# *Too Much or Not Enough?*

# *An Inside Look at Michigan's New Utilization Review Process*

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*Executive Summary*

When the Michigan No-Fault Act was reformed on June 11, 2019, one of the many changes was the implementation of a utilization review process. This new process allows insurers and the Michigan Catastrophic Claims Association (MCCA) to seek further information, and make determinations, regarding treatment, products, services, or accommodations that were potentially overutilized or inappropriate. It also allows for providers to appeal these determinations to the Department of Insurance and Financial Services (DIFS).

Per the No Fault statute, the specific rules governing the utilization review process was left for DIFS to define through the administrative rules making process. Effective December 18, 2020, DIFS has promulgated rules that provide procedures for insurers and the MCCA to request more information from providers, and make determinations as to overutilization and appropriateness of treatment, products, services, or accommodations. The rules also provide for appeals of determinations by providers to DIFS, and judicial review of DIFS decisions by trial courts.

While these rules provide further guidance on the utilization review process, there are still several questions left unanswered. Once utilization reviews are implemented for claims throughout Michigan, various issues will likely be addressed through litigation. This article outlines the obligations for insurers and providers under the new rules for utilization reviews, and explores certain areas that are yet to be determined.

*Recent Changes Brought On by No-Fault Reform*

On June 11, 2019, the Michigan No-Fault Act was amended, bringing sweeping changes to several provisions of a law that had been substantially the same for almost 50 years. Prior to these amendments, there was no mechanism to address the overutilization or appropriateness of treatment outside of the normal claims adjustment process and subsequent litigation.

One of the changes ushered in by reform was the addition of MCL 500.3157a, which provides for utilization reviews and related requirements. A utilization review is defined as "the initial evaluation by an insurer or the [Michigan Catastrophic Claims Association] of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided …. based on medically accepted standards."[1]

By rendering treatment, services, products, or accommodations to an injured person who is covered by personal injury protection (PIP) benefits, a physician, hospital, clinic, or other person is considered to have agreed to two obligations[2]. The first is to submit necessary records and other information concerning the treatment, products, services, or accommodations provided for the purpose of a utilization review. The second is to comply with any decision rendered by the director for DIFS.

Under this new statute, DIFS is required to promulgate rules under the Administrative Procedures Act to establish criteria for utilization reviews based on medically accepted standards and provide procedures for the utilization reviews[3]. The procedures are required to address acquiring records, bills, and other information. In addition, they are required to address allowing an insurer to request an explanation and requiring a provider to provide an explanation for the treatment, products, services or accommodations provided. The procedures are also required to address the appeal of DIFS determinations by insurers and the MCCA.

Under MCL 500.3157a, an insurer or the MCCA may require a provider to explain the necessity or indication for treatment, products, services, or accommodations under the procedures promulgated by DIFS[4]. In addition, if an insurer or the MCCA determines that the treatment, products, services, or accommodations were overutilized or that the cost was inappropriate, a provider may appeal under the rules created by DIFS[5].

After a lengthy public comment period and several revisions, DIFS issued its final rules effective December 18, 2020. These rules define the scope of utilization reviews, as well as set forth procedures for insurers to initiate utilization reviews and appealing certain

adverse determinations. The rules also provide for judicial review of decisions issued by DIFS, an issue not specifically addressed by MCL 500.3157a.

***The Scope of Utilization Reviews[6]***

Utilization review rules are only applicable to benefits for treatment, training, products, services, and accommodations[7] provided to an injured person who is insured under a Michigan no-fault automobile insurance policy. The rules also only apply to treatment and training provided *after* July 1, 2020. The rules promulgated by DIFS apply to all automobile insurers providing coverage through a no-fault policy, a managed care plan, or through the Michigan Assigned Insurance Placement Facility (MAIPF). The rules also apply to the Michigan Catastrophic Claims Association (MCCA)[8].

The rules make it clear that insurers and the MCCA are not limited in their ability to contract with a medical review organization to perform utilization reviews on their behalf. The use of a medical review organization, however, does not absolve an insurer from complying with its obligations under the Michigan No-Fault Act or the administrative rules for utilization reviews.

***The Request for Explanation[9]***

A utilization review can be requested by an insurer or the MCCA when the treatment or training provided is:

- Not usually associated with a diagnosis or condition;
- Longer in duration than is usually required for a diagnosis for condition;
- More frequent than is usually required for the diagnosis or condition; or
- Extends over a greater number of days than is usually required for the diagnosis or condition.

In order to trigger the review, an insurer must submit a request to the provider[10] to explain the necessity or indication of the treatment in writing. The written request for information must be submitted within thirty (30) days of receiving a bill related to the treatment or training.

Once a provider receives a request for information, the provider must respond to the request within thirty (30) days of receiving the request. An insurer may request that the provider include medical records, bills, and other information concerning the treatment or training provided. If the request for medical records, bills, or other information exceeds the information customarily submitted to the insurer with a bill, the insurer must reimburse the provider at a reasonable and customary fee, plus the actual costs of

copying and mailing. The provider must be reimbursed within thirty (30) days of the request for information by the insurer.

***Determinations by the Insurer[11]***

After reviewing the provider's written explanation, an insurer may make a determination that the provider overutilized, otherwise rendered or ordered inappropriate treatment or training, or that the cost[12] of the treatment or training was inappropriate. The insurer must issue a written notice of this determination, and must do so within thirty (30) days of receipt of the written explanation from the provider.

The written notice of the determination must include specific information. This includes:

- The criteria or standards the insurer relied on in making the determination;
- Specific reference to the insurer's utilization review process and procedure;
- The amount of payment to the provider based on the results of the determination;
- An explanation of the difference between the amount paid and the amount billed;
- If applicable, a description of any additional records the provider must submit to the insurer in order to reconsider its determination;
- The date of the determination;
- A form to appeal the decision to DIFS.

As suggested above, a provider can appeal to DIFS the denial of a provider's bill on the basis that the provider overutilized or provided inappropriate treatment or training, or that the cost was inappropriate. A provider is permitted to pursue such an appeal regardless of whether the insurer has requested a written explanation.

This section of the rules implicates an interesting issue. While the rules are set up for the insurer to initiate the utilization review process, the rules suggest that a provider can appeal *any* denial of a provider bill, as long as it was based on overutilization, inappropriate treatment, or inappropriate cost. For example, this would suggest that where an insurer did not request information pursuant to the rules, but denied on the basis of a medical examination, a provider could appeal to DIFS. Given the use of the word "may" for insurers and providers alike, the parties can likely choose to forego the utilization review process entirely, and address the claim through the normal litigation process. This will likely be resolved through litigation.

***The Appeals Process to DIFS[13]***

A provider must appeal a determination made by an insurer within ninety (90) days of the date of the disputed determination. The appeal must be submitted on a form approved by the department.[14] Within fourteen (14) days of receiving the appeal, DIFS must notify the insurer and injured person of the appeal and request any additional information necessary to review the appeal. Within twenty-one (21) days of the date of the DIFS' notice, an insurer or the MCCA may file a reply.

Within twenty-eight (28) days of the insurer's reply, the director of DIFS is required to issue a decision. The director may take an additional twenty-eight (28) days upon written notice to the insurer and the provider. The director must base his or her decision upon the written materials submitted by the parties. If the insurer does not file a reply, then the director will make a decision based on the information available.

***Judicial Review of the DIFS Decision[15]***

A party can seek judicial review of a DIFS decision pursuant to MCL 500.244(1), which permits a person aggrieved by a decision under the Michigan Insurance Code to invoke judicial review under the Administrative Procedures Act[16]. This permits judicial review only after the party has exhausted all the available administrative remedies. A petition seeking judicial review of the determination must be filed in the county where the petitioner resides, has a principal place of business, or in Ingham County Circuit Court[17].

A petition must be filed within sixty (60) days of mailing the notice of decision from director of DIFS. Within sixty (60) days of the filing of the petition, DIFS must provide the entire record of the proceedings unless the parties stipulate to shorten the record. Any party unreasonably refusing to shorten the record can be taxed additional costs.

The review is conducted by the Court without a jury and is confined to the record, unless evidence of a procedural irregularity is necessary. The Court may request oral argument and the submission of written briefs. In addition, a party can seek leave of the Court to present additional evidence to DIFS, and the Court can order additional evidence be taken by DIFS. The party must make a showing, however, that there was an inadequate record made to DIFS or that additional evidence is material, and there is a good reason for failing to submit it to DIFS in the original proceeding.

The Court may affirm, reverse, or modify the ruling by DIFS. The Court has the authority to set aside the ruling by DIFS if the substantial rights of the petitioner have been prejudiced because the decision or order is:

- In violation of the constitution or a statute;

- In excess of the statutory authority or jurisdiction of the agency;
- Made upon unlawful procedure resulting in material prejudice to a party;
- Not supported by competent, material and substantial evidence on the whole record;
- Arbitrary, capricious or clearly an abuse or unwarranted exercise of discretion; or
- Affected by other substantial and material error of law.

***Requirements of Insurers[18]***

Within sixty (60) days of the effective date of the rules[19], i.e. February 16, 2021, insurers must have a utilization review program in place to review records and bills. The program must:

- Provide for bill review, including whether the provider charges for treatment and training comply with the Michigan No-Fault Act;
- Make determinations regarding the appropriateness of treatment and training based on medically accepted standards; and
- Issue determinations regarding whether treatment or training was overutilized or inappropriate, and if the cost was inappropriate.

"Medically accepted standards" means the most appropriate practice guidelines for the treatment or training provide to an injured person. These practice guidelines may include generally accepted practice guidelines, evidence-based practice guidelines, or any other guidelines developed by the federal government or national or professional medical societies, boards, and associations.[20]

Insurers must submit the program to the director of DIFS on an annual basis on a form approved by DIFS[21]. No later than ninety (90) days after submission of the carrier's plan[22], DIFS must issue either a conditional or unconditional certification. The director may issue an unconditional certification for a period of three (3) years. The director may issue a conditional certification if the insurer does not substantially satisfy the stated criteria and the insurer agrees to take corrective action. At any time, the director may modify the certification from unconditional to conditional if the director determines that the insurer fails to comply with the rules for utilization review. The certification can be revoked completely if the insurer violates the rules and fails to complete a corrective action plan.

Insurers must apply for renewal of its certification no less than ninety (90) days prior to the expiration of the current certification. Each insurer must submit an annual report

no later than March 31 of each year regarding utilization review data and activities. The report will be subject to disclosure under the Michigan Freedom of Information Act[23]. Any proprietary information submitted by insurers is exempt from disclosure. Insurers must also retain copies of all requests, explanations, and determinations issued under the utilization review rules for at least (2) two years. The records must be submitted to DIFS upon request.

***Issues Left to Be Determined***

As referenced above, it is up to the insurers and the MCCA to develop a utilization review program. Certainly, it is possible that some carriers will create and administer their own program from scratch. However, it seems more likely that insurers and the MCCA will engage a medical review organization to assist with development of the program and, perhaps, perform some or all of the utilization review. Previously, these medical review organizations were used to perform bill audits based on the CPT codes, to assist with evaluating the reasonable and customary charges for allowable expenses. These organizations can also be utilized for similar purposes in determining whether a certain treatment modality, or the length or frequency of treatment, is generally associated with a certain condition or diagnosis. One would expect that a medical professional would be involved in the process.

In litigation, such organizations have been subject to evidentiary foundation challenges by providers and claimants demanding to know the specific criteria and data used to reduce charges in conjunction with billing audits. With the rules directly referencing these organizations, insurers are further bolstered in using these organizations. However, it will be important that these organizations make their criteria and data available if requested.

It does not appear mandatory for an insurer to initiate the utilization review process to challenge a provider's claim. It is also appears that providers may be able to utilize the appeal process to DIFS without the insurer performing a utilization review. Whether an insurer or provider avails themselves of the process may depend on whether they believe DIFS to be a more advantageous venue to challenge the issue. If they avail themselves of the process, the administrative process must be exhausted before litigation can commence.

If the utilization review process truly is permissive, and not an exclusive remedy, then the benefits of this review process are mitigated. It would seem that a goal of this process would be to streamline disputes over utilization and cost, and, subsequently, reduce litigation and expense to the parties. If parties can pick and choose whether to

participate in this process, it could lead to a chaotic and costly system where insurers and providers are subject to two adjudication systems with varying results on the same issues.

If litigation is commenced, the scope of that litigation is yet to be determined. Obviously, if neither party avails themselves of the utilization review process, then litigation would proceed in same fashion as any standard no-fault case. However, if the process is utilized, then the litigation would essentially be an appeal of the DIFS ruling with a highly deferential standard of review. It is possible that future challenges will shape whether that deferential standard of review applies, or whether such a review would be "de novo" with no deference to the underlying decision as if it never happened. Case law will undoubtedly provide further guidance on this process.

Furthermore, what constitutes "medically accepted standards" is vague. Providers and insurers will no doubt have vastly different positions on what constitutes medically accepted standards. This is one of the issues most likely to be litigated extensively.

Lastly, the utilization review rules make an insurer subject to interest if DIFS finds that a provider is entitled to payment under MCL 500.3142. This is found nowhere in MCL 500.3157a, and would seem to be modifying the reasonable proof standard referenced in MCL 500.3142, and case law making this generally a question for the jury to decide. It will be interesting to see if this automatic entitlement to interest is upheld. It also may give rise to additional lawsuits by providers seeking interest and attorney fees, under MCL 500.3148, only.

***Conclusion***

The new rules promulgated by DIFS provide the procedures that providers and insurers are required to follow should they implement a utilization review process The rules also provide several requirements that insurers and the MCCA must follow when implementing these reviews. There are strategic considerations for all parties when determining whether to avail themselves of the utilization review process, including the nature and extent of the review. There are also several questions left unanswered which will require intervention by the courts. It will be essential for insurers, providers, and their counsel to become familiar with what these rules say, and don't say, going forward.

[1] MCL 500.3157a(6)
[2] MCL 500.3157a(1)
[3] MCL 500.3157a(3)
[4] MCL 500.3157a(4)
[5] MCL 500.3157a(5)
[6] R 500.62
[7] For the remainder of this article, the phrase "treatment or training" refers to "treatment, training, products, services, and accommodations", which mirrors the usage of the phrase throughout the no-fault reform legislation, including MCL 500.3157(13)(k). Of note, though, is while the rules refer to "training", MCL 500.3157a makes no such reference.
[8] While the Rules indicate throughout that insurers and the MCCA can avail themselves of the utilization review process, in most cases it will be insurers utilizing this process. Therefore, this article will reference the applicability of the utilization review rules as they relate to insurers, only.
[9] R 500.63
[10] A provider includes a physician, hospital, clinic, or other person providing treatment, training, products, services, and accommodations to an injured person. R 500.61(l)
[11] R 500.64
[12] It should be noted that the cost of treatment or training is not mentioned as a trigger to initiate a utilization review, but the rules reference it as appropriate issue for determination.
[13] R 500.65
[14] The approved DIFS Provider Appeal Request form is attached as Appendix 1.
[15] R 500.65(7)
[16] MCL 24.301-306
[17] This would be a departure from the normal venue rules for a no-fault lawsuit Michigan. Currently, an insurer is deemed to conduct business in every county in the state, thus, making it subject to being sued in any county.
[18] R 500.66
[19] The effective date of the rules is December 18, 2020.
[20] R 500.61(i)
[21] The approved form for the program is attached as Appendix 2
[22] DIFS can extend the time an additional 30 days upon written notice to the insurer.
[23] MCL 15.231-246