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NYS Workers' Comp Variance Training **Chiropractic Providers**

TRAINING GUIDE

SUBMITTING VARIANCES FOR CHIROPRACTIC TREATMENT UNDER NEW YORK STATE WORKERS' COMPENSATION LAW

10 Essential Questions & Answers for Practicing Chiropractors

This guide covers the MTG Variance PAR process as administered through the NYS Workers' Compensation Board's OnBoard system, documentation requirements, common pitfalls, and best practices for chiropractic providers.



IMPORTANT DISCLAIMER

This training guide is for educational purposes only and does not constitute legal advice. The information is based on the NYS Workers' Compensation Board's Medical Treatment Guidelines, fee schedules, and published guidance as of early 2026. Regulations, forms, and procedures are subject to change. Always consult the WCB website (www.wcb.ny.gov) for the most current rules, and consider consulting with a workers' compensation attorney for case-specific legal questions.



NYS Workers' Comp Variance Training *Chiropractic Providers*

10 Essential Questions & Answers for Practicing Chiropractors

Q1. What are the New York State Medical Treatment Guidelines (MTGs), and when is a variance required?

A: The MTGs are evidence-based protocols adopted by the NYS Workers' Compensation Board that establish the standard of care for treating work-related injuries involving the cervical spine, lumbar and thoracic spine, shoulder, knee, carpal tunnel syndrome, and non-acute pain. Treatment that correctly follows the MTGs is pre-authorized—no prior approval from the insurance carrier is needed. A variance is required whenever you need to provide treatment that is not recommended by the MTGs, or that exceeds the frequency or duration limits they set. The carrier is not liable for non-guideline treatment unless a variance has been approved.

Q2. How are variance requests submitted?

A: Since May 2, 2022, all variance requests must be submitted electronically as MTG Variance PARs (Prior Authorization Requests) through the WCB's OnBoard system, accessed via the Medical Portal. The former paper MG-2 form can no longer be faxed, emailed, or mailed. OnBoard automatically routes the request to the correct claim administrator. Your office staff may help prepare the PAR as delegates in the system, but you as the treating chiropractor are responsible for the clinical content and the Statement of Medical Necessity.

Q3. What are the response deadlines for the insurance carrier after I submit a Variance PAR?

A: The carrier has 15 calendar days to respond (calculated under General Construction Law, so if the deadline falls on a weekend or holiday it extends to the next business day). If the carrier instead elects to arrange an Independent Medical Examination (IME) or medical records review, it must notify the parties within five business days and then has 30 calendar days from receipt of the request to respond. If the carrier fails to respond within the required timeframe, the variance is deemed approved by an Order of the Chair.



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Q4. What must my Statement of Medical Necessity include when requesting additional visits beyond the MTG limits?

A: Your statement must include four elements: (1) The basis for your opinion that the proposed care is appropriate and medically necessary at this time. (2) An explanation of why alternative treatments in the MTGs are not appropriate or sufficient. (3) A description of the functional outcomes that have continued to demonstrate objective improvement and are reasonably expected to further improve with additional treatment. (4) The specific duration or frequency of treatment you are requesting. Vague statements like “patient is improving” are insufficient—you must be precise and quantitative.

Q5. What types of objective functional improvement should I document to support a variance?

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Q6. What are the chiropractic visit limits under the MTGs for mid/low back injuries, and what triggers the need for a variance?

A: For acute and sub-acute low back pain, chiropractic manipulation is generally authorized at up to three times per week for the first month, and up to twice per week for the second month. The MTGs also require that manipulation has produced a documented beneficial effect between the first and sixth treatments. Once you reach the maximum authorized visits, you must submit a Variance PAR before continuing care. For treatment beyond three months, you must clearly document re-injury, interrupted continuity of care, exacerbation of symptoms, or proof of co-morbidity. Scheduled, prophylactic treatment will not be approved.



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Q7. Should I use specific language from the MTGs in my variance requests?

A: Yes—this is strongly recommended. Reviewers at the insurance carrier and the WCB evaluate your request against the language in the guidelines. Mirroring terms such as “objective functional improvement,” “positional tolerances,” “activities of daily living,” and “re-injury or exacerbation of symptoms” demonstrates that you understand and are applying the Board’s framework. This significantly increases the likelihood of approval.

Q8. What is an ongoing maintenance care program, and can I request a variance for additional maintenance visits?

A: An ongoing maintenance care program provides spinal manipulation (or other modalities) for patients who have reached Maximum Medical Improvement (MMI) and have a documented permanent disability. It is limited to 10 visits per year and does not require a variance. However, no variance for visits beyond the 10-visit annual cap is permitted. If the patient experiences a significant change in condition—such as an exacerbation or aggravation—new treatment may be requested based on that change, but it is treated as a new treatment episode, not an extension of the maintenance program.

Q9. What happens if my Variance PAR is denied?

A: If denied, the injured worker has 21 business days to request a hearing before a Workers’ Compensation Law Judge. Alternatively, both parties may opt for resolution by a Medical Arbitrator designated by the Chair. You may resubmit a substantially similar variance only if you include additional supporting medical evidence not present in the original submission. If no new clinical evidence exists, a duplicate request will be rejected without review.



Q10. What are the most common reasons chiropractic variance requests are denied, and how can I avoid them?

A: The most common reason is inadequate documentation—specifically, relying on subjective patient reports instead of objective, measurable functional improvement; failing to explain why MTG-recommended alternatives are insufficient; requesting routine or palliative care (which is never approved); and not specifying the exact number of visits, frequency, and duration requested. To optimize approvals: document quantifiable improvement at every visit, use the specific language of the MTGs, submit your variance before the authorized treatment window expires (not after you have already exceeded the limits), be precise about what you are requesting, and track all response deadlines in OnBoard so you can identify deemed approvals if the carrier fails to respond in time.

BONUS QUESTION

Q11. What are some of the most common “mistakes” made when requesting treatment or documenting care?

A: One of the most common “mistakes” when documenting care is the overuse of the term “exacerbation.” In Workers’ Compensation Law, this is a loaded term that has many applications. In some instances, an exacerbation could be considered a new accident and thus complicate a claimant’s claim moving forward. The history taken at any given exam may have a significant effect on a claimant’s ability to seek continued care under Workers’ Compensation Law or even wage replacement benefits. Please be mindful that if you are going to document an exacerbation, a detailed history must be taken as to the cause of the exacerbation and whether it would be considered a new injury or just a temporary increase in symptoms without a “true” inciting event.



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Additionally, it's important to remember that a claimant is entitled to "pre-authorized" care under the medical treatment guidelines.

For example:

On page 47 of the NYS WCB MTG - Mid and Low Back Injury notes:

Recommended - for treatment of acute back pain when tied to objective measures of improvement and there is no evidence of fracture or significant instability. Care needs to be taken in patients with known spinal stenosis.

Frequency: Up to three times per week for the first four weeks as indicated by the severity of involvement and the desired effect, then up to two treatments per week for the next four weeks with re-evaluation for evidence of functional improvement or need for further workup.

Time to produce effect for all types of manipulative treatment: one to six treatments.

Continuance of treatment will depend upon functional improvement

Optimum Duration: Eight to twelve weeks. Maximum Duration: Three months. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities.

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