DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

UTILIZATION REVIEW

Filed with the secretary of state on

These rules take effect immediately upon filing with the secretary of state unless adopted under section 33, 44, or 45a(6) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of state.

(By authority conferred on the director of insurance and financial services by section 3157a of the insurance code of 1956, 1956 PA 218, 500.3157a, and Executive Reorganization Order No. 2013-1, MCL 550.991)

R 500.61, R 500.62, R 500.63, R 500.64, R 500.65, R 500.66, R 500.67, R 500.68, and R 500.69 are added to the Michigan Administrative Code as follows:

PART 1. GENERAL

R 500.61 Definitions.

Rule 61. As used in these rules:

(a) "Act" means the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(b) "Association" means the association created under section 3104 of the act.

(c) "Department" means the department of insurance and financial services.

(d) "Director" means the director of the department.

(e) "Facility" means an entity licensed by the state pursuant to the public health code, 1978 PA 368, MCL 333.1101 to 333.25211. The office of an individual practitioner is not considered a facility.

(f) "Injured person" means a person who has suffered an accidental bodily injury covered by personal protection insurance provided under chapter 31 or 31A of the act, MCL 500.3101 to 500.3179 or MCL 500.3181 to 500.3189.

(g) "Insurer" means that term as defined in section 106 of the act, MCL 500.106.

(h) "Managed care option" means that term as defined in section 3181 of the act, MCL 500.3181.

(i) "Medically accepted standards" means the most appropriate practice guidelines for the treatment, training, products, services and accommodations provided to an injured person. These practice guidelines may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(j) "Personal protection insurance" means benefits provided under section 3107(1)(a) of the act, MCL 500.3107(1)(a).

(k) "Practitioner" means an individual who is licensed, registered, or certified as used in the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(l) "Provider" means a physician, hospital, clinic, or other person providing treatment, training, products, services, and accommodations to an injured person.

(m) "Utilization review" has the same meaning as in section 3157a(6) of the act, MCL 500.3157a(6).

R 500.62 Scope and applicability.

Rule 62. (1) These rules do all of the following:

(a) Establish criteria and standards for utilization review that identify utilization of treatment, training, products, services, and accommodations provided to an injured person for the injured person's care, recovery, or rehabilitation as required under section 3107(1)(a) of the act, MCL 500.3107(1)(a), above the usual range of utilization, based on medically accepted standards.

(b) Establish procedures for all of the following:

(i) Acquisition of necessary records, medical bills, and other information concerning the treatment, training, products, services, and accommodations provided to an injured person.

(ii) For an insurer and for the association to request an explanation for, and requiring a provider to explain, the reasonable necessity or indication for treatment, training, products, services, and accommodations provided to an injured person.

(iii) Provider appeals to the department from an insurer's or the association's determination that the provider overutilized or otherwise rendered or ordered inappropriate treatment, training, products, services, and accommodations, or that the cost of the treatment, training, products, services, and accommodations was inappropriate under chapter 31 of the act, MCL 500.3101 to 500.3179, and rules promulgated thereunder.

(c) These rules apply to treatment, training, products, services, and accommodations provided after July 1, 2020, to an injured person who is insured under a policy of no-fault automobile insurance issued under chapter 31 or chapter 31A of the act, MCL 500.3101 to 500.3179 or MCL 500.3181 to 500.3189.

(d) These rules apply to all insurers providing personal protection insurance under chapter 31 of the act, MCL 500.3101 to 500.3179 or under chapter 31A of the act, MCL 500.3181 to 500.3189, and to the catastrophic claims association created under section 3104 of the act, MCL 500.3104. Nothing in these rules should be construed to limit the ability of insurers and the catastrophic claims association to contract with a medical review organization to perform utilization review activities on their behalf. An insurer that uses a medical review organization remains responsible for complying with the act and any rules promulgated thereunder.

PART 2. REQUESTS FOR EXPLANATION AND RECORD RETENTION

R 500.63. Requests for explanation.

Rule 63. (1) If a provider provides treatment, training, products, services, or accommodations to an injured person that are not usually associated with, are longer in duration than, are more frequent than, or extend over a greater number of days than the treatment, training, products, services, or accommodations usually required for the diagnosis

or condition for which the injured person is being treated, the insurer or the association may request that the provider explain the necessity or indication for the treatment, training, products, services, or accommodations in writing. An insurer or the association may request that the provider include in its written explanation medical records, bills, and other information concerning the treatment, training, products, services, or accommodations.

(2) If an insurer or the association requests a provider to provide a written explanation under this rule, the request must be submitted to the provider within 30 days of the insurer's or association's receipt of the bill related to the treatment, training, products, services, or accommodations.

(3) A provider that receives a request for a written explanation from an insurer or the association must respond within 30 days of receipt of the insurer's or association's request.

(4) If an insurer's or the association's request for records under subrule (1) requires the provider to provide medical records, bills, or other information in excess of that which customarily accompany a bill submitted to the insurer or the association, the insurer or the association must reimburse the provider at a reasonable and customary fee, plus the actual costs of copying and mailing, within 30 days of the insurer's or association's request.

PART 3. INSURER AND ASSOCIATION DETERMINATIONS AND PROVIDER APPEALS

R 500.64 Determinations by an insurer or the association.

Rule 64. (1) If, after reviewing a provider's written explanation provided under part 2 of these rules, an insurer or the association determines that a provider overutilized or otherwise rendered or ordered inappropriate treatment, training, products, services, or accommodations, or that the cost of the treatment, training, products, services, or accommodations was inappropriate under chapter 31 of the act, MCL 500.3101 to 500.3179, the insurer or the association must issue a written notice of the determination to a provider within 30 days of receipt of the provider's written explanation. The notice must include all of the following:

(a) The criteria or standards on which the insurer relied in making its determination, with specific reference to the insurer's utilization review program.

(b) The amount of payment to the provider that has been made as a result of the determination, including an explanation for the difference between that amount and the amount billed by the provider.

(c) If applicable, a description of any additional records the provider must submit to the insurer in order for the insurer or the association to reconsider its determination.

(d) A copy of the form referenced in R 500.65(1).

(e) The date of the determination.

(2) The association's determination may be used by an insurer as the criteria or standards identified in an insurer's written notice described in R 500.64(1).

(3) An insurer's or the association's denial of a provider's bill on the basis that the provider overutilized or otherwise rendered or ordered inappropriate treatment, training, products, services, or accommodations, or that the cost of the treatment, training, products, services, or accommodations was inappropriate under chapter 31 of the act, MCL 500.3101 to 500.3179, is a determination from which a provider may appeal to the department under R 500.65,

regardless of whether the insurer has requested a written explanation from the provider under this rule.

R 500.65 Appeals to the department.

Rule 65. (1) A provider may appeal a determination made by an insurer or the association. The appeal must be filed within 90 days of the date of the disputed determination and must be made on a form prescribed by the department.

(2) Within 14 days of receipt of a provider appeal, the department shall notify the insurer or the association and the injured person of the appeal and request any additional information necessary to review the appeal.

(3) An insurer or the association may file a reply to a provider's appeal no later than 21 days after the date of the notice provided under subrule (2) of this rule.

(4) The director shall base his or her decision upon written materials submitted by the parties. Failure of any party to supply any information in a timely manner shall result in a decision based upon information available to the director at the time of the decision.

(5) The director shall issue a decision within 28 days after the insurer or the association files a reply to a provider's appeal or, if a reply is not filed, within 28 days after the time for filing a reply has expired. The director may, upon written notice to the insurer or the association and the provider, take an additional 28 days to issue a decision under this rule.

(6) If a provider appeals a determination made by an insurer and the department issues a decision that the provider is entitled to payment, the provider is entitled to interest on any overdue payments as set forth in section 3142 of the act, MCL 500.3142.

(7) A decision issued by the department under these rules is subject to judicial review as provided in section 244(1) of the act, MCL 500.244(1).

PART 4. INSURER UTILIZATION REVIEW PROGRAM

R 500.66 Required components of an insurer's utilization review program.

Rule 66. (1) Within 60 days of the effective date of these rules, insurers must have in place a utilization review program to review records and bills for treatment, training, products, services, and accommodations provided to an injured person that is above the usual range of utilization based on medically accepted standards.

(2) The utilization review program must do all of the following:

(a) Provide for bill review, including whether provider charges for treatment, training, products, services, and accommodations comply with chapter 31 of the act, MCL 500.3101 to 500.3179, and rules promulgated thereunder.

(b) Make determinations regarding the appropriateness of treatment, training, products, services, and accommodations based on medically accepted standards.

(c) Issue determinations under R 500.64.

(3) Insurers must submit information regarding their utilization review program to the director annually on a form prescribed by the department.

(4) No later than 90 days after the submission of the information required under R 500.66(3), the director shall issue a certification of the insurer's utilization review program.

Certification shall be either unconditional or conditional. The director may extend the time for review by an additional 30 days upon written notice to the insurer.

(5) The director may issue unconditional certification for a period of 3 years.

(6) The director may issue conditional certification if it determines that the insurer or other entity does not substantially satisfy the criteria in R 500.66(2). If the insurer agrees to undertake corrective action, then conditional certification shall be granted by the department for a maximum period of 1 year.

(7) The director may at any time modify an unconditional certification to a conditional certification if the director determines that an insurer has failed to comply with any of these rules. The director shall provide written notice to the insurer in the event of such a modification. The unconditional certification shall be reinstated upon satisfactory completion of a corrective action plan developed by the insurer and approved by the director.

(8) The director may revoke a certification upon a finding that an insurer has failed to comply with any of the rules and has failed to satisfactorily complete a corrective action plan. The director shall provide written notice to an insurer upon revocation.

R 500.67 Renewal of certification.

Rule 67. An insurer must apply for renewal of its certification on a form prescribed by the department. The application must be submitted no less than 90 days prior to the expiration of the insurer's current certification.

PART 5. ANNUAL REPORT AND RECORD RETENTION

R 500.68 Annual report.

Rule 68. (1) No later than March 31 of each year, each insurer shall submit a report on a form prescribed by the department regarding utilization review data and activities. The department shall provide instruction to insurers regarding completion of the report.

(2) The annual report is subject to disclosure under the freedom of information act, MCL 15.231 et seq.

R 500.69 Record retention.

Rule 69. Insurers, the association, and providers must retain copies of all requests, explanations, and determinations issued under these rules for at least two years after the date of the request, explanation, or written notice, and must submit them to the department upon request.