I understand that both parties, the carrier and the claimant, must opt in writing for resolution by the medical arbitrator; otherwise a decision will be made at a WCB Hearing. I understand that if both parties opt for resolution by the medical arbitrator, our right to an expedited hearing is waived, and that the resolution by the medical arbitrator is binding and not appealable under WCL § 23. I understand that if I choose to not complete this section, the variance issue will be decided at a Hearing.

By: (print name)..... Title: .....

Signature: ..... Date: .....

F. **CLAIMANT'S REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S / CARRIER'S DENIAL**

☐ I request that the Workers' Compensation Board review the carrier's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made by the ❑ Medical Arbitrator designated by the Chair or ❑ at a WCB Hearing. I understand that both parties, the carrier and the claimant, must opt in writing for resolution by the medical arbitrator; otherwise a decision will be made at a WCB Hearing. I understand that if both parties opt for resolution by the medical arbitrator, our right to an expedited hearing is waived, and that the resolution by the medical arbitrator is binding and not appealable under WCL § 23. I understand that if I choose to not complete this section, the variance issue will be decided at a Hearing.

Claimant's Signature: ..... Date: .....

G. **CARRIER'S / EMPLOYER'S GRANTING OF ATTENDING DOCTOR'S VARIANCE REQUEST AFTER INITIAL DENIAL.**

I certify that the provider's variance request initially denied above is now granted.

By: (print name)..... Title:.....

Signature:..... Date:.....

REQUEST FOR APPROVAL TO VARY FROM MEDICAL TREATMENT GUIDELINES

1. This form is used for a workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit case as follows:
To request approval to vary the treatment of the claimant identified on this form from the relevant Medical Treatment Guidelines.

2. Treating Medical Providers, which includes any physician, podiatrist, chiropractor or psychologist who is providing treatment and care to an injured worker pursuant to the Workers' Compensation Law, **must** treat injuries to the mid and low back, neck, shoulder and knee pursuant to the relevant Medical Treatment Guidelines. The Medical Treatment Guidelines are posted on the Board's website. For additional information, please call 1-800-781-2362.

3. The Medical Treatment Guidelines are the standard of care for injured workers.

4. A variance must be requested using this form. All questions on this form must be answered completely. The treating medical provider must prove that it is appropriate and medically necessary to vary from the Board's Medical Treatment Guidelines in the treatment of this claimant. Failure to provide sufficient reasons why a variance is necessary may result in the denial of the variance or may delay its approval. Your explanation must provide the following information:
   - the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
   - an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

   If applicable, your explanation must also provide:
   - the symptoms, signs, or lack of improvement that compel you to seek the proposed treatment, or
   - a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment.
   - the specific duration or frequency of treatment for which a variance is requested.

   You have the option to submit citations or copies of relevant literature published in recognized, peer-reviewed medical journals as part of the basis in support of this variance request.

5. A supporting medical report must be submitted with this request if such report is not already in the Board's case file. No action will be taken on cases without a supporting medical.

6. If approval or denial is not forthcoming within 15 calendar days after the carrier has received the request and an IME or records review is not required, the variance is deemed approved and the Board will issue an Order of the Chair stating the request is approved. If the payer decides either an IME or records review is required, the payer must notify the Board and Provider within 5 business days that it will be obtaining an outside opinion. The payer has 30 calendar days to get the IME exam or Medical Records Review and submit Form IME-4. If no notice of an IME or Record Review is submitted, the payer has 15 calendar days from the date of the request to reply to the variance request.

7. If the claim is controverted, the Treating Medical Provider must request approval for the variance from the insurance carrier or Special Fund who would be responsible if the claim is established using this form and process.

8. This form must be signed by the Medical Treatment Provider and must contain his/her authorization certificate number and code letters. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.

9. If the carrier has checked "GRANTED WITHOUT PREJUDICE" on the front of this form, the liability for this claim has not yet been determined. This authorization is made pending final determination by the Board. Pursuant to 22NYCRR§325-1.4(b) this authorization is limited to the question of medical necessity only and is not an admission that the condition for which the services are required is compensable. This authorization does not represent an acceptance of this claim by the carrier, self-insured employer, employer or Special Fund or guarantee payment for the services authorized. When a decision is rendered regarding liability, you will receive a Notice of Decision by mail. The carrier, self-insured employer, employer or Special Fund will only provide payment for these services if the claim is established and the carrier, self-insured employer, employer or Special Fund is found to be responsible for the claim.

10. Please ask your patient for his/her WCB case number and the carrier's case number and show these numbers on the form. In addition, ask your patient if he/she has retained a representative. If represented, ask for the name and address of the representative.

11. This request **must be sent by mail, fax or email to the Board** and on the same day serve a copy by mail, fax or email on the workers' compensation insurance carrier or self-insured employer, the patient and the patient's attorney or licensed representative, if represented.

12. HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

TO THE CARRIER/EMPLOYER/SELF-INSURED EMPLOYER/SPECIAL FUND

Response Time and Notification Required:
The carrier/employer/self-insured employer/Special Fund must approve or grant each variance request in writing by completing this form and sending it by fax or email to the Treating Medical Provider, claimant's legal counsel, if any, any parties of interest, and the Workers' Compensation Board. The carrier/employer/self-insured employer/Special Fund may respond orally to the Treating Medical Provider about the variance requested by such provider. If the insurance carrier or Special Fund responds orally, it still must send a written response within the appropriate time period. If the carrier submits a notice of an IME or Medical Records Review within 5 business days of the variance request, the carrier has 30 calendar days to get the IME exam or Medical Records Review and submit Form IME-4. If no notice of an IME or Record Review is submitted, the carrier has 15 calendar days from the date of the request to reply to the variance request.

Denial of the Variance Request: For a denial of a variance request for medical treatment to an established body part the carrier/employer/self-insured employer/Special Fund must explain why it was denied and attach the written report of the medical professional--a physician, registered physician assistant, registered professional nurse, or nurse practitioner licensed by New York State, or the appropriate state where the professional practices, who is employed by an insurance carrier or Special Fund, or has been directly retained by the insurance carrier or Special Fund or is employed by a URAC accredited company retained by the insurance carrier or Special Fund through a contract to review claims and advise the insurance carrier or Special Fund--that reviewed the variance request. Such report shall include a list describing the medical records reviewed by the medical professional when considering the variance request. The carrier has the option to submit citations or copies of relevant literature published in recognized, peer-reviewed medical journals in support of a denial of a variance request

Controverted Claims: If the compensation case is controverted, the carrier/self-insured employer/employer/Special Fund must still respond to the variance request timely and in the same manner as requests in non-controverted claims. If the carrier/employer/self-insured employer/Special Fund approves a variance request when a claim is controverted or the compensability of the body part is controverted, the approval only relates to medical necessity and shall not be construed as an admission that the condition for which variance is requested is compensable. The carrier/employer/self-insured employer/Special Fund shall not be responsible for the payment of medical care which is the subject of the variance request until the question of compensability is resolved.

Failure to Timely Respond to Form MG-2: The variance shall be deemed approved by an Order of the Chair issued by the Workers' Compensation Board if the carrier/employer/self-insured employer/Special Fund fails to respond within the time frames specified above. The Order of the Chair is the final decision of the Board.