IMPORTANT:

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

MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'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-variance-request

NEW YORK STATE | Workers' Compensation Board

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

MG-2

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

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

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

Patient's Address: _____

Employer's Name & Address: _____

Insurer's Name & Address: _____

B. Attending Doctor's Name & Address: _____

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

Telephone No.: _____ Fax No.: _____

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

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. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (<u>one</u> request type per form)

STATEMENT OF MEDICAL NECESSITY - See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- 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; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of service of supporting medical in WCB case file, if not attached: _____

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

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-variance-request. 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**. If you are unable to send or receive email or fax, complete **C**.

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:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

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 patient understands and agrees to undergo the proposed medical care. I ☐ did / ☐ did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) _____ and spoke to (person spoke to or was not able to speak to anyone) _____

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: _____

MG-2.0 4-18

Patient Name:	WCB Case #:	Date of Injury/Illness:

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

☐ The self-insurer/insurer hereby gives notice that it will have the patient 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: _____

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

_____

_____

_____

_____

_____

INSURER'S / EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space provided.

☐ Granted
☐ Granted in Part
☐ Without Prejudice

☐ Denied
☐ Burden of Proof Not Met
☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

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

By: (print name) _____ Title: _____

Insurer's Signature: _____ Date: _____

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.

☐ I request that the Workers' Compensation Board review the insurer'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 ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's 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.

NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-52055

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337

TO THE PROVIDER - 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 patient identified on this form from the relevant Medical Treatment Guidelines.

2. This form must be signed by the Treating Medical Provider and must contain his/her 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.

3. Please ask your patient for his/her WCB case number and the claim administrator claim (carrier 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.

4. This request must be served on the workers' compensation insurer, Special Fund, or self-insured employer's designated contact identified on the Board's website: wcb.ny.gov/medical-treatment-guideline-variance-request. **Failure to submit the request to the designated contact identified on the Board's website may result in your request being denied.** It may be mailed, return receipt requested, if the certification is completed that the Treating Medical Provider is not equipped to send and receive the form by one of the prescribed methods of the same day transmission. On the same day, a copy must also be sent to the Board, the patient, and the patient's legal representative, if any.

5. 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 patient, and that patient agrees to the proposed medical care. 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 patient and is medically necessary at this time; and
   - an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

   Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
   - 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; and
   - the specific duration or frequency of treatment for which a variance is requested.

   Variance requests for treatment or testing that is not recommended or not addressed, must include:
   - the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
   - medical evidence in support of efficacy of the proposed treatment or testing - may include relevant medical literature published in recognized peer reviewed journals.

   No variance will be permitted for patients who exceed the 10 visit annual maximum for on-going maintenance care.

6. 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 report. A medical report supporting the denial of the variance request is not necessary when the denial is based upon the allegation that (1) the provider did not meet the burden of proof that a variance is appropriate, (2) the medical care for which the variance is requested has already been rendered, (3) the medical care requested is not covered under Section 13(a) of the Workers' Compensation Law, (4) the patient did not appear for a scheduled independent medical examination. or (5) a new variance request was submitted prior to a substantially similar being granted or denied or a prior identical variance request has been denied, and the resubmitted request does not contain any additional documentation or justification.

7. If approval or denial is not forthcoming within 15 calendar days after the insurer has received the request and an IME or Medical Record 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 insurer decides either an IME or records review is required, the insurer must notify the Board and Treating Medical Provider within 5 business days that it will be obtaining an outside opinion. The insurer 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 Medical Record Review is submitted, the insurer has 15 calendar days from the date of the request to reply to the variance request.

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

9. If the insurer has checked "GRANTED" or "GRANTED IN PART" AND "WITHOUT PREJUDICE" in Section E, the liability for this claim has not yet been determined. This authorization is made pending final determination by the Board. Pursuant to 12 NYCRR § 324.3(b)(4), 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.

10. If the insurer has checked "SUBSTANTIALLY SIMILAR REQUEST PENDING OR DENIED" in Section E, the denial is not subject to an Order of the Chair. A substantially similar variance request may not be submitted unless the insurer has denied a previous request. Substantially similar requests that were previously denied may be submitted with additional documentation or justification.

11. 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.

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

13. 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.

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

Response Time and Notification Required:
The insurer/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 insurer/ employer/self-insured employer/Special Fund may respond orally to the Treating Medical Provider about the variance requested by such provider. If the insurer or Special Fund initially respond orally, it still must send a written response within the appropriate time period. If the insurer submits a notice of an IME or Medical Records Review within 5 business days of the variance request, the insurer 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 Medical Record Review is submitted, the insurer 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, the insurer/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 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 -- 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 insurer 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. A medical report supporting the denial of the variance request is not necessary when the denial is based upon the allegation that (1) the provider did not meet the burden of proof that a variance is appropriate, (2) the medical care for which the variance is requested has already been rendered, (3) the medical care requested is not covered under Section 13(a) of the Workers' Compensation Law, (4) the claimant did not appear for a scheduled independent medical examination, or (5) a new variance request was submitted prior to a substantially similar request being granted or denied or a substantially similar variance request has been denied, and the resubmitted request does not contain any additional documentation or justification.

Controverted Claims:
If the compensation case is controverted, the insurer/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 insurer/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 insurer/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 Variance Report:
A valid variance may be deemed approved by an Order of the Chair issued by the Workers' Compensation Board if the insurer/employer/self-insured employer/Special Fund **fails to respond to a properly completed request within the time frames specified above**. The Order of the Chair is the final decision of the Board.