

Contra Costa Health Plan

Utilization Mgmt.

Title: Second Opinion

Policy #: UM15.027

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Author: Pauline Jones, Nursing Director

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Author: Florence Chan, Director of Auth &UM

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Reviewer: Dennis Hsieh, MD, JD, CMO

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Applies to:

Medi-Cal

Medicare

Commercial

BHC/HCCI

State Sponsored

All

N/A

Regulatory/Accreditation:

DHCS

CMS:

DMHC:

Other Regulatory Ref: California H&S Code 1383.15

NCQA:

Units:

Administration

Advice Nurses

All Staff

Business Services

Case Management

Health Education

Marketing

Member Services

Planning, Survey, Reg Affairs

Provider Affairs

Quality Management

Auth/Utilization Management

POLICY

Upon request by an enrollee or a participating health care professional treating the enrollee, Contra Costa Health Plan (CCHP) will provide and/or authorize a medically necessary second opinion to an appropriately qualified health care professional* for covered services. The second opinion shall be rendered in a timely manner, appropriate to the nature of the enrollee's condition.

An approval for a second opinion is an approval for a one-time only consultation. The approval does not imply that the second opinion's recommendations or treatment plan are authorized to the consulting provider. Prior authorization is required for any recommended service or treatment and whenever possible, the requested service or treatment shall be redirected to an in-network provider.

CCHP reserves the right to request a second medical opinion evaluation by a health care professional on behalf of a member before the commencement or continuation of a medical treatment regimen.

PURPOSE

To ensure enrollees have appropriate access to second opinions. To provide an opportunity for enrollees to request a second opinion to determine if recommended services are the most effective method of treating the enrollee's condition or if there is an alternative treatment available.

PROCEDURE

The enrollee or the contracted healthcare professional treating the enrollee may request a second medical opinion. The request for the second medical opinion should indicate the following information:

1. The diagnosis with a brief history of the condition or injury, signs, and symptoms, current or previous treatment modalities and its effectiveness, and other clinical indicators such as laboratory values and radiology reports.
2. The number of visits, type of test or procedure requested.
3. Anticipated date and length of service.

Upon receipt of a request for a second opinion, the Utilization Management (UM) nurse will review the medical information for clinical indication and if necessary, forward request to the Chief Medical Officer or designee to determine medical necessity.

A request for a second opinion is granted if the requested service(s) is a covered benefit and:

1. The enrollee questions the reasonableness or necessity of the recommended surgical procedures.
2. The enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
3. The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.
4. The treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.
5. The enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

DETERMINATION

A decision to grant or deny a second opinion request is made within the specified timeframe established for any authorization request as indicated in Policy #UM15.015.a (Timeliness of the Utilization Review Decision Process). The timeframe to communicate the decision to the enrollee and the provider will also comply with the standards established in the previously mentioned policy.

Second opinion request is processed either as a routine or urgent request. A request for a **routine** second opinion is processed within 5 business days from receipt of information reasonably necessary and requested to make a determination. When an enrollee's condition is such that the enrollee faces an imminent and serious threat of his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness would cause severe pain or be detrimental to the enrollee's ability to regain maximum function, the request will be processed urgently. An **urgent** request for a second opinion is processed in a timely manner, not to exceed 72 hours after the receipt of the request, whenever possible.

An enrollee that is granted a second opinion will only be responsible for the costs of applicable copayments that the CCHP requires for similar referrals. If CCHP denies a second opinion request, the Health Plan will notify the enrollee in the same manner as established in Policy #15.015.a (Timeliness of the Utilization Review Decision Process).

If the enrollee requests a second opinion about care provided by his or her PCP:

The enrollee can select an appropriately qualified health care professional* within their provider

network based on their insurance coverage (*see UM 15.004*) to perform the second opinion.

If the enrollee requests a second opinion about care provided by a specialist:

A provider of the enrollee's choice within the member's provider network based on their insurance coverage, excluding tertiary care centers, can provide the second opinion. If there is no available provider within a member's network based on their insurance coverage, CCHP work with the member within its contracted CCRMC and CPN network. CCHP will incur the cost or negotiate the fee arrangements of the second opinion, beyond applicable copayments. If the required specialty is not available within the Health Plan's nontertiary provider network (CCRMC and CPN), a contracted tertiary care center may be considered.

If there is no participating provider within the Health Plan provider network that meet the criteria of a qualified health care professional:

The second opinion will be authorized to a non-network appropriately qualified health care professional* outside of CCHP's nontertiary provider network. CCHP will first consider a contracted tertiary care center. Beyond this, CCHP will authorize to a non-network appropriately qualified health care professional. The Health Plan will take into account the ability of the enrollee to travel to the provider.

The Health Plan will require that the second opinion health professional provide the enrollee and the original health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes are appropriate.

Referrals for second medical opinion will be tracked through the IS system (*see policy #UM15.006*). In addition to tracking the frequency of second medical opinion requests, these requests shall be monitored and reviewed periodically (no less than on an annual basis) for, but not limited to:

1. Timeliness of determination and communication to the provider and member.
2. Reason or circumstance for granting the second opinion.
3. Information to the provider and member regarding applicable copayments.
4. Adherence to providing/referring member to an appropriately qualified professional* as defined in this policy.

Please Note: CCHP administers the BHC and Low Income Health Programs, HCI and MCE for Contra Costa County Health Services Division. BHC/HCI/MCE recipients are not Health Plan members. In general, second opinions for BHC/HCI/MCE recipients are available within Contra Costa Regional Medical Center and its Health Centers. Exceptions may be granted on a case-by-case basis.

*For the purpose of this policy, an appropriately qualified health care professional is a primary care physician or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.