STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Lighthouse Rehabilitation Center
Petitioner

File No. 21-1010

v

Pioneer State Mutual Insurance Company
Respondent

Issued and entered
this 21st day of May 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. Procedural Background

On March 3, 2021, Lighthouse Rehabilitation Center (Petitioner) filed with the Director of 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 payments made by Pioneer State Mutual Insurance Company (Respondent) to the Petitioner.

The Department accepted the request for an appeal on March 3, 2021. Pursuant to R 500.65, the Department notified Respondent and the injured person of Petitioner's request for an appeal on March 23, 2021. The Department provided a written notice of extension to the Petitioner and Respondent on April 20, 2021.

The Petitioner's appeal is made under R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. Accordingly, the denial constitutes a determination from which a provider may file and appeal to the Department. The Petitioner seeks reimbursement in the amount of $300.70, which is the difference in payments for the dates of service at issue.

For this appeal, the Department assigned an independent review organization (IRO) to review the issues in this appeal and provide a report and recommendation to the Department. The IRO submitted its report to the Department on May 19, 2021.

II. Factual Background

At issue are three dates of service in October 2020 on which the Petitioner provided psychotherapy treatments under Current Procedural Terminology (CPT) codes 90834 and 90837. In November 2020, the Petitioner submitted a bill to the Respondent for reimbursement of those treatments. On November 30, 2020, the Respondent issued an Explanation of No-Fault Health Care Reimbursement, in which the Respondent paid the Petitioner less than the Petitioner's billed amount. On December 29, 2020, the Petitioner submitted a letter to the Respondent requesting a reconsideration of the reimbursement.

On January 20, 2021, the Respondent issued a reevaluation of the Explanation of No-Fault Health Care Reimbursement to the Petitioner, in which the Respondent maintained its reduced reimbursement on the basis that the Petitioner had been reimbursed at the 80th percentile and in accordance with the Fair Health Pricing database.

Petitioner's Argument:

In its appeal request, the Petitioner argues that because the CPT codes at issue were fully reimbursed for other injured persons the Petitioner has cared for on or around the same time, full reimbursement is appropriate. To support its argument, the Petitioner provided redacted Explanation of Reviews from other auto insurers that provided full reimbursement for the CPT codes at issue. In addition, the Petitioner provided its yearly expense budget to justify the reasonableness of its charges.

Respondent's Argument:

In its reply, the Respondent argues that reimbursement for CPT codes 90837 and 90834 for three dates of service in October 2020 is based on the 80th percentile of allowable reimbursement in accordance with data obtained from the Fair Health database. Further, the Respondent asserts that because the treatment was administered by a licensed practitioner with a master's degree and not a physician, the reimbursement must be reduced based on coding standards outlined in the National Correct Coding Initiative.

III. Analysis

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that a 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 does not involve claims of overutilization; rather, it is a dispute regarding the appropriateness of cost for treatment rendered by the Petitioner.

In support of its position, the Petitioner asserts that it is entitled to full reimbursement for the dates of service at issue because their charges are "reasonable" based on their expense budget, fee schedule, and other auto insurers have fully reimbursed for the same CPT codes. Under Chapter 31 of the Code, a provider may charge a reasonable amount for treatment, training, products, services, or accommodations; however, an insurer is only required to reimburse "reasonable charges" for services. See MCL 500.3157(1)[2], MCL 500.3107(1)(a). Under the Code, "the 'customary charge' limitation in § 3157 and the 'reasonableness' language in § 3107 constitute separate and distinct limitations on the amount health-care providers may charge and what insurers must pay with respect to victims of automobile accidents who are covered by no-fault insurance." *Advocacy Org for Patients & Providers v Auto Club Ins Ass'n*, 257 Mich App 365 at 376, 670 NW2d 569 (2003), aff'd 472 Mich 91, 693 NW2d 368 (2005).

In its reply, the Respondent stated that the reduced reimbursement was reasonable because the procedure codes should have included modifiers to indicate that the services were provided by a non-physician provider. The Respondent provided medical documentation to show that the provider who administered the services was not a physician; rather the provider was licensed with a master's level education. The Petitioner did not include a license level modifier indicating the provider's education on its bill; therefore, the Respondent applied the modifier based on the treatment notes provided by the Petitioner, and the payment was reduced to the 80th percentile under the FAIR Health database for allowable reimbursement.

In its report, the IRO recommended that the Department uphold the Respondent's determination. Specifically, the IRO report stated:

> The coding consultant explained that the claim was coded correctly based on CPT coding guidelines, but based on the filing provided for review, this claim was missing the license level modifiers that the Insurer requires. The coding consultant indicated that, based on the available information, it appears that the provider is "an MA [medical assistant] billing as an LLP", which would make the correct modifier for these CPT codes the HO modifier.
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> The table below reflects amounts the [Petitioner] billed and the [Respondent] allowed for the codes at issue in this appeal, as well as the 80th percentile of the charge and allowed amounts in Fair Health, and the 80% percentile of the charge and allowed amounts in Fair Health adjusted according to the [Respondent's] rate for modifier HO. The "charge amount" in Fair Health is the average amount charged for that code and the "allowed amount" is the amount that is allowed for that same code. The [Respondent's] submission states that the reimbursement for the HO modifier is 80% of the 80th percentile.

CPT Code	Provider billed amount	Fair Health 80th percentile charge amount	Fair Health charge amount adjusted for HO modifier	Insurer allowed amount	Fair Health 80th percentile allowed amount	Fair Health allowed amount adjusted for HO modifier
90834	$197.25	$145.00	$116.00	$106.40	$84.00	$67.20
90837	$263.00	$236.00	$188.80	$144.00	$112.00	$89.60

> Therefore, the [Respondent] allowed more than the 80th percentile of the Fair Health allowed amount, with or without the adjustment for the HO modifier, for the services at issue in this appeal.

Under MCL 500.3107(1)(a), an insurer is only required to pay a reasonable amount. "[W]hen assessing the reasonableness of a medical charge, relevant evidence includes the full range of charges and payments falling within the pertinent timeframe for the particular services, products, and treatment at issue in the case." *Spectrum Health Hospitals v Farm Bureau Mut Ins Co of Michigan*, No. 347553, 2020 WL 5266148, at *19 (Mich Ct App, September 3, 2020). Where the amount paid is based on a determination of what is reasonable, there is no violation of the Code, even if the amount is less than what the provider has charged. In this case, the Respondent's reimbursement amounts were not unreasonable, and the Department concludes that the reimbursement amounts paid for the dates of service at issue were appropriate under the Code.

IV. ORDER

The Director upholds Respondent's determination dated January 20, 2021.

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:

Recoverable Signature

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford