WORKERS' COMPENSATION BOARD
New York State

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

MG-1

State of New York - Workers' Compensation Board

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

Answer all questions where information is known.

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

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

Patient's Address: _____

Employer's Name & Address: _____

Insurance Carrier'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.: ☐☐☐☐☐☐-☐☐ 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 body part: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, C = **C**arpal Tunnel In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)*

Date of Service of Supporting Medical in WCB Case File: _____ (**if not already in file, please attach**.)

Other Comments:

I certify that I am making the above request for optional prior approval and my affirmative statements are true and correct. I ☐ did / ☐ did not contact the carrier by telephone to discuss this request before making it. I contacted the carrier by telephone on (date) _____ and spoke to (person spoken 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 number or e-mail address required) _____

A copy was sent to the Workers' Compensation Board (see the Board's email address and fax number on the reverse), and copies were provided to the claimant's legal counsel, if any, and to any other parties of interest on the date below.

Provider's Signature: _____ Date: _____

D. CARRIER'S / EMPLOYER'S RESPONSE (Response is due 8 business days from 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 TO CARRIER 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), the claimant's legal counsel, if any, and any other parties of interest, on the date below.

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 carrier'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 is/are available in the WCB case file.

Provider's Signature: _____ Date: _____

F. CARRIER / 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: _____

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 insurance carrier, self-insured employer, employer or Special Fund that the procedure or test is based on a correct application of the 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 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. Additional information about the Guidelines, including e-learning training, is available on the Board's website.

4. This form must be signed by the treating medical provider and must contain her/his 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. 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.

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

This request must be sent to the Workers' Compensation Board, the workers' compensation insurance carrier, self-insured employer, employer or Special Fund, and, if the patient is represented by an attorney or licensed representative, to such legal representative. If your patient is not represented, a copy must be sent to your patient.

6. If authorization or denial is not forthcoming within 8 business days after the carrier 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.

7. 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 22 NYCRR § 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.

8. 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.

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

A denial of this request based on Medical Guideline reasons does not require a supporting medical; however, the carrier/ self-insurer/employer/special fund should indicate the section of the 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 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. 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 22 NYCRR § 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.

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

Customer Service Toll-Free Number: 877-632-4996

Address for Email Filing: wcbclaimsfiling@wcb.ny.gov **Statewide Fax Line: 877-533-0337**