THE HEALTH CARE PROVIDER'S GUIDE TO MICHIGAN'S AUTO INSURANCE UTILIZATION REVIEW APPEAL PROCESS

This guide will provide information about Michigan's auto insurance utilization review provider appeals process.

Objectives in this Guide:

- Understand the steps a provider should take to file an appeal.
- Understand the appeal process and timelines.
- Understand how to complete required forms.

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

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Utilization Review for Auto Insurance

Under Michigan's auto insurance law, medical care provided to auto accident victims must meet requirements for medical appropriateness. This review by insurers is known as Utilization Review, which is defined by MCL 500.3157a(6) as "the initial evaluation by an insurer or the association created under section 3104 of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided under this chapter based on medically accepted standards."

Using their utilization review programs, auto insurers will evaluate whether an injured person's medical care was medically necessary, and that the cost of care was appropriate under Michigan law. If the insurer determines that the care provided was above the usual range of utilization based on medically accepted standards or the cost was inappropriate, the insurer must provide notice to the health care provider.

Insurer's Request for Explanation

What is a "request for explanation" and why would a health care provider receive a request for explanation from an insurer?

An insurer may request that a health care provider explain the necessity or indication for the treatment, training, products, services, or accommodations in writing. This is called a "request for explanation" and must be submitted to the health care provider within 30 days of the insurer's receipt of the bill.

What is the health care provider expected to submit when responding to an insurer's request for explanation?

When responding to a request for explanation, the health care provider should first directly answer the specific question(s) posed by the insurer. The health care provider's written response may also include medical records, bills, and other information concerning the treatment, training, products, services, or accommodations to the injured person. Written explanations are due to the insurer within 30 days of receipt of the request for explanation.

Can the health care provider be reimbursed for costs related to the request for explanation?

If the insurer's request requires the health care provider to send medical records, bills, or other documentation in excess of what is customary, the insurer must reimburse the health care provider a reasonable and customary fee, plus the actual costs of copying and mailing, within 30 days of the insurer's request.

What happens after the health care provider submits the written explanation to the insurer?

After receipt of the health care provider's written explanation, the insurer must pay the bill or deny payment, either in part or in full. When denying payment, the insurer must issue a written notice of determination to the health care provider within 30 days of receipt of the health care provider's written explanation.

Determinations

A "determination," for the purposes of DIFS Utilization Review, is a bill denial made by an auto insurer that indicates the health care provider overutilized treatment, training, products, services, and accommodations for services provided to a person injured in a motor vehicle accident, based on medically accepted standards; or the cost of the care was inappropriate. A determination can be a written notice or a denial of a health care provider's bill.

If a health care provider disagrees with a determination made by an auto insurer, the health care provider may appeal within 90 days of the date of the determination.

Not all issues are appealable to DIFS Utilization Review. In order for a health care provider to appeal a determination, the dispute must be related to utilization or cost. Health care providers and auto insurers should continue the practice of engaging in informal communications to resolve disputes that are not appropriate for DIFS Utilization Review. The chart on page 4 provides guidance for what is considered appropriate for appeal to DIFS.

Appeals related to medical necessity require documentation to be supplied at the time of the appeal request. These documents must include a copy of the determination and medical records of the injured person and any other related information.

For disputes solely involving health care provider charges or insurer reimbursement rates, the health care provider should submit documentation to support its assertion that the health care provider's costs are not inappropriate, or that the amount paid by the insurer is not reasonable or is otherwise contrary to the applicable provisions of Chapter 31 of the Insurance Code.

<table>
<tr><th colspan="2">Appropriate for Review by DIFS UR</th></tr>
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<td>Written Notice of Determination

A written notice of determination should include the following:

➢ Criteria or standards the insurer relied on for its determination.
➢ Amount of payment to the provider that has been made based on the determination, including an explanation for the difference between the payment amount and the amount billed by the provider.
➢ A description of any additional records the provider must submit to the insurer for the insurer to reconsider its determination.
➢ A copy of the provider appeal form (FIS 2356).
➢ The date of the determination.

In these instances, be sure to include all necessary documents with the Provider Appeal Request (FIS 2356).</td>
<td>Denial of Health Care Provider’s Bill

Insurer denied payment on the basis that the health care 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.

Examples:
• Explanation of Review (EOR)
• Explanation of Benefits (EOB)

In these instances, be sure to include all necessary documents with the Provider Appeal Request (FIS 2356).</td>
</tr>
<tr><th colspan="2">Not Appropriate for Review by DIFS UR</th></tr>
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<td>Billing or Coding Error

A mistake or omission on a health care provider bill or insurer Explanation of Review (EOR), Explanation of Benefits (EOB), or written notice of determination.

Examples:
• The insurer bundled two procedures together in error and only paid one procedure.
• Missing or incorrect information.
• Incorrect procedure code.

In these instances, the provider should work with the insurer to resolve the error.</td>
<td>No Written Determination or Denial of Bill

The health care provider has not received timely payment or communication from an insurer for a claim submitted without any errors.

Example:
• When the insurer has not responded to an invoice or bill submission and remains non-responsive after communication attempts from the health care provider.

In these instances, the provider may contact the Office of Consumer Services at DIFS to file a complaint at 877-999-6442.</td>
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Utilization Review Appeals: What to Expect and Timelines

What is the deadline for submitting **an appeal to the Department of Insurance and Financial Services (DIFS)?**

The time period for submitting an appeal with DIFS begins with the date of the insurer's notice of determination or bill denial and extends 90 days. An appeal received after 90 days of the date of the notice cannot be reviewed by DIFS, but the dispute may still be resolved directly with the insurer.

Where can a health care provider find the Provider Appeal Request (FIS 2356) form?

The Provider Appeal Request form (FIS 2356) can be viewed and downloaded at DIFS' auto insurance utilization review webpage: www.michigan.gov/AutoInsuranceUR.

What must a health care provider include with the Provider Appeal Request form?

Health care providers must fully complete the form and include the following information:

- Provider and claim information, including date(s) of service, date of accident, claim number, and date of insurer's determination.
- Contact information for the insurer and the injured person (name and address).
- Detailed written narrative of the reason(s) for the request.
- Copy of the notice of determination or insurer's denial of the provider's bill.
- All correspondence and documents related to a request for explanation exchanged between the provider and the insurer prior to the appeal request.
- Pertinent clinical information and any other supporting documents. Be sure to list all attached documentation in the box provided on the form.

All documentation relevant to the appeal must be provided with the appeal form.

When and how will the health care provider, insurer, and injured person (patient) be notified of the appeal?

- DIFS will send the insurer a Notice of Appeal within 14 days of accepting the appeal.
- DIFS will send a copy of the Notice of Appeal to the health care provider and the injured person **for notification purposes only.** If the health care provider receives questions from the injured person about the appeal, the health care provider should reassure the injured person that the injured person has no active role in the process.
- The insurer will have 21 days to reply to DIFS by completing the Insurer Reply (FIS 2361) form.
- The insurer and injured person will not be notified if the appeal is rejected. For more information regarding rejected appeal submissions, please see the FAQ section below.

When and how will the health care provider and insurer receive a final decision from DIFS on the appeal?

- DIFS will issue a decision 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. DIFS may, upon written notice to both parties, take an additional 28 days to issue a decision.
- DIFS will issue the decision to the insurer and provider by email. The decision will be based on the supporting documentation submitted to DIFS by the parties.

Frequently Asked Questions

Q: Can a health care provider submit an appeal to DIFS without a letter of determination and/or denial bill from the insurer?

A: No. A health care provider must receive a letter of determination and/or a bill denial from the insurer in order to submit an appeal request to DIFS.

Q: What should be included in "a detailed narrative of reason(s) for an appeal request" (checkbox 1, section IV. of the appeal form)?

A: A health care provider should submit their reasoning for why they do not agree with the insurer's denial or determination.

Q: Can a provider submit supporting documentation after an appeal request has been filed with DIFS?

A: No. DIFS will not accept additional supporting documentation after an appeal request has been filed. It is the responsibility of the health care provider to ensure all necessary and relevant documentation is provided when the appeal request is filed.

Q: What is considered "timely" for a provider appeal submission?

A: DIFS will consider a provider appeal to be timely if it involves dates of service that occurred on or after July 2, 2020, and a date of determination within the last 90 days from the date of submission.

Q: What should a health care provider do if an injured person calls them regarding the appeal?

A: A health care provider should assure the injured person that no action is needed. DIFS will not accept any correspondence from the injured person regarding the appeal. The notice of appeal letter is provided to the injured person for informational purposes only.

Q: What should a health care provider do if a dispute with the auto insurer is settled after an appeal has been submitted but before DIFS has issued a decision?

A: If the health care provider and the auto insurer resolve their dispute prior to DIFS rendering a decision, the health care provider should email the analyst listed on the Notice of Appeal letter and request a withdrawal in writing. If the provider does not have the analyst's email address, please send the request for withdrawal to DIFS-URAppeals@michigan.gov. DIFS will issue a **Settlement of Disputed Determination and Dismissal of Appeal Request** to both parties and close the appeal request.

Keys to an Acceptable Provider Appeal

The health care provider provided care to an injured person for treatment related to an auto accident, and the treatment was rendered after July 1, 2020.

The health care provider has received a formal denial or determination from the auto insurer on the bill or claim at issue, and this denial or determination is dated no more than 90 days prior to the submission date of the appeal request.

The insurer's bill denial or determination specifically relates to overutilization or inappropriate cost of treatment, training, products, services, or accommodations.

The bill at issue did not originate from an error or miscommunication between the provider and auto insurer. If it did, to the provider and auto insurer must resolve such issues directly.

The provider has fully completed the Provider Appeal Request (FIS 2356) form and verified that all the information provided is accurate and legible.

The provider has submitted all documents to support its appeal, including the insurer's determination or bill denial and pertinent records. All supporting documents must be received at the time of the request for appeal.

The provider has submitted the completed FIS 2356 form with supporting documentation via email to DIFS-URAppeals@michigan.gov.