Insurers' Utilization Review Program Could Impact Future Litigation

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PRACTICE AREAS

Insurance Defense

When the Michigan No-Fault Act (MCL 500.3101 et seq) was drastically amended on June 11, 2019, one of the many key changes was the enactment of an administrative utilization review for medical providers and insurers, under MCL 500.3157a.

This procedure provides methods for insurers to obtain further information for making determinations concerning the treatment, training, products, services, or accommodations should it appear to be excessive, outside of medically accepted standards, or simply unnecessary. The utilization review also gives medical providers an option to appeal the determination made by the insurers or Michigan Catastrophic Claims Association (MCCA) to the Department of Michigan of Insurance and Financial Services (DIFS).

On December 18, 2020, DIFS implemented the utilization review regulations, which are governed by the Administrative Procedures Act (APA) and apply to all treatment, training, products, services, and accommodations provided after July 1, 2020. Insurers are required to have a utilization review program in place and filed with DIFS by **February 16, 2021**.

There are many time-sensitive, strategic considerations for both insurers and medical providers.

- Insurers/MCCA may have the ability to initiate the utilization review process by timely requesting an explanation from a medical provider or by issuing a determination. Timeliness is of the essence for the utilization process to be properly initiated — and ultimately could impact a medical provider's ability to file a lawsuit.
- If an insurer/MCCA requests a determination that the medical provider deems to be adverse, the medical provider has the option to appeal the decision to DIFS within 90 days of the date of the determination. This occurs even if the medical provider was not requested to provide more information. Should a provider appeal an insurer's determination, DIFS is mandated to inform the insurer/MCCA and the injured person of the appeal. Upon receipt of the

notification of the appeal from DIFS, an insurer/MCCA may file a reply to the medical provider's appeal within 21 days after receiving the notice from DIFS. We would recommend providing the appeal to your legal counsel immediately as DIFS may not only find that the insurers/MCCA's determination was incorrect, but that it may also order that the provider is entitled to interest on any overdue payments as set forth in MCL 500.3142. Providing the appeal to your legal counsel will also allow for the day-to-day claim management to be maintained without disruption.

- It is not entirely clear how the utilization review rules will impact litigation - particularly medical provider lawsuits - however, it seems that the adoption of the utilization review regulations demonstrates that the Michigan Legislature and DIFS are focused on having medical provider claims first reviewed on the administrative level. This is important as a failure to appeal any decisions that a provider deems adverse under this process could then be used strategically by insurers and the MCCA. For example, if a medical provider does not file an administrative appeal and attempts to seek direct recourse by initiating a lawsuit, the courts may lack jurisdiction over the lawsuit due to the provider's failure to first exhaust its administrative remedies.

We look forward to working with our clients as they navigate the next steps of the Michigan No-Fault reform. Please contact our office to discuss the utilization review in more detail or any other of the changes to the Michigan No-Fault Act.