6/26/19

New Information From Your CPMG Medical Directors…
… always interesting to us – hopefully useful to you!

Many of you have posed good questions regarding your proper role when a family discusses/requests a second specialty opinion. We have compiled the information you need to help guide you as you work with the family, and offer it to you in the attached document.

Do not hesitate to contact us if you have questions or concerns.

Best wishes,

Whitney Carr Edwards, MD, FAAP
Senior Medical Director, CPMG

Marshall J. Littman, MD, FAAP
Associate Medical Director, CPMG

Second Opinions for Managed Care Patients 101

One of the more frequent questions both primary care and specialty providers get from the families of patients is how they can obtain a second opinion. Patients under all health plans are entitled to a second opinion, but second opinions fall into two broad categories and are handled differently. It's clear from the questions, requests, and documentation we see both from primary and specialty providers that there is a lot of confusion regarding this topic.

The most common kind of second opinion request, and the easiest to obtain, is a PATIENT OR FAMILY REQUESTED SECOND OPINION. This is a situation in which the child is being seen by an in-network provider but the family wants confirmation of the assessment and plan from someone outside the network. (No authorization of any kind is required for a second opinion from another in-network provider.) Sometimes this is because they don't agree with the assessment, but more often it's because they're feeling uncertain, having to make a significant decision, are hoping for a "better" answer, or just want reassurance that they're doing the right thing. All a family needs to do to access this benefit is call their health plan members' services number on the back of their card and say, "I'm seeing a specialist in this division and I'd like a second opinion from so-and-so at such-and-such a place." Typically the only limitations on accessing this service are (1) the family has to have gotten a first opinion from an in-network provider in that specialty, (2) they can't have already gotten a second opinion from someone in that specialty for that diagnosis (although some health plans will also authorize a THIRD opinion if the first and second opinions are at significant odds), and (3) the request has to come from the family. It's fine, if the family asks for a recommendation, to offer a name, but it should be documented as such, e.g. "Joe's family would like a second opinion and asked if I could recommend someone. I told them that Dr. So-and-so at CHLA is very knowledgeable in this area and would be a reasonable choice." Generally, the specific provider request will be accommodated. Occasionally, the health plan will redirect the request to a provider within their broader contracted network. Families can also request a generic second opinion from, say, an out-of-network pediatric neurologist (for example) and the health plan will direct them to someone based on geographic proximity and their contracted network. In the age of Google, however, usually they have a specific doc they want to see, even if they didn't ask you for a recommendation.

Note - occasionally when families call the health plan, they will be given incorrect information that this request needs to be submitted by a provider. Should this happen, please alert us and we will intercede with the plan.

Far less common are PROVIDER INITIATED SECOND OPINIONS. This is a situation in which the child is being seen by an in-network specialist and THAT PROVIDER and his/her division chief or department head agree that because of the specific medical scenario, we are clinically unable to meet the needs of that child within our network, and that he or she needs to be receiving care from someone elsewhere with far greater expertise. These are the kids who, if the families were perfectly happy with our care, and had no interest in going elsewhere, we would say

“we’re not able to meet the medical needs of this child.” Those are the situations in which there should be clear documentation that (1) the child’s needs cannot be met in our system and why, (2) the place to which you are referring can meet those needs because of greater expertise or ability to provide a service, and (3) that determination is being made by you, and not at the request of the family (even if they have asked about it). These requests are placed by our in-network specialist to an out-of-network colleague in the same specialty and are directed to the medical group (CPMG).

It is clear that many providers believe that in order for a family to access a second opinion, they (the docs) need to document some kind of medical reason for why the family should be able to get the second opinion. In fact, this actually often DELAYS the family’s access to that authorization.

So, in summary: When a family requests information regarding obtaining a second opinion, the best information you can give them is that (1) they are entitled to one, (2) if they’d like to see one of your colleagues (if appropriate) you’d be happy to facilitate it, and (3) if they’d prefer to go elsewhere, all they need to do is call the members’ services number on the back of their child’s insurance card and request it. Provide the name of a colleague you believe would be appropriate if the family asks for it. Avoid using the word “recommend” either in written or verbal communication or documentation.