SHARP Health Plan

Clinical Policy

Subject: **SECOND OPINION - MEDICAL, SURGICAL or PATHOLOGY**

Policy Number: **HS-CP-M8**

Effective Date: **June 28, 2023**

Product/Service Line: Medicare & Behavioral Health

These guidelines are used in conjunction with the independent judgment of a qualified licensed physician and do not constitute the practice of medicine or medical advice. This Clinical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This Clinical Policy is not intended to recommend treatment for members. Members should consult with their treating provider in connection with diagnosis and treatment decisions.

Sharp Health Plan develops Clinical Policies that serve as guidelines for medical necessity decisions utilizing evidence-based guidelines, compiled from local, national, governmental and professional organizations, literature and current peer-reviewed publications, as described in further detail below.

I. **Benefit Statement:** Any service reviewed and approved by this Sharp Health Plan Clinical Policy must be a covered benefit according to the member's evidence of coverage (EOC). Since benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in this clinical policy, decisions are subject to all terms and conditions of the applicable benefit plan. Benefit determinations should be based in all cases on the member's contract benefits in effect at the time of service. All reviewers must first identify member eligibility and all decisions of this clinical policy are subject to current state and/or federal law. This Clinical policy does not constitute plan authorization, nor is it an explanation of benefits. In the event of a conflict, a member's benefit plan, EOC, always supersedes the information in the Clinical Policies.

II. **Regulatory:** Per CMS Medicare Managed Care Manual Chapter 15 Physician Services Section 30-D. D. Patient-Initiated Second Opinions Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results

of tests done by the first physician may be available to the second physician.

III. Description:

This policy defines the Sharp Health Plan (Plan) clinical criteria for patient initiated second opinion consultations for medical, surgical, or pathology evaluation or treatment consistent with the requirements of CMS.

IV. Definitions:

A. **Plan Medical Group (PMG)** means a group of physicians, organized as or contracted through a legal entity, that has met the Plan's criteria for participation and has entered into an agreement with the Plan to provide and make available professional services, and to provide or coordinate the provision of other covered benefits to Members on an independent contractor basis and that is included in the Member's plan network.

B. **Plan Network** means that network of providers selected by the employer or the Member, as indicated on the Member Identification Card. Sharp Health Plan's Plan Networks includes the Sharp Choice, Sharp Value, Sharp Performance and Sharp Premier Networks.

C. **Plan Physician** means any Doctor of Medicine, Osteopathy, or Podiatry licensed by the State of California who has agreed to provide professional services to Members, either through an agreement with the Plan or as a member of a PMG.

D. **Qualified Health Professional** means a primary care physician (PCP), or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease or condition, or conditions associated with the request for a second opinion. For purposes of determining a Qualified Health Professional, SHP utilizes the American Board of Medical Specialties approved Specialty and Subspecialty Certification and American Osteopathic Association Certifying Board.

V. Medical Necessity:

A. Second and third opinions are considered medically necessary when the following are met:

1. Member questions the reasonableness or necessity of a recommended surgery or major nonsurgical diagnostic or therapeutic procedure. (This means that member has had a first opinion by a specialist or provider who is recommending the surgery or procedure).
2. A third opinion regarding the surgery or other major procedure is considered if the first and second opinions differ.
3. The second and third opinions are covered even if the surgery or procedure is determined not covered unless an excluded service such as cosmetic surgery.

4. Second and third opinions may include a history and physical examination.
5. Second and third opinions may include other diagnostic testing required for determining the need for surgery or a procedure. All procedures or testing must be prior authorized and meet medical necessity.

VI. Not Medically Necessary:

A. Second opinion requests will be denied if a first opinion was not obtained.

B. A third opinion is not medically necessary if the first and second opinion agree on plan of care or surgical procedure.

C. Additional requested opinions beyond a third opinion is not deemed as being medically necessary.

D. A second opinion is not medically necessary for excluded services, such as cosmetic surgery.

VII. Process/Attachments:

A. All second and third opinions must be prior authorized per standard SHP standard Utilization Management Process.

B. If an appropriately Qualified Health Professional (QHP) of the same or equivalent specialty is not available within the Plan Network, the second opinion will be provided by a Plan Physician who is an appropriately Qualified Health Professional. The Plan shall take into account the ability of the member to travel to the provider.

C. A second opinion from a non-contracted Qualified Health Professional will be authorized only when there is not a Plan Physician who is a Qualified Health Professional. The plan determines a QHP based, in part, on the CV of the physician, training, fellowship, experience performing the requested service, etc. The Plan shall take into account the location of the provider in rendering an authorization.

D. If there is not an appropriately Qualified Health Professional available within the Plan Medical Group (PMG) able to treat the member, the second opinion will be authorized by the PMG or SHP if not belonging to a PMG (Independent Network).

E. The Qualified Health Professional rendering the second opinion must supply the member, PCP and Plan with consultation report and treatment recommendations in a timely manner. The standard time frame for submission of the consultant report will be two (2) weeks from the date of service. If the Qualified Health Professional is unable to comply with the time frame proposed, a written request for extension should be made prior to the expiration of the original time frame or an opinion from another Qualified Health Professional will be sought.

F. The Qualified Health Professional rendering the second opinion is limited to consultation only, and no other service, procedure, or care will be covered unless prior authorized. (Including labs and x-rays) The service or procedure must be required to properly evaluate the member's need for a procedure and for the QHP to render a professional opinion.

G. All requests for second opinions from a specialist will be reviewed by the Plan in an expeditious manner and administered consistent with the Plan benefit.

H. If the member is approved to receive a second opinion from an out of network specialist, then the Plan incurs the cost or negotiates the fee arrangement for the second opinion, beyond the applicable copayments paid by the enrollee. If the Plan denies the request for a second opinion, then additional medical opinions not authorized by the Plan are the enrollee's responsibility.

I. A determination on the request shall be made in an expeditious manner, when a member's condition is such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the member's ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the request.

J. The PMG and Plan shall notify the member in writing of any denial of request for a second opinion including the reason for the denial and the right of the member to appeal the decision and/or to file a grievance with the Plan.

VIII. Codes: N/A

IX. References:

A. Medicare Benefit Policy Manual Chapter 15 Section 30.0 C. Rev. 11901, 03-16-23. Reviewed 5/23

B. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guideline, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare Managed Care Manual Ch. 4 90.5) Reviewed 5/23

X. Revision History:

Date	Modification (Original, Reviewed or Revised)
6/26/19	Original
6/24/2020	Reviewed, no major changes
6/30/21	Updated Name based on change to clinical policies
6/29/22	Updated
6/28/23	Reviewed, Updated reference.

Approved by: _____ Date: 6/28/23

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