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. 21-1915**

v

Progressive Michigan Insurance Company
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On December 27, 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 Progressive Michigan 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 Respondent issued the Petitioner a written notice of the Respondent's determination under R 500.64(1) on October 27, 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 December 28, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on January 10, 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 January 31, 2022.

The Department assigned an independent review organization (IRO) to provide a recommendation on the appropriateness of the cost for the dates of service at issue. The IRO submitted its report and recommendation to the Department on April 4, 2022.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for inpatient medical services rendered from August 11 through August 14, 2021. The Petitioner billed the Respondent for inpatient services under Diagnosis Related Group (DRG) 208, which is described as respiratory system diagnosis with ventilator support <=96 hours.

With its appeal request, the Petitioner submitted supporting documentation that included an explanation of review letter from the Respondent, a calculation table representing the Petitioner's claimed Medicare reimbursement amount for DRG 208, medical records to support the DRG selected, and a detailed narrative of reason for appeal. The Petitioner's request for an appeal stated:

> This request for utilization review is due to the auto insurers failing to make payment under the Medicare fee schedule, as required by section 3157… in this particular claim, [the Respondent] paid $26,642.25. The amount due to [the Petitioner], under section 3157 of the Michigan insurance code and Michigan administrative code rules 500.201- 500.206, is $58,126.36, representing an underpayment by [the Respondent] of $31,484.11.
>
> [R 500.203] provides that "[w]hen calculating the amount payable to a provider for a service under Medicare … MCL 500.3157(5) provides that, for the services described above, [the Petitioner] is not eligible for payment or reimbursement for more than "250% of the amount payable to [the Petitioner] for the treatment or training under Medicare." The Rule provides that "[w]hen calculating the amount payable to a provider for a service under Medicare, the amounts payable to participating providers under the applicable fee schedule shall be utilized." R 500.203. And it defines "fee schedule" to mean "as applicable, 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." R 500.201(h). the amounts payable to participating providers under the applicable fee schedule shall be utilized." R 500.203. And it defines "fee schedule" to mean "as applicable, 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." R 500.201(h)…

In its reply, the Respondent stated:

> The Provider is requesting to be paid more than what it actually billed. The bill in question originally totaled $57,927.06. However, per the provider's calculation and interpretation of MCL 500.3157(5). It believes it is now entitled to $58,126.36 (i.e., $199.30 more than it "customarily charges"). MCL 500.3157(1) clearly states that a provider's "charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance." As such, the provider's claim fails to meet this requirement under the statute.

Secondly, it's the respondent's position that the provider in this matter utilized the wrong DRG code and that is why its proposed Medicare fee schedule base rate is considerably inflated. The provider states in its appeal "Hurley believes the "amount payable" to Hurley under Medicare, within the meaning of MCL 500.3157 and R 500.203, is $23,250.55." They then multiply that figure by 250%. Since this is an inpatient hospital bill, pricing is based on DRG coding. The respondent applied DRG 640, but the provider calculated by applying an improper DRG code 208 (which can be seen on its bill and on page 14 of its appeal), which could be leading to the discrepancy in what it believes to be the proper base Medicare fee schedule rate for the subject bill. The respondent calculated the correct Medicare fee schedule base rate for the bill and then applied the 250% to that figure pursuant to MCL 500.3157(5), based upon the provider's status under that statute.

It is the respondent's position that it correctly repriced the subject bill pursuant to the Medicare fee schedule pursuant to MCL 500.3157 and then correctly applied MCL 500.3157(5) to that sum and issued the correct payment amount to the provider.

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 Director assigned an IRO to provide a recommendation on the appropriate calculation of the reimbursement due to the Petitioner in this appeal. In its report, the IRO reviewer concluded that, based on the submitted documentation, the Petitioner correctly billed under DRG 208.

The file was reviewed by a certified professional coding consultant and by a licensed attorney on the IRO staff. The coding consultant explained:

> [B]ased on the medical records submitted and both the Centers for Medicare & Medicaid Services (CMS) and Mediregs DRG grouper 38, the correct DRG for this case is 208. The consultant indicated that DRG 208 was originally submitted by the provider. The coding consultant explained that the diagnoses and procedures outlined in the medical records were all monitored and/or treated, therefore the correct DRG based on the CMS Grouper is DRG 208. The consultant indicated that the Insurer stated that the DRG that should have been submitted is 640, miscellaneous disorders

> of nutrition, metabolism, fluids, and electrolytes with mcc. The consultant indicated that the injured person developed acute hypoxemic respiratory failure and required intubation, cardiopulmonary resuscitation (CPR) was performed, and had seizures during his inpatient admission. The consultant explained that those medical issues along with the other treatments and interventions while an inpatient are all aspects of, and equate to, DRG 208, respiratory system diagnosis with ventilator support of less than or equal to 96 hours.

The Department accepts the IRO's conclusion that the correct DRG in this case is 208. Accordingly, the Department concludes that the Petitioner correctly calculated the amount payable under Medicare for the services and dates of service at issue in this appeal. However, the Petitioner cannot be reimbursed for more than the amount it actually charged, which was $57,927.06. Accordingly, the Department concludes that the Respondent must reimburse the Petitioner for the difference between the amount it has already paid to the Petitioner (i.e., $26,642.25) and $57,927.06 (the amount actually billed by the Petitioner).

IV. ORDER

The Director reverses the Respondent's determination dated October 27, 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

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford

April 13, 2022

Utilization Review Section
Office of Research, Rules, and Appeals
Michigan Department of Insurance and Financial Services
530 West Allegan Street, 7th Floor
Lansing, MI 48909-7720

RE: NO-FAULT INSURANCE UTILIZATION INDEPENDENT REVIEW
Case Number: 21-1915
Auto Insurer: Progressive Insurance
Health Care Provider: Hurley Medical Center
Date(s) of Service: 8/11/21 through 8/14/21
Maximus Case #: MI22-00029

Summary: The Maximus review determined that the correct DRG for the dates of service 8/11/21 through 8/14/21 should be 208.

Dear Utilization Review Section:

Maximus Federal Services, Inc. ("Maximus") is an organization that contracts with the Michigan Division of Insurance and Financial Services to provide independent reviews of No-Fault Utilization Reviews involving Michigan Insurers. Maximus review personnel and consultant specialty physicians are impartial. Maximus does not work for and is not affiliated with any Michigan Insurer.

On 2/18/22, Maximus was assigned this case for independent review of a no-fault insurance utilization determination. On 2/18/22, Maximus began its review of the case file. Maximus requested additional information for this review. These medical records were received on 2/28/22. Maximus completed its review of the case file on 3/7/22.

This case has been reviewed by a certified professional coding consultant and by a licensed attorney on the Maximus professional appeals staff. Based upon this review, the coding consultant determined the correct DRG for the dates of service 8/11/21 through 8/14/21 should be 208.

The purpose of this letter is to report the Maximus review findings and rationale.

Case File Abstract:

This case concerns a request for payment for services provided to the injured person on 8/11/21 through 8/14/21. On 12/27/21, a representative for the provider of these services wrote a letter in support of the request. It indicated that the Insurer failed to make full payment under the Medicare fee schedule as required by Section 3157. It indicated that the Insurer paid $26,642.25 and the amount due to the provider under Section 3157 of the Michigan Insurance Code and Michigan Administrative Code Rules 500.201 to 500.206 is $58,126.36 representing an underpayment by the Insurer of $31,484.11. It noted that the Insurer made no requests for additional information under R 500.63 and the request is submitted in compliance with R 500.64(3) and Section 3157a(5). It provided information on MCL 500.3157(5), R 500.203, and R 500.201(h). It explained

that because the treatment provided to the injured person is covered under Medicare part A, the applicable fee schedule under Rule 500.201(h) is the inpatient prospective payment system (IPPS). It indicated that the full amount payable to the provider for these services under the IPPS after excluding the limitations or supplemental payments under MCL 500.3157(15)(f) is $23,250.55. It indicated that the provider is eligible under MCL 500.3157(5) to receive payment or reimbursement for 250 percent of that amount for a total of $58,126.36. It also indicated that the Insurer failed to comply with R 500.64 and the provider was provided insufficient information to understand the Insurer's determination. It further indicated that the Insurer failed to provide any information demonstrating that it attempted to comply with the Medicare fee schedule established under Section 3157.

The Auto Insurer indicated that the provider is requesting to be paid more than what was actually billed. The Insurer indicated that the bill in question originally totaled $57,927.06. It explained that per the provider's calculation and interpretation of MCL 500.3157(5), the provider believes it is entitled to $58,126.36 which is $199.30 more than it "customarily charges." The Insurer noted that MCL 500.3157(1) states that a provider's "charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance." The Insurer indicated that the provider's claim fails to meet this requirement under the statute. The Insurer indicated that the respondent's position is that the provider in this matter utilized the wrong diagnosis related group (DRG) code and that is why its proposed Medicare fee schedule base rate is considerably inflated. The Insurer noted that the provider stated in the appeal "Hurley believes the 'amount payable' to Hurley under Medicare, within the meaning of MCL 500.3157 and R 500.203 is $23,250.55." The Insurer indicated that the provider multiplied this figure by 250 percent. The Insurer explained that since this is an inpatient hospital bill, pricing is based on DRG coding. The Insurer explained that the respondent applied DRG 640, but the provider calculated by applying an improper DRG code 208 which could be leading to the discrepancy in what the provider believes to be the proper base Medicare fee schedule rate for the subject bill. The Insurer indicated that the respondent calculated the correct Medicare fee schedule base rate for the bill and then applied the 250 percent to that figure pursuant to MCL 500.3157(5) based upon the provider's status under that statute. The Insurer further indicated that it is the respondent's position that it correctly repriced the subject bill pursuant to the Medicare fee schedule pursuant to MCL 500.3157 and then correctly applied MCL 500.3157(5) to that sum and issued the correct payment amount to the provider.

The documentation provided for review included:

- No-Fault Utilization Review Insurer Reply to Provider Appeal dated 1/31/22.
- Progressive Explanation of Benefits dated 10/27/21.
- Auto Insurance Utilization Review Provider Appeal Request dated 12/27/21.
- Letter on behalf of Honigman dated 12/27/21.
- Copy of Progressive check dated 10/27/21.
- Progressive Advice for Payment 2040070794.
- Progressive Account History Report.
- Calculation of Fee.
- Medical Records dated 8/11/21 to 8/14/21.

Standard of Review:

In rendering its decision, Maximus has interpreted the rights and responsibilities of the parties in accordance with applicable Michigan Law, and generally accepted standards of coding and sound medical practice.

Recommended Decision:

The coding consultant determined that the correct DRG for the dates of service 8/11/21 through 8/14/21 should be 208.

Rationale:

The results of the coding consultant's review indicate that in this case, the Provider billed for a DRG code on 8/11/21 and 8/14/21.

The Maximus coding consultant explained that based on the medical records submitted and both the Centers for Medicare & Medicaid Services (CMS) and Mediregs DRG grouper 38, the correct DRG for this case is 208. The consultant indicated that DRG 208 was originally submitted by the provider. The coding consultant explained that the diagnoses and procedures outlined in the medical records were all monitored and/or treated, therefore the correct DRG based on the CMS Grouper is DRG 208. The consultant indicated that the Insurer stated that the DRG that should have been submitted is 640, miscellaneous disorders of nutrition, metabolism, fluids, and electrolytes with mcc. The consultant indicated that the injured person developed acute hypoxemic respiratory failure and required intubation, cardiopulmonary resuscitation (CPR) was performed, and had seizures during his inpatient admission. The consultant explained that those medical issues along with the other treatments and interventions while an inpatient are all aspects of, and equate to, DRG 208, respiratory system diagnosis with ventilator support of less than or equal to 96 hours.

Pursuant to the information set forth above and available documentation, the Maximus review determined that the correct DRG for the dates of service 8/11/21 through 8/14/21 should be 208.

Sincerely,

Maximus Federal Services, Inc.
State Appeals

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 **Case No. 21-1915**

Petitioner,

v

Progressive Michigan Insurance Company
NAIC No. 10187

Respondent.
_____/

CERTIFICATE OF SERVICE

I certify that on April 14, 2022, I served a copy of the ORDER issued April 14, 2022, upon the following parties by email only:

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

Respondent via Progressive Michigan Insurance Company at: DIFS-URAppeals@progressive.com

Jill A. Hubbard
Senior Executive Management Assistant
DIFS-Office of Research, Rules, and Appeals