STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Bulletin 2021-36-INS

In the matter of:

No-Fault Billing Disputes
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Issued and entered
this 5th day of October 2021
by Anita G. Fox
Director

On September 22, 2021, in response to providers experiencing delays in receiving reimbursement from auto insurers, the Department issued Bulletin 2021-35-INS, which set forth expectations for timely and appropriate payment of auto no-fault benefits. This bulletin is being issued to remind insurers that payments are due to providers upon receipt of reasonable proof of loss, and addresses three common situations: 1) the provider has not used the insurer's preferred billing format; 2) the insurer disputes whether the provider has submitted adequate documentation for the insurer to calculate the appropriate reimbursement under MCL 500.3157(7); 3) and the insurer and provider disagree that the claims have been billed using the appropriate code.

Applicable Law

Under MCL 500.3142, PIP benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained.[1] If a bill is not provided to an insurer within 90 days after the product, service, accommodations, or training is provided, the insurer has 90 days to pay before the benefits are overdue. MCL 500.3142(3). Overdue payments bear simple interest at the rate of 12% per annum. MCL 500.3142(4).

MCL 500.3142(2) "requires only reasonable proof of the amount of loss, not exact proof." *See Williams v AAA Michigan*, 250 Mich App 249, 267; 646 NW2d 476, 485 (2002). An insurer that "ignore[s] definite but inexact claims" may be liable for interest under MCL 500.3142. *Id*. An insurer may not withhold payment entirely while it awaits clarification on "the exact amount of money [it owes]." *Id*. at 267. Once a provider submits a bill, an insurer that wishes to challenge or investigate the amount billed should do so "during the thirty-day legislative grace period to establish a lesser amount of … benefits owed." *Id*. If an insurer is liable for at least some of the bill, the insurer must at least pay that amount prior to the expiration of the time frame for payment under MCL 500.3142 while they investigate whether they are liable for more than the amount paid.

Billing Format Disputes

The Department is aware that some insurers have been refusing to pay provider bills on the basis that the bill is not in the insurer's preferred format or on the insurer's preferred form. The Insurance Code does not mandate that a provider use a particular form to be entitled to reimbursement, and a provider's failure to use

[1] MCL 500.3142(3) further states that, if a bill is not submitted to an insurer within 90 days of the date of service, the insurer has an additional 60 days to pay before benefits are overdue.

the insurer's preferred billing format is not, itself, failure to provide "reasonable proof of loss."

While some insurers may have a preferred billing form (e.g., the CMS-1500 or CMS-1450 / UB-04), a provider who uses a different form or an invoice to submit a bill that is otherwise payable is nonetheless entitled to timely payment. Similarly, a provider who submits a bill for services that is otherwise payable but is not on the insurer's preferred billing form must be reimbursed within the time frames set forth in MCL 500.3142, and an insurer will be liable for interest if the bill is not paid timely.

Charge Description Master or "Average Amount" Documentation Disputes

The Department is also aware of circumstances in which a provider has submitted a bill for dates of service on or after July 2, 2021, for which reimbursement must be calculated under MCL 500.3157(7). An insurer that receives such a bill may request a charge description master or "average amount" from a provider in order to calculate the amount of the provider's reimbursement.[2] The insurer must request this information as promptly as possible, but in no event later than the time frames set forth in MCL 500.3142. The insurer must reimburse the provider promptly upon receipt of the required documentation.

Coding Disputes

The Department has been notified of instances where insurers have repeatedly rejected providers' bills solely because the insurer believes the provider did not correctly code the services. As Bulletin 2021-35-INS stated, insurers are expected to engage in a dialogue with providers to assist them in understanding the insurer's review of the provider's bills; and to expedite bills resubmitted with corrected codes.

Enforcement of MCL 500.3142

The Department may consider any of the following to be a pattern of conduct in violation of MCL 500.2026: repeatedly refusing to pay claim amounts that are not reasonably in dispute; insisting on a specific form as the sole basis for refusing payment; rejecting bills repeatedly without offering assistance to a provider; or repeated violations of MCL 500.3142. Insurers found to be in violation of these provisions of the Insurance Code will be subject to administrative action.

Any questions regarding this bulletin should be directed to:

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/s/
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Anita G. Fox
Director

[2] MCL 500.3157(7) provides that reimbursement under that section is calculated based on the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, the average amount the provider charged on January 1, 2019. Insurers should only request an "average amount" if the provider does not have a charge description master.