STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Hurley Medical Center
Petitioner **File No. 21-1920**

v

Pioneer State Mutual Insurance Company
Respondent

Issued and entered
this 7th day of April 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 29, 2021, Hurley Medical Center (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 Pioneer State Mutual 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 the Petitioner a bill denial on October 29, 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 January 13, 2022. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on January 13, 2022 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on February 3, 2022. The Department issued a notice of extension to both parties on February 15, 2022.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for inpatient hospital services rendered on August 22, 2021 through August 31, 2022. The Petitioner billed for the inpatient services under the diagnosis related group (DRG) 957, which is described as other operating room procedures for multiple significant trauma with major complications or comorbidities.

With its appeal request, the Petitioner submitted supporting documentation that included an *explanation of review* letter from the Respondent; medical documentation to supports its use of DRG 957; calculation of fee estimation which details the DRG weight value used to calculate reimbursement; and a detailed narrative of reason for appeal. The Petitioner stated "This request for utilization review is due to the auto insurer failing to make full payment under the Medicare fee schedule, as required by Section 3157."

Specifically, the Petitioner stated:

> In this particular claim, Pioneer State Mutual Insurance Company paid $145,525.07. The amount due to Hurley, under Section 3157 of the Michigan Insurance Code and Michigan Administrative Code Rules 500.201 – 500.206, is $161,016.88, representing an underpayment by Pioneer of $15,491.81...because the treatment provided to patient as covered under Medicare Part A, the applicable fee schedule under rule 500.201(h) is the IPPS. See 42 USC § 1395 ww. As described above, the full amount payable to [the Petitioner] for these services under the IPPS, after excluding the limitations or supplemental payments under MCL 500.3157(15)(f) is $64,406.75. Accordingly, [the Petitioner] believes the amount payable to [the Petitioner] under Medicare, within the meaning of MCL 500.3157 and R500. 203 is $64,406.75 and [the Petitioner] is eligible under MCL 500.31575 to receive payment or reimbursement of 250% of that amount, or $161,016.88.

In its explanation of review, the Respondent stated the reimbursement was priced using contract pricing. In its reply, the Respondent stated:

> Per the Medicare IPPS pricer, reimbursement should have been $62,999.55 * 250%= $157,498.88. The bill was originally approved at $155,558.15 minus [the contracted rate] discount of $10,033.08= $145,525.07. A reevaluation has been completed (see attached) for the additional $11,973.81 owed. ....Hurley is also asking for Pass-Through Adjustments totaling $1407.20. These adjustments include Graduate Medical Education Pass-Through Adjustment, Nursing & Allied Health Pass-Through Adjustment and Ancillary Pass-Through Adjustment. Per Senate Bill No. 1 (attached) Section 3151, subsection 15, Letter F, "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 … We ask that these Pass-Through Adjustments be denied and accept the reevaluation for the additional $11,973.81 as payment in full for this bill.

On January 13, 2022 the Department requested the Petitioner's CDM. See MCL 500.3157(7). The Petitioner responded and submitted its January 1, 2019 on February 3, 2022.

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 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 Petitioner billed for the services at issue in this appeal on the basis of the Medicare Acute Inpatient Prospective Payment System (IPPS). Under the IPPS, each patient's case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, which is then divided into a labor-related and nonlabor share. The labor-related share is adjusted by the wage index applicable to the

area where the hospital is located. This base payment rate is multiplied by the DRG relative weight. If the hospital treats a high-percentage of low-income patients, it receives a percentage add-on payment (disproportionate share hospital adjustment, or DSH) applied to the DRG-adjusted base payment rate. Further, if the hospital is an approved teaching hospital, it receives a percentage add-on payment (indirect medical education, or IME) for each case. In addition, for unusually costly cases, known as outlier cases, the IPPS payment is increased. Any outlier payment is added to the DRG-adjusted base payment rate, plus any DSH or IME adjustments.

Under IPPS, the Petitioner is entitled to the base payment rate multiplied by the DRG relative weight, plus any supplemental payments that are unrelated to utilization, readmissions, recaptures, bad debt adjustments, or sequestration. See MCL 500.3157(15)(f). Additionally, under MCL 500.3157(5), enhanced reimbursement is owed to a provider that has 30% or more indigent volume determined pursuant to the methodology used by the Michigan Department of Health and Human Services in determining inpatient medical/surgical factors used in measure eligibility for Medicaid disproportionate share payments. For the dates of service at issue in this appeal, Petitioner qualified for enhanced reimbursement under MCL 500.3157(5); see DIFS Bulletin 2021-26-INS, issued June 9, 2021. Accordingly, Petitioner is eligible for reimbursement of 250% of the amount payable under Medicare, as described above, for the services and dates of service at issue.

The only amounts at issue in this appeal are the amounts payable for certain “pass-through” adjustments: the Graduate Medical Education Pass-Through Adjustment, the Nursing and Allied Health Pass-Through Adjustment, and the Ancillary Pass-through Adjustment. The specific amounts payable for each pass-through adjustment are not in dispute; rather, the dispute is whether these amounts are payable at all under MCL 500.3157. These adjustments are not “supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration.” Accordingly, they are amounts payable to the Petitioner for the dates of service at issue in this appeal.

The Director concludes that the Respondent’s determination was in error and that the Petitioner is due additional reimbursement in the amount of $3,518.00 ($1,407.20 x 250%).

IV. ORDER

The Director reverses the Respondent’s determination dated October 29, 2021.

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 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
Special Deputy Director
Signed by: Sarah Wohlford

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

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_____/

CERTIFICATE OF SERVICE

I certify that on April 8, 2022, I served a copy of the ORDER issued April 7, 2022, upon the following parties by email only:

Petitioner via Hurley Medical Center at: pruddell@honigman.com

Respondent via Pioneer State Mutual Insurance Company at: Ssayer@psmic.com

Michele D. Estrada
Legal Secretary
DIFS-Office of Research, Rules, and Appeals