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

MG-2

State of New York - Workers' Compensation Board

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

WCB Case Number: 00000005	Carrier Case Number: 028905	Date of Injury: 07/05/14

A. Patient's Name: Jack (First) D (MI) Ryan (Last) Social Security No.:

Patient's Address: 872 State Highway 97, Hancock, NY

Employer's Name & Address:

Insurance Carrier's Name & Address: All Insurance Company, 4 South Street, Anytown, NY

B. Attending Doctor's Name & Address: Cristina Yang MD, Central Hospital, Hancock, NY 13783

Individual Provider's WCB Authorization No.: I R 1 1 1 1 - 1 1 Telephone No.: 607-555-1212 Fax No.: 607-555-1213

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

Guideline Reference: B - D 9 a ☐ *(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: (one request type per form)

Therapeutic exercise 3x/wk additional 4 weeks

STATEMENT OF MEDICAL NECESSITY - See item 4 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 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.

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 already submitted: Sep 18, 2014

Date(s) of previously denied variance request for substantially similar treatment, if applicable: None

See attached statement of necessity.

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 (fax number or email address required) 607-444-9999
A copy was sent 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 within two (2) business days of 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 _____

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: Cristina Yang MD Date: Sep 19, 2014