Marketplace Benefit Interpretation

Marketplace National Regional Benefit Interpretation Document

Benefit Name	MEMBER INITIATED SECOND OPINION
Applicable State	California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin
Benefit Definition	This policy addresses member-initiated second medical opinions. Covered benefits are listed in three (3) Sections - A, B and C. 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. **A. FEDERAL/STATE MANDATED REGULATIONS** **Note: The most current federal/state mandated regulations for each state can be found in the links below.** **FLORIDA:** Fla. Stat. § 641.51: Second medical opinion requirement **KENTUCKY:** Ky. Rev. Stat. 304.17A-520(4): Second Opinion **B. STATE MARKET PLAN ENHANCEMENTS** **None** **C. COVERED BENEFITS** **IMPORTANT NOTE:** Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section. Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

MEMBER INITIATED SECOND OPINION

ALL STATES:

Molina members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, prior authorization is required to obtain the second opinion of an out of network provider. Members should refer to their benefit documents (such as Schedule of Benefits and/or Evidence of Coverage) for cost--share information and any limits related to second opinions. Claims for out of network providers that do not have a prior authorization will be denied.

If we approve the second opinion from a non-par physician that does not mean we approve the treatment recommended by that physician.

CALIFORNIA:

Second Opinions: A Member or PCP may want a second doctor to review the Member's condition. This can be a primary care provider or a Specialist. This new doctor looks the Member's medical record. The doctor may see the Member at their office. This doctor may suggest a plan of care. This is called a second opinion.

A Member's PCP can refer the Member to a Participating Provider for a second opinion. Members do not need permission from Molina to get a second opinion from a Participating Provider. If there is no provider in the network to give a second opinion, the Member may be able to get a second opinion from a Non-Participating Provider. If a Member asks for a second opinion from a Non-Participating Provider, Molina will review and let the Member know if the second opinion was approved.

Here are some reasons why a Member may want a second opinion:

- The Member's symptoms are complex or confusing.
- The first doctor is not sure the diagnosis is correct.
- The Member has followed a doctor's plan of care, and the Member's health has not improved.
- The Member is not sure if surgery is needed, or the Member thinks surgery is needed.
- The Member does not agree with what a doctor thinks is the problem.
- The Member does not agree with a doctor's plan of care.
- A doctor has not answered the Member's concerns about a diagnosis or plan of care.
- There may be other reasons.

The second doctor will write a report of what he or she finds. The Member and the Member's PCP will get a written report of the second opinion.

The Member may contact Member Services for help getting a second opinion.

FLORIDA:
Second Opinions: A Member or a Member's PCP may want another doctor (a PCP or Specialist Physician) to review the Member's condition. This doctor looks at the Member's medical record and may see the Member. This new doctor may suggest a plan of care. This is called a second opinion.

Here are some, but not all, reasons why a Member may get a second opinion:

- A Member's symptoms are complex or confusing.
- A doctor is not sure the diagnosis is correct.
- A Member has followed the doctor's plan of care for a while, and the Member's health has not improved.
- A Member is not sure that surgery is needed, or a Member thinks surgery is needed.
- A Member does not agree with what the doctor thinks is the problem.
- A Member does not agree with a doctor's plan of care.
- A doctor has not answered the Member's concerns about a diagnosis or plan of care.

Second Opinions from Non-Participating Providers: A Member may obtain a second opinion from the provider of his or her choice, including from a Non-Participating Provider, for the following reasons:

- The Member disputes Molina's or a physician's opinion of the reasonableness or necessity of surgical procedures.
- The Member is seriously injured or ill.

Prior Authorization is required for a second opinion from a Non-Participating Provider. Suppose Molina authorizes a physician that is a Non-Participating Provider. In that case, Molina will pay the amount of all charges that are usual, reasonable, and customary in the community. The Member will be responsible for a coinsurance payment in the amount of 40% of the Allowed Amount. The Non-Participating Provider must be in the Molina Service Area for this product unless Molina gives Prior Authorization for another provider. For tests deemed necessary by the physician, Molina may require the tests to be conducted by Participating Provider test facilities.

A Member may be limited to three second-opinion requests per calendar year under this product.

IDAHO:
Second Opinion: A Member or their Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care.

ILLINOIS:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider. Following a recommendation for elective surgery. Coverage will be provided at 100% of claim charge for one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in the member's opinion, is not resolved by the first consultation.

KENTUCKY:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Passport only covers Second Opinions when furnished by a Participating Provider.

MICHIGAN:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

MISSISSIPPI:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

NEW MEXICO:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may

review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

OHIO:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

SOUTH CAROLINA:
Second Opinion: A Member or a Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

TEXAS:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

UTAH:
Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

WASHINGTON:
Second Opinion: A Member or their Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. Molina only covers Second Opinions when furnished by a Participating Provider.

WISCONSIN:
Molina may require a Member to obtain a second opinion from another health care provider at Molina's expense. This provider must be experienced in the use of empirically validated tools specific for Autism Spectrum Disorders. The Member, the Member's parent or the Member's authorized representative and

Molina must agree upon the provider. Coverage for the cost of a second opinion will be in addition to the benefit mandated by Section 632.895 (12m), Wisconsin Statutes, as amended.

D. NOT COVERED

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

E. DEFINITIONS

See Glossary

F. POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

Procedure Codes (Internal Use Only)

Coding Disclaimer: Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

Prior Authorization

For the MHI PA Matrix, if a code is NOT listed, it could EITHER be:

a. Covered and No PA Required
b. Not Covered

You cannot use the MHI PA Matrix to make coverage determinations.

	PA Lookup Tool
Approval	

Departments	Product	CIM	Clinical Management
Date	11/9/2021		11/9/2021