	POLICIES AND PROCEDURES
Policy #: 404-1307	Lead Department: Utilization Management
Title: Medical Second Opinions	
Original Date: 05/01/2000	Date Published: 02/19/2025
Approved by: Utilization Management Work Group (UMWG)	

Purpose:

To describe Central California Alliance for Health's (the Alliance's) policy on obtaining medical second opinions.

Policy:


Medical second opinions, when requested by a member, member's parents, member's custodial parents, member's legal guardians, other authorized representatives for the member, or health care professional, will be honored and approved by the Alliance, and provided by a qualified health care professional.

Prior authorization is required for any service provided by a non-contracted or non-credentialed Provider. In the following instances Alliance members may access services from any provider, including providers not contracted with the Alliance without referral or authorization.

1. **Sensitive Services:** Pregnancy testing and counseling, birth control, human immunodeficiency virus infection (HIV)/acquired immunodeficiency syndrome (AIDS) testing, sexually transmitted infection (STI) testing and treatment, and termination of pregnancy. For a specific list of sensitive services please reference Alliance Policies *404-1309 - Member Access to Self-Referred Services* and *404-1709 – Provision of Family Planning Services to Members*. Medi-Cal members may access sensitive services from any Medi-Cal enrolled provider. Alliance IHSS members, must first attempt to obtain services from an in-network provider.
2. **Emergency Services:** Inpatient and Outpatient covered services that are furnished by a Provider that is qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. Members may receive emergency services from any provider, including providers not contracted with the Alliance and not enrolled in Medi-Cal.


Procedures:

1. Second opinions may be requested by the member, member's parents, member's custodial parents, member's legal guardians, other authorized representatives for the member, or health care professional with whom the member is under care. Reasons for a second opinion include, but are not limited to:
 - a. The member questions the reasonableness or necessity of a recommended surgical procedure.

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- b. The member questions a diagnosis or course of treatment for a condition that threatens loss of life, loss of limb, loss of bodily function, or impairment, including but not limited to a serious chronic condition.
 - c. Clinical indicators 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 member requests an additional diagnosis.
 - d. If the current treatment plan is not improving the member's medical condition within an appropriate period of time given the diagnosis, and the member requests a second opinion regarding the diagnosis or continuance of treatment.
 - e. If the member has attempted to follow a course of treatment or consulted with the initial professional concerning serious doubts about the diagnosis or treatment plan.
2. A health care professional qualified to render a second opinion is considered to be a primary care physician or a specialist acting within the scope of practice 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.
 3. A member may choose a provider to render a second opinion as follows:

If a member is requesting a second opinion about care from their primary care physician, the second opinion shall be provided by an appropriately qualified health care professional, as stated above, of the member's choice within the Alliance contracted network. If the member is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the same or equivalent specialty of the member's choice from a contracted specialist within the network if possible.
 4. Second opinions may be rendered outside the Alliance's provider network with prior authorization in instances where a qualified specialist is not available within the network; this includes Centers of Excellence such as academic tertiary centers. For more information on out-of-network referrals, please see Alliance Policy 404-1310 - *Authorization Process for Referrals to Out of Network Providers*.
 5. Timeframes for second opinions:
 - a. If authorization is required, second opinions will be authorized by the Alliance according to the Alliance's authorization timelines.

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- b. In urgent or emergent situations, second opinions will be arranged within 24-72 hours.
 - c. For routine non-emergent situations, timelines will be based on the Alliance's accessibility timelines.
6. The health professional providing the second opinion shall provide to the member's Primary Care Physician (PCP) and/or requesting specialist a consultation report, including any recommended procedures or tests that they feel are medically necessary and clinically indicated.
7. Members who experience difficulty in obtaining a referral for a second opinion may contact the Alliance Member Services Department for assistance. Any member experiencing difficulty or who is refused a second opinion may file a complaint with the Alliance.
8. Co-payments for a medical second opinion may or may not be required, depending on the member's line of business. No co-payments are required in the Medi-Cal program. Medi-Cal members may obtain a second opinion at no cost from a qualified health professional. Co-payment responsibilities are identified in each Evidence of Coverage (EOC).
9. The above information shall be made available to members upon request.
10. If the Alliance denies a request by a member for a second opinion, it shall notify the member in writing of the reasons for the denial and shall inform the member of the right to file a grievance with the plan. The notice shall comply with subdivision (b) of California Health and Safety Code, Section 1369.02.


References:

Alliance Policies:

- 300-4080 – Open Access to Care
- 404-1309 – Member Access to Self-Referral Services
- 404-1310 – Authorization Process for Referrals to Out of Network, Non-Contracted Specialty Providers
- 404-1702 – Provision of Family Planning Services to Members

Impacted Departments:

- Care Management

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Member Services

Provider Services

Regulatory:

CA Health and Safety Code Section 1369.02

CA Health and Safety Code Section 1383.15

Legislative:

Contractual (Previous Contract):

DHCS Medi-Cal Contract, Exhibit A, Attachment 5. Provision 1.C

Contractual (2024 Contract):

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.3.c

DHCA All Plan Letter:

NCQA:

Supersedes:

Other References:

Strategic Plan 2022-2026 – Central California Alliance for Health:

PERSON-CENTERED DELIVERY SYSTEM TRANSFORMATION

Attachments:

Lines of Business This Policy Applies To

- ☐ DSNP
- ☒ Medi-Cal
- ☒ Alliance Care IHSS

LOB Effective Dates


(01/01/2026 – present)

(01/01/1996 – present)

(07/01/2005 – present)

Review History:

Reviewed Date	Revised Date	Changes Made By	Approved By
05/15/2018	05/15/2018	Dale Bishop, MD, CMO	UMWG
04/16/2019	04/16/2019	Gilly Guez, MD Medical Director	UMWG
12/22/2020	12/22/2020	Tammy Brass, RN UM/CCM Manager	UMWG
04/24/2023	04/25/2023	Carissa Grepo, RN UM Manager	UMWG
09/22/2023	9/22/2023	Danah Hernandez, UM Regulatory Reporting Supervisor	UMWG

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Reviewed Date	Revised Date	Changes Made By	Approved By
10/04/2024	10/04/2024	Tisa L. Llamas, RN UM/PA Supervisor	UMWG
12/27/2024	12/27/2024	Kelly Tlemcani, Business Analyst II	UMWG