STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Best Care Nursing Services
Petitioner **File No. 21-1441**

v

Citizens Insurance Company of America
Respondent

Issued and entered
this 14th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 12, 2021, Best Care Nursing Services (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Citizens Insurance Company of America (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner bill denials on August 9, 17, 18, and 27, 2021 and September 7, 8, and 15, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on October 15, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on October 15, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on November 5, 2021. The Department issued a Notice of Extension to both parties on December 3, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health services rendered on 57 dates of service[1] under Healthcare Common Procedural Coding System (HCPCS) Level II code G0156 with

[1] The dates of service at issue are July 4-July 31, 2021, and August 1-29, 2021.

modifier TG, which is described as which is described as home health or hospice aide in a home setting, each 15 minutes. Modifier TG is described as complex/high tech level care.

With its appeal request, the Petitioner submitted 8 *Explanations of Review* letters for the dates of service in issue and a narrative outlining the reason for its appeal. In its narrative, the Petitioner explained that the injured person "is a spinal cord injured quadriplegic that requires twenty four hour care, seven days a week, plus daily nursing and up to two hours of overlaps per day."

Additionally, the Petitioner stated:

> [We] received short payments in the amount of $[redacted] /hour for [outstanding invoices] for dates of service [at issue]. The reason given for the short payment listed on the [Explanation of Benefits] is; "the provider's charge for the service rendered exceed an amount which would appear reasonable when compared to Fair Health Relative Value HCPCS Benchmark Database." This is in direct violation of the new law which spells out reimbursement for services that 1) use a Medicare code with a fee schedule, and 2) have a January, 2019 Chargemaster.

In its *Explanations of Reviews* letters, the Respondent stated that "the [Petitioner's] charge for the service rendered exceeds an amount which would appear reasonable when compared to Fair Health Relative Value HCPCS Benchmark Database." In its reply, the Respondent stated that payment was issued based on MCL 500.3157. Specifically, the Respondent stated:

> In this case, the [Petitioner's] charge is for continuous aide care for an individual in their home. Medicare does not provide an amount payable for continuous care in the home, and as such, the provisions of MCL 500.3157(7) provide the methodology of issuing payment; that is, paying 55% of the [Petitioner's] January 2019 charge description master plus a CPI adjustment for the services rendered after July 1, 2021 and before July 2, 2022.

On October 15, 2021, the Department requested that the Petitioner submit its charge description master (CDM). See MCL 500.3157(7). The Petitioner submitted its CDM to the Department on October 15, 2021.[2]

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the

[2] The CDM the Petitioner submitted to the Department upon request listed variable amounts for the service termed "high-tech aide." The Department requested the Petitioner submit documentation in the form of bills and reimbursements from insurers to substantiate the average amount charged on January 1, 2019. The supporting documentation showed that the Petitioner charged $[redacted] an hour for high tech aides. The Department then divided this amount by 4 to calculate the 15-minute increments billed, resulting in an average amount charged of $[redacted] per 15-minute unit.

treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

MCL 500.3157(15)(f) defines "Medicare" as "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." Under MAC R 500.203, reimbursements payable to providers are calculated according to "amounts payable to participating providers under the applicable fee schedule." "Fee schedule" is defined by MAC R 500.201(h) as "the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered." Accordingly, reimbursement to providers under MCL 500.3157 is calculated either on a fee schedule (i.e., fee-for-service) basis or on a prospective payment system basis.

HCPCS Level II Code G0156 has an amount payable under Medicare when it is billed on a prospective payment system basis. No payment amount is available for HCPCS Level II Code G0156 under on a fee-schedule basis because that code is not priced separately. Although the Petitioner stated that it was billing on the basis of the HHPPS, the Petitioner did not provide any supporting documentation to substantiate this assertion. Where there is no amount payable under Medicare, reimbursement is calculated based on a provider's charge description master or average amount charged on January 1, 2019. See MCL 500.3157(7).

To calculate the appropriate reimbursement amount, the Department relied on the Petitioner's submitted CDM as of January 1, 2019 for G0156 with modifier TG, as substantiated by the additional documentation received from the Petitioner. Pursuant to MCL 500.3157(7), the amounts payable to the Petitioner for the procedure code at issue for the dates of service at issue are:

HCPCS code	January 1, 2019 average amount charged	55% of January 1, 2019 average amount charged	4.11% CPI adjustment	Amount payable for the dates of service at issue
G0156-TG	$[redacted]/unit	$[redacted]	$[redacted]	$[redacted]/unit
G0156-TG (holiday)	$[redacted]/ unit	$[redacted]	$[redacted]	$[redacted]/unit

Accordingly, the Department concludes that the Petitioner is entitled to additional reimbursement for procedure code G0156 with a TG modifier for the dates of services at issue.

IV. ORDER

The Director reverses the Respondent's determinations dated August 9, 17, 18, and 27, 2021 and September 7, 8, and 15, 2021 that the cost of the services for the dates of services at issue in this appeal was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner is entitled to reimbursement in the amount payable under MCL 500.3157 for the treatment on the dates of service discussed herein, and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford