HOUSE DOCKET, NO. 1530 FILED ON: 1/20/2011

HOUSE . . . . . No. 1187

The Commonwealth of Massachusetts

PRESENTED BY:

Kay Khan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying:

An Act providing for certain standards in health care insurance coverage.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Kay Khan	*11th Middlesex*
John P. Fresolo	*16th Worcester*
Timothy J. Toomey, Jr.	*26th Middlesex*
Elizabeth A. Malia	*11th Suffolk*
Stephen R. Canessa	*12th Bristol*
Denise Provost	*27th Middlesex*
William Smitty Pignatelli	*4th Berkshire*

HOUSE DOCKET, NO. 1530 FILED ON: 1/20/2011

HOUSE . . . . . No. 1187

By Ms. Khan of Newton, a petition (accompanied by bill, House, No. 1187) of Kay Khan and others relative to requiring that certain health insurance policies include coverage for eating disorders. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
HOUSE
, NO. *936* OF 2009-2010.]

The Commonwealth of Massachusetts

An Act providing for certain standards in health care insurance coverage.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Subsection (a) of Section 22 of Chapter 32A, as so appearing, is hereby
2 amended by striking out, in line 10, the words "and (10)" and inserting in place thereof the
3 following:— (10) eating disorders, and (11).

4 SECTION 2. Subsection (d) of Section 22 of Chapter 32A, as so appearing, is hereby
5 stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing
6 such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime
7 dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental
8 disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on
9 coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing,
10 a carrier will be deemed to be non-compliant with this section if utilization review criteria and
11 guidelines for application of medical necessity standards for diagnosis and treatment of mental
12 disorders are developed or applied to in a manner that unduly restricts coverage of medically
13 necessary health care services as determined by the commissioner of insurance.

14 SECTION 3. Subsection (g) of Section 22 of Chapter 32A, as appearing in the 2004
15 Official Edition, is hereby stricken and replaced with the following:--

16 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
17 intermediate, and outpatient services that shall permit medically necessary diagnosis and

18 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
19 accordance with generally accepted principles of professional medical practice. For purposes of
20 this section, inpatient services may be provided in a general hospital licensed to provide such
21 services, in a facility under the direction and supervision of the department of mental health, in a
22 private mental hospital licensed by the department of mental health, or in a substance abuse
23 facility licensed by the department of public health. Intermediate services shall include, but not
24 be limited to, Level III community-based detoxification, acute residential treatment, partial
25 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
26 public health or the department of mental health. Outpatient services may be provided in a
27 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
28 health, a public community mental health center, a professional office, or home-based services,
29 provided, however, services delivered in such offices or settings are rendered by a licensed
30 mental health professional acting within the scope of his license. No policy subject to this section
31 shall contain a blanket exclusion of services that qualify as intermediate services for mental
32 disorders covered under this section, including but not limited to residential services. A carrier
33 subject to this section must ensure that its network, including the network of any entity that
34 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
35 services, contains a sufficient number of providers representing the range of services required by
36 this subsection so that an insured may obtain medically necessary services within a clinically
37 reasonable period of time.

38 SECTION 4. Subsection (a) of Section 47B of Chapter 175, as so appearing, is hereby
39 amended by striking out, in line 16, the words “and (10)” and inserting in place thereof the
40 following:—(10) eating disorders, and (11).

41 SECTION 5. Subsection (d) of Section 47B of Chapter 175, as appearing in the 2004
42 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall
43 be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not
44 contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis
45 and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of
46 service limitation imposed on coverage for the diagnosis and treatment of physical conditions.
47 Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if
48 utilization review criteria and guidelines for application of medical necessity standards for
49 diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly
50 restricts coverage of medically necessary health care services as determined by the commissioner
51 of insurance.

52 SECTION 6. Subsection (g) of Section 47B of Chapter 175, as appearing in the 2004
53 Official Edition, is hereby stricken and replaced with the following:--

54 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
55 intermediate, and outpatient services that shall permit medically necessary diagnosis and

56 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
57 accordance with generally accepted principles of professional medical practice. For purposes of
58 this section, inpatient services may be provided in a general hospital licensed to provide such
59 services, in a facility under the direction and supervision of the department of mental health, in a
60 private mental hospital licensed by the department of mental health, or in a substance abuse
61 facility licensed by the department of public health. Intermediate services shall include, but not
62 be limited to, Level III community-based detoxification, acute residential treatment, partial
63 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
64 public health or the department of mental health. Outpatient services may be provided in a
65 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
66 health, a public community mental health center, a professional office, or home-based services,
67 provided, however, services delivered in such offices or settings are rendered by a licensed
68 mental health professional acting within the scope of his license. No policy subject to this section
69 shall contain a blanket exclusion of services that qualify as intermediate services for mental
70 disorders covered under this section, including but not limited to residential services. A carrier
71 subject to this section must ensure that its network, including the network of any entity that
72 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
73 services, contains a sufficient number of providers representing the range of services required by
74 this subsection so that an insured may obtain medically necessary services within a clinically
75 reasonable period of time.

76 SECTION 7. Subsection (a) of Section 8A of Chapter 176A, as so appearing, is hereby
77 amended by striking out, in line 13, the words “and (10)” and inserting in place thereof the
78 following:-- “(10) eating disorders, and (11)”.

79 SECTION 8. Subsection (d) of Section 8A of Chapter 176A, as so appearing, is hereby
80 stricken and replaced with the following:-- Subsection (d) of Section 47B of Chapter 175, as
81 appearing in the 2004 Official Edition, is hereby stricken and replaced with the following:-- (d)
82 Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if
83 the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage
84 for the diagnosis and treatment of said mental disorders which is less than any annual or lifetime
85 dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of
86 physical conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant
87 with this section if utilization review criteria and guidelines for application of medical necessity
88 standards for diagnosis and treatment of mental disorders are developed or applied to in a
89 manner that unduly restricts coverage of medically necessary health care services as determined
90 by the commissioner of insurance.

91 SECTION 9. Chapter 176A, as so appearing, is hereby amended by striking out
92 subsection (g) of Section 8A, as so appearing, and inserting in place thereof the following
93 section:--

94 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
95 intermediate, and outpatient services that shall permit medically necessary diagnosis and
96 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
97 accordance with generally accepted principles of professional medical practice. For purposes of
98 this section, inpatient services may be provided in a general hospital licensed to provide such
99 services, in a facility under the direction and supervision of the department of mental health, in a
100 private mental hospital licensed by the department of mental health, or in a substance abuse
101 facility licensed by the department of public health. Intermediate services shall include, but not
102 be limited to, Level III community-based detoxification, acute residential treatment, partial
103 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
104 public health or the department of mental health. Outpatient services may be provided in a
105 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
106 health, a public community mental health center, a professional office, or home-based services,
107 provided, however, services delivered in such offices or settings are rendered by a licensed
108 mental health professional acting within the scope of his license. No policy subject to this section
109 shall contain a blanket exclusion of services that qualify as intermediate services for mental
110 disorders covered under this section, including but not limited to residential services. A carrier
111 subject to this section must ensure that its network, including the network of any entity that
112 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
113 services, contains a sufficient number of providers representing the range of services required by
114 this subsection so that an insured may obtain medically necessary services within a clinically
115 reasonable period of time.

116 SECTION 10. Subsection (a) of Section 4A of Chapter 176B, as so appearing, is hereby
117 amended by striking out, in line 14, the words “and (10)” and inserting in place thereof the
118 following:-- “(10) eating disorders, and (11)”.

119 SECTION 11. Subsection (d) of Section 4A of Chapter 176B, as appearing in the 2004
120 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall
121 be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not
122 contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis
123 and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of
124 service limitation imposed on coverage for the diagnosis and treatment of physical conditions.
125 Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if
126 utilization review criteria and guidelines for application of medical necessity standards for
127 diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly
128 restricts coverage of medically necessary health care services as determined by the commissioner
129 of insurance.

130 SECTION 12. Subsection (g) of Section 4A of Chapter 176B, as so appearing, is hereby
131 stricken and replaced with the following:--

132 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
133 intermediate, and outpatient services that shall permit medically necessary diagnosis and
134 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
135 accordance with generally accepted principles of professional medical practice. For purposes of
136 this section, inpatient services may be provided in a general hospital licensed to provide such
137 services, in a facility under the direction and supervision of the department of mental health, in a
138 private mental hospital licensed by the department of mental health, or in a substance abuse
139 facility licensed by the department of public health. Intermediate services shall include, but not
140 be limited to, Level III community-based detoxification, acute residential treatment, partial
141 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
142 public health or the department of mental health. Outpatient services may be provided in a
143 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
144 health, a public community mental health center, a professional office, or home-based services,
145 provided, however, services delivered in such offices or settings are rendered by a licensed
146 mental health professional acting within the scope of his license. No policy subject to this section
147 shall contain a blanket exclusion of services that qualify as intermediate services for mental
148 disorders covered under this section, including but not limited to residential services. A carrier
149 subject to this section must ensure that its network, including the network of any entity that
150 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
151 services, contains a sufficient number of providers representing the range of services required by
152 this subsection so that an insured may obtain medically necessary services within a clinically
153 reasonable period of time.

154 SECTION 13. Subsection (a) of Section 4M of Chapter 176G, as so appearing, is hereby
155 amended by striking out, in line 12, the words “and (10)” and inserting in place thereof the
156 following:-- “(10) eating disorders, and (11)”.

157 SECTION 14. Subsection (d) of Section 4M of Chapter 176G, as so appearing, is hereby
158 stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing
159 such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime
160 dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental
161 disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on
162 coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing,
163 a carrier will be deemed to be non-compliant with this section if utilization review criteria and
164 guidelines for application of medical necessity standards for diagnosis and treatment of mental
165 disorders are developed or applied to in a manner that unduly restricts coverage of medically
166 necessary health care services as determined by the commissioner of insurance.

167 SECTION 15. Subsection (g) of Section 4M of Chapter 176G, as so appearing, is hereby
168 stricken and replaced with the following:--

169 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
170 intermediate, and outpatient services that shall permit medically necessary diagnosis and
171 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
172 accordance with generally accepted principles of professional medical practice. For purposes of
173 this section, inpatient services may be provided in a general hospital licensed to provide such
174 services, in a facility under the direction and supervision of the department of mental health, in a
175 private mental hospital licensed by the department of mental health, or in a substance abuse
176 facility licensed by the department of public health. Intermediate services shall include, but not
177 be limited to, Level III community-based detoxification, acute residential treatment, partial
178 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
179 public health or the department of mental health. Outpatient services may be provided in a
180 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
181 health, a public community mental health center, a professional office, or home-based services,
182 provided, however, services delivered in such offices or settings are rendered by a licensed
183 mental health professional acting within the scope of his license. No policy subject to this section
184 shall contain a blanket exclusion of services that qualify as intermediate services for mental
185 disorders covered under this section, including but not limited to residential services. A carrier
186 subject to this section must ensure that its network, including the network of any entity that
187 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
188 services, contains a sufficient number of providers representing the range of services required by
189 this subsection so that an insured may obtain medically necessary services within a clinically
190 reasonable period of time.

191 SECTION 16. Section 1 of Chapter 176O, as appearing in the 2004 Official Edition, is
192 hereby amended by inserting after “Ambulatory review” the following definition: -- “Attending
193 health care professional”, a health care professional providing health care services to an insured
194 within the scope of said professional’s license, accreditation or certification.

195 SECTION 17. Section 1 of Chapter 176O, as so appearing, is hereby amended by
196 striking out the definition of “Second opinion” and replacing it with the following: -- “Second
197 opinion", an opportunity or requirement to obtain a clinical evaluation by a health care
198 professional other than the health care professional who made the original recommendation for a
199 proposed health service, to assess the clinical appropriateness of the initial proposed health
200 service.

201 SECTION 18. Section 1 of Chapter 176O, as so appearing, is hereby amended by
202 striking out the definition of “Utilization review” and replacing it with the following: --
203 "Utilization review", a set of formal techniques designed to evaluate the clinical appropriateness
204 or efficacy of health care services, procedures or settings. Such techniques may include, but are
205 not limited to, ambulatory review, prospective review, second opinion, certification, concurrent
206 review, case management, discharge planning or retrospective review.

207 SECTION 19. Subsection (h) of Section 2 of Chapter 176O, as so appearing, is hereby
208 amended by inserting after the second sentence the following: -- Satisfaction by a carrier of the
209 minimum standards for accreditation set forth in subsection (a) of this section shall not excuse a
210 carrier, or any entity with which the carrier contracts to perform functions governed by this
211 chapter, from fulfilling all other obligations set forth in this chapter.

212 SECTION 20. Subsection (a)(9) of Section 6 of Chapter 176O, as so appearing, is hereby
213 amended by striking out, in line 1, the word "summary" and by inserting after the word "carrier"
214 in line 1 the following: -- in sufficient detail that the average insured adult could reasonably be
215 expected to understand the impact of such programs on the scope of health care services to be
216 provided,

217 SECTION 21. Section 6 of Chapter 176O, as so appearing, is hereby amended by
218 inserting after subsection (a)(14) the following: -- (15) instructions on how to obtain additional
219 information on any of the areas required to be included in the evidence of coverage by this
220 subsection (a).

221 SECTION 22. Subsection (a)(15) of Section 6 of Chapter 176O, as so appearing, is
222 hereby amended by renumbering said subsection "(a)(16)".

223 SECTION 23. Subsection (a)(3) of Section 7 of Chapter 176O, as so appearing, is hereby
224 amended by striking out the word "summary" and by inserting after the word "developed" the
225 following: -- that is sufficiently detailed for the average adult insured to reasonably be expected
226 to understand the impact of said programs on the scope of health care services to be provided.

227 SECTION 24. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby
228 amended by inserting at the end of the first paragraph the following: -- The documentation of
229 utilization review required by this paragraph shall be made available, upon request, to an insured
230 and the attending health care professional.

231 SECTION 25. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby
232 amended by inserting after the first sentence of the second paragraph the following: -- To the
233 extent that another entity conducts utilization review for the carrier, the carrier shall be
234 responsible for said entity's full compliance with this section.

235 SECTION 26. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby
236 amended by inserting at the end of the second paragraph the following: -- A carrier or utilization
237 review organization shall apply utilization review criteria in a manner that permits an
238 individualized medical assessment based on specific medical data. To the extent that no
239 independent evidence-based standards exist for the use of a treatment in a specific case, the
240 carrier or utilization review organization shall not deny coverage on the basis that the treatment
241 does not meet an evidence-based standard.

242 SECTION 27. Subsection (b) of Section 12 of Chapter 176O, as so, is amended by
243 inserting after the second full sentence the following – A carrier or utilization review
244 organization shall not be deemed to have obtained all necessary information within the meaning
245 of this section if it has not made reasonable efforts to obtain all relevant clinical documentation
246 from the attending health care professional.

247 SECTION 28. Subsection (d) of Section 12 of Chapter 176O, as so appearing i, is hereby
248 stricken and replaced with the following: -- (d) The written notification of an adverse
249 determination shall be in clear, understandable language and shall include a substantive clinical
250 justification for said determination, which is consistent with generally accepted principles of
251 professional medical practice. The notification shall, at a minimum: (1) identify the specific
252 information and factual bases upon which the adverse determination was based; (2) discuss the
253 insured's presenting symptoms or condition, diagnosis and treatment interventions and the
254 specific reasons such medical evidence fails to meet the relevant medical review criteria; (3)
255 specify any alternative treatment option offered by the carrier, if any; (4) reference and include
256 applicable clinical practice guidelines and review criteria, including, but not limited to, internal
257 rules, guidelines, protocols and other similar criteria, relied upon in making the adverse
258 determination; (5) provide for the identification of medical experts whose advice was obtained
259 by the carrier or utilization review organization in connection with the benefit determination,
260 whether or not said advice was relied on in making the ultimate adverse determination; and (6)
261 include the name, contact information and qualifying credentials of the clinical reviewer or
262 reviewers that made the adverse determination. The notification must be sufficiently specific to
263 enable the insured and the attending health care professional to make an informed decision about
264 whether to appeal the adverse determination and to determine the issues to address in the appeal.
265 A notification shall not be in compliance with this subsection if it states only, in generalized
266 language, without identifying information and analysis specific to the insured's claim, that a
267 requested treatment is not medically necessary.

268 SECTION 29. Section 12 of Chapter 176O, as so appearing, is amended by inserting after
269 subsection (e) the following: – (f) A carrier or utilization review organization shall orally inform
270 the attending health care professional of all relevant utilization review requirements and of the
271 medical necessity criteria and guidelines to be used in making a claim determination. The carrier
272 or utilization review organization shall provide upon request and free of charge to the insured
273 and, if requested, to the attending health care professional, copies of all documents, records and
274 other information relevant to the claim. Relevant documents shall mean any documents
275 submitted, considered or generated in the course of making the determination, including any
276 statements of policy or guidance concerning the denied treatment for the insured's diagnosis,
277 whether or not such documents were relied upon in making the ultimate adverse determination.

278 SECTION 30. Section 13 of Chapter 176O, as so appearing, is amended by inserting after
279 subsection (c) the following: – (d) The internal grievance process provided by a carrier or
280 utilization review organization pursuant to this section shall provide for a review that does not

281 afford deference to the initial adverse benefit determination and that is conducted by an
282 independent clinical peer reviewer that is neither the individual who made the adverse benefit
283 determination that is the subject of the grievance nor the subordinate of such individual.

284 SECTION 31. Section 14 of Chapter 176O, as so appearing, is amended by striking out
285 subsection (a) and replacing it with the following:-- (a) (i) An insured who remains aggrieved by
286 an adverse determination and has exhausted all remedies available from the formal internal
287 grievance process required pursuant to section 13, may seek further review of the grievance by a
288 review panel established by the office of patient protection pursuant to paragraph (5) of
289 subsection (a) of section 217 of chapter 111. The insured shall pay the first $25 of the cost of the
290 review to said office which may waive the fee in cases of extreme financial hardship. The
291 commonwealth shall assess the carrier for the remainder of the cost of the review pursuant to
292 regulations promulgated by the commissioner of public health in consultation with the
293 commissioner of insurance.

294 (ii) The office of patient protection shall contract with at least three unrelated and
295 objective review agencies through a bidding process, and refer grievances to one of the review
296 agencies on a random selection basis. The review agencies shall develop review panels
297 appropriate for the given grievance, which shall include qualified clinical decision-makers
298 experienced in the determination of medical necessity, utilization management protocols and
299 grievance resolution, and shall not have any financial relationship with the carrier or utilization
300 review organization making the initial determination. A review panel shall include at least one
301 person who is in the same licensure category and has comparable expertise to the attending
302 health care professional with respect to the health care service that is the subject of the grievance.
303 With respect to an adverse determination that involves a mental health or substance abuse
304 service, the panel shall include at least one licensed physician who is board certified in the
305 relevant specialty to the treatment under review and who is either actively practicing in that
306 specialty or has demonstrated expertise in the particular treatment under review.

307 (iii) The standard for review of a grievance by a review panel shall be the determination
308 of whether the requested treatment or service is medically necessary, as defined herein, and a
309 covered benefit under the policy or contract. The panel shall consider, but not be limited to
310 considering: (i) written documents submitted by the insured, (ii) additional information from the
311 involved parties or outside sources that the review panel deems necessary or relevant, and (iii)
312 information obtained from any informal meeting held by the panel with the parties. Any
313 documents or information submitted by a party in support of its position shall be shared with the
314 other party or parties. The carrier or utilization review organization shall have the burden of
315 producing substantial, reliable evidence in support of the adverse determination and of
316 demonstrating that, in reaching said determination, it adequately considered the insured's
317 individual circumstances. A carrier or utilization review organization may not rely in a
318 proceeding before an independent review panel on any basis not stated in its final adverse
319 determination at the conclusion of internal review pursuant to section 13 of this chapter.

320 (iv) The review panel shall send final written disposition of the grievance, and the
321 reasons therefore, to the insured and the carrier within 60 days of receipt of the request for
322 review, unless the panel determines additional time is necessary to fully and fairly evaluate the
323 grievance and notifies the carrier and the insured of the decision to extend the review beyond 60
324 days.

325 (b) If a grievance is filed concerning the termination of ongoing coverage or treatment,
326 the disputed coverage or treatment shall remain in effect through completion of the formal
327 internal grievance process. Except when services were not initially authorized by the carrier or
328 are subject to termination based on a specific time or episode-related exclusion in the policy, the
329 external review panel shall order the continued provision of the health care services which are
330 the subject of the grievance during the course of said external review unless the carrier or
331 utilization review organization demonstrates that there will be no harm to the health of the
332 insured absent such continuation.

333 SECTION 32. Subsection (h) of Section 15 of Chapter 176O, as so appearing, is hereby
334 stricken and replaced with the following:--

335 (h) A carrier shall provide coverage of pediatric specialty care, including mental health
336 care, by persons with recognized expertise in specialty pediatrics to insured requiring such
337 services. A carrier shall be deemed not in compliance with this subsection if the carrier's
338 network lacks sufficient providers so that an insured must wait a clinically inappropriate period
339 of time to receive medically necessary health care services. A carrier may achieve compliance
340 with this subsection if it provides coverage for treatment by non-network providers when there
341 are insufficient numbers of network providers with appropriate expertise available to an insured
342 within a clinically reasonable period of time.

343 SECTION 33. Subsection (b) of Section 16 of Chapter 176O, as so appearing, is hereby
344 stricken and replaced with the following:--

345 (b) A carrier shall be required to pay for health care services ordered by a treating
346 physician if (1) the services are a covered benefit under the insured's health benefit plan; and (2)
347 the services are medically necessary. A carrier may develop guidelines to be used in applying the
348 standard of medical necessity, as defined herein. Any such medical necessity guidelines utilized
349 by a carrier in making coverage determinations shall be: (i) developed with input from practicing
350 physicians in the carrier's or utilization review organization's service area; (ii) developed in
351 accordance with the standards adopted by national accreditation organizations; (iii) updated at
352 least biennially or more often as new treatments, applications and technologies are adopted as
353 generally accepted professional medical practice; and (iv) evidence-based, if practicable.

354 In applying the medical necessity guidelines, a carrier shall consider the range of health
355 care services and treatments that fall within the professional standard of care for a particular
356 illness, injury or medical condition, in light of the individual health care needs of the insured. In

357 determining medical necessity, a carrier must determine the safety and efficacy of a requested
358 treatment independent of any consideration of cost. A carrier shall determine the effectiveness of
359 a requested treatment based on consideration of evidence in the following order, depending on
360 availability: 1) scientific evidence; 2) professional standards and 3) expert opinion. A carrier
361 shall give due deference to the opinions and recommendations of the attending health care
362 professional.