

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of the Department of Insurance and Financial Services

In the matter of:

Mary Free Bed Rehabilitation Hospital
Petitioner

File No. 25-1589

v

Auto-Owners Insurance Company
Respondent

Issued and entered
this 5th day of September 2025
by Joseph A. Garcia
Senior Deputy Director and General Counsel

ORDER

I. PROCEDURAL BACKGROUND

On July 2, 2025, Mary Free Bed Rehabilitation Hospital (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-Owners Insurance Company (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 a bill denial to the Petitioner on May 2, 2025.

The Department accepted the request for an appeal on July 11, 2025. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on July 24, 2025, and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on August 8, 2025.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for occupational therapy treatments rendered on August 7, 2024. The Petitioner billed the Respondent for these treatments using Current Procedural Terminology (CPT) codes 97110, 97140, and 97014. These procedure codes are described as

therapeutic exercises to develop strength and endurance, range of motion and flexibility, 1 or more areas, each 15 minutes; manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes; and unattended electrical stimulation to 1 or more areas; respectively.

With its appeal request, the Petitioner submitted supporting documentation which included the determination issued by the Respondent, the billing claim form for the date of service at issue, a narrative outlining its reason for the appeal, and its January 1, 2019, charge description master (CDM). The Petitioner's CDM identified a charged amount of \$ [REDACTED] per unit for procedure codes 97110, 97140, and 97014. The Petitioner's request for an appeal stated:

This request for utilization review is based on the [Respondent] failing to make full payment under the Medicare fee schedule, as required by Section 3157.... MCL 500.3157(5) provides that, for the services described above, [we are] not eligible for payment or reimbursement for more than [']220% of the amount payable to [us] for the treatment or training under Medicare.'... Because the treatment provided to [the injured person] is covered under Medicare part B with service dates in the year 2024 and under locality 99, the applicable 'fee schedule' under Rule 500.201(h) is the 2024 Medicare Physician Fee Schedule for Michigan Locality 99.... [We] respectfully request that ... [the Department] order [the Respondent] to pay \$ [REDACTED] in full satisfaction of the claim, plus interest.

In its determination, the Respondent noted that "Medicare does not recognize 97014 and should be billed under G0283 which allows \$ [REDACTED] and is less than the original payment."¹ In its reply, the Respondent reaffirmed its initial determination and stated, "It is [our] opinion that payment has been made in full per the Michigan No-Fault Fee Schedule with no additional payment owed."

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

¹ The Department's utilization review appeal process does not adjudicate disputes related to billing and coding. Insurers may have specific billing requirements, and health care providers are encouraged to work directly with the insurer to resolve billing and coding issues.

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(2) through (6) is calculated either on a fee-for-service basis or on a prospective payment system basis.

The Department determined that procedure codes 97110 and 97140 have amounts payable under Medicare. Accordingly, to calculate the appropriate reimbursement amount, the Department relied on information maintained by the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule for the service year and specific Medicare locality at issue, which is 2024A and "08202-99 Rest of Michigan."² Further, pursuant to MCL 500.3157(3)(c) and MCL 500.3157(4)(b), enhanced reimbursement is owed to a freestanding rehabilitation facility that has been designated by the Director for each specified year. For the date of service at issue in this appeal, the Petitioner qualified for enhanced reimbursement of 220% under MCL 500.3157(3)(c); see Bulletin 2024-25-INS. Therefore, the amounts payable under Medicare for procedure codes 97110 and 97140 for the date of service at issue are listed below.

CPT Code	Amount payable under Medicare	220% of the amount payable under Medicare	Amount payable for the date of service at issue
97110	\$ [REDACTED] /unit	\$ [REDACTED] /unit	\$ [REDACTED] /unit
97140	\$ [REDACTED] /unit	\$ [REDACTED] /unit	\$ [REDACTED] /unit

² R 500.201(h) defines "fee schedule" 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." A "service year" runs "...from July 2 through July 1 of the following year," See R 500.201(j). Therefore, the applicable fee schedule is the 2024A CMS Physician Fee Schedule as it was in effect on March 1, 2024.

These amounts do not exceed the average amount the Petitioner charged as of January 1, 2019, as represented by the CDM the Petitioner submitted to the Department, and as adjusted for the appropriate consumer price index (CPI); see MCL 500.3157(8) and (9). Accordingly, the Department concludes that the Petitioner is not due additional reimbursement for procedure codes 97110 and 97140 rendered on the date of service at issue.

The Department determined that procedure code 97014 does not have an amount payable under Medicare. Accordingly, to calculate the appropriate reimbursement amount the Department relied on the Petitioner's CDM as of January 1, 2019. Pursuant to MCL 500.3157(7)(b)(iii) the amount payable for procedure code 97014, for the date of service at issue is listed below.

CPT Code	January 1, 2019 CDM amount	66.5% of January 1, 2019 CDM amount	10.16% CPI adjustment	Amount payable for the date of service at issue
97014	\$ [REDACTED] /unit	\$ [REDACTED] /unit	\$ [REDACTED]	\$ [REDACTED] /unit

The Department concludes that the Petitioner is due additional reimbursement for procedure code 97014 for the date of service at issue.

IV. ORDER

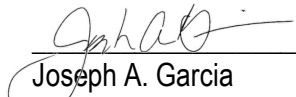
The Director reverses, in part, the Respondent's determination dated May 2, 2025.

The Petitioner is entitled to additional reimbursement as set forth in this order 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 is subject to judicial review as provided in section 244(1) of the Code, MCL 500.244(1).

This order applies only to the treatment and date 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 Appeals and Market Regulation, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:



Joseph A. Garcia
Senior Deputy Director and General Counsel