Auto Casualty

Michigan No-Fault Auto Fee Schedule Frequently Asked Questions

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On July 2, 2021, the new Michigan fee schedule goes into effect for services rendered on or after that date. As we approach the effective date, there are details of the fee schedule that are still unclear. In Mitchell's most recent webinar about the new fee schedule, we collected a list of questions from carriers across the industry; below, you'll find our responses to help you better prepare for the new fee schedule. For more background on the fee schedule, visit Mitchell's dedicated Michigan Auto Reform webpage, which includes webinars, videos and other resources that detail the history, overview and structure of the fee schedule.

General Questions

What are your thoughts on the implementation date of this fee schedule moving or being delayed? When do you expect to receive the final rules from the state?

We have spoken to The Michigan Department of Insurance and Financial Services (DIFS) on several occasions and they are adamant the date of July 2, 2021 will not be moved. We feel we will not have final rules until September or October 2021.

Are there any exceptions to the fee schedule, meaning are any prior policies exempt?

To our knowledge, this is a date-of-service driven fee schedule and the policies have all been distributed. The fee schedule applies to services rendered on or after July 2, 2021.

Will DIFS be posting responses to questions on their FAQ site?

Yes, you can view the DIFS FAQ site for the latest information.

Medicare Questions

Can you describe the difference between a participating and a limiting provider of Medicare?

The Medicare-approved amount for payment of providers who participate in the Medicare system is called the "participating" amount. The “limiting” charge is the upper limit on how much providers who do not accept Medicare's approved amount (participating) can charge. Usually, the patient pays the difference between the participating and limiting amount, and depending on the state, this can range from 5% to 20%. In Michigan, the limiting amount is approximately 15% higher than the participating amount. The Medicare-described calculation for limiting is to pay 95% of 115% of the established participating fee.

What Medicare fee schedule and code is being used or accepted beginning July 2, 2021?

There is no distinction in the statute regarding the Medicare fee schedule that should be used, other than the description of the fee schedule that was in place for the date of service. The draft administrative rules for the fee schedule are attempting to implement an annual March 1 cutoff date that would apply to the preceding dates of service after July 2 through July 1 of the following year.

Reading the 5200.203 Medicare calculation, it indicated in part "the amounts payable to participating providers under the applicable fee schedule.” Can you provide input?

Currently, the administrative rules are in draft form and this terminology is not written into the statute. Until it is finalized by JCAR, it really does not exist, which makes it difficult to implement.

Do the draft administrative rules imply the usage of the participating Medicare rate?

They can, but we need the draft to be finalized before answering conclusively.

Where is the best place to access the Medicare rates for this fee schedule?

The Centers for Medicare and Medicaid Services (CMS) is the source of truth for all Medicare rates. Due to the provisions in the statute whereby we need to remove items such as sequestration from the fee schedule calculation, the CMS maintains these amounts, which can be accessed on that site.

Charge Description Master and Average Charged Amount Questions

How is a company that wasn’t in existence in 2019 paid?

A company not in existence in 2019 is not addressed in the statute. However, in the draft administrative rules, R500.205 (c) states: “If a provider does not meet the criteria under subdivision (a) or (b) of this subrule, the department shall consult the FAIR Health benchmarking database to determine the average amount charged in the applicable geozip for the service or services at issue based on FAIR Health’s most recently published data that includes dates of service on January 1, 2019, as adjusted in accordance with subrule (6) of this rule.”

What type of procedures do you foresee not having Medicare rates and would require a Charge Description Master or Average Charged Amount?

Mostly Part B professional services that are typically bundled into other services that Medicare pays for, such as a hot pack. However, hot packs provided in other settings, like outpatient facilities, would be covered with the Medicare payment method use (i.e., OPPS). In addition, we will see procedures billed that are unspecified and unlisted—these are vague codes that are billed today, variable and should be carrier reviewed for documentation (and potentially recoded to a procedure code that may be subject to the fee schedule).

Do you have a sense of what percent of billing will go unaddressed in the fee schedule that will defer to the Charge Description Master or Average Charged Amount based upon industry historical billing?

Overall, a very small quantity of bills will require Charge Description Master or Average Charge, mostly on the Part B side. In addition, carriers should review the incoming medical records on unlisted codes to ascertain if the services can be addressed with more specific codes, allowing the Medicare fee schedule to function.

Attendant Care Questions

How is the fee schedule reimbursement built regarding attendant care?

There is not a standard billing code or format available for attendant care provided to patients within the definition outlined in the statute. The bill review system will not have insight into the specifications required to bill attendant care and will not apply this part of the fee schedule. Attendant care billed by professionals in the healthcare industry, like "Home Health," will have specific codes and be subject to the normal fee schedule.

We have been told there isn't an attendant care fee schedule, but there is an arbitrary reduction. Where is the fee schedule coming from or where can it be found?

The attendant care fee schedule only applies to:

1. An individual related to the injured person.
2. An individual domiciled in the household of the injured person.
3. An individual with whom the injured person had a business or social relationship before the injury.

The insurer is only required to pay benefits for attendant care up to an hourly limitation of the Michigan workers' compensation fee schedule (up to 56 hours per week). There are no codes in CPT or HCPCS that meet this definition of attendant care. The distinction between a person meeting the criteria of attendant care is not provided in billing formats. These bill types will need to be handled outside of the bill review application and fee schedule. Insurers can contract for different amounts or add a rider to a policy for attendant care. Attendant care provided by a Home Care agency has a fee schedule and will be applied with the normal process.

At this point, what is your understanding of the status in Home Health Aide fee schedule? If an insured requires 24-hour-care and the current Medicare Reimbursement is $68 per visit, would the insured be eligible for 12 visits per day at the rate up to 200% or average charge of the Medicare rate?

This question should be directed to the carrier's utilization review program and the Michigan Catastrophic Claims Association (MCCA).

Is there a FAIR Health rate for attendant care in Michigan?

There is no code for attendant care meeting the definition outlined by Michigan.

Case Management Questions

Does Case Management fall outside of the fee schedule?

No, it appears to be inclusive of the fee schedule.

Case managers in Michigan are being asked by insurance companies to bill a Medicare billing code moving forward. What codes are recommended for case management, as previously case managers were told there is not a Medicare code for auto nurse case management?

It depends on the type of case management services being rendered as to whether or not there is a Medicare rate. Some case management services may not have a Medicare rate and may be subject to the 55% of Charge Description Master or Average Charge in effect on January 1, 2019. There are several case management codes that can be billed and are detailed in CPT or HCPCS under case management.

Feedback from case managers is that they don't have a code to use for their services. What would you suggest as far as guiding these providers to the appropriate codes?

Case managers need to review the codes in CPT/HCPCS. There is likely a code that describes the services and are subject to the fee schedule. Codes to review are: 98966, 98967, 98968, 98970, 98971, 98972, 99366, 99367, 99368, 99421, 99422, 99423, 99439, 99441, 99442, 99443, 99446, 99447, 99449, 99484, 99487, 99489, 99490, 99491, 99492, 99493, 99494, 99495, 99496, 99497, 99498, G0076, G0077, G0078, G0079, G0080, G0081, G00882, G0083, G0084, G0085, G0086, G0087, G0506, G0912, T1016, T1017, T2022, T2023.

If Mitchell/Genex performs case management services by request of the insurer, does the fee schedule apply?

It appears the fee schedule does apply.

Pharmacy Bill Questions

How are pharmacy bills going to be priced? Medispan/Redbook?

Pharmacy bills are not addressed in the fee schedule. Other than the drugs that can be repriced using a HCPCS code, the carrier should still use the same review efforts they use today.

How/where do you feel prescription medications fall under the new statute? For example, will fee schedule somehow apply?

The only place where drugs are addressed is under Medicare Part B. Other than this, drug reimbursement should be handled the way it is today (i.e., PBM, drug databases like Medispan, Redbook).

Provider Billing Questions

Since there is no requirement for providers to bill on standardized formats like UB04s and CMS 1500, what issues can arise from this?

You may not have the complete picture of the patient care being reported or the identification of the provider. You may also be missing required fields to properly price facility bills such as DRG, Inpatient Rehab or Skilled Nursing. Medicare payment systems require specific bill elements to properly determine recommended allowance.

Do you believe there will be a shift in the way providers bill for this fee schedule and if so, where do you see those changes happening?

Yes. We expect to see upcoding with Evaluation and Management (E/M) services, and we will see more utilization of services.

Have you heard about medical providers creating new companies/TINs to avoid their current charge master? Is DIFS aware that this may be happening as well? Have you heard any feedback on that issue from DIFs?

We have not heard from DIFS on this subject but have from our customer base.

Mitchell Bill Review Solution Questions

Will Mitchell support the fee schedule on July 2? How will we get updates when the rules are finalized?

Yes, updates will be provided as they are administered and within our KPIs with customers.

As the draft rules will likely not be approved by July 2, what fee schedule will be in the Mitchell bill review application?

The most current Medicare fee schedule will be in place while the draft rules are awaiting approval.

Since FAIR Health was added for use by DIFS during the appeals process, will Mitchell customers have access to the benchmark rates in the product?

Yes.

Can Mitchell review bills from other countries for Michigan policyholders when the accident occurs outside Michigan, or if the accident occurs in Michigan, can we review care from another country?

First and foremost, bills must be in English and will need to contain all the elements needed to process a fee schedule. There are no Medicare fee schedule rates in other countries and there is no instruction in the statute or draft rules to utilize a particular geographic area of Medicare to process claims. Claims in this circumstance will need to rely on the provider's Charge Description Master or Average Charge in effect on January 1, 2019 in order to make payment per the fee schedule. The Michigan Assigned Claims Plan allows for the coverage of out-

of-state accidents for residents in Michigan and does include passengers of these vehicles involved in an accident.

When using the FAIR Health benchmark after July 2, are the recommended charges reduced per the fee schedule or would payment per FAIR Health be the same as pre-July 2?

If a carrier chooses to use FAIR Health for any reason, the modules are on the same update schedule as they are today. There is no new FAIR Health module that will be implemented on July 2, 2021, for the Michigan fee schedule.

We know the Mitchell bill review product "retrofits" non-standard bills into 1500 or UB. With what we know, will there be a rejection of non-standard billings back to the provider?

The only rejection back to the provider, unless directed by the customer, will be if the provider does not provide enough information for bill processing or if critical elements are missing.

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