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, R 500.69, and R 500.70 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. A reference to "insurer" in these rules includes the association.

(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) "Medical care" means 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).

(j) "Medically accepted standards" means standards or criteria that are set by a competent authority as the rule for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place.

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

(l) "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.

(m) “Provider” means a physician, hospital, clinic, or other person providing medical care to an injured person.

(n) “Utilization review” has the same meaning as in section 3157a(6) of the act, MCL 500.3157(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 medical care provided to an insured person 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 medical care provided to an injured person.

(ii) Procedures for an insurer to request an explanation for, and requiring a provider to explain, the necessity or indication for medical care provided to an injured person.

(iii) Provider appeals to the department from an insurer’s determination that the provider overutilized or otherwise rendered or ordered inappropriate medical care, or that the cost of the medical care was inappropriate under chapter 31 or chapter 31A of the act, MCL 500.3101 to 500.3179 or MCL 500.3181 to 500.3189, and rules promulgated thereunder.

(c) These rules apply to medical care 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.

PART 2. RECORD ACQUISITION AND REQUESTS FOR EXPLANATION

R 500.63. General record acquisition.

Rule 63. (1) An insurer may request from a provider necessary records, medical bills, and other information concerning the medical care provider too an injured person.

(2) If an insurer’s request for records under subrule (1) requires the provider to provide medical records in excess of those that accompany an invoice submitted to the insurer, the insurer must reimburse the provider at the provider’s average hourly rate.

R 500.64 Insurer requests for explanation.

Rule 64. (1) An insurer may request from a provider a written explanation regarding the necessary or indication for medical care provided to an injured person.

(2) A provider that receives a request for a written explanation from an insurer must respond within 60 days.

(3) The insurer must reimburse the provider who provides the report at the provider’s average hourly rate.

(4) Insurers and providers must retain copies of all requests and explanations and submit them to the department in the event of a provider appeal under part 3 of these rules.

PART 3. INSURER DETERMINATIONS AND PROVIDER APPEALS

R 500.65 Determinations by an insurer.

Rule 65. (1) An insurer that determines that a provider overutilized or otherwise rendered or ordered inappropriate medical care, or that the cost of the medical care was inappropriate under chapter 31 or chapter 31A of the act, MCL 500.3101 to 500.3179 or MCL 500.3181 to 500.3189, must issue a written notice of the determination to a provider. The notice must include all of the following:

(a) The criteria or standards on which the insurer relied in making its determination.

(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 invoiced by the provider.

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

(d) A copy of the form referenced in R 500.66(1).

(e) The date of the determination.

R 500.66 Appeals to the department.

Rule 66. (1) A provider may appeal a determination made by an insurer made under R 500.65 on a form prescribed by the department. The appeal must be filed within 90 days of the date of the disputed determination.

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

(3) An insurer 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 determination within 28 days after the insurer 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 and the provider, take an additional 28 days to issue a determination under this rule.

(6) The director shall indicate in the determination that if either the insurer or the provider disagrees with the determination, the director, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, and R 500.2121 through R 500.2142.

(7) A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies for issues that were not subject to the appeal.

PART 4. INSURER UTILIZATION REVIEW PROGRAM

R 500.67 Required components of an insurer's utilization review program.

Rule 67. (1) Within 60 days of the effective date of these rules, insurers must have in place a utilization review program.

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

(a) Provide for bill review, including whether provider charges for medical care comply with chapter 31 and chapter 31A of the act, MCL 500.3101 to 500.3179 or MCL 500.3181 to 500.3189, and rules promulgated thereunder.

(b) Make determinations regarding the appropriateness of medical care, in terms of both the level and quality of medical care based on medically accepted standards.

(c) Provide for the scheduling and performance of independent medical examinations pursuant to section 3151 of the act, MCL 500.3151.

(d) Issue determinations under R 500.65.

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

(4) No later than 90 days after the submission of the information required under R 500.67(3) and, if applicable, R 500.68, the director shall issue a certification of the insurer's utilization review program. Certification shall be either unconditional or conditional.

(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 500.67(2) and, if applicable, R 500.68. 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 certificate 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 500.68 Medical review organizations.

Rule 68. (1) An insurer may, but is not required to, contract with a medical review organization to perform utilization review activities on its behalf. An insurer that uses a medical review organization remains responsible for complying with the act and any rules promulgated thereunder.

(2) An insurer that contracts with a medical review organization to perform professional utilization review activities on its behalf must provide the following to the department in addition to the information required under R 500.67(2):

(a) Contact information for no fewer than two individuals from the medical review organization who are responsible for responding to the department's inquiries.

(b) A detailed description of the medical review organization's experience in the review of medical care.

(c) A description of the medical review organization's procedures for utilization, especially as it relates to the provision of personal protection insurance benefits.

(d) A current list identifying all property/casualty insurers, health insurers, health maintenance organizations and health care providers with which the medical review organization maintains any business arrangement, including a brief description of the nature of the arrangement.

(e) Any other information requested by the director.

(3) Any changes in the information filed under subrule (2) of this rule shall be reported to the director as an amendment to the materials filed within 30 days of the change.

R 500.69 Renewal of certification.

Rule 69. (1) 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

R 500.70 Annual report.

Rule 70. (1) No later than March 31 of each year, each insurer shall submit a report on 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.