KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Second Opinions	**Policy #**	3.09-P
Policy Owner	Utilization Management	**Original Effective Date**	2/2002
Revision Effective Date	1/2026	**Approval Date**	03/02/2026
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

Medicine is far from an exact science, and it is an area of knowledge that is rapidly changing. In recognition of this, Kern Health Systems (KHS) understands that at times, a patient may disagree with the diagnostic and treatment plan offered by a primary care provider or specialist. At times, a second medical opinion is needed to resolve controversy or help a patient make a choice between available treatment options.

II. POLICY

Second medical opinions are customarily performed by a physician not affiliated with the physician rendering an initial opinion so that the second opinion is provided without bias. Exceptions to this guideline can be made. Members have a right to a second opinion in most circumstances. A request for a second opinion may come from a physician or directly from the member.

KHS will provide second medical opinions in accordance with state and federal regulations and the guidelines outlined in this policy

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. REQUEST

Requests for a second opinion may originate from the member or a health care professional. Authorizations for second opinions will be granted through the referral process.

Referral requests for second opinions should document the initial opinion and the person requesting the second opinion (usually the member, the PCP, or the initial specialist). Justification for a second opinion may include, but is not limited to:

1. The member questions the reasonableness or necessity of recommended surgical procedures or medical treatment plan.

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. 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. 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 continuance of the treatment.

5. 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. The recommendations of the first consultation have been clearly documented.

7. The reason the member desires a second opinion must be clearly documented.

8. The provider of the second opinion must understand what is being requested. The provider of the second opinion is ethically prohibited from providing anything other than a recommendation.

9. If the circumstances find the first opinion and the second opinion are not in agreement, the Chief Medical Officer will review the recommendations and decide on the course of action. This may involve a third opinion.

Chief Medical Officer Review

All requests for second opinions are reviewed by the KHS Chief Medical Officer or their designee and granted at his/her discretion. Such review is intended to make sure that a request for a second opinion is not capricious and has a potential to benefit the patient. The ultimate criteria used in reviewing requests for second medical/surgical opinions is whether the second opinion could potentially lead to improved

health or wellbeing of the patient or assist the patient's physicians in providing the most effective medical care. The Chief Medical Officer or their designee also considers the following broad criteria in the review process:

1. Is the area of medicine controversial such that additional perspective would clarify alternatives?

2. Are multiple diagnostic or treatment plans the current standard of practice in the community?

3. Is there a possible non-standard treatment or an experimental treatment that has shown a high probability of being effective for the diagnosed disease and for the specific patient?

4. Is there reasonable doubt that the diagnosis from the initial opinion is incorrect or should be modified?

5. Would a second opinion assist the patient in making a choice when multiple diagnostic or treatment options are presented?

The Chief Medical Officer or their designee may seek the advice of other experts when needed to clarify the issues involved.

Timeliness of Decision

Authorization/denial and second opinion evaluation is accomplished in a timely manner. Urgent second opinion requests are accomplished within seventy two (72) hours from the plan's receipt of request, whenever possible, in the setting where enrollee's condition poses an imminent and serious threat to his/her health, including potential loss of life, limb, or other major bodily function or lack of timeliness would be detrimental to enrollee's ability to regain maximum function. For routine second opinion requests, determinations are issued within seven (7) calendar days of request.

The timeline for responding to second opinion requests is made available to the public upon request. Any amendment to the timelines will be filed with the Department of Managed Health Care within thirty (30) days of the amendment.

B. PERFORMANCE OF APPROVED SECOND OPINIONS

Second medical opinions are provided by a KHS contracted PCP, specialist, or other licensed health care provider acting within the scope of practice and who possesses clinical background including training and expertise, related to the particular illness or condition associated with the request for a second opinion. Subsequently, second opinion determinations are not delegated to any provider for final decision.

Enrollees may seek a second opinion from any provider that meets these requirements after authorization by KHS. Exceptions to this guideline are made only if there are no contracted providers capable of providing a valid second opinion. In this case, KHS authorizes a non-contracted physician/specialist agreed upon by the requesting party to provide the second opinion. Fees for opinions from non-contracted providers are negotiated by Provider Relations staff within the required time constraints. The non-contracted physician/specialist is informed that the fees agreed upon shall constitute full compensation for covered services rendered to the members. The physician/specialist also agrees not to bill or assess any

surcharge to KHS members except for applicable copayments as indicated on the approved referral form. The copayment amount for second opinions is the same amount applicable to contracted providers.

The physician provides KHS with a consultation report, including any recommended procedures or tests that the second opinion physician believes appropriate. When the appointment for a second opinion is made, the physician is made aware of the requirement to provide the member and original provider with a report.

C. RESULTS AND FURTHER CARE

If the second opinion confirms the initial opinion, it is expected that the patient will receive further care from the initial physician unless there is a compelling reason to change physicians.

If the second opinion differs from the initial opinion, the patient must choose which physician will continue to provide the needed medical services. The member's primary care physician and/or the Chief Medical Officer or their designee assists the member in these matters as needed.

D. CHIEF MEDICAL OFFICER INITIATED SECOND OPINION

At times the KHS Chief Medical Officer or their designee may initiate a second medical opinion. This may occur when the Chief Medical Officer or designee has a significant concern about a proposed diagnostic or treatment plan and is unable to come to a resolution by discussing the case with the requesting physician.

E. ADDITIONAL OPINIONS

Requests for additional medical opinions are reviewed on a case-by-case basis. Approvals/denials of such requests are processed in the same manner as all other requests for services as outlined in KHS Policy and Procedure #3.22 – Referral Process.

F. DELEGATION OF SECOND OPINION DETERMINATIONS

KHS is responsible for ensuring that all delegates comply with all applicable state and federal law and regulations, contract requirements, and other DHCS guidance including APLs 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
Other KHS Policies	KHS Policy and Procedure #3.22 – Referral Process

Choose an item.	
Choose an item.	

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2026-01	Routine review of policy by Utilization Management Department.	
Revised	2025-08	Routine review of policy by Utilization Management Department.	
Revised	2020-06	Routine review of Policy by Chief Health Services Officer. No material changes.	
Revised	2015-01	Policy updated into new format. Titles updated. No material changes.	
Revised	2009-09	Routine review by Utilization Management Department.	
Revised	2002-06	Revised per DHS Comment (04/05/02).	
Effective	2002-02	Information was previously included in Policy #3.22 - Referral Process. Created stand-alone policy for simplification purposes.	

VIII. APPROVALS

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

Regulatory Agencies (if applicable)	Date Reviewed	Date Approved
Department of Managed Health Care (DMHC)	02/12/2026	
Choose an item.		
Choose an item.		