Member Initiated Second and Third Opinion

Policy Number: BIP157.K
Effective Date: January 1, 2024

Instructions for Use

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Related Benefit Interpretation Policies

- Medical Necessity

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

Oregon

ORS 743B.227 Referrals to Specialists

https://www.oregonlaws.org/ors/743B.227

1. (c) The plan must allow an enrollee to request and obtain a second medical opinion or consultation from a second physician who is a network provider and who is authorized to make decisions regarding the need for a referral to a specialist. If the plan does not have a network provider available to give a second medical opinion or consultation, the plan must allow the enrollee to obtain the opinion or consultation from a similarly qualified physician who is not a network provider. The plan may not impose a charge for the second medical opinion or consultation that is greater than the cost that the enrollee would otherwise pay for an initial medical opinion or consultation from the second physician.

Washington

RCW 48.43.515

https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.515

6) Each carrier must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice.

WAC 284-170-360 Enrollee's Access to Providers

https://apps.leg.wa.gov/wac/default.aspx?cite=284-170-360

(5) Each issuer must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice. The issuer may not impose any charge or cost upon the enrollee for such second opinion other than the charge or cost imposed for the same service in otherwise similar circumstances.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine the coverage eligibility.

Second medical opinions will be provided or authorized in the following circumstances:

- When the member questions the reasonableness or necessity of recommended surgical procedures;
- When the member questions a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment (including, but not limited to, a serious chronic condition);
- When the clinical indications are not clear, or are complex and confusing;
- When a diagnosis is in doubt due to conflicting test results;
- When the treating provider is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second medical opinion regarding the diagnosis or continuance of the treatment;
- When the member has attempted to follow the treatment plan or consulted with the first provider and still have serious concerns about the diagnosis or treatment.

A Second medical opinion may include, but is not limited to:

- A history and physical examination of the member.
- Any covered diagnostic testing required to evaluate the need for surgery or procedure. Diagnostics must be obtained in network when possible.

If the first two opinions differ, a third opinion will be covered if member meets above criteria (C.1).

Notes:

- All second and third medical opinions, whenever possible, should be provided in-network and must be authorized by the member's network medical group or UnitedHealthcare medical director. Out-of-network second/third medical opinions will be considered if there is no available or appropriate in-network provider and must be authorized by the member's network medical group or UnitedHealthcare medical director. This requirement does not apply when state mandate requires another process. Refer to the *Federal/State Mandated Regulations* section.
- The fact that an appropriately qualified provider gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is medically necessary or a covered health care service
- Once the second or third opinion is provided, regardless of where it was rendered, all diagnostic testing, treatment and/or surgical intervention must be authorized and directed by the member's network provider.

Not Covered

- Self-referred second medical opinion
- Second medical opinion for a non-covered service

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
01/01/2024	All	**Related Policies** • Added reference link to the Benefit Interpretation Policy titled *Medical Necessity* **Supporting Information** • Removed *Definitions* section • Archived previous policy version BIP157.J

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Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.