Policy:	GG.1538
Title:	**Referral for Second Opinion**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	11/01/2015
Revised Date:	12/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health and its contracted Health Networks shall provide a Member with timely referral for a Second Opinion by an Appropriately Qualified Health Care Professional.

II. POLICY

A. CalOptima Health and its contracted Health Networks shall inform a Member of his or her right to request a Second Opinion in the Medi-Cal Member Handbook or OneCare Member Handbook at the time of enrollment and on the CalOptima Health website at https://www.caloptima.org.

B. A Member, Authorized Representative, physician, or Provider may request a Second Opinion, in accordance with the terms and conditions of this Policy.

C. CalOptima Health or a Health Network shall authorize a request for a Second Opinion based on, but not limited to, the following criteria:

1. A Member questions the reasonableness or necessity of a recommended surgical procedure;

2. A 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. Clinical indications 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, and the Member requests an additional diagnosis;

4. The Treatment plan in progress is not improving a Member's medical condition 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; and

5. A 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.

D. CalOptima Health or a Health Network shall authorize a request for a third opinion if the recommendations of the first and second Practitioner differ regarding the need for a medical procedure and a Member, Authorized Representative, physician, or Provider requests such third opinion.

E. When there is a question if the requested Covered Service is Medically Necessary, such as plastic surgery, CalOptima Health or a Health Network may authorize second and third opinions to validate that a procedure is not a Covered Service.

F. CalOptima Health or a Health Network shall refer a Member who requests a Second Opinion to an Appropriately Qualified Health Care Professional at no cost to the Member.

G. CalOptima Health or a Health Network may limit a Member's choice of the Appropriately Qualified Health Care Professional to CalOptima Health, or Health Network provider network if there is an Appropriately Qualified Health Care Professional within the network.

H. CalOptima Health or a Health Network shall refer a Member to an Appropriately Qualified Health Care Professional outside the CalOptima Health or Health Network provider network, if an Appropriately Qualified Health Care Professional is not available within the network.

I. CalOptima Health or a Health Network, based on its independent determination, may authorize additional medical opinions concerning the medical condition of a Member.

J. CalOptima Health or a Health Network shall process a request for a Second Opinion, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

K. If CalOptima Health or a Health Network denies a request by a Member for a Second Opinion, CalOptima Health or a Health Network shall notify the Member, in writing, of the following:

1. Reasons for the denial;

2. Member's right to Appeal the denial, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process, HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, MA.9003: Standard Pre-Service Appeal, MA.9004: Expedited Pre-Service Appeal, and MA.9015: Standard Integrated Appeals; and

3. Information about how to contact and file a Complaint with the Department of Health Care Services, and/or the California Quality Improvement Organization.

L. CalOptima Health may delegate authorization of Second Opinions to a Health Network, in accordance with CalOptima Health Policy GG.1541: Utilization Management Delegation.

III. PROCEDURE

A. If a Member or Authorized Representative requests a Second Opinion about care from the Member's PCP, the Member may receive the Second Opinion from an Appropriately Qualified Health Care Professional of the Member's choice from within the CalOptima Health, or contracted Health Network's provider network.

B. If a Member, Authorized Representative, physician, or Provider requests a Second Opinion about care from a Specialist Physician, the Member may receive the Second Opinion from any Specialist Physician of the same or equivalent specialty of the Member's choice within the CalOptima Health or Health Network's provider network. If such Specialist Physician is not available within the CalOptima Health or Health Network's provider network, CalOptima Health, or a Health Network,

shall arrange for the Second Opinion from a Non-Contracted Provider and shall incur the cost, or negotiate, the fee arrangement of that Second Opinion.

C. A Member may receive a third opinion, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

D. The financial responsibility for additional medical opinions outside CalOptima Health or the Health Network's network that are not authorized by CalOptima Health, or the Health Network, shall lie with the Member.

   1. CalOptima Health or the Health Network shall notify the Member of his or her financial responsibility for charges incurred by accessing unauthorized services outside the CalOptima Health or Health Network's provider network. Such notice shall include the Member's right to Appeal CalOptima Health's or the Health Network's decision.

E. CalOptima Health or a Health Network may authorize a Member's request for a Second Opinion but may limit the Member's choice of an Appropriately Qualified Health Care Professional, in accordance with Section II.G. of this Policy.

F. CalOptima Health or a Health Network shall include the following information on the authorization notice of action to an Appropriately Qualified Health Care Professional, approved to provide a Second Opinion:

   1. The request is for a second opinion only and the Appropriately Qualified Health Care Professional shall provide the Member and the Member's PCP with a written consultation report including recommended procedures or tests.

G. CalOptima Health and contracted Health Networks shall approve a Second Opinion for a one (1) time consultation. The Appropriately Qualified Health Care Professional shall direct the Member back to the Member's treating physician, or Provider, for all diagnostic tests, laboratory tests, or diagnostic imaging services.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Policy AA.1220: Member Billing
D. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
E. CalOptima Health Policy GG.1510: Member Appeal Process
F. CalOptima Health Policy GG.1541: Utilization Management Delegation
G. CalOptima Health Policy HH.1102: Member Grievance
H. CalOptima Health Policy HH.1103: Health Network Member Grievance and Appeal Process
I. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
J. CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal
K. CalOptima Health Policy MA.9015: Standard Integrated Appeals
L. Health and Safety Code, §1383.15
M. Title 42, Code of Federal Regulations (CFR), §438.206(b)(3)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/03/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2015	GG.1538	Referral for Second Opinion	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1538	Referral for Second Opinion	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1538	Referral for Second Opinion	Medi-Cal OneCare OneCare Connect
Revised	07/01/2018	GG.1538	Referral for Second Opinion	Medi-Cal OneCare OneCare Connect
Revised	08/01/2021	GG.1538	Referral for Second Opinion	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1538	Referral for Second Opinion	Medi-Cal OneCare
Revised	12/31/2023	GG.1538	Referral for Second Opinion	Medi-Cal OneCare
Revised	12/01/2024	GG.1538	Referral for Second Opinion	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Appropriately Qualified Health Care Professional	A Primary Care Physician (PCP), specialist, or other licensed health care provider 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, or condition associated with the request for a Second Opinion.
Authorized Representative	Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. OneCare : Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by a Member's Authorized Representative.

Term	Definition
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.

Covered Service	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health

Term	Definition
	Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Integrated Appeal	The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561.Integrated appeals do not include appeals related to Part D benefits.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a).Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a).Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Plan of Care	An individual written plan of care completed, approved, and signed by a Physician and maintained in the Member’s medical records according to Title 42, Code of Federal Regulations (CFR).

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP.A PCP may also be a Non-physician Medical Practitioner (NMP)(e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Second Opinion	A consult visit to an Appropriately Qualified Health Care Professional in order for a Member or Contracted Provider who is treating the Member, to receive the additional information for the Member to make an informed decision regarding care and treatment.
Serious Chronic Condition	A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that either: 1. Persists without full cure or worsens over an extended period, or 2. Requires ongoing treatment to maintain remission or to prevent deterioration.
Specialist Physician	For the purposes of this policy, a physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.