Government Business Division
Policies and Procedures

Section (Primary Department) **Utilization Management**		**SUBJECT (Document Title)** **Second Medical Opinion - CA**	
Effective Date 09/18/2002	**Date of Last Review** 10/26/2023	**Date of Last Revision** 10/26/2023	**Dept. Approval Date** 10/26/2023
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Medicaid (Anthem) covers a second medical opinion, at no cost to the member, upon request by a member or a participating health professional treating a member. The second medical opinion must be provided by an appropriately qualified health care professional.

DEFINITIONS:

Qualified Health Care Professional: Primary care provider (PCP), specialists and other health care providers acting within his or her scope of practice and with a clinical background, including training and expertise related to the condition associated with the second opinion request.

PROCEDURE:

I. Members are informed about their second medical opinion rights, including how to request a second medical opinion, in their Evidence of Coverage (EOC).

II. Physicians or members may request a second opinion for the following medical categories:
   A. A member questions the reasonableness or necessity of recommended surgical procedures;
   B. A member questions a diagnosis or treatment plan of care for a condition that threatens loss of life, loss of limb, loss of bodily functions or substantial impairment including a serious chronic condition;
   C. The clinical conditions are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results or the treating provider is unable to diagnose the condition;
   D. The treatment plan in progress is not improving the medical condition within an appropriate period of time given the diagnosis and plan of care;

E. The member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

III. When a member requests a second opinion from his or her PCP, the second opinion shall be provided by an appropriately qualified health care professional within the plan's network. When the request is regarding care from a specialist, the second opinion shall be given by a provider of the same specialty. This specialist shall be within the plan's network and may be selected by the member.

IV. To ensure provision of second opinion is done in a timely manner, no authorization is required if the provider is within the plan's network. In cases where there is no provider within the network that meets above specified qualifications, Anthem may authorize a second opinion by a qualified provider outside of the network. Anthem shall incur the cost or negotiate the fee arrangements of the second opinion by a qualified provider outside of the network, beyond the applicable co-payments which shall be paid by the member (Medi-Cal excluded) per 42 CFR section 438.206. Any authorization or denial decision shall be provided in an expeditious manner as described in California Medicaid Policy #CA_UMXX_041 and #CA_UMXX_013.

V. A written notification is sent to the member for any denial determination as described in California Medicaid Policy #CA_UMXX_013 and per the notification and timeframes outlines in California Medicaid Policy #CA_UMXX_117.

VI. Physicians that perform second opinions are to report back to the PCP and to the member with a Consultation Report, including any recommended procedures or tests that the second opinion health professional believes appropriate.

REFERENCES:

- 42 CFR section 438.206.
- California Medicaid Policy #CA_UMXX_013 "Non-authorization of Medical Service"
- California Medicaid Policy #CA_UMXX_041 "Pre-service Authorization of Services"
- California Medicaid Policy #CA_UMXX_117 "Decision and Notification Timeframes"
- DHCS Contract section 2.3 (C)Evidence of Coverage and Disclosure Form, Effective 2023
- Health & Safety Code, section 1383.1, 1383.15
- Medi-Cal EOC - Member Handbook Effective 2023

RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management (UM)

Section (Primary Department)	**SUBJECT (Document Title)**
Utilization Management	**Second Medical Opinion - CA**

Secondary Department(s):
Case Management (CM)

EXCEPTIONS:

None