POLICY AND PROCEDURE	
Policy # and TITLE: Second Medical Opinion	
Primary Policy owner: Utilization Management	**POLICY #:** UM16
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☒Behavioral Health (BH) 3) ☐Benefits Administration (BA) 4) ☒Care Management (CM) 5) ☐Claims (CLMS) 6) ☐Community Marketplace & Member Engagement (MAR) 7) ☐Compliance (CMP/HPA) 8) ☐Configuration (CFG) 9) ☐Provider Contracting (CONT) 10) ☐Cultural & Linguistics (CL) 11) ☐Customer Service (CS)	12) ☐Facilities (FAC) 13) ☐Finance (FIN) 14) ☐Human Resources (HR) 15) ☐Information Technology / Core Systems (IT) 16) ☒Pharmacy (PH) 17) ☐Provider Networks (PRO) 18) ☒QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☒ Utilization Management (UM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** N/A

I. PURPOSE

To describe Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan")'s process for the provision of a second medical opinion. Members are entitled to a second opinion if they have questions about a provider's recommendations for care.

II. POLICY

A. The Health Plan provides a second medical opinion to members by an appropriately qualified healthcare professional at no cost to the

member, if requested by a member or a participating provider who is treating the member.

1. This information can be found in the members EOC (Evidence of Coverage).

B. Reasons for a second opinion to be authorized shall include, but are not limited to:

1. The member questions the reasonableness or necessity of recommended surgical procedures.
2. The member 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, the diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.
4. The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time, given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
5. The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

III. PROCEDURE

A. The Health Plan does not require authorization for second opinion for an in-network provider.

B. The Health Plan reviews a request for authorization for second opinion with out of network provider in accordance with the Health Plan's policy UM 01: Authorization and Referral Review.

C. The member or participating healthcare professional who is treating the member requests a second medical opinion with an OON provider, an authorization shall be provided in a timely and expeditious manner, appropriate for the nature of the member's condition.
    1. If the Health Plan denies a request for a member for a second opinion with an OON provider, the health Plan notifies the enrollee in writing of the reasons for the denial and shall inform the enrollee of the right to file a grievance with the plan. The notice complies with subdivision (b) of Section 1368.02 (b).

D. If there is no available participating provider, the Health Plan authorizes a second opinion by an appropriately qualified health professional outside the Health Plan's network.

E. If the member is requesting a second medical opinion about care from his/her primary care provider, the second opinion is provided by an appropriately qualified healthcare professional of the member's choice who is also a contracted provider of the Health Plan.

F. The Health Plan arranges for transportation if needed to the second opinion provider.

G. The Health Plan requires the second opinion healthcare professional to provide the member and the initial healthcare professional with a consultation report, including any recommended procedures or tests that the second opinion healthcare professional believes appropriate. The Health Plan, based on its independent determination, may authorize additional medical opinions concerning the member's medical condition.

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

A. California Health and Safety Code, Sections 1383.1 and 1383.15(a), (b), (c), (f) and (i)
B. DHCS Contract Exhibit A, Attachment 5.1 c

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
000	3/01, 4/02, 1/06, 5/06, 10/08, 1/15, 4/16, 8/17, 8/18, 12/19, 12/20, 11/21, 10/22	N/A
001	Moved UM16 to new template	2/9/2024
002		
003		
Initial Effective Date: 1/1/2000		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	2/15/2024
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	001	1/17/2024
Quality and Utilization Management		
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	N/A	N/A	N/A

Department of Managed Care (DMHC)	DMHC Attorney	001	12/5/2023

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy