*Michigan's New No-Fault Fee Schedule for Fools (*Like Me)*

Prepared by Matthew LaBeau
Matthew.LaBeau@Ceflawyers.com

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Executive Summary

From the time that the Michigan No-Fault Act was passed in 1973, the only limitation on the amount of a medical provider's charge arising out of a motor vehicle accident was that it had to be "reasonable." A large body of case law was created over the years addressing what information could be considered when determining whether a charge, or a payment of that charge if less than the full amount, was reasonable.

That all changed with the reform legislation passed on June 11, 2019. As of July 2, 2021, a physician, hospital, clinic, or other person that renders treatment or training for injuries arising out of a motor vehicle accident will be subject to a fee schedule. The amount payable under the fee schedule for these charges depends on the nature of the medical care provided. In addition, providers will be entitled to a different reimbursement rate if the service has a rate payable under Medicare.

The statute also provides other limitations and restrictions on benefits. A neurological rehabilitation clinic is not entitled to payment or reimbursement unless accredited by an approved organization. In-home, non-professional attendant care, previously unlimited, is now subject to the 56 hour per week limitation found in the Michigan Workers' Disability Compensation Act. There is also a new administrative process for challenging the overutilization of services.

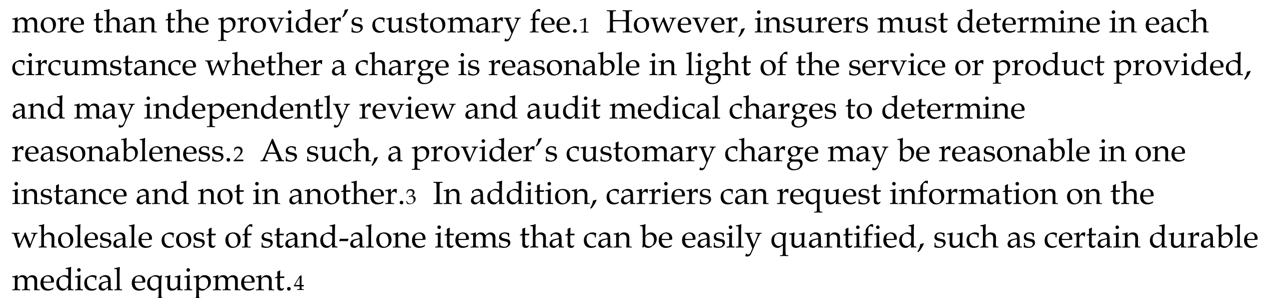
There is a pending constitutional challenge to the new fee schedule, and we can expect further challenges as parties attempt to implement this new law. That being said, here is what we know now….

The Current "Reasonable" Standard

The current standard for claims covered by personal injury protection benefits remains in effect through July 1, 2021. That standard is as follows:

> "A physician, hospital, clinic, or other person or institution lawfully rendering treatment … may charge a **reasonable amount** for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution **customarily** charges for like products, services and accommodations in cases not involving insurance."

Therefore, a provider's charges under the No-Fault Act has to be a reasonable amount and the amount that was customarily charged. These are two separate standards. A provider is barred from charging a no-fault patient, and thus the carrier, any amount



more than the provider's customary fee.[1] However, insurers must determine in each circumstance whether a charge is reasonable in light of the service or product provided, and may independently review and audit medical charges to determine reasonableness.[2] As such, a provider's customary charge may be reasonable in one instance and not in another.[3] In addition, carriers can request information on the wholesale cost of stand-alone items that can be easily quantified, such as certain durable medical equipment.[4]

This undefined standard has resulted in endless litigation between medical providers and carriers, with injured persons sometimes caught in the middle. For example, an MRI facility charges $5,400 and an insurance carrier pays $1,700 based on its audit of the charges. With no guidance on what charge is or is not reasonable, litigation ensues resulting in a settlement or jury verdict somewhere between the two numbers.

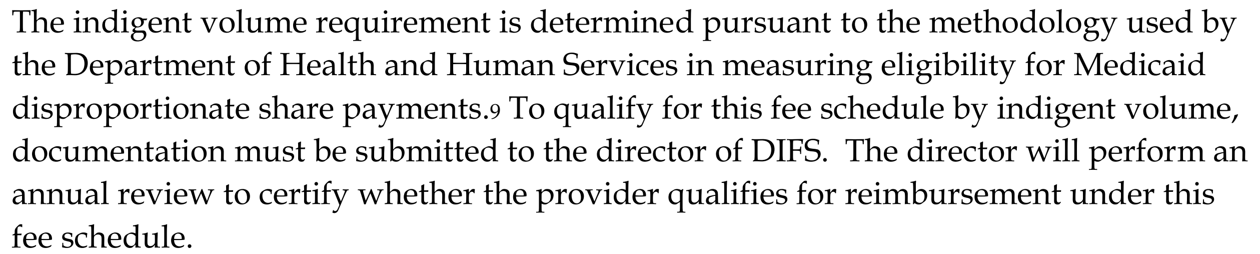
The current law remains in effect through July 1, 2021, with the new fee schedule applying to treatment provided on or after July 2, 2021.[5] Until that time, the reasonable charge standard continues to apply.[6] *Ellen Andary et al v USAA Casualty et al*[7], a new lawsuit pending in the Ingham County Circuit Court, challenges the applicability of the new fee schedule, and other limitations set forth in Section 3157, to persons injured in motor vehicle accidents occurring prior to June 11, 2019. It also seeks to invalidate the fee schedule and eliminate other limitations.

The Fee Schedule for Indigent Volume or Freestanding Rehabilitation Facilities

Even after the implementation of the amended statute, the above language of MCL 500.3157 largely remains intact, but the statute has been expanded to include a fee schedule that limits reimbursement rates. The fee schedule applies depending on the nature of the medical care provided.

A provider that has 20- 30% indigent volume or is a freestanding rehabilitation facility is subject to the following.[8]

- After July 1, 2021 and before July 2, 2022, 230% of amount payable under Medicare (or 70% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 225% of amount payable under Medicare (or 68% of charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 220% of amount payable under Medicare (or 66.5% of charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).



The indigent volume requirement is determined pursuant to the methodology used by the Department of Health and Human Services in measuring eligibility for Medicaid disproportionate share payments.[9] To qualify for this fee schedule by indigent volume, documentation must be submitted to the director of DIFS. The director will perform an annual review to certify whether the provider qualifies for reimbursement under this fee schedule.

Note that if the indigent volume for a provider is 30% or more of the total treatment or training, the above fee schedule is disregarded. The provider, instead, is entitled to 250% of the amount payable to the person for the treatment or training under Medicare, or 78% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable.

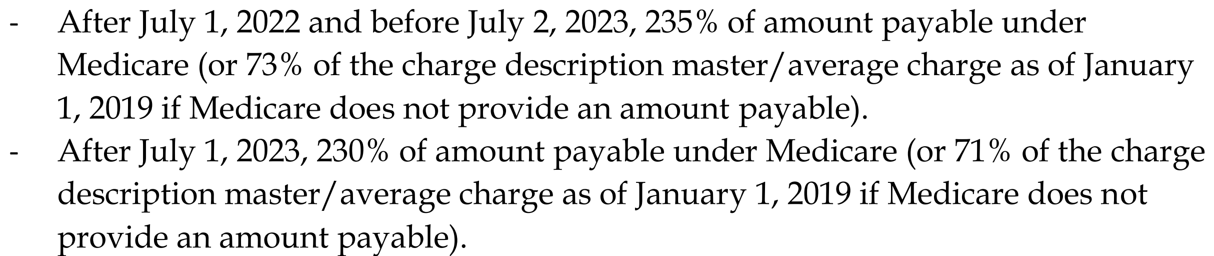
The Director for DIFS will designate not more than two freestanding rehabilitation facilities that will qualify for payments under this specific fee schedule per year. A "freestanding rehabilitation facility" means an acute care hospital to which all of the following apply:

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.

The Fee Schedule for Level I or Level II Trauma Centers

Hospitals that are classified as a level I or level II trauma center have their own fee schedule.[10] A Level I or II trauma center is defined as a hospital verified as a level I or level II trauma center by the American College of Surgeons Committee on Trauma.[11] Those facilities are subject to the following:

- After July 1, 2021 and before July 2, 2022, 240% of amount payable under Medicare (or 75% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).



- After July 1, 2022 and before July 2, 2023, 235% of amount payable under Medicare (or 73% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 230% of amount payable under Medicare (or 71% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).

In order to be subject to this fee schedule, the treatment must be for an emergency medical condition and rendered before the patient is stabilized or transferred. If the treatment is not for an emergency medical condition, or is rendered after the patient is stabilized or transferred, then this fee schedule does not apply.

The statute takes the definition of "emergency medical condition" from the Social Security Act.[12] In that statute, the term "emergency medical condition" means:

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--
>
> > (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
> > (ii) serious impairment to bodily functions, or
> > (iii) serious dysfunction of any bodily organ or part; or
>
> (B) with respect to a pregnant woman who is having contractions--
>
> > (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
> > (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

The terms "stabilized" and "transfer" also are defined through the Social Security Act.[13] "Stabilized" means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer from a facility, or in the instance of a pregnancy, the woman has delivered. "Transfer" means the movement (including discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or associated with) the hospital.

The Fee Schedule that Applies to All Other Providers

Medical providers that do not fall into either of the above categories are subject to a fee schedule that provides lower reimbursement rates.[14] A provider that renders treatment

or rehabilitative occupational training is limited to payment or reimbursement as follows:

- After July 1, 2021 and before July 2, 2022, 200% of amount payable under Medicare (or 55% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 195% of amount payable under Medicare (or 54% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 190% of amount payable under Medicare (or 52.5% of the charge description master/average charge as of January 1, 2019 if Medicare does not provide an amount payable).

Calculation of Charges with No Medicare Rate

As referenced above, when Medicare does not provide an amount payable, providers are subject to a different reimbursement rate.[15] In that instance, the rate is calculated by taking a percentage of the amount payable for the treatment or training under the provider's charge description master in effect on January 1, 2019. If the provider did not have a charge description master on that date, then the percentage is taken from the average amount the provider charged for the treatment on January 1, 2019.

The amounts payable under Medicare refer to fees for service payments under parts A, B, and D of the federal Medicare program.[16] The fees do not consider, however, limitations unrelated to the rates in the fee schedule, such as limitations or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration.

A "charge description master" is a uniform schedule of charges represented by the person as its gross billed charge for a given service or item, regardless of payer type. There is no guidance on how the average amount charged by the provider is established, so that is left up to interpretation.

The amount in effect on January 1, 2019 must be adjusted annually for inflation by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. In this instance, the Consumer Price Index refers to the most comprehensive index of consumer prices available for Michigan under the United States Department of Labor, Bureau of Labor Statistics.

Attendant Care Limitations

Attendant care is an "allowable expense" under MCL 500.3107(1)(a) and, prior to reform was not subject to any specific limitations in amount or duration to the extent the benefit was payable. The amended statute incorporates the restrictions on attendant care provided in the Michigan Workers' Disability Compensation Act, which limits certain attendant care to 56 hours per week.[17]

The limitation relates to attendant care provided in the injured person's home. Thus, it is unclear whether it applies when provided in someone else's home. This limitation only applies to attendant care 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, or
> (c) An individual with whom the injured person had a business or social relationship before the injury.

The categories of people subject to this limitation in the No-Fault Act are much broader than those identified in the workers' compensation law, which only limits the number of hours of attendant care payable when that care is provided by the person's spouse, brother, sister, child, or parent. The categories in the amended No-Fault Act expand to any relative without limitation, any person (related or not) that is domiciled with the injured person, and anyone with a business or social relationship with the injured person before the injury. This most likely covers most, if not all, individuals providing attendant care outside of an agency or professional organization.

An insurer is permitted to enter into a contract to pay benefits in excess of the hourly limitations. This will likely occur in the instance of a catastrophically injured individual with a policy providing lifetime allowable expenses. It is anticipated that an attendant care agency or inpatient facility would charge more for rendering care as compared to a friend or family member, especially where the friend or family member has no special training. If the injured person is receiving some, or all, of the attendant care from an agency or facility, an insurer may consider contracting with a family or friend to provide care in the home for long term cost savings.

Neurological Rehabilitation Mandatory Accreditation

The amended statute introduces the concept of a neurological rehabilitation clinic[18]. This is defined as a person, including an institution that "provides post-acute brain and spinal rehabilitation care."[19] A neurological rehabilitation clinic would likely fall within the general fee schedule, and it is fairly likely that the services provided would not have an amount payable under Medicare.

A neurological rehabilitation clinic is not entitled to payment or reimbursement unless it is accredited by the Commission on Accreditation of Rehabilitation Facilities or a similar organization recognized by the director of DIFS. This accreditation requirement does not apply if the clinic is in the process of becoming accredited on July 1, 2021, as long as 3 years have not passed since the beginning of that process, and the clinic is still not accredited.

Utilization Reviews

Pursuant to MCL 500.3157a, a new section under the statute, medical providers are required to submit to utilization reviews if requested by an insurer or the Michigan Catastrophic Claims Association (MCCA). A utilization review is defined as the initial evaluation by an insurer or the MCCA of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided based on medically accepted standards.

An insurer or the MCCA may require a provider to explain the necessity or indication for treatment in writing. The circumstances that trigger such a review are if the provider provides treatment, products, services, or accommodations that (1) are not usually associated with, (2) are longer in duration than, (3) are more frequent than, or (4) extend over a greater number days than usually required for the diagnosis or condition for which the person is being treated.

If an insurer or the MCCA deems treatment to be over-utilized or inappropriate, or the cost of a treatment to be inappropriate, the provider may appeal the decision to DIFS. The use of the word "may" suggests that this is not a mandatory administrative process that needs to be exhausted prior to litigation, however a dispute over that issue is anticipated. A provider who knowingly submits false or misleading documents or other information to an insurer, the MCCA, or DIFS, commits a fraudulent insurance act and is subject to criminal penalty.

Any provider who has rendered treatment to an injured person covered by no-fault insurance is considered to have consented to submit documentation for a utilization review, and agrees to abide by any decision rendered by DIFS. This amendment applies to treatment, products, services, or accommodations provided after July 1, 2020. DIFS is in the process of implementing administrative rules providing the procedure for these utilization reviews, and we will know more about the process once that is finalized.

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[1] *Advocacy Org for Patients & Providers v Auto Club Ins Ass'n,* 257 Mich App 365 (2003), *aff'd by memorandum opinion,* 472 Mich 91 (2005)
[2] *Id.*
[3] *Id.*
[4] *Bronson Methodist Hosp v. Home-Owners Ins Co,* 295 Mich App 431 (2012)
[5] MCL 500.3157(14)
[6] State of Michigan Department of Insurance Financial Services (DIFS), *Bulletin 2019-11-INS*
[7] Ingham County Circuit Court, Case No. 19-738-CZ
[8] MCL 500.3157(3); MCL 500.3157(7)(b)
[9] MCL 500.3157(4)(a)
[10] MCL 500.3157(6); MCL 500.3157(7)(d)
[11] MCL 500.3157(15)(d)
[12] MCL 500.3157(15)(c); 42 USC 1395dd(e)(1)
[13] MCL500.3157(15)(i) & (j); 42 USC 1395(e)(3)(B); 42 USC 1395(e)(4)
[14] MCL 500.3157(2)
[15] MCL 500.3157(7)
[16] MCL 500.3157(15)(f); 42 USC 1395 to 1395lll
[17] MCL 500.3157(10); MCL 418.315
[18] MCL 500.3157(12)
[19] MCL 500.3157(15)(g) & (h)