HOW TO GET PAID: NAVIGATING THE OLD AND NEW NO-FAULT ACT

Prior title was -
But, is the price right:
Reasonable and customary pricing in provider litigation and PIP cases

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How To Get Paid
June 11, 2019, the legislature adopted comprehensive amendments to the No-Fault Act, including a fee schedule. Certain amendments took effect immediately, certain others take effect July 1, 2020, and the rest take effect July 1, 2021.

Step 1: Set Rates
Step 2: Confirm Coverage
Step 3: Submit Bills
Step 4: Review EOB/EOR
Step 5: When to Sue
Other Notable Amendments


*The statute requires that an insurer only pay on behalf of the insured a “reasonable” charge for the particular product or service. However, the Legislature has not defined what is “reasonable” in this context, and, consequently, insurers must determine in each instance whether the charge is reasonable in light of the service or product provided.* Adv. Organization for Patients & Providers v. Auto Club Ins. Ass’n, 257 Mich.App. 365, 379, 670 N.W.2d 569 (2003).

“A court may award an insurer a reasonable amount against a claimant as an attorney fee for the insurer’s attorney in defending against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation.” MCL 500.3148(2).
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Step 1: Set Rates (cont.)

Customary: this is a term of art used differently in the PIP context than with health insurance. This limitation is only that a provider’s charge cannot be higher when billed to PIP than other insurance or for an uninsured patient. The accepted payment can vary from case to case; the only requirement is that the charge be consistent regardless of the fact or type of insurance coverage.

Manipulation

Coup of the inquiry: whether the provider’s rate is consistent with or comparable to the rates charged by similar facilities for the same or similar services in the local geographic area.

Provider manipulation: the higher the rate is, the higher the average is for the area, thus increasing the voluntary pay rates.

Insurer manipulation: control over data used to the point of committing fraud and racketeering, or even just relying on data that is not relevant to Michigan PIP claims or litigation.

Ingenix

Database owned by Aetna and United Healthcare designed to provide "UCR" rates for medical services by CPT code.

Various settlements resulted in payment of over $400 million dollars to various classes of individuals and providers after allegations of intentionally misrepresenting data to reduce insurance payments.

$50 million of the various settlements went to start a supposedly unbiased and impartial database, FairHealth, but the same intrinsic problems remain.

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Step 1: Set Rates (cont.)

Providers

- Use of investigative, experimental, or uncommon procedures.
- Ambulatory surgical facilities
- Manipulation under anesthesia
- P-Stim devices
- EEGs
- Transportation

New

- Medicare Fee Schedule Application
  - July 1, 2021 – July 1, 2022: 200% of Medicare (240% for hospitals)
  - July 2, 2022 – July 1, 2023: 195% of Medicare (233% for hospitals)
  - July 2, 2023 – July 1, 2024: 190% of Medicare (230% for hospitals)

Services not Paid by Medicare

- July 1, 2021 – July 1, 2022: 55% of 2019 charge
- July 2, 2022 – July 1, 2023: 52.5% of 2019 charge
- July 2, 2023 – July 1, 2024: 50% of 2019 charge

*The fee schedule applies to all treatment during these time periods regardless of when the accident occurred

*Some insurers are taking the position that these rates are what is "reasonable" under the current version of the statute
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**Step 2: Confirm Coverage**

**Determine Priority**

Old: for accidents occurring prior to June 11, 2019
- Personal, spouse, resident relative
- Insurer of the owner of the vehicle occupied
- Insurer of the driver of the vehicle occupied
- MACP

New: for accidents occurring on or after June 11, 2019
- Personal, spouse, resident relative
- MACP

*Various exceptions or modifications for factual circumstances (e.g., not an occupant of a vehicle, injured in the course of employment, the occupied vehicle was operated in the business of transporting passengers)*

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**Step 2: Confirm Coverage (cont.)**

**Call an Insurer**

No-fault insurers and the MACP subscribe to databases that can identify potential higher priority insurance. Submit the claim early and follow up; the adjuster will be happy to help you find the correct insurer.

Remember that all insurers attempt to point the finger elsewhere, and the data on which they rely in doing that is often faulty. Cover all of your bases and submit bills to everyone.

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**Step 3: Submit Bills**

**Reasonable Proof of the Fact and Amount of Loss**


"Thus, even though reasonable proof of loss to cause the payment of different benefits would require varying information depending on the benefit sought, once there was 'reasonable proof of the fact and of the amount of loss sustained,' the statute was clear that the benefit must be paid in a prompt manner or the insurer was subject to the interest penalty because payment was overdue." Cruz v. State Farm Mut. Automobile Ins. Co., 466 Mich. 588, 596; 648 N.W.2d 591 (2002).

"In Williams, 250 Mich.App. at 257, this Court held that the plaintiff's letter setting forth the total bill for medical services and accompanied by a statement from the hospital certifying that the bill was reasonable proof of what plaintiff expended for the treatment of her injuries constituited 'reasonable proof of the fact and of the amount of loss sustained' as required by MCL 500.3142(2). In this case, Titan received documents on September 24, 2013 that provided reasonable proof that French was in an automobile accident, injured, sustained significant medical bills for her care and treatment, and that neither she, the driver, nor the vehicle owner were covered by insurance... Accordingly, we reverse the trial court's denial of penalty interest and remand for findings regarding when Titan received 'reasonable proof of the fact and of the amount of loss sustained' as that phrase is interpreted by case law, and for a calculation of penalty interest." Bronson Health Care Group, Inc. v. Titan Ins. Co., 314 Mich.App. 577, 583; 887 N.W.2d 205 (2016).

Summary: "reasonable proof" may require more information than you have as a provider, but it always requires submission of medical records corresponding to the billed charges.
How To Get Paid
Step 3: Submit Bills (cont.)

CPT Coding Shenanigans

Upcoding: billing for a more extensive procedure or service than was actually provided (e.g. 99205 as opposed to 99204 when the office visit did not meet the applicable requirements).

Unbundling: billing a separate charge for a service that is included in another billed code (e.g. 64483 as well as 76000 for the fluoroscopy when the epidural injection code includes guidance).

Modifiers: using 50 for bilateral when already included, or overusing 22 for increased procedural services without documented support of complexity.

Units: billing multiples of a charge for services dependent on time when not supported by the records (e.g. billing three units of 97110 therapeutic exercise when the logs reflect only 20 minutes, which is only enough for two units under the Eight Minute Rule promulgated by CMS).

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Step 4: Review EOB/EOR

Denial: usually applies where some sort of coverage or necessity investigation has been completed (e.g. the applicable PIP policy lapsed prior to the accident or there has been a defense medical examination resulting in a termination of benefits as unrelated to the accident after a certain date).

Investigation: this could mean just about anything, but the insurer will never explain unless it needs more information specifically from you. Often applies where the insurer is trying to figure out a way around liability (e.g. locating a higher priority insurer), but could be a legitimate concern about proof of loss (e.g. no police report, ER records, or incident report by the insured).

Payment: obviously the best possible outcome, but there will always be reductions in amounts paid. If Provider A charges $100 and Provider B charges $200 for the same service, the PIP insurer may pay Provider B $150, but will still reduce the payment to Provider A to something like $90. Also, make sure to review the EOB for denials of particular charges despite payment of some services - the report will always indicate payment amounts and reasons for each individual service billed.

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Step 5: When to Sue

MCL 500.3145 – Statute of Limitations for PIP Insurer

Old
- Notice or Filing Limitation: litigation for unpaid PIP benefits must be filed within one year of the accident unless: (1) notice of the claim (including name and address of the claimant as well as time, place, and nature of injury) was provided within a year, or (2) the insurer issued any payment on the claim at any time.
- Recovery Limitation or "Year-Back Rule": even where notice was provided or payment issued, recovery of unpaid PIP benefits through litigation is limited to charges incurred within a year of commencement of the action.

New: "A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence."

Questions
- What constitutes a specific claim for payment?
- What constitutes a formal denial?
- What constitutes reasonable diligence?
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Step 5: When to Sue (cont.)

MCL 600.5807 – Limitation Period for Patient

General rule for breach of contract is six years.


- Compass provided MVA related treatment, billed PIP, and received partial payment
- Compass attempted to collect the balance from the patient and never pursued Auto-Owners
- Auto-Owners repeatedly instructed Compass that it was the only entity that could be liable for the balance
- Compass continued to attempt to collect the balance from the patient (at least 10 collection letters, ignoring the cease and desist from Auto-Owners)
- Auto-Owners sued for an injunction

Holding: the "year-back rule" applied to bar even the provider's claim against the patient, not just the provider's claim against the PIP insurer

Step 5: When to Sue (cont.)

Summary

- Outright Denial: sue.
- Under Investigation: if no additional information is requested from your facility specifically, sue.
- Payment: if you believe your facility's rates are reasonable, sue.

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Other Notable Amendments

PIP Caps

Effective for all new or renewed policies after July 1, 2020 (policies are grandfathered in until first renewal).

MCL 500.3107c

- $50,000 if the insured is enrolled with Medicaid
- $100,000
- $500,000
- Unlimited

MCL 500.3107d

- Complete opt out of PIP coverage if the insured has "qualified health coverage"
- Modification to the current health insurance coordination provisions, but much riskier for individuals who may lose health coverage after obtaining no-fault insurance
- No explanation for "qualified health coverage"

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Other Notable Amendments (cont.)

Statutory Cause of Action

Effective for all treatment after June 11, 2019 regardless of when the accident occurred.

MCL 500.3112

- A health care provider listed in section 3157 may make a claim and assert a direct cause of action against an insurer or under the assigned claims plan under sections 3171 to 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person.
- Possible dispute as to when benefits are "overdue"
- Still advisable to obtain assignments to avoid the insurer discharging liability by paying the patient
Questions?

Thank you.

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