PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="3">Policy/Procedure Number: MPUP3078</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Second Medical Opinions</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/20/2016 – Medi-Cal</td><td colspan="3">Next Review Date: 09/11/2025
Last Review Date: 09/11/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 09/11/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
D. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Grievance and Appeals

III. DEFINITIONS:

A. Urgent Request: A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, ***or***
   2. In the opinion of a licensed health care practitioner, with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the indications and process for Second Medical Opinions.

VI. POLICY / PROCEDURE:

A. When a second medical opinion is requested by a Member, a Member's authorized representative and/ or health professional, the request will be reviewed. The Member does not need permission from Partnership HealthPlan of California (Partnership) for a second opinion from a network provider. If there is no provider in the Partnership network who can provide the second opinion, a prior authorization will be required and if approved, Partnership will pay for the second opinion from an approved out-of-network provider who is certified by Medi-Cal. Reasons for second opinions include, but may not be limited to the following:
   1. The Member has questions concerning the reasonableness or necessity of a recommended surgical

procedure or treatment.

2. The Member questions the diagnosis or course of treatment for a condition that threatens loss of life, limb, bodily function or impairment, including but not limited to a serious chronic condition.
3. The diagnosis is in doubt due to conflicting test results, or the treating practitioner is unable to make an accurate diagnosis of the situation.
4. The current treatment plan is not improving the medical condition within an appropriate period of time for the known diagnosis.
5. The Member has attempted to follow the course of treatment or consulted with the initiating professional and still has serious doubts about the diagnosis or treatment plan.

B. An appropriately qualified health care professional, qualified to render a second opinion, is considered to be a primary care provider or specialist acting within the scope of practice and who possesses a clinical background including training and expertise related to the particular illness, disease or condition associated with the request for a second opinion.

C. The plan reserves the right to limit a Member's choice of provider for the second opinion from within the network/contracted providers when there is a qualified professional available. The Member shall be referred outside the network to a Medi-Cal certified provider when there is not a qualified network/contracted professional available (see discussion of out of network referrals in policy MCUP3124 Referral to Specialists [RAF] Policy.) Note that any out of network treatments recommended would be subject to the treatment authorization (TAR) process as per policy MCUP3041 Treatment Authorization Request (TAR) Review Process.

D. Timeframes for out-of-network second opinions will be as follows:
   1. If a Member's request requires an urgent review, a determination will be made within 72 hours after receipt of the request.
   2. For a non-urgent request, the Member will be notified within 5 business days as to whether or not the provider he/she requested for a second opinion was approved.

E. If a Member's request for second opinion is not granted by the primary care provider, the Member may contact the Grievance Coordinator at Partnership HealthPlan and file a grievance.

F. If the health plan denies a request for a second opinion, the Member will be notified in writing of the reasons for the denial, the Member's right to appeal or file a grievance, and information on how to file an appeal and how to file a grievance.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III, Section 2.3. C.
B. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2024) UM 5 Timeliness of UM Decisions Element E

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Medi-Cal:
04/20/16 initial; 04/19/17; *06/13/18; 08/14/19; 08/12/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

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Applies to:	☒ **Medi-Cal**		☐ **Employees**

Note – Policy initially developed under the Healthy Kids Program 11/16/2005

PREVIOUSLY APPLIED TO:
Healthy Kids – MPUP3078, KK UM115 (Healthy Kids program ended 12/01/2016):
11/16/05; 11/21/07; 11/19/08; 10/01/10; 08/19/15; 04/20/16 to 12/01/2016

Healthy Families:
MPUP3078 - 10/01/2010 to 03/01/2013

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.