CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE **MG-2.1**

Patient	WCB Case Number	Carrier Case Number	Date of Injury

Doctor's Name	Doctor's WCB Authorization Number	Patient's Social Security Number

INSTRUCTIONS TO ATTENDING DOCTOR: **This form is not to be filed separately.** Attach to completed Form MG-2 if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

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

Date of service of supporting medical in WCB case file (attach if not in file): _____ Date(s) of previously denied variance request (for substantially similar treatment, if applicable): _____

Approval Requested for: _____

Medical Necessity: _____

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

Date of service of supporting medical in WCB case file (attach if not in file): _____ Date(s) of previously denied variance request (for substantially similar treatment, if applicable): _____

Approval Requested for: _____

Medical Necessity: _____

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

Date of service of supporting medical in WCB case file (attach if not in file): _____ Date(s) of previously denied variance request (for substantially similar treatment, if applicable): _____

Approval Requested for: _____

Medical Necessity: _____

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

Date of service of supporting medical in WCB case file (attach if not in file): _____ Date(s) of previously denied variance request (for substantially similar treatment, if applicable): _____

Approval Requested for: _____

Medical Necessity: _____

STATEMENT OF MEDICAL NECESSITY - See requirements on Form MG-2.

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.

 CONTINUED ON REVERSE

Patient Name: _____	WCB Case Number: _____	Date of Injury: _____

HEALTH PROVIDER'S CERTIFICATION

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 number or e-mail address required) _____

A copy was sent (see address 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 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: _____

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

☐ The carrier/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

C. CARRIER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Carrier's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons according to Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 3: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 4: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 5: ☐ 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 appropriate: _____

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 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, 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 ☐ at a WCB Hearing. I understand that if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing; the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, 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: _____

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/CARRIER'S DENIAL

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

☐ I request that the Workers' Compensation Board review the carrier's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 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 if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing;the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, 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: _____