

financial interest include, but are not limited to, the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation making a direct or indirect payment or granting a financial incentive to the attorney or a related person of the attorney relating to the treatment, product, service, rehabilitative occupational training, or accommodation within 24 months before or after the treatment, product, service, rehabilitative occupational training, or accommodation is provided.

Sec. 3151. (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) The examining physician is a licensed, board certified, or board eligible physician qualified to practice in the area of medicine appropriate to treat the person's condition.

(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.

Sec. 3157. (1) Subject to subsections (2) to (14), a physician, hospital, clinic, or other person that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the treatment or training. The charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance.

(2) Subject to subsections (3) to (14), a physician, hospital, clinic, or other person that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is not eligible for payment or reimbursement under this chapter for more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 200% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 195% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 190% of the amount payable to the person for the treatment or training under Medicare.

(3) Subject to subsections (5) to (14), a physician, hospital, clinic, or other person identified in subsection (4) that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is eligible for payment or reimbursement under this chapter of not more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 230% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 225% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 220% of the amount payable to the person for the treatment or training under Medicare.

(4) Subject to subsection (5), subsection (3) only applies to a physician, hospital, clinic, or other person if either of the following applies to the person rendering the treatment or training:

(a) On July 1 of the year in which the person renders the treatment or training, the person has 20% or more, but less than 30%, indigent volume determined pursuant to the methodology used by the department of health and human services in determining inpatient medical/surgical factors used in measuring eligibility for Medicaid disproportionate share payments.

(b) The person is a freestanding rehabilitation facility. Each year the director shall designate not more than 2 freestanding rehabilitation facilities to qualify for payments under subsection (3) for that year. As used in this subdivision, "freestanding rehabilitation facility" means an acute care hospital to which all of the following apply:

(i) The hospital has staff with specialized and demonstrated rehabilitation medicine expertise.

- (ii) The hospital possesses sophisticated technology and specialized facilities.
- (iii) The hospital participates in rehabilitation research and clinical education.
- (iv) The hospital assists patients to achieve excellent rehabilitation outcomes.
- (v) The hospital coordinates necessary post-discharge services.
- (vi) The hospital is accredited by 1 or more third-party, independent organizations focused on quality.
- (vii) The hospital serves the rehabilitation needs of catastrophically injured patients in this state.
- (viii) The hospital was in existence on May 1, 2019.

(5) To qualify for a payment under subsection (4)(a), a physician, hospital, clinic, or other person shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to determine whether the person qualifies. The director shall annually review documents and information provided under this subsection and, if the person qualifies under subsection (4)(a), shall certify the person as qualifying and provide a list of qualifying persons to insurers and other persons that provide the security required under section 3101(1). A physician, hospital, clinic, or other person that provides 30% or more of its total treatment or training as described under subsection (4)(a) is entitled to receive, instead of an applicable percentage under subsection (3), 250% of the amount payable to the person for the treatment or training under Medicare.

(6) Subject to subsections (7) to (14), a hospital that is a level I or level II trauma center that renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, if the treatment is for an emergency medical condition and rendered before the patient is stabilized and transferred, is not eligible for payment or reimbursement under this chapter of more than the following:

(a) For treatment rendered after July 1, 2021 and before July 2, 2022, 240% of the amount payable to the hospital for the treatment under Medicare.

(b) For treatment rendered after July 1, 2022 and before July 2, 2023, 235% of the amount payable to the hospital for the treatment under Medicare.

(c) For treatment rendered after July 1, 2023, 230% of the amount payable to the hospital for the treatment under Medicare.

(7) If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under subsection (2), (3), (5), or (6), the physician, hospital, clinic, or other person that renders the treatment or training is not eligible for payment or reimbursement under this chapter of more than the following, as applicable:

(a) For a person to which subsection (2) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

(i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 55%.

(ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 54%.

(iii) For treatment or training rendered after July 1, 2023, 52.5%.

(b) For a person to which subsection (3) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment or training on January 1, 2019:

(i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 70%.

(ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 68%.

(iii) For treatment or training rendered after July 1, 2023, 66.5%.

(c) For a person to which subsection (5) applies, 78% of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, 78% of the average amount the person charged for the treatment on January 1, 2019.

(d) For a person to which subsection (6) applies, the applicable following percentage of the amount payable for the treatment under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

(i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 75%.

(ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 73%.

(iii) For treatment or training rendered after July 1, 2023, 71%.

(8) For any change to an amount payable under Medicare as provided in subsection (2), (3), (5), or (6) that occurs after the effective date of the amendatory act that added this subsection, the change must be applied to the amount

allowed for payment or reimbursement under that subsection. However, an amount allowed for payment or reimbursement under subsection (2), (3), (5), or (6) must not exceed the average amount charged by the physician, hospital, clinic, or other person for the treatment or training on January 1, 2019.

(9) An amount that is to be applied under subsection (7) or (8), that was in effect on January 1, 2019, including any prior adjustments to the amount made under this subsection, must be adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment.

(10) For attendant care rendered in the injured person's home, an insurer is only required to pay benefits for attendant care up to the hourly limitation in section 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.315. This subsection only applies if the attendant care is provided directly, or indirectly through another person, by any of the following:

- (a) An individual who is related to the injured person.
- (b) An individual who is domiciled in the household of the injured person.
- (c) An individual with whom the injured person had a business or social relationship before the injury.

(11) An insurer may contract to pay benefits for attendant care for more than the hourly limitation under subsection (10).

(12) A neurological rehabilitation clinic is not entitled to payment or reimbursement for a treatment, training, product, service, or accommodation unless the neurological rehabilitation clinic is accredited by the Commission on Accreditation of Rehabilitation Facilities or a similar organization recognized by the director for purposes of accreditation under this subsection. This subsection does not apply to a neurological rehabilitation clinic that is in the process of becoming accredited as required under this subsection on July 1, 2021, unless 3 years have passed since the beginning of that process and the neurological rehabilitation clinic is still not accredited.

(13) Subsections (2) to (12) do not apply to emergency medical services rendered by an ambulance operation. As used in this subsection:

(a) "Ambulance operation" means that term as defined in section 20902 of the public health code, 1978 PA 368, MCL 333.20902.

(b) "Emergency medical services" means that term as defined in section 20904 of the public health code, 1978 PA 368, MCL 333.20904.

(14) Subsections (2) to (13) apply to treatment or rehabilitative occupational training rendered after July 1, 2021.

(15) As used in this section:

(a) "Charge description master" means a uniform schedule of charges represented by the person as its gross billed charge for a given service or item, regardless of payer type.

(b) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(c) "Emergency medical condition" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(d) "Level I or level II trauma center" means a hospital that is verified as a level I or level II trauma center by the American College of Surgeons Committee on Trauma.

(e) "Medicaid" means a program for medical assistance established under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5.

(f) "Medicare" means fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration.

(g) "Neurological rehabilitation clinic" means a person that provides post-acute brain and spinal rehabilitation care.

(h) "Person", as provided in section 114, includes, but is not limited to, an institution.

(i) "Stabilized" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(j) "Transfer" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(k) "Treatment" includes, but is not limited to, products, services, and accommodations.

Sec. 3157a. (1) 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.

(b) Comply with any decision of the department under this section.

(2) A physician, hospital, clinic, or other person or institution that knowingly submits under this section false or misleading records or other information to an insurer, the association created under section 3104, or the department commits a fraudulent insurance act under section 4503.

(3) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to do both of 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.

(4) If a physician, hospital, clinic, or other person provides treatment, products, services, or accommodations under this chapter that are not usually associated with, are longer in duration than, are more frequent than, or extend over a greater number of days than the treatment, products, services, or accommodations usually require for the diagnosis or condition for which the patient is being treated, the insurer or the association created under section 3104 may require the physician, hospital, clinic, or other person to explain the necessity or indication for the treatment, products, services, or accommodations in writing under the procedures provided under subsection (3).

(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 under the procedures provided under subsection (3).

(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.

Sec. 3157b. Any proprietary information or sensitive personally identifiable information regarding a patient that is submitted to the department under section 3157a is exempt from disclosure under section 13(d) of the freedom of information act, 1976 PA 442, MCL 15.243, and the department shall exempt any such information from disclosure under any other applicable exemptions under section 13 of the freedom of information act, 1976 PA 442, MCL 15.243.

Sec. 3163. An insurer authorized to transact automobile liability insurance and personal and property protection insurance in this state is not required to provide personal protection insurance or property protection insurance benefits under this chapter for accidental bodily injury or property damage occurring in this state arising from the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle by an out-of-state resident who is insured under the insurer's automobile liability insurance policies, unless the out-of-state resident is the owner of a motor vehicle that is registered and insured in this state.

Sec. 3172. (1) A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may claim personal protection insurance benefits through the assigned claims plan if any of the following apply:

(a) No personal protection insurance is applicable to the injury.

(b) No personal protection insurance applicable to the injury can be identified.

(c) No personal protection insurance applicable to the injury can be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss.

(d) The only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

(2) Unpaid benefits due or coming due as described in subsection (1) may be collected under the assigned claims plan, and the insurer to which the claim is assigned is entitled to reimbursement from the defaulting insurers to the extent of their financial responsibility.

(3) A person entitled to claim personal protection insurance benefits through the assigned claims plan under subsection (1) shall file a completed application on a claim form provided by the Michigan automobile insurance placement facility and provide reasonable proof of loss to the Michigan automobile insurance placement facility. The Michigan automobile insurance placement facility or an insurer assigned to administer a claim on behalf of the Michigan automobile