STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Cardinal Healthcare, LLC
Petitioner **File No. 21-1507**

v

Auto Club Insurance Association
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On October 11, 2021, Cardinal Healthcare, LLC (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 Auto Club Insurance Association (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 bill denials on September 14, 20, and 22, 2021. The Petitioner now seeks reimbursement in the full amount billed for the dates of service at issue.

The Department accepted the request for an appeal on October 19, 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 19, 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 3, 2021. The Department issued a Notice of Extension to both parties on December 1, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health aide services and home nursing services rendered on 45[1] dates of service under Healthcare Common Procedure Coding System

[1] The dates of service at issue are July 2, 2021-August 27, 2021.

(HCPCS) Level II codes G0299 and G0156, which are described as direct skilled nursing services of a registered nurse, in the home health or hospice setting, each 15 minutes; and home health aide, in a home or hospice setting, each 15 minutes.

With its appeal request, the Petitioner submitted documentation that included *Explanation of Benefits (EOB)* letters issued by the Respondent, a copy of its 2019 charge description master (CDM), a prescription from a medical doctor ordering attendant care and nursing care, and its narrative outlining its reason for appeal. The Petitioner stated that "[s]killed nursing care is billable under Medicare. The [injured person] requires skilled nursing as ordered by the physician and only her care can be performed by a skilled nurse as it is out of the scope of practice for high tech aides."

Additionally, the Petitioner's request for appeal stated:

> Under the MCL 500.3107 the charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance. It also notes that 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… This case has required RN's [who] are very familiar with the required care process. The billing rate for this type of skilled nursing service in 2019 is $[redacted] an hour and $[redacted] for a high tech aide who is trained in catheterizations.

In its *Explanation of Benefits* letters, the Respondent stated that it based its reimbursement amount on the "applicable percentage of the Petitioner's CDM and adjusted by the annual Consumer Price Index (CPI)." In its reply, the Respondent stated:

> [The Respondent] reviewed the appeal and is unable to provide a response on this case because the denial does not involve a [utilization review] or [fee schedule] denial. The provider is disputing their own CDM, and all bills in question have been priced according to the CDM the [Petitioner] submitted to the [Respondent]. Enclosed is the documentation to support the denial including the EOB/bill review.

On October 19, 2021, the Department requested that the Petitioner submit its CDM. See MCL 500.3157(7). The Petitioner responded and submitted its CDM to the Department on October 19, 2021.

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 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 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 codes G0299 and G0156 have an amount payable under Medicare when they are billed on a prospective payment system basis. However, no payment amount is available for HCPCS Level II Code G0299 and G0156 on a fee schedule basis because these codes are not priced separately under Medicare. Although the Petitioner stated that "[s]killed nursing care is billable under Medicare," the Petitioner did not provide any supporting documentation to substantiate that they were billing under the prospective payment system. Where there is no amount payable under Medicare, reimbursement is calculated 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 HCPCS Level II coded G0299 and G0156. Pursuant to MCL 500.3157(7), the amounts payable to the Petitioner for the procedure code and dates of service at issue are:

HCPCS code	January 1, 2019 charge description master amount	55% of January 1, 2019 charge description master amount	4.11% CPI adjustment	Amount payable for the dates of service at issue
G0299	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit
G0156	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit

Accordingly, the Department concludes that the Petitioner is not eligible for additional reimbursement for procedure code G0156 on the dates of service at issue; however, the Petitioner is eligible for additional reimbursement for procedure code G0299 on the dates of service at issue.

IV. ORDER

The Director reverses, in part, the Respondent's determinations dated September 14, 20, and 22, 2021.

The Petitioner is entitled to additional reimbursement for procedure code G0299 for the dates of service at issue 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