Provider Guide for Auto No-Fault Utilization Review

Timeline for Claims Submission, Insurer UR, and Provider Appeals

1. Providers should submit bills within 90 days of the date of service.
2. The insurer has 30 days to pay the bill before interest starts accruing. Within this 30 days, the insurer may submit a request for explanation to the provider.
3. Providers must respond within 30 days. If the insurer's request is in excess of information that typically accompanies the bill, insurers must pay a reasonable and customary fee, plus copying and mailing costs, within this 30 days.
4. Within 30 days of its receipt of the explanation, the insurer must issue a determination.
5. Providers wishing to appeal must appeal to DIFS within 90 days of the date on the denial.
6. DIFS then has 14 days to notify the patient and the insurer and request additional information from them.
7. The insurer has 21 days from the date of DIFS's notice to file a reply.
8. The DIFS director then has 28 days to issue a decision, which it can extend for an additional 28 days.

Required Content of Insurer Determination Notice to Providers:

1. The criteria or standards that insurer relied on for its determination, referencing its UR program.
2. The amount the insurer paid the provider, including an explanation for the difference between that amount and the amount billed by the provider.
3. If applicable, a description of any additional records the provider must submit to the insurer for the insurer to reconsider its denial.
4. A copy of the provider appeal form for appeal to DIFS.
5. The date of the determination.

Providers may appeal insurer determinations using the form at
https://www.michigan.gov/documents/difs/FIS_2356_709652_7.pdf

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