NEW YORK STATE | Workers' Compensation Board

IMPORTANT:

PLEASE READ CAREFULLY THE FOLLOWING INFORMATION FOR DETERMINING HOW TO FIND INSURER/SELF-INSURER CONTACTS

MG-1, ATTENDING DOCTOR'S REQUEST FOR OPTIONAL PRIOR APPROVAL AND INSURER'S/EMPLOYER'S RESPONSE

This form requires the name and fax number or email address of the insurer's designated contact listed on the Workers' Compensation Board's website.

Insurer/Self-Insurer's designated contact information is available online at:
wcb.ny.gov/medical-treatment-guideline-optional-prior-approval

NEW YORK STATE Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR OPTIONAL PRIOR APPROVAL AND INSURER'S/EMPLOYER'S RESPONSE

MG-1

FOR ADDITIONAL APPROVAL REQUESTS IN THIS CASE, ATTACH FORM MG-1.1

Answer all questions where information is known.

WCB Case #:	Claim Administrator Claim (Carrier Case) #:	Date of Injury/Illness:

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

Patient's Address: _____

Employer's Name & Address: _____

Insurer's Name & Address: _____

Note: This form is used only if the employer/carrier participates in the Optional Prior Approval program. You can obtain participation status from the WCB Website.

B. Attending Doctor's Name & Address: _____

Individual Provider's WCB Authorization No.: ☐☐☐☐☐☐ - ☐☐ NPI No.: _____

Telephone No.: _____ Fax No.: _____

C. DATE REQUEST SUBMITTED: _____

The undersigned requests optional prior approval under the WCB Medical Treatment Guidelines as indicated below:

Treatment/Procedure Requested: _____

Guideline Reference: ☐ - ☐☐☐☐ *(In first box, indicate injury and/or condition: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, C = **C**arpal Tunnel, P = Non-Acute **P**ain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)*

Date of Service of Supporting Medical in WCB Case File: _____ (**Attach if not already submitted**.)

Comments: _____

Provider **must** enter in **A** the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-optional-prior-approval. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete **B**.

A. *Insurer's designated fax # or email address as provided on the Board's website:* _____

☐ ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

A copy was sent to the Workers' Compensation Board (see the Board's email address and fax number on the reverse).

I certify that I am making the above request for authorization. This request was made to the insurer/self-insurer using the following means of same-day transmission (A or B):

Provider's Signature: _____ Date: _____

D. INSURER'S / EMPLOYER'S RESPONSE (Response is due within 8 business days of receipt of this request or medical care is deemed approved (12 NYCRR 324.4(c)). The provider's request is: ☐ **Granted** ☐ **Granted without Prejudice (see item 7 on reverse)** ☐ **Denied**

IF DENIED, STATE THE BASIS FOR THE DENIAL IN THE SPACE PROVIDED BELOW. **SEE IMPORTANT INFORMATION FOR INSURER ON REVERSE.**

Name of the Medical Professional who Reviewed the Denial: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting optional prior approval, the Workers' Compensation Board (see email address and fax number on the reverse).

By (print name): _____ Title: _____

Signature: _____ Date: _____

E. MEDICAL PROVIDER'S REQUEST FOR REVIEW BY MEDICAL ARBITRATOR OF DENIAL

☐ I hereby request review by a medical arbitrator designated by the Chair of the insurer's decision to deny optional prior approval of the above request. I understand that resolution by the medical arbitrator is binding and is not appealable under Workers' Compensation Law §23. (Request is due within 14 calendar days of the date of denial.) Supporting medical report(s) dated _____ is/are attached or available in the WCB case file.

Provider's Signature: _____ Date: _____

F. INSURER / EMPLOYER IS APPROVING THIS REQUEST FOR OPTIONAL PRIOR APPROVAL AFTER AN INITIAL DENIAL

☐ I certify that the provider's request for optional prior approval given above, **which was initially denied on** _____, is now granted.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

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REQUEST FOR OPTIONAL PRIOR APPROVAL

IMPORTANT TO TREATING MEDICAL PROVIDER

1. This form is used for a workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit case as follows: To request optional confirmation from the insurer, self-insured employer, employer or Special Fund that the procedure or test is based on a correct application of the Medical Treatment Guidelines.

2. This form must be signed by the treating medical provider and must contain her/his authorization number and code letters. Out-of-State medical providers must enter their NPI number. 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. The signature can be the original or a stamp or an electronic signature as long as the medical provider has the intent to sign the completed form. The provider must review and approve each completed form. Also, someone else cannot sign the medical provider's name.

3. Please ask the patient for his/her WCB case number, if available, and the claim administrator claim (carrier case) number and show these numbers on this form.

4. Provider **must** enter in **A** the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-optional-prior-approval. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete **B**. **Failure to submit the request to the designated contact identified on the Board's website may result in your request being denied.** A copy should also be sent to the Board on the same day using one of the prescribed methods of same day transmission.

5. If authorization or denial is not forthcoming within 8 business days after the insurer has received the request, the test or treatment is deemed approved and the Board will issue a Notice of Resolution stating the request is approved.

6. If the insurer 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 12 NYCRR § 324.4(d) 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 insurer, 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 insurer, self-insured employer, employer or Special Fund will only provide payment for these services if the claim is established and the insurer, self-insured employer, employer or Special Fund is found to be responsible for the claim.

7. 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 pursuant to the relevant Medical Treatment Guidelines. The Medical Treatment Guidelines are posted on the Board's website. For additional information, please call (800) 781-2362.

8. The Medical Treatment Guidelines are the standard of care for injured workers. Additional information about the Medical Treatment Guidelines, including e-learning training, is available on the Board's website.

9. HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL § 13-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 insurer or employer. Pursuant to 45 CFR §164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

IMPORTANT INFORMATION TO THE INSURER / SELF-INSURER/ SPECIAL FUND

A denial of this request based on Medical Treatment Guideline reasons does not require a supporting medical; however, the insurer/self-insurer/employer/special fund should indicate the section of the Medical Treatment Guidelines that supports its denial. All denials must be reviewed by a 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 insurer or Special Fund, or has been directly retained by the insurer or Special Fund or is employed by a URAC accredited company retained by the insurer or Special Fund through a contract to review claims and advise the insurer or Special Fund. If the claim is controverted or the time to controvert the case has not expired, this authorization is made pending final determination by the Board. Pursuant to 12 NYCRR § 324.4(d) 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 insurer, 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 insurer, self-insured employer, employer or Special Fund will only provide payment for these services if the claim is established and the insurer, self-insured employer, employer or Special Fund is found to be responsible for the claim.

NYS Workers' Compensation Board
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Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: 877-632-4996 • Statewide Fax: 877-533-0337