

HOUSE No. 937

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 adoption of the accompanying bill:

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

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Kay Khan</i>	<i>11th Middlesex</i>
<i>Marcos A. Devers</i>	<i>16th Essex</i>
<i>Ann-Margaret Ferrante</i>	<i>5th Essex</i>
<i>Elizabeth A. Malia</i>	<i>11th Suffolk</i>
<i>William Smitty Pignatelli</i>	<i>4th Berkshire</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>
<i>Bruce E. Tarr</i>	<i>First Essex and Middlesex</i>
<i>Timothy J. Toomey, Jr.</i>	<i>26th Middlesex</i>

HOUSE No. 937

By Ms. Khan of Newton, a petition (accompanied by bill, House, No. 937) 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. 1187 OF 2011-2012.]

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

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

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

11 SECTION 2. Subsection (g) of Section 22 of Chapter 32A, as appearing in the 2004
12 Official Edition, is hereby stricken and replaced with the following:--

13 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
14 intermediate, and outpatient services that shall permit medically necessary diagnosis and
15 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
16 accordance with generally accepted principles of professional medical practice. For purposes of
17 this section, inpatient services may be provided in a general hospital licensed to provide such

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

35 SECTION 3. Subsection (d) of Section 47B of Chapter 175, as appearing in the 2004
36 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall
37 be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not
38 contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis
39 and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of
40 service limitation imposed on coverage for the diagnosis and treatment of physical conditions.
41 Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if
42 utilization review criteria and guidelines for application of medical necessity standards for
43 diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly
44 restricts coverage of medically necessary health care services as determined by the commissioner
45 of insurance.

46 SECTION 4. Subsection (g) of Section 47B of Chapter 175, as appearing in the 2004
47 Official Edition, is hereby stricken and replaced with the following:--

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

57 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
58 public health or the department of mental health. Outpatient services may be provided in a
59 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
60 health, a public community mental health center, a professional office, or home-based services,
61 provided, however, services delivered in such offices or settings are rendered by a licensed
62 mental health professional acting within the scope of his license. No policy subject to this section
63 shall contain a blanket exclusion of services that qualify as intermediate services for mental
64 disorders covered under this section, including but not limited to residential services. A carrier
65 subject to this section must ensure that its network, including the network of any entity that
66 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
67 services, contains a sufficient number of providers representing the range of services required by
68 this subsection so that an insured may obtain medically necessary services within a clinically
69 reasonable period of time.

70 SECTION 5. Subsection (d) of Section 8A of Chapter 176A, as so appearing, is hereby
71 stricken and replaced with the following:-- Subsection (d) of Section 47B of Chapter 175, as
72 appearing in the 2004 Official Edition, is hereby stricken and replaced with the following:-- (d)
73 Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if
74 the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage
75 for the diagnosis and treatment of said mental disorders which is less than any annual or lifetime
76 dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of
77 physical conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant
78 with this section if utilization review criteria and guidelines for application of medical necessity
79 standards for diagnosis and treatment of mental disorders are developed or applied to in a
80 manner that unduly restricts coverage of medically necessary health care services as determined
81 by the commissioner of insurance.

82 SECTION 6. Chapter 176A, as so appearing, is hereby amended by striking out
83 subsection (g) of Section 8A, as so appearing, and inserting in place thereof the following
84 section:--

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

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

107 SECTION 7. Subsection (d) of Section 4A of Chapter 176B, as appearing in the 2004
108 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall
109 be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not
110 contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis
111 and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of
112 service limitation imposed on coverage for the diagnosis and treatment of physical conditions.
113 Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if
114 utilization review criteria and guidelines for application of medical necessity standards for
115 diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly
116 restricts coverage of medically necessary health care services as determined by the commissioner
117 of insurance.

118 SECTION 8. Subsection (g) of Section 4A of Chapter 176B, as so appearing, is hereby
119 stricken and replaced with the following:--

120 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
121 intermediate, and outpatient services that shall permit medically necessary diagnosis and
122 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
123 accordance with generally accepted principles of professional medical practice. For purposes of
124 this section, inpatient services may be provided in a general hospital licensed to provide such
125 services, in a facility under the direction and supervision of the department of mental health, in a
126 private mental hospital licensed by the department of mental health, or in a substance abuse
127 facility licensed by the department of public health. Intermediate services shall include, but not
128 be limited to, Level III community-based detoxification, acute residential treatment, partial
129 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
130 public health or the department of mental health. Outpatient services may be provided in a
131 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
132 health, a public community mental health center, a professional office, or home-based services,
133 provided, however, services delivered in such offices or settings are rendered by a licensed
134 mental health professional acting within the scope of his license. No policy subject to this section

135 shall contain a blanket exclusion of services that qualify as intermediate services for mental
136 disorders covered under this section, including but not limited to residential services. A carrier
137 subject to this section must ensure that its network, including the network of any entity that
138 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
139 services, contains a sufficient number of providers representing the range of services required by
140 this subsection so that an insured may obtain medically necessary services within a clinically
141 reasonable period of time.

142 SECTION 9. Subsection (d) of Section 4M of Chapter 176G, as so appearing, is hereby
143 stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing
144 such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime
145 dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental
146 disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on
147 coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing,
148 a carrier will be deemed to be non-compliant with this section if utilization review criteria and
149 guidelines for application of medical necessity standards for diagnosis and treatment of mental
150 disorders are developed or applied to in a manner that unduly restricts coverage of medically
151 necessary health care services as determined by the commissioner of insurance.

152 SECTION 10. Subsection (g) of Section 4M of Chapter 176G, as so appearing, is hereby
153 stricken and replaced with the following:--

154 (g) Benefits authorized pursuant to this section shall consist of a range of inpatient,
155 intermediate, and outpatient services that shall permit medically necessary diagnosis and
156 treatment of mental disorders to take place in a clinically appropriate setting, as determined in
157 accordance with generally accepted principles of professional medical practice. For purposes of
158 this section, inpatient services may be provided in a general hospital licensed to provide such
159 services, in a facility under the direction and supervision of the department of mental health, in a
160 private mental hospital licensed by the department of mental health, or in a substance abuse
161 facility licensed by the department of public health. Intermediate services shall include, but not
162 be limited to, Level III community-based detoxification, acute residential treatment, partial
163 hospitalization, day treatment and crisis stabilization licensed or approved by the department of
164 public health or the department of mental health. Outpatient services may be provided in a
165 licensed hospital, a mental health or substance abuse clinic licensed by the department of public
166 health, a public community mental health center, a professional office, or home-based services,
167 provided, however, services delivered in such offices or settings are rendered by a licensed
168 mental health professional acting within the scope of his license. No policy subject to this section
169 shall contain a blanket exclusion of services that qualify as intermediate services for mental
170 disorders covered under this section, including but not limited to residential services. A carrier
171 subject to this section must ensure that its network, including the network of any entity that
172 contracts with the carrier for the provision of mental health, behavioral health or substance abuse
173 services, contains a sufficient number of providers representing the range of services required by

174 this subsection so that an insured may obtain medically necessary services within a clinically
175 reasonable period of time.

176 SECTION 11. Section 1 of Chapter 176O, as appearing in the 2004 Official Edition, is
177 hereby amended by inserting after “Ambulatory review” the following definition: -- “Attending
178 health care professional”, a health care professional providing health care services to an insured
179 within the scope of said professional’s license, accreditation or certification.

180 SECTION 12. Section 1 of Chapter 176O, as so appearing, is hereby amended by
181 striking out the definition of “Second opinion” and replacing it with the following: -- “Second
182 opinion”, an opportunity or requirement to obtain a clinical evaluation by a health care
183 professional other than the health care professional who made the original recommendation for a
184 proposed health service, to assess the clinical appropriateness of the initial proposed health
185 service.

186 SECTION 13. Section 1 of Chapter 176O, as so appearing, is hereby amended by
187 striking out the definition of “Utilization review” and replacing it with the following: --
188 "Utilization review", a set of formal techniques designed to evaluate the clinical appropriateness
189 or efficacy of health care services, procedures or settings. Such techniques may include, but are
190 not limited to, ambulatory review, prospective review, second opinion, certification, concurrent
191 review, case management, discharge planning or retrospective review.

192 SECTION 14. Subsection (h) of Section 2 of Chapter 176O, as so appearing, is hereby
193 amended by inserting after the second sentence the following: -- Satisfaction by a carrier of the
194 minimum standards for accreditation set forth in subsection (a) of this section shall not excuse a
195 carrier, or any entity with which the carrier contracts to perform functions governed by this
196 chapter, from fulfilling all other obligations set forth in this chapter.

197 SECTION 15. Subsection (a)(9) of Section 6 of Chapter 176O, as so appearing, is hereby
198 amended by striking out, in line 1, the word “summary” and by inserting after the word “carrier”
199 in line 1 the following: -- in sufficient detail that the average insured adult could reasonably be
200 expected to understand the impact of such programs on the scope of health care services to be
201 provided,

202 SECTION 16. Section 6 of Chapter 176O, as so appearing, is hereby amended by
203 inserting after subsection (a)(14) the following: -- (15) instructions on how to obtain additional
204 information on any of the areas required to be included in the evidence of coverage by this
205 subsection (a).

206 SECTION 17. Subsection (a)(15) of Section 6 of Chapter 176O, as so appearing, is
207 hereby amended by renumbering said subsection “(a)(16)”.

208 SECTION 18. Subsection (a)(3) of Section 7 of Chapter 176O, as so appearing, is hereby
209 amended by striking out the word “summary” and by inserting after the word “developed” the
210 following: -- that is sufficiently detailed for the average adult insured to reasonably be expected
211 to understand the impact of said programs on the scope of health care services to be provided.

212 SECTION 19. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby
213 amended by inserting at the end of the first paragraph the following: -- The documentation of
214 utilization review required by this paragraph shall be made available, upon request, to an insured
215 and the attending health care professional.

216 SECTION 20. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby
217 amended by inserting after the first sentence of the second paragraph the following: -- To the
218 extent that another entity conducts utilization review for the carrier, the carrier shall be
219 responsible for said entity’s full compliance with this section.

220 SECTION 21. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby
221 amended by inserting at the end of the second paragraph the following: -- A carrier or utilization
222 review organization shall apply utilization review criteria in a manner that permits an
223 individualized medical assessment based on specific medical data. To the extent that no
224 independent evidence-based standards exist for the use of a treatment in a specific case, the
225 carrier or utilization review organization shall not deny coverage on the basis that the treatment
226 does not meet an evidence-based standard.

227 SECTION 22. Subsection (b) of Section 12 of Chapter 176O, as so, is amended by
228 inserting after the second full sentence the following – A carrier or utilization review
229 organization shall not be deemed to have obtained all necessary information within the meaning
230 of this section if it has not made reasonable efforts to obtain all relevant clinical documentation
231 from the attending health care professional.

232 SECTION 23. Subsection (d) of Section 12 of Chapter 176O, as so appearing i, is hereby
233 stricken and replaced with the following: -- (d) The written notification of an adverse
234 determination shall be in clear, understandable language and shall include a substantive clinical
235 justification for said determination, which is consistent with generally accepted principles of
236 professional medical practice. The notification shall, at a minimum: (1) identify the specific
237 information and factual bases upon which the adverse determination was based; (2) discuss the
238 insured’s presenting symptoms or condition, diagnosis and treatment interventions and the
239 specific reasons such medical evidence fails to meet the relevant medical review criteria; (3)
240 specify any alternative treatment option offered by the carrier, if any; (4) reference and include
241 applicable clinical practice guidelines and review criteria, including, but not limited to, internal
242 rules, guidelines, protocols and other similar criteria, relied upon in making the adverse
243 determination; (5) provide for the identification of medical experts whose advice was obtained
244 by the carrier or utilization review organization in connection with the benefit determination,

245 whether or not said advice was relied on in making the ultimate adverse determination; and (6)
246 include the name, contact information and qualifying credentials of the clinical reviewer or
247 reviewers that made the adverse determination. The notification must be sufficiently specific to
248 enable the insured and the attending health care professional to make an informed decision about
249 whether to appeal the adverse determination and to determine the issues to address in the appeal.
250 A notification shall not be in compliance with this subsection if it states only, in generalized
251 language, without identifying information and analysis specific to the insured's claim, that a
252 requested treatment is not medically necessary.

253 SECTION 24. Section 12 of Chapter 176O, as so appearing, is amended by inserting after
254 subsection (e) the following: – (f) A carrier or utilization review organization shall orally inform
255 the attending health care professional of all relevant utilization review requirements and of the
256 medical necessity criteria and guidelines to be used in making a claim determination. The carrier
257 or utilization review organization shall provide upon request and free of charge to the insured
258 and, if requested, to the attending health care professional, copies of all documents, records and
259 other information relevant to the claim. Relevant documents shall mean any documents
260 submitted, considered or generated in the course of making the determination, including any
261 statements of policy or guidance concerning the denied treatment for the insured's diagnosis,
262 whether or not such documents were relied upon in making the ultimate adverse determination.

263 SECTION 25. Section 13 of Chapter 176O, as so appearing, is amended by inserting after
264 subsection (c) the following: – (d) The internal grievance process provided by a carrier or
265 utilization review organization pursuant to this section shall provide for a review that does not
266 afford deference to the initial adverse benefit determination and that is conducted by an
267 independent clinical peer reviewer that is neither the individual who made the adverse benefit
268 determination that is the subject of the grievance nor the subordinate of such individual.

269 SECTION 26. Section 14 of Chapter 176O, as so appearing, is amended by striking out
270 subsection (a) and replacing it with the following:-- (a) (i) An insured who remains aggrieved by
271 an adverse determination and has exhausted all remedies available from the formal internal
272 grievance process required pursuant to section 13, may seek further review of the grievance by a
273 review panel established by the office of patient protection pursuant to paragraph (5) of
274 subsection (a) of section 217 of chapter 111. The insured shall pay the first \$25 of the cost of the
275 review to said office which may waive the fee in cases of extreme financial hardship. The
276 commonwealth shall assess the carrier for the remainder of the cost of the review pursuant to
277 regulations promulgated by the commissioner of public health in consultation with the
278 commissioner of insurance.

279 (ii) The office of patient protection shall contract with at least three unrelated and
280 objective review agencies through a bidding process, and refer grievances to one of the review
281 agencies on a random selection basis. The review agencies shall develop review panels
282 appropriate for the given grievance, which shall include qualified clinical decision-makers

283 experienced in the determination of medical necessity, utilization management protocols and
284 grievance resolution, and shall not have any financial relationship with the carrier or utilization
285 review organization making the initial determination. A review panel shall include at least one
286 person who is in the same licensure category and has comparable expertise to the attending
287 health care professional with respect to the health care service that is the subject of the grievance.
288 With respect to an adverse determination that involves a mental health or substance abuse
289 service, the panel shall include at least one licensed physician who is board certified in the
290 relevant specialty to the treatment under review and who is either actively practicing in that
291 specialty or has demonstrated expertise in the particular treatment under review.

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

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

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

318 SECTION 27. Subsection (h) of Section 15 of Chapter 176O, as so appearing, is hereby
319 stricken and replaced with the following:--

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

328 SECTION 28. Subsection (b) of Section 16 of Chapter 176O, as so appearing, is hereby
329 stricken and replaced with the following:--

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

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