

**HOUSE . . . . . No. 01187**

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

# HOUSE . . . . . No. 01187

By Ms. Kay Khan of Newton, petition (accompanied by bill, House, No. 01187) of William "Smitty" Pignatelli and others relative to requiring that certain health insurance policies include coverage for eating disorders. Joint Committee on Financial Services.

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

## The Commonwealth of Massachusetts

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**In the Year Two Thousand Eleven**  
\_\_\_\_\_

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  
40 following:—(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.