

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

NO-FAULT FEE SCHEDULE

(By authority conferred on the director of the department of insurance and financial services by section 210 of the insurance code, 1956 PA 218, MCL 500.210)

R 500.201 Definitions.

Rule 1. As used in these rules:

- (a) “Act” means the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.
- (b) “Charge description master” means that term as defined in section 3157(15)(a) of the act, MCL 500.3157.
- (c) “Department” means the department of insurance and financial services.
- (d) “Director” means the director of the department.
- (e) “Medicare” means that term as defined in section 3157(15)(f) of the act, MCL 500.3157.
- (f) “Neurological rehabilitation clinic” means that term as defined in section 3157(15)(g) of the act, MCL 500.3157.
- (g) “Provider” means a physician, hospital, clinic, or other person lawfully rendering a service to an injured person.
- (h) “Fee schedule” means, 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. The applicable fee schedule applies to services rendered during that service year, notwithstanding any subsequent change made to the fee schedule.
- (i) “Service” means “treatment,” as that term is defined in section 3157(15)(k) of the act, MCL 500.3157, and also includes training and rehabilitative occupational training, as described in section 3157 of the act, MCL 500.3157.
- (j) “Service year” means the period from July 2 through July 1 of the following year.

History: 2021 AACs.

R 500.202 Scope and applicability.

Rule 2. These rules do the following:

- (a) Define the applicable Medicare fee schedule.
- (b) Establish procedures for determining which providers are eligible for enhanced reimbursement.
- (c) Establish procedures for the department to collect information related to amounts charged by providers as of January 1, 2019, for the purposes of resolving provider appeals under R 500.65.
- (d) Establish a date and methodology for determining the adjustment of payment or reimbursement under section 3157(9) of the act, MCL 500.3157.
- (e) Establish procedures for the department to administer the accreditation requirements under section 3157(12) of the act, MCL 500.3157.

History: 2021 AACCS.

R 500.203 Medicare calculation.

Rule 3. When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the amounts payable to participating providers under the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019.

History: 2021 AACCS.

R 500.204 Eligibility for enhanced reimbursement.

Rule 4. (1) No less frequently than annually, the department shall issue a bulletin designating not more than 2 freestanding rehabilitation facilities pursuant to section 3157(4)(b) of the act, MCL 500.3157. A freestanding rehabilitation clinic that seeks to be recognized by the department shall submit an application for recognition on a form prescribed by the department. The department's designation remains in effect until revoked by the department.

(2) No less frequently than annually, the department shall issue a bulletin that lists which providers are entitled to enhanced reimbursement under section 3157(4)(a) or section 3157(5) of the act, MCL 500.3157. To determine whether a provider qualifies for enhanced reimbursement under section 3157(4)(a) or section 3157(5) of the act, MCL 500.3157, the department shall rely on data provided by the department of health and human services related to the provider's indigent volume factor as of July 1 of the immediately preceding year.

(3) No less frequently than annually, the department shall issue a bulletin that lists which hospitals are Level I or Level II trauma centers for purposes of enhanced reimbursement under section 3157(6) of the act, MCL 500.3157. This list must be based on the hospital's designation on January 1 of that year.

History: 2021 AACCS.

R 500.205 Charge description master; average amount charged; average charge; submissions to department in connection with an appeal under R 500.65.

Rule 5. (1) Upon the department's request, a provider that appeals a determination to the department under R 500.65, shall make the following submissions to the department, in a form and manner prescribed by the department, as applicable:

(a) If a provider has a charge description master that was in effect on January 1, 2019, the provider shall submit to the department the provider's charge description master that was in effect on January 1, 2019.

(b) If a provider offered or rendered services on January 1, 2019, and does not have a charge description master that was in effect on January 1, 2019, or has a charge description master that was in effect on January 1, 2019 that does not list all of the provider's services offered or rendered on January 1, 2019, the provider shall submit to the department the provider's average amount charged for any service offered or rendered on January 1, 2019, that is not included in a charge description master submitted to the department under subdivision (a) of this subrule.

(c) 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.

(2) A provider that submits information under subrules (1)(a) or (b) must also submit an attestation that the information provided is accurate.

(3) A provider must retain its charge description master in effect on January 1, 2019 and documentation containing the average amount charged for services on January 1, 2019, as applicable, until the provider permanently ceases to render services to injured persons for accidental bodily injuries covered by personal protection insurance under chapter 31 of the act, MCL 500.3101 to 500.3179.

(4) Upon request by the department, a provider submitting its charge description master in effect on January 1, 2019 or average amount charged for services on January 1, 2019 shall also submit to the department any documents, materials, and information the department considers necessary to assess the submission's accuracy and to resolve the provider's appeal under R 500.65.

(5) Any proprietary information or sensitive personally identifiable information regarding a patient that is submitted to the department under this rule must be afforded the same level of protection by the department as the information described under section 3157b of the act, MCL 500.3157b.

(6) An average amount charged for each service on January 1, 2019, or amount listed on a charge description master in effect on January 1, 2019, must be adjusted annually by the percentage change in the medical care component of the consumer price index for the year preceding the adjustment. Beginning in 2021, and annually thereafter, the department shall issue a bulletin no later than March 1 of each year setting forth the applicable percentage change in the medical care component of the consumer price index for the year preceding the adjustment. This percentage change applies to services rendered between July 2 of that year and July 1 of the following year.

History: 2021 AACs.

R 500.206 Neurological rehabilitation clinic accreditation; information submission.

Rule 6. (1) The department shall issue a bulletin recognizing the organizations it deems similar to the Commission on Accreditation of Rehabilitation Facilities (CARF) for the accreditation of neurological rehabilitation clinics pursuant to section 3157(12) of the act, MCL 500.3157. The department's recognition remains in effect until revoked.

(2) A neurological rehabilitation clinic that seeks payment or reimbursement for services rendered to an injured person for an accidental bodily injury covered by personal protection insurance under chapter 31 of the act, MCL 500.3101 to 500.3179, shall, upon the department's request, submit on a form prescribed by the department the following information, as applicable:

(a) Proof of accreditation by CARF or a similar organization recognized by the director as referenced in subrule (1) of this rule.

(b) If a neurological rehabilitation clinic is in the process of becoming accredited on July 1, 2021, information concerning its status in the accreditation process with updates provided to the department every 6 months thereafter until the neurological rehabilitation clinic is accredited.

(3) A neurological rehabilitation clinic that is in the process of becoming accredited on July 1, 2021, is entitled to payment or reimbursement for services for 3 years after the date on which the

neurological rehabilitation clinic submitted its application for accreditation. A neurological rehabilitation clinic is not entitled to payment or reimbursement after three years have elapsed since the date its application for accreditation was submitted and is not entitled to payment or reimbursement unless and until it becomes accredited.

History: 2021 AACCS.