Second and Third Opinions

Policy Number: MCS082.02
Approval Date: June 14, 2021

Instructions for Use

Table of Contents Page

Related Policies
None

Coverage Guidelines

Second and third physician opinions are only covered when Medicare criteria are met.

Second and third opinions are covered according to the following criteria:

- Second opinions are covered if the opinion is provided at the member's request to determine the advisability of undergoing surgery or a major non-surgical diagnostic or therapeutic procedure.
- Third opinions are covered if the recommendations of the first and second physician differ regarding the need for surgery or other major procedure.
- Second and third opinions are covered even if the surgery or other procedure, if performed, is not covered.
- Second or third opinions may include, but are not limited to:
  - A history and physical examination of the member
  - Any diagnostic testing required for determining the need for surgery or a procedure. All services must be a UnitedHealthcare Medicare Advantage plan covered benefit.

There is no coverage for the provider or the facility charges if the proposed surgery or procedure is a non-covered UnitedHealthcare Advantage Medicare plan benefit.

Notes:

- Once the second opinion is provided, regardless of where it was rendered, all diagnostic testing, treatment and/or surgical intervention must meet the UnitedHealthcare Medicare Advantage plan medical necessity and or benefit criteria to be covered.
- Only for Medicare Advantage plan members required to get referrals through the Primary Care Physician/IPA or UnitedHealthcare: All second and third opinions, whenever possible, should be provided in-network and must be authorized by the member's medical group/IPA or UnitedHealthcare. Out-of-network second/third opinion will be considered if there is no available or appropriate in-network provider and must be authorized by the member's medical group/IPA or UnitedHealthcare.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §30 – C (Consultations) & D (Patient Initiated Second Opinions). (Accessed May 25, 2021)

Policy History/Revision Information

Date	Summary of Changes
06/14/2021	• Routine review; no change to coverage guidelines • Archived previous policy version MCS082.01

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

CPT® is a registered trademark of the American Medical Association.