DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

SURPRISE MEDICAL BILLING

(By authority conferred on the director of the department of insurance and financial services by section 24517 of the public health code, 1978 PA 368, MCL 333.24517)

R 500.241 Definitions.

Rule 1. (1) As used in these rules:

(a) "Act" means the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(b) "Median amount" means the median amount negotiated by the carrier for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles. The carrier shall determine the region and provider specialty.

(2) A term defined in the act for the purposes of article 18 of the act, MCL 333.24501 to 333.24517, has the same meaning when used in these rules.

History: 2021 MR 12, Eff. June 24, 2021.

R 500.242 Scope and applicability.

Rule 2. These rules do the following:

(a) Establish procedures for the department to review and resolve requests for calculation review submitted pursuant to section 24510 of the act, MCL 333.24510.

(b) Establish procedures for approving arbitrators to provide binding arbitration pursuant to section 24511 of the act, MCL 333.24511.

History: 2021 MR 12, Eff. June 24, 2021.

R 500.243 Requests for calculation review.

Rule 3. (1) A nonparticipating provider must make a request for a review of the calculation described in section 24510(1) of the act, MCL 333.24510, on a form provided by the department.

(2) In response to a request from a nonparticipating provider for a calculation review under section 24510 of the act, MCL 333.24510, the department shall do the following within 14 days of the date of the request:

(a) Notify the carrier of the request for a calculation review.

(b) Request data on the carrier's median amount or any documents, materials, or other information the department believes is necessary to assist in reviewing the calculation described in section 24510(1) of the act, MCL 333.24510.

(3) A carrier must respond within 14 days of the date of the department's request under subrule (2)(b) of this rule. If the information provided is incomplete, the department may, at its discretion, request additional information, or issue a determination based solely on the information provided as of the date on which the carrier's response was due. If the department

makes 1 or more requests for additional information, the carrier must respond within 14 days of the date of the department's request.

(4) The department shall issue a determination resolving the request for a calculation review no later than 14 days after the carrier submits a timely and complete response under subrule (3) of this rule or after the expiration of the time period within which the carrier was required to respond, including any extensions provided following the department's request for additional information under subrule (3) of this rule.

History: 2021 MR 12, Eff. June 24, 2021.

R 500.244 Median amount; access to database.

Rule 4. (1) Subject to subrule (3) of this rule, a carrier may satisfy the requirement under R 500.243 by providing the department with access to a database that contains all of the carrier's median amounts. The database must meet all of the following requirements:

(a) Be updated no less frequently than quarterly.

(b) Be searchable by region, provider specialty, and health care service.

(c) Include negotiated rates for all health care services covered by the carrier.

(d) Be continuously accessible to the department.

(2) For the purposes of conducting a calculation review under section 24510 of the act, MCL 333.24510, the department may, at its discretion, consult any external database described under section 24510(2) of the act, MCL 333.24510, without regard to whether a carrier made the database accessible to the department or whether the database otherwise meets the requirements under subrule (1) of this rule.

(3) A carrier's provision of access to a database under this rule does not preclude the department from requesting any documents, materials, or other information the department believes is necessary to assist in reviewing the calculation described in section 24510(1) of the act, MCL 333.24510.

History: 2021 MR 12, Eff. June 24, 2021.

R 500.245 Approval of arbitrators.

Rule 5. (1) The department shall create and maintain a list of arbitrators trained by the American Arbitration Association or American Health Lawyers Association and approved by the director. This list must be updated no less frequently than annually and must be posted on the department's website.

(2) Arbitrators seeking to be included in the list under subrule (1) of this rule must apply on a form prescribed by the department.

(3) The department shall approve or disapprove an application no later than 60 days after the date of receipt of the application. Applicants whose application has been disapproved may reapply at any time.

(4) If approved for inclusion in the list under subrule (1) of this rule, arbitrators must annually provide to the department, on a form prescribed by the department, an attestation acknowledging that the information provided to the department in the arbitrator's application under subrule (2) of this rule remains complete and accurate.

(5) Arbitrators included on the department's list under subrule (1) of this rule must notify the department of any changes to the information contained in the arbitrator's application under subrule (2) of this rule within 30 days of the change. An arbitrator's failure to inform the department of these changes may result in revocation of the arbitrator's approval and removal from the list under subrule (1) of this rule.

History: 2021 MR 12, Eff. June 24, 2021.