

**The California Commission
on Health and Safety
and Workers' Compensation**



**CHSWC Report and Recommendations on the
Spinal Surgery Second-Opinion Process**

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I. EXECUTIVE SUMMARY

Faced with the perception that back surgery was being recommended too frequently and possibly inappropriately by treating physicians, the legislature enacted Senate Bill (SB) 228 in 2003. SB 228 created the Spinal Surgery Second-Opinion Process (SSSOP) specifically for the narrow purpose of allowing employers and employees an avenue to resolve disputes over the medical necessity of spinal surgery. SB 228 also adopted Labor Code Section 4610 covering utilization review (UR) formalizing the process for employers' objections to medical treatment.

A provision of SB 228 requires the Commission on Health and Safety and Workers' Compensation (CHSWC) to conduct a study on the SSSOP and issue a report concerning the findings of the study and recommendations for further legislation.

CHSWC contracted with the University of California (UC) Berkeley for an evaluation of the SSSOP. Subsequently, CHSWC added a survey component with injured workers to the study. This report updates the August 5, 2006 SSSOP Interim Report, incorporates the results of the survey, and proposes two alternatives to address additional concerns raised. (See Proposed Legislative Alternatives, Appendix I).

Analysis by UC Berkeley finds that the concurrent adoption of UR made important parts of the SSSOP legislation unnecessary. In light of the findings of the report, CHSWC recommends the following legislative alternatives for consideration:

- The SSSOP should be eliminated, so that spinal surgery issues are subject to the same UR and agreed medical evaluator/qualified medical evaluator (AME/QME) process as other treatment issues,

Or

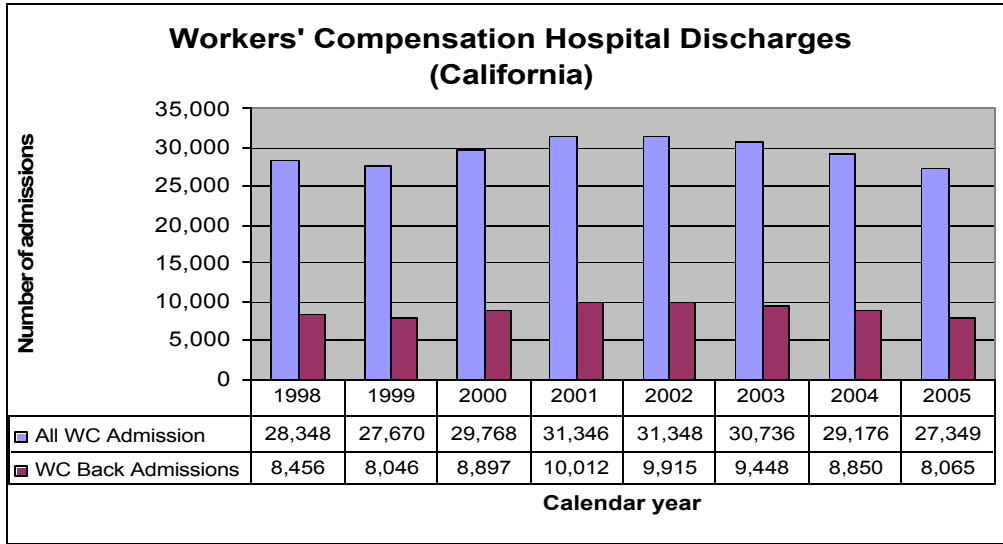
- The SSSOP should become solely the method for an injured worker to challenge a UR decision denying authorization for spinal surgery, while UR would be the sole method for an employer to object to a recommendation for spinal surgery on the grounds of medical necessity.

Modifications to the SSSOP statutory language could significantly streamline the medical review process, limit delays, and reduce costs while still controlling unnecessary surgeries. Below is a summary the findings from the CHSWC study and their implications for legislative action.

Frequency of Spinal Surgery

The CHSWC Interim Report found that spinal surgery for occupational injuries was 60% to 110% more common in California than nationally, suggesting that the workers' compensation community's perception that surgeries were too frequent was correct. An update extending the data from that study finds that the frequency of spinal surgery peaked in 2001 and has since declined by 20%. However, the decline in spinal surgery began well before the adoption of SSSOP, and the trend did not change subsequent to its implementation.

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Impact of SSSOP on Utilization and Outcomes

UC Berkeley conducted a survey of workers for whom an SSSOP was requested. The survey was requested by CHSWC to determine how the SSSOP was affecting surgery decisions and, in turn, how it was affecting workers' outcomes.

| Survey of Workers Originally Recommended for Surgery by Treating Physician | | |
|---|------------------|--------------|
| | Non-SSSOP | SSSOP |
| Received a 2nd opinion | 87.6% | 91.5% |
| 2nd opinion agreed with Treating Physician | 65.9% | 71.4% |
| Had spinal surgery | 63.6% | 65.2% |
| Returned to work | 34.1% | 24.1% |
| Back condition change (1= much worse, 5=much better) | 3.2 | 3.1 |

No differences are statistically significant except return to work.

The survey compared the response of workers who were subject to the SSSOP to a similar number of workers whose employers requested a second opinion, but because of missed deadlines or other regulatory missteps, the request for a second opinion was denied.

It is reasonable to consider these two groups of potential back surgery patients as similar. All of the workers had treating physicians who recommended back surgery. In all cases, the employer/claims administrator objected to the surgery. In addition, in all cases, the employer/claims administrator filed a request for a second opinion to determine the appropriateness of surgery. These cases appear to differ mainly in whether the employer/claims administrator accurately pursued the second-opinion process and did so within the narrow time frames required by regulation. When the employer followed the procedures accurately, the worker was required to get a second opinion from a state-designated spinal surgery specialist. When the employer did not accurately follow procedures, the employer/claims administrator could not compel a second opinion, but could request that the worker seek a second opinion, the option available before the SSSOP was adopted. Any differences between these two groups could be seen as the impact of a mandatory second-opinion process.

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The comparison is quite compelling:

- Even though employers could not compel a second opinion when failing to complete the SSSOP, workers reported high and very similar probabilities that they received a second opinion in both groups.
- A reason for random assignment of second-opinion evaluators is the concern that workers may be directed to evaluators who favor one side's position. However, it was observed that both groups responded that the second opinion disagreed with the original recommendation for surgery at very similar rates.
- Most telling, the probability that the worker actually got surgery was nearly identical between the two groups, despite the differences in the process.
- The only statistically significant difference is on the return-to-work measure. Workers who did not go through the SSSOP were more likely to be back at work on the interview date. The most likely explanation for this difference is that the SSSOP took longer to complete than second opinions achieved under an alternative process. Time from surgery to interview is an important determinant of the probability that a worker will be back at work on the interview date.
- Respondents in both groups reported similar change in their back condition. Those reporting improvement were almost entirely balanced out by those reporting their condition as worse than before the original recommendation for surgery.

Consequently, given UR regulations, there is little support for the SSSOP affecting employers' ability to obtain a second opinion or avoid unnecessary surgery. In addition, the SSSOP does not seem to affect workers' ability to get a fair evaluation.

On the other hand, recent court decisions have made clearer the role of SSSOP as an avenue for workers to dispute UR decisions. For workers, the SSSOP offers access to independent opinions rendered by high-quality physicians appropriately trained to render decisions on spinal surgery.

CHSWC recommendations for changes in legislative language covering SSSOP are meant to clarify the interaction with UR, limit unnecessary employer requests for SSSOP assignment, and highlight the role of SSSOP for resolving workers' disputes of UR rejections of surgery.

Other key findings:

- Workers who had surgery reported much greater improvement in their health status relative to their condition when surgery was originally recommended.
- On the other hand, workers who had surgery were much less likely to be back at work.
- Finally, an interesting and challenging result was that women who had a second opinion were much more likely than men to have that opinion disagree with surgery. This result deserves further review.

These data were collected an average of 12 months after the original recommendation for surgery. It might be important to follow up these workers at 2 years to determine the effect of surgery on health and work status.

In conclusion, SSSOP was adopted when statute, regulation, and custom did not allow for extensive use of UR by employers/insurers. The adoption of more intensive UR and introduction of the American College of Occupational and Environmental Medicine (ACOEM) guidelines have probably eliminated the need for SSSOP. Comparing workers subject to SSSOP and those who were not, no important differences were observed in the likelihood of a second opinion being issued or the probability that the second opinion recommends against surgery. On the other hand, the SSSOP process may require more time and delay return to work.

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II. SPINAL SURGERY SECOND-OPINION STUDY

II.a Recent Legislative and Statutory Changes Affecting Treatment and Surgical Intervention for Back Conditions in Workers' Compensation

A number of statutory and regulatory changes to the delivery of medical treatment were adopted as part of a series of legislative changes meant to control medical-treatment costs and improve the quality of medical care while maintaining access to high-quality medical treatment for injured workers. Among the changes was the introduction of a second-opinion process when the treating physician recommended spinal surgery for a workers' compensation case.

In 2003, the California workers' compensation system had become by far the most expensive such system in the country. Compensation costs in California had risen from \$9 billion in 1993 to \$32 billion in 2002, and cost as a percent of payroll was projected to be \$6.10/\$100 as of January 1, 2004. The bi-annual publication by the Oregon Department of Consumer and Business Services, comparing the relative cost of states' workers' compensation systems, ranked California number one, almost 40% higher than the next-highest state (Florida) and almost two and a half times the national median (Reinke and Manley, 2004). This crisis led to a number of significant reforms that were meant to reduce costs, particularly medical-treatment costs.

In 2003, two bills signed by former Governor Gray Davis, Assembly Bill (AB) 227 and SB 228, established standardized reimbursement rates for virtually every medical care provider, including out-patient surgery centers; reduced fee schedule amounts for pharmaceuticals; capped the number of visits to chiropractors and physical therapists; required UR which would apply standards of care for injuries; and backed utilization reviews with standardized guidelines developed by the ACOEM. Despite the reforms, workers' compensation in California remained the most expensive system in the country.

In April 2004, Governor Arnold Schwarzenegger signed additional reform legislation, SB 899. The law tightened eligibility for permanent disability payments; reduced indemnity payments for most permanent impairments; capped payments for temporary disability; allowed employers the option of establishing a medical provider network which would allow medical control for the life of the claim; and clarified the legal authority of the ACOEM guidelines. Combined, the series of reforms was expected to reduce costs by more than \$10 billion.

During this series of legislative reforms, employers and insurers had raised particular concerns about spinal surgery. The main concerns were that: (1) the incidence of spinal surgery was increasing rapidly; (2) the rate of spinal surgery in California was out of line with other states and other medical systems; (3) the outcomes for workers were generally poor; and (4) additional utilization control procedures were necessary to effectively control inappropriate over-utilization. These concerns, if true, suggested that reducing the frequency of spinal surgery could potentially reduce costs for employers while improving outcomes for workers. Consequently, SB 228 provided a mechanism allowing employers to require a second opinion before spinal surgery was performed, the SSSOP. This was meant to limit inappropriate back surgery cases.

II.b Concerns Leading to SSSOP

Expanding on the discussion above, the Legislature enacted SSSOP because of arguments that:

- 1) Hospital costs were increasing rapidly.
- 2) The rapid increase in spinal surgery was an important cost-driver in hospital costs.
- 3) The rate of spinal surgery in California was out of line with other states and other medical systems.

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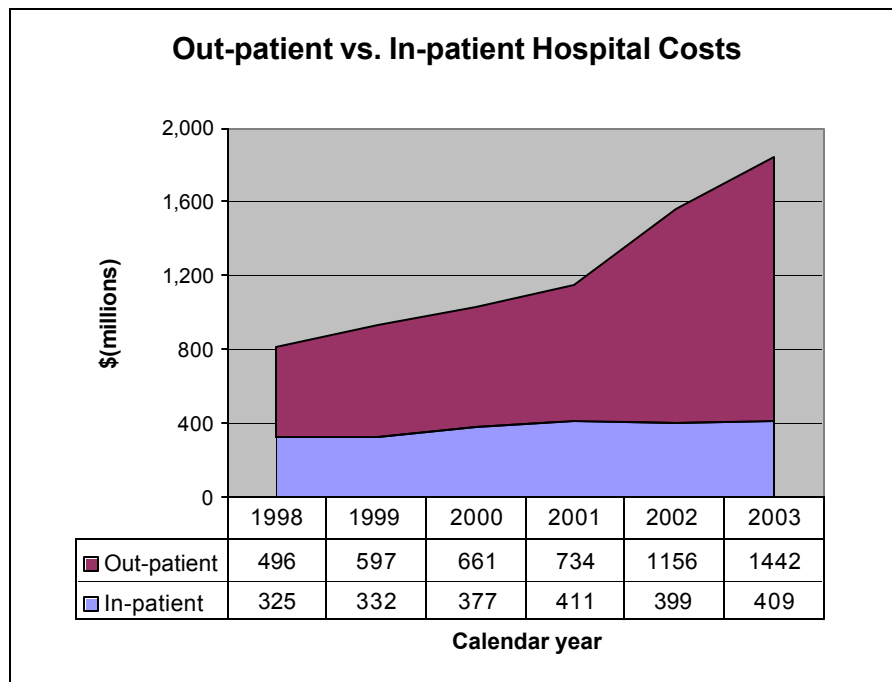
- 4) Outcomes for workers were generally poor and might not be cost-effective.
- 5) Appropriate UR procedures would be effective controls on inappropriate over-utilization.

The arguments will be analyzed, evaluating the support and supplying data that can be used over time to monitor the impact of the SSSOP process.

II.b.1 Were hospital costs increasing rapidly?

During the late 1990s and early 2000s, hospital costs were second only to pharmaceuticals as having the highest annual growth in calendar-year paid amounts [Workers' Compensation Insurance Rating Bureau (WCIRB) annual reports 1999-2004]. Total paid amounts for insured employers classified as "hospital" increased from \$800 million to \$1.9 billion over the five years between 1998 and 2003. However, "hospital" costs as defined by the WCIRB combine both inpatient stays (overnight) and out-patient/ambulatory surgery centers. Spinal surgery, because of the complex nature of the procedure, is ordinarily done on an inpatient basis. In addition, while inpatient procedures were controlled by a fee schedule, out-patient procedure charges were not covered by a fee schedule until SB 228 in 2003. The lack of a fee schedule to control out-patient surgery was seen as a probable cost-driver in this area of "hospital" payments. What was not known was the portion of "hospital" costs that was driven by inpatient spinal surgery.

Consequently, for this report, we made separate estimates for inpatient and out-patient paid amounts. We used data on all inpatient stays in California from a database maintained by the Office of State Health Planning and Development (OSHPD) for the years 1998-2003 in combination with the Division of Workers' Compensation (DWC) Inpatient Hospital Fee Schedule for the same period.¹ These data are presented in the graph and table below.



Inpatient paid amounts increased only moderately over this period, increasing 26% or about 4.8% annually. Out-patient/ambulatory surgery increased by 191% over the same period, about 24% annually, with the rate accelerating rapidly after 2001. It can be concluded that despite the common perception,

¹ Available at <http://www.dir.ca.gov/dwc/OMFS9904.htm>

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inpatient hospital costs were not the main driving force behind hospital cost growth, and similarly, were not the driver behind overall medical cost growth.

II.b.2 Was the occurrence of spinal surgery increasing rapidly?

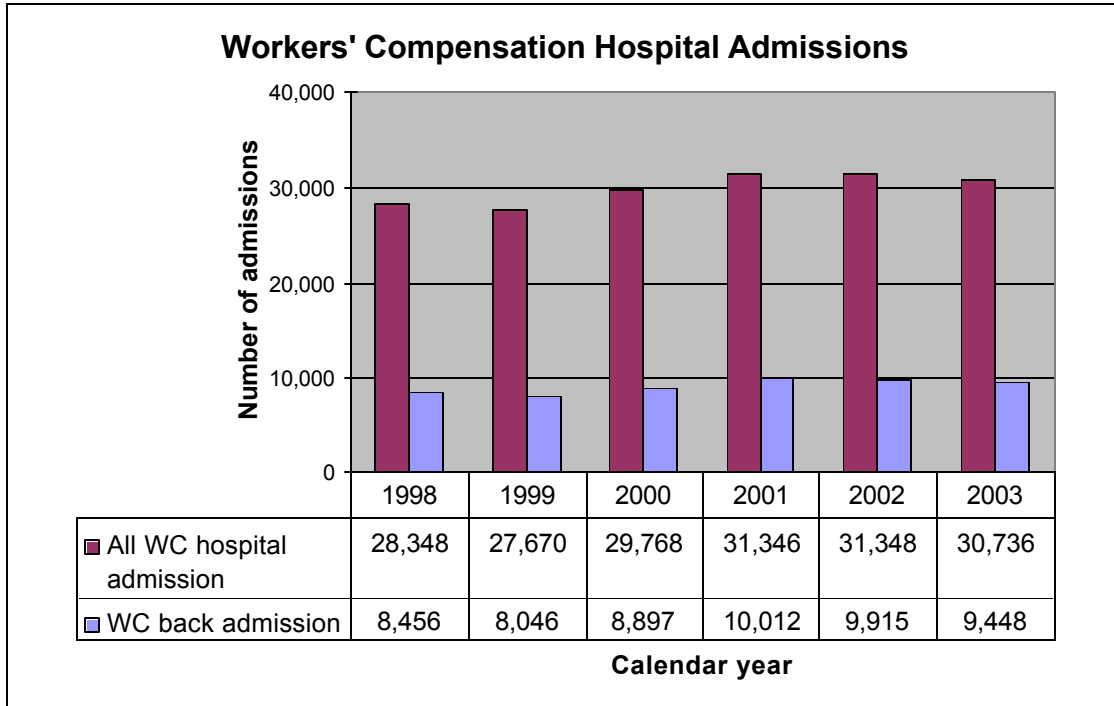
Even if inpatient hospital costs were fairly stable, as observed above, occurrence of spinal surgery could be increasing rapidly if most other procedures were declining in frequency or severity. A possible explanation for this is explored in this section.

OSHPD data includes the Diagnostic Related Group (DRG) under which the inpatient stay was billed. DRGs are used by most payors (including California workers' compensation and Medicare/Medicaid) to reimburse hospitals. The table below gives the DRGs that cover spinal surgery inpatient stays. OSHPD data also identify the source of payment, including workers' compensation. The table also gives the Relative Value which is used to determine payments. Relative Values are multiplied by a fixed dollar amount to determine the ultimate paid amount.

| DRG | Description | Relative Value (2003) |
|---|--|----------------------------------|
| 496 | Combined anterior/posterior spinal fusion | 5.6839 |
| 497 | Spinal fusion with complications | 3.4056 |
| 498 | Spinal fusion without complications | 2.5319 |
| 499 | Back & neck procedure except fusion w/ CC | 1.4244 |
| 500 | Back & neck procedure except fusion w/o CC | 0.9369 |
| 511* | Cervical fusion w/ CC | 2.4266 |
| 512* | Cervical fusion w/o CC | 1.5780 |
| *511 & 512 were separated from 497 and 498 respectively in 2002 | | |

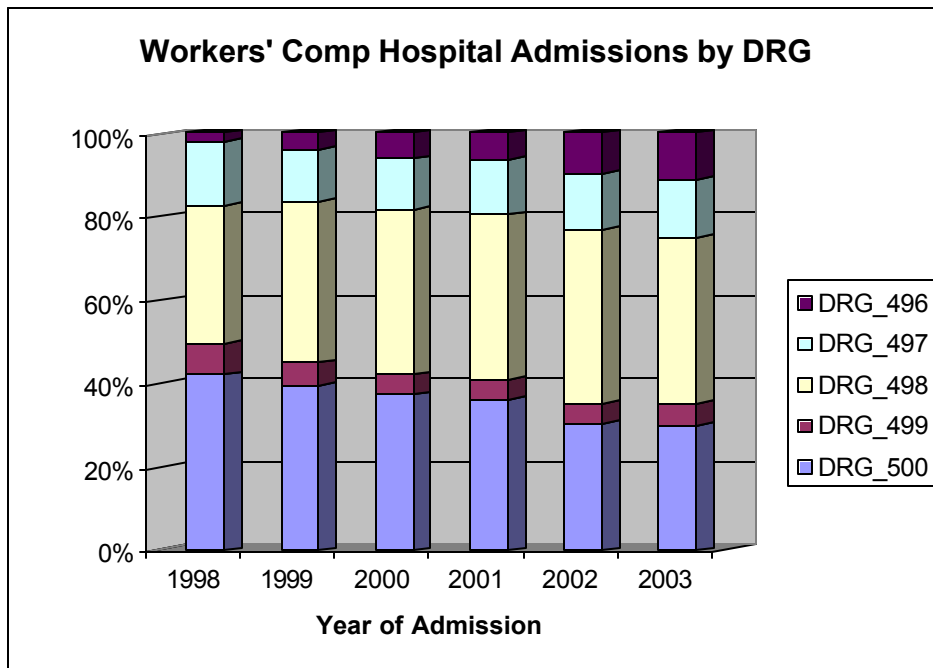
Using the codes for primary payor and DRGs listed above, all workers' compensation cases and the subset that also involved spinal surgery were identified. The chart and table below give the distribution of both spinal surgery and all other admissions. The number of workers' compensation hospital admissions has remained fairly steady, with a slight rise through 2001 and slight decline in the subsequent years. Admissions related to spinal surgery DRGs follow the same pattern. As a result, spinal surgery admissions have stayed relatively constant as a percentage of all hospital admissions, rising from 29.8% of admissions in 1998 to 30.7% of admissions in 2003. Again, it can be concluded that an increase in the frequency of spinal surgery was not a driving force in medical cost increases.

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There is an alternative explanation for spinal surgery as a cost-driver. The DRGs that comprise spinal surgery have very different Relative Values. Relative Values are equivalent to differences in the paid amounts for each DRG. A shift from less to more costly DRGs could drive an increase in the total cost of inpatient stays related to spinal surgery even if the number of surgeries did not change.

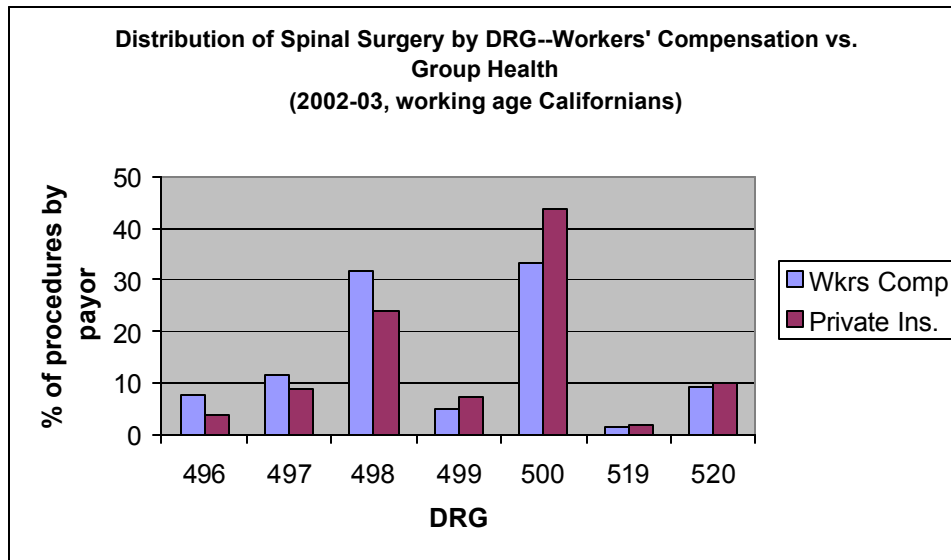
The following chart gives evidence that the composition of surgeries performed on an inpatient basis has shifted towards more complex and expensive DRGs. Because in 2002, DRGs 497 and 498 were split into two new DRGs (511 and 512), the DRGs were combined using the definition operative in 1998 (497+511 and 498+512) in order to create a consistent time series.



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As exhibited in the table above, DRGs 496 and 498 are two of the three most complex and expensive. These were also the two DRGs with the greatest increase in their proportional share of all spinal procedures (400% and 20% respectively). On the other hand, DRGs 499 and 500 are the least complex and least expensive. These two DRGs showed the greatest proportional decline (29% and 30%, respectively). This indicates that while back surgeries as a portion of all workers' compensation admissions have not increased significantly, the complexity and expense of these surgeries have increased. This drove costs higher and may have increased the risk of poor outcomes. The effect of a shift from less complex to more complex procedures would result in a 15% increase in spinal surgery costs at 2003 reimbursement rates.

The distribution of spinal DRGs in California workers' compensation is also more skewed toward complex surgeries and those with poorer outcomes (complications) than observed for the working-age population treated under group health. The following chart shows the distribution of spinal surgery DRGs for both workers' compensation and group health. This indicates that workers' compensation admissions are skewed towards DRGs 496-498, back surgery involving fusion, and group health admissions more frequently involve 499 and 500, back surgery not involving fusion. This comparison is controlling for age. The major difference besides payor is that all of the workers' compensation patients were working at injury, but only about 60-70% of the group health patients were working.



In conclusion, while the frequency of spinal surgeries has not shown a substantial increase, the portion of surgeries involving both anterior and posterior fusion or fusion with complications has increased dramatically. Given that the frequency of occupational injuries has been declining for a number of years, there has to be concern that the treatment of workers is being driven by increasingly aggressive interventions on patients who may be at greater risk.

From the narrow perspective of cost, this analysis suggests that while back surgeries are not an important cost-driver in medical costs or total hospital costs, they may represent an increasingly important component of an otherwise constant inpatient cost. Also, inpatient treatment may be associated with increasingly complex surgeries with increasingly more uncertain outcomes for the injured workers.

II.b.3 Is California out of line with national surgery rates?

While the data indicate that spinal surgery is not a main driver in workers' compensation medical cost growth, there is another potentially compelling consideration for limiting spinal surgery workers' compensation cases and that is the question that while not increasing rapidly, are back surgeries simply

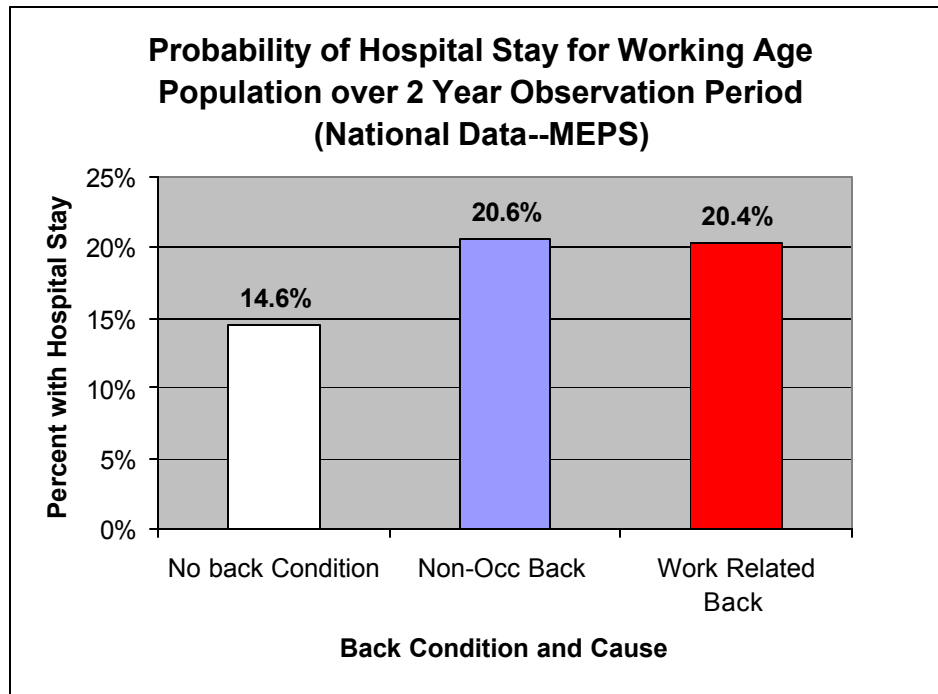
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much more common in workers' compensation cases and/or does California have higher rates of spinal surgery than workers' compensation systems in other jurisdictions?

These have been difficult questions to answer because until this report, there have been no data from which to construct surgery rates conditional on persons having back conditions from occupational causes compared to non-occupational causes. Such a measure is constructed here, and California is compared with the rest of the nation.

First, the Medical Expenditure Panel Survey (MEPS) conducted by the Federal Agency for Healthcare Quality and Research (AHQR) was used.² This is a nationally representative sample of the U.S. population and includes extensive medical information including medical conditions and all medical-treatment transactions. The public use Household segment of this survey allowed identification of (1) medical conditions reported by each person, (2) whether the condition was occupational-related, and (3) whether or not the person had an inpatient hospital stay during the period of observation (two years).

Since the focus of this analysis is on occupational injuries, the sample was limited to persons who worked during any quarter of the two-year period of observation. The file was split into (1) those workers with occupational-related back conditions, (2) those whose back condition was non-occupational, and (3) those who did not report any back condition. The rates of inpatient hospitalization for each of the three groups were then compared. The results are displayed in the following chart.



These data indicate that a person with a back condition has about an additional 3% chance in any year of an inpatient hospital stay (5.8%-6.0% over two years). Interestingly, given the common wisdom that back surgery is much more frequent in workers' compensation, at the national level, there was no difference observed in the probability of surgery based on whether the condition was occupational or not. A caveat on these data is that the public use dataset did not allow a determination of whether a particular hospital stay was for spinal surgery. The assumption was made that after controlling for important observed characteristics, the additional hospital stays can be attributed to the existence of back conditions.

The next step in this analysis was to compare the incidence of work-related spinal surgery in California with the U.S. Since population totals (denominators) for work-related back conditions are not available, an alternative approach was used. The portion of all spinal surgeries in California that were paid by

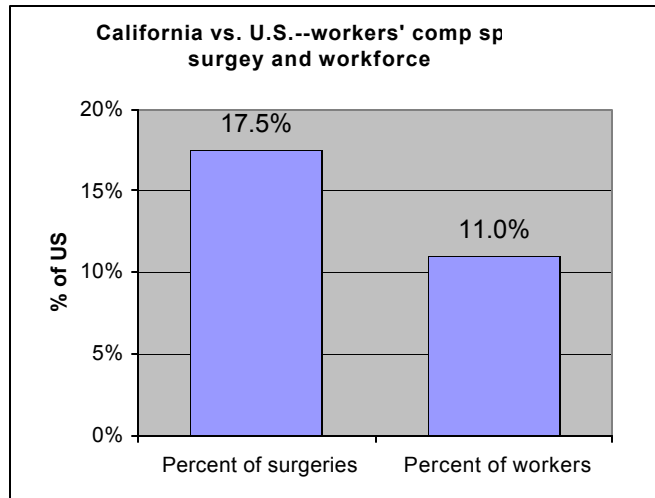
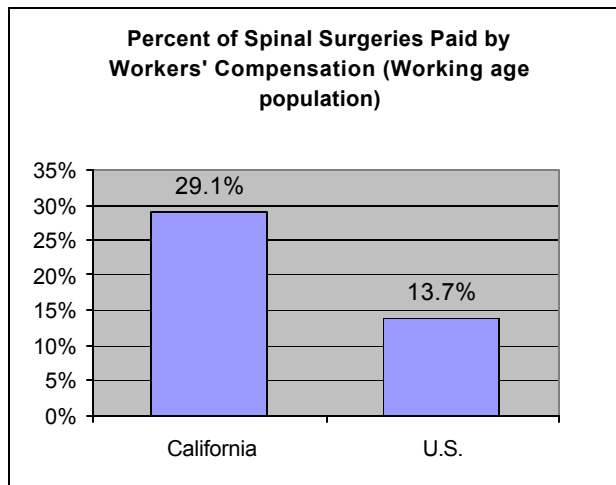
² Information available at: <http://www.meps.ahrq.gov/>

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workers' compensation was compared with the portion paid for by workers' compensation in the rest of the nation.

It was found that spinal surgery admission in California for working-age adults was paid under workers' compensation 29.1% of the time (2000-2002). For the rest of the U.S., these same admissions were paid by workers' compensation only 13.7% of the time, less than half the portion observed in California. This difference could be attributable to less aggressive treatment in California for non-workers' compensation patients or more aggressive treatment for workers' compensation back cases.

To examine this issue further, the portion of all workers' compensation surgeries nationwide that are accounted for by California was evaluated. Over the period 2000-2002, California accounted for 17.5% of all workers' compensation-related spinal surgeries nationwide. During that same period, California accounted for only 11% of the working population.



These data suggest that spinal surgery is about 60%-110% more likely to be performed on workers' compensation cases in California than in the typical workers' compensation system or in group health for persons with similar conditions. The lower-bound estimate suggests both that California non-occupational health care providers treat spinal injuries less aggressively and workers' compensation more aggressively. The upper bound assumes that California non-occupational back conditions receive surgical intervention at rates similar to the U.S. as a whole.

Nationally, the probability of surgery, given a back condition, is similar between occupational- and non-occupational-related conditions. On the other hand, workers' compensation cases in California are much more likely than California group health or the other U.S. workers' compensation systems generally to receive surgery for occupational-related back conditions. This offers strong support for California's adoption of measures to limit spinal surgeries and assess whether they are appropriate and justified on the basis of current medical knowledge.

II.b.4 Outcomes for workers

A wide range of literature on the effectiveness of spinal surgery is available. The scope of this literature makes it beyond this study to assess. Some research finds very high disability rates for spinal fusion patients. A Washington state study found 2/3 of patients not working at two years post-surgery (Franklin, et al., 1994). A study of Utah workers' compensation back surgery patients found employment rates of 75% (DeBerard, et al., 2001). This rate of labor-force participation would be very similar to what we would expect to observe for a sample of uninjured workers re-interviewed after three years (Neuhauser, 1997). Virtually all of these studies lack randomized control groups because it is generally unethical to ration care in a random way.

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There is some research that suggests poorer outcomes from spinal surgery when the payor is workers' compensation or another indemnity system. (Harris, 2005; Cherington and Cherington, 1992). Again, the study designs do not allow convincing conclusions on causality.

The Washington state study and to some extent the studies evaluating recovery under workers' compensation were evaluating systems at a time when surgery was considered heavily over-utilized. As such, the findings on outcomes under compensation systems highlight an important point about judging SSSOP. The main concern is not the outcome of the average patient. Spinal surgery, including spinal fusion, is a respected surgical procedure for certain cases. The concern is controlling over-utilization, and SSSOP is meant to control inappropriate treatment at the margin. When spinal surgery and particularly fusion surgery are being aggressively used as they were in Washington state prior to the study and may be used in indemnity compensation systems, the additional patients will be coming from cases that are more borderline candidates for surgery. The data on California's workers' compensation system indicate that utilization of spinal surgery, especially fusion and anterior/posterior fusion, is moving substantially beyond the range of cases treated by other systems. The outcomes for these marginal cases should be the real concern when evaluating SSSOP. Future research is being designed to evaluate the effectiveness of spinal surgery in these marginal cases, based on outcomes for the injured workers.

II.b.5 Conclusion concerning pre-SB 899 utilization

- Spinal surgery was not an important cause of the rapid rise in total workers' compensation costs or workers' compensation medical costs.
- However, spinal surgery was used much more aggressively in California workers' compensation than in other jurisdictions or in California's group health system.
- The surgical techniques used in California workers' compensation are much more invasive and complex than surgical techniques used for treatment of back conditions in California group health.
- This indicates that effective review of workers' compensation spinal surgery in California could improve outcomes and limit cost by limiting marginal surgeries. SSSOP focuses on eliminating marginal surgeries and may be an important tool for reducing medical cost while improving outcomes.

These results suggest that a program to assess surgery decisions at the margin has the potential to lower employer costs and improve outcomes for workers. Second opinions, focused narrowly on spinal surgery, may be a well-targeted solution.

II.c Motivation for SSSOP

In the previous report, we reviewed the past experience of employers and workers related to spinal surgery. The findings were that conditional on having a back diagnosis, spinal surgery was no more common, nationally, for workers' compensation claims than non-occupational injuries. However, in California, spinal surgery was much more common for workers' compensation back patients than non-occupational back patients. Spinal surgery was 160% to 300% more likely for occupational injuries in the California workers' compensation system than other jurisdictions or other medical systems. The study also found that the types of surgery performed on workers' compensation patients were more complex and invasive and the level of treatment intensity was increasing over time. These issues raised important concerns about the frequency and invasiveness of surgical intervention for occupational back conditions in California.

The purpose of a state-directed SSSOP to replace an undirected process negotiated between employers/insurers and injured workers is based on two motivations. First, employers were concerned about reducing high-cost, inappropriate surgical interventions. Second, workers could be concerned that when directed by the employer/insurer to a provider for a second opinion, the employer/insurer, with better knowledge, might direct the workers to very conservative doctors who more frequently recommend against surgery.

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Consequently, the Legislature enacted a process that requires a second opinion, but delivers that opinion in a way (random assignment of the evaluator) that is affected by incentives and should deliver fair and, hopefully, cost-effective decisions about the appropriateness of spinal surgery.

Assuming these motivations, the appropriateness of the second-opinion process rests upon accomplishing at least one of the following goals:

1. A reduction in the frequency (and cost) of surgeries. This is clearly suggested by the much higher probability of spinal surgery for occupational back conditions observed for California workers' compensation claims.
2. A fairer process of determining the appropriateness of surgery. "Fairness" in this case is a function of the probability that any worker gets a positive second opinion. The probability of a positive second opinion should be independent of every variable other than the worker's medical condition.

The statutorily-imposed, second-opinion process will be evaluated against these efficiency criteria.

II.d Evaluating the Spinal Surgery Second-Opinion Process

The second-opinion process was one of several legislative changes among a series of reforms focused on limiting over-utilization of medical treatment. Consequently, the effects of different reforms may overlap with the second-opinion process. The most important overlapping changes are the extension of employer control of the medical-treatment provider through the use of medical provider networks and the adoption of ACOEM utilization guidelines including language affecting the guidelines' strength as evidence in legal disputes. These two provisions were expected to substantially limit medical-treatment utilization (Neuhauser, 2003). However, recent work by RAND has raised concerns about the comprehensiveness of the ACOEM guidelines when used to evaluate appropriateness of spinal surgery (Nuckols et al., 2004). Other guidelines have been considered for adoption to cover the area of spinal surgery; however, until this gap is filled, the second-opinion process may be a crucial component of controlling unnecessary procedures.

The SSSOP legislated under SB 228 was meant to imitate the second-opinion process used by the Department of Managed Health Care (DMHC) to resolve disputes between HMOs and patients over denials of specific procedures. The HMO second-opinion process has been seen as a success by patient and provider advocates alike. However, the motivation for these two programs is almost exactly opposite. The DMHC process is meant to avoid under-utilization. There are also substantial differences in the design of the two programs, the nature of the disputes, and the legal environment under which decisions are made.

II.d.1 History of second surgical opinion process (SSOP)

Interestingly, surgery second opinions (note, these programs dealt with all forms of surgery, not just spinal surgery) were first introduced in 1972 as a management-labor effort to control Taft-Hartley union health plan costs (Lindsay and Newhouse, 1990, Wagner and Wagner, 1999). The focus of the effort was surgery because of the belief that too many operations were being performed adding to health care costs. Subsequently, most research in this area focused on the federal insurance programs, Medicaid and Medicare. Medicare and Medicaid programs in the 1970s were similar in many ways to workers' compensation programs in the current era. They were fee-for-service and had few utilization control mechanisms typical of today's group health and federal programs. The second surgical opinion process (SSOP) program was meant to reduce the number of surgeries by reducing the number of inappropriate surgeries (Wagner and Wagner, 1999). The focus, in the early years, was clearly on payors being able to limit procedures.

A number of studies demonstrated a positive impact of these programs in reducing expensive medical procedures. However, a systematic review of these studies done at the end of the 1980s found the quality

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of the studies poor and, consequently, the impacts inconclusive (Lindsey and Newhouse, 1990). Several of the studies found that a crucial component of the savings came from patients who did not follow up with the second-opinion process when required. In essence, the extra burden of seeking a second opinion was sufficient to reduce the number of expensive services (Chu, Lavoie, and McCarthy, 1992). (This issue will be critical in the discussion below of the early data on the California workers' compensation SSSOP.) Lindsey and Newhouse also found evidence from studies that a key source of reduction was the impact of reducing the number of requests made by providers. Both of these effects can be thought of as "passive" restrictions on utilization.

The introduction of other managed care techniques dramatically changed the focus of SSOP in group health. Managed care shifted the financial risk of medical treatment towards providers and gave them a financial incentive to limit inappropriate treatment. Consequently, the focus of SSOP became protecting the right of patients to treatment, that is, avoiding under-treatment, not over-treatment. For example, the SSOP introduced by the California DMHC is meant to be a patient protection. Patients denied treatment use the DMHC second-opinion process to appeal the denial.

II.d.2 Effectiveness of utilization review in workers' compensation

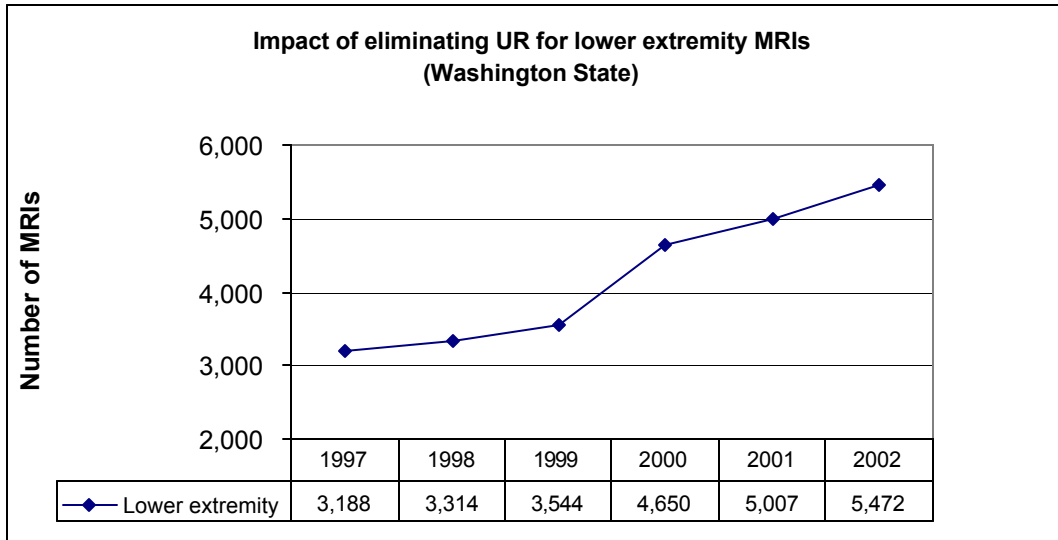
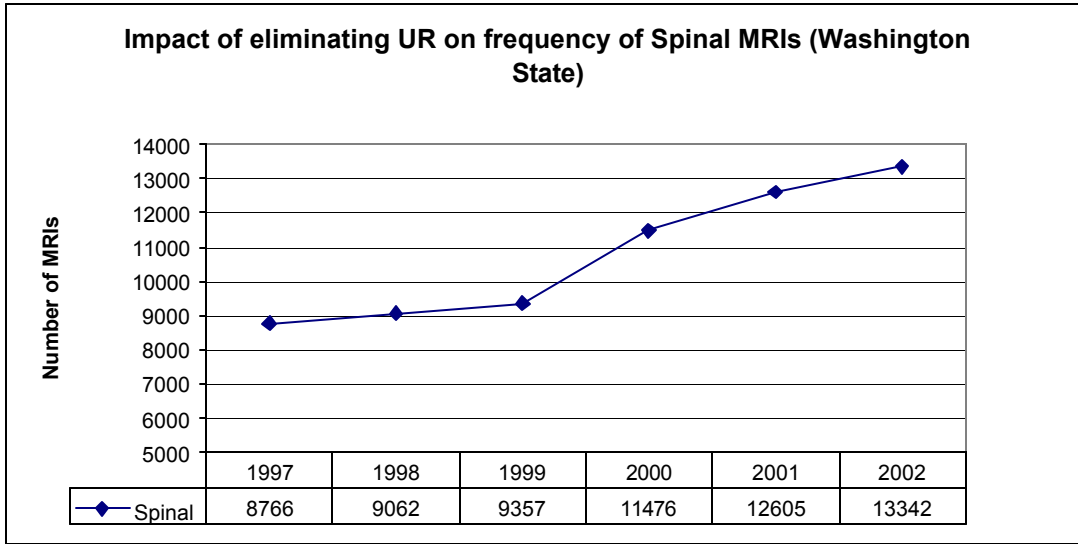
The second-opinion process is a special case of UR. The very limited research literature on UR in workers' compensation was reviewed for a previous CHSWC study and is summarized here.

Washington's Department of Labor and Industry introduced guidelines in 1988 for elective lumbar fusion. Spinal surgery can involve fusion (more complex) or other procedures (less complex) and is defined by the nature of the inpatient hospital admission. Elam, et al. (1997) evaluated the introduction of workers' compensation practice guidelines on lumbar-spinal fusion in Washington. The authors evaluated the rate of lumbar fusion for workers' compensation patients over the period 1987-1992 and found a decline of 33% in fusion rates, while non-fusion rates remained constant. Prior to the introduction of guidelines, the rate of fusion operations as a fraction of all lumbar surgeries was higher among the workers' compensation inpatient population than for a similar non-occupational inpatient population. After the introduction of guidelines, the rate declined below that for the non-occupational treatment population. Above, a similar pre-reform situation in California is observed, where utilization of more complex surgeries (e.g., DRGs 496-498) involving fusion are much more common in workers' compensation as a portion of all spinal surgeries than in group health. It will have to be seen if SSSOP has the same effect of reducing the portion of more invasive surgeries.

Ideally, an evaluation of a second-opinion process requires analysis at three stages. First, the process potentially imposes additional burden on physicians who may be less inclined to recommend surgery in borderline cases if surgery is less likely to be approved and where the process of requesting the procedure imposes additional burdens such as added paperwork and delays. Second, the process may discourage workers from pursuing surgery where it requires submitting to additional appointments and evaluations. (Lindsey and Newhouse, 1990) Third, there may be substantially fewer surgeries when the second opinion does not support the request for surgery.

The impact of the first barrier, the threshold issue for the physician, was well demonstrated in a 1999 Washington state study evaluating the cost effectiveness of UR on MRIs. Initially, Washington had UR in place for all MRI requests. They did a study and found that the rejection rate was so low (2%) that the UR process cost twice as much as was saved on MRI costs. A decision was made to discontinue UR on MRIs in 1999. The following two charts show the responsiveness of utilization to relaxation of review (the opposite of imposing new requirements). There is a clear inflection point in the trend on the number of MRIs that is coincidental with the elimination of UR. The frequency showed an initial jump and a significant change in trend for both spinal and lower-extremity MRIs. The initial change is equivalent to an increase of between 19.4% (spine) and 25.5% (lower extremity) with additional utilization increases due to more rapid growth in subsequent years. The impact on upper-extremity MRIs was less clear. This is strong evidence of the impact of UR on controlling requests by providers and echoes the findings of the CHSWC study on the primary treating physician (PTP) (Neuhauser, 2001).

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II.e Spinal Surgery Second-Opinion Process Under California Workers' Compensation

SB 228 amended Labor Code Section 4062 instituting a new evaluation procedure when a treating physician recommends spinal surgery and an employer objects. The legislation allowed employers to request a second opinion. The second opinion is rendered by physicians randomly assigned by the Administrative Director (AD) of the Division of Workers' Compensation (DWC) from a list developed by the DWC. The statute requires a second opinion within 45 days of the original physician's recommendation.

While the language in SB 228 established the spinal surgery second-opinion process, it required additional specificity through regulation for execution. For example, spinal surgery was not clearly defined, nor did the language indicate how second-opinion physicians would be selected. In addition, the statute did not provide details as to what is to be covered by the report of the second-opinion physician, whether the physician is to examine the employee, or how the physician is to be paid. To implement the

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statute, the AD of the DWC adopted regulations governing the selection of spinal surgery second-opinion physicians, their reports, and their compensation.³

If the claims administrator or insurer, on behalf of the employer, disagrees with the treating physician's recommendation for spinal surgery, the claims administrator/insurer files an objection by completing a DWC 233 Form and a declaration attesting to the date of receipt of the treating physician's recommendation for spinal surgery.⁴ The objection must be served to the employee, the employee's attorney, if any, the AD, and the treating physician within ten days of receipt of the spinal surgery recommendation. This process pertains to any date of injury.

If the employee is represented by an attorney, the parties have the option of jointly selecting an agreed medical evaluator (AME) to evaluate the treatment plan and to issue a second opinion. Once agreement is reached, the AD must be notified within one day. If the employee is not represented by an attorney or the parties cannot agree on an AME within the ten-day timeframe, then the AD randomly selects a second-opinion surgeon from a pool of qualified physicians. A physician is deemed qualified by applying to serve as a second-opinion spinal surgeon and meeting the inclusion/exclusion criteria.

Within five working days of the AD's receipt of an objection to a recommendation for spinal surgery, the AD must randomly select a physician from a group of six qualified physicians. A computerized process searches geographically, initially using a 30-mile radius from the employee's address and proceeding with ever-increasing radii until six second-opinion providers are found. Currently, however, until a computerized system is in place, the AD shall select from those physicians located within the same zip code as the employee, and then additional adjacent zip codes shall be used until there are at least six physicians found within the geographic area of selection. With either process, the AD then randomly selects the second-opinion physician from the group of six.

The selected physician must notify the AD within five working days and the employee and employer may object to the second-opinion physician, in writing, within ten days on the basis that the selected physician has a material professional, familial or financial affiliation with any of the persons or entities listed in subdivision (c) Labor Code Section 4062. The AD may either sustain the employee or employer's objection, in which case a new selection shall be made, or deny the objection.

The second-opinion physician or agreed second-opinion physician may elect to render the second opinion in the absence of physically examining the patient and base his/her opinion solely on a review of the medical documentation submitted. However, if the result of said review disagrees with the recommendation of the treating physician, the second-opinion physician must physically examine the patient. If there is to be a physical examination, the physician shall, at least ten days in advance of the scheduled examination, send written notice of the date, time, and place of the examination to the employee, employee's attorney, if any, and the party who objected to the recommended surgery.⁵

If the employee fails to attend the examination with the second-opinion physician and the physician is unable to reschedule the appointment prior to the 35th day after receipt of the treating physician's report by the employer, then the second-opinion process is extended an additional 45 days. If a second-opinion physician is unable to schedule another appointment within the 45-day extension, the AD, upon request, will select another second-opinion physician.

If the second-opinion or agreed second-opinion physician disagrees with the recommendation of the treating physician, and if the parties do not agree with the second opinion or agreed second-opinion physician's determination, the employer will file a declaration of readiness to proceed and initiate dispute resolution before the Workers' Compensation Appeals Board (WCAB).⁶

³ Article 5.1 of Subchapter 1, Chapter 4.5 of Title 8, California Code Regulations Sections 9788.01-9788.91 (http://www.dir.ca.gov/t8/ch4_5sb1a5_1.html).

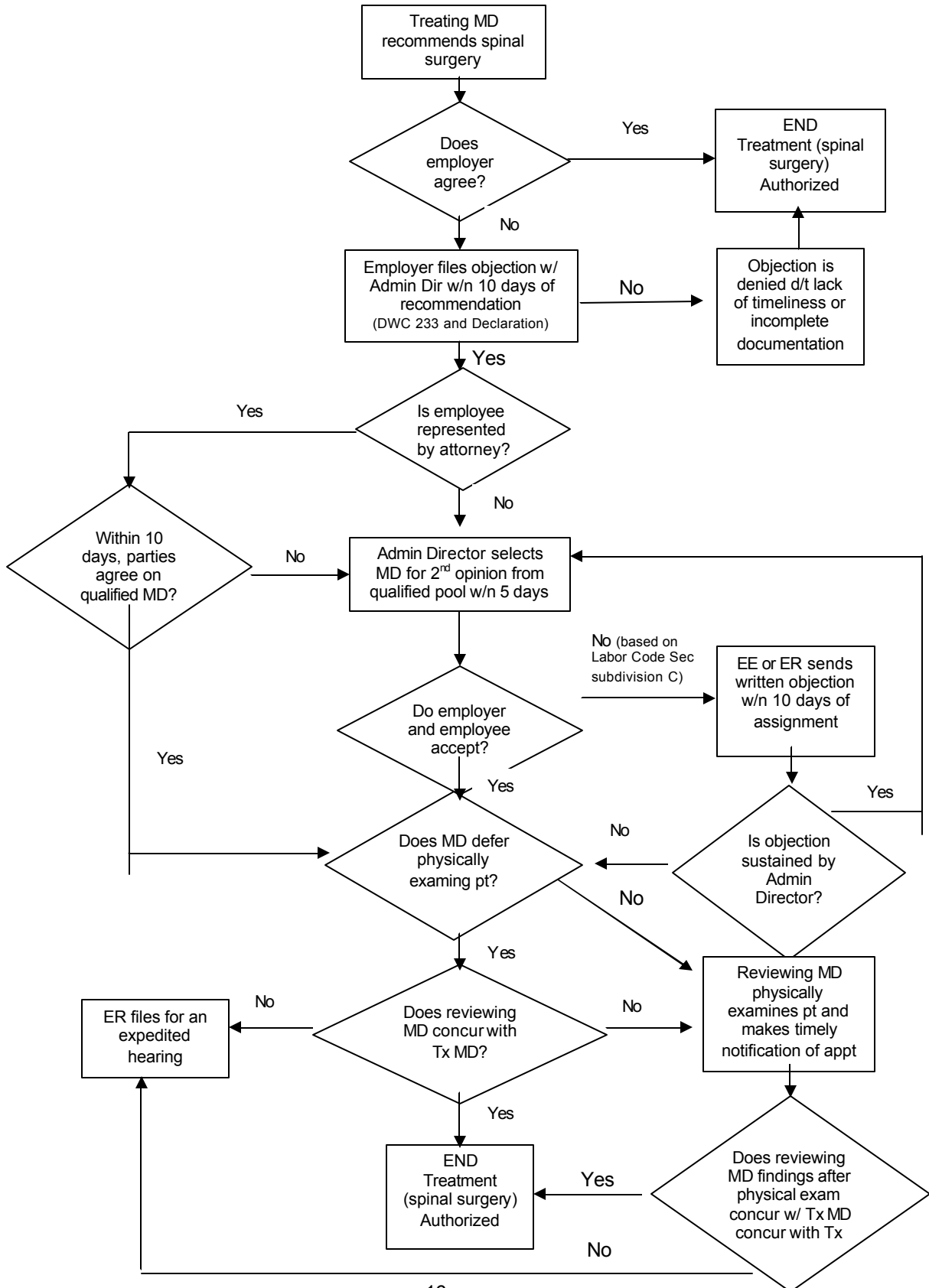
⁴ 8 CCR§9788.11 Form for the employer's Objection to Report of Treating Physician Recommending Spinal Surgery.

⁵ 8 CCR§§ 9788.6 Examination by Second Opinion Physician or Agreed Second Opinion Physician.

⁶ Labor Code§ 4062(b)

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The following flowchart illustrates the process as described.



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II.f Analysis of Early SSSOP Data

The following table summarizes the data on the SSSOP process through May of 2005, the first 10+ months of SSSOP. These data need to be considered carefully. The initial start-up period may be characterized by lags due to time between receipt of request and submission of a second opinion, including reporting errors by requesting parties and second-opinion providers. However, the SSSOP process has short turn-around times, so a steady state of requests, processing, and second opinions was probably reached reasonably quickly, and data from 2005 can be interpreted more confidently.

Data through May 21, 2005

| | 2004 | July | August | September | October | November | December | Total (2004) | 2005 | January | February | March | April | May (3 weeks) | Total (2005) | TOTAL (2004-05) |
|---------------------------------------|-----------|-----------|-----------|-----------|------------|-----------|------------|--------------|-----------|-----------|------------|------------|-----------|---------------|--------------|-----------------|
| # received | 27 | 100 | 55 | 81 | 101 | 79 | 443 | | 93 | 96 | 125 | 114 | 103 | | 531 | 974 |
| # processed/ assigned | 8 | 36 | 31 | 30 | 41 | 30 | 176 | | 40 | 33 | 37 | 49 | 31 | | 190 | 366 |
| # returned for 10+ days | 16 | 26 | 13 | 27 | 23 | 10 | 115 | | 18 | 23 | 16 | 13 | 7 | | 77 | 192 |
| # returned for wrong form | 4 | 5 | 2 | 3 | 4 | 4 | 22 | | 1 | 2 | 1 | 4 | 1 | | 9 | 31 |
| # returned for incomplete | 0 | 4 | 1 | 0 | 3 | 3 | 11 | | 6 | 10 | 8 | 20 | 15 | | 59 | 70 |
| # returned for consult rpt only | 0 | 11 | 17 | 8 | 22 | 27 | 85 | | 26 | 19 | 34 | 32 | 17 | | 128 | 213 |
| Not spinal surgery/ IW req. | 0 | 0 | 1 | 0 | 1 | 1 | 3 | | 0 | 0 | 5 | 8 | 3 | | 16 | 19 |
| # withdrawn | 2 | 5 | 7 | 3 | 19 | 5 | 41 | | 3 | 8 | 3 | 9 | 5 | | 28 | 69 |
| TOTAL | 30 | 87 | 72 | 71 | 113 | 80 | 453 | | 94 | 95 | 104 | 135 | 79 | | 507 | 960 |
| # 2nd opinions received | 0 | 1 | 1 | 8 | 9 | 12 | 31 | | 16 | 20 | 18 | 10 | 11 | | 75 | 106 |

Data provided by the Division of Worker's Compensation-Medical Unit—May 2005

The number of requests received per month in 2005 is about 100 to 125. This suggests approximately 1200 to 1500 requests per year. Some of these requests should be excluded, e.g., “not spinal surgery/not worker request” (2%). A significant fraction is also likely to be duplicate requests because of initial errors: “returned, wrong form (3%)”; “returned, incomplete (7%)”; and “returned, consult not treating physician (22%)” may be duplicated by subsequent submissions. Some of these requests would not fall into the exclusion of exceeding 10+ days (an example of the overlap), and some may not be resubmitted if the claims administrator realizes that the regulatory deadline had been missed. Consequently, counting

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all categories except “not spinal surgery,” “returned wrong form,” “returned, incomplete,” and “returned, consult not treating physician” is a conservative estimate of unique requests. This is the lower-bound estimate that will be used in the subsequent analysis. The upper-bound estimate assumes that reports by consulting physicians represented unique requests that were not resubmitted because the regulatory timeframes were exceeded. This gives a range of unique requests between 850 and 1150 annually. With approximately 9,500 inpatient spinal surgeries annually prior to introduction of SSSOP, this suggests that about 9%-12% are being formally challenged through the SSSOP process.

The SSSOP cases represent a very significant rate of formal challenge. This is substantially more challenged cases than reviewed by the DMHC for all issues related to HMO care in California in a year. In the first 4½ years, DMHC conducted 3,116 independent medical reviews (IMRs) in all categories. If the sample is limited to only orthopedic treatments of all kinds, there were a total of 547 disputes over the 4+ years. There were only a handful of orthopedic surgical cases that went to IMR.⁷

II.f.1 Passive reductions in spinal surgery

As described above, there are one active way and two passive ways in which a process like SSSOP can reduce utilization. The two passive ways involve: (1) discouraging initial requests by physicians by increasing burden or lowering the probability of acceptance; and (2) increasing the requirements on workers and thus discouraging workers from pursuing the request. The results on the passive reduction impact will be reviewed first, since these two steps are the initial barriers. The active reduction comes when the second-opinion process recommends against surgery, which will be reviewed later.

The Washington state data on relaxation of utilization protocols indicate that a major, if not primary, impact of utilization controls like SSSOP is that requests for borderline procedures are not even submitted in the first place. Requiring requests for approval increases the burden on treating physicians at the same time that the process is reducing the probability that requests will be approved. The greater the percent of requests that are opposed by the second-opinion physician, the greater the burden and lower the probability of approval. There is no research that would allow us to estimate an appropriate challenge rate, but like DMHC, typically these rates are very low. For SSSOP, these rates of challenge appear quite high. Once challenged, the treating physician has to submit a substantial amount of paperwork supporting the request for surgery, including submitting copies of all key medical records.

The portion of requests being challenged under SSSOP (9-12%), while high relative to other systems, may not be inappropriately high for California’s workers’ compensation system. As observed in the data above, California’s workers’ compensation system performs 60%-110% more spinal surgeries than would be expected in other states’ compensation systems or California’s group health system. Hence, we might expect a higher rate of initial denials by insurers/employers. In addition, we would expect that this high level of challenges will reduce requests and surgeries. However, it will be some time before the passive reduction in initial requests can be confidently estimated.

The second passive way in which SSSOP reduces utilization is by placing additional requirements on workers. In previous studies (Rosenberg, et al., 1995, Lindsey and Newhouse, 1990) of second-opinion processes, patients were observed to fail to complete the process about 1/3 of the time.

It is challenging to estimate the portion of workers under SSSOP who fail to pursue the second opinion because reporting to the DWC Medical Unit has been incomplete. One cannot assume that all reports that are ultimately not submitted to the DWC because the worker failed to make or attend the appointment.

According to the DWC Medical Unit, not all doctors are aware that they are required to submit a copy of the finished report to the Medical Unit. Consequently, the non-completion rate of workers cannot be simply estimated by estimating the portion of reports not submitted by SSSOP providers. Instead, the

⁷ Approximately 2/3 of DHMC decisions upheld the denial by the HMO. For orthopedic disputes, 72% were upheld (392 of 547).

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portion of workers completing the process is based on the portion of reports submitted by doctors who submitted at least one completed report.⁸

Based on the initial 8+ months of SSSOP requests (the last 2 months of requests were dropped because doctors and workers may not have had sufficient time to submit the finished report), an estimated 29% of workers did not complete the second-opinion process.

In a substantial fraction of cases, the SSSOP provider completed the opinion based solely on records submitted and did not require the worker to participate in an in-person evaluation. Consequently, this rate of non-completion by workers (29%) should be viewed as a lower bound and the actual passive-discouragement factor is likely substantially higher and likely larger than observed in other systems. Reasons for this level of worker discouragement will be discussed below.

II.f.2 Geographic proximity and worker compliance

Why might the barriers to completion discourage a greater fraction of workers under the SSSOP process than other similar UR programs? The most obvious reason is that the SSSOP process may require substantial travel and time commitments.

At the time of the study, there were only about 197 SSSOP providers at 157 different geographic locations to cover the entire state of California. The DWC is required to apply a two-step process for selecting a second-opinion provider. First, the DWC randomly selects six providers within a 30-mile radius of the injured worker. If there are not six providers within 30 miles, they expand the search area until six providers are identified. The second stage is random selection of one provider from among the six. That provider becomes the second-opinion provider on that case. Consequently, that provider is randomly distributed among all six providers selected, from the most proximal to the farthest away from the worker's residence.

With the assistance of the California Workers' Compensation Institute (CWCI), the expected distance to providers on the SSSOP list and the location of 60,000 workers who reported back conditions in the California workers' compensation system were analyzed. The results of this analysis are striking.

⁸ It is difficult to confirm that this is an appropriate way to estimate the rate of completion using mathematics. Consequently, we tested the assumption using simulations of the reporting process where we knew the rate of compliance by doctors and the rate of participation by workers. The simulations demonstrated that this was a robust way to estimate the portion of SSSOP cases that were being completed by workers. The estimates ultimately converged on the correct proportion. Design of the simulation is available upon request from CHSWC or the authors.

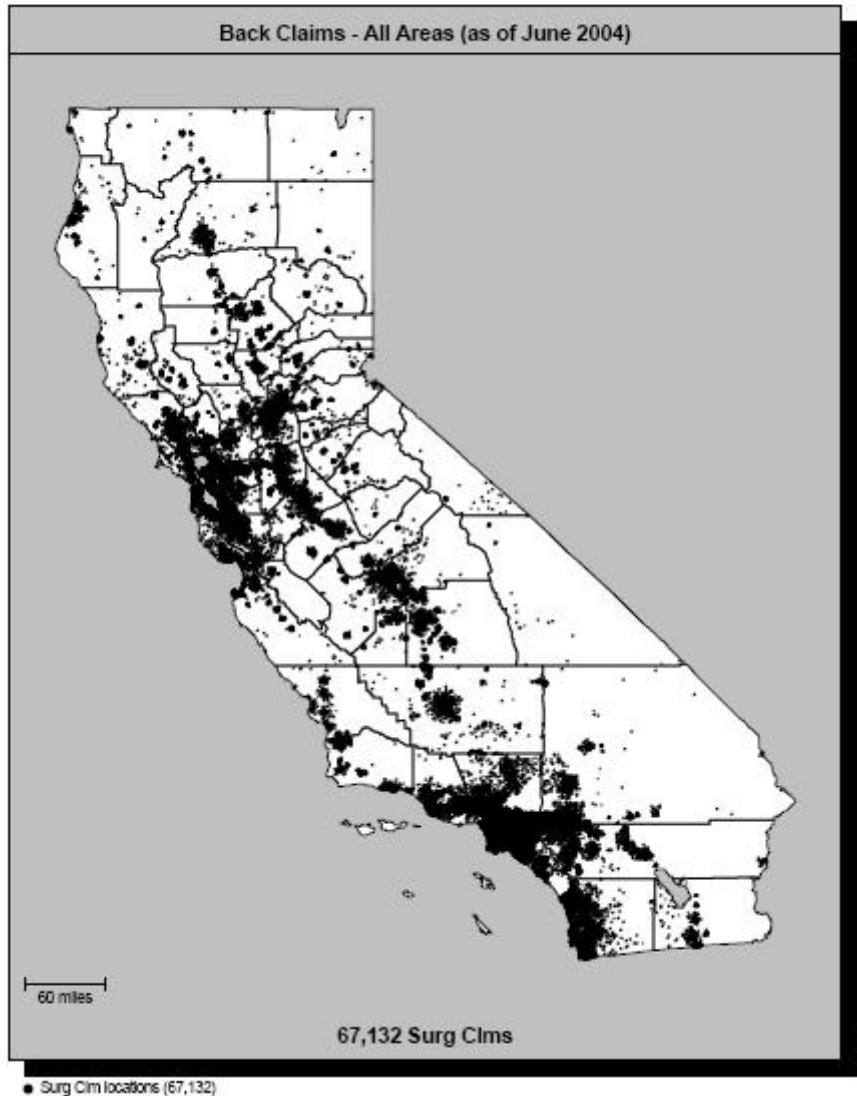
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Injured workers with back conditions are widely distributed across the state, including large numbers of workers in rural areas.

2nd Surgery Report Docs - Back Surgery Candidates

2ndSrg

Surg Clm locations



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However, there are only a limited number of second-opinion providers and these are highly concentrated, mostly in a few major urban areas such as San Diego, Los Angeles, San Francisco/Alameda, and Sacramento.

2nd Surgery Report Docs - Back Surgery Candidates

2ndSrg -

Report Prov locations



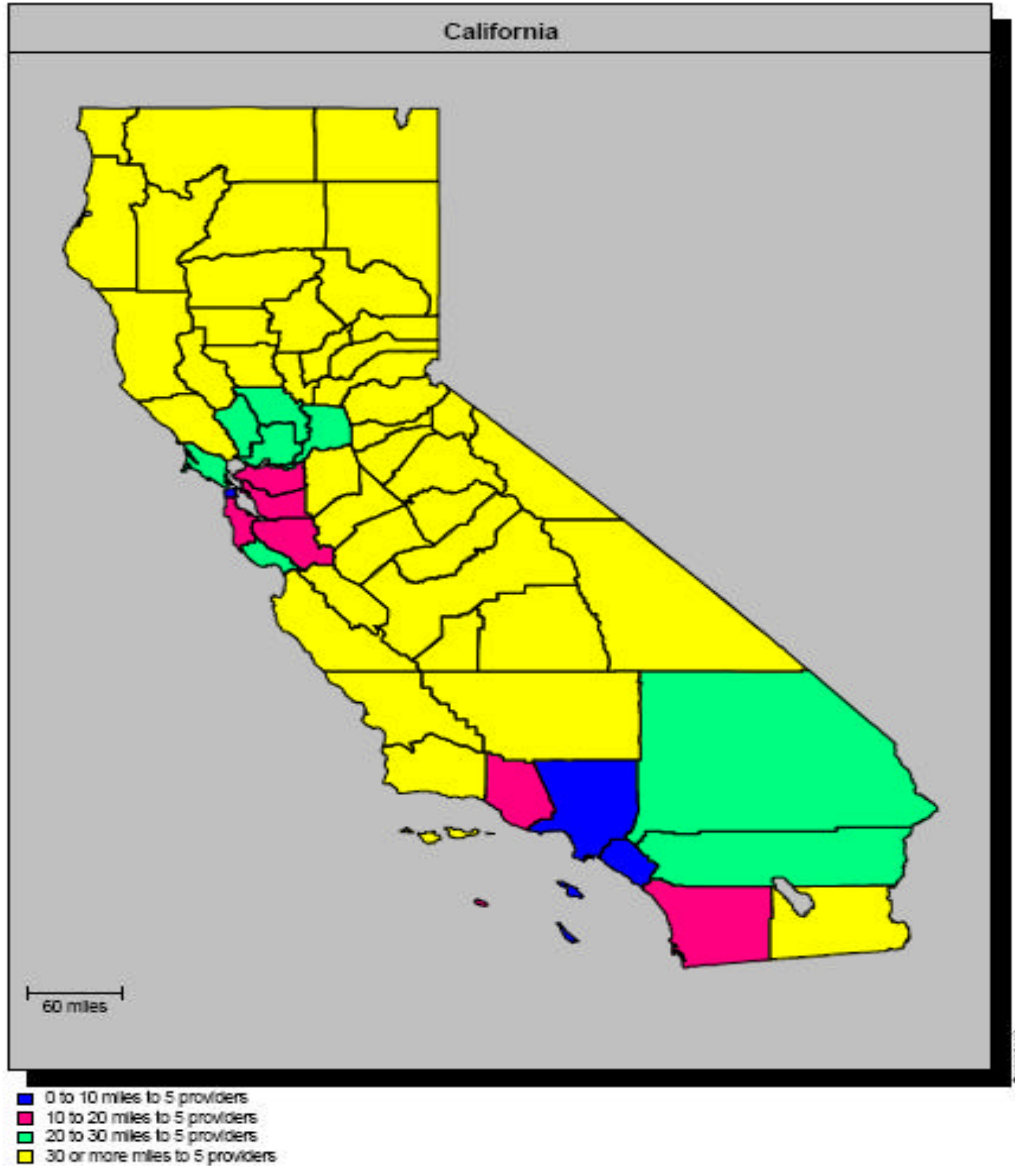
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This means that the average distance to at least six providers can substantially exceed the distance of 30 miles suggested by the SSSOP regulations.

2nd Surgery Report Docs - Back Surgery Candidates

2ndSrg

Thematic map



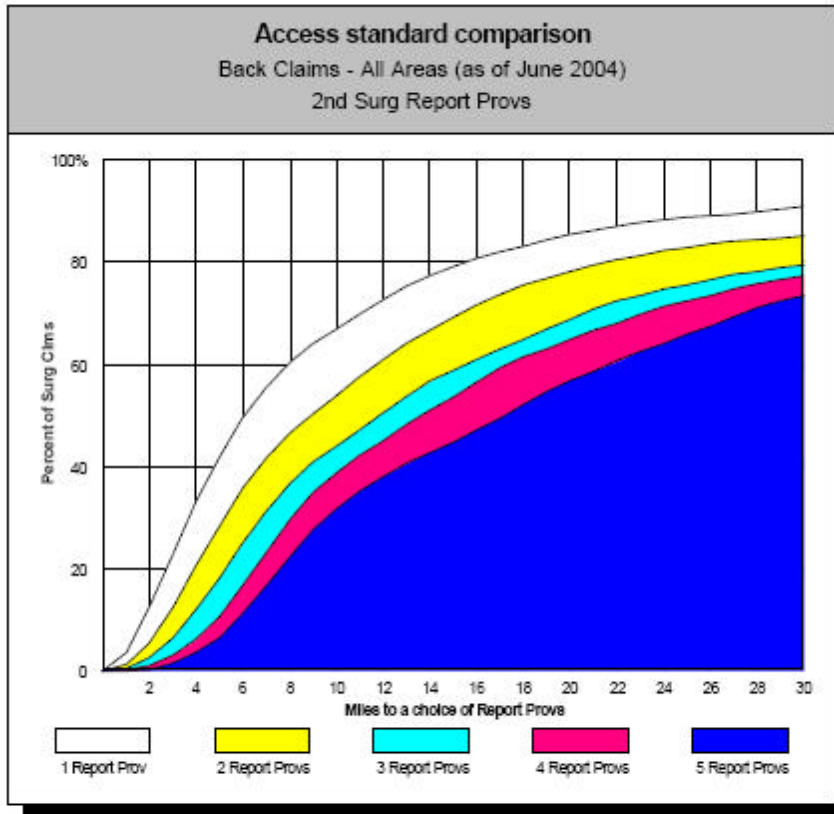
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Overall, an important fraction of workers will face substantial travel when the provider is randomly selected from the closest six.

2nd Surgery Report Docs - Back Surgery Candidates

2ndSrg -

Access standard comparison



**Average distance to a choice of
2nd Surg Report Provs**

| Number of Report Provs | 1 | 2 | 3 | 4 | 5 |
|------------------------|------|------|------|------|------|
| Miles | 11.2 | 15.9 | 20.7 | 24.9 | 28.1 |

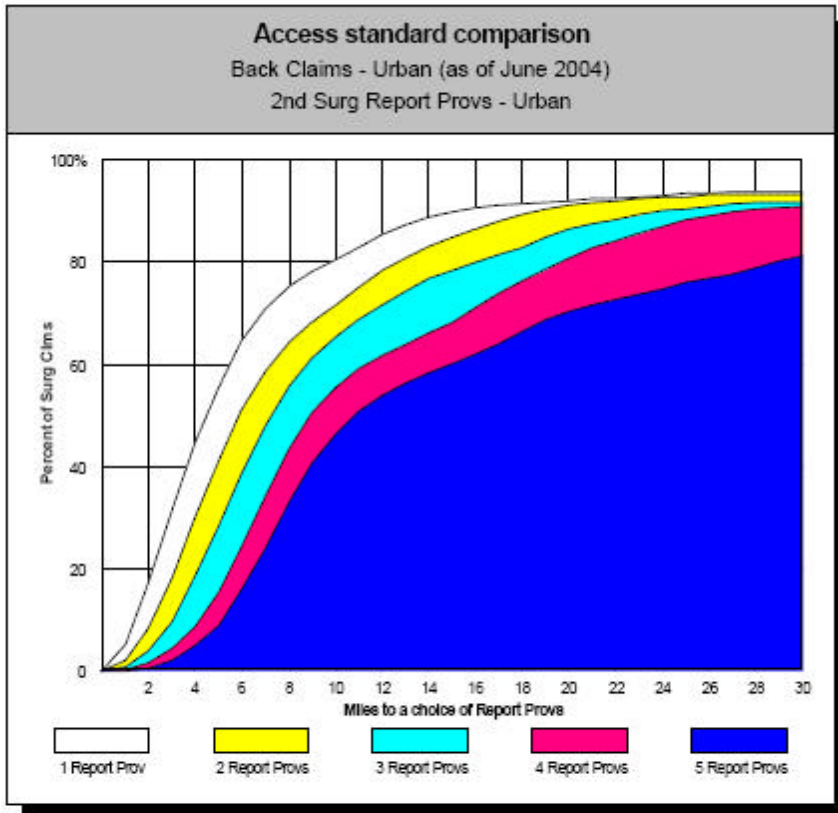
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The situation is less severe for workers in urban areas where a high proportion has multiple choices of second-opinion providers within a reasonable distance.

2nd Surgery Report Docs - Back Surgery Candidates

2ndSurg

Access standard comparison



Average distance to a choice of
2nd Surg Report Provs - Urban

| Number of Report Provs | 1 | 2 | 3 | 4 | 5 |
|------------------------|-----|------|------|------|------|
| Miles | 9.6 | 11.7 | 13.5 | 15.8 | 20.3 |

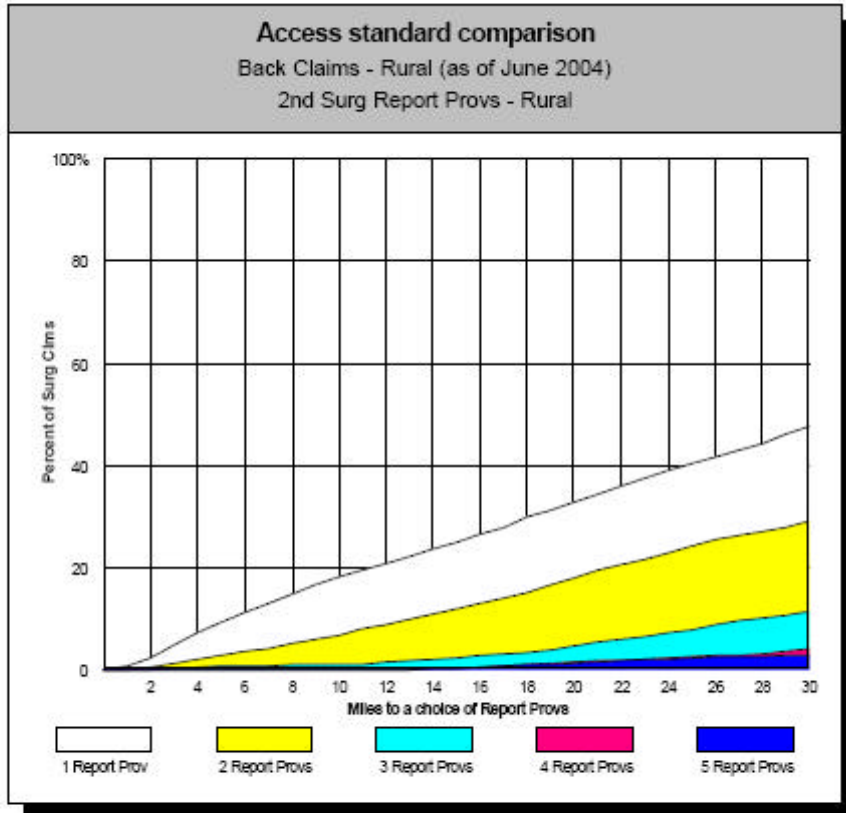
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However, in rural areas, the problems are severe. Only a small fraction of workers will have a choice of six providers within a reasonable distance from their residence.

2nd Surgery Report Docs - Back Surgery Candidates

2ndSrg

Access standard comparison



Average distance to a choice of
2nd Surg Report Provs - Rural

| Number of Report Provs | 1 | 2 | 3 | 4 | 5 |
|------------------------|------|------|------|------|-------|
| Miles | 33.6 | 52.7 | 67.4 | 85.5 | 107.6 |

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The implications of the geographic analysis are that the limited number of second-opinion providers, particularly in rural areas, places a very substantial burden on injured workers. This is particularly true because of the manner in which the SSSOP provider is selected. The DWC locates a minimum of six providers and then randomly selects from among those six providers. For rural areas, it is clear that the sixth provider can be substantially more than 50 miles away. Consequently, the burden of workers residing in non-urban areas may be quite high.

Two alternatives present themselves for resolving this distance issue. The most obvious answer is to recruit a broader range of medical providers to assist in the SSSOP process. This would reduce the average travel distance for workers while increasing the choice of providers. This is the best solution.

The alternative solution is to limit the geographic range of the search. For example, one might limit the geographic distance to 30 miles or the distance to at least one provider, whichever is greater. This has the effect of limiting the choice of providers (which is sub-optimal) but also limiting the travel distance for workers, improving the chance that they will comply with the requirements of the process and get an impartial evaluation of the appropriateness of surgery.

II.f.3 Decisions by second-opinion providers

For this study, all of the opinions by SSSOP providers that were submitted to the Medical Unit of the DWC were reviewed⁹. Submitted reports were made available at the Medical Unit's office and reviewed for the decision of the second-opinion provider.

In approximately one-half (51.5%) of all reports submitted to the Medical Unit, the SSSOP provider supported the request for surgery. Symmetrically, in about half (48.5%) the cases, the SSSOP provider recommended against surgery. Statistically, these are indistinguishable.

There is little research that allows evaluation of this level of acceptance/denial. The original SSOP processes that were introduced because of a perception of over-utilization of surgery found similar levels of negative second opinion (Lindsey and Newhouse, 1990, Rosenberg, et al., 1995). In any case, this level of denial suggests that the active limitation on utilization is likely to have a substantial impact on the frequency of spinal surgery.

II.f.4 Second-opinion providers and potential bias

A problem with limiting the geographic distance from which to make a selection and, consequently, the number of providers in the potential selection pool is that workers or employers/insurers in specific areas may be subject to non-neutral bias in the decision by second-opinion providers. Random selection of a provider from a large pool of providers tends to ensure that the decisions of the provider are not affected by the incentives to please one side or the other. Consequently, if a very limited number of providers are available, it becomes more likely that incentives for bias will develop. For example, if there are a very limited number of providers, or even just one provider, in an area recommending against spinal surgery, in most cases, it may encourage employer/insurers to request more second opinions, potentially inappropriately reducing surgery for workers. From this perspective, it is important to keep the number of potential second-opinion providers in the pool high to avoid incentives by any party.

There is a second and even more important issue for the DWC. There is some evidence that bias exists in the decisions by providers independent of any incentives. That is, second-opinion providers, acting completely independently, may be introducing a level of bias into the decision process. This bias may not affect the overall expected distribution of positive or negative decisions, but may result in non-random decisions for individual workers. In addition, this may be highly concentrated geographically when there are limited providers in an area.

⁹ Special thanks are extended to the Medical Unit of DWC for assisting in this portion of the study. Also, special thanks to CHSWC staff who assisted in this complex task of reviewing all of the submitted reports.

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For this analysis, all second-opinion providers who submitted more than one report to the DWC were examined. Keep in mind that this is (1) a limited range of providers since many submitted no reports to the DWC, and (2) this is early in the process, and a limited number of submitting providers had multiple reports. Consequently, the analysis is only suggestive of potential areas concerning where the DWC should concentrate future attention.

The following charts give the distribution of positive and negative recommendations by the small pool of providers observed giving multiple reports.

In this limited sample, it was observed that there is some indication that truly neutral providers are under-represented among SSSOP providers in the data. Consequently, provider decisions appear (weakly) to be distributed towards biases for approval or disapproval. That is, a number of providers may consistently approve nearly all surgeries and some may consistently disapprove of nearly all surgeries.

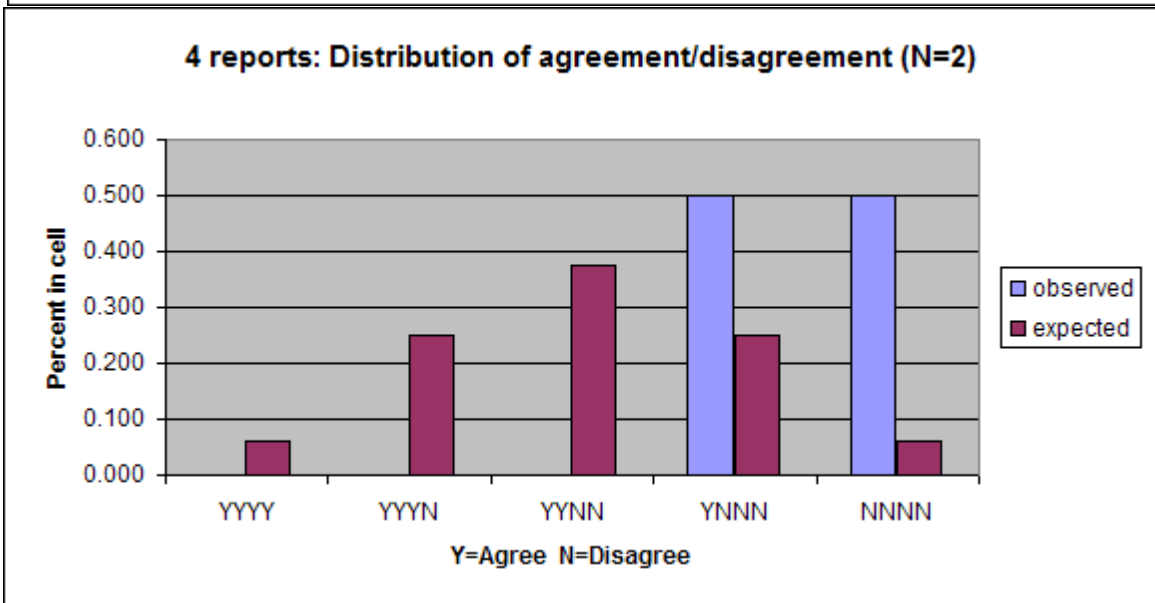
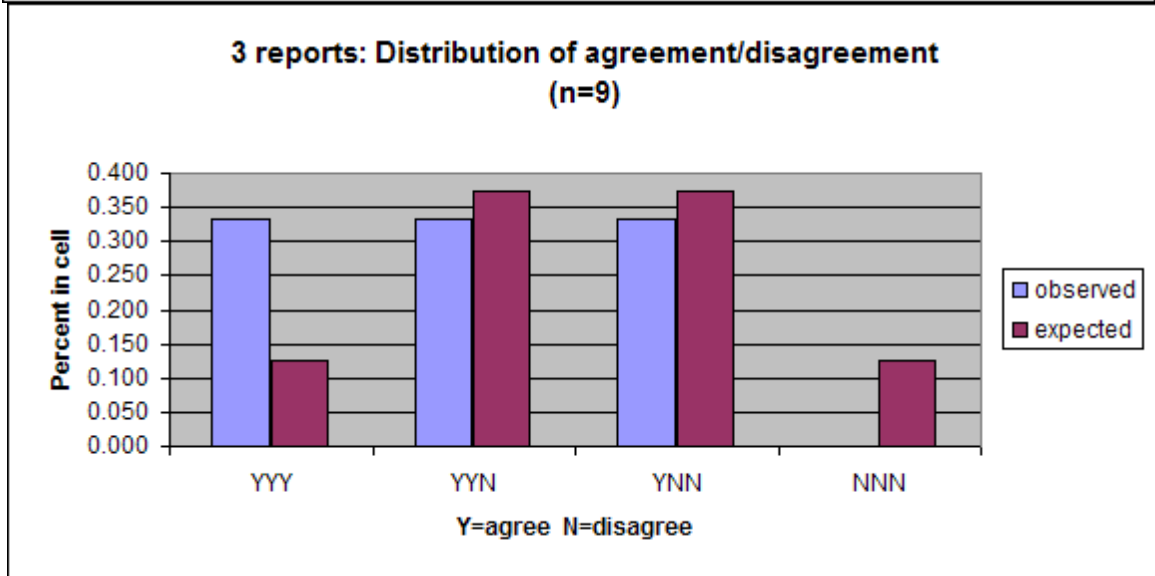
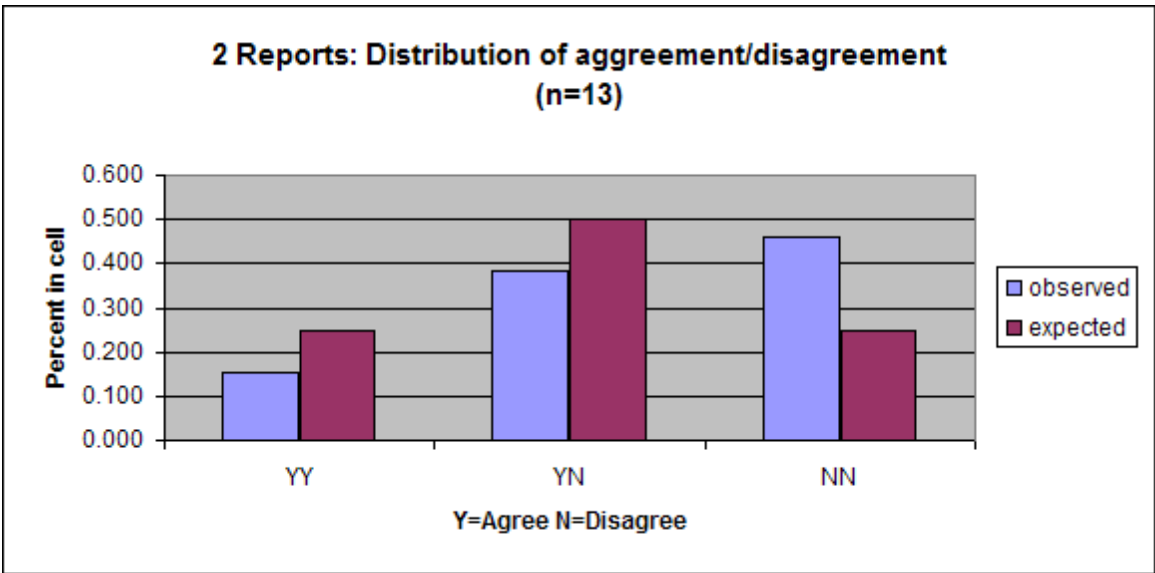
SSSOP providers are selected because they meet certain criteria. However, these criteria do not include any training in how to make balanced decisions about the appropriateness of surgery, a decision process that puts aside a provider's particular bias towards the effectiveness of surgery. SSSOP providers are meant to assess the appropriateness of surgery against common standards, not against their own perception of the effectiveness of spinal surgery. The decision about whether a worker receives or does not receive surgery should be based, in significant part, on the chance that he or she drew a second-opinion provider who was consistently pro-surgical intervention or consistently conservative in his or her judgment. As a worse case, this could be compared to flipping a coin to determine the outcome of the second-opinion process. Currently, there is no formal process in place to review decisions by SSSOP providers.

While the evidence is weak because the samples are quite small, these data are an indication that the DWC needs to monitor more carefully the results for individual providers. Specifically, the DWC should track the positive and negative recommendations on each case submitted and link these decisions back to the specific provider. Over time, the DWC will create a database of sufficient precision to identify providers who should be consulted on their decision process and methods. Providers exhibiting potential bias could be included in special education programs or, in problematic cases, excluded from participation.

In a critical and not very resource-intensive check on the system, two researchers, not completely familiar with these reports, reviewed every report submitted during the first ten months of the SSSOP process and defined approval or disapproval in 95% of the cases. This took only a single afternoon. This suggests that ongoing review and tracking of decisions would require less than .05 full-time equivalent employee (FTE) to monitor the process or substantially less than two weeks per year by one employee.

Criteria for identification of outlier physicians could be developed by the DWC or any number of research organizations that appropriately traded off the risk that the provider imposed a bias against the risk that the provider randomly received a sample of appropriate or inappropriate surgical requests. This is a standard statistical decision-making issue that DWC researchers should be able to implement, possibly with outside input.

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II.g Survey of 2005 SSSOP Requests

A survey of 2005 SSSOP requests was performed by UC Berkeley. The survey sample was based on all injuries for which a spinal surgery second-opinion request was submitted to the DWC during calendar-year 2005 (n=1,119).

The survey was conducted from May 19, 2006, though June 31, 2006. Mail surveys were sent and follow-up telephone surveys were conducted on non-respondents after three weeks. The survey was conducted in English. Less than 1% of telephone interviews resulted in non-completion due to language barriers. The table below gives the basic distribution of important criteria related to the mail and phone survey.

| Table 1 -- Sample Information | | |
|---|-------------|--------------|
| Original sample | 1,119 | |
| Incomplete or incorrect address information | 116 | |
| Final mail sample | 1,003 | |
| | Mail | Phone |
| Respondents | 246 | 121 |
| Refusals (phone) | N/A | 1 |
| % language barrier | N/A | 1 |

| Table 2—Comparison of Respondents and Sample | | |
|---|--------------------|---------------|
| Characteristic | Respondents | Sample |
| Male | 51.5% | 55.4% |
| SSSOP evaluator assigned | 51.6% | 47.1% |
| Region (worker) | | |
| So. California | 56.7% | 49.1% |
| Cent. California | 9.6% | 9.4% |
| Nor. California | 33.7% | 41.5% |
| DOI to SSSOP request (median days) | 901 | 818 |
| DOI to SSSOP request (mean days) | 1,627 | 1,409 |
| SSSOP request to survey date (mean days) | 341 | 338 |

The final estimated survey response rate is 36%. This response rate will differ from typical response rates because we had a target of 300 responses. The telephone interviews began a set time after the survey was mailed out. Additional responses to reach the necessary 300 were quickly achieved. There was only one refusal among the telephone respondents who were contacted. Subsequently, additional mail surveys were received.

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Comparing the respondents to the full sample, only marginal differences across the limited set of characteristics that can be compared were observed. None of the differences were statistically significant. Hence, there are no substantial concerns that the answers from the survey respondents will differ in important ways from the full sample of workers whose employer requested a second opinion.

11.g.1 Construction of Comparison Groups

The regulatory process surrounding an employer/insurer request for a second opinion is complex and the required timeframes are narrow. As a result, over half (52.9%) of requests for a spinal surgery second-opinion through the legislated process are rejected by the DWC on technical issues. When rejected, the employer/insurer loses the statutory right to a second-opinion process using a qualified medical evaluator (QME) assigned by the state. Hence, the employer/insurer is operating under the legal status extant prior to the adoption of the SSSOP.

This circumstance allowed for creating a quasi-experimental design using the rejected requests as the “control” group and the workers assigned a second-opinion QME as the treatment group. The assumption is that the outcomes for the control group (probability of surgery, probability of being back at work, and average change in condition of back) are similar to what they would have been in the absence of the adoption of the SSSOP, but with the new UR regulations in place. Any differences between the treatment and control groups would be the effect of the second-opinion process.¹⁰ Not all of the respondents could be assigned to the treatment or control groups because of missing data or incomplete administrative records.

| Table 3--Characteristics of Treatment and Controls | | |
|---|-----------|---------|
| | Treatment | Control |
| Gender = male | 54.3% | 44.1% |
| Region | | |
| DOI to Request (mean days) | 1,840 | 1,337 |
| Request to survey (mean days) | 345 | 327 |
| Percent 2nd opinion issued | 76.9% | 68.2% |
| Percent 2 nd opinion agrees (self-report) | 70.2% | 65.9% |
| Percent with Surgery | 65.2% | 63.6% |
| Percent Return to work | 24.1% | 34.1% |
| N= | 161 | 129 |

11.g.2 Main findings on treatment and control comparisons

The main finding in this section is that the SSSOP had no noticeable effect on most of the main outcome variables.

¹⁰ Note that any request that was withdrawn from DWC because the parties had decided upon an AME after the initial request was filed was pooled into the treatment group.

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Likelihood a worker gets a second opinion

First, workers not subject to the SSSOP (control group) were nearly as likely (68.2%) to have a second opinion as were workers who went through the SSSOP (76.9%). Apparently, insurers/employers are able to request a second opinion, and workers comply even when the second opinion is not mandatory. It is possible that workers are as interested as employers in obtaining a second opinion before undergoing a major surgical procedure like spinal surgery.

Likelihood the second opinion disagrees with the treating physician recommendation

The SSSOP is designed to ensure that evaluators are “neutral” by randomly assigning evaluators from among all evaluators within a set geographical distance from the injured worker. As noted above, a main motivation for the SSSOP process was concern that an employer/insurer, with greater knowledge of evaluator preferences would guide workers to conservative second-opinion providers. Also, the second opinion was important in the final determination of whether to perform surgery. Workers had surgery 88% of the time when the second opinion supported the need for surgery, but about half as often (47%) when the second opinion recommended against surgery. However, it was again observed that there is no difference in the probability that a second opinion will agree with the treating physician’s original recommendation for spinal surgery. SSSOP second opinions recommended surgery 70.2% of the time while non-SSSOP second opinions recommended surgery 65.9% of the time.

Probability that a worker has surgery

There was also no difference in the probability of back surgery for the treatment or controls. A number of variables that intervene between the original surgery recommendation and the actual surgery (time, change in condition, legal resolution when the opinions differ) mean that a positive or negative second opinion does not necessarily mean that surgery was performed or denied. Still, the treatment and control groups had near identical probabilities of surgery (65.7% vs. 63.6%).

Change in self-reported health condition of back

Treatment and control groups report very similar levels of change in the condition of their back between date of original surgery request and date of survey. For those subject to SSSOP, 46% reported their back was better or much better, and 34.9% reported it was worse or much worse. For the control group, not subject to SSSOP, 47.6% reported their back was better or much better, and 33.1% reported it was worse or much worse. As seen below, this similarity in current back condition is not surprising because the most important determinant change in condition was whether or not a worker had surgery and rates of surgery were the same for treatments and controls.

Probability of return to work at one year

The only statistically significant difference observed among the outcomes in Table 3 is that workers who underwent the SSSOP process were less likely to be back at work when surveyed. Workers were surveyed, on average, about one year after their treating physician requested surgery. The percent of workers that were working at the time of the survey was very low, 34.1% for workers not subject to SSSOP. However, the percent of those working among those undergoing SSSOP was even worse, only 24.1% were back at work.

It is not clear why workers subject to SSSOP were less likely to be back at work. One possibility is that the SSSOP process takes longer to produce a second opinion than the less formal agreement by the parties for a second opinion. This would result in less time for recovery after surgery and hence, at least in the short-term to medium-term, fewer workers back at work.

Worker perception of quality of second-opinion examination

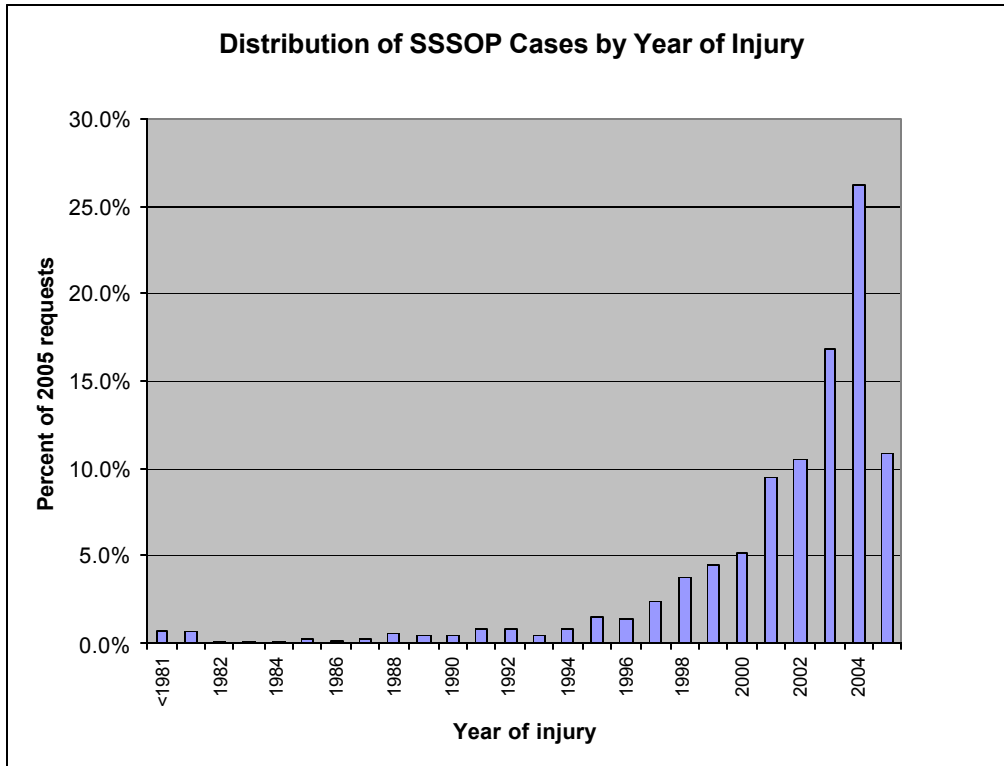
As a final observation, state-mandated evaluations are often accused of being performed in a perfunctory manner. However, no differences were observed in the perception of the quality of the second-opinion appointment dependent on whether the worker went through the SSSOP or had a second-opinion doctor determined outside the statutory process.

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11.g.3 Other findings from the survey of SSSOP

Distribution of spinal surgery cases by year of injury

Workers' compensation insurance is often noted for the very long "tail" for medical costs. That is, a substantial fraction of medical expenditures on claims is incurred years after the dates of injury. The distribution of requests for a second opinion by the year of the injury was examined. The chart below shows that while over half (54%) of SSSOP requests were on injuries that occurred between 2003 and 2005, almost 1/10 (9.5%) of the requests were for claims with dates of injuries occurring more than ten years prior. Four-fifths of the cases had injury dates between 2000 and 2005.



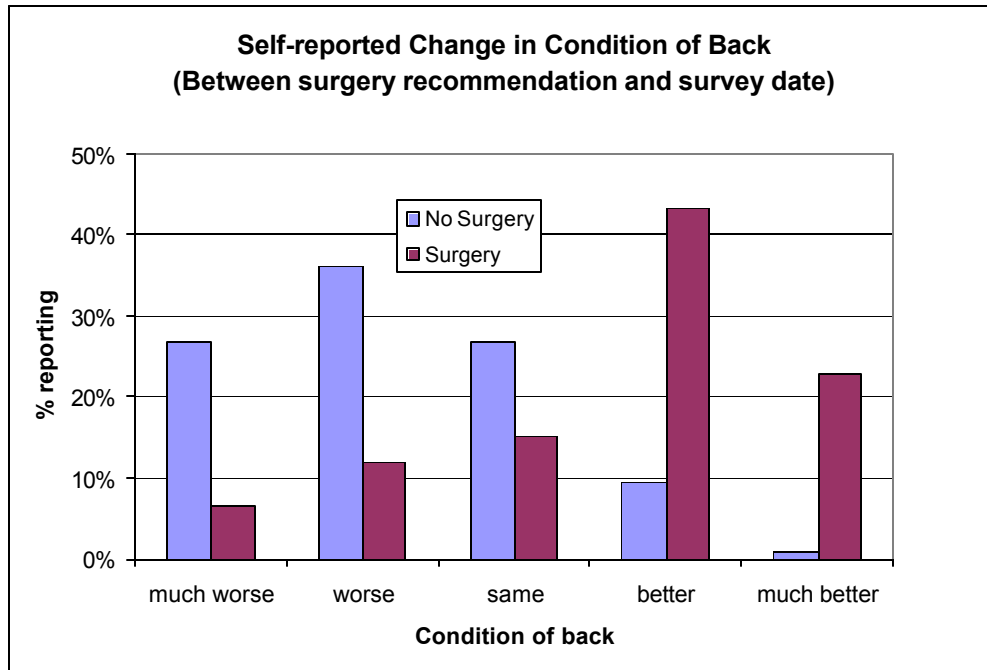
Impact of surgery on return to work and health status

Despite the fact that all of the workers in our study had initially been recommended for spinal surgery, about 1/3 (37%) had not undergone surgery by the survey date. A challenging finding concerning surgery is that persons in our sample were 50% more likely to be back at work if they did not undergo surgery. 38.6% of those without surgery were working at the time of interview while only 26.9% of those who had surgery were working. This is a difficult finding to interpret. Those who forgo surgery or receive a negative second opinion may be less severely injured, or the health of these workers may have improved between the recommendation for surgery and the survey to the extent that they could work.

However, review of how respondents report the condition of their back at the time of the survey as compared to when surgery was originally recommended does not support the argument that surgery was forgone because their back got better. It was just the opposite, as it was observed that respondents who did not have surgery report much poorer health outcomes relative to the time surgery was initially recommended. The chart below shows the percent of respondents reporting that their condition was much worse, worse, same, better, and much better. It is clear that those undergoing surgery perceived their condition as markedly improved, while those without surgery perceived significant deterioration in their

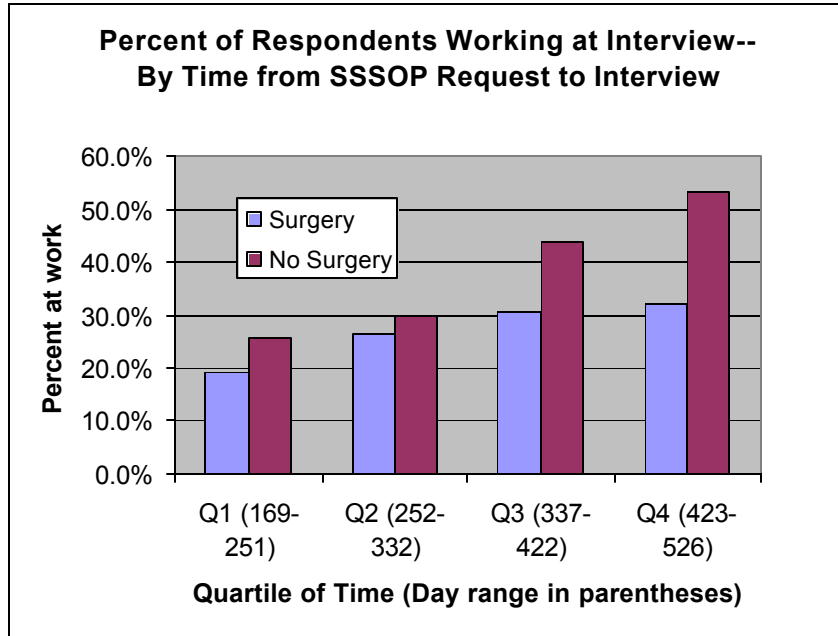
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condition. These results are difficult to reconcile with the lower probability, that of returning to work for those workers having surgery.



One possible explanation is that workers undergoing surgery require recovery time, while those that do not have surgery return to work because they have exhausted possible therapies. If the worker is declared permanent and stationary, temporary disability payments would end and would result in the ability to delay return to work. Again, it is difficult to resolve this question. However, if surgery results in better outcomes and these translate into better return to work, we might expect to see that workers without surgery initially have better return to work, but those with surgery eventually do better. This is not what was observed over the relatively limited time horizon of the survey. A steady increase in the percent of non-surgery cases returning to work was observed, increasing from about 25% for those surveyed 6-9 months after the treating physician recommended surgery to about 54% at 14-18 months. Surgery cases have lower initial return to work, but despite reporting better health outcomes, their return to work appears to plateau around 30-32% even at 14 to 18 months post-surgery recommendation.

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Workers who undergo surgery may have poorer return to work because of more severe initial conditions. It is important that doctors make clear to their patients who are considering surgery that if they have surgery, the probability of returning to work in the medium-term is quite low.

Gender

One of the most interesting and puzzling findings is the extent of differences by gender. Women have very different patterns than men. First, the odds that the second opinion will disagree with the first opinion are 50% to several times higher for women than for men. There are two measures of agreement between the original recommendation and the second opinion. The first is what could be determined from the doctors reports returned to the DWC; the second opinion in these cases is known absolutely. However, only a minority of doctors submitted second opinions to the DWC. For this limited sample of cases, women were 4 times more likely to get a negative second opinion. The second source is what is reported by the respondents. This is known on almost every mail or telephone survey. The recall of the respondents taking the survey may be less than perfect, although any bias *a priori* is unknown. For this broader sample, women were 50% more likely to get a negative second opinion.

Second, women are also much less likely to have surgery than men, even though the treating physician initially recommended surgery in all cases in the study. Three-fourths of men (74.7%) had surgery by the survey date, but only 56.4% of women had surgery. This difference is probably greater than any impact driven by the greater likelihood that women get negative second opinions.

Third, women also report poorer health outcomes relative to their health status at the time of the original recommendation for surgery. This is consistent with women having fewer surgeries, since people who did not undergo surgery, male or female, report poorer health status.

Finally, women are much more likely (36.3%) than men (25.5%) to be back at work at the time of the survey. Much of this may be explained by the lower rate of surgery that women experience. Surgery predicts poor return to work, at least by the time of interview.

III CONCLUSIONS

SSSOP was adopted when statute, regulation, and custom did not allow for extensive use of utilization review by employers/insurers. The adoption of more intensive UR and introduction of the ACOEM

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guidelines have probably eliminated the need for SSSOP. Comparing workers subject to SSSOP and those who were not, no important differences in the likelihood of a second opinion being issued or the probability that the second opinion recommends against surgery was observed. On the other hand, the SSSOP process may require more time and delay return to work.

The SSSOP is a resource-intensive regulatory process that appears to accomplish little or nothing that the parties have been unable to accomplish on their own when required to negotiate a mutually agreed solution. If anything, the parties seem to agree to the same procedures (i.e., similar frequency of second opinions, similar levels of agreement between initial and second opinion, similar rates of surgery), but when they agree outside the regulatory process, the outcomes of interest, return to work and health status, are as good or better.

IV. FUTURE RESEARCH FOCUS

There are a number of important areas where the DWC should consider focusing attention with regard to SSSOP.

First, there is a large fraction of cases where no report is submitted to the DWC. This may indicate that a significant fraction of workers are being discouraged, maybe appropriately, from pursuing spinal surgery as an option. This percentage is estimated to be at least 29%. Key questions are: what are the outcomes for these workers; and why did they not complete the process?

Second, for workers who were ultimately denied surgery, what were their outcomes? Did they ultimately undergo surgery at their own expense or the expense of a third party? This was a common outcome for workers denied services under the Texas workers' compensation system's SSOP (See Appendix 1, 38% of workers who were denied spinal surgery had the surgery performed at their own expense) and a common outcome observed in studies evaluating SSOP process in other medical systems. However, this is inconsistent with many stakeholders' perception of appropriate reimbursement to workers and consistent internalization of occupational injury costs by employers.

Third, when surgery is performed, when surgery is denied, or when surgery is denied and subsequently performed at the worker's or third party's expense, what are the health and economic outcomes? Ultimately, the evaluation of a second-opinion process rests on the outcomes of the patients balanced against the costs to payors. These outcomes should be measured and considered when recommending for or against legislative or regulatory modifications to the SSSOP process.

The basic element of research in this area is to solicit information from workers themselves about how and why they made their decision and what they perceived as their economic and medical outcomes. This is most efficiently done through a two-stage survey process. First, a mail-administered survey would be sent to all workers who participated in the process, that is, where the employer made a request for a second opinion. Workers would be asked basic questions about whether they completed the process and if not, why not. They would also be asked to comment on current health and work status.

Since response rates to mail surveys can be inconsistent, a follow-up phone survey should be conducted to ensure that the results are statistically strong and not influenced by non-response bias. Telephone surveys are expensive, but if the response is reasonable on the mail survey, the cost of a telephone follow-up of non-respondents will be greatly reduced.

Ultimately, when the pool of SSSOP cases is large, linking these survey responses to outcome measures in insurer data (indemnity payments, temporary disability duration, permanent disability percent rating, and Employment Development Department (EDD) outcomes (first quarter of substantial return to work, quarters worked since injury, average earnings since injury) will give a strong basis for evaluating the effectiveness of the SSSOP and spinal surgery in general.

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A mail-based survey with telephone follow-up is a very inexpensive way to achieve high response rates. Following up with linkages to insurer and EDD data is a very cost-effective way to test the effectiveness of the process.

V. OTHER ISSUES THAT SHOULD BE ADDRESSED

There is no process in place to deal with those objections that fail to meet the ten-day requirement. The question remains, is the recommendation for spinal surgery automatically accepted? If so, is this the proper course of action given that the recommendation for spinal surgery was questioned?

Findings

Currently, the DWC Worker's Compensation Medical Unit is denying untimely requests for second opinions. Therefore, by a default, the injured worker is allowed the spinal surgery even though the treating physician's recommendation was questioned.

Recommendation

A possible solution is to assess the employer a penalty for submissions received on day 11 through a given day regardless of the reason for delay. Penalties could be assessed based on the number days the submission was late. The employer then has the option to accept the penalty and proceed or withdraw the request. This will allow time to review the objection and make a determination on whether or not spinal surgery is appropriate. Reasonably, there would need to be a statutory limit on extension as the injured worker does deserve treatment without undue delays.

An alternate solution draws from the Department of Managed Care's IMR model:

“A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars (\$5,000) for each day the decision is not implemented.”

Issues/Concerns

The process in place to deal with objections returned due to technical issues, such as the use of the wrong form, incomplete forms and/or missing documentation, does little to support the intent of the regulation.

Findings

Approximately 24.5% second-opinion requests were returned and hence denied due to technical issues, such as the use of the wrong form, incomplete forms, and/or missing documentation.

Recommendation

A process similar to that used under the Department of Managed Care's Independent Medical Review could form the basis for a solution. In summary:

If the Independent Medical Review application is incomplete (under the SSSOP it would be the DWC 233 and supporting documentation), the Department will attempt to contact the enrollee (the entity that filed the objection) at least two times to obtain the necessary information. The Department will also attempt to obtain the missing information from the HMO (claims administrator). If the Department is unable to reach the enrollee (entity that files the objection) or is unable to obtain the necessary information from the HMO (claims administrator), the case will be closed and the enrollee (objecting party) notified that once the necessary information is provided, the case will be re-opened.¹¹

¹¹ 8 CCR§§9788.88 Examination by Second Opinion Physician or Agreed Second Opinion Physician.

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Appendix 1: Proposed Legislative Alternatives

The SSSOP is not well coordinated with other provisions of law involving utilization (UR) review and dispute resolution through the process of Agreed Medical Evaluator or Qualified Medical Evaluator (AME/QME process). Existing law is open to conflicting interpretations, and the debate has not been settled by the one WCAB case that attempted to interpret the process. As illustrated in the flowcharts later in this report, the dispute resolution path is convoluted, to say the least. There is widespread agreement that it should be improved by one or the other of two alternatives. The alternatives are:

- The SSSOP should be eliminated, so that spinal surgery issues are subject to the same UR and AME/QME process as other treatment issues,

Or

- The SSSOP should become solely the method for an injured worker to challenge a UR decision denying authorization for spinal surgery, while UR would be the sole method for an employer to object to a recommendation for spinal surgery on the grounds of medical necessity.

Suggested statutory language for both alternatives is provided below.

Alternative 1: Eliminate the Spinal Surgery Second Opinion Process.

4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. ~~Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610.~~

If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section **4062.2**, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section **4062.1**, and no other medical evaluation shall be obtained.

~~(b) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.~~

(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

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(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section

5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section.

Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the

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public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph.

Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section **4062**. ~~If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision~~

~~(b) of Section **4062**.~~

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section **4062**. ~~, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section **4062**.~~ Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and-relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the-payments, in a manner set forth by the respective board and in such-a way as to minimize reporting costs both to the board and to the-insurer or self-insured employer, for evaluation as to possible-violations of the statutes governing appropriate professional-practices. No fees shall be levied upon insurers or selfinsured-employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately

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notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

Alternative 2: Amend the provisions of Labor Code Section 4602 dealing with SSSOP to specify the sequence of events and the issues that are subject to that sequence. The following proposed language would provide (see flow chart illustration of the proposed alternative):

1. All questions of medical necessity are initially subject to UR, including questions of medical necessity of spinal surgery.
2. An employer is bound by a medical necessity finding in UR.
3. An employee who objects to a negative determination in UR may request a medical evaluation of the disputed issue.
 - a. Ordinarily, medical necessity disputes go to the QME process under Labor Code 4062(a).
 - b. For spinal surgery, medical necessity disputes go to the SSSOP under Labor Code 4062(b).
4. An employer is bound by a medical necessity finding of the SSSOP.
5. An employee may file a Declaration of Readiness if the employee wishes to contest a negative finding of the SSSOP.
6. If there are multiple issues, such as whether surgery is necessary for the spinal condition and whether the condition is caused by the industrial injury, only the medical necessity issue is determined by SSSOP.
 - a. A QME on other issues may be pursued concurrently with UR and SSSOP on the medical necessity issue.
 - b. If an employee is represented, the parties may agree on a physician for the SSSOP and may agree that the same physician will serve as an agreed medical examiner on other issues.

Proposed Language for Spinal Surgery Second Opinion Process

§4062 (a)(1) If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. ~~Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. An employer objection to the treating physician's recommendation for any treatment, including a recommendation for spinal surgery, on the ground of medical necessity for the workers' medical condition, shall be made only in accordance with Section 4610 regardless of any concurrent objection made on any other ground.~~ If the employee objects to a decision made pursuant to Section 4610 to modify, delay, or deny a treatment recommendation, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an

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attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in Section 4062.1, and no other medical evaluation shall be obtained.

(b) (1) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. Notwithstanding subdivision (a), if the employee objects to a decision made pursuant to Section 4610 to modify, delay or deny a treatment recommendation for spinal surgery, the medical evaluation to determine the disputed issue of medical necessity of the spinal surgery shall be obtained pursuant to this subdivision. No other medical evaluation on the disputed issue of the medical necessity of spinal surgery for the employee's medical condition shall be obtained except as provided under this subdivision. Any medical evaluation for a disputed medical issue other than the medical necessity of spinal surgery for the employee's medical condition shall be obtained pursuant to Section 4060, 4061, or subdivision (a) of Section 4062, as appropriate. A spinal surgery second opinion obtained pursuant to this section shall not determine any disputed medical issue other than the medical necessity of the spinal surgery except as provided by paragraph (3). The time limits in this subdivision may be extended by good cause or by mutual agreement.

(2) If the employee objects to a decision made pursuant to Section 4601 to modify, delay or deny a treatment recommendation for spinal surgery, the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. If the employee is not represented by an attorney, the objection shall also be filed with the administrative director in the form and manner provided by the administrative director.

(3) If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. An agreement under this paragraph may also provide that other disputed medical issues shall be submitted to the second opinion physician as an agreed medical evaluator pursuant to Section 4602.2.

(4) If no agreement is reached within 10 days of service of the employee's objection pursuant to subdivision, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation.

(5) Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. service of the employee's objection upon the employer. If the second opinion report recommends surgery, the employer shall authorize the surgery unless in accordance with subdivision (a) or Section 4060 the employer also timely objected to the medical determination made by the treating physician on grounds other than the medical necessity of the surgery. If the second opinion report does not recommend surgery, the employer shall inform the employee of the right to file a declaration of readiness to proceed.

(6) The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision unless the second opinion report finds that delay of the surgery pending the second opinion report would have posed an imminent and serious threat to the employee's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or would have jeopardized the employee's ability to regain maximum function.

(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

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(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

[Section 4610 is not changed by the proposed amendment. It is reproduced below for convenience of the reader to observe the relationship to Section 4062. Portions highlighted in bold type have particular relevance to the spinal surgery second opinion process.]

§4610. (a) For purposes of this section, "**utilization review**" means **utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity** to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) **Every employer shall establish a utilization review process in compliance with this section**, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge

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shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3)(A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. **If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.**

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be

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consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

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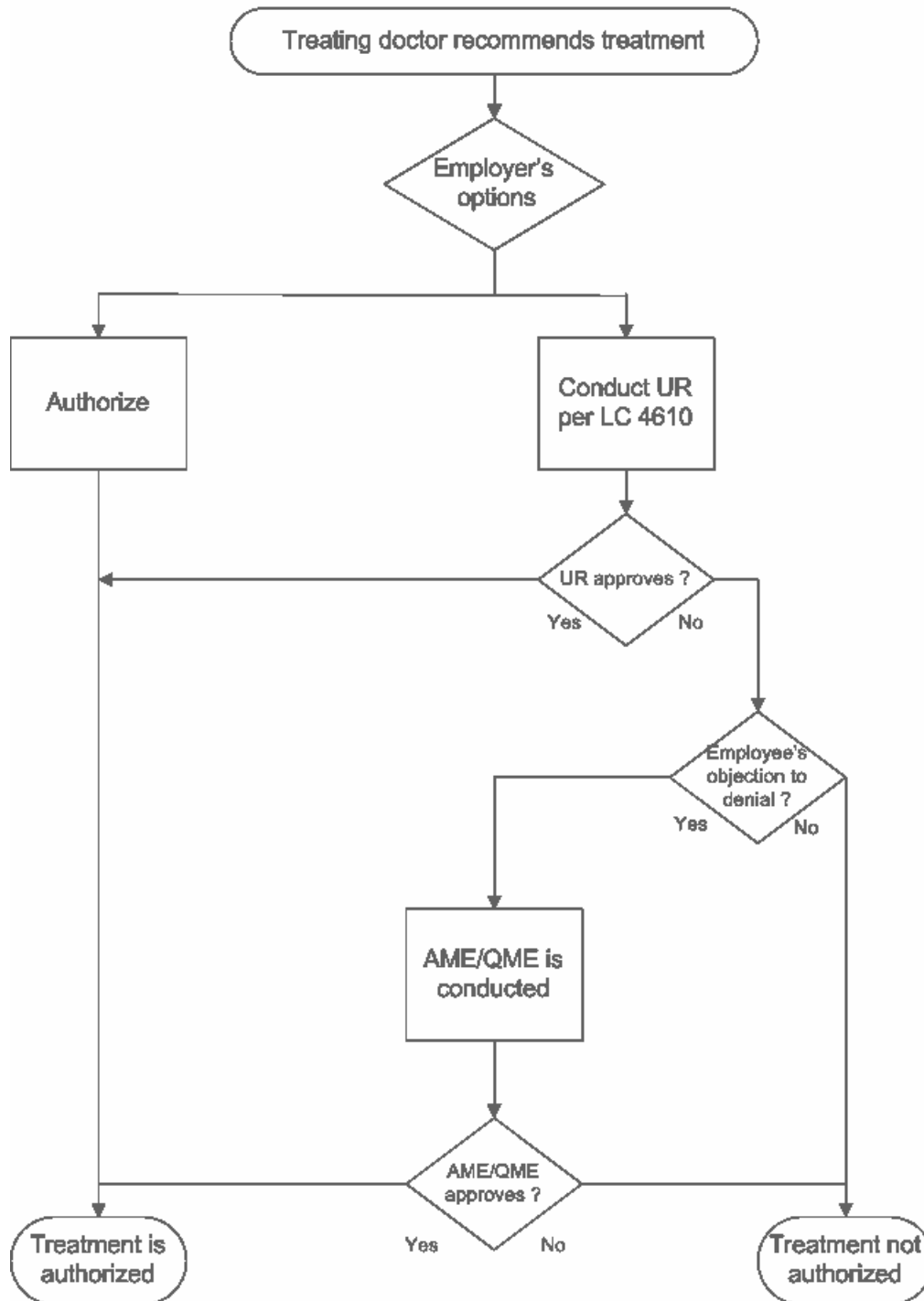
**FLOWCHARTS TO ILLUSTRATE
CHSWC RECOMMENDATION ON
SPINAL SURGERY SECOND-OPINION PROCEDURE**

The following diagrams illustrate the similarities and differences in the process to determine the medical necessity of treatment recommended by a treating physician, depending on the type of treatment:

- Existing law applicable to all recommendations other than spinal surgery.
- Existing law applicable to recommendations for spinal surgery (as interpreted in one recent WCAB significant panel decision).
- The proposed recommendation applicable to recommendations for spinal surgery.

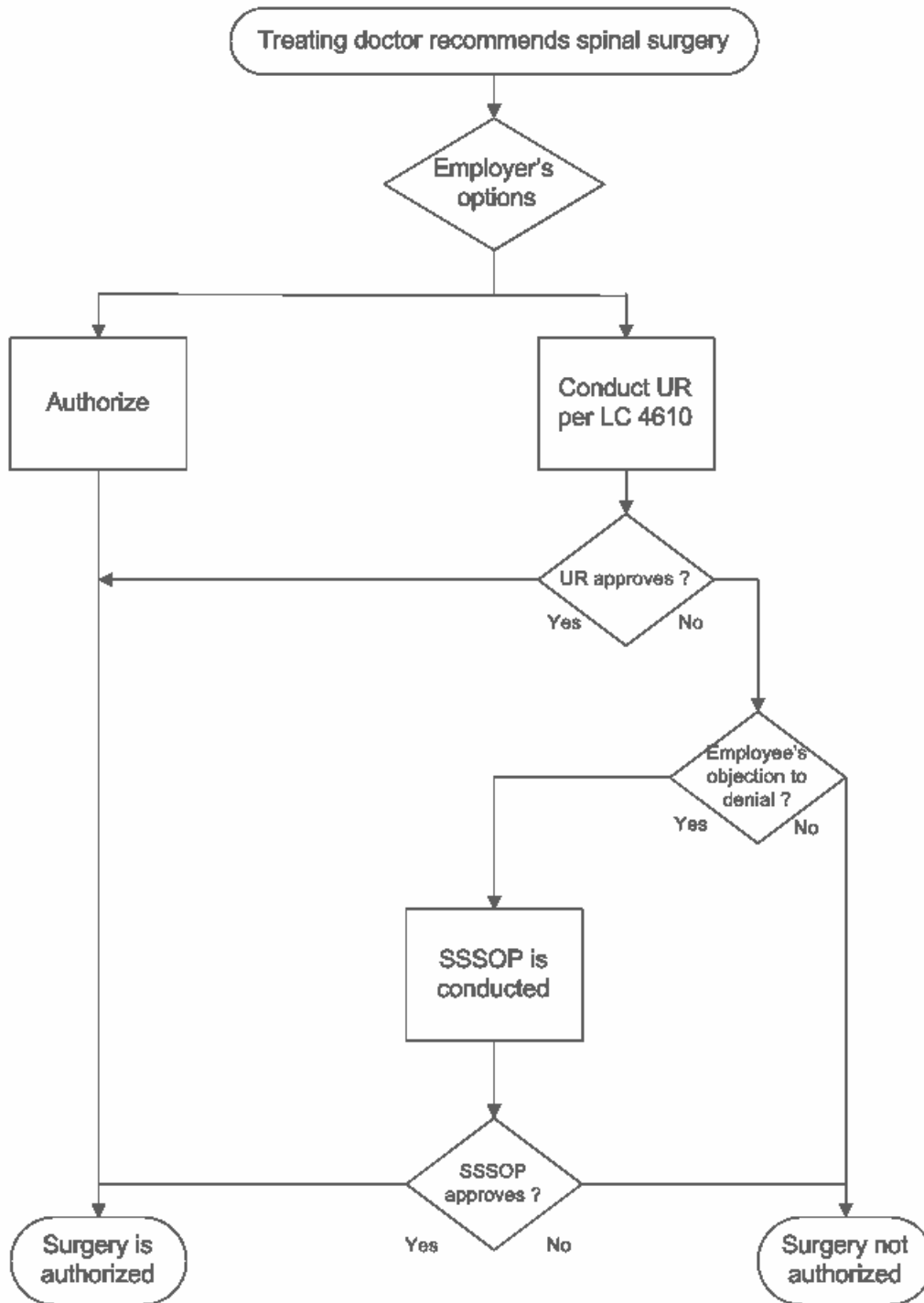
The diagrams are intended only to illustrate the similarities and differences, not to present a comprehensive description of the process.

STANDARD UR AND QME PROCESS (other than spinal surgery)



SPINAL SURGERY SECOND OPINION PROCESS

proposed CHSWC recommendation 10/5/06



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Appendix 2: Case Study—Texas Second-Opinion Process

Ever since the workers' compensation reform in 1989, Texas law has allowed for both the employee and the insurance carrier to utilize a second-opinion process for determination of spinal surgery. In 2002, the state of Texas found the need to make changes to this process by which spinal surgery is approved. They estimated the new process will expedite decisions regarding spinal surgery and allow for broader access to doctors in other health systems and specialties to evaluate the appropriateness of spinal surgeries. It will further ensure that qualified medical experts conduct those reviews.¹²

Under the new law, HB 2600, spinal surgery requests are subject to preauthorization by insurance carriers. The carrier has three working days to accept or reject the request. If the carrier denies the surgery, the physician then can appeal to an Independent Review Organization (IRO). The IRO has 20 days to approve or disapprove. Regardless of outcome, the carrier is required to pay the IRO fees.¹³ The contention behind this change in procedure is that preauthorization will expedite decisions regarding spinal surgery and allow for broader access to doctors in other health systems and specialties to evaluate the appropriateness of the surgeries.¹⁴

A telephone survey of 679 injured workers in Texas was conducted in June 1997 to determine the experiences of injured workers who were denied spinal surgery. 87% reported that the second-opinion process ultimately approved their surgeries, while 13% got denied. Of those who had their surgery denied, 38% went ahead with the surgery and paid out of pocket.¹⁵ A companion report done at the same time looked at Texas workers who were denied treatment through the preauthorization process. Out of the 928 workers surveyed, 47% reported that a treatment or service was denied. The various treatments denied did not include spinal surgery since it operated under the second-opinion process during that time.¹⁶

According to the Texas Workers' Compensation System Data Report of June 2002, the estimated savings from the second-opinion process from 1997 through 2001 are over 20 million dollars annually. Cost savings from the preauthorization measure through the same period averages to half a million dollars annually.¹⁷ A subsequent report completed in June 2004 offers new cost savings amount with the preauthorization measure. In 2002 and 2003, this measure saved the workers' compensation an average of three million dollars. Cost savings from spinal surgery denials are now included within this savings. These data show a large discrepancy between the money saved from preauthorization versus second-opinion process for spinal surgery. The authors noted that the "cost savings reported will not comprehensively reflect service provided during the recent periods until the medical billing data has matured."¹⁸

¹² <http://www.tdi.state.tx.us/company/roc/hb2600mon.html>

¹³ <http://www.texpac.org/legislative/hb2600twcs.html>

¹⁴ <http://www.tdi.state.tx.us/company/roc/hb2600mon.html>

¹⁵ <http://www.tdi.state.tx.us/company/coc/spinal.html>

¹⁶ <http://www.tdi.state.tx.us/company/roc/preauth.html>

¹⁷ http://www.twcc.state.tx.us/sdr_june2002.pdf

¹⁸ http://www.twcc.state.tx.us/sdr_june2004.pdf

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Appendix 3: Spinal Surgery Second-Opinion Process - Regulations

§9788.01. Definitions

As used in this Article:

(a) "Agreed second opinion physician" is a physician agreed upon by an employer and represented employee pursuant to Labor Code Section 4062 subdivision (b).

(b) "Completion of the second opinion process" occurs on the forty-fifth day after the receipt of the treating physician's report by the employer, unless the time has been extended by mutual written consent of the parties as provided in these regulations, or unless the time has been extended as provided in these regulations because the employee failed to attend an examination with the second opinion physician or agreed second opinion physician.

(c) "CPTã" means the procedure codes set forth in the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.

(d) "Income" of a person includes the income of that person's business partner, physician member of the office of a group practice as defined in Labor Code section 139.3, spouse, cohabitant, and immediate family. Income of a second opinion physician does not include income from employment which had terminated prior to the time the physician was selected as a second opinion physician where there is no reasonable prospect of future employment.

(e) "Material familial affiliation" means a relationship in which one of the persons or entities listed in subdivision (c) of Labor Code section 4062 is the parent, child, grandparent, grandchild, sibling, uncle, aunt, nephew, niece, spouse, or cohabitant of the second opinion physician. For entities of the employer, insurer, physician, medical group, independent practice association, administrator, utilization review entity, facility, or institution mentioned in subdivision (c) of Labor Code section 4062, which are not persons, the familial affiliation shall be determined by considering the relationship of all of the officers, directors, owners and management employees, and individual claims administrators and supervisors to the second opinion physician.

(f) "Material financial affiliation" includes all of the following financial relationships between the second opinion physician and another person or entity listed in subdivision (c) of Labor Code section 4062, or parent or subsidiary or otherwise related business entity of a person or entity:

(1) One has a direct or indirect investment worth two thousand dollars or more in the other;

(2) One is a director, officer, partner, trustee, employee, or holds any position of management in the other;

(3) One has a direct or indirect interest worth two thousand dollars or more in fair market value in an interest in real estate owned or controlled by the other;

(4) One has received income of any kind, including gifts, from the other, aggregating three hundred dollars or more within the twelve months prior to the time of selection as a second opinion physician, except that the following income shall not be counted for this purpose:

A. income for services as a second opinion physician;

B. income for services as a treating physician;

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C. income for services as an agreed medical examiner;

D. income for services as a panel Qualified Medical Evaluator selected for unrepresented employees;

E. income from services as a Qualified Medical Evaluator for represented employees.

F. income for services as a Qualified Medical Evaluator for an employer from the first five cases in any twelve month period for the same employer, carrier, or administrator.

(5) One has an employment or promise of employment relationship with the other.

(g) "Material professional affiliation" is any relationship in which the second opinion physician shares office space with, or works in the same office of, any of the other persons or entities listed in subdivision (c) of Labor Code section 4062.

(h) "Parent, subsidiary, and otherwise related business entity" have the same meanings as in Section 18703.1, Title 2, Division 6 of the California Code of Regulations.

(i) "Receipt of the treating physician's report" is the day it was first received by the employer, insurance carrier, or administrator.

(j) "Retired spinal surgeon" is a physician currently licensed in the State of California who once had, but no longer has, hospital privileges to perform spinal surgery described in Section 9788.2(c)(2). "Retired spinal surgeon" does not include a physician whose hospital privileges to perform spinal surgery were either surrendered by the physician or were terminated or not renewed by the hospital, after disciplinary charges were filed or after a disciplinary investigation was commenced.

(k) "Second opinion physician" is the physician who is randomly selected pursuant to subdivision (b) of Labor Code section 4062 to render the second opinion on a treating physician's recommendation of spinal surgery.

(l) "Spinal surgery" includes:

(1) any of the procedures listed in the Official Medical Fee Schedule denominated by the following CPTR procedure code numbers: 22100, 22101, 22102, 22103, 22110, 22112, 22114, 22116, 22210, 22212, 22214, 22216, 22220, 22222, 22224, 22226, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22850, 22851, 22852, 22855; 22899; 62287, 62292, 63001 through 63615; and,

(2) any other procedure, which is not listed in subdivision (l)(1), which is a non-diagnostic invasive procedure to the spine or associated anatomical structures to perform an operative or curative procedure which is not primarily an analgesic procedure; and,

(3) any procedure which involves the introduction of energy, a foreign substance, or a device that destroys tissue in the spine and/or associated structures, including nerves and disks, or involves the implantation of devices into the spine and associated structures, including nerves and disks, and which is not primarily an analgesic procedure;

(4) Notwithstanding subdivisions (1) through (3), "spinal surgery" does not include penetration of the body by needles in the performance of acupuncture by a practitioner whose license permits the performance of acupuncture, nor does "spinal surgery" include surgery which is required because of a bona fide medical emergency.

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§9788.1. Employer's Objection To Report Of Treating Physician Recommending Spinal Surgery

(a) An objection to the treating physician's recommendation for spinal surgery shall be written on the form prescribed by the Administrative Director in Section 9788.11. The employer shall include with the objection a copy of the treating physician's report containing the recommendation to which the employer objects. The objection shall include the employer's reasons, specific to the employee, for the objection to the recommended procedure. The form must be executed by a principal or employee of the employer, insurance carrier, or administrator.

(b) Declarations.

(1) Declaration as to receipt of treating physician's recommendation.

The employer's objection shall include one of two versions of a declaration made under penalty of perjury regarding the date the report containing the treating physician's recommendation was first received by the employer, employer's insurance carrier, or administrator, in the format of the form prescribed by Section 9788.11.

Version A of the declaration shall be used if the declarant has personal knowledge of all the facts. Version B of the declaration may be used if the recipient employer, insurance carrier or administrator has a written policy of date-stamping every piece of mail on the date it was delivered to its office, this policy is consistently followed, the declarant is knowledgeable about the policy, and the report bears a legible date stamp showing when it was received in the office.

The declaration must be executed by a principal or employee of the employer, insurance carrier, or administrator.

(2) Declaration as to service of objection.

The employer's objection shall include a declaration made under penalty of perjury, in the format of the form prescribed by Section 9788.11 as to the date and time the objection was served, and the manner in which the objection was served.

The declaration must be executed by a principal or employee of the employer, insurance carrier, or administrator.

(c) Service of Objection.

(1) The employer shall serve the objection and the report containing the treating physician's recommendation on the Administrative Director, the employee, the employee's attorney, if any, and on the treating physician within 10 days of receipt of the treating physician's report containing the recommendation. An objection which is mailed to the Administrative Director and is received more than ten days after the date of receipt of the treating physician's report is untimely unless it bears a postmark date no later than the tenth day after the date of receipt of the treating physician's report. The employer shall serve the original of the objection on the Administrative Director.

(2) Service on the Administrative Director shall be by mail or physical delivery. Service on the employee, employee's attorney, and treating physician shall be by mail or physical delivery or, if prior consent has been obtained from the recipient to be served by fax, may be by fax.

(d) If after an employer has served the objection on the Administrative Director, either the employer and a represented employee agree to an agreed second opinion physician or the employer withdraws its objection to the treating physician's recommendation for spinal surgery, the employer shall notify the

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Administrative Director within one working day of the agreement or withdrawal of objection. This notification may be by fax.

§9788.11. Form for Employer's Objection to Report of Treating Physician Recommending Spinal Surgery

[PLEASE NOTE: DWC Form 233 is displayed in *Appendix 4* and available at [DWC form 233](#) (.pdf document)]

This form, together with the report of the treating physician containing the recommendation for treatment which is objected to, is to be mailed to the Administrative Director, Medical Unit, P.O. Box 8888, San Francisco, CA 94128-8888, and copies served by mail or physical delivery or fax on the employee, employee's attorney, and treating physician. The objection form and report may be served on the employee, employee's attorney, and treating physician by fax, but only if prior consent has been obtained from the recipient to be served by fax. This form may not be served on the Administrative Director by fax. This Objection must be sent within ten (10) days of the first receipt by any of the employer, insurance carrier, or administrator, of the treating physician's report containing the recommendation.

Declarations

The form contains two declarations to be signed under penalty of perjury. The first is a declaration specifying the date that the report containing the treating physician's recommendation was first received by the employer, insurance carrier, or administrator. The second declaration specifies the date and manner of serving of the objection.

The form includes two versions of the declaration specifying the date of receipt of the report. Only one version needs to be completed. Version A shall be completed by an employee having personal knowledge of the facts of when the report was received, such as the person who opened the mail. Version B shall be completed by an employee who knows from the date stamp when the report was received, if all mail to the firm is date-stamped on the date it is received, the signer is readily knowledgeable about the policy, the policy is consistently followed, and the report bears a legible date stamp.

The declaration regarding service of the objection must be signed by the person having knowledge of how the report was served.

§9788.2. Qualifications of Spinal Surgery Second Opinion Physicians

(a) An agreed second opinion physician may be any California licensed board-certified or board-eligible orthopaedic surgeon or neurosurgeon.

(b) The Administrative Director shall maintain a list of qualified surgeons who have applied, and whom the Administrative Director has found to be eligible to give second opinions under Labor Code § 4062 (b) after random selection by the Administrative Director.

(c) To apply to be on the Administrative Director's list, a physician shall demonstrate to the satisfaction of the Administrative Director that the physician:

(1) Is currently board certified either as a neurosurgeon by the American Board of Neurological Surgery or the American Osteopathic Board of Surgery, or as an orthopaedic surgeon by either the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery;

(2) Has current hospital privileges in good standing at an accredited hospital in California to perform spinal surgery without proctoring;

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- (3) Has an unrestricted license as a physician and surgeon in California;
 - (4) Has no record of previous discipline by any governmental physician licensing agency, and is not then under accusation by any governmental physician licensing agency;
 - (5) Has not been terminated or had discipline imposed by the Industrial Medical Council or Administrative Director in relation to the physician's role as a Qualified Medical Evaluator; is not then under accusation by the Industrial Medical Council or Administrative Director; has not been denied renewal of Qualified Medical Evaluator status, except for non-completion of continuing education or for non-payment of fees; has neither resigned nor failed to renew Qualified Medical Evaluator status while under accusation or probation by the Industrial Medical Council or Administrative Director or after notification that reappointment as a Qualified Medical Evaluator may or would be denied for reasons other than non-completion of continuing education or non-payment of fees; and has not filed any applications or forms with the Industrial Medical Council or Administrative Director which contained any untrue material statements; and
 - (6) Has not been convicted of any crime involving dishonesty or any crime of moral turpitude.
- (d) The Administrative Director may also accept to be on the list a retired spinal surgeon who does not meet the qualifications of subdivision (c)(2), but who does meet the qualifications of subdivisions (c)(1), (c)(3), (c)(5), (c)(6), and either (c)(4) or (e), if the retired spinal surgeon met the qualifications of subdivision (c)(2) within three years of application. The qualification of such physician shall not extend longer than three years from the last time the physician met the requirements of subdivision (c)(2).
- (e) The Administrative Director may also accept to be on the list a physician who does not meet the qualifications of subdivision (c)(4), but who does meet the qualifications of subdivisions (c)(1), (c)(2), (c)(5), (c)(6), and either (c)(3) or (d), if at least five years have elapsed since discipline was imposed, the physician is not currently the subject of a discipline accusation, and the Administrative Director finds that the physician has been rehabilitated.

§9788.3. Application Procedures

Physicians seeking to serve as a second opinion physician shall:

- (a) Make application to the Administrative Director on the form prescribed by the Administrative Director in Section 9788.31.
- (b) Furnish certified copies of their board certification and hospital privileges, and shall submit other documentation of their qualifications as the Administrative Director may require.
- (c) Both after making application, and after being notified by the Administrative Director that the application has been accepted, the physician shall keep the Administrative Director informed of any change of address, telephone, or fax number.
- (d) The physician shall also notify the Administrative Director within 10 days, if the California Medical Board, or any other state medical board from whom the physician is licensed, files any accusation or charges against the physician, or imposes any discipline.

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§9788.32. Administrative Director's Action on Application

a) After reviewing a completed application, if the Administrative Director finds that the applicant meets the qualifications, he/she shall notify the applicant by mail, and add the applicant's name to the list of second opinion physicians.

(b) If a physician applicant does not qualify only because the physician has a record of previous discipline by a governmental physician licensing agency and if at least five years have elapsed since discipline was imposed, the Administrative Director shall notify the physician that the physician may within ninety days submit written evidence of the physician's rehabilitation from the offenses or inadequacies for which discipline was imposed. If no evidence is submitted within that time period, the Administrative Director shall reject the application. If the physician submits evidence, the Administrative Director shall consider any written evidence submitted by the physician along with any other evidence the Administrative Director may obtain through investigation. The Administrative Director shall make a finding as to whether the physician has been rehabilitated from the offenses or inadequacies for which discipline was imposed. If the Administrative Director does not find that the physician has been rehabilitated, the Administrative Director shall reject the application.

(c) If the Administrative Director finally determines that an applicant does not meet the qualifications, he/she shall notify the applicant by mail that the application is rejected.

(d) An applicant whose application has been rejected may, within 30 days of the mailing of the notice of rejection, request a hearing by filing a written request for hearing with the Administrative Director. If a written request for hearing is not received by the Administrative Director within 30 days of the mailing of the notice of rejection, the applicant shall be deemed to have waived any appeal or request for hearing.

(e) Upon receipt of a written request for hearing, the Administrative Director shall serve a statement of issues, as provided in Government Code section 11504.

(f) Hearings shall be held under the procedures of Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code (commencing with section 11500) and the regulations of the Office of Administrative Hearings (California Code of Regulations, Title 1, Division 2).

(g) Failure to file timely a mailed notice of defense or failure to appear at a noticed hearing or conference shall constitute a waiver of a right to a hearing.

(h) An applicant whose application has been rejected may reapply after:

1. one year has elapsed from the date his application was rejected; or
2. the time when the deficiencies which were the reasons for rejection have been corrected; whichever occurs first.

§9788.4 Removal of Physicians from the Spinal Surgery Second Opinion Physician List

(a) The Administrative Director may remove from the list any physician whenever the Administrative Director learns:

- (1) That the physician no longer meets the qualifications to be on the list; or
- (2) That the California Medical Board, or any other state medical board from whom the physician is licensed, has filed any accusation against the physician; or

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(3) That the physician, having been notified by the Administrative Director of the physician's selection to render a second opinion in any case, has not served the second opinion report in that case within forty-five days after the receipt of the treating physician's report by the employer, unless the employee failed to attend an examination; or

(4) That the physician's application to be on the list contained statements which were not true; or

(5) That the physician has at any time failed to disclose to the Administrative Director that the physician had a material professional, familial, or financial affiliation with any of the persons or entities listed in subdivision (c) of Labor Code section 4062 in any case in which the physician had been selected as a second opinion physician.

(6) That the physician has declined to accept assignment as a second opinion physician at any time except during a period for which the physician had notified the Administrative Director of unavailability per Section 9788.45.

(7) That the physician has filed notifications of unavailability for more than 120 days of any one year period. The first one year period shall commence with the date the physician was added to the list of spinal surgery second opinion physicians by the Administrative Director.

(b) Upon removal of a physician from the list, the Administrative Director shall advise the physician by mail of the removal, the Administrative Director's reasons for removal, and the right to request a hearing on the removal.

(c) A physician who has been mailed a notice of removal from the list may, within 30 days of the mailing of the notice of removal, request a hearing by filing a written request for hearing with the Administrative Director. If a written request for hearing is not received by the Administrative Director within 30 days of the mailing of the notice of removal, the physician shall be deemed to have waived any appeal or request for hearing.

(d) Upon receipt of a written request for hearing, the Administrative Director shall serve an accusation, as provided in Government Code section 11503.

(e) Hearings shall be held under the procedures of Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code (commencing with section 11500) and the regulations of the Office of Administrative Hearings (California Code of Regulations, Title 1, Division 2).

(f) Failure to file timely a mailed notice of defense or failure to appear at a noticed hearing or conference shall constitute a waiver of a right to a hearing.

(g) A physician who has been removed from the list may petition for reinstatement after one year has elapsed since the effective date of the decision on the physician's removal. The provisions of Government Code section 11522 shall apply to such petition.

§9788.45 Unavailability of Second Opinion Physician

A physician who will be unavailable to accept assignments for a period of 30 days or more for any reason, shall, at least 30 days prior to a period of unavailability, notify the Administrative Director in writing of the dates of the physician's unavailability.

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§9788.5 Random Selection of Second Opinion Physician

(a) Within five (5) working days of the Administrative Director's receipt of an objection to a recommendation for spinal surgery, the Administrative Director shall randomly select a physician from those listed physicians located within a thirty (30) mile radius of the employee's address, provided that six physicians are located within that radius; and if six are not located within that radius, using ever increasing radii, until at least six (6) physicians are located from which a random selection may be made. The Administrative Director shall not include among the six physicians any physician that the Administrative Director has determined, from the information submitted to the Administrative Director by the physician and by the employer objecting to the treating physician's recommendation, has a material affiliation prohibited by subdivision (c) of Labor Code section 4062. The selected second opinion physician shall notify the Administrative Director if he/she has a material professional, familial, or financial affiliation with any of the persons or entities listed in subdivision (c) of Labor Code section 4062, within five working days of the physician's receipt of notification of selection. Upon such notification, the Administrative Director shall immediately select a replacement second opinion physician.

(b) Until the Administrative Director shall have a computerized system for random selection of physicians, the Administrative Director shall manually make random selections as in subdivision (a), except that instead of using an initial thirty mile radius, the Administrative Director shall select from those physicians located within the same zipcode as the employee's address, or if there are not at least six physicians located within that zipcode, then additional adjacent zipcodes shall be used until there are at least six physicians found within the geographic area of selection.

(c) Upon selection by the Administrative Director, the second opinion physician shall, unless the physician notifies the Administrative Director of a material professional, familial, or financial affiliation, notify the parties within five working days of the physician's receipt of notification of selection of the date and time of any appointment for examination of the employee. If the physician arranges an appointment with the employee by telephone, the physician shall thereafter send the employee a written notice containing the details of the appointment.

(d) Within ten days of the selection of a second opinion physician, either the employer or the employee may object to the selection on the basis that the second opinion physician has a material professional, familial, or financial affiliation with any of the persons or entities listed in subdivision (c) of Labor Code section 4062, by filing a written objection with the Administrative Director and serving the other parties. The Administrative Director may either sustain the objection, in which case a new selection shall be made, or deny the objection.

(e) The Administrative Director shall exclude from the selection process any physician who has notified the Administrative Director of unavailability pursuant to Section 9788.45.

§9788.6 Examination by Second Opinion Physician or Agreed Second Opinion Physician

(a) The second opinion physician or agreed second opinion physician may physically examine the patient-employee, if the second opinion physician or agreed second opinion physician determines in his or her sole discretion that an examination of the patient-employee is required, but nevertheless must physically examine the patient-employee before finally rendering a second opinion in all cases in which the second opinion physician or agreed second opinion physician disagrees with the recommendation of the treating physician. If there is to be a physical examination of the patient-employee, the second opinion physician or agreed second opinion physician shall schedule the examination, and shall, at least ten days in advance of the scheduled examination, send written notice of the date, time, and place of the examination to the employee, the employee's attorney, if any, and the party who objected to the recommended surgery.

(b) The employer shall, and the employee may, furnish all relevant medical records to the second opinion physician or agreed second opinion physician, including x-ray, MRI, CT, and other diagnostic films, and any medical reports which describe the employee's current spinal condition or contain a recommendation

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for treatment of the employee's spinal diagnoses. The employer shall serve all reports and records on the employee, except for x-ray, MRI, CT and other diagnostic films and for other records which have been previously served on the employee. If a special form of transportation is required because of the employee's medical condition, it is the obligation of the employer to arrange for it. The employer shall furnish transportation expense in advance of the examination. Except for during the examination, a second opinion physician or agreed second opinion physician shall have no ex parte contact with any party.

(1) In the case of a represented employee, except for matters dealing with the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, all communications between a second opinion physician or agreed second opinion physician and any party shall be in writing, with copies served on the other parties.

(2) In the case of an unrepresented employee, except for during the examination and for matters dealing with the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, there shall be no communications between any party and a second opinion physician until after the report has been served.

(c) If the employee fails to attend an examination with a second opinion physician or agreed second opinion physician, and the physician is unable to reschedule the employee's appointment before the 35th day after receipt of the treating physician's report, the time to complete the second opinion process shall be extended for an additional 30 days. If a second opinion physician is unable to schedule another examination within the 30 additional days, the Administrative Director, upon request, will select another second opinion physician.

§9788.7. Contents of Second Opinion and Agreed Second Opinion Physician Reports

(a) If the second opinion physician or agreed second opinion physician disagrees with the recommendation of the treating physician, the second opinion physician's or agreed second opinion physician's report may include a recommendation for a different treatment or therapy.

(b) Reports of second opinion physicians and agreed second opinion physicians shall include, where applicable:

(1) The date of the examination;

(2) The patient's complaints;

(3) A listing of all information received from the parties reviewed in preparation of the report or relied upon for the formulation of the physician's opinion;

(4) The patient's medical history relevant to the treatment determination;

(5) Findings on record review or examination;

(6) The relevant diagnosis;

(7) The physician's opinion whether or not the proposed spinal surgery is appropriate or indicated, and any alternate treatment recommendations;

(8) The reasons for the opinion, including a reference to any treatment guidelines referred to or relied upon in assessing the proposed medical care;

(9) The signature of the physician.

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(c) Second opinion physicians and agreed second opinion physicians shall serve with each report the following executed declaration made under penalty of perjury:

“In connection with the preparation and submission of the attached report of second opinion on recommended spinal surgery, I declare, on the date next written, under penalty of perjury of the laws of the State of California, that I have no material familial affiliation, material financial affiliation, or material professional affiliation prohibited by Labor Code Section 4062, subdivision (c).

date

signature”

§9788.8 Time Limits for Providing Reports

Second opinion physicians and agreed second opinion physicians shall simultaneously serve the report on the Administrative Director, the employer, the employee, and the employee's attorney, if any, as soon as possible, but in any event within forty-five days of receipt of the treating physician's report (as defined herein), unless the parties have agreed in writing to extend the time to a later date.

§9788.9 Charges for Services of Second Opinion Physician and Agreed Second Opinion Physician

Payment for the services of the second opinion physician shall be made by the employer. The fee shall be:

(a) if the physician examines the injured worker, the same as the fee allowed under Section 9795 for a Basic Comprehensive Medical-Legal Evaluation, without modifiers which might otherwise be allowed under Section 9795(d); or,

(b) if the physician does not examine the injured worker, one half of the fee allowed under Section 9795 for a Basic Comprehensive Medical-Legal Evaluation, without modifiers which might otherwise be allowed under Section 9795(d).

§9788.91 Filing of a Declaration of Readiness to Proceed

(a) If the report of the second opinion physician or agreed second opinion physician concurs with the treating physician's recommendation for surgery, the employer shall authorize the surgery and communicate that authorization to the treating physician within three working days of receipt of the second opinion physician's report.

(b) If the report of the second opinion physician or agreed second opinion physician does not concur with the treating physician's recommendation for surgery, the employer shall file a declaration of readiness to proceed within 14 days of receipt of the second opinion physician's report, unless the parties agree with the determination of the second opinion physician or agreed second opinion physician, or unless the employer has authorized the surgery.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7-2-2004 order, including amendment of section, transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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Appendix 4:

DWC Form 233 – Objection to Treating Physician’s Recommendation for Spinal Surgery

State of California
Department of Industrial Relations
Division of Workers’ Compensation



**OBJECTION TO TREATING PHYSICIAN'S
RECOMMENDATION FOR SPINAL SURGERY**

| EMPLOYEE | | | | |
|--|-------------|-----------------------|------------------------|----------------|
| Last Name | First Name | Other names/initials | Social Security Number | Date of Injury |
| W.C.A.B. Case No. | | | | |
| RESIDENCE ADDRESS: Street | | City | State | Zip Code |
| EMPLOYER | | | | |
| Name | | | | |
| MAILING ADDRESS: Street | | City | State | Zip Code |
| Insurance Carrier: | | | | |
| Claims Administrator: | | | | |
| Company providing utilization review: | | | | |
| Employer health care provider: | | | | |
| EMPLOYEE'S ATTORNEY | | | | |
| Name | | | | |
| MAILING ADDRESS: Street | | City | State | Zip Code |
| Telephone: | | Fax Number: | | |
| TREATING PHYSICIAN | | | | |
| Last Name: | First Name: | Other names/initials: | | |
| MAILING ADDRESS: Street | | City | State | Zip Code |
| Telephone: | | Fax Number: | | E-mail: |
| Physician's Medical Group: | | | | |
| Independent Practice Association: | | | | |
| Exact procedure which is being objected to: | | | | |
| Name of facility or institution at which the proposed procedure is to be performed: | | | | |
| Name of facility or institution at which an alternative procedure (if any) recommended by the employer, employer health care provider, carrier, or administrator is proposed to be performed: | | | | |

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| | | | |
|--|--|-------------|---------------------|
| Date that the treating physician's recommendation for this procedure was first received by any of employer, insurance carrier, administrator: | | | |
| Name of entity which received it on that date: | | | |
| Type of entity (employer, insurance carrier, or administrator): | | | |
| NAME OF PERSON SIGNING THIS OBJECTION: | | | |
| Name: | | Company: | |
| MAILING ADDRESS: Street | | City | State Zip Code |
| Telephone: | | Fax Number: | E-mail: |
| Reason(s) for this objection, specific to this employee: | | | |

I declare under penalty of perjury of the laws of the State of California on (date) _____,
that the enclosed physician's report was first received by the employer, insurance carrier or administrator
on (date) _____, and that on (date) _____,
I served the enclosed objection on:

| (name of person served) | (means of service: e.g. mail/certified mail/fax/FedEx) | (time, if by fax) |
|-------------------------|--|-------------------|
| ADMINISTRATIVE DIRECTOR | | |
| | | |
| | | |
| | | |
| | | |

(Signature)

The declaration and this form must be signed by a Principal or Employee of the employer, insurance carrier, or administrator.

This form, together with the report of the treating physician containing the recommendation for treatment which is objected to, is to be mailed to the Administrative Director, Medical Unit, P.O. Box 8888, San Francisco, CA 94128-8888, and copies served by mail or other rapid means of delivery (such as fax or overnight delivery) on the employee, employee's attorney, and treating physician. This Objection is to be sent within ten (10) days of the first receipt by any of the employer, insurance carrier, or administrator, of the treating physician's report containing the recommendation.