ALAMEDA Alliance FOR HEALTH

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-005
Policy Name	Second Opinions
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	All
Effective Date	02/01/2000
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

A. PCP (Primary Care Physician)/BH (Behavioral Health) Providers, Specialists, and Members (if the practitioner refuses), have the right to request a second opinion from a qualified health professional, at no cost to the Member from the Alliance, (Per 42 CFR section 438.206,) regarding proposed medical, surgical or behavioral health treatments from an appropriately qualified participating healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition, or conditions associated with the request for a second opinion.

B. Second opinions from contracted providers do not require authorization and are arranged through the Member's assigned PCP or BH Provider.

C. The Alliance provides for a second opinion from a qualified health care professional in network or arranges for the enrollee to obtain one out of network, at no cost to the enrollee.

D. A prior authorization from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.

E. The second opinion authorization or a denial shall be provided in an expeditious manner appropriate to the nature of the member's condition, not to exceed 72 hours after the Alliance's receipt of the request.

PROCEDURE

A. Members should request a second opinion through their PCP, specialist, or BH Provider. If the PCP, specialist, or BH Provider refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through the Alliance

Member Services.

B. Second opinions rendered by a contracted Alliance provider does not require prior authorization; the member's PCP, specialist, or BH Provider can coordinate the referral directly with the provider rendering the second opinion. Members can call the Alliance Member Services department to obtain assistance with this coordination.

C. Second opinions rendered by a non-contracted Alliance provider do require prior authorization. The PCP, specialist, or BH Provider submits the authorization request for a second opinion to the Alliance including documentation regarding the Member's condition and proposed treatment.

D. If the referral for a second opinion is approved, the Alliance makes arrangements for the Member to see a physician/BH Provider in the appropriate specialty.

E. If the referral for an out of network second opinion is denied or modified, the Alliance provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision.

F. The Alliance must consider the ability of the Member to travel to the second opinion practitioner's office, and if necessary, arrange transportation for the Member.

G. If there is no physician within the Alliance network that meets the qualifications for a second opinion, the Alliance must authorize a second opinion by a qualified physician or BH Provider outside the Alliance network.

H. Members disagreeing with an Alliance or Delegated Medical Group (DMG) denial of a second opinion may appeal through the Alliance appeal process.

I. In situations where the Member believes that the need for a second opinion is urgent, they can request facilitation by the Alliance by contacting the Alliance Member Services Department.

J. Reasons for providing or authorizing a second opinion include, but are not limited, to the following:

   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. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/specialist/BH Provider is unable to diagnose the condition and the Member requests an additional diagnostic opinion;

   4. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; and

   5. The Member has attempted to follow the plan of care or consulted with the initial physician/BH Provider regarding serious concerns about the diagnosis or plan of care.

K. If the Member is requesting a second opinion about care from his or her PCP/BH

Provider, the second opinion must be provided by an appropriately qualified physician/BH Provider.

L. If the Member is requesting a second opinion about care from a specialist, the second opinion must be provided by any physician of the same or equivalent specialty of the Member's choice, within the Alliance.

M. 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 when there is not an available/ qualified professional available.

N. The request to the practitioner that is performing the second opinion must include the timeframe for completion of the consultation and the requirements to be included in the consultation report.

O. The second opinion practitioner is responsible for submitting consultation reports to the Member, requesting practitioner, and PCP/BH Provider, within three working days of the visit.

P. If the second opinion is deemed urgent, the submission of the consultation report must be within 24 hours of the visit.

Q. Mandated timeframes for decision including approval, denial, or modification of a request for a second opinion and subsequent notification to the Member and practitioner are as follows:

1. Prior Authorization for Non-Urgent Second Opinions with Out-of-Network Providers:

   a. The prior authorization process is initiated when the Member's physician requests a second opinion.

   b. The timeframes for completion and adjudication of the second opinion are as follows:

      1). Practitioners have two days from the determination that a second opinion is necessary to submit the referral.

      2). The Alliance's decision to approve, modify, or deny must be made within five working days of obtaining only the information reasonably necessary to make a determination.

      3). If sufficient information is not available with the second opinion request, the Alliance contacts the requesting practitioner for the additional clinical information. The Alliance must annotate that additional information has been requested and must include the date of the request. A decision to approve, deny or defer must be made within the five calendar day timeframe.

      4). Practitioners must be initially notified within 24 hours of the decision by telephone or in writing. Telephonic communications of decisions must be

documented including date, time, name of contact person, and initials of the person making the call.

5). The Alliance must notify both the Member and practitioner in writing of all decisions, within two working days of the decision.

2. Prior Authorization of Urgent Second Opinions with Out-of-Network Providers:

   a. Practitioners must submit urgent requests for a second opinion the same day of the determination that the second opinion is necessary.

   b. Decisions regarding prior authorization for urgent second opinions and notification of decisions to practitioners must be completed within 72 hours of the receipt of the request.

   c. Practitioners are notified of the decision by telephone or in writing within 24 hours of the decision and not to exceed 72 hours of receipt of request. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

   d. Notification must be made to the Member and practitioner, in writing, within 72 hours of receipt of the request. If verbal notification is given within 72 hours of receipt of request, written or electronic notification must be given no later than three calendar days after the initial verbal notification.

   e. Both the Member and practitioner must be notified of how to file an expedited review at the time they are notified of the denial.

3. Inpatient Second Opinions:

   a. Requests for second opinions for Members in an inpatient setting at the same facility do not require prior authorization.

   b. A request for second opinions for Members in an inpatient setting at a different facility, which requires the members to be transferred, requires authorization. Practitioners must be initially notified within 24 hours of the decision by telephone. If the practitioner cannot be reached by telephone, a fax can be utilized. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

   c. The practitioner must be notified of denials in writing within 24 hours of the receipt of the request. If verbal notification is given within 24 hours of request, then written/ electronic notification must be given no later than three calendar days after verbal notification.

   d. Notification must be made to both the Member and practitioner on how to file an expedited review.

4. Expedited Review:

   a. If the practitioner receives a denial for an urgent or inpatient second opinion request, the practitioner can request an expedited review by contacting the Alliance's Chief Medical Officer or Medical Director.

   b. If the Member receives a denial for an urgent or inpatient second opinion request, the Member can request an expedited review by contacting the Alliance's Member Services Department.

   c. Timeframes for decisions and notifications of the decisions to the Member and the practitioner regarding the expedited review are as follows:

1). Decisions must be made within 72 hours of the initiation of the expedited review and both the Member and the practitioner must be notified within one day after the decision is made.

5. Written confirmation of the decision must be provided to the Member and the practitioner within two working days from notification of the decision if the decision was not previously made in writing.

Q. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 Delegation Oversight.

DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Program
UM-057 Authorization Service Requests
BH-002 Behavioral Health Services
CMP-019 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHE ATTACHMENTS

NONE

REVISION HISTORY

2/27/2001, 1/1/2008, 10/28/2009, 9/15/2011, 6/14/2012, 7/14/2013, 1/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 04/24/2024

REFERENCES

1. California Health & Safety Code, Section 1383.15
2. 42 CFR Section 438.206

MONITORING

The Compliance, Utilization Management and Behavioral Health Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.