

HOUSE No. 936

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 bill:

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

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Kay Khan	11th Middlesex
Barbara A. L'Italien	18th Essex
William Smitty Pignatelli	4th Berkshire
Elizabeth A. Malia	11th Suffolk
Stephen R. Canessa	12th Bristol
John P. Fresolo	16th Worcester
Benjamin Swan	11th Hampden
Martha M. Walz	8th Suffolk
John W. Scibak	2nd Hampshire
Timothy J. Toomey, Jr.	26th Middlesex
Patricia D. Jehlen	Second Middlesex
Jennifer M. Callahan	18th Worcester
Steven J. D'Amico	4th Bristol
Susan C. Fargo	Third Middlesex
Kathi-Anne Reinstein	16th Suffolk

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 989 OF 2007-2008.]

The Commonwealth of Massachusetts

In the Year Two Thousand and Nine

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 amended
2 by striking out, in line 10, the words “and (10)” and inserting in place thereof the following:—
3 (10) eating disorders, and (11).

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

12 developed or applied to in a manner that unduly restricts coverage of medically necessary health
13 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 Official
15 Edition, is hereby stricken and replaced with the following:--

16 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate,
17 and outpatient services that shall permit medically necessary diagnosis and treatment of mental
18 disorders to take place in a clinically appropriate setting, as determined in accordance with
19 generally accepted principles of professional medical practice. For purposes of this section,
20 inpatient services may be provided in a general hospital licensed to provide such services, in a
21 facility under the direction and supervision of the department of mental health, in a private
22 mental hospital licensed by the department of mental health, or in a substance abuse facility
23 licensed by the department of public health. Intermediate services shall include, but not be
24 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 amended
39 by striking out, in line 16, the words “and (10)” and inserting in place thereof the following:—
40 (10) eating disorders, and (11).

41 SECTION 5. Subsection (d) of Section 47B of Chapter 175, as appearing in the 2004 Official
42 Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall be
43 deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain
44 any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and
45 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 Official
53 Edition, is hereby stricken and replaced with the following:--

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

56 disorders to take place in a clinically appropriate setting, as determined in accordance with
57 generally accepted principles of professional medical practice. For purposes of this section,
58 inpatient services may be provided in a general hospital licensed to provide such services, in a
59 facility under the direction and supervision of the department of mental health, in a private
60 mental hospital licensed by the department of mental health, or in a substance abuse facility
61 licensed by the department of public health. Intermediate services shall include, but not be
62 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 amended
77 by striking out, in line 13, the words “and (10)” and inserting in place thereof the following:--
78 “(10) eating disorders, and (11)”.

79 SECTION 8. Subsection (d) of Section 8A of Chapter 176A, as so appearing, is hereby stricken
80 and replaced with the following:-- Subsection (d) of Section 47B of Chapter 175, as appearing in
81 the 2004 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such
82 policy shall be deemed to be providing such benefits on a nondiscriminatory basis if the policy
83 does not contain any annual or lifetime dollar or unit of service limitation on coverage for the
84 diagnosis and treatment of said mental disorders which is less than any annual or lifetime dollar
85 or unit of service limitation imposed on coverage for the diagnosis and treatment of physical
86 conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with
87 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 subsection (g) of
92 Section 8A, as so appearing, and inserting in place thereof the following section:--

93 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate,
94 and outpatient services that shall permit medically necessary diagnosis and treatment of mental
95 disorders to take place in a clinically appropriate setting, as determined in accordance with
96 generally accepted principles of professional medical practice. For purposes of this section,
97 inpatient services may be provided in a general hospital licensed to provide such services, in a
98 facility under the direction and supervision of the department of mental health, in a private
99 mental hospital licensed by the department of mental health, or in a substance abuse facility
100 licensed by the department of public health. Intermediate services shall include, but not be
101 limited to, Level III community-based detoxification, acute residential treatment, partial

102 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
103 public health or the department of mental health. Outpatient services may be provided in a
104 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
105 health, a public community mental health center, a professional office, or home-based services,
106 provided, however, services delivered in such offices or settings are rendered by a licensed
107 mental health professional acting within the scope of his license. No policy subject to this section
108 shall contain a blanket exclusion of services that qualify as intermediate services for mental
109 disorders covered under this section, including but not limited to residential services. A carrier
110 subject to this section must ensure that its network, including the network of any entity that
111 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
112 services, contains a sufficient number of providers representing the range of services required by
113 this subsection so that an insured may obtain medically necessary services within a clinically
114 reasonable period of time.

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

118 SECTION 11. Subsection (d) of Section 4A of Chapter 176B, as appearing in the 2004 Official
119 Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall be
120 deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain
121 any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and
122 treatment of said mental disorders which is less than any annual or lifetime dollar or unit of
123 service limitation imposed on coverage for the diagnosis and treatment of physical conditions.

124 Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if
125 utilization review criteria and guidelines for application of medical necessity standards for
126 diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly
127 restricts coverage of medically necessary health care services as determined by the commissioner
128 of insurance.

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

131 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate,
132 and outpatient services that shall permit medically necessary diagnosis and treatment of mental
133 disorders to take place in a clinically appropriate setting, as determined in accordance with
134 generally accepted principles of professional medical practice. For purposes of this section,
135 inpatient services may be provided in a general hospital licensed to provide such services, in a
136 facility under the direction and supervision of the department of mental health, in a private
137 mental hospital licensed by the department of mental health, or in a substance abuse facility
138 licensed by the department of public health. Intermediate services shall include, but not be
139 limited to, Level III community-based detoxification, acute residential treatment, partial
140 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
141 public health or the department of mental health. Outpatient services may be provided in a
142 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
143 health, a public community mental health center, a professional office, or home-based services,
144 provided, however, services delivered in such offices or settings are rendered by a licensed
145 mental health professional acting within the scope of his license. No policy subject to this section
146 shall contain a blanket exclusion of services that qualify as intermediate services for mental

147 disorders covered under this section, including but not limited to residential services. A carrier
148 subject to this section must ensure that its network, including the network of any entity that
149 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
150 services, contains a sufficient number of providers representing the range of services required by
151 this subsection so that an insured may obtain medically necessary services within a clinically
152 reasonable period of time.

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

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

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

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

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

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

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

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

210 SECTION 20. Subsection (a)(9) of Section 6 of Chapter 176O, as so appearing, is hereby
211 amended by striking out, in line 1, the word “summary” and by inserting after the word “carrier”

212 in line 1 the following: -- in sufficient detail that the average insured adult could reasonably be
213 expected to understand the impact of such programs on the scope of health care services to be
214 provided,

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

218 SECTION 22. Subsection (a)(15) of Section 6 of Chapter 176O, as so appearing, is hereby
219 amended by renumbering said subsection “(a)(16)”.

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

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

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

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

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

244 SECTION 28. Subsection (d) of Section 12 of Chapter 176O, as so appearing i, is hereby
245 stricken and replaced with the following: -- (d) The written notification of an adverse
246 determination shall be in clear, understandable language and shall include a substantive clinical
247 justification for said determination, which is consistent with generally accepted principles of
248 professional medical practice. The notification shall, at a minimum: (1) identify the specific
249 information and factual bases upon which the adverse determination was based; (2) discuss the
250 insured's presenting symptoms or condition, diagnosis and treatment interventions and the
251 specific reasons such medical evidence fails to meet the relevant medical review criteria; (3)
252 specify any alternative treatment option offered by the carrier, if any; (4) reference and include
253 applicable clinical practice guidelines and review criteria, including, but not limited to, internal
254 rules, guidelines, protocols and other similar criteria, relied upon in making the adverse

255 determination; (5) provide for the identification of medical experts whose advice was obtained
256 by the carrier or utilization review organization in connection with the benefit determination,
257 whether or not said advice was relied on in making the ultimate adverse determination; and (6)
258 include the name, contact information and qualifying credentials of the clinical reviewer or
259 reviewers that made the adverse determination. The notification must be sufficiently specific to
260 enable the insured and the attending health care professional to make an informed decision about
261 whether to appeal the adverse determination and to determine the issues to address in the appeal.
262 A notification shall not be in compliance with this subsection if it states only, in generalized
263 language, without identifying information and analysis specific to the insured's claim, that a
264 requested treatment is not medically necessary.

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

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

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

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

291 (ii) The office of patient protection shall contract with at least three unrelated and objective
292 review agencies through a bidding process, and refer grievances to one of the review agencies on
293 a random selection basis. The review agencies shall develop review panels appropriate for the
294 given grievance, which shall include qualified clinical decision-makers experienced in the
295 determination of medical necessity, utilization management protocols and grievance resolution,
296 and shall not have any financial relationship with the carrier or utilization review organization
297 making the initial determination. A review panel shall include at least one person who is in the
298 same licensure category and has comparable expertise to the attending health care professional
299 with respect to the health care service that is the subject of the grievance. With respect to an

300 adverse determination that involves a mental health or substance abuse service, the panel shall
301 include at least one licensed physician who is board certified in the relevant specialty to the
302 treatment under review and who is either actively practicing in that specialty or has demonstrated
303 expertise in the particular treatment under review.

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

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

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

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

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

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

341 (b) A carrier shall be required to pay for health care services ordered by a treating physician if
342 (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services

343 are medically necessary. A carrier may develop guidelines to be used in applying the standard of
344 medical necessity, as defined herein. Any such medical necessity guidelines utilized by a carrier
345 in making coverage determinations shall be: (i) developed with input from practicing physicians
346 in the carrier's or utilization review organization's service area; (ii) developed in accordance
347 with the standards adopted by national accreditation organizations; (iii) updated at least
348 biennially or more often as new treatments, applications and technologies are adopted as
349 generally accepted professional medical practice; and (iv) evidence-based, if practicable.

350 In applying the medical necessity guidelines, a carrier shall consider the range of health care
351 services and treatments that fall within the professional standard of care for a particular illness,
352 injury or medical condition, in light of the individual health care needs of the insured. In
353 determining medical necessity, a carrier must determine the safety and efficacy of a requested
354 treatment independent of any consideration of cost. A carrier shall determine the effectiveness of
355 a requested treatment based on consideration of evidence in the following order, depending on
356 availability: 1) scientific evidence; 2) professional standards and 3) expert opinion. A carrier
357 shall give due deference to the opinions and recommendations of the attending health care
358 professional.