VENTURA COUNTY HEALTH CARE PLAN

UM Policy: **Second Opinions**

Effective: Feb 5, 1997
Revised January 05; March 08, February 2015
Reviewed: November 7, 2011, January 2012, February 2013, February 2014, February 2015, May 2015, February 2016, February 2017, November 2017, February 2018, February 2019

Second Opinions

POLICY:

VCHCP authorizes a second opinion, when requested by a Member or a Participating (In-Network) Provider who is treating a Member, for the following reasons:

1. The Member questions the reasonableness or necessity of recommended surgical or medical 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. If the clinical indications 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.
4. If 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 the continuance of the treatment.
5. If 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.
6. Any other reasonable circumstance that is authorized by the Plan's Medical Director.

PROCEDURE:

Second opinions will be rendered by an appropriately qualified health care professional. This is defined as a Primary Care Physician or Specialist acting within his or her scope of practice and 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. The provider will be selected to render the second opinion as follows:

1. The provider chosen by the Member or by the Participating Provider who is treating the Member will be authorized if the provider meets the above definition of an appropriately qualified health care professional and if the provider is a Network Provider. This includes all contracted primary care physicians and all contracted specialists.

2. Otherwise, the plan will select a provider, taking into consideration the ability of the Member to travel to the provider. The plan will limit referrals to its network of providers if there is a participating plan provider who meets the above definition of an appropriately qualified health care professional.

In general, specialists contracted with Ventura County Medical Center will be preferentially selected over other contracted providers of the same specialty; a provider will be selected who is not in the same practice as the provider who rendered the first opinion unless the member agrees to stay within the same practice; and specialists located within the Service Area (Ventura County) will be selected in preference to specialists located outside the Service Area. If there is no Participating provider within the plan's network that is qualified, the plan will authorize a referral to a qualified out-of-network provider.

3. All second opinion requests may originate from a member, a member's primary care provider or the specialist who consulted for the initial opinion. Requests originating from a member's primary care provider or specialist must be submitted to the Plan on the appropriate Treatment Authorization Request form (TAR). For requests originating from a member, Medical Management will request the TAR from a member's primary care provider or specialist who consulted for the initial opinion. (Note: Member can request second opinion per legislation 1383.15).

4. For plan authorized second opinions, the Member will only be responsible for the applicable copayment required for similar referrals. Referrals authorized by the plan to out-of-network providers have copayments consistent with the copays that apply to in-network providers for the same type of service.

5. The member is responsible for costs related to travel, lodging, or food incurred while obtaining such second opinion.

6. Second opinion providers will be advised of the requirement to provide a consultation report to the Member and to a requesting Participating Provider who is treating the Member.

7. Follow up visits, tests or procedures requested by the physician rendering the second opinion will generally be authorized to be done locally unless unavailable.

<u>Second Opinion Time Lines</u>

Second opinion referral requests are processed in a timely fashion appropriate for the nature of the Member's condition. Second opinion referrals are processed within the following time lines after the plan's receipt of the request, whenever possible:

1. Requests for emergency needs are authorized or denied within 24 hours. Emergency needs are defined as medical conditions that pose imminent and serious threat to a Member's health, including potential loss of life, limb, or other major bodily function or where lack of timeliness would be detrimental to the Member's ability to regain maximum function.
2. Requests for urgent needs are processed by the end of the next business day.
3. Requests for normal priority needs are processed within five business days.
4. Retrospective authorization requests are processed within 30 days of the plan's receipt of the information necessary to make an authorization decision.

VENTURA COUNTY
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Denials of Second Opinion Requests

If the plan 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.

How to Request a Second Opinion

Members may request a second opinion referral by contacting:

Ventura County Health Care Plan
Member Service Department
2220 E. Gonzales, Suite 210B
Oxnard, CA 93036
Telephone: (805) 981-5050 or facsimile: (805) 981-5051

Plan-required Second Opinions

The plan's Medical Director may determine that a second opinion is necessary in order to make an authorization decision. The Member and the Member's physician are notified, in writing, of this requirement. (The status of the authorization is designated "pending expert".) The plan generally selects the health care professional that will render the second opinion.

A. Attachments: None

B. References: None

C. History:

Reviewers: Richard O. Ashby MD, Larry Keller Insurance Service Administrator
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Reviewed/No Updates: Linda Baker, RN & Catherine Sanders, MD

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Reviewed/Revised: Faustine Dela Cruz, RN & Catherine Sanders, MD
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Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
11/9/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	All second opinion requests may originate from a member, a member's primary care provider or the specialist who consulted for the initial opinion. Requests originating from a member's primary care provider or specialist must be submitted to the Plan on the appropriate Treatment Authorization Request form (TAR). For requests originating from a member, Medical Management will request the TAR from a member's primary care provider or specialist who consulted for the initial opinion. (Note: Member can request second opinion per legislation 1383.15).
2/8/18	No	Catherine Sanders, MD; Robert Sterling, MD,	Annual review

		Faustine Dela Cruz, RN	
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review