I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus

R67(2)(c), goes beyond the language of that statute by calling this examination “independent.” I recommend R67(2)(c) is revised to state:

> “Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer.”

Thank you.

We are a Provider who serve clients with traumatic brain injury due to a Motor Vehicle Accident. After reviewing the Second Draft for the Utilization Review Rules of 2/15/20. Now after the Public Hearing of 4/10/20. We are submitting a request to be taken under review that enhances a more specific language and detailed time frames under which your department has the authority to endorse and preserve the care and rehabilitation to the valuable clients we serve.

Rule 61 (j)

I am not in agreement with the way the rule is currently written. I think the definition should be focused on the practices in the medical community and the definition should be changed to:

"Medically accepted standards" means standards or criteria that are accepted by practicing Physicians for evaluating quality of medical care ensuring that the medical care is suitable for a Particular person, condition, occasion or place." The concern also does not define WHO will be the participants in this forum. They should be licensed medical personnel

Rule 64 (3)

I am not in agreement with the way the rule is currently written. The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. A deadline for payment must be included in which the insurer must issue payment. We would suggest that a 30 day time limit should be imposed for the insure to issue a payment to a provider.

Rules 65 The same deadlines imposed on the providers should be imposed on the insurers. Insurers must respond and make determinations in a timely manner. Again, we would suggest a 30 day time period for which a insure makes a determination I more than enough time to make that decision.

Rule 66 It seems confusing about the rights of providers to avail itself of civil remedies. Perhaps 66 (7) is changed to ensure it is consistent with MCL 500.3112 and should read:

"A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

Rule 67 I'm concerned about the procedure and conduct of the hearings. Sounds like it will be decided on written documents only? Need more details about the hearing process. We would suggest that an extension should be given in order to have a public hearing after the COVID-19 issue has resolved and public forum can happen.

Rule 67 (2) (c) Referring to "Independent" medical exams pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Therefore, goes beyond the language of that statute by calling this examination "independent." Rule 67 (2) (c) should be revised to state: "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Debra Emery
4780 Clear Lake Road
North Branch, MI 48461

DIFS
c/o: Michele Estrada
P.O. Box 30220
Lansing, MI 48909

April 16, 2020

Re: MCL 500.3157 Utilization Review

Dear DIFS,

For the past nine years, I have had the pleasure to serve as Case Manager for individuals who have sustained Traumatic Brain Injuries and Spinal Cord Injuries resulting from a motor vehicle accident. I am writing to you to with regard to the accreditation requirements referenced in MCL 500.3157 which indicates that "neurological rehabilitation clinics defined as a person that provides post-acute brain and spinal rehabilitation care". The rule is currently being interpreted as Case Managers are required to obtain CARF accreditation.

> The Commission for Case Management Certification (CCMC) defines case management as "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs". (https://ccmcertification.org/).

The Professional Case Manager provides coordination, assessment and evaluation of health and services, but not direct patient care.

I encourage DIFS to provide clarification for required accreditation of Case Mangers. Should it be determined that accreditation is essential, I ask DIFS to consider Certified Case Manger (CCM) as the required accreditation.

Thank you for your consideration.

Sincerely,

Debra Emery BS., CCM, CBIS

MSMS
MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw Street | East Lansing, Michigan 48823
517-337-1351 | msms@msms.org | www.msms.org

April 16, 2020

Via email (EstradaM1@michigan.gov)
Michele Estrada
Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Re: Administrative Rules for Utilization Review - Rule Set 2019-136 IF

Dear Ms. Estrada:

I am writing on behalf of the Michigan State Medical Society (MSMS) regarding the proposed Utilization Review rules. MSMS represents approximately 15,000 Michigan physicians, residents and medical students of all specialties and practice settings.

MSMS appreciates the Department's revisions to the rules throughout this process. Several of our concerns related to administrative burdens, negative impact on access to care and costs, and the need for clarity and balance which have been addressed in the draft currently presented for public comment. Overall, MSMS is supportive of the revised rules. However, MSMS respectfully requests consideration of two revisions as follows:

1. Revise Proposed Rule 500.66 by adding new subsection (8) which would state: "If a provider appeals a determination made by an insurer and the Department determines that the provider is entitled to payment for medical care rendered, the provider is entitled to recover interest accrued for overdue benefits in accordance with section 3142. A provider's appeal of an insurer's determination to the Department shall not toll the accrual of interest for overdue benefits."

   Rationale: Rule 500.66, as proposed, leaves unclear if or when interest begins to accrue for monies due to a provider following a successful appeal to the Department. Payments are "overdue" if they are not received within the timeframes specified by MCL §500.3142 following the provider's submission of a bill or other reasonable proof of the claim to the insurer. In addition, overdue payments accrue simple interest at the rate of 12% per year. If a provider does appeal an insurer's determination to the Department, and to be consistent with MCL §500.3142, interest should continue to accrue as to any monies which have not been paid to the provider unless the Department determines on appeal that the provider is not entitled to payment. Our proposed revisions to Rule 500.66 would add a new subsection (8) to make this point clear.

2. Revise Proposed Rule 500.67(1) to state as follows (proposed new language is identified by underlining): "(1) Within 60 days of the effective date of these rules, insurers must have in place a utilization review program <u>to review records and bills of medical care provided to an injured person that is above the usual range of utilization for such medical care based on medically accepted standards</u>."

Rationale: Part 4 of the Revised Rules regarding an insurer's utilization review program does not limit the types of claims which may be subject to utilization review. MCL §500.3157a(3)(a) requires the Department to establish criteria or standards for utilization review that "identify utilization of treatment, products, services, or accommodations under this chapter **above the usual range of utilization for the treatment, products, services, or accommodations based on medically accepted standards**." (Emphasis added).

The Revised Rules fail to track the standard specified in MCL §500.3157a(3)(a) which triggers utilization review. The Revised Rules do not limit the scope of the utilization review program to benefits that are provided above the usual range of utilization based on medically accepted standards, which is the standard mandated by MCL §500.3157a(3)(a).Without the proposed revision, nearly any claim submitted by a provider, regardless of the utilization of the claim for a specific injured person, could become subject to an insurer's utilization review program. This is not permitted by MCL §500.3157a(3)(a).

Thank you for the opportunity to comment. Your thoughtful consideration is appreciated.

Sincerely,

Julie L. Novak
Chief Executive Officer

April 15, 2020

Anita Fox, c/o Michele Estrada
DIFS - Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, Michigan 48909-7720

RE: Comments on Administrative Rules for Utilization Review, Rule Set 2019-136 IF

Dear Ms. Fox,

On behalf of the Michigan Physical Therapy Association (MPTA), I am submitting comments regarding Administrative Rules for Utilization Review, Rule Set 2019-136 IF. Comments regarding specific rules and recommendations for ensuring accountability and protection of the public are provided below:

R 500.67 (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.

Greater specificity is required to adequately protect Michigan's citizens from inappropriate insurer determinations made by unqualified individuals. MPTA recommends that these determinations must be made, at least in part, by individuals licensed in the same profession as the service under review. Similar to the use of expert witnesses in legal proceedings, ***only an individual licensed in the same profession is able to comment on acceptable standards of practice for that profession and whether the service provided is clinically indicated and necessary.***

R 500.68 (2)(b) A detailed description of the medical review organization's experience in the review of medical care.

Greater specificity and public transparency are needed in this provision. MROs should be required to provide and make publicly available all statistics regarding denials and appeals, including a complied listing of reasons for denials by volume. Additionally, explicit inclusion of provisions that establish MRO and insurer accountability to DIFS in response to complaints is needed. ***Public accountability to MRO decision-making is critical for protecting Michigan's citizens from abusive MRO practices.***

R 500.68(2)(c) A description of the medical review organization's procedures for utilization, especially as it relates to the provision of personal protection insurance benefits.

This provision should require more than simply reporting of procedures. Administrative burden associated with MRO procedures is a significant, well-recognized problem that substantially adds to the cost of health care delivery. Although it might be difficult to prescribe specific procedures, ***explicitly establishing MRO and insurer accountability to DIFS in response to patient and provider complaints is critical.***

R 500.68(2)(e) Any other information requested by the director.

MPTA recommends that the rules also require insurer disclosure of incentive payment arrangements with MROs. This is especially important for incentive payments that are based upon denial rates which incentive abusive MRO practices.

Thank you for your consideration of these comments.

Sincerely,

Michael J. Shoemaker, PT, DPT, PhD
President
Michigan Physical Therapy Association

Nicole R. Whitlow
Vice President, Casualty Claims
Auto Club Insurance Association
1 Auto Club Drive
Dearborn, MI 48126-2694
Tel: (313) 336-1728
Fax: (313) 336-2626

Via E-Mail Only – *EstradaM1@michigan.gov*

April 17, 2020

Michele Estrada
Office of Research, Rules, and Appeals
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, Michigan 48909-7720

Dear Ms. Estrada:

Please find enclosed The Auto Club Group's Public Comments on the Utilization Review Proposed Administrative Rules (Rule Set 2019-136 IF). Please also find attached "Exhibit: The Auto Club Group's Suggested Changes to the Utilization Review Rules" which provides recommended modifications to the proposed Utilization Review rules, in redline format. We appreciate your consideration and for the opportunity to provide this input.

Please let me know if you have any questions, concerns, or comments.

Sincerely,

Nicole Whitlow

Nicole R. Whitlow
Vice President, Casualty Claims

The Auto Club Group's Public Comments on the Utilization Review Proposed Administrative Rules (Rule Set 2019-136 IF) April 17, 2020

This public comment document is respectfully submitted by The Auto Club Group (hereafter "Auto Club") in response to the Michigan Department of Insurance and Financial Services' Utilization Review Draft Rule Language as posted online on March 5, 2020 and as also published as Proposed Administrative Rules at 2020 MR 5 pp 2–6 (Apr. 1, 2020). These comments are provided within the framework of ensuring that the proposed rules comport with the intent of the legislature in enacting MCL 500.3157a, which established utilization review as a key element of comprehensive no-fault reform in Michigan.

Attached as an exhibit to these written comments are Auto Club's recommended modifications to the proposed Utilization Review rules, in redline format, including recommendations to delete terms that appear to be remnants of the original rules posted by the Department of Insurance and Financial Services (hereinafter referred to as "Department") on December 16, 2019 . The remainder of this document provides the policy and legal rationales for these modifications as well as Auto Club's other comments on the proposed rules. It concludes with a section in which Auto Club responds to several oral comments made during the April 10, 2020 virtual public hearing.

I. *The proposed rules do not effectuate the legislative mandate to establish substantive criteria or standards governing utilization review.*

Section 3157a specifies that the Department of Insurance of Financial Services "shall promulgate rules under the administrative procedures act of 1969" to, among other things,

> Establish criteria or standards for utilization review that identify utilization of treatment, products, services, or accommodations under this chapter above the usual range of utilization for the treatment, products, services, or accommodations based on medically accepted standards.

MCL 500.3157a(3)–(3)(a). R 500.62(1)(a) then goes on to recite that the proposed rules do in fact establish such criteria or standards. The Regulatory Impact Statement, moreover, recognizes that the first desired outcome of this rulemaking is for the rules "to impose a uniform standard for utilization review." RIS, Answer 6C (March 4, 2020).

It appears that the proposed rules do not establish any uniform standards for utilization review. Indeed, they do not establish any criteria or standards of the kind mandated by Section 3157a.

The only information the rules add to what Section 3157a already sets forth concerning the substance of utilization review is a definition of the term "medically accepted standards":

> "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.

R 500.61(j) (emphasis added). But the rules do not define term "competent authority," which is vaguer than the phrase "medically accepted standards" it is used to define.

Presumably, the Department chose its proposed definition of "medically accepted standards" based on the definition of that term within the Worker's Compensation Health Care Services administrative rules

concerning utilization review.[1] The problem with doing so, however, is that the Department's proposed rules, unlike the Worker's Compensation rules, do not provide other guidance about where to find the substantive criteria or standards governing utilization review.[2] So while the absence of a definition of "competent authority" within the Worker's Compensation rules may be largely immaterial, the absence of a definition of "competent authority" within these proposed rules leaves insurers without sufficient guidance about how to set up a utilization-review program that will be acceptable to the Department and otherwise lawful.

This particular problem could be solved easily enough. Drawing on Section 418.101204(5) of Michigan's Worker's Compensation rules, the Department could define "competent authority" as "published, appropriate standard medical practices and resource documents." The exhibit to these Comments incorporates this recommended language.

The more important point and bigger concern, however, is that Section 3157a's mandate *obligates the Department itself*—not some other "competent authority"—to set the utilization-review standards or criteria mentioned in the No-Fault Act. Even with the above revisions to the definitions section, the rules still contain no true criteria or standards that will allow an insurer to establish a utilization-review program with assurance that the program will not be later rejected by the Department as somehow insufficient. And they contain no criteria or standards that an insurer can rely on in making a specific utilization-review determination under R 500.65(1)(a) with confidence that the determination will be upheld upon appeal. That subrule specifically requires an insurer to state, in any written notice of determination to a provider, the "criteria or standards on which the insurer relied in making its determination." These are precisely the criteria or standards that are required to be, but have not, been promulgated by rule.

Instead of establishing actual criteria or standards for utilization review, the proposed rules appear to envision that the Department will later flesh out the "criteria or standards" through adjudications of appeals under R 500.66 and through the certification process under R 500.67. However, Section 3157a simply does not contemplate that the Department may establish the appropriate "standards or criteria" for utilization review by adjudicative policymaking. Instead, the statute expressly mandates the Department "shall promulgate rules" establishing such "standards or criteria."

This problem can be remedied by the Department establishing, *by rule*, substantive criteria or standards for utilization review. Accordingly, the Department should draft a new rule that sets forth sufficiently clear and comprehensive criteria or standards so that insurers can, *based on the actual language of the rule*, "identify utilization of treatment, products, services, or accommodations above the usual range of utilization for the treatment, products, services, or accommodations based on medically accepted standards" in a fully lawful manner.

Moreover, insurers should not be required to "have in place a utilization review program" until after such a new substantive rule is promulgated, because insurers must structure their utilization-review programs so as to be fully compliant with the criteria or standards set forth in the new rule. It is further recommended that

---

[1] *See* Mich Admin R 418.10109(d) (providing that "'medically accepted standards' means a measure that is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services ensuring that the health care is suitable for a particular person, condition, occasion, or place").

[2] *See*, *e.g.*, *id.* at R 418.101204(5) ("The carrier shall determine medical appropriateness for the services provided in connection with the treatment of a covered injury or illness, using published appropriate standard medical practices and resources documents. Utilization review shall be performed using 1 or both of the following approaches:
(a) Review by licensed, registered, or certified health care professionals.
(b) The application by others of criteria developed by licensed, registered, or certified health care professionals.")

the Department also delete the requirement at R 500.67(1) that insurers have a utilization-review program in place within 60 days of the effective date of this ruleset.

II. *The proposed rules incorrectly imply that the administrative appeals process mandated by Section 3157a is optional.*

At R 500.66(7), the Department has included language implying that when a dispute emerges between a provider and an insurer concerning utilization review, the provider has a free choice between initiating an administrative appeal under R 500.66 or filing a lawsuit pursuant to Section 3112. This contravenes both the intent of Section 3157a and the administrative-law doctrine requiring the exhaustion of available administrative remedies before initiating court proceedings. Accordingly, the Department should delete subrule 500.66(7) and clarify that a "provider shall follow the process specified in [R 500.66] for resolving disputes with an insurer regarding amounts invoiced by a provider but rejected by an insurer in a determination made under R 500.65."

Section 3157a unequivocally requires the Department to promulgate rules establishing an administrative process for "[a]ppealing determinations." MCL 500.3157a(b)(*iii*). It further mandates that this appeals process be available to a provider whenever an insurer makes an adverse determination that the provider "overutilized or otherwise rendered or ordered inappropriate treatment, products, services or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under this chapter." MCL 500.3157a(5). The rules themselves properly state that a provider may take an administrative appeal of an insurer's adverse determination. *See* R 500.66(1).

R 500.66(7), however, unnecessarily creates uncertainty regarding the need for a provider to exhaust the appeals process with respect to an adverse determination by an insurer. That subrule states that a "provider that files an appeal with the department under this rule does not waive its right to seek civil remedies that were not subject to the appeal." This language is both misleading and unnecessary. It is misleading insofar as it creates the illusion that a provider may forego appealing certain parts of an insurer's adverse determination but then bring a lawsuit to challenge those aspects of the determination. That is not the law. The "doctrine of exhaustion of administrative remedies requires that where an administrative agency provides a remedy, a party must seek such relief before petitioning the court." *Cummins v Robinson Tp*, 283 Mich App 677, 691 (2009); *see also Schwartz v Mich Sugar Co*, 106 Mich App 471, 480 (1981) (plaintiff's failure to pursue available administrative remedies precluded his action in the Circuit Court). So to the extent that R 500.66(7) implies that a provider may pick and choose what issues in a determination it wishes to appeal to the Department and what issues it wants to litigate in court, that subrule is contrary to law. Providers wishing to contest an adverse utilization-review determination must first exhaust the appeals process set forth in R 500.66.

Moreover, to the extent that R 500.66(7) implies that a provider does not waive its right to seek civil remedies for issues unrelated to an insurer's adverse utilization-review determination, the subrule is entirely unnecessary. The appeals process in R 500.66 provides for appeals only of adverse determinations by an insurer. One is not required to exhaust an administrative remedy that cannot address the alleged wrong the person has suffered or will suffer. *See Cummins*, 283 Mich App at 691.

For these reasons, subrule R 500.66(7) should be deleted from the rules and the Department should instead clarify that providers must follow the administrative appeals process for utilization-review disputes.

In addition, Auto Club believes that the appeals process should be electronic, so that the entire process will be more standardized, more efficient, and speedier—both for the Department and for disputants. Auto Club's recommended change to this effect, as well as its other recommended changes to R 500.66, are reflected in the exhibit to these Comments.

III. *The records-acquisition procedures are inefficient, incentivize providers to impose new and undue costs on insurers, do not comport with the statutory intent to ensure an effective and timely utilization-review process, and do not comport with Section 3107(1)(a) and 3158.*

Auto Club is concerned about the accuracy of providers' representations to the Department regarding current billing practices, particularly as that picture emerges from the Regulatory Impact Statement. Currently, when providers submit invoices to Auto Club, those invoices are usually accompanied by medical records necessary to support the charges for which the provider is seeking payment. Such records typically include appropriate diagnostic reports, daily treatment records, and surgical reports. Accordingly, Auto Club usually does not need to request further records to determine whether the charges submitted and the treatments rendered were appropriate.

Under R 500.63, not only are providers seemingly not required to accompany an invoice with *any* records whatsoever, but providers are also expressly allowed to extract fees from insurers for any records the insurer needs—even the most basic medical reports necessary to support the charges billed. The rules would overturn and remake the set of record-production practices that the market has come to follow, and would allow providers to extract fees from automobile insurers that providers could never charge to health insurers.

If the rules take effect as proposed, Auto Club anticipates that providers will no longer send invoices accompanied by all medical records necessary to evaluate the billing. This is just a matter of microeconomics. Under R 500.63(2) and R 500.64(3), providers have nothing to lose and much to gain by submitting as few records as possible with an invoice; given the extremely high medical-record and written-explanation fees in the proposed rules, providers can bill substantial extra time and charge extra fees to automobile insurers for providing information that providers now typically provide upfront and at no cost. This would be a highly inefficient upheaval of a system that is well-ingrained and that promotes the full and timely exchange of necessary medical information at low cost. When that system disappears, it will leave automobile insurers with little choice but to hire and train new administrators whose sole job would be to secure all necessary records from providers. Auto Club anticipates that the cost of merely obtaining copies of necessary and customary medical records could be a significant new financial burden.

In sum, the proposed rules would effect a substantial and inefficient change in current practices, and they would undermine Section 3157a's goal of allowing insurers to control costs by conducting thorough utilization review—for which automobile insurers will need all the records that providers until now have sent at no cost as a matter of course. This is contrary to the mandate that the Department "shall design the rule to achieve the regulatory objective in the most cost-effective manner allowed by law." MCL 10.151(7).

To remedy this concern, Auto Club offers two basic approaches. First, the rules could require providers to accompany their invoices with certain basic records necessary to support the charges billed. Second, the rules could require that providers submit such records to insurers at no cost upon the insurer's request. Auto Club urges the Department to follow the first approach.

The first approach better comports with the statutory scheme of the No-Fault Act and the language of Section 3157a, 3107(1)(a), and 3158. While Section 3157a(3)(b)(*ii*) provides for insurers "to request" written explanations, Section 3157a(3)(b)(*i*) does not refer to any need for insurers to "request" existing records and information necessary for effective utilization review. This difference in statutory language indicates that providers should be required to provide insurers with certain necessary records and information at the outset of the claims process, *without any "request" from the insurer*.

Moreover, Section 3107(1)(a) requires that "personal protection insurance benefits are payable" for "reasonably necessary products, services and accommodations" at a "reasonable charge." Additionally, Section 3158 already authorizes insurers to "request" certain information from providers *after* a claim is

made. Accordingly, Auto Club believes that the Legislature in enacting Section 3157a(3)(b)(*i*) envisioned that the Department would make rules expressly stating what records an insurer is entitled to "acquire" *at the same time* the provider sends the initial invoice. Otherwise, R 500.63 is superfluous. This is clearly not what the Legislature envisioned when it passed MCL 500.3157a(3)(b) while leaving Section 3158 unchanged.

Accordingly, the exhibit to these Comments suggests revising the rules to require a provider to provide certain customary and necessary records alongside an initial invoice.

It is also recommended that R. 500.63 be revised to provide for an administrative charge for records instead of a charge based upon "the provider's average hourly rate." Specifically, Auto Club recommends adopting, in relevant part, the language set forth in MCL 333.26269 regarding charges for copying medical records. Such revisions would avoid economic misincentives and ensure that providers do not charge more than a reasonable administrative charge to provide further records under R 500.63(3). Moreover, Rule 500.64 should also be revised to ensure that a provider does not charge more than a reasonable rate for a written explanation and ensure that a provider does not charge automobile insurers more than the provider's usual and customary charge for written reports in cases not involving automobile insurance.

Auto Club believes that the revisions of R 500.63 and 500.64 outlined above and shown in the exhibit to these Comments will accomplish all of these necessary goals and minimize or eliminate the potential inefficient economic incentives and legal concerns introduced by the rules as currently proposed.

IV. *Subjecting insurers' annual utilization-review reports to blanket disclosure under the FOIA conflicts with Section 3157b's FOIA exemption for proprietary information submitted under Section 3157a*.

Proposed R 500.70 is insufficient to ensure consistency with the FOIA exemption at Section 3157b of the No-Fault Act and to protect insurers' proprietary commercial and financial information from competitors. The Department should revise the rule accordingly.

R 500.70(1) provides that insurers must submit an annual report "on form [*sic*] prescribed by the department regarding utilization review data and activities. The department shall provide instruction to insurers regarding completion of the report." R 500.70(2) provides that an insurer's annual utilization-review report "is subject to disclosure under the freedom of information act." Neither subrule contains guidance about what utilization-review-related information the Department will require insurers to submit in their annual report, or what purpose the annual report will serve.

It appears, however, that whatever information is required from insurers in an annual report, will be available to all an insurer's competitors by means of a simple FOIA request. Crucially, though, MCL 500.3157b exempts from disclosure under the Freedom of Information Act, MCL 15.231 *et seq.* (the "FOIA") "[a]ny proprietary information…submitted to the department [of Insurance and Financial Services] under section 3157a." It similarly exempts from disclosure any "sensitive personally identifiable information regarding a patient" submitted to the Department under 3157a. The language of R 500.70(2) does not appear to recognize or give effect to these exemptions; instead, the subrule seems to state that the Department will turn over an annual report in its entirety in response to a FOIA request.

The best solution to this problem is to strike subrule R 500.70(2) from the rules altogether. First, it is unclear that administrative agencies possess the authority to promulgate a rule subjecting information to disclosure under the FOIA. That is particularly the case given that the FOIA, unlike the Insurance Code, is not a statute administered by the Department. Second, it is unclear what statutory language in Section 3157a—which is the source of the Department's statutory authority for this rulemaking—gives the Department the authority to make a rule regarding disclosure under the FOIA. And finally, there is simply no need for the rules to address disclosure of utilization-review-related information under the Freedom of

Information Act. Michigan courts are well-versed in applying the detailed statutory provisions of the FOIA (including the ample caselaw interpreting the narrow exemptions to disclosure) to records in the possession of administrative agencies and other public bodies, and they can readily apply the FOIA with respect to any information that the Department chooses to require insurers to submit in their annual report. Accordingly, and as shown in the exhibit to these Comments, subrule R 500.70(2) should be deleted from the proposed rules.

Responses to Oral Comments Made at the April 10, 2020 Virtual Public Hearing:

Auto Club wishes to respond to several problematic comments and suggestions made during the April 10, 2020 virtual public hearing, as voiced by the Sinas Dramis Law Firm and the Michigan Brain Injury Provider Council ("MBIPC").

Comment: Proposed R 500.65 and R 500.66 could be interpreted to require providers to exhaust administrative remedies, but requiring providers to exhaust administrative remedies will interfere with providers' direct cause of action under Section 3112.

Response: As already discussed above under heading **II**, under well-established principles of Michigan law, Section 3157a itself requires providers to exhaust the administrative appeals process with respect to an adverse determination by an insurer. *Supra* pp 4–5. The Department lacks authority to promulgate a rule that would change this.

When the Legislature creates by statute both an administrative remedy and a direct cause of action but does not wish to require exhaustion, it will provide appropriate statutory language to that effect. *See*, *e.g.*, MCL 37.1607 (providing that "[t]his act shall not diminish the right of a person to seek direct and immediate legal or equitable remedies in the courts of this state"); *Marsh v Dep't of Civil Service*, 142 Mich App 557 (1985) (pursuant to MCL 37.1607 and Michigan constitution, individual is not required to exhaust administrative remedies created under section 605 of the Handicappers' Civil Rights Act ("HCRA"), MCL 37.1605, before bringing a civil action in circuit court against an employer for violation of the HCRA pursuant to statutorily created direct cause of action under section 606 of the HCRA, MCL 37.1606).[3] The No-Fault Act contains no provision similar to MCL 37.1607—no provision, that is, which would excuse a provider from exhausting administrative remedies before bringing suit under 3112 when the administrative appeals procedure under Section 3157a is available to the provider.

The Department, like all administrative agencies, has no power or authority "to *abridge* or enlarge its authority" under the guise of its rulemaking power. *See York v City Detroit*, 438 Mich 744, 767 (1991) (citation omitted) (emphasis added). Section 3157a *requires* that the Department establish an administrative process whereby a provider may appeal to the Department an insurer's adverse utilization-review determination. *See generally* MCL 500.3157a(3)(b)(*iii*); 500.3157a(5). The Department thus has no authority to contract or modify the scope of its duty to hear such appeals by promulgating a rule stating that providers are free to run into court and avoid some or all aspects of the administrative appeals process.

[3] The analysis is different when the cause of action is not statutory. Exhaustion is sometimes not required before a plaintiff brings a common-law cause of action, because a statutory remedy for enforcement of a common-law right is deemed only cumulative. *See generally Burns v Stanford Bros, Inc*, No. 259013, 2006 WL 2061471 at *4 (Mich Ct App July 25, 2006) ("a plaintiff specifically alleging common law claims separate and distinct from policy violations expressed in and prohibited by statute is not required to exhaust administrative remedies before bringing the *common law* claims in circuit court) (emphasis in original).

Auto Club mentions this point so as to rebut in advance any reliance by providers on caselaw involving common-law rather than statutory causes of action when discussing Section 3112.

The fact that Section 3157a(5) uses the word "may" does not affect the analysis. *See*, *e.g.*, *Schwartz v Mich Sugar Co*, 106 Mich App 471, 480 (1981) (plaintiff's failure to pursue available administrative remedies under MCL 408.1065(2)–(8) precluded his action in the Circuit Court); MCL 408.1065(2) (providing that employee "*may* file a complaint with the department of labor") (emphasis added).

Comment: The Department should revise the definition of "medically accepted standards" to eliminate any reference to a "competent authority." Instead, "medically accepted standards" should be defined with reference to what is "generally accepted by practicing physicians," since the regulatory definition should "reflect a community standard rather than a supposed authority of unknown origin."

Response: This recommendation is incompatible with the statutory language of Section 3157a and with the general legal background concerning utilization review. It also would be exceedingly difficult if not impossible for insurers to apply and for the Department for administer, and would undermine the Department's goal of providing a "uniform standard to ensure consistency of utilization review determinations." *See* RIS, Answer 6B. The Department should therefore reject it.

When defining "utilization review" at Section 3157a(6) by reference to "medically accepted standards," the Legislature modeled its language directly on the definition of utilization review in the Worker's Disability Compensation Act. *See* MCL 418.315(5). And long before the passage of 2019 PA21 & 22, the Workers' Compensation Agency promulgated rules defining "medically accepted standards" to involve a measure set by a "competent authority." *See* Mich Admin R 418.10109(d). When construing a statute, one must presume that the Legislature is familiar with the interpretation given to particular language by executive agencies. *See Melia v Appeal Bd of Mich Employment Sec Comm*, 346 Mich 544 (1956). Accordingly, the Department is correct to presume that the Legislature, when using the term "medically accepted standards" at Section 3157a(6), intended that phrase to be defined in terms of "competent authority."

Further, defining "medically accepted standards" by reference to "standards or criteria generally accepted by practicing physicians" would make it extremely difficult for insurers to develop and administer a workable utilization-review program overseen by the Department. Simply put, there is no compendium or reference containing any generally accepted practices of practicing physicians. What does exist in readily accessible form are standard treatment, diagnosis, and specialty guidelines developed and published by universally recognized medical authorities such as the American Medical Association (AMA) or medical specialty organizations recognized by the Accreditation Council for Graduate Medical Education. That is a large part of the reason why Auto Club has proposed defining "competent authority" in terms of *published* standard practices and resources. Doing so will reduce uncertainty. It will also minimize disputes, because it will avoid battles of the experts concerning what standards or criteria are generally accepted among certain groups of practicing providers. In addition, relying on standards set by a "competent authority" will ensure high-quality patient care in accordance with best medical practices; after all, authorities such as the AMA are hardly "supposed authorities of unknown origin."

Finally, defining "medically accepted standards" as "standards or criteria generally accepted by practicing physicians" would not ensure consistency of utilization-review determinations. To the contrary: relying on a "community standard" could mean that certain treatments that are appropriate for patient X in city Y are not appropriate for patient A in city B, despite the fact that the patients have the same condition. Section 3157a contains no language indicating that "medically accepted standards" should vary in this way. If the Legislature wanted to incorporate local standards of practice, it could have indicated as much in the statute. Needless to say, it did not do so.

Comment: R 500.68 "impermissibly would allow insurers to delegate their [utilization-review] responsibilities to an outside organization." Moreover, because Section 3157a contains no language specifically allowing an insurer to contract with an external medical review organization, the Department may not allow that by rule.

Response: It is Auto Club's position that this comment is misplaced for a number of reasons.

First, it is universally recognized that insurers of all kinds regularly retain a specialized utilization-review organization as their agent in performing utilization review. Second, when any principal retains an agent to perform a certain task or tasks, it is still the principal who is responsible for performing that task with respect to third parties. Accordingly, when an insurer retains an utilization-review organization to evaluate the quantity and quality of care rendered by a provider, the insurer is still the entity performing that evaluation for purposes of Section 3157a. It is well-settled law that principals are free to retain an agent to accomplish a given task. Contrary to what was offered at the hearing, the rules would not impermissibly allow insurers to "offload" their utilization-review responsibilities to a third party. Indeed, the proposed rules specifically provide that insurers will remain "responsible for complying with the act and any rules promulgated thereunder" notwithstanding their retention of a utilization-review organization. R 500.68(1).

Third, requiring insurers to perform utilization review in-house would be extremely inefficient. Utilization-review organizations have extensive expertise and experience in utilization review and can therefore perform such review at lower overall cost than insurers could ever do on their own. Allowing insurers to retain utilization-review organizations as their agents thus furthers Section 3157a's goal of reducing overall auto-insurance costs in Michigan.

Comment: The Department should eliminate R 500.67(2)(c), concerning independent medical examinations ("IMEs"), or at least should delete the adjective "independent."

Response: It is difficult to understand the request that the Department eliminate R 500.67(2)(c) as anything other than an attempt to prevent insurers from conducting IMEs as part of utilization review. In any case, the language of Section 3151 and Section 3157a(5) clearly countenance that an insurer may base an adverse utilization-review determination on the results of an IME, so nothing prevents the Department from addressing IMEs in this rulemaking.

Section 3151(1) provides that "[i]f the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, at the request of an insurer the person shall submit to mental or physical examination by a physician." Notably, the statute is not limited to claims made by an injured individual; it applies to any claim, including a claim submitted by a provider. Section 3157a(5), in turn, contemplates that insurers may make determinations not only concerning overutilization strictly speaking but also concerning other inappropriate care (or inappropriate costs) rendered or ordered by a provider. Accordingly, insurers may render adverse "determinations" under Section 3157a pursuant to an independent medical examination conducted under Section 3151. It therefore is perfectly valid for the Department to address IMEs under the Utilization Review rules, even if it is simultaneously true that *not all* IMEs will be conducted as a part of utilization review.

In addition, Auto Club raises concern with MBIPC's request that R 500.67(2)(c) should use the term "medical examinations" instead of "independent medical examinations." MBIPC attempted to justify this request by stating that "Section 3151 of the Act does not use the phrase 'independent medical examination.'" But Section 3151 does not even use the term "medical examination." Indeed, the entire phrase "independent medical examination" is simply a legal term of art commonly used to refer to mental or physical examinations conducted by physicians at the request of insurers pursuant to Section 3151. *See*, *e.g.*, *Muci v State Farm Mut Ins Co*, 478 Mich 178 (2007). Auto Club therefore sees no need to avoid the use of this phrase in the rules.

EXHIBIT

Exhibit – The Auto Club Group's Suggested Changes to the Utilization Review Rules

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) "Competent authority" means published, appropriate standard medical practices and resource documents.

(d~~e~~) "Department" means the department of insurance and financial services.

(e~~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~~h) "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~~i) "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~~j) "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~~k) "Provider" means a physician, hospital, clinic, or other person providing medical care to an injured person.

(~~n~~l) "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~~ injured 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) When submitting an invoice to an insurer, a provider shall accompany the invoice with copies of all medical records from the date or dates of service supporting the charges invoiced, including copies of all diagnostic reports supporting diagnostic-testing charges invoiced and all surgical reports supporting surgical charges invoiced.

(2) An insurer may request from a provider further necessary records, medical bills, and other information concerning the medical care provided~~r~~ to~~o~~ an injured person.

(3~~2~~) If an insurer's request for records under subrule (2~~1~~) requires the provider to provide medical records in excess of those that must accompany an invoice submitted to the insurer under subrule (1), the insurer must pay the provider an administrative charge for the records. ~~reimburse the provider~~. The charge for providing paper copies are as follows: (i) $1.00 per page for the first 20 pages; (ii) $0.50 per page for pages 21 through 50; and (iii) $0.20 for pages 51 and over, plus the actual cost of mailing. For electronic copies, an administration charge for the provider or provider staff's time to retrieve the records shall be paid as follows: 0-15 minutes, $2.50; each additional 15-minue increment, $2.50. ~~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~~ necessity 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~~ written explanation at a reasonable rate based upon the provider's average hourly rate. The provider's total charge must not exceed the provider's usual and customary charge for providing like reports in cases that do not involve automobile insurance.
(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 shall follow the process specified in subrules (2)-(7) of this rule for resolving disputes with an insurer regarding amounts invoiced by the provider but rejected by the insurer in a determination made under R 500.65.
(~~1~~2) A provider may appeal a determination made by an insurer made under R 500.65 on a form prescribed by the department. All appeals shall be filed electronically, in accordance with instructions on the form. The appeal must be filed within 90 days of the date of the disputed determination.
(~~2~~3) 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~~4) 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~~5) 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~~6) 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~~7) 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~~ 2102 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 a 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.~~

MHA Michigan Health & Hospital Association | Leading Healthcare

Via Email

April 17, 2020

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for Utilization Review
Rule Set 2019-136 IF

Dear Ms. Estrada:

The Michigan Health and Hospital Association submits this letter to the Department of Insurance and Financial Services ("DIFS") for consideration with respect to the public comment period for the Administrative Rules for Utilization Review, Rule Set 2019-136 IF, that DIFS promulgated pursuant to MCL 500.3157a, which requires the establishment of a utilization review program related to the no-fault automobile insurance reforms in PA 21 and 22 of 2019.

We respectfully submit the following comments.

1. R 500.61(g) provides that "Insurer" has the same meaning as Michigan's insurance code (at MCL 500.106), and R 500.62(d) provides that the utilization review rules apply to all insurers that provide personal protection insurance under chapter 31 of the act, MCL 500.3101 or under chapter 31A of the act, MCL 500.3181, and to the catastrophic claims association created under section 3104 of the Act, MCL 500.3104.

a. Because many insurers who provide Auto No Fault insurance also provide other types of health insurance, these utilization review rules as currently drafted may be construed to broadly apply to all insurance operations of these insurers. The rules should be revised to state that the utilization review rules only apply to an insurer's management of Auto No Fault insurance claims.

2. Under R 500.63(1), insurers may request information from providers including "necessary records" and medical bills pertaining to the medical care provided to accident victims.

a. This regulation does not limit or specify the purpose for which the insurer may request such information. This regulation should specify that the insurer may only request the minimum information necessary for utilization review required under these rules.

3. R 500.63(2) provides that if insurers request information in excess of the documents the provider submitted to the insurer with the invoice for the medical care provided to the accident victim, the insurer must reimburse the provider at the provider's "average hourly rate," which is not defined.

a. This rule should be modified to state that the "average hourly rate" reimbursed for gathering this information will include all wages, benefits, payroll taxes, etc. required by state law to be paid to such administrative support staff.

4. R 500.65(1) enables insurers to make the following determinations: (i) a provider overutilized medical care, (ii) a provider rendered or ordered inappropriate medical care, or (iii) that the cost of the care was inappropriate under the no-fault law.

a. There is no definition of "overutilized," or "inappropriate medical care" or objective standard to determine such; rather, insurers need only specify the criteria or standards on which the insurer relied, and the provider has the burden to appeal the determination. We request that the rules provide more guidance on "overutilized" and "inappropriate medical care" in order to ensure that insurers are only challenging claims where appropriate and that providers are subject to a single objective standard. Additionally, including a specific, uniform objective standard would further the objective of the rules to ensure greater consistency in automobile insurers' determinations regarding the appropriateness of care provided to injured persons.

b. Not all care provided to accident survivors is "medical". Therefore, non-medical care should be outside the scope of these rules. By way of example, attendant care services for activities of daily living, adult foster care, or even nursing home services may be related to non-medical, non-physical deficits and should be clearly stated as outside the scope of these rules.

5. R.500.67(2)(b) requires that an insurer's utilization review program make determinations regarding the medical appropriateness for services, including both the level and quality of care provided to injured persons using "medically accepted standards." R500.61(j) defines the term "medically accepted standards" to mean "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."

a. The term "competent authority" is vague and will create uncertainty. The scope of "medically accepted standards" should be limited to those generally recognizable in the health care industry. We recommend more universally accepted and utilized language: The term "medically accepted standards" shall mean either of the following: (1) Standards that are based on credible scientific evidence published in peer-reviewed,

medical literature generally recognized by the relevant medical community or (2) Physician Specialty Society recommendations.

b. As noted above in Section 4(b), not all care provided to accident survivors is "medical". Therefore, non-medical care should be outside the scope of these rules and not subject to standards that apply to medical care.

6. The Administrative Rules do not provide any required time period following which insurers must pay submitted bills, nor do the rules limit the time period of the claims subject to utilization review (*e.g.*, requiring any utilization review on each claim to be completed within one year of the date of service).

a. The lack of a specified overpayment recoupment period, which effectively creates an infinite recoupment period, will lead to financial uncertainty for healthcare providers. Many of MHA's members do not have the financial reserves to support a system that does not impose a time limit for insurers to seek recovery of overpayments. An unlimited period for recovery of payment will be especially burdensome for small hospitals and health care providers that do not have significant cash reserves. Also, if the insurer fails to make a determination when the bill when it is submitted, the rules as written given the insurer a "second bite at the apple" in that the insurer may have missed the first chance to adjust the claim but now has an unlimited time to make a determination under R500.65(1) and seek repayment. We propose that the rules be revised to require that determinations under R500.65(1) regarding overutilization or the inappropriateness of medical care be made when an insurer pays a bill, and that payments and determinations under R500.65(1) be made within 3 months of an insurer's receipt of a bill.

Respectfully Submitted,

Laura Appel | Senior Vice President
Chief Innovation Officer
Michigan Health & Hospital Association
110 W. Michigan Ave | Lansing, MI 48933
517-703-8606 Office | 517-285-2962 Cell
lappel@mha.org

Wohlford, Sarah (DIFS)

From: Charlie Avila <cavila@eisenhowercenter.com>
Sent: Friday, April 17, 2020 11:49 AM
To: Estrada, Michele (DIFS)
Subject: Urgent need

I have been forwarded the Draft Utilization Review Rules 2.27.20 because I have been asked to be kept informed. While I am not an attorney and I am not a physician I am very aware of the impact it will have on my family members with catastrophic injuries that require therapy and care.
One (SJ) of the injured did not have the wonderful coverage we had when he was originally injured and he suffered and continues to suffer in a nursing home with inadequate care. We are headed down this path given the draft as stated. Another (JB Jr) is racking up hundreds of thousands of dollars due to the insurance company fighting the cost of care in the family's opinion dragging out payment and waiting for the opportunity to just have it dropped leaving the injured person on the streets with a huge debt (he was rundown while crossing the street on his break from work and the person fled the hit and run). The third (MM) and fourth (DH) had the coverage they needed got the help and are both working full-time taking care of themselves and their family.
I am the admissions manager for a rehabilitation facility and I turn away so many persons in need that need care it is hard to imagine what will happen if the Draft is not changed. I had an opportunity to speak to a community mental health social worker who reported that they do not recognize Traumatic Brain Injury and therefore are not covered unless there is a dual diagnosis that qualifies. Medicaid is not sufficient care for these individuals and I am concerned for the masses that this affects.
If this is the case your draft will effectively cost loss of care for thousands of people in need and putting them on the streets and in homes without supervision or jail due to not being able to properly maintain appropriate behavior or being taken advantage of. I urge you to make the changes that are being proposed.

Thank you in advance for a response,

Charlie Avila, CBIS
Admissions Manager
Eisenhower Center
3200 E. Eisenhower Pkwy
Ann Arbor, MI 48108
734.677.0070. x.273
Fax: 734.794.9808
cavila@eisenhowercenter.com
Kindness, compassion and quiet strength, moving your journey forward

Wohlford, Sarah (DIFS)

From: Amy Baranek <abaranek@eisenhowercenter.com>
Sent: Wednesday, April 15, 2020 2:45 PM
To: Estrada, Michele (DIFS)
Subject: DIFS concerns

Ms. Michele Estrada:

I am a provider of care for persons with brain injurie
Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically a
"competent authority." In my experience, this could l
whose credentials are less than transparent. I think th
medical community and the definition changed to:

> "'Medically accepted standards' mean
> practicing physicians for evaluating qu
> care is suitable for a particular person,

Rule 64(3). The insurer is obligated to reimburse the
or deadline for payment to be issued. I suggest a dea
issue payment.

Rule 65. There is a lack of stated deadline imposed

Wohlford, Sarah (DIFS)

From: Chad Brendtke <cbrendtke@eisenhowercenter.com>
Sent: Friday, April 17, 2020 7:37 AM
To: Estrada, Michele (DIFS)
Subject: Concern about Auto no fault changes

To Whom it may concern,

My name is Chad Brendtke, and I am very concerned with the auto no fault changes that will take place in July 2020. I personally take care of 170 clients give or a take 1 or 2, depending on discharges. My biggest concern is always the clients I serve. I am concerned when there is denial for much needed therapy by non qualified adjusters. It is much cheaper to have people mobile as much as possible to avoid pressure sores and for muscle strength. I agree that some of my guys are not making huge strides that can be measured as a tremendous gain, but the physical maintenance that is provided by a licensed professional makes a difference in my clients life. Also, an adjuster is not a doctor and does not have the knowledge to approve or deny treatment or care. I work at one of the least expensive traumatic brain injury rehabilitation facilities in the state and we provide a ton of services for our clients. I don't believe that insurance companies will act in the best interest of the client when they benefit by saying no. The insurance companies have been requesting independent medical examinations for many of my clients and I have been present and some how they don't see documented deficits, because they choose not to, because they are paid by the insurance companies. Lastly, there is no timeline for payment reimbursement for services rendered. If this practice is implemented, business' that care for people will go out of business waiting for the payment.
We provide a safe, caring and client centered environment for them to live a high quality of life. We love our clients and they didn't choose to be injured, but they were. At this point, they need our support and care in their time of need. I hope that none of us that are able to provide services ever need the support we provide daily to my clients, it would mean that we had a tragic accident.

Thank you for your consideration,
Chad Brendtke
Program Coordinator, Eisenhower Center
734-796-3700

Sent from Mail for Windows 10

Wohlford, Sarah (DIFS)

From: Mary Ellen Clark <clarkclown@yahoo.com>
Sent: Friday, April 17, 2020 2:15 PM
To: Estrada, Michele (DIFS)
Cc: Mary Ellen Clark; mlevandowski@cpan.us
Subject: Statute dealing with mandatory utilization review

The new rule in the auto insurance law that mandates a mandatory review process etc. is designed for one purpose and that is to deny benefits to the newly injured and the previously injured who will have or now have catastrophic injuries due to auto accidents. We are going from a fully funded fund in which we have saved 25 billion dollars over a 40yr. period to a for profit insurance. Instead of being a state with the largest number of state-of-the-art facilities for brain and spinal cord injuries we will have to erect nursing homes for the injured to languish in.

The initial evaluation should not be done by the insurer. We know the insurer has only one thing in mind - cost. I see no criteria for people who are supposed to evaluate. One victim could have a number of specialists needed on a team to treat the injury. There should be a number of specialists on the evaluation team with approved credentials and the patient case manager should be informed. The first responders should be on the evaluation team. If there is a conflict with the evaluators how will that be handled? The initial doctors and specialists should be the evaluators.This statute is backwards. This will delay treatment and cost more. We were only paying $200.00 a year for all expenses paid.

What rights do the victims have ? Have the rights of the victims been taken away so that benefits can be denied ? Evidently we are being dictated by an insurance company. We don't know who these evaluators will be or their connection with the various insurance companies. This statute is very vague lending itself to abuse of the victim. We have had experience with Workmen's Comp. You own doctor will say that you need a certain treatment and the doctor for Workmen's Comp denies it. I see that happening here except that your own doctor doesn't get the first chance.

Originally, you have an accident, you might be in a coma. Your case manager is chosen by the patient advocate (which could be a spouse or parents) since the patient is in a coma. The case manager oversees the treatment and makes sure the providers are paid by the insurance companies and the fund managers. It is unclear what will happen now. This new plan does not protect the victim.

The victim of the accident is more vulnerable now than ever. God help us.

Submitted by Mary Ellen Clark
18101 Coyle
Detroit, MI 48235 clarkclown@yahoo.com

Wohlford, Sarah (DIFS)

From: Tobias Roberts <troberts@crci.biz>
Sent: Tuesday, April 14, 2020 10:31 AM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Concerns

I am a provider of care for persons with brain injuries. I have concerns with the 2/15/20 drift of Utilization Review Rules: R67(2)(c), goes beyond the language of that statute by call this examination "independent." I recommend R67(2)(c) is revised to state:

"Provide for the scheduling and performance of mental or physcial examinations by physicians at the request of an insurer."

Thank you,
Tobias Roberts
President
CRCI Case Management

Wohlford, Sarah (DIFS)

From: Brittani Davis <bdavis@eisenhowercenter.com>
Sent: Friday, April 17, 2020 1:55 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Rules Concerns

Hi Michele,

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you,

Brittani Davis, MBA
Human Resources Generalist

Eisenhower Center
3200 Eisenhower Parkway
Ann Arbor, MI 48108
bdavis@eisenhowercenter.com
hr@eisenhowercenter.com
Phone: (734) 677-0070, ext. 301
Toll Free: (800) 554-5543
Fax: (734) 677-0890

Wohlford, Sarah (DIFS)

From: Dan Bogosian <dbogosian@eisenhowercenter.com>
Sent: Tuesday, April 14, 2020 11:55 AM
To: Estrada, Michele (DIFS)
Subject: Concerns with 2/15/2020 Draft Utilization Review Rules

H Michele Estrada,

My name is Daniel Bogosian, the Quality Services Manager and Board Member of a Traumatic Brain Injury Facility named Eisenhower Center. Over my eight years at Eisenhower Center I have personally seen 840 lives helped. Eisenhower Center itself has been open for 25+ years. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. In my experience insurance driven individuals are not looking out for the long term health of their patients. I think the definition should be focused on the practices in the medical community and the definition changed to.

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment. By not having a deadline, the insurer can delay the reimbursement and this would affect the lives of the patients and the staff at the facility. Small facilities will not have the cash flow to stay open for business.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute **DOES NOT** use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your time,
Daniel Bogosian

Wohlford, Sarah (DIFS)

From: Ashley El-Asri <aelasri@eisenhowercenter.com>
Sent: Thursday, April 16, 2020 10:01 AM
To: Estrada, Michele (DIFS)
Subject: Concerns with Utilization rules

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

As a healthcare provider working with traumatic brain injury population, their care is unique in that they often require residential treatment, therapies and equipment needs long term to ensure medical stability, personal safety and positive quality of life. It is of utmost importance that they have practicing physicians making decisions for "medically accepted standards", not insurance companies or those that are not familiar with medical needs of this population.

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

As a clinician working with client's with TBI, a delay in treatment or equipment can be dire. Client's with TBI's require intense therapy to improve physical, cognitive, and emotional well-being, to strive for the best quality of life after an injury. Client's often require equipment to ensure greatest independence and safety with ADL and IADL skills.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you.

Wohlford, Sarah (DIFS)

From: Jeff Fried <jfried@friedporter.com>
Sent: Monday, April 13, 2020 4:16 PM
To: Estrada, Michele (DIFS)
Subject: Regarding utilization rules for auto no fault

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you,

Jeff fried

Sent from my iPhone

Wohlford, Sarah (DIFS)

From: Meg Scaling <mscaling@galaxybraincenter.com>
Sent: Monday, April 13, 2020 3:08 PM
To: Estrada, Michele (DIFS)
Subject: DIFS concerns

I own Galaxy Brain and Therapy Center and am greatly concerned about the draft of the 2/15/2020 draft Utilization Review Rules.

The language in this draft does not protect the provider, and requires providers to comply and adhere to strict deadlines and standards, but does not hold the same level of accountability to the insurance companies. There are many issues I have with the requirements that are being placed on providers (more requirements than what medical insurance requires), and the financial hardship that these utilization reviews and accreditations will cost a small single operation clinic. While now is not the time to discuss all of those concerns, I do want to highlight concerns with the 2/15/2020 draft as written:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your time and consideration,

Meg Scaling, CEO
Galaxy Brain and Therapy Center
5840 Interface Drive, Suite 400
Ann Arbor, MI 48103

--

Move Forward. Give Back.
Live Your Best Life!

Meg Scaling, Chief Executive Officer, OTRL
Galaxy Brain and Therapy Center
5840 Interface Drive, Ste. 400
Ann Arbor, MI. 48103
c: 734-904-4072
o: 844-816-0226
f: 734-433-1989

LinkedIn Profile

Email confidentiality Notice: The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPPA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of this message is strictly prohibited and may subject you to criminal or civil penalties. If you received this transmission in error, please contact the sender immediately by replying to this email and delete the material from any computer. Information transmitted is not considered medical advice and should not be understood as such.

Wohlford, Sarah (DIFS)

From: Elizabeth Gava <egava@eisenhowercenter.com>
Sent: Friday, April 17, 2020 1:57 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Rules

Good afternoon, Ms. Estrada:

My name is Elizabeth Gava, and I am the Communications Coordinator for Eisenhower Center, a facility that has been servicing traumatic brain injury survivors for over 25 years. I have witnessed many individuals beat the odds and regain their lives through the rehabilitation, care, and compassion we have provided. I am concerned about the following facets of the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for taking the time to consider these concerns.

Sincerely,

Elizabeth Gava
Communications Coordinator
734-677-0070 (ext 370)

Wohlford, Sarah (DIFS)

From: Charlie Green-Avila <4abuela88@gmail.com>
Sent: Friday, April 17, 2020 11:46 AM
To: Estrada, Michele (DIFS)
Subject: Urgent

I have been forwarded the Draft Utilization Review Rules 2.27.20 because I have been asked to be kept informed. While I am not an attorney and I am not a physician I am very aware of the impact it will have on my family members with catastrophic injuries that require therapy and care.

One (SJ) of the injured did not have the wonderful coverage we had when he was originally injured and he suffered and continues to suffer in a nursing home with inadequate care. We are headed down this path given the draft as stated. Another (JB Jr) is racking up hundreds of thousands of dollars due to the insurance company fighting the cost of care in the family's opinion dragging out payment and waiting for the opportunity to just have it dropped leaving the injured person on the streets with a huge debt (he was rundown while crossing the street on his break from work and the person fled the hit and run). The third (MM) and fourth (DH) had the coverage they needed got the help and are both working full-time taking care of themselves and their family.

I am the admissions manager for a rehabilitation facility and I turn away so many persons in need that need care it is hard to imagine what will happen if the Draft is not changed. I had an opportunity to speak to a community mental health social worker who reported that they do not recognize Traumatic Brain Injury and therefore are not covered unless there is a dual diagnosis that qualifies. Medicaid is not sufficient care for these individuals and I am concerned for the masses that this affects.

If this is the case your draft will effectively cost loss of care for thousands of people in need and putting them on the streets and in homes without supervision or jail due to not being able to properly maintain appropriate behavior or being taken advantage of. I urge you to make the changes that are being proposed.

Thank you in advance for a response,

Roberta L. Green Avila

605 S. Franklin Ave.

Flint, Mi 48503

Wohlford, Sarah (DIFS)

From: Marsha Hacker <marmomsobern@gmail.com>
Sent: Friday, April 17, 2020 11:59 AM
To: Estrada, Michele (DIFS)
Subject: DIFS rules

I am a provider of care for persons witI have brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

I have personally seen individuals go with out needed care even in the current system. When adujusters make determinations inspite of doctors orders, loss of phsyciacl, and massage therapies for pain mangmant, leading further escalation of opiod use. This will only further medical decsion making by non medical providers**.** **Rule 61(j)**. The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

This is just common sense individuals and facitlites can not contine with life when payments are not timely.

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

This is called RED TAPE and the injured wait for care enough as ti is with out creating more.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

Clarity is parmount. **R67(2)(c).** This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

These changes will be estential in contined provisions of care.
Thank you.

--
Sincerely,
Marsha C Hacker RN BSN ADON

Wohlford, Sarah (DIFS)

From: Stephanie Harris <sharris@eisenhowercenter.com>
Sent: Friday, April 17, 2020 1:58 PM
To: Estrada, Michele (DIFS)
Subject: Concerns about Utilization Review Rules

I am a provider of care for persons with Traumatic Brain Injuries in Michigan. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you in advance and stay safe.

Stephanie Harris
Eisenhower Center
3200 E Eisenhower Parkway
Ann Arbor, MI 48108
Direct Line: (734) 794-9677
Direct Fax: (734) 794-9777
Email: sharris@eisenhowercenter.com

Eisenhower CENTER
Jacksonville CENTER
After the Impact PROGRAM

To make a referral, please visit http://www.eisenhowercenter.com or call (734) 645-2324 or (734) 677-0070 ext 273

Wohlford, Sarah (DIFS)

From: Lance Treece <ltreece1@hcaccg.com>
Sent: Monday, April 13, 2020 4:11 PM
To: Estrada, Michele (DIFS)
Subject: Utilization review rules & concerns

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you.

Thank you,
Lance Treece

www.healthcareassociates.net

Health Care Associates
Community Care Givers

Office 616-531-9973

Making life better every day

Wohlford, Sarah (DIFS)

From: Heidi Hess-Willis <hhess@eisenhowercenter.com>
Sent: Friday, April 17, 2020 11:30 AM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Rule Draft

Hello Michele Estrada,

My name is Heidi Hess-Willis and I work at a Traumatic Brain Injury Facility, Eisenhower Center. Over my twelve years at Eisenhower Center I have personally witnessed hundreds of lives helped and transformed. Eisenhower Center itself has been open for 25+ years. Because I value the lives of our clients and anyone else who has experienced such hardship, I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. In my experience insurance driven individuals are not looking out for the long term health of their patients. I think the definition should be focused on the practices in the medical community and the definition changed to.

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment. By not having a deadline, the insurer can delay the reimbursement and this would affect the lives of the patients and the staff at the facility. Small facilities will not have the cash flow to stay open for business.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute **DOES NOT** use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your time and consideration,

Heidi Hess-Willis
Eisenhower Center – Billing Dept
3200 E. Eisenhower Pkwy.
Ann Arbor, MI. 48108
(734) 677-0070 ext. 241
hhess@eisenhowercenter.com

Wohlford, Sarah (DIFS)

From: Matt Ingram <mingram@eisenhowercenter.com>
Sent: Wednesday, April 15, 2020 1:15 PM
To: Estrada, Michele (DIFS)
Subject: Utilization rules flawed

Hello DIFS

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to: "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so. To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:
"A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to “independent” medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase “independent medical examination.” Thus

R67(2)(c), goes beyond the language of that statute by calling this examination “independent.” I recommend R67(2)(c) is revised to state:
“Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer.”

Thank you for listening to these concerns. I look forward to you making the appropriate adjustments to the rules. Rules that don't immediately assume all providers and patients are trying to defraud the system, but instead create a fair system for all.

Matthew Ingram, MBA, CBIS

Wohlford, Sarah (DIFS)

From: Jennifer Johnson <jjohnson@eisenhowercenter.com>
Sent: Wednesday, April 15, 2020 1:06 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Rules

Good afternoon Ms. Estrada. I hope this email finds you healthy and doing well. I am contacting you regarding the current draft of the Utilization Review Rules (2/15/20). I am a behavior analyst working within a residential rehabilitation program for individuals with traumatic brain injury as well as individuals with severe and persistent mental illness and autism. I have significant concerns related to the current draft of the utilization review rules. Here are some of my concerns:

- **Rule 61(j)**. The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to: "'Medically accepted standards' meaning standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place." It is my opinion that the best person to decide regarding my healthcare would be my healthcare providers, rather than an individual whose credentials are unknown to me and who does not know my intricate medical history.

- **Rule 64(3)**. The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a 30-day deadline for payment is included in which the insurer must issue payment. I am expected to pay my bills within a specific time deadline. This should be true of insurers.

- **Rules 65**. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so. To be clear, I am asking that these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

- **Rule 66**. I am concerned that Rule 66 contradicts or at least causes confusion about the rights of providers to avail themselves of civil remedies. I suggest Rule 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read: "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

- **R67.** In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated. I strongly believe that written documents do not provide a comprehensive picture.

- **R67(2)(c).** This rule refers to “independent” medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase “independent medical examination.” Thus R67(2)(c), goes beyond the language of that statute by calling this examination “independent.” I recommend R67(2)(c) is revised to state: “Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer.”

I sincerely thank you for your attention and consideration of these concerns.

Jenni Johnson, MS, LLP
Behavior Analyst
Eisenhower Center
3200 E. Eisenhower Pkwy
Ann Arbor, MI 48108
(734) 677-0070 x533
jjohnson@eisenhowercenter.com

Wohlford, Sarah (DIFS)

From: Kroese, Margaret <MKroese@hopenetwork.org>
Sent: Thursday, April 16, 2020 10:21 AM
To: Estrada, Michele (DIFS)
Subject: [EXTERNAL] Comments for Utilization Review for ANF
Attachments: 2020-04-15 UR DIFS Comments.pdf

Good morning Ms. Estrada,

Please find my comments on Utilization Review attached to this email. I greatly appreciate the extended opportunity to submit comments, especially during this very unique time.

Thank you!

Margaret Kroese, MSSW, CBIS
EVP & Executive Director
Hope Network Neuro Rehabilitation
1490 East Beltline SE
Grand Rapids MI 49506

616-475-7571
M 616-901-5623
mkroese@hopenetwork.org
www.hopenetworkrehab.org

Wohlford, Sarah (DIFS)

From: Margaret Lanham <mlanham@eisenhowercenter.com>
Sent: Thursday, April 16, 2020 11:53 AM
To: Estrada, Michele (DIFS)
Subject: Call to Action

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to “independent” medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase “independent medical examination.” Thus R67(2)(c), goes beyond the language of that statute by calling this examination “independent.” I recommend R67(2)(c) is revised to state:

> “Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer.”

Thank you.

Maggie Lanham, BS, CBIS
Program Manager-Manchester
Eisenhower Center
8735 MI State Road 52
Manchester MI 48158
734-395-0767
www.eisenhowercenter.com

"*A woman who knows what she brings to the table, isn't afraid to eat alone*" - *Unknown*

Wohlford, Sarah (DIFS)

From: Lipsy, Donald <Donald.Lipsy@sedgwick.com>
Sent: Friday, April 17, 2020 11:34 AM
To: Estrada, Michele (DIFS)
Subject: Comments in Relation to Proposed Utilization Review Rule Set, 2019-136 IF

Ms. Estrada,

On behalf of Sedgwick Claims Management Services, please see the below questions and recommendations regarding the proposed Utilization Review Rule Set, 2019-136 IF.

- Comment 1 - R 500.67 Required components of an insurer's utilization review program: One of the components of the proposed Rules that presents a go-forward challenge for providers, injured persons and review organizations is that there does not appear to be a defined standard around what is "medically accepted care." Does DIFS intend to either develop or adopt a series of guidelines regarding medical care that stakeholders would be able to reference as a standard?
- Comment 2 – R 500.65 Determinations by an insurer. – The proposed Rule does not appear to establish a date by which the insurer must provide a response back regarding their determination. Additionally, the proposes Rules do not appear to account for emergency care-based services which may require more expedient feedback. Sedgwick's recommendation would be that the timelines for response to non-emergent utilization reviews mirror the current timelines which the State mandates for workers' compensation utilization review.
- Comment 3 – R 500.70 Annual report. – Sedgwick is concerned that without an established list of reporting elements in place for this annual report that section (2) of the proposed rule could require utilization review and medical review organizations to produce reporting which includes proprietary and confidential disclosures that would then be publishable to outside parties via the State's freedom of information act. Sedgwick's recommendation would be to remove section (2) of the proposed rule at this time, until the required elements of the annual report are more clearly defined.
- Question 1- Given the extended nature of the commentary and virtual hearing period, does DIFS still intend to move forward with the finalization of the Rules by 7/1/20?
- Question 2 - If the answer to question #1 is "yes" , does DIFS have a plan in place to be able to certify all Utilization Review/Medical Review organizations that submit for certification on or before 7/1/20?
- Question 3 – When does DIFS plan to finalize and publish the Rules?

Sedgwick and its partner clients are excited to see the DIFS progress with respect to development and implementation of these rules.

Thank you for your hard work,

Don Lipsy | AVP, Managed Care Government Relations
Sedgwick Claims Management Services, Inc.
MOBILE 520.309.0137
EMAIL DONALD.LIPSY@SEDGWICK.COM
www.sedgwick.com | **Caring counts℠**

Wohlford, Sarah (DIFS)

From: Linda Mound <lmound@eisenhowercenter.com>
Sent: Friday, April 17, 2020 1:49 PM
To: Estrada, Michele (DIFS)
Subject: Proposed Utilization Review Rules

Hello,

I am an employee of the Eisenhower Center, Ann arbor, MI.

We are a residential facility caring for persons with TBI and mental health issues.

Among the many concerns we have with caring for our residents – we have concerns with the utilization review rules:

Rule 61 - The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Wohlford, Sarah (DIFS)

From: Tim <mucha1tl@gmail.com>
Sent: Tuesday, April 14, 2020 2:43 PM
To: Estrada, Michele (DIFS)
Cc: d12hav@gmail.com
Subject: Comments re: 2/15/2020 DIFS draft Utilization Review Rules

Good afternoon,

My name is Tim Mucha and I am a resident of Michigan, and provider of care for persons with brain injuries. I have concerns about the 2/15/2020 draft Utilization Review Rules, which are illustrated below. Thank you kindly for your time and consideration in this matter.

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." This could be an insurance-oriented organization, or "authority" whose credentials are less than transparent. This section specifically needs to contain language which clearly articulates differentiates between "medically accepted standards" and "medically accepted standards **in rehabilitation from auto accidents** (specifically for TBI). One could argue it is medically accepted that the maximum amount of physical therapy one should receive a year is whatever limited amount Medicare covers. However, that is not in line with "best practices". In order to protect patients, this should be indicated somewhere here.
I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 62. The rules must state somewhere here that there is a standard assumption of propriety on the behalf of the providers. Everything in the proposed rules appears to read from the perspective that providers are fraudulent, instead of an assumption that they are providing appropriate levels of care. It should be explicitly stated that the former is the case, and that the burden of proof is on the insurer. This standard will protect the patient/consumer.

Rule 64(3). An insurer is obligated to reimburse the provider for providing a narrative, but there is no timeline for payment. I suggest a deadline (standard 30 days) for payment is included in which the insurer must issue payment. This would be in line with the other timelines presented in the rules.

Rule 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

Rule 66(1). I do not see any protections for the consumer/patient or provider during this process. Care should be allowed to continue until the final decision after all appeals have been exhausted. I am also concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under

this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

Rule 66(5). Why is this power delegated to a single individual, as opposed to a panel. I suggest a three-person panel consisting of the director, a patient advocate, and an impartial/currently practicing (e.g. maintaining active caseload) physician.

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated. Some concerns include:

- **Rule 67(2b):** Clear need for patient advocate to be participating in process
- **Rule 67(2c):** Independent Medical Examiner qualifications need to be outlined. For example, establishing a pool of agreed upon doctors with active caseloads. Where is the protection for patient/consumer that insurance companies can't "hand pick" IME doctors as they currently can and do? Alternatively, phrasing it to be more in line with MCL 500.3151 would be acceptable:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer"

- **Rule 67(3):** What checks on these programs exist to protect patients/consumers and providers? What standards/metrics exist to ensure an insurer isn't simply saying EVERYONE is a fraudulently high utilizer. I suggest there be standards placed on insurers to ensure overzealous U&R programs don't cut services to an excessive number of patients/consumers, and that there be corrective systems in place (with strong and enforceable consequences).
- **Rule 67(6):** Certification period should be an annual requirement no matter what. I suggest the three year certification be removed. I further suggest criteria mentioned be expanded to include aforementioned patient protections against overzealous U&R programs.
- **Rule 68(2b):** I suggest there be a mandate that criteria be developed around the definition of "medical review organization experience". How are patients/consumers and providers protected against information from less robust systems (e.g. Florida, Ohio) being utilized to make decisions about care in Michigan? Such an organization should:
  - Be required to be Michigan based
  - Be required to have experience with Michigan auto no-fault/specialized care
- **Rule 68(2d):** I suggest in addition to proposed list that medical review organizations be required to provide to DIFS data regarding historical findings. Does the organization find that 99% of the time patients/consumers are overutilizing? 50% of the time? These numbers give weight to their credibility as experts and will again protect patients/consumers and providers against overzealous U&R programs.
- **Rule 70:** I suggest general criteria for an annual report be described, and, at a minimum, should contain statistics on number of over-utilization claims, number of appeals, and other identified "areas of concern" for DIFS. This report should be utilized as a quality improvement tool whereby areas of concern are required to be addressed by insurers in a timely fashion (with significant penalties for failure to do so). Otherwise, what is the purpose of this report? For example,

> "No later than 30 days from the date the annual report is completed, the department shall receive from insurance industry a corrective action plan to address concerns identified in the annual report".

Wohlford, Sarah (DIFS)

From: Kim Nolan <kim.nolan@progressivealt.com>
Sent: Friday, April 17, 2020 1:38 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Rules Concerns
Attachments: PastedGraphic-2.tiff

Dear Ms. Estrada,
I am a small business that has been working with long term victims of car accidents for years. These individuals are like family to me as I daily assist them in maintaining at least a decent quality of life. During this time especially when we are dealing with such tragedy it is seems overwhelming to me when I think of the difficulties yet to come that face our patients. I am concerned that those we serve will be forced from their homes and suffer drastic changes as a result of this legislation.
As a provider, I have many concerns regarding the 2/15/2020 Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

The public has no idea of the results of our new legislation. I appreciate anything that you can do to help those in need and those that will face a very different future. Thank you for your consideration.

Kim Nolan, R.N.
CEO

PROGRESSIVE ALTERNATIVES

Visit Our Website at www.ProgressiveAlt.com
Office: (269) 207-0091
Fax: (269) 353-9011
424 S. Drake Rd
Kalamazoo, MI 49009

Wohlford, Sarah (DIFS)

From: dl.nystrom@usfamily.net
Sent: Thursday, April 16, 2020 6:50 AM
To: Estrada, Michele (DIFS)
Cc: dl.nystrom@usfamily.net
Subject: DIFS Virtual Public Hearing April 12, 2020 (comments)

To all concerned:

Thank you for the information and format from the DIFS virtual information meeting. My comments will be simple and to the point.

My wife is a 30 year MVA survivor sustaining major bodily injuries and thankfully no head injury. She was on her way home from work as a Nurse. Incidentally my career was in sales and service / warranty processing in the automotive industry. We have experienced over 125 major reconstruction procedures along with ongoing PT for the purpose of recovery and mobility. Also to be noted, our careers clearly enabled us to navigate our auto insurance claim processing and medical necessities for recovery. Note that a large portion of time has been focused on keeping medical claims in order and confronting the insurance claim processers. For the record, as a MVA survivor our past requests for input and comments have typically been looked at as being exaggerated, unbelievable or thievery. Clearly, thievery seems to be and has been the theme for the reinvention of the No-fault law. Here are my final comments:

- I am optimistic that the insurance companies and all parties processing loss claims **will be** held accountable.
- I do agree with the statements made for and by CPAN, George Sinas Law Firm and the Michigan Brain Injury Association.

Respectfully submitted,

Dana and Denny Nystrom

Wohlford, Sarah (DIFS)

From: Gregory Kirk <gkirk@onwardtherapyservices.com>
Sent: Monday, April 13, 2020 3:11 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Concerns

Michele,

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you.

Onward,

Greg Kirk
Owner
O: (248) 792-3633 | M: (586) 292-8334

CLINIC NOW OPEN! (Birmingham/Troy Area)

3250 W. Big Beaver Rd, Suite 300 | Troy, MI 48084 | OnwardTherapyServices.com

Wohlford, Sarah (DIFS)

From: Erika Parker <eparker@eisenhowercenter.com>
Sent: Friday, April 17, 2020 4:43 PM
To: Estrada, Michele (DIFS)
Subject: DIFS

Hello Ms. Estrada,
I am a provider of persons with Traumatic Brain Injuries and I would like to share my concerns regarding the DIFS Utilization Review Rules.

The main concern that I would like to share is regarding the rules' definition of "medically acceptable standards" under Rule 61(j), which states that the standards will be created by a "competent authority." I recommend that the definition state that a practicing physician will evaluate and determine the quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Thank you for your time and consideration.

Best Regards,

Erika Parker, MS, LLP
Psychotherapist
Eisenhower Center
3200 East Eisenhower Parkway
Ann Arbor, MI 48108
P: 734.677.0070
F: 734.677.0890
www.eisenhowercenter.com

*** In case of an emergency, please dial 911 or go to your nearest Emergency Room. Please do not send an email or leave a voicemail for emergencies. Thank you***

Wohlford, Sarah (DIFS)

From: Karen Pusilo <kpusilo@eisenhowercenter.com>
Sent: Wednesday, April 15, 2020 1:24 PM
To: Estrada, Michele (DIFS)
Subject: 2/15/2020 draft of Utilization Review Rules

Importance: High

I am an essential worker for a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent**. I think the definition should be focused on the practices in the medical community and the definition changed to:**

> **"'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."**

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. **I suggest a deadline for payment is included in which the insurer must issue payment.**

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. **I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:**

> **"A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."**

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only**. Any greater details about the hearing process is appreciated.**

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." **I recommend R67(2)(c) is revised to state:**

> **"Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."**

Thank you.

Karen Pusilo
Sr. Human Resources Generalist
Eisenhower Center
3200 Eisenhower Parkway
Ann Arbor, MI 48108
kpusilo@eisenhowercenter.com
hr@eisenhowercenter.com
Phone: (734) 677-0070, ext. 288
Toll Free Phone: (800) 554-5543
Fax: (734) 677-0890
www.eisenhowercenter.com
Kindness. Compassion. Quiet Strength. Moving Your Journey Forward.

"It is never wrong to do the right thing." Mark Twain

Wohlford, Sarah (DIFS)

From: Sarah Gibbs <sgibbs@rehabpathwaysgroup.org>
Sent: Tuesday, April 14, 2020 11:28 AM
To: Estrada, Michele (DIFS)

Dear Ms. Estrada,

My name is Sarah Gibbs and I am the CEO for Rehab Pathways Group. We provide support services for those recovering from Traumatic Brain Injuries.

I have read through the Utilization Review Rules and I have some concerns.

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organization or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:
"'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so. To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

"A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus, R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

"Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you.

Kind Regards,

Sarah A. Bradley Gibbs, BA, CBIS
Chief Executive Officer

2800 Livernois, Bldg E, Ste 162
Troy, MI 48083
(248) 528-6667 (phone)
(248) 528-6668 (fax)
(586) 703-2767 (mobile)
www.rehabpathwaysgroup.org

Approved By: State of Michigan, Department of Labor, Bureau of Workers' Disability Compensation

Follow Us On:

LinkedIn

Wohlford, Sarah (DIFS)

From: Tammy Goulding <tammygoulding@rehabwithoutwalls.com>
Sent: Monday, April 13, 2020 3:24 PM
To: Estrada, Michele (DIFS)
Subject: Feedback on Draft UR rules

I am the Executive Director of Rehab Without Walls. Rehab Without Walls provides home and community rehabilitation for persons with brain injuries. We provide treatment in their own home and their local community focusing on functional daily independence. I have a number of concerns regarding the February 15, 2020 draft utilization review rules. I have outlined a few of my concerns below but support ALL of the recommended changes that the Michigan Brain Injury Provider Council has gathered from providers and shared with DIFS. I hope we are able to get this right so that our payers and providers such as my program have fair, clear and reasonable expectations surrounding utilization review.

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." Who is a competent authority? This could be an insurance-oriented organizations or "authority" whose credentials are less than fair and objective. It should be focused on the practices in our medical community and thus should be defined as such.

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. Shouldn't there be a deadline for payment in which the insurer must issue payment?

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

Thank you for your consideration.

Tammy Goulding
Executive Director
888-619-9735
Rehab Without Walls
NeuroSolutions

Wohlford, Sarah (DIFS)

From: Lynn Rhodes <lrhodes@eisenhowercenter.com>
Sent: Friday, April 17, 2020 11:35 AM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Rules

Good morning,
I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

I was in the understanding that the purpose of the change was to make the insurance world more transparent. Rather than forcing the insurance carriers to itemize and explain what we as consumers are paying for directly rather than just changing the over all cost of medical care. The insurance carriers weren't forced to show their cards at all, instead they are being allowed to carry on with the under-handed tactics to gain wealth at the expense of Michigan drivers.

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under

this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

"Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your diligence,
Lynn Rhodes
Oakland County, Michigan

Wohlford, Sarah (DIFS)

From: Stacy Rudd <srudd@eisenhowercenter.com>
Sent: Friday, April 17, 2020 12:34 PM
To: Estrada, Michele (DIFS)
Subject: strong concerns to share with DIFS about the proposed rules

Ms. Michele Estrada,

My name is Stacy Rudd, I work at a traumatic brain injury rehabilitation center and I am very concerned with the auto no fault changes that will take place in July 2020. I have strong concerns to share with DIFS about the proposed rules.

I am concerned when there is denial for much needed therapy by non-qualified adjusters. It is much cheaper to have people mobile as much as possible to avoid pressure sores and for muscle strength. I agree that some of my guys are not making huge strides that can be measured as a tremendous gain, but the physical maintenance that is provided by a licensed professional makes a difference in my clients life. Also, an adjuster is not a doctor and does not have the knowledge to approve or deny treatment or care. I work at one of the least expensive traumatic brain injury rehabilitation facilities in the state and we provide a ton of services for our clients. I don't believe that insurance companies will act in the best interest of the client when they benefit by saying no. The insurance companies have been requesting independent medical examinations for many of my clients and I have been present and somehow they don't see documented deficits, because they choose not to, because they are paid by the insurance companies. Lastly, there is no timeline for payment reimbursement for services rendered. If this practice is implemented, business' that care for people will go out of business waiting for the payment.

We provide a safe, caring and client centered environment for them to live a high quality of life. We love our clients and they didn't choose to be injured, but they were. At this point, they need our support and care in their time of need. I hope that none of us that are able to provide services ever need the support we provide daily to my clients, it would mean that we had a tragic accident.

Thank you for your consideration,

Stacy Rudd
Business Operations Assistant

Moriah Inc, dba Eisenhower Center
Moriah Enrichment Center
Eisenhower Center Jacksonville LLC
734-796-3700

Wohlford, Sarah (DIFS)

From: Mark Schloemer <mark.schloemer@stateauto.com>
Sent: Friday, April 17, 2020 3:06 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Comments

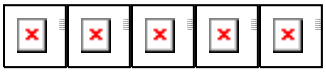
Thank you for the opportunity to provide comments on the utilization review proposal. Ours are below:

- In Part 2, R 500.63 General record acquisition.
  Rule 63. State Auto recommends adding (3) Reimbursement should have to be returned to the insurer if the department finds in favor of the insurer as the cost to complete the additional reporting occurred due to the unnecessary charges.
- In Part 2, R 500.64 Insurer requests for explanation
  Rule 64. State Auto recommends adding (4) Reimbursement should have to be returned to the insurer if the department finds in favor of the insurer as the cost to complete the additional reporting occurred due to the unnecessary charges.
- In Part 2, R 500.64 Insurer requests for explanation
  In (2) State Auto recommends clarifying what type of response is required.
- In Part 3, R500.65 Determinations by an insurer
  State Auto has a comment regarding (d) the insurer providing a form to the provider. The provider will know their rights to appeal and this may only encourage additional appeals.
- In Part 4, R 500.68 Medical Review Organization
  State Auto has a comment regarding (c) How a person is treated should not matter based on the type of insurance coverage available.
- In Part 4, R 500.68 Medical Review Organization
  State Auto has a comment regarding (3) Making changes to filings based on the business contracts a vendor has with other customers is not reasonable. If the state wishes to certify medical review organizations, they should do so separately from certification requirements of insurance companies.
- In Part 5, R 500.70 Annual report
  State Auto has a comment regarding (2). We do not know the data requested to be able to understand whether there are concerns about the proprietary information being in scope for this data call.

Please let me know if you have any questions or would like any more information. Thank you!

Mark

Mark Schloemer
External Relations Director
State Auto Insurance Companies
Phone: 6149174351



Wohlford, Sarah (DIFS)

From: Priscilla Scovic <pscovic@eisenhowercenter.com>
Sent: Friday, April 17, 2020 11:06 AM
To: Estrada, Michele (DIFS)
Subject: IMPORTANT: Concerns regarding proposed changes to the Utilization Review Board

Dear Ms. Michele Estrada,

I am a rehabilitation provider for over 20 years serving and caring for catastrophically injured persons who have sustained traumatic brain and spinal cord injuries in motor vehicle related accidents. I have the significant concerns about the 2/15/2020 draft Utilization Review Rules that would adversely affect our ability to provide the necessary care and services to our population served if the following changes are enacted by the Utilization Review boards:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules to also be imposed on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

I greatly appreciate your consideration in allowing providers such as myself and especially the members of the Michigan Brain Injury Providers Council, the Coalition to Protect Auto No-Fault and Brain Injury Association of Michigan to have a seat at the table and work cooperatively to make any necessary changes that will benefit all and not just the insurers.

Sincerely,

Priscilla Scovic
Program Coordinator
Eisenhower Center

Wohlford, Sarah (DIFS)

From: Chuck Seigerman <cseigerman@gmail.com>
Sent: Monday, April 13, 2020 4:04 PM
To: Estrada, Michele (DIFS)
Subject: DIFS Utilization Review Rules

Dear Ms. Estrada,

I am a board-certified neuropsychologist and have been caring for persons with brain injuries, for over 35 years both as part of a hospital-based program and currently in private practice.

I had the opportunity to review the 2/15/2020 draft of the Utilization Review rules and have a number of concerns:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

These rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly, and potential beneficial treatment delayed unnecessarily.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians and or other qualified professionals at the request of an insurer."

Thank you.

Sincerely,

Charles Seigerman, Ph.D., ABN
Licensed Michigan Psychologist
Board Certified Neuropsychologist

--
Charles Seigerman, Ph.D
20006 Farmington Road
Livonia, Mi 48152
248-477-9940 (office)
248-477-9941 (Fax)

Wohlford, Sarah (DIFS)

From: Bernadette Skodack <bsko.mtbc@gmail.com>
Sent: Friday, April 17, 2020 12:53 PM
To: Estrada, Michele (DIFS)
Subject: concerns regarding utilization review rules

Good afternoon, Ms. Estrada,

My name is Bernadette Skodack. I am a music therapist in Ypsilanti. I have some concerns about the current draft of the utilization review rules.

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent or misleading. As a music therapist, we see cases of people misrepresenting our work and what we do consistently, nor do they have the training to handle complicated medical and mental health issues that may arise in treatment. The definition should be focused on the practices in the medical community and the definition changed to:

"Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. Not having a timeline will lead to delays in payment, meaning businesses may shutter, jobs may be lost, and Michigan citizens who need the care they deserve will be left on their own without care. I suggest a deadline for payment is included in which the insurer must issue payment.

Rule 67. I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

Rule 67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." By not stating "independent medical examination", the door is left open for anyone to conduct the examination. I recommend R67(2)(c) is revised to state:

"Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

I would also ask that the rules are written so that providers and patients are presumed to be acting in good faith as opposed to being assumed to be fraudulent from the start. In the court system, we are presumed innocent until proven otherwise. This should be the same standard for providers and patients.

Thank you for taking feedback regarding this matter.

Bernadette Skodack, MM, CBIS, MT-BC
--
Bernadette Skodack, MM, CBIS, MT-BC
Board Certified Music Therapist
Neurologic Music Therapist, Fellow

Pronouns: she/her
(734) 660-4209

Wohlford, Sarah (DIFS)

From: Ghassan Souri <sourigus@gmail.com>
Sent: Thursday, April 16, 2020 9:23 AM
To: Estrada, Michele (DIFS)
Subject: Re: Proposed Rules (2019-136IF)
Attachments: Comments regarding the drafted rules of Utilization Review.pdf

Good Morning Michele,

Please find the attached comments/feedback regarding the proposed rules for the Utilization Review .
Please note that I am echoing the thoughts and feedback of hundreds of my disabled clients that I serve.
(I understand that DIFS are not re-writing the law , just the specific rules, but those are the comments of my clients).
Thanks for your time.

On Wed, Apr 15, 2020 at 1:46 PM Estrada, Michele (DIFS) <EstradaM1@michigan.gov> wrote:

> Good Afternoon:
>
> You have until 5:00 p.m. on Friday, April 17, 2020 to submit additional comments and feedback.
>
> Thank you.
>
> Michele D. Estrada
>
> Legal Secretary
>
> Office of Research, Rules, and Appeals
>
> 530 W. Allegan St, 8th Floor
>
> Lansing, MI 48933
>
> 517-284-8735
>
> Estradam1@michigan.gov

From: Ghassan Souri <sourigus@gmail.com>
Sent: Wednesday, April 15, 2020 11:53 AM
To: Estrada, Michele (DIFS) <EstradaM1@michigan.gov>
Subject: Re: Proposed Rules (2019-136IF)

thanks Michele.

If I have feedback/comments, is it too late to provide ?

On Wed, Apr 15, 2020 at 10:00 AM Estrada, Michele (DIFS) <EstradaM1@michigan.gov> wrote:

> Good Morning Gus:
>
> Please find attached a copy of the Draft Rules, 2/27/2020.
>
> Michele D. Estrada

Legal Secretary

Office of Research, Rules, and Appeals

530 W. Allegan St, 8th Floor

Lansing, MI 48933

517-284-8735

Estradam1@michigan.gov

From: Ghassan Souri <sourigus@gmail.com>
Sent: Wednesday, April 15, 2020 9:42 AM
To: Estrada, Michele (DIFS) <EstradaM1@michigan.gov>; HartC4@michgian.gov
Subject: Proposed Rules (2019-136IF)

Hi,

I was wondering if I can get a copy of the Proposed Rules for Utilization Review (2019-136IF) as I was unable to find online.

Thanks in advance.

Gus Souri

Assistive Technology of Michigan, Inc.

248-348-7161

Wohlford, Sarah (DIFS)

From: Shannon Revelle <ShannonRevelle@specialtree.com> on behalf of Joseph C. Richert <JoeRichert@specialtree.com>
Sent: Wednesday, April 15, 2020 7:49 AM
To: Estrada, Michele (DIFS)
Subject: Concerns re: 2/15/2020 Draft Utilization Review Rules

Good Morning Ms. Estrada,

My name is Joseph Richert. I am the President and CEO of Special Tree Rehabilitation System, with 30+ locations in Michigan caring for those who have sustained a life altering brain or spinal cord injury. I have some concerns to share with DIFS about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to “independent” medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase “independent medical examination.” Thus R67(2)(c), goes beyond the language of that statute by calling this examination “independent.” I recommend R67(2)(c) is revised to state:

> “Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer.”

Thank you,

Joseph C. Richert
President/ CEO
734-893-1015

Wohlford, Sarah (DIFS)

From: Amy Stewart <stewartrehabservices@gmail.com>
Sent: Tuesday, April 14, 2020 6:10 AM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Rules

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

"A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

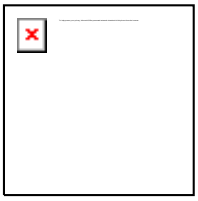
R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

"Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you.

--



Amy M. Stewart, MS, CTRS, CBIS, CCM

Stewart Rehab Services

P.O. Box 2284 Midland, MI 48641

P: 517-304-5184 F: 855-488-8854

Wohlford, Sarah (DIFS)

From: Tanja Taddonio <ttaddonio@eisenhowercenter.com>
Sent: Friday, April 17, 2020 11:16 AM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Rules

Good Morning Michelle Estrada,

My name is Tanja Taddonio, the Billing and Collections Manager for a Traumatic Brain Injury facility called Eisenhower Center. I have worked in billing and collections at EC for almost 15 years. I have seen hundreds of lives be affected by the rehabilitation we have provided. I see little miracles every day! We have been able to provide our clients with the best rehab in the nation because our Auto No-Fault insurance previously allowed for our facilities to provide the NECESSARY care for this population. By implementing the utilization review rules as they are now, would bring our abilities of providing NECESSARY services to a stand-still. I have personally witnessed, too many times, an insurance adjuster, company or their 3rd party review companies making medical decisions that do not even compare to the necessary treatment recommended by the client's clinical team. There needs to be more balance in the rules and I believe that the changes that the MBIPC have recommended would improve these rules. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under

this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

"Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your time,

Tanja Taddonio
Billing and Collections Manager
Eisenhower Center
3200 E. Eisenhower Parkway
Ann Arbor, MI 48108
734-677-0070
ttaddonio@eisenhowercenter.com

Wohlford, Sarah (DIFS)

From: Marcia TeVelde <marcia@ocsmgt.com>
Sent: Thursday, April 16, 2020 7:18 PM
To: Estrada, Michele (DIFS)
Subject: DIFS

Dear Ms. Michele Estrada,

My name is Marcia TeVelde, and I am the proprietor of a 6-bed residential facility specializing in Traumatic Brain Injury, Northern Comfort Specialized Care, Inc., in the Upper Peninsula of Michigan. We are a small facility, and we have never had a optimum cash flow- currently having 3 out of the six beds filled. I was hoping to attend the CARF workshop scheduled for 04/01/20 in Grand Rapids, but it was cancelled due to the Covid 19 restrictions. I have many concerns regarding payment for the care we provide for our residents related to PIP coverage, as I have never been in a financial position to consider CARF certification. It is my understanding that there have not been any postponements or extensions to the July 2020 deadline for implementation of rate payment changes.
The I would also like to express the following concerns regarding the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."
>
> Thank you for your time and consideration in addressing the aforementioned concerns.
>
> Sincerely,
>
> Marcia TeVelde

--
Marcia TeVelde
Case Manager
OCS "Your Caring Professionals"
Phone: 906-450-5723
Fax: 425-940-2180
Email: marcia@ocsmgt.com
Website: www.ocsmgt.com

Please connect with us on Facebook and LinkedIn

Wohlford, Sarah (DIFS)

From: brentewald1@charter.net
Sent: Friday, April 17, 2020 1:36 PM
To: Estrada, Michele (DIFS)
Subject: Concern for the Utilization review rules

H Michele Estrada,

My name is Brent Ewald, small business owner, tax consultant for the elderly, adjunct Instructor Cleary University, Associate Member of the Association of Certified Fraud Examiners, and Board Member of a Traumatic Brain Injury Facility named Eisenhower Center. With over 20 years of insurance experience (i.e. Selling all lines, teaching, billing, collecting) and assisting over 3000 insurance clients in my career, 30 years of management, and along with mentoring over 800 college students in accounting, business and management skills. Eisenhower Center itself has been open for 25+ years. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

No where do I see penalty's for insurance company's moving offices 3 times in a year and not informing the elderly clients of these moves.

No where do I see any penalties for insurance companies denying, delaying payments while a senior or military vet is losing their home to foreclosure.

No where do I see any penalties for MCCA not allowing independent Audits of the books from the Coalition protecting auto no fault.

No where do I see any penalties for when an insurance company sells their debt to another insurance company, who then proceed to investigate the claim delaying payments for 11 months only to eventually pay, no interest penalty as they claim proper procedures.

No where do I see any reduction in the fees lawyers charge for their services.

No where do I see that the insurance company's must pay all reasonable legal fees incurred in our lawsuits and interest when they lose.

No where do I see penalties for insurance company's using 3rd party billers who lose, misplace, and fail to pay claims within 180 days. (Ex> Citizen's using med data).

No where do I see penalties for insurance company forcing medical examinations on elderly and brain trauma patients without another family member or a representative in the room.

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. In my experience insurance driven individuals are not looking out for the long term health of their patients. I think the definition should be focused on the practices in the medical community and the definition changed to.

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment. By not having a deadline, the insurer can delay the reimbursement and this would affect the lives of the patients and the staff at the facility. Small facilities will not have the cash flow to stay open for business.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67 (2) (c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67 (2) (c), goes beyond the language of that statute by calling this examination "independent." I recommend R67 (2) (c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your time,

Brent Ewald, M.S. Acy, MBA, CBCS

5516 Dexter-Pinckney Road
Dexter, Michigan 48130-9587
734-657-0996

Wohlford, Sarah (DIFS)

From: Monica J. Van Acker <mjvanacker@willowbrookrehab.com>
Sent: Tuesday, April 14, 2020 2:16 PM
To: Estrada, Michele (DIFS)
Subject: follow up to utilization review

Dear Ms. Estrada:

I am the owner of Willowbrook Rehabilitation Services a provider of care for persons with brain injuries for the last 31 years in Michigan.

Thank you for putting together the virtual meeting for Utilization Review I wanted to forward my concerns in writing regarding the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" suggests the standards as created by a "competent authority." It has been my experience that Insurance Companies will use this to mean insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. Even though we regularly submit Monthly Summaries and Daily Notes we are constantly being told they were not received (even when they were stapled to the claim form which they did receive) or better yet we send them to the insurer and they only send the claim form to the review company who then reaches out to us and says we need to submit the documentation. This process results in an inordinate amount of time and resources as well as delayed payment.

I recommend a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts and/or causes confusion about the rights of providers to avail itself of civil remedies. I support that 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. I remain very concerned about the actual procedure of the hearings. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your time and attention.

Sincerely,

Monica Van Acker
Program Director
Willowbrook Rehabilitation Services
810-227-0119 ext 204

Wohlford, Sarah (DIFS)

From: Fonda Wilson <fwilson@eisenhowercenter.com>
Sent: Friday, April 17, 2020 11:49 AM
To: Estrada, Michele (DIFS)
Subject: Concerns re: 2/15/20 Draft Utilization Review Rules

Dear Ms. Michele Estrada,

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 Draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

"'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.
To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66 (7) is changed to make sure it is consistent with MCL 500.3112 and should read:

"A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to “independent” medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase “independent medical examination.” Thus R67(2)(c), goes beyond the language of that statute by calling this examination “independent.” I recommend R67(2)(c) is revised to state:
“Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer.”

Thank you,

Fonda Wilson, B.S.W
Program Coordinator
Eisenhower Center
3200 E. Eisenhower Pkwy
Ann Arbor, MI 48108
(734) 677-0070 ext.623
Direct Fax Line # (734) 794-9799
EC Main Fax Line # (734) 677-0890
1-800-554-5543

fwilson@eisenhowercenter.com

To make a referral, please visit http:/www.eisenhowercenter.com
www.tbienrichmentcenter.com
www.aftertheimpactranch.com

Wohlford, Sarah (DIFS)

From: Lorraine Zorbo <lzorbo@advisacare.com>
Sent: Friday, April 17, 2020 1:23 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Rules

Dear Ms. Estrada,

AdvisaCare is a provider of home care services for persons with brain injuries. We have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In our experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. We think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. We suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. We are concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. We suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, We are concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to “independent” medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase “independent medical examination.” Thus R67(2)(c), goes beyond the language of that statute by calling this examination “independent.” I recommend R67(2)(c) is revised to state:

> “Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer.”

Thank you.

--
Lorraine (Lorrie) Zorbo

Executive Director of Network Development
(616)295-4418

Comments to Proposed Administrative Rules Pertaining to Utilization Review of Auto No-Fault Claims
Submitted by William Bloom, Ph.D., Licensed Psychologist
April 15, 2020

Introductory Remarks

Utilization Review as a cost containment activity has been in development in the medical community for the last 40 years. In its current state, and largely as a result of heavy fines and judgements against utilization review companies, cost containment activities are set within the context of quality standards.

Whereas utilization review in the general medical community has had four decades of refinement, the utilization review standards for auto no-fault claims are being collated and enacted within a number of months. There are clearly going to be numerous areas of concern due to, for no other reason, the mandate to act quickly leaves no room for thoughtfulness in applying what has been learned in the general medical community to the arena of auto-no fault claims. This had been clearly evident by a comment I heard expressed in the open session conducted by the Department. In that session a gentleman identifying himself as representing an insurance company stated that the experience in New Jersey indicates that in order to curtail "abuse", precertification of services in absolutely necessary. This particular issue has been intensively studied in cost containment models. What has emerged, after 40 years of study, is that micromanaging some types of care is prohibitively expensive to insurers and does not reap financial benefit. In today's healthcare environment, precertification is very targeted and with many procedures it is merely an administrative step, rather than a focus of clinical evaluation. Insurers benefit greatly from understanding when clinical management of service pays off and when it does not. Ultimately, the consumer will pay for mistakes auto insurers will undoubtedly make in applying various untested utilization review practices.

Specific Comments

With that in mind, I see the following three issues of most concern:

1. It is universal practice in the utilization review community for utilization review companies to have available to providers two types of documents:
    a. A Provider Manual outlining in detail expectations for practice management, clinical documentation requirements, ethical and privacy guidelines, and other important management tools necessary to meet the utilization review company's minimum requirements.
    b. Access to published clinical guidelines for care and treatment of various clinical groups and diagnoses. These published clinical guidelines are sometimes found as citations in respected scientific journals and at other times are guidelines developed by the clinical team within the utilization review company and are made available to providers on the company website. In all cases, providers know, in a contemporaneous fashion, what the expectation for treatment is and what can be considered clear violations of that standard. To expect providers to comply with a utilization standard which is not shared with the provider in a contemporaneous manner is profoundly unfair to providers as well as unfair to consumers of services to stand to lose their treatment. It does not comport with prevailing standards of utilization review. Utilization review systems are not in-house independent medical exams where there is great latitude in how opinion is derived and expressed. Rather, a utilization review system is a highly structured and

codified process where clarity of expectation provides the greatest balance of cost containment potential with fairness.

It is going to be my personal strategy on July 1, 2020 to ask each insurance company to whom I send claims to provide me a Provider Manual and citations where I can review their standards for care and treatment of various client groups and diagnoses. I am fully aware of my own profession's standards of care, and will comport with those. If my work is going to be reviewed according to some other standard, it is imperative I know what that standard is if I am expected to comply with it. This is to protect both my own financial interests, as well as to protect my patient's continued access to care.

Note: Many of the concepts I am discussing can be found on the United Healthcare website.

2. I have concerns about the second level of appeal conducted by the Department.
    a. If I am going to send clinical records to the Department, I will need to have a HIPAA Business Associate Agreement in place with the Department's explicit commitment to adhere to all stipulations regarding Personal Health Information. Just stating the records will be kept confidential is not sufficient for me to release records. As it stands now, the regulations place me in conflict between the Federal HIPAA regulations and the State of Michigan utilization review regulations.
    b. This level of appeal remains within the utilization review system. As such, it is a medical activity, not an administrative one. The Law blurs that distinction by giving an administrative entity authority to make medical decisions based on medical necessity and appropriateness of care criteria. The Auto No-Fault law appears to be in conflict with pre-existing regulations within the Michigan Department of Licensing and Regulatory Affairs which identifies specific health care professionals with the authority to diagnose and treat. How can the Department end a treatment based on medical necessity and/or appropriateness of care criteria without having a specific professional license permitting diagnosis and treatment? That would clearly be practicing medicine without a license. While the courts do that all the time after listening to various medical experts. utilization review is a medical activity. The Department clearly needs to think of ways to impartially review appeals at the same time comply with regulatory issues regarding diagnosis and treatment of medical conditions.
3. I have concerns that the proposed rules do not provide any guidance regarding utilization review for chronic conditions where management of the condition or injury is the focus of treatment, rather than a resolution of the condition. Medicare has clear guidelines which make the distinction between management of a condition, and treatment with the expectation of resolution of the problem. Medicare deems both medically necessary treatments. As many motor vehicle accident victims are left with chronic conditions and disability, how is the utilization review process going to protect medically necessary interventions to maintain gains, minimize backsliding, and prevent complications. Children with traumatically induced conditions and disabilities are a special category as the condition and/or disability impacts the developmental trajectory along a long period of time. How is the treatment for children going to be articulated within a utilization review model?

Yours truly,

William Bloom, Ph.D., Licensed Psychologist
Clinical Director and Owner, Children's Orthogenic Institute, PLLC
Troy, Michigan

DIFS
c/o: Michelle Estrada
P.O. Box 30220
Lansing, MI 48909

April 16, 2020

Re: MCL 500.3157 Utilization Review

Dear DIFS,

Case Management Society of America, Detroit Chapter (a non-profit, multi-disciplinary society comprised of case management professionals of all professions) is writing to you to inquire about the accreditation requirements referenced in MCL 500.3157. Specifically, we are looking for clarification regarding the need for accreditation that applies to "neurological rehabilitation clinics defined as a person that provides post-acute brain and spinal rehabilitation care". Some are interpreting this definition to include the work of Professional Case Managers. As you may be aware, the Professional Case Manager's primary role is the coordination of care, therefore no direct patient care is completed. As a collective group, we are hoping that DIFS will consider the following when issuing guidance on the accreditation requirement:

> The Commission for Case Management Certification (CCMC) defines case management as "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs".

The true definition of case management supports the act of coordination, assessment and evaluation of health and services but not the care or treatment.

Additionally, if after considering the above, DIFS still deems it necessary that case managers must be accredited, we hope that you will consider CCM Certification that is accredited by National Commission for Certifying Agencies (NCCA) as an appropriate standard to meet the criteria in lieu of Commission on Accreditation for Rehabilitation Facilities (CARF). Please find the provided link for additional information regarding this certification and the accrediting body, NCCA: https://ccmcertification.org/about-ccmc/ncca-accreditation

In closing, we are requesting that DIFS issue clarification as to the scope of the accreditation requirement to make it clear that accreditation applies to neurological rehabilitation clinics only, meaning a person that provides post-acute brain and spinal rehabilitation care and not to case managers specifically.

Sincerely,

CMSA Detroit Chapter Board of Directors

37537 Five Mile Road #240
Livonia, MI 48154
Phone (248) 663-4103
cmsadetroit.org

MBIPC
Michigan Brain Injury Provider Council

7305 Grand River, Suite 100
Brighton, MI 48114-7379

April 14, 2020

DIFS
Attention: Director Anita Fox
PO Box 30220
Lansing, MI 48909

RE: Utilization Review Rules – Public Comment

Director Fox:

Since 1987, MBIPC, a 501 (c)(6) trade association has served providers in professions related to brain injury rehabilitation. Our purpose is to enhance the ability of its members to provide high quality, ethical rehabilitation, health care, and related services to people with a brain injury. We have over 140 members throughout the state, comprised of physicians, brain injury rehabilitation centers, transportation companies, case managers, guardians, pharmacies, home health, durable medical equipment providers, and other specialty service providers. The Utilization Review Rules effect all of our members. Enclosed you will find a document comprised as our public comment, with input garnered from our members.

On January 10, 2020, we provide our response to the first set of drafted Utilization Review rules. We expressed our deep concern for the rules as drafted in terms of the fairness and demands they placed on the providers, jeopardizing an efficient delivery of reasonably necessary services, products and accommodations to victims of automobile accidents.

We would like to thank you for hearing our concerns, and those of other vested stakeholders. This new set of utilization review rules demonstrate the Department's openness to feedback and willingness to work together to implement rules that safeguard the system, reduce costs, and protect the rights of consumers to reasonably necessary services, products, and accommodations for their recovery, rehabilitation and care arising from an automobile accident.

The enclosed document provides comments on each issue that our membership provides troubling and/or need clarification in order to be able to conform to the rules (our comments are in red within the relevant sections and subsections). The following is an outline of the most consistent and pressing concerns

> **Rule 61(j)**. The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." This could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. The definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. We urge there be a deadline in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. Rule 66 contradicts, or at least causes confusion, about the rights of providers to avail itself of civil remedies. We urge Rule 66(7) be changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. There is concern over the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." R67(2)(c) should be revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

We urge your department to read our comments thoroughly and thoughtfully in order to understand our concerns, the contradictions to statute contained, and the risks associated with the implementation of these rules as written.

Since the passage of PA 21, we have offered to serve as a resource to the Department in order to implement the new policies in a fair and balanced way. We hope that the public comments provided in the enclosed document and our general concerns outlined in this letter are viewed as a continuation of these efforts.

Sincerely,

Tim Hoste, MBIPC President

CC:
Kevin McKinney, McKinney & Associates
Office of Governor Gretchen Whitmer

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.

Comment:

- What about a group practice? Multiple psychologists vs 1; multiple Speech pathologists? Multiple Voc counselors?

(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).

Comments:

- Within PA-21, the only reference to "medical care" is found in Section 3157 (9) and this phrase is only used there with respect to the "medical care competent" of the CPI required annual price adjustments.
- "Medical care" is used in the 2-15-2020 draft UR Rules to encompass the scope of "treatment, training, products, services, and accommodations provided to an injured person for the injured person's care, recovery, or rehabilitation" …
- "Medical care" is an excessively limiting term which has a connotation of much more narrow meaning than "treatment" versus "training, products, services, and accommodations" allowed under PA 21.
- "Medical care" can be misconstrued. This will cause needless confusion, and besides confusion, potentially denials that are contradictory to the intent and language of PA 21.
- Instead of using a defined term, "medical care", why not drop the phrase "medical care" for all the reasons noted above, and instead incorporate the elements of "treatment, training, products, services, and accommodations provided to an injured person for the injured person's care, recovery, or rehabilitation" into R 500.62 Scope and Applicability? This would be far simpler and consistent with the law.
-

(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.

Comments:

- Question continues to remain who determines who the "competent authority" is and what evidence/source is this person using to determine medically "accepted standards". Is it universal? Or do insurers have their own in house person. Is this person's credential's transparent? And is the foundation of this determination (the evidence to support the decision) transparent?

- This point specifically needs contain language which clearly articulates differentiates between “medically accepted standards” and “medically accepted standards in rehabilitation from auto accidents (specifically for TBI). One could argue it is medically accepted that the maximum amount of physical therapy one should receive a year is whatever Medicare covers. However, that is not in line with what we see with catastrophic TBIs. In order to protect patients, this should be indicated somewhere here.
- Competent authority needs more clarification. Who is the authority for Neuropsych? There are for example multiple boards and prof organizations?
- “Medically accepted standards” as used in the 2-15-2020 draft UR Rules presents related concerns in that, within the “medically accepted standards” definition, the term “medical care” (see above) is used.
- Not all the services provided under Michigan’s Auto No-fault law are “medical care” but are otherwise needed and reasonable.
- Can the rules drafters substitute “generally accepted standards” for “medically accepted standards”?

(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.

Comment:

- Where does the “usual range” come from? Patients present with various levels of injury ie Mild/Mod/Severe TBI, concomitant medical and physical problems, etc

(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.

Comment: These rules must state somewhere (maybe here) that there is a standard assumption of propriety on the behalf of the providers. Everything in here operates from an assumption of fraudulent practice instead of an assumption of providing appropriate levels of care. It should be explicitly stated that the former is the case, and that the burden of proof is on the insurer.

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.

Comment:

- Plus the cost of copying, postage, correct?

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.

Comment:

- What is the time frame an insurer must respond in?

- This rule is missing a time limit for the insurer's permitted request from a provider for a written explanation. Recommend a 30-day time limit.
- "Necessary" appears to be a typo; "necessity" may be the more appropriate term.

(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:

Comment:

- Suggest a timeframe to correspond with issuance of a "written notice"
- Once the requested materials from the provider are received by the insurer, a timeline for the insurer to make their written determination known to the provider should be detailed.
- There is no deadline for the insurer to issue the required written notice of determination to the provider. The time frame needs to be reasonable; otherwise the provider's cash flow will be severely harmed. **Recommend 60 days following receipt of provider's explanation.**

(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.

Comment: May the patient file an appeal, or must it be the provider only?

(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.

Comment:

- The rule states "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."
- Please delete "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.

Comment:

- What are the qualifications of those making the determinations and where do the standards come from?

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

Comment: Will insurers be allowed to withhold payment during utilization review? If they are permitted to pend payment while scheduling IMEs, waiting for the report, reviewing the report, etc., this could easily take 6+ months and that's not counting the 90 days afforded to the director to make a decision.

(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.

Comment: Is there an auditing process or some sort of oversight to ensure forms contain results of all utilization review efforts made by insurance companies (not just those that resulted in a determination of over utilization)?

(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.

Comment:

- This still does not clarify who is making the determinations. I.e. is a Nurse deciding how much OT or SLP a patient should have?
- Would like to ensure that utilization review companies be Michigan based, using Michigan data

(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.

Comment: Also, consider making sure the MRO has specific experience with catastrophic injuries (when appropriate for the review)

(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.

Comment: Transparent data should be shared on the outcomes of the MROs – how often do they determine in favor of insurer vs. insured/provider.

(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.

Comment: Include an improvement plan if the Department finds areas of concern based on report with a timeframe (30 days) to submit the improvement plan.

(2) The annual report is subject to disclosure under the freedom of information act, MCL 15.231 et seq.

To: Department of Insurance and Financial Services

Re: Utilization Review

My name is Dianne Mateja RN BS. I have been involved in Michigan Workers Compensation and Auto No Fault bill review and Utilization review for over 30 years. I have seen a lot of things change. Here are my comments with regards to the content of the draft for Utilization Review.

500.63 General Record Acquisition

Overall, I have a great concern because unlike Workers Compensation, I cannot locate anywhere the definition of a properly submitted bill. A properly submitted bill should not only be on a 1500 or a UB04 with valid revenue codes, CPT codes or HCPC codes ect, it should also include all necessary documentation to be able to review the bill for payment. This would include all the therapy notes and exercise logs. We would need all the daily treatment notes from a Neurological Rehabilitation Center. Anesthesia records are needed to determine start and stop times. There are many more examples that I could cite. Without a written guideline, I am worried we will only get an evaluation or monthly note, and when we ask for the records, a fee will be charged, payment to the providers will be delayed, and appeals will get filed. This needs to be clearly defined.

500.65 Insurer Determination and Provider Appeals

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

Before a formal Utilization Review is done, the carrier or their Medical Review Organization requests all the medical records from the provider. When the review is completed, the carrier or Medical Review Organization may not have any idea what other records the provider could have since we should have them all; therefore, I am not sure this is appropriate.

What should be part of the rules is telling the treating providers that they have a certain amount of time to ask for a re consideration, and that they can submit additional medical records or a narrative report explaining why they think that the utilization review determination is incorrect. This reconsideration with the carrier or Medical Review Organization should be Mandatory before an appeal is filed with DIFS. This should be true not only for Utilization Review but for bill review also. Without this formal process DIFS could get slammed with requests for Appeals that may have been resolved between the carrier and the provider.

Should you have any questions regarding my comments, please feel free to contact me at 248-514-9426.

Sincerely,

Dianne Mateja RN BS

REVIEW Works
Managing Care | Managing Costs

certified WBENC
WOMEN'S BUSINESS ENTERPRISE

21500 Haggerty Road, Suite 250
Northville, MI 48167
Fax 248.305.7055
800.443.1320
248.848.5100
www.reviewworks.com

Michigan Occupational Therapy Association

The Voice of Occupational Therapy in Michigan

April 17, 2020

Anita Fox, c/o Michele Estrada
DIFS - Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, Michigan 48909-7720

RE: Comments on Administrative Rules for Utilization Review, Rule Set 2019-136 IF

Dear Ms. Fox and Whom it May Concern,

The Michigan Occupational Therapy Association (MiOTA) represents the interests of nearly 7,000 Occupational Therapy Practitioners in the State of Michigan as well as promoting the provision of safe and appropriate services for consumers of Occupational Therapy in the state of Michigan.

In review of the Administrative Rules for Utilization Review, Rule Set 2019-136 IF, MiOTA would respectfully like to provide several comments that we feel will decrease the burden on health care professionals as well as strengthen safety and protection of Michigan consumers through promotion of policy that ensures basic accountability standards.

Comment 1 - RE: R 500.67 (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.

> MiOTA Comment: Rehabilitation of injured individuals post motor vehicle accident (MVA) is highly complex and variable. Greater specificity is required to adequately protect Michigan's citizens from inappropriate insurer determinations made by unqualified or underqualified individuals. Individuals who are undergoing rehabilitation post MVA should have determinations for appropriateness of level and quality of medical care at least in part by individuals who are licensed in the same profession as the service under review. Similar to the use of expert witnesses in legal proceedings, ***only an individual licensed in the same profession is able to comment on acceptable standards of practice for that profession and whether the service provided is clinically indicated and necessary.***

Comment 2 - RE: R 500.68 (2)(b) A detailed description of the medical review organization's experience in the review of medical care.

> MiOTA Comment: MiOTA feels that greater specificity and public transparency are needed for this provision. Specificity and public transparency of Medical Review Organizations (MROs) will help reduce and/or prevent abuse on the part of MROs to maximize profits over consumer needs and rights. MROs should be required to provide and make publicly available all statistics regarding denials and appeals, including a compiled listing of reasons

for denials by volume. MROs should additionally have an outlined process for appeals for consumers and/or medical professionals when there is a difference in professional opinions. Additionally, explicit inclusion of provisions that establish MRO and insurer accountability to DIFS in response to complaints is needed. ***Public accountability to MRO decision-making is critical for protecting Michigan's citizens from abusive MRO practices.***

Comment 3 - RE: R 500.68(2)(c) A description of the medical review organization's procedures for utilization, especially as it relates to the provision of personal protection insurance benefits

MiOTA Comment: We recommend this provision require more than simply reporting of procedures. Administrative burden associated with MRO procedures is a significant, well-recognized problem that substantially adds to the cost of health care delivery. Although it might be difficult to prescribe specific procedures, ***explicitly establishing MRO and insurer accountability to DIFS in response to patient and provider complaints is critical.***

Comment 4 – RE: R 500.68(2)(e) Any other information requested by the director.

MiOTA Comment: MiOTA recommends that the rules also require insurer disclosure of incentive payment arrangements with MROs. This is especially important as incentive payments that are based upon denial rates can promote abusive MRO practices, which is not in the best interest of the consumer.

Thank you for the opportunity to provide comments regarding Rule Set 2019-136 IF. MiOTA appreciates your consideration and review of these comments. Please feel free to contact us should you want additional clarification or supportive information.

Sincerely,

Jeannie Kunz, MOT, OTRL, BCP
Director of Advocacy, MiOTA
Direct email: reachotkunzj@gmail.com or Direct phone: (586) 214-3394

Kirsten Matthews, MA, OTRL, CLT
Outgoing Leader of the Executive Committee, MiOTA
kirstenmatthews@charter.net

Cathleen Johnson, OTD, OTRL, FMiOTA
Incoming Leader of the Executive Committee, MiOTA

COMMENTS CONCERNING
ADMINISTRATIVE RULES FOR UTILIZATION REVIEW
RULE SET 2019-136 IF

We applaud the efforts of the Michigan legislature and the Department of Insurance and Financial Services, with respect to the comprehensive reforms that have already been enacted. And there is little doubt that these reforms will be extremely beneficial for insurers and insureds alike. However, our concern today is that is that the reforms only adequately address one-half of the cost-containment issues.

I am the Chief Operating Officer of Citizens United Reciprocal Exchange, or CURE Auto Insurance, a regional auto insurance headquartered in Princeton, New Jersey. CURE is licensed to write private passenger auto insurance in both Pennsylvania and New Jersey. CURE was founded in 1990 and is currently one of the largest direct writers of auto insurance in New Jersey. New Jersey, much like Michigan, has gone through sweeping no-fault reform. I am hoping that my limited testimony here today will encourage you to adopt some of the reforms that helped to change the insurance landscape in New Jersey.

At their essence, no-fault cost-containment concerns can be broken down into two categories. The first is ensuring that the cost for auto-related healthcare services are reasonable. The second is to ensure that any treatment is medically appropriate. By adopting the Medicare fee schedule, the legislature has adequately addressed this first issue. The second issue, ensuring that treatment is medically appropriate, is best addressed through utilization review procedures. Here, we believe that the currently proposed approach provides an excellent foundation for a strong utilization review system, but that more granular measures need to be implemented in order fully address this issue.

Based on our experiences in New Jersey, a no-fault state that has successfully gone through similar reform efforts, we are encouraging the Department to consider additional reforms that New Jersey has adopted over the course of its no-fault history. Primarily, we urge you to adopt precertification protocols, protocols that have been instrumental in effective utilization management.

New Jersey has offered no-fault PIP benefits since 1972. In the almost 50 years since, New Jersey has made substantial reforms to the PIP system in recognition of the issues that New Jersey experienced subsequent to its implementation. These reforms included a transformation like that which Michigan is now undergoing – from a system of unlimited no-fault benefits to a system that offers limited benefits.

New Jersey's reforms were all designed to further the initial cost-saving goals of the no-fault act which, like the Michigan No-Fault Act, includes a system permitting utilization review. Thanks to these reform measures, consumers have benefited with lower rates and a more competitive marketplace. In fact, before New Jersey's reforms, almost 50% of New Jersey's drivers were insured by the residual marketplace. Today, there are almost 80 companies fighting for these same drivers, and the residual market now insures fewer than 1% of New Jersey's drivers. This a testament to the success of the reforms.

COMMENTS CONCERNING
ADMINISTRATIVE RULES FOR UTILIZATION REVIEW
RULE SET 2019-136 IF

One of the most effective tools that New Jersey developed as part of its utilization review system was to establish standards for precertification of medical care in conjunction with the treatment of automobile accident injuries. This allows a proactive approach to utilization management that is invaluable in its application.

The precertification process is one in which physicians and other health care providers must obtain advance approval from an insurer before specific pre-identified procedures, services, devices, supplies or medications are delivered to the patient to qualify for coverage.

Based upon our experience under the New Jersey no-fault system, adopting a precertification system for utilization management will help you achieve the goal of more affordable insurance to everyone, while still providing the necessary benefits of an effective no-fault system.

Precertification determines if a patient's medical procedure is necessary and meets the qualifications of their insurance plan prior to the administration of the treatment. This not only helps to prevent unnecessary treatment, it also helps the patient avoid unnecessary out-of-pocket expenses. Precertification saves both the medical provider and patient's time and money by first confirming appropriate coverage through the insurer.

Not allowing for a precertification process could have unintended, but major consequences. For example, under the current proposed regulations, there is no proactive way to prevent unnecessary treatment, and treatment that is later deemed to be unnecessary – and therefor uncovered – could continue for months before any final determination is made.

Under the proposed regulations, a dispute with regard to the necessity of a medical treatment that is ongoing could take as long as 213 days to resolve. And this period only begins after an insurer requests an explanation from the provider regarding the necessity for the treatment on a disputed bill. It can take over half a year between that time and the time in which the director issues a determination. Further, this determination would only apply to the treatment that was on the disputed bill. Any treatment that was submitted on subsequent bills would have equal delays. All the while, the patient is continuing treatment and paying the patient's share of the treatment costs.

This extended time frame raises significant questions for both the provider's continued treatment of the injured party and how the Insurer will handle incoming bills from the provider while the dispute is ongoing. Clearly, an opportunity for the Insurer to review and provide either approval or a denial of treatment prior to the treatment actually being performed would be in the best interest of not only the Insurers, but of the providers and injured persons alike.

Attached, for guidance, are several Exhibits which are part of New Jersey's system and that may aid the Department in its promulgation of regulations that will fulfill the cost-containment directive of the PIP laws.

Precertification Exhibits

COMMENTS CONCERNING
ADMINISTRATIVE RULES FOR UTILIZATION REVIEW
RULE SET 2019-136 IF

Exhibit A is the primary New Jersey Regulation that pertains to precertification.

The following are some highlights from the regulation:

- The regulation includes guidance and requirements for insurers with respect to the communication of the precertification requirements to health care providers and insureds which, in New Jersey, is in the form of a Decision Point Review Plan. See e.g. N.J.A.C. 11:3-4.7 (d).
- The regulation includes certain restrictions and requirements that the insurers must follow when creating their precertification requirements. See e.g. N.J.A.C. 11:3-4.7 (c)2.
- The regulation provides that precertification requirements do not apply within 10 days of the insured event or to emergency care or for a new-patient evaluation and management visit that is necessary for the provider to develop the plan of care that is incorporated into a precertification request for treatment or diagnostic testing. See N.J.A.C. 11:3-4.7 (b) and (c)2.
- The regulation includes a three business-day deadline for insurers to respond to precertification request. See e.g. N.J.A.C. 11:3-4.7 (c)2. See N.J.A.C. 11:3-4.7 (c)4.

Exhibit B is an excerpt from a New Jersey insurers Decision Point Review Plan, defining the medical services, treatments and procedures that are subject to the insurer's precertification requirements.

Exhibit C is an excerpt from a New Jersey insurers Decision Point Review Plan that provides a list of medical tests that require precertification and review.

Exhibit D is an Attending Provider Treatment Plan form – which is a standardized form developed by the New Jersey Department of Banking and Insurance – which is utilized by New Jersey providers for the purpose of requesting precertification from an insurer.

PROPOSED NO-FAULT INSURANCE COST CONTAINMENT REGULATIONS

EXHIBIT A

Excerpt from New Jersey Regulations Outlining Precertification Rules

New Jersey Administrative Code
Title 11. Insurance
Chapter 3. Automobile Insurance (Refs & Annos)
Subchapter 4. Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests

N.J.A.C. 11:3–4.7

11:3–4.7 Decision point review plans

(a) No insurer shall impose the co-payments permitted in N.J.A.C. 11:3–4.4 (e), (f) and (g) unless it has an approved decision point review plan.

1. Initial decision point review plan filings and amendments to approved plans shall be submitted to the Department through the use of the NAIC electronic filing system SERFF (System for Electronic Rate and Form Filing).

(b) No decision point or precertification requirements shall apply within 10 days of the insured event or to emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

(c) A decision point review plan filing shall include the following information:

1. Identification of any PIP vendor with which the insurer has contracted and a copy of the contract between the insurer and the PIP vendor. No insurer shall contract with a PIP vendor unless the vendor is registered with the Department pursuant to N.J.A.C. 11:3–4.7A;

2. Identification of any specific medical procedures, treatments, diagnoses, diagnostic tests, other services or durable medical equipment that are subject to precertification. The inclusion of precertification requirements in a decision point review plan is optional. The medical procedures, treatments, diagnoses, diagnostic tests or durable medical equipment required to be precertified shall be those that the insurer has determined may be subject to overutilization and that are not already subject to decision point review. The insurer shall not require the precertification of a new-patient evaluation and management visit that is necessary for the provider to develop the plan of care that is incorporated into a precertification request for treatment or diagnostic testing;

3. Copies of the informational materials described in (d) below and an explanation of how the insurer will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim.

4. Procedures for the prompt review, not to exceed three business days, of decision point review and precertification requests by insureds or providers. All determinations on treatments or tests shall be based on medical necessity and shall not encourage over or underutilization of benefits. Denials of decision point review and precertification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist;

5. Procedures for the scheduling of physical examinations pursuant to (e) below;

6. An internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or the administration of a test;

7. Reasonable restrictions on the assignment of benefits pursuant to N.J.A.C. 11:3–4.9(a);

8. Reasonable restrictions on what types of providers may submit decision point review requests; and

9. The information required in order to use a network pursuant to N.J.A.C. 11:3–4.8(d), if applicable.

(d) The informational materials for policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the information in (d)1 through 9 below. In order to make the requirements of this subchapter easier for insureds and providers to use, the Commissioner may by Order require the use of uniform forms, layouts and language of information materials.

1. How to contact the insurer or vendor to submit decision point review/precertification requests including the telephone, facsimile numbers, e-mail addresses or through a website. The insurer or its vendor shall be available, at a minimum, during normal working hours to respond to decision point review/precertification requests;

2. An explanation of the decision point review process including a list of the identified injuries and the diagnostic tests in N.J.A.C. 11:3–4.5(b). The materials shall include copies of the Care Paths or indicate how copies may be obtained;

3. A list of the medical procedures, treatments, diagnoses, diagnostic tests, durable medical equipment or other services that require precertification, if any;

4. An explanation of how the insurer will respond to decision point review/precertification requests, including time frames. The materials should indicate that:

i. Telephonic responses will be followed up with a written authorization, denial or request for more information within three business days;

5. An explanation of the insurer's option to require a physical examination pursuant to (e) below;

6. An explanation of the penalty co-payments imposed for the failure to submit decision point review/precertification requests where required in accordance with N.J.A.C. 11:3–4.4(e);

7. An explanation of the insurer's voluntary network or networks for certain types of testing, durable medical equipment or prescription drugs authorized by N.J.A.C. 11:3–4.8, if any;

8. An explanation of the alternatives available to the provider if reimbursement for a proposed treatment, diagnostic test or durable medical equipment is denied or modified, including insurer's internal appeal process and how to use it; and

9. An explanation of the insurer's restrictions on assignment of benefits, if any.

(e) A physical examination of the injured party shall be conducted as follows:

1. The insurer shall notify the injured person or his or her designee that a physical examination is required to determine the medical necessity of further treatment, diagnostic tests or durable medical equipment. An insurer shall include reasonable procedures for the notification of the injured person and the treating medical provider where reimbursement of further treatment, diagnostic testing or durable medical equipment will be denied for failure to appear at scheduled medical examinations.

2. The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice in (e)1 above unless the injured person agrees to extend the time period.

3. The medical examination shall be conducted by a provider in the same discipline as the treating provider.

4. The medical examination shall be conducted at a location reasonably convenient to the injured person.

5. The injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before.

6. The insurer shall notify the injured person or his or her designee and the treating medical provider whether it will reimburse for further treatment, diagnostic tests or durable medical equipment as promptly as possible but in no case later than three business days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

7. Insurers may include in their decision point review plan a procedure for the denial or reimbursement for treatment, diagnostic testing or durable medical equipment after repeated unexcused failure to attend a scheduled physical examination. The procedure shall provide for adequate notification of the insured and the treating provider of the consequences of failure to attend the examination.

(f) In administering decision point review and precertification, insurers shall avoid undue interruptions in a course of treatment. As part of their decision point review plans, insurers may include provisions that encourage providers to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries to minimize the need for piecemeal review. An agreed comprehensive treatment plan may replace the requirements for notification to the insurer at decision points and for treatment, diagnostic testing or durable medical equipment requiring precertification. In addition, the insurer may provide that reimbursement for treatment, diagnostic tests or durable medical equipment consistent with the agreed plan will be made without review or audit.

(g) An insurer shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless the request involved fraud or misrepresentation, as defined in N.J.A.C. 11:16–6.2, by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

Credits

Amended by R.2000 d.454, effective November 6, 2000. Adopted by, R.2004 d.218, effective June 7, 2004 (operative October 27, 2004). Amended by R.2006 d.243, effective July 3, 2006; R.2009 d.190, effective June 15, 2009; R.2010 d.142, effective July 6, 2010; R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).

CHAPTER EXPIRATION DATE

PROPOSED NO-FAULT INSURANCE COST CONTAINMENT REGULATIONS

EXHIBIT A

<Chapter 3, Automobile Insurance, expires on December 3, 2020.>

Current through amendments included in the New Jersey Register, Volume 51, Issue 15, dated August 5, 2019.

N.J.A.C. 11:3–4.7, NJ ADC 11:3–4.7

End of Document

PROPOSED NO-FAULT INSURANCE COST CONTAINMENT REGULATIONS
EXHIBIT B

Mandatory Pre-Certification Requirements

1. You or your provider is required to obtain pre-certification of all the services listed below. If you or your provider fails to submit requests for the pre-certification of all the services listed below or fails to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. You are encouraged to maintain communication with CURE on a regular basis as pre-certification requirements may change.

Pre-certification is mandatory as to any of the following medical services, treatments, and procedures once 10 days have elapsed since the accident:

a) non-emergency inpatient and outpatient hospital care;

b) non-emergency surgical procedures;

c) outpatient care, including follow-up evaluations, for soft tissue/disc injuries of the insured person's neck, back and related structures not included within the diagnoses covered by the Care Paths;

d) temporomandibular disorders; any oral facial syndrome

e) carpal tunnel syndrome;

f) outpatient psychological/psychiatric testing and/or services;

g) home health care;

h) durable medical goods with an aggregate cost or monthly rental in excess of $75.00, including durable medical equipment and associated supplies, prosthetics and orthotics,

i) non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $75.00, including but not limited to the following:

    1) vehicles,

    2) modifications to vehicles,

    3) durable goods,

    4) furnishings,

    5) improvements or modifications to real or personal property,

    6) fixtures,

    7) spa/gym memberships,

8) recreational activities and trips,

9) leisure activities and trips;

j) non-emergency medical transportation with a round trip transportation expense in excess of $75.00;

k) non-emergency dental restoration;

l) physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation, including follow up evaluations by the referring physician, except that provided for identified injuries in accordance with Decision Point Review;

m) pain management treatment except that provided for identified injuries in accordance with Decision Point Review, including but not limited to the following:

1) acupuncture,

2) nerve blocks,

3) manipulation under anesthesia,

4) anesthesia when performed in conjunction with invasive techniques,

5) epidural steroid injections,

6) radio frequency/rhyzotomy,

7) narcotics, when prescribed for more than three months,

8) biofeedback,

9) implantation of spinal stimulators or spinal pumps,

10) trigger point injections;

n) Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;

o) Prescriptions, including but not limited to Schedule II, III and IV Controlled Substances; and

p) Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.

PROPOSED NO-FAULT INSURANCE COST CONTAINMENT REGULATIONS
EXHIBIT C

TESTS REQUIRING PRIOR NOTIFICATION AND REVIEW

Tests Requiring Prior Notification and Review to Establish Medical Necessity

1. Brain audio evoked potential (BAEP);
2. Brain evoked potential (BEP);
3. Computer assisted tomographic studies (CT, CAT Scan);
4. Dynatron/cyber station/cybex;
5. H-reflex Study;
6. Magnetic resonance imaging (MRI);
7. Verve conduction velocity (NCV);
8. Somasensory evoked potential (SSEP):
9. Sonogram/ultrasound;
10. Visual evoked potential (VEP);
11. Any of the following "diagnostic tests: when not excluded under Exclusion C.
    a. Brain mapping;
    b. Doppler ultrasound;
    c. Electroencephalogram (EEG);
    d. Needle electromyography (Needle EMG);
    e. Sonography;
    f. Thermography/thermograms; or
    g. Videoflouroscopy;
12. Any other diagnostic test that is subject to the requirements of our Decision Point Review Plan by New Jersey law or regulation.

Proposed No-Fault Insurance Cost Containment Regulations Exhibit D

ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

DATE SUBMITTED: Month | Day | Year

TYPE OR PRINT LEGIBLY

CLAIM #:

PATIENT INFORMATION

1. PATIENT'S NAME — Last | First | Initial
2. PATIENT'S ADDRESS (No. Street)
3. CITY | 4. STATE
5. ZIP CODE | 6. TELEPHONE # (Include Area Code)
7. PATIENT BIRTHDATE | 8. SEX ☐ M ☐ F
9. INSURANCE COMPANY
10. POLICY NUMBER
11. DATE OF ACCIDENT
12. IS PATIENT'S CONDITION RELATED TO:
A. EMPLOYMENT? ☐ YES ☐ NO
B. AUTO ACCIDENT? ☐ YES ☐ NO
C. OTHER ACCIDENT? ☐ YES ☐ NO
13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

POLICYHOLDER INFORMATION (if different)

14. POLICYHOLDER'S NAME — Last | First | Initial
15. POLICYHOLDER'S ADDRESS (No. Street)
16. CITY | 17. STATE
18. TELEPHONE # (Include Area Code) | 19. ZIP CODE
20. RELATIONSHIP TO PATIENT

PROVIDER INFORMATION

21. NAME OF TREATING PROVIDER — Last | First | Initial
22. TAX I.D. | 23. NPI | 24. SPECIALTY | 25. FACILITY OR OFFICE NAME
26. FACILITY /OFFICE ADDRESS (No. Street) | 27. CITY | 28. STATE | 29. ZIP CODE
30. TELEPHONE # (Include Area Code) | 31. EMAIL ADDRESS | 32.. FAX # (Include Area Code) | 33. INITIAL DATE OF TX | 34. DATE OF LAST VISIT

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ MEDICATIONS ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTIC TEST ☐ EXISTING CONDITIONS ☐ COMORBIDITIES ☐ OTHER

36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below using Diagnosis Pointer in section 38 below) ICD Ind. ☐ 9 ☐ 10

A. B. C. D.
E. F. G. H.
I. J. K. L.

37. CHECK APPROPRIATE CARE PATH (if applicable)

☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

38. DATE(S) OF REQUEST — FROM (MM | DD | YY) → TO (MM | DD | YY)

PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	EQUIPMENT Purchase	EQUIPMENT Rental	SPINAL INJECTION Unilateral	SPINAL INJECTION Bilateral	DIAGNOSIS POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS

☐ **INCLUDE SUPPORTING DOCUMENTS**

FRAUD PREVENTION - NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND PREVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

39

SIGNATURE OF PROVIDER DATE

April 17, 2020

Sarah Wohlford, Esq.
Senior Deputy Director
Director, Office of Research, Rules, and Appeals
Department of Insurance and Financial Services
530 W. Allegan St., 8th Floor
Lansing, Michigan 48933-7720

Re: DIFS Proposed Rule 2019-136 IF
Utilization Review
Claims Payment, Adjustment, Dispute Resolution

Dear Ms. Wohlford:

Mitchell International Inc. (Mitchell) greatly appreciates the department developing needed administrative rules to provide greater form and function to the language and goals of Sec. 3157a of the insurance code, added by the legislature in 2019 as part of comprehensive no-fault auto insurance reform. Mitchell products serve the P&C industry with bill and medical review solutions for Michigan and national claims (www.mitchell.com) and have provided services to Michigan auto insurers for over 25 years. Our depth and breadth of knowledge in Utilization Review programs spans all 50 states in multiple coverage types focusing on the auto insurance industry. We hope our commentary will provide some insight into clarifications and experiences we have had in other venues in adopting these types of rules in the P&C claims environment. In addition, we appreciate the opportunity to provide comments related to the proposed UR rules, which are included below.

Standards for Utilization Review:

Generally speaking, the rules need to provide greater standards and clarity for what the department will be looking for in terms of a "utilization review" program under R500.67. Currently, R500.62(1)(a) states the rules "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." Further, R500.67(2)(b) requires that an insurer's utilization review program must "make determinations regarding the appropriateness of medical care, in terms of both the level and quality of medical care based on *medically accepted standards*."

Mitchell would also like to ask the department in establishing criteria and standards for utilization review R500.62 (1) to define a timeline in which insurers must render determinations under R500.67 (2). When establishing a timeline, Mitchell would also request the department provide more clarity surrounding utilization review calculation of time.

The core term, "medically accepted standards," is defined in R500.61 (j) as "standards or criteria that are *set by a competent authority* as the rule for evaluating the quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

- First, the term "competent authority" is not itself defined, so insurers are left with the question of what it means or includes; AND
- Second, R500.67(2)(b) requires that an insurer's utilization review program must "make determinations regarding the appropriateness of medical care, in terms of both the level and quality of medical care based on *medically accepted standards*."

Mitchell would ask the department to expand on the definition under R500.61 (j) to include a definition for the term "competent authority".

- For example, would URAC (https://www.urac.org/) be an appropriate "competent authority," and therefore its standards for such a program accepted? Learning of standards or criteria missed or not met *after* filing would put an insurer looking to comply in a very difficult position given the remaining time involved.

Mitchell would also ask the department to provide further clarification on *"medically accepted standards"* under R 500.67(2)(b).

- For example, insurers can establish within their UR plans submitted to the DIFS for approval a list of nationally accepted treatment guidelines that will be utilized in making determinations regarding the appropriateness of medical care, e.g., ACOEM, ODG, Interqual, etc.

Provider Records Submission:

MCL 500.3157a(1) provides,

> By rendering any treatment, products, services, or accommodations to 1 or more injured persons for an accidental bodily injury covered by personal protection insurance under this chapter after July 1, 2020, a physician, hospital, clinic, or other person is considered to have agreed to do both of the following:
>
> (a) *Submit necessary records and other information* concerning treatment, products, services, or accommodations provided for utilization review under this section.

On the other hand, R500.63 (1), General Record Acquisition, only provides that "an insurer *may request* from a provider necessary medical records, medical bills, and other information concerning the medical care provide[d] to [] an injured person. [*sic]* The intent of the legislature to create proper utilization review would be better served if the proposed rule provided greater definition to the type of documents medical providers must submit as a matter of course for utilization review. This would be important when establishing utilization review plans for clarity on when calculation of time begins/ends under R500.62 (1). In addition, it will assist in avoiding unnecessary delays in utilization review processing timelines due to incomplete/insufficient requests for utilization review including unnecessary cost burden to insurers.

R500.63 (2) further provides that if an insurer is requesting documents "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." Proper utilization review will require additional material than just that

submitted with an invoice, which may only provide a list of services provided and amounts charged. This subsection of the rule forces insurers to pay medical providers for what we believe the legislature intended them to already submit, and should be revised or deleted. Alternatively, we would submit that the proper "average hourly rate" should be for that of an administrative staff person, rather than the provider, as much of these requests would be for copies of other existing documents or ask the department to considering establishing a Michigan auto procedure code to bill flat fee to reduce confusion.

Provider Administrative Appeals:

Additional clarity in wording would be appreciated to specify in particular that the administrative appeal process of R500.66 is the exclusive remedy for medical providers objecting to insurer determinations. We recall the Legislature's intent to create a strong utilization review mechanism aimed at reducing excessive, unnecessary, and fraudulent claims/litigation involving medical utilization and billing. Therefore, the administrative appeals process should be clarified as the exclusive remedy of medical providers for these disputes. Furthermore, Mitchell feels to support the Legislature's intent, the addition of an internal appeals/reconsideration process prior to the initiation of the administrative appeals process would be beneficial in reducing excessive, unnecessary, and fraudulent claims/litigation involving medical utilization and billing.

Additionally, R500.66(1) states that provider appeals must be "filed within 90 days of the date of the disputed [insurer] determination." Mitchell International requests the Department consider adding a consequence to a provider's failure to appeal an insurer determination within the 90-day timeline.

As a final comment, Mitchell would request greater specificity with respect to which "utilization and review activities" the department will require insurers to include in their annual reports per R500.70.

Thank you in advance for your attention to this matter. We look forward to working with the department on the development and implementation of these rules, as well as broader no-fault auto insurance reform.

Please let me know if you have any questions or comments.

Sincerely,

Michele Hibbert-Iacobacci, OHCC, CCSP
Sr. VP Regulatory Compliance Management
Casualty Solutions Group
Mitchell International Inc.
Michele.Hibbert@mitchell.com

Attorneys:

George T. Sinas
Michael E. Larkin▲
James F. Graves*
Bryan J. Waldman*
Stephen H. Sinas
Thomas G. Sinas+

Jacquelyn A. Dupler
Joel T. Finnell
Jonathon K. Homa
Lauren E. Kissel
Kevin Z. Komar
Brian A. McKenna*
Brian A. Molde
Catherine E. Tucker
Steven H. Weston
Daniel S. Zick

Of Counsel:
Timothy J. Donovan
Bernard F. Finn

*Also Licensed in Illinois
▲Also Licensed in Arizona
+Also Licensed in Minnesota

SINAS DRAMIS LAW FIRM
Since 1951

SINAS, DRAMIS, LARKIN, GRAVES & WALDMAN, P.C.

sinasdramis.com

Offices:

3380 Pine Tree Road
Lansing, MI 48911
(o) 517-394-7500
(f) 517-394-7510

312 Fulton Street East
Grand Rapids, MI 49503
(o) 616-301-3333
(f) 616-301-3344

4000 Portage St., Ste. 110
Kalamazoo, MI 49001
(o) 269-443-8415
(f) 269-443-8416

24825 Little Mack Ave., Ste. 200
St. Clair Shores, MI 48080
(o) 313-202-2000
(f) 313-965-4315

77 W. Wacker Dr., Ste. 4500
Chicago, IL 60601
(o) 312-332-6162
(f) 312-332-6164

PUBLIC COMMENTS

TO: Anita Fox, DIFS Director

FROM: Sinas Dramis Law Firm
By Catherine E. Tucker, Esq. and George T. Sinas, Esq.
On behalf of the following associations and providers:

A. Coalition Protecting Auto No-Fault;

B. Health Partners, Inc.;

C. Origami Brain Injury Rehabilitation Center; and

D. Rehab Without Walls, Inc.

DATE: April 17, 2020

RE: **Public Comments Regarding DIFS' Draft Utilization Review Rules Released on February 27, 2020**

INTRODUCTION

Last spring, the Michigan Legislature passed vast and sweeping changes to the Michigan No-Fault Automobile Insurance Act ("*the No-Fault Act"*) and the Michigan Insurance Code, which Governor Whitmer signed into law on June 11, 2019. Among the significant changes to the No-Fault Act was the addition of a statutory provision which imposes a mandatory utilization review process for any provider rendering products, services or accommodations to an injured person covered by PIP. *See* MCL 500.3157a. This new statutory provision defines "*utilization review*" 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*." MCL 500.3157a(6).

Under this new statutory provision, the Department of Insurance and Financial Services ("*DIFS*") is responsible for promulgating rules to implement the utilization review process. Specifically, DIFS was charged with creating rules that do the following:

> *(a) Establish criteria or standards for utilization review that identify utilization of treatment, products, services, or accommodations under this chapter above the usual range of utilization for the treatment, products, services, or accommodations based on medically accepted standards.*
>
> *(b) Provide procedures related to utilization review, including procedures for all of the following:*
>
> *(i) Acquiring necessary records, medical bills, and other information concerning the treatment, products, services, or accommodations provided.*
> *(ii) Allowing an insurer to request an explanation for and requiring a physician, hospital, clinic, or other person to explain the necessity or indication for treatment, products, services, or accommodations provided.*
> *(iii) Appealing determinations."*

MCL 500.3157a(3).

Pursuant to the authority vested in it by the Legislature, DIFS has promulgated a proposed set of rules and standards for the implementation of the "*utilization review*" process required by the new law. The original version of the "*draft*" rules were publicly released by DIFS on December 16, 2019. That original set was later withdrawn and replaced with a revised set of rules, which were released by DIFS on February 27, 2020. If ultimately adopted, these rules will be filed with the Secretary of State, become part of Chapter 500 of the Michigan Administrative Code, and apply to treatment, products, services or accommodations rendered *after* July 1, 2020. *See* Rule 62(1)(c).

After a careful and thorough review of the draft rules that DIFS released on February 27, 2020, we have identified several rules that not only pose significant concerns for the medical provider community in Michigan but that are also substantively and/or constitutionally invalid and, therefore, unenforceable. ***There are 3 rules of particular concern – Rules 66, 67 and 68.*** A thorough analysis of each of these draft rules, our objections to them and the legal authority and principles that form the basis for those objections is set forth below.

APPLICABLE LEGAL AUTHORITY AND PRINCIPLES

The foundational legal principle underlying the objections raised herein is that ***"[t]o be enforceable, administrative rules must be constitutionally valid, procedurally valid and substantively valid***." *Michigan Farm Bureau v Dep't of Envtl Quality,* 292 Mich App 106, 129 (2011), citing LeDuc, *Michigan Administrative Law* (2001), §4.30, p 214.

Analyzing the ***constitutional validity*** of administrative rules requires a careful review of the provisions of the state or federal constitution implicated by the rules. Where a rule violates a constitutional provision, it will be rendered invalid and unenforceable. LeDuc, *Michigan Administrative Law* (2019), §4:31. See also *Herrick Dist Library v Library of Michigan*, 293 Mich App 571 (2011) (holding that DOE rule was constitutionally invalid because it violated §9, Article VIII of the Michigan Constitution).

In assessing the ***substantive validity*** of rules promulgated by a State administrative agency, Michigan courts employ the following 3-part conjunctive test:

> "*(1) whether the rule is* ***within the subject matter of the enabling statute****, (2) if so, whether it* ***complies with the underlying legislative intent****, and (3) if it meets the first two requirements, [whether] it is arbitrary and capricious.*"

Lutrell v Dept of Corrections, 421 Mich 93, 100 (1984) (*emphasis added*).

Failure to satisfy any prong of that 3-part test makes an administrative rule both ***substantively invalid and unenforceable***. *Michigan Farm Bureau,* 292 Mich App at 129.

With regard to the first prong (*i.e., "whether the rule is within the subject matter of the enabling statute"*), Michigan appellate courts have long and consistently held that administrative agencies like DIFS have no power or authority other than that expressly conferred to them by "*clear and unmistakable*" statutory language. *Mason Co Civil Research Council v Mason Co*, 343 Mich 313, 326 (1955). *See also York v Detroit (After Remand),* 438 Mich 744, 767 (1991). As the Court of Appeals has explained:

> "***[T]he powers of administrative agencies . . . are limited to those expressly granted by the Legislature****. And though an agency may have implied powers, our*

> *caselaw narrowly restricts such authority to that " 'necessary to the due and efficient exercise of the powers expressly granted' by the enabling statute."* [*Herrick*, 293 Mich App at 574 (*emphasis added; internal citations omitted).*]

Regarding the second prong (i.e., "*whether [the rule] complies with the underlying legislative intent*"), it is important to bear in mind that the legislative intent underlying the enabling statute – i.e., the No-Fault Act – was to provide a comprehensive scheme of compulsory insurance which would ensure prompt payment for the medical expenses and other losses incurred by auto accident victims in Michigan. As the Michigan Supreme Court has explained:

> *"The Michigan No–Fault Insurance Act, which became law on October 1, 1973, was offered as an innovative social and legal response to the long delays, inequitable payment structure, and high legal costs inherent in the tort (or "fault") liability system.* ***The goal of the no-fault insurance system was to provide victims of motor vehicle accidents with assured, adequate, and prompt reparation for certain economic losses****. The Legislature believed this goal could be most effectively achieved through a system of compulsory insurance, whereby every Michigan motorist would be required to purchase no-fault insurance or be unable to operate a vehicle legally in this state. Under this system, victims of motor vehicle accidents would receive insurance benefits for their injuries as a substitute for their common-law remedy in tort."*

Shavers v Attorney General, 402 Mich 554, 578–579, (1978) (*emphasis added*).

The No-Fault Act was specifically "*designed to* ***minimize administrative delays and factual disputes that would interfere with achievement of the goal of expeditious compensation*** *of damages suffered in motor vehicle accidents*." *Miller v State Farm Mut Automobile Ins Co*, 410 Mich 538, 568 (1981) (*emphasis added*). In accordance with this goal, "*even when there is some doubt about the insured's entitlement to the payment,*" the Act and "*court decisions*" interpreting it "*encourage prompt payment of insurance benefits*." *Mich Educ Employees Mut Ins Co v Morris*, 460 Mich 180, 199-200 (1999).

With this legislative intent, and these legal principles in mind, we turn now to our objections, which will be fully detailed in the following section.

OBJECTIONS

I. OBJECTION #1: TO THE EXTENT THAT DRAFT RULE 66 INTERFERES WITH A PROVIDER'S "*DIRECT CAUSE OF ACTION*," IT IS BOTH SUBSTANTIVELY AND CONSTITUTIONALLY INVALID AND UNENFORCEABLE.

Part 3 of the draft DIFS rules address "*Insurer Determinations and Provider Appeals*." Rule 65 authorizes an insurer to make a determination as to two issues: (1) whether the medical care utilized, rendered or ordered was appropriate; and (2) whether the cost of that care was appropriate. Specifically, Rule 65 provides, in relevant part, as follows:

> "*(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*** *. . . must issue a written notice of the determination to a provider . . ."*

R. 65(1) (*emphasis added*).

Draft Rule 66 governs "*Appeals to the department*" and sets forth the process for appealing an insurer's determination (under Rule 65) to DIFS. This proposed Rule authorizes the DIFS Director to hear a dispute over an insurer's determination as a contested case.[1] Further, it makes clear that, when a provider files an appeal, it does not waive its right to pursue civil remedies for issues other than those subject to the appeal. Specifically, Rule 66 provides, in relevant part, as follows:

> "(1) ***A provider may appeal a determination made by an insurer 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 . . .*
>
> (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 . . .*
>
> (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."***

R. 66(1);(6); and (7) (*emphasis added*).

[1] Nothing in the plain language of §3157a, or in any other provision of the No-Fault Act, expressly or impliedly confers that authority on the DIFS Director.

A. DRAFT RULE 66 EXCEEDS THE SCOPE AND UNDERMINES THE LEGISLATIVE INTENT OF THE NO-FAULT ACT AND IS, THEREFORE, SUBSTANTIVELY INVALID.

Since Rule 66(7) explicitly excludes issues *not* subject to an appeal from being considered waived, the clear implication of that Rule is that a provider *does* somehow waive its right to seek civil remedies for issues[2] that *were* subject to an appeal to DIFS taken under Rule 66. Moreover, the implication from the Rule is that providers who do *not* seek an appeal have waived all rights to seek civil remedies. These readings are all consistent with the long-established maxim of statutory construction[3] *expressio unius est exclusio alterius* – i.e., the express mention of one thing implies the exclusion of other similar things. *Stowers v Wolodzko*, 386 Mich 119, 133 (1971).

If interpreted and enforced in this way, Rule 66(7) would result in (a) the ***unlawful imposition of a condition precedent*** to enforcement of a provider's rights to assert a direct cause of action against an insurer to recover benefits and to have that action adjudicated by a jury at trial; and (b) the ***unlawful deprivation of those legal rights*** in cases where an appeal was not taken, thus making DIFS the final arbiter of those claims. Such a result would violate a provider's statutory and constitutional rights and contravene the Legislature's intent in enacting the recent amendments to the No-Fault Act and our entire no-fault system, as will be discussed more fully below.

One of the central features of the amended version of the No-Fault Act that the Legislature adopted last June was the restoration of a provider's direct right of action to recover payment from an insurer for treatment rendered to an auto accident victim. Specifically, §3112 of the revised Act now provides, in relevant part, as follows:

> "***A health care provider listed in section 3157[1] may make a claim and assert a direct cause of action against an insurer***, *or under the assigned claims plan under sections 3171 to 3175,*[2] ***to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person***."

MCL 500.3112 *(emphasis added).*

---

[2] As noted above, the two issues which an insurer is authorized to "*determin[e]*" and which are, therefore, subject to appeal are: (1) 1) whether the medical care utilized, rendered or ordered was appropriate; and (2) whether the cost of that care was appropriate.

[3] "*In construing administrative rules, courts apply principles of statutory construction.*" *Detroit Base Coal for Human Rights of Handicapped v Dept of Soc Services*, 431 Mich 172, 185(1988).

In examining the plain language of that provision, which is the "*most reliable evidence*" of the Legislature's intent, it is clear that §3112 was intended to restore a provider's right to file a civil lawsuit, thus permitting providers to have unfettered access to Michigan courts to enforce their claims for unpaid services rendered to accident victims. *Whitman v City of Burton*, 493 Mich 303, 311 (2013). Although the phrase "*direct cause of action*" is not defined in the No-Fault Act, basic principles of statutory construction dictate that "*words are to be given their common, generally accepted meaning*" and that it is appropriate to "*consult dictionary definitions.*" *People v Denio*, 454 Mich 691, 699 (1997). Merriam-Webster's Dictionary defines a "*cause of action*" as follows: "*[T]he grounds . . . that entitle a plaintiff to* ***bring a suit.***"[4]

This dictionary definition is also consistent with the Michigan Supreme Court's interpretation of that phrase in *Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co*, 500 Mich 191(2017). Throughout its Opinion, the *Covenant* Court used the phrases "*direct cause of action*" and "*a statutory right to directly sue*" interchangeably, signaling that it construes them as synonymous phrases. *Covenant,* 500 Mich at 196, 200. Applying this construction, it is clear that the "*direct cause of action*" the Legislature intended to restore to medical providers by enacting §3112 was the "*right to directly sue*" or "*to bring a suit*" against insurers in courts of competent jurisdiction.

Nothing in §3157a, or in any other provision of the No-Fault Act, authorizes DIFS to impose a condition precedent to the enforcement of that unfettered statutory right. DIFS has no power to make "*fil[ing] an appeal with the department*" a precondition to a provider's right to file a civil lawsuit to challenge an insurer's determination as to the propriety of the treatment that provider rendered or its cost. Likewise, nothing in the Act authorizes DIFS to deprive a provider of the right to file a lawsuit altogether if it does not, or cannot, pursue an administrative appeal. Indeed, nothing in the statute permits DIFS to interfere in any way with a provider's right to assert a direct cause of action. To the extent that Rule 66 imposes a precondition on or deprives a provider of the ability to exercise that right, it impermissibly exceeds the scope of the enabling statute.

Further, to the extent that Rule 66 abrogates or interferes, in any way, with a provider's right to file a lawsuit, it is wholly inconsistent with the legislative intent underlying §3112 and the entire no-fault scheme. As noted above, the "*goal of the no-fault insurance system was to provide . . . assured, adequate, and prompt reparation*" for losses due to motor vehicle accidents and to "*minimize administrative delays and factual disputes that would interfere with achievement of [that] goal of expeditious compensation.*" *Shavers,* 402 Mich at 578–579; *Miller*, 410 Mich at 568. If adopted, Rule 66 will do just the opposite.

To the extent that it requires providers to pursue an administrative appeal *before* exercising their right to file a civil lawsuit, Rule 66 will only serve to promote delays and

[4] "*Cause of action.*" Merriam-Webster.com. Accessed 8 April 2020.

disputes in most cases. Making an administrative appeal a precondition to a civil lawsuit will lengthen – not "*expedit[e]*" – the process of challenging an insurer's determination and receiving compensation for most providers. *Miller, supra.* Further, to the extent that it deprives providers of the right to file a lawsuit altogether in some cases, Rule 66 will only assure that reparation is neither "*assured*" nor "*adequate*." *Shavers, supra.*

Since it fails the first two prongs of the test that Michigan courts have adopted for assessing the substantive validity of an administrative rule, Rule 66 is both substantively invalid and unenforceable. *Michigan Farm Bureau,* 292 Mich App at 129.

B. DRAFT RULE 66 INFRINGES UPON THE RIGHT TO JURY TRIAL GUARANTEED BY THE MICHIGAN CONSTITUTION AND IS, THUS, CONSTITUTIONALLY INVALID.

In addition to the fact that draft Rule 66 is substantively invalid, it is also constitutionally invalid to the extent that it threatens to infringe upon a medical provider's right to a civil jury trial. That right is guaranteed by §14 of Article I of the Michigan Constitution of 1963. Specifically, §14 provides, in relevant part, as follows:

> "***The right of trial by jury shall remain****, but shall be waived in all civil cases unless demanded by one of the parties in the manner prescribed by law..."*

MI CONST Art. 1, § 14 (*emphasis added).*

Although our State Constitution predates the No-Fault Act by a decade, this constitutional guarantee applies "*to cases arising under statues enacted subsequent to adoption of the Constitution which are similar in character to cases in which the right to jury trial existed before the Constitution was adopted. " New Products Corp v Harbor Shores BHBT Land Dev, LLC,* 308 Mich App 638, 645 (2014) (*internal quotations omitted*). The Michigan Supreme Court has previously recognized the right to a jury trial in first-party cases arising under the No-Fault Act. *See, e.g., Nasser v Auto Club Ins Ass'n*, 435 Mich 33, 53 (1990).

Michigan courts have held that ***"[t]he right to a trial by jury . . . is sancrosanct*** *and any doubt should be resolved in favor of permitting a jury trial*." *Nice v Chesapeake & O Ry Co,* 305 F Supp 1167, 1185 (WD Mich 1969) (*emphasis added*). Consistent with this principle, the Michigan Court Rules expressly provide that ***"[t]he right of trial by jury as declared by the constitution must be preserved to the parties inviolate***." MCR 2.508(A).

Importantly, the right of trial by jury guaranteed by our State Constitution ***"encompasses the right to have a jury hear a claim and determine issues of fact."*** *Phillips v Mirac, Inc*, 251 MichApp 586, 594 (2002). In a no-fault lawsuit brought against an insurer by a medical provider under §3112, those issues of fact would necessarily include the reasonableness of that provider's charges and the necessity of the treatment it rendered.

To the extent that draft Rule 66 deprives a provider of the right to have a jury hear and determine issues relating to the "*reasonableness*" or a provider's charges or the necessity of the treatment it rendered, or makes the DIFS Director the final arbiter of those issues, it clearly violates §14 of Article I of the Michigan Constitution. As such, it is constitutionally invalid and, therefore, unenforceable. *Michigan Farm Bureau, supra.*

II. OBJECTION #2: INSOFAR AS RULE 67(2)(C) AUTHORIZES OR REQUIRES UTILIZATION REVIEW PROGRAMS TO REGULATE MEDICAL EXAMINATIONS, IT IS SUBSTANTIVELY INVALID AND UNENFORCEABLE.

Part 4 of the proposed Rules address the "*Insurer Utilization Review Program*" and impose requirements on an insurer in adopting and implementing its mandatory "*utilization review program.*" Specifically, proposed Rule 67 provides, in relevant part:

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

R. 67(2)(c) (*emphasis added).*

A. DRAFT RULE 67(2)(C) IMPERMISSIBLY EXCEEDS THE SCOPE OF THE ACT.

As an administrative agency, DIFS' powers "*are limited to those expressly granted by the Legislature*." *Herrick, supra* at 574. Yet, "*medical examinations*" are not among the subjects for which DIFS was charged to promulgate rules, or to establish criteria, standards, or procedures under the amended version of the No-Fault Act. *See* MCL 500.3157a(3). Nothing in §3157a expressly, or impliedly, empowers DIFS to make any rules or establish procedures for "*medical examinations*." In fact, the term "*medical examinations*" does not even appear in §3157a. These "*examinations*" were never intended to be included in the subject matter of the statutorily-adopted utilization review program or in any administrative rules to implement that program.

To the contrary, when it enacted sweeping changes to the No-Fault Act last spring, the Legislature specifically addressed in the legislation the subject matter of medical examinations, including how and by whom they may be conducted. The section of the amended Act that governs "*medical examinations*" is §3151, and it provides as follows:

> "*(1) If the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits,* ***at the request of an insurer the person shall submit to mental or physical examination by physicians.*** *A personal protection insurer may include reasonable provisions that are in accord with this section in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits.*
>
> *(2)* ***A physician who conducts a mental or physical examination under this section must be licensed as a physician in this state or another state and meet the following criteria****, as applicable:*
> *(a) If care is being provided to the person to be examined by a specialist, the examining physician must specialize in the same specialty as the physician providing the care, and if the physician providing the care is board certified in the specialty, the examining physician must be board certified in that specialty.*
> *(b) During the year immediately preceding the examination, the examining physician must have devoted a majority of his or her professional time to either or both of the following:*
> *(i) The active clinical practice of medicine and, if subdivision (a) applies, the active clinical practice relevant to the specialty.*
> *(ii) The instruction of students in an accredited medical school or in an accredited residency or clinical research program for physicians and, if subdivision (a) applies, the instruction of students is in the specialty.*

MCL 500.3151 (*emphasis added).*

By requiring insurers to provide for the "*scheduling and performance*" of medical examinations as part of their "*utilization review program*", Rule 67(2)(c) impermissibly exceeds the scope of the enabling statute.

B. RULE 67(2)(C) IS INCONSISTENT WITH THE LEGISLATIVE INTENT OF THE ACT.

In addition to not "*fall[ing] within the subject matter*" of the No-Fault Act, Rule 67(2)(c) also contravenes its "*underlying legislative intent*." *Lutrell,* 421 Mich at 100. A review of the plain language of the statute, which is the "*most reliable evidence*" of the Legislature's intent, makes clear that medical examinations are to be governed by and conducted according to the parameters and procedures set forth in §3151 of the Act. *Whitman*, 493 Mich at 311. Since nothing in §3157a, or in any other provision of the statute, empowers DIFS to promulgate or enforce any rules relative to such examinations, it is equally clear that the Legislature did *not* intend for it to do so.

Had the Legislature intended for DIFS to address the subject of "*medical examinations*" in its rules, it would have explicitly authorized it to do so, as it did with the subjects specifically identified in §3157a(3). Further, had it intended for such examinations to be regulated by an "*insurer's utilization review program*", it would have said so. Yet, it did neither. And one of the basic principles of statutory construction is that it is improper to "*read a requirement into a statute the Legislature has 'seen fit to omit*.'" *Book-Gilbert v Greenleaf*, 302 Mich App 538, 542 (2013).[5]

Accordingly, to the extent that Rule 67(2)(c) addresses the subject matter of "*medical examinations*," and requires utilization review programs to regulate such examinations, it is wholly inconsistent with the intent of the Act, substantively invalid and unenforceable in that it clearly attempts to impose regulations and conditions on a subject matter that the Legislature has preempted by its recent amendment to §3151.

III. OBJECTION #3: DRAFT RULE 68 UNLAWFULLY PERMITS INSURERS TO DELEGATE THEIR STATUTORY OBLIGATIONS TO THIRD-PARTY "*MEDICAL REVIEW ORGANIZATIONS.*"

As noted above, Part 4 of the Rules impose several requirements on an insurer relative to its "*Utilization Review Program*". However, under Part 4, DIFS also *permits* an insurer to delegate its statutory obligation to conduct utilization review activities to a third-party. Specifically, draft Rule 68 provides, in relevant part, as follows:

> *"(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.*

[5] *See also Potter v McLeary*, 484 Mich 397, 422 n 30 (2009) (holding that courts must "*refrain from adding requirements to a statute that are not contained within its language*").

> *(d) A current list identifying all property/casualty insurers, health insurers, health maintenance organizations and health are 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 . . .*"

R. 68 (*emphasis added*).

A. DRAFT RULE 68 IMPERMISSIBLY EXCEEDS THE SCOPE OF THE NO-FAULT ACT.

The obligation to implement "*utilization review*" is one that the Legislature assigned expressly and exclusively to insurers and the MCCA. Specifically, §3157a provides, in relevant part, as follows:

> "*(5) If an* ***insurer or the association created under section 3104*** *determines that a physician, hospital, clinic, or other person overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under this chapter, the physician, hospital, clinic, or other person may appeal the determination to the department . . .*"
>
> *(6) As used in this section, "utilization review" means 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."* [MCL 500.3157a(5)-(6) (*emphasis added*).]

Under this plain language, the only two entities lawfully vested and charged with implementing "*utilization review*" (i.e., making *initial* determinations regarding the appropriateness of the treatment rendered to auto accident victims and the cost of that treatment) are insurers and the MCCA.

As noted above, Michigan courts have long held that administrative agencies have no authority other than that expressly conferred to them by "*clear and unmistakable*" statutory language. *Mason*, 343 Mich at 326. Indeed, an *"agency that acts outside its statutory boundaries usurps the role of the legislature." Herrick*, 293 Mich App at 582.

Nothing in §3157a, or in any other provision of the No-Fault Act, permits an insurer to delegate or reassign its statutory obligation to conduct "*utilization review*" activities to any third-party, including, but not limited to, a "*medical review organization.*" In fact, the term "*medical review organization*" does not even appear in the No-Fault Act.

Yet, without any statutory authority or apparent reason, DIFS has promulgated an administrative rule entirely devoted to "*[m]edical review organizations*" in which it explicitly permits insurers to offload their statutory obligations to these third-parties. In doing so, DIFS has not only "*usurp[ed] the role of the legislature*" but also impermissibly exceeded the authority conferred upon it by and the subject matter of the No-Fault Act.

B. DRAFT RULE 68 IS INCONSISTENT WITH THE LEGISLATIVE INTENT OF THE ACT.

In addition to the fact that draft Rule 68 falls outside the subject matter of the No-Fault Act, it also completely contradicts the "*underlying legislative intent*" of §3157a. *Lutrell, supra*. As noted above, a review of the plain language of that statutory provision, reveals that only two entities are properly charged with conducting "*utilization review*" and making initial determinations: insurers and the MCCA. MCL 500.3157a(5)-(6).

If the Legislature had intended to allow these two entities to delegate their statutorily-imposed obligations, it would have expressly provided for such a delegation. In the absence of such a provision, DIFS lacks any authority to grant insurers the right to reassign their statutory duties to third-party "*medical review organizations*." *Herrick, supra.* In doing so, Rule 68 contravenes the Legislature's intent in enacting §3157a(5)-(6).

Further, Rule 68 is also inconsistent with the legislative purpose underlying the entire no-fault system, which is to provide "*assured, adequate, and prompt reparation*" for losses suffered as a result of motor vehicle accidents – and to minimize "a*dministrative delays and factual disputes*." *Shavers, supra*; *Miller, supra*. Contrary to that purpose, by permitting insurers to offload their obligations to "*medical review organizations,*" Rule 68 will only promote "*administrative delays and factual disputes*" and increase the likelihood that payment will be neither "*adequate*" nor "*prompt.*" After all, as a practical matter, such organizations exist largely to dispute charges and reduce payment to providers. By authorizing the involvement of these organizations in an insurer's "*utilization review*" responsibilities, Rule 68 will impose unnecessary bureaucracy, complicate the decision-making process, and undermine the goal of "*expeditious compensation*." *Miller, supra.*

CONCLUSION

For all of the reasons stated above, the administrative rules identified herein – i.e., Rules 66, 67(2)(c) and 68 – are invalid and unenforceable. *Michigan Farm Bureau, supra.* Insofar as they exceed the scope of the enabling statute and are inconsistent with its underlying legislative intent, all fail the first two prongs of the conjunctive test adopted by Michigan appellate courts to assess substantive validity. In addition, to the extent that it infringes upon the right to a civil jury trial on all contested issues guaranteed under §14 of Article I of the Michigan Constitution, Rule 66 is constitutionally invalid.

Accordingly, on behalf of our clients in the Michigan medical provider community, who will be uniquely affected by and share a special interest in the promulgation and enforcement of the DIFS "*Utilization Review*" rules, we strongly object to adoption of these rules as written. We respectfully request that DIFS withdraw draft Rules 67(2)(c) and 68 from consideration altogether. Further, we encourage DIFS to replace draft Rule 66(7) with a new sub-rule that encompasses the following concepts:

(1) A provider need not exhaust the appeal provisions referenced in the proposed rules *before* filing or pursuing a civil lawsuit; it may file a lawsuit in lieu of appealing an insurer's determination to the department.

(2) By appealing an insurer's determination to DIFS, a provider does not waive its right to file or pursue any civil remedies otherwise available to it, regardless of whether the provider's claim was the subject of the appeal.
.

(3) The right to pursue a direct cause of action against a no-fault insurer under the No-Fault Act and the right to pursue an appeal of an insurer's determination under the Act and the DIFS rules may be exercised by a provider simultaneously.
.

In promulgating any rules regarding "*utilization review*", DIFS should be guided by the overarching intention of Michigan's auto no-fault reparations system which is to simplify the claim-making process, to avoid unnecessary administrative delay and bureaucracy, and to promote the expeditious payment of no-fault claims. *See Shavers, supra; Miller; supra; Morris, supra.*

Insurance Alliance of Michigan

April 17, 2020

Sarah Wohlford, Esq.
Senior Deputy Director
Director, Office of Research, Rules, and Appeals
Department of Insurance and Financial Services
530 W. Allegan St., 8th Floor
Lansing, Michigan 48933-7720

Re: DIFS Proposed Rule 2019-136 IF
Utilization Review
Claims Payment, Adjustment, Dispute Resolution

Dear Ms. Wohlford:

The Insurance Alliance of Michigan (IAM) is the state trade association representing property and casualty insurers operating in Michigan, who collectively write approximately 75 percent of the automobile insurance market in the state. On behalf of the members of the IAM, I write to express our thoughts and concerns regarding proposed rule 2019-136 IF.

As an initial point, we greatly appreciate the department developing needed administrative rules to provide greater form and function to the language and goals of Sec. 3157a of the insurance code, added by the legislature in 2019 as part of comprehensive no-fault auto insurance reform.

Our concerns, however, are as follows:

Standards for Utilization Review:

Generally speaking, the rules need to provide greater standards and clarity for what the department will be looking for in terms of a "utilization review" program under R500.67. Currently, R500.62(1)(a) states the rules "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." Further, R500.67(2)(b) requires that an insurer's utilization review program must "[m]ake determinations regarding the appropriateness of medical care, in terms of both the level and quality of medical care based on *medically accepted standards*."

The core term, "medically accepted standards," is defined in R500.61(j) as "standards or criteria that are *set by a competent authority* as the rule for evaluating the quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place." The term "competent authority" is not itself defined, so insurers are left with the question of what it means or includes.

For example, would URAC (https://www.urac.org/) be an appropriate "competent authority," and therefore its standards for such a program accepted? Learning of standards or criteria missed or not met *after* filing would put an insurer looking to comply in a very difficult position given the remaining time involved.

Ultimately, insurers believe the establishment of clear and objective standards set by a recognized authority, as opposed to indeterminate and subjective "community-based" standards, will be vital to the success of the utilization review effort envisioned by the Legislature and placed in statute. Otherwise, providers will solely control the standards that they want to set in their community, and there will be no objective source against which their actions can be evaluated.

Provider Records Submission:

MCL 500.3157a(1) provides,

> By rendering any treatment, products, services, or accommodations to 1 or more injured persons for an accidental bodily injury covered by personal protection insurance under this chapter after July 1, 2020, a physician, hospital, clinic, or other person is considered to have agreed to do both of the following:
>
> (a) *Submit necessary records and other information* concerning treatment, products, services, or accommodations provided for utilization review under this section.

On the other hand, R500.63(1), General Record Acquisition, only provides that "an insurer *may request* from a provider necessary medical records, medical bills, and other information concerning the medical care provider too (*sic*) an injured person." The intent of the legislature to create proper utilization review would be better served if the proposed rule provided greater definition to the type of documents medical providers must submit as a matter of course for utilization review.

R500.63(2) further provides that if an insurer is requesting documents "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." Proper utilization review will require additional material than just that submitted with an invoice, which may only provide a list of services provided and amounts charged. This subsection of the rule forces insurers to pay medical providers for what we believe the legislature intended them to already submit, and should be revised or deleted. Alternatively, we would submit that the proper "average hourly rate" should be for that of an administrative staff person, rather than the provider, as much of these requests would be for copies of other existing documents.

Provider Administrative Appeals:

Additional clarity in wording would be appreciated to specify in particular that the administrative appeal process of R500.66 is the exclusive remedy for medical providers objecting to insurer determinations. We recall the Legislature's intent to create a strong utilization review mechanism aimed at reducing excessive, unnecessary, and fraudulent claims/litigation involving medical utilization and billing. Therefore, the administrative appeals process should be clarified as the exclusive remedy of medical providers for these disputes.

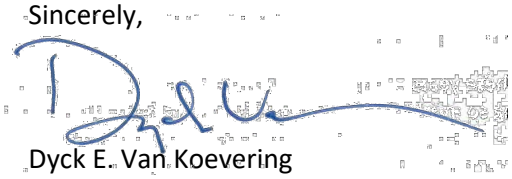
Additionally, R500.66(1) states that provider appeals must be "filed within 90 days of the date of the disputed [insurer] determination." IAM requests the Department consider adding a consequence to a provider's failure to appeal an insurer determination within the 90-day timeline.

Further, IAM members would request greater specificity with respect to which "utilization and review activities" the department will require insurers to include in their annual reports per R500.70. And as a final comment, insurers' right to review medical billings, and the use of third parties to do so, has long been recognized and nothing in the amended Act puts limits on either. The objection to this practice raised at the formal hearing should be given no weight.

Thank you in advance for your attention to this matter. We look forward to working with the department on the development and implementation of these rules, as well as broader no-fault auto insurance reform.

Please let me know if you have any questions or comments.

Sincerely,



Dyck E. Van Koevering
General Counsel

MBIPC
Michigan Brain Injury Provider Council

7305 Grand River, Suite 100
Brighton, MI 48114-7379

April 14, 2020

DIFS
Attention: Director Anita Fox
PO Box 30220
Lansing, MI 48909

RE: Utilization Review Rules – Public Comment

Director Fox:

Since 1987, MBIPC, a 501 (c)(6) trade association has served providers in professions related to brain injury rehabilitation. Our purpose is to enhance the ability of its members to provide high quality, ethical rehabilitation, health care, and related services to people with a brain injury. We have over 140 members throughout the state, comprised of physicians, brain injury rehabilitation centers, transportation companies, case managers, guardians, pharmacies, home health, durable medical equipment providers, and other specialty service providers. The Utilization Review Rules effect all of our members. Enclosed you will find a document comprised as our public comment, with input garnered from our members.

On January 10, 2020, we provide our response to the first set of drafted Utilization Review rules. We expressed our deep concern for the rules as drafted in terms of the fairness and demands they placed on the providers, jeopardizing an efficient delivery of reasonably necessary services, products and accommodations to victims of automobile accidents.

We would like to thank you for hearing our concerns, and those of other vested stakeholders. This new set of utilization review rules demonstrate the Department's openness to feedback and willingness to work together to implement rules that safeguard the system, reduce costs, and protect the rights of consumers to reasonably necessary services, products, and accommodations for their recovery, rehabilitation and care arising from an automobile accident.

The enclosed document provides comments on each issue that our membership provides troubling and/or need clarification in order to be able to conform to the rules (our comments are in red within the relevant sections and subsections). The following is an outline of the most consistent and pressing concerns

> **Rule 61(j)**. The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." This could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. The definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. We urge there be a deadline in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. Rule 66 contradicts, or at least causes confusion, about the rights of providers to avail itself of civil remedies. We urge Rule 66(7) be changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. There is concern over the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." R67(2)(c) should be revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

We urge your department to read our comments thoroughly and thoughtfully in order to understand our concerns, the contradictions to statute contained, and the risks associated with the implementation of these rules as written.

Since the passage of PA 21, we have offered to serve as a resource to the Department in order to implement the new policies in a fair and balanced way. We hope that the public comments provided in the enclosed document and our general concerns outlined in this letter are viewed as a continuation of these efforts.

Sincerely,

Tim Hoste, MBIPC President

CC:
Kevin McKinney, McKinney & Associates
Office of Governor Gretchen Whitmer

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.

Comment:

- What about a group practice? Multiple psychologists vs 1; multiple Speech pathologists? Multiple Voc counselors?

(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).

Comments:

- Within PA-21, the only reference to "medical care" is found in Section 3157 (9) and this phrase is only used there with respect to the "medical care competent" of the CPI required annual price adjustments.
- "Medical care" is used in the 2-15-2020 draft UR Rules to encompass the scope of "treatment, training, products, services, and accommodations provided to an injured person for the injured person's care, recovery, or rehabilitation" …
- "Medical care" is an excessively limiting term which has a connotation of much more narrow meaning than "treatment" versus "training, products, services, and accommodations" allowed under PA 21.
- "Medical care" can be misconstrued. This will cause needless confusion, and besides confusion, potentially denials that are contradictory to the intent and language of PA 21.
- Instead of using a defined term, "medical care", why not drop the phrase "medical care" for all the reasons noted above, and instead incorporate the elements of "treatment, training, products, services, and accommodations provided to an injured person for the injured person's care, recovery, or rehabilitation" into R 500.62 Scope and Applicability? This would be far simpler and consistent with the law.
-

(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.

Comments:

- Question continues to remain who determines who the "competent authority" is and what evidence/source is this person using to determine medically "accepted standards". Is it universal? Or do insurers have their own in house person. Is this person's credential's transparent? And is the foundation of this determination (the evidence to support the decision) transparent?

- This point specifically needs contain language which clearly articulates differentiates between "medically accepted standards" and "medically accepted standards in rehabilitation from auto accidents (specifically for TBI). One could argue it is medically accepted that the maximum amount of physical therapy one should receive a year is whatever Medicare covers. However, that is not in line with what we see with catastrophic TBIs. In order to protect patients, this should be indicated somewhere here.
- Competent authority needs more clarification. Who is the authority for Neuropsych? There are for example multiple boards and prof organizations?
- "Medically accepted standards" as used in the 2-15-2020 draft UR Rules presents related concerns in that, within the "medically accepted standards" definition, the term "medical care" (see above) is used.
- Not all the services provided under Michigan's Auto No-fault law are "medical care" but are otherwise needed and reasonable.
- Can the rules drafters substitute "generally accepted standards" for "medically accepted standards"?

(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.

Comment:

- Where does the "usual range" come from? Patients present with various levels of injury ie Mild/Mod/Severe TBI, concomitant medical and physical problems, etc

(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.

Comment: These rules must state somewhere (maybe here) that there is a standard assumption of propriety on the behalf of the providers. Everything in here operates from an assumption of fraudulent practice instead of an assumption of providing appropriate levels of care. It should be explicitly stated that the former is the case, and that the burden of proof is on the insurer.

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.

Comment:

- Plus the cost of copying, postage, correct?

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.

Comment:

- What is the time frame an insurer must respond in?

- This rule is missing a time limit for the insurer's permitted request from a provider for a written explanation. Recommend a 30-day time limit.
- "Necessary" appears to be a typo; "necessity" may be the more appropriate term.

(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:

Comment:

- Suggest a timeframe to correspond with issuance of a "written notice"
- Once the requested materials from the provider are received by the insurer, a timeline for the insurer to make their written determination known to the provider should be detailed.
- There is no deadline for the insurer to issue the required written notice of determination to the provider. The time frame needs to be reasonable; otherwise the provider's cash flow will be severely harmed. **Recommend 60 days following receipt of provider's explanation.**

(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.

Comment: May the patient file an appeal, or must it be the provider only?

(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.

Comment:

- The rule states "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."
- Please delete "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.

Comment:

- What are the qualifications of those making the determinations and where do the standards come from?

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

Comment: Will insurers be allowed to withhold payment during utilization review? If they are permitted to pend payment while scheduling IMEs, waiting for the report, reviewing the report, etc., this could easily take 6+ months and that's not counting the 90 days afforded to the director to make a decision.

(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.

Comment: Is there an auditing process or some sort of oversight to ensure forms contain results of all utilization review efforts made by insurance companies (not just those that resulted in a determination of over utilization)?

(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.

Comment:

- This still does not clarify who is making the determinations. I.e. is a Nurse deciding how much OT or SLP a patient should have?
- Would like to ensure that utilization review companies be Michigan based, using Michigan data

(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.

Comment: Also, consider making sure the MRO has specific experience with catastrophic injuries (when appropriate for the review)

(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.

Comment: Transparent data should be shared on the outcomes of the MROs – how often do they determine in favor of insurer vs. insured/provider.

(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.

Comment: Include an improvement plan if the Department finds areas of concern based on report with a timeframe (30 days) to submit the improvement plan.

(2) The annual report is subject to disclosure under the freedom of information act, MCL 15.231 et seq.

April 9, 2020

DIFS
PO Box 30220
Lansing, MI 48909-7720

RE: Auto No-Fault Utilization Review Feedback

Dear Michele Estrada,

I own a case management company so I have a broad vantage point on problems that occur with insurance payments across the continuum of care that effect both providers and claimants. My company has been serving people injured in car accident for fifteen years. We are looking forward in taking a pivotal role in assuring that our clients maximize the care they need within the parameters of the new law.

A problem I encounter is when an insurance company schedules a newly admitted claimant for an IME and won't pay for services already provided pending the results of the IME. Or, they schedule an IME at any time during a claimant's treatment and stop payment until the results are received. Oftentimes the IME notice is sent a month or two after a claimant begins services. Sometimes there are multiple IME's and all providers are put on notice about payment. If the IME physician disagrees with the plan of care developed by the claimant's own physician, the insurance will often cut the claimant's benefits and pay nothing retroactively to the providers who provided care.

Empirical research supports better recovery results when people receive treatment and rehab as soon as possible after sustaining injuries. The above problem creates large costs to providers and prevents claimants from receiving needed care prescribed by their physicians.

An IME is a tool that insurance companies use for a second opinion but is often used to override the treating physician to cut off benefits. I'm sure the IME will be a tool used by the Utilization Review Departments. Most of the utilization rules developed by DIFS provides a provider and claimant recourse for appealing a decision by the insurance Utilization Review department. I'm concerned that the lack of payment pending an IME is a loophole that will create high costs to providers and claimants and prevent the claimant from necessary services. Also, as providers bill the claimant for unpaid bills because they were not paid, the claimant is at risk of going into collections with ruined credit.

The solution is for providers to be paid for their services until the results and action of the IME is known - assuming that the products, services and accommodations are prescribed by the claimant's physician. The claimant's prescribing physician is the lead in the claimant's care and knows what is best for his or her patient. From there, there are recourses already in place and outlined in the new Utilization Review rules the claimant and providers can follow if there is a disagreement with actions taken because of an IME.

Thank you for your time. I can be reached at 517-381-3430 or by email at piner@ambroseconsult.com for further clarification.

Respectfully,

Elizabeth Piner, LMSW, ACSW, CCM
President
Ambrose Case Management

Jeffrey Junkas
Vice President, State Government Relations

April 9, 2020

sent via email: estradam1@michigan.gov

Ms. Michele Estrada
Michigan Department of Insurance and Financial Services
Office of Research, Rules and Appeals
P.O. Box 30330
Lansing, MI 48909-7720

RE: Proposed Rules 2019-136 IF – Utilization Review

Dear Ms. Estrada:

The American Property Casualty Insurance Association (APCIA) is the primary national trade association for home, auto, and business insurers that promotes and protects the viability of private competition for the benefit of consumers and insurers. We respectfully submit the following comments regarding the proposed rules 2019-136 IF concerning utilization review for auto no-fault claims.

APCIA greatly appreciates DIFS' efforts on this rule set and the improvements made in this revised version from the draft issued in December 2019. Our internal and member review of these revised rules did produce some questions and concerns as detailed below for which we request some modifications and clarifications.

- Part 1, R 500.61 (j)

Similar to my letter on January 17, 2020 commenting on the Regulatory Impact Statement, we would again recommend that a the "…competent authority…" be defined to be an entity like OGD, an MCG Health Company; or Fair Health; or even referencing AMA treatment guidelines, similar to what is used in the workers compensation context.

- Part 2, R 500.63 (2) and R 500.64 (3)

These two items seemingly require an insurer to pay a medical provider what could be expensively high hourly rates simply for providing often necessary supporting information and details that may not be on an invoice – which could just be a date and charge amount. Providing even mailed copies of billing or procedure details should not be labor intensive or costly in and of itself, and in fact in today's current system a vast majority of such inquires do not include such charges. Leaving the rules as-is, absent any caps or controls on this, doctors could charge say $250/hour for standard documents. APCIA requests that language be modified to not require any mandated administrative costs, or at the very least provide that such information be at a small, predictable, flat fee.

- Part 2, R 500.64 (2)

The draft rule indicates a provider has 60 days to respond to an insurers request for additional information. While we are glad it is a 'must' requirement, we believe 60 days is much too long a timeframe and can inhibit, or even risk a stoppage of, treatment while the insurer waits for paperwork. A more reasonable timeframe should be 10 business days, or perhaps 30 days or less.

- Part 3, R 500.66

This section is somewhat unclear as to if the provider even must proceed first through an appeals process with the Department (per line (1) saying "…may appeal…"). Clarity is needed on if this process is required, e.g. "If a provider disagrees with a determination by an insurers, the provider must appeal…".

Thank you for the consideration of our perspective and request for changes and clarifications to the revised rules before they are finalized.

Please contact me directly at 847-894-6715 (mobile) or via email at jeffrey.junkas@acpi.org or APCIA's Michigan counsel, Andrew Doerr at 517-374-9187 or via email at ADoerr@dykema.com, with any questions.

Sincerely,

Jeffrey Junkas

Estrada, Michele (DIFS)

From: Jeff Fried <jfried@friedporter.com>
Sent: Monday, April 13, 2020 4:16 PM
To: Estrada, Michele (DIFS)
Subject: Regarding utilization rules for auto no fault

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you,

Jeff fried

Sent from my iPhone

Estrada, Michele (DIFS)

From: Meg Scaling <mscaling@galaxybraincenter.com>
Sent: Monday, April 13, 2020 3:08 PM
To: Estrada, Michele (DIFS)
Subject: DIFS concerns

I own Galaxy Brain and Therapy Center and am greatly concerned about the draft of the 2/15/2020 draft Utilization Review Rules.

The language in this draft does not protect the provider, and requires providers to comply and adhere to strict deadlines and standards, but does not hold the same level of accountability to the insurance companies. There are many issues I have with the requirements that are being placed on providers (more requirements than what medical insurance requires), and the financial hardship that these utilization reviews and accreditations will cost a small single operation clinic. While now is not the time to discuss all of those concerns, I do want to highlight concerns with the 2/15/2020 draft as written:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

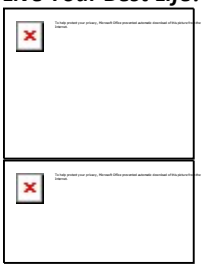
> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you for your time and consideration,

Meg Scaling, CEO
Galaxy Brain and Therapy Center
5840 Interface Drive, Suite 400
Ann Arbor, MI 48103

--

Move Forward. Give Back.
Live Your Best Life!



Meg Scaling, Chief Executive Officer, OTRL
Galaxy Brain and Therapy Center
5840 Interface Drive, Ste. 400
Ann Arbor, MI. 48103
c: 734-904-4072
o: 844-816-0226
f: 734-433-1989

LinkedIn Profile

Email confidentiality Notice: The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPPA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of this message is strictly prohibited and may subject you to criminal or civil penalties. If you received this transmission in error, please contact the sender immediately by replying to this email and delete the material from any computer. Information transmitted is not considered medical advice and should not be understood as such.

Estrada, Michele (DIFS)

From: Lance Treece <ltreece1@hcaccg.com>
Sent: Monday, April 13, 2020 4:11 PM
To: Estrada, Michele (DIFS)
Subject: Utilization review rules & concerns

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.
Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hearing process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you.

Thank you,
Lance Treece

www.healthcareassociates.net

Health Care Associates
Community Care Givers

Office 616-531-9973

Making life better every day

Medlogix
Expect exceptional.

300 American Metro Blvd., Suite 170, Hamilton, NJ 08619
(800) 293-9795 • www.medlogix.com

April 9, 2020

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
530 W. Allegan St, 7th Floor P.O. Box 30220
Lansing, MI 48933
Attn: Michele Estrada at EstradaM1@michigan.gov

SENT VIA E-MAIL

RE: Administrative Rules for Utilization Review, Rule Set 2019-136 IF

Dear Ms. Estrada,

Medlogix, LLC. – a New Jersey based Medical Claims Management company, is submitting the following questions related to the Michigan Department of Insurance and Financial Services Utilization Review draft rule:

1) Is the Utilization Review (UR) Program able to be administered by either the insurer, a medical review organization on behalf of the insurer or the MCCA? If yes, what is the role of the MCCA?

1a) How does the MCCA guidelines impact the UR Program?

2) Is the UR Program only the review of the appropriateness, based on medically accepted standards, of the level and the quality of treatment, products, services, or accommodations provided under PIP? Is causality or causal relation a criteria of the UR Program?

3) Are the UR Services required to be performed within the State of Michigan?

3a) Are the UR Services required to be performed only by Michigan licensed clinicians?

4) With regard to R 500.63. General record acquisition – how is the provider's hourly rate determined 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?

5) Will DIFS issue standardized forms that will be required for:

a. R 500.64 Insurer requests for explanation
b. R 500.66 Appeals to the department

6) Under R 500.65 Determinations by an insurer - (e) The date of the determination; has DIFS defined the turn-around-time requirement to issue a determination?

Medlogix
Expect exceptional.

300 American Metro Blvd., Suite 170, Hamilton, NJ 08619
(800) 293-9795 • www.medlogix.com

Ms. Estrada, on behalf of Medlogix and the insurers we represent, I would like to thank you and the Department for considering our inquiries above.

Please contact me directly at cell 732.859.7519 or Steve.Armenti@Medlogix.com should you have any questions or need additional information from Medlogix.

Sincerely,

Steven A. Armenti
SVP, Business Development

Cc: C. Goldstein, Medlogix

MICHIGAN ASSOCIATION *for* JUSTICE

Stephen V. Pontoni
Executive Director
Michigan Association for Justice
325 S. Walnut St
Lansing, MI 48933

Michele Estrada
Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

April 9, 2020

The Michigan Association for Justice is the association of trial lawyers. Our members represent those who have been injured in car crashes. We operate on the frontline of Michigan's Auto No-Fault system. We appreciate the work and care that has gone into developing these rules, however we do have some thoughts. The following are our concerns and suggestions as to the latest version of the proposed Utilization Review Rules:

I. R61(j). This rule effectuates the new statutory requirement in §3157a(3)(a) to "[e]stablish criteria or standards for utilization review...based on medically accepted standards." We believe that "medical accepted standards" refers to those practices that are generally accepted in the medical community. The proposed rule instead seeks to define "medically accepted standards" by reference to "a competent authority." In our experience, resort to "an authority" results in standards being set by insurance-oriented organizations. While we laud the concept of "evidence based medicine", we have often found that there is little actual evidence to support opinions ostensibly based on "evidence based medicine." This approach generally does not reflect the actual practices in the community. Therefore, we recommend that rule be revised to read as follows:

"'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

II. R66(2). Notice to the injured person. R66(2) requires notice to the patient only of a provider's appeal. We believe that notice must be given to the patient of all actions by an insurer.

III. R66(7) and Exclusive Remedy concerns. We have been concerned that the rules do not taken away rights to civil remedies. R66(1) now says that providers "may appeal." R66(7) makes clear that a provider "that files an appeal...does not waive its right to seek civil remedies." Also, we note that the new statute gives service providers a right of direct action per §3112. Therefore, we believe that the R66(7) should more broadly state:

"A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies."

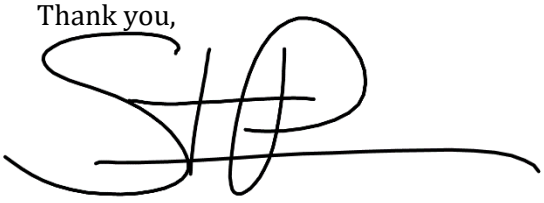
IV. R67 in general. We expressed our interest and concern into the actual conduct of the hearings. We understand that the review will be without oral argument and will be decided under the preponderance of evidence standard. We will be interesting in any further details of the hearing process.

V. R67(2)(c). This rule refers to "independent" medical examinations pursuant to §3151 of the no-fault law. Such examinations are not "independent" as they are done at the request of a no-fault insurer. Indeed, §3151 does not use the phrase "independent medical examination. Rather, §3151 states in pertinent part: "If the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, at the request of an insurer the person shall submit to mental or physical examination by physicians." Therefore, R67(2)(c) should be revised to state:

"Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

The above summarizes our concerns and suggestions. Thank you for your consideration.

Thank you,



Stephen V. Pontoni
Michigan Association for Justice
Executive Director

325 S. Walnut ◆ Lansing, MI 48933
Phone (517) 321-3073 ◆ FAX (517) 321-4694
maj@michiganjustice.org ◆ www.michiganjustice.org

MICHIGAN ASSOCIATION *for* JUSTICE

325 S. Walnut ◆ Lansing, MI 48933
Phone (517) 321-3073 ◆ FAX (517) 321-4694
maj@michiganjustice.org ◆ www.michiganjustice.org

Estrada, Michele (DIFS)

From: Gregory Kirk <gkirk@onwardtherapyservices.com>
Sent: Monday, April 13, 2020 3:11 PM
To: Estrada, Michele (DIFS)
Subject: Utilization Review Concerns

Michele,

I am a provider of care for persons with brain injuries. I have the following concerns about the 2/15/2020 draft Utilization Review Rules:

Rule 61(j). The proposed definition for "Medically accepted standards" identifies the standards as created by a "competent authority." In my experience, this could be an insurance-oriented organizations or "authority" whose credentials are less than transparent. I think the definition should be focused on the practices in the medical community and the definition changed to:

> "'Medically accepted standards' means standards or criteria that are generally accepted by practicing physicians for evaluating quantity or quality of medical care ensuring that the medical care is suitable for a particular person, condition, occasion, or place."

Rule 64(3). The insurer is obligated to reimburse the provider for providing a narrative but there is no timeline or deadline for payment to be issued. I suggest a deadline for payment is included in which the insurer must issue payment.

Rules 65. There is a lack of stated deadline imposed on the insurer for response and determination to providers. The insurer is obligated to provide a lot of detailed information to providers but there is no timeline or deadline imposed on the insurer to do so.

To be clear, MBIPC seeks these rules impose on insurers, much like providers, deadlines for insurer action to respond and issue determinations. Without these kind of short time periods under which insurers must respond, or make determinations, the usefulness of a review of this kind for providers is undermined significantly.

Rule 66. I am concerned that 66 contradicts or at least causes confusion about the rights of providers to avail itself of civil remedies. I suggest 66(7) is changed to make sure it is consistent with MCL 500.3112 and should read:

> "A provider is not obligated to resort to appeal under these rules. A provider may choose to exercise its rights to civil remedies. A provider that files an appeal with the department under this rule does not waive its right to seek civil remedies. Nothing in these rules limits an injured person's right to pursue his or her civil remedies to secure benefits under the No-Fault Act."

R67. In general, I am concerned about the actual conduct and procedure of the hearings. It seems it will be decided on written documents only. Any greater details about the hering process is appreciated.

R67(2)(c). This rule refers to "independent" medical examinations pursuant to MCL 500.3151 but the actual statute DOES NOT use the phrase "independent medical examination." Thus R67(2)(c), goes beyond the language of that statute by calling this examination "independent." I recommend R67(2)(c) is revised to state:

> "Provide for the scheduling and performance of mental or physical examinations by physicians at the request of an insurer."

Thank you.

Onward,

Greg Kirk
Owner
O: (248) 792-3633 | M: (586) 292-8334

CLINIC NOW OPEN! (Birmingham/Troy Area)

3250 W. Big Beaver Rd, Suite 300 | Troy, MI 48084 | OnwardTherapyServices.com

Estrada, Michele (DIFS)

From: Bill Buccalo <bill.buccalo@rainbowrehab.com>
Sent: Tuesday, April 7, 2020 10:36 AM
To: Estrada, Michele (DIFS)
Cc: Bill Buccalo; Lynn Brouwers; Jonathan Dean
Subject: Public Comment regarding the February 15, 2020 draft of the DIFS Utilization Review Rules.

Dear Ms. Estrada,

Below is Public Comment from Rainbow Rehabilitation Centers, Inc. regarding the February 15, 2020 draft of the DIFS Utilization Review Rules.

Sincerely,

Bill Buccalo

----------/

April 7, 2020

Dept. of Insurance and Financial Services
Office of Research, Rules, and Appeals
PO Box 30220
Lansing, MI 48909-7720

Re: Public Comment on Draft Administrative Rules for Utilization Review

To the Office of Research, Rules, and Appeals:

Rainbow Rehabilitation Centers wishes to offer the following comments, concerns, and recommendations regarding the February 15, 2020 draft of the DIFS Utilization Review Rules.

R 500.61 Definitions
Rule 61 (i) "Medical care"

- Within PA-21, the only reference to "medical care" is found in Section 3157 (9) and this phrase is only used there with respect to the "medical care competent" of the Consumer Price Index relating to annual price adjustments.
- "Medical care" is used in the 2-15-2020 draft UR Rules to encompass the scope of "treatment, training, products, services, and accommodations provided to an injured person for the injured person's care, recovery, or rehabilitation" …
- "Medical care" is an excessively limiting term which has a connotation of much more narrow meaning for "treatment" as compared to the phase "training, products, services, and accommodations" allowed under PA 21.
- "Medical care" can be misconstrued. This will cause needless confusion, and besides confusion, potentially denials that are contradictory to the intent and language of PA 21.
- Instead of using a defined term, "medical care", why not drop the phrase "medical care" for all the reasons noted above, and instead incorporate the elements of "treatment, training, products, services, and

accommodations provided to an injured person for the injured person's care, recovery, or rehabilitation" into R 500.62 Scope and Applicability? This would be far simpler and consistent with the law.

Rule 61 (j) "Medically accepted standards"

- "Medically accepted standards" as used in the 2-15-2020 draft UR Rules presents related concerns in that, within the "medically accepted standards" definition, the term "medical care" (see above) is used.
- Not all the services provided under Michigan's Auto No-fault law are "medical care" but are otherwise needed, reasonable, and compensable under the law if those services meet required elements.
- We recommend the rules drafters substitute "generally accepted standards" for "medically accepted standards" or another phase consistent with the law.

R 500.64 Insurer requests for explanation.
Rule 64 (1)

- This rule is missing a time limit for the insurer's permitted request from a provider for a written explanation. Recommend a 30-day time limit.
- The word "necessary" appears to be a typo; "necessity" may be the more appropriate term.

R 500.65 Determinations by an insurer
Rule 65 (1)

- There is no deadline for the insurer to issue the required written notice of determination to the provider. The time frame needs to be reasonable; otherwise the provider's cash flow will be severely harmed. We recommend not more than 30 days following receipt of provider's explanation.

R 500.65 Appeals to the department
Rule 66 (7)

- The rule states "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."
- Please delete "for issues that were not subject to the appeal."

Thank you for your consideration. Please feel free to contact me with questions or for further discussion at 734-482-7100 or email me at bill.buccalo@rainbowrehab.com.

Sincerely,

Bill Buccalo
President and CEO
(734) 482-1200
rainbowrehab.com