KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Second and Third Opinions	**Policy #**	30.74-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	1/16/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To define Kern Health System's (KHS) process to provide Members, who meet specific criteria, with a second opinion consultation by an appropriately qualified health care practitioner.

II. POLICY

A. A second opinion may be requested by any member of the healthcare team, member, parent(s) and /or guardian(s), or a social worker.

B. KHS Members who meet specific criteria may have a second opinion consultation by an appropriate qualified health care professional.

C. The member must receive a first opinion rendered by their Primary Care Physician (PCP) or through a referral to a KHS/ specialist and must meet the following criteria:

1. The Member is questioning the reasonableness or necessity of recommended treatment

2. Member is questioning 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. Member feels 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 diagnosis the condition and the member requests an additional assessment/evaluation.

4. The current treatment plan is not resulting in improvement of the member's medical condition within an appropriate timeframe, given the diagnosis. The member is requesting a second opinion regarding the diagnosis or the continuation of treatment.

5. The member must receive a first opinion rendered by his/her PCP or through a referral to an in-network specialist and must meet established criteria. If the member requests a second medical opinion from a PCP, the second medical opinion may be obtained with a KHS network provider with the same or equivalent specialty at no cost to the member beyond the member's applicable co-pay.

D. If the member requests a second medical opinion outside of the KHS network, and the request meets the criteria previously identified, the request will be redirected to an in-network provider. If there is not an in-network provider to provide the second opinion, KHS will authorize an out of network provider.

E. A second opinion consists of one (1) office visit for an evaluation only. The member must obtain all follow-up care through an in-network board certified provider when an appropriately qualified provider exists. Out-of-network requests will require approval by the member's health plan.

F. The second opinion consultation report must be provided to the members' PCP by the provider performing the second opinion timely.

G. The consultation report should provide the details of the consultation and any recommendations for procedures and tests.

III. DEFINITIONS

TERMS	DEFINITIONS
Qualified Health Care Professional	A PCP or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise related to the member's particular illness, disease, or condition(s).

IV. PROCEDURAL

A. The member must first receive a first opinion rendered by their primary care physician (PCP) or through a referral to a KHS specialist.

B. The member has made a reasonable attempt to follow the plan of care or has consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

C. A second opinion consultation request will be reviewed within five (5) days when requested by a member based on care received from his/her PCP to an appropriate specialist of the same or equivalent specialty of the member's choice within the KHS network.

1. The authorization process considers the member's ability to travel to the practitioner rendering the second or third medical opinion.

D. If a Specialist is not available within the KHS provider network, KHS shall arrange for the second opinion from a non-contracted provider and shall incur the cost or negotiate the fee arrangement of that second opinion.

E. The second opinion decision must be rendered within five (5) business days from the date of receipt of the request but as expeditiously as the member's health condition requires.

F. The provider who rendered the second opinion must provide the member with a consultation report including any recommended procedures or tests as expeditiously as the patient's health condition requires.

G. In cases where the member faces a serious threat to his/her health including, but not limited to potential loss of life, limb or other major bodily function, the second opinion must be rendered within one (1) working day of receipt of necessary information, but not to exceed seventy-two (72) hours after receipt of request.

H. Member-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.

I. 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.

J. Second opinions are covered even if the recommended surgery or procedure is ultimately determined to be non-covered.

K. Payment may be made for the member's history and physical examination, as well as for other covered diagnostic services necessary to appropriately evaluate the need for a procedure and to provide a professional opinion.

1. In some cases, the results of tests done by the first physician may be available to the second physician.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and or Department of Managed Health Care (DMHC) guidance, including applicable All Plan Letters (APLs), Health Plan Management System (HPMS) memos, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

Attachment A:	
N/A	

VI. REFERENCES

Reference Type:	Specific Reference
Regulatory	CA Health & Safety Code (HS&C) 1383.15(b) (d)(e)].
Regulatory	Medicare Manual Chapter 15-Covered Medical and Other Health Services Section 40.8

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with D-SNP	UM

VIII. APPROVALS

Committees | Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		

Regulatory Agencies (if applicable)	Date Reviewed	Date Approved
Choose an item.		