PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

333.24511 Increased reimbursement claim for health care service involving a complicating factor; required documentation; denial; binding arbitration; "complicating factor" defined.

Sec. 24511. (1) A nonparticipating provider who provides a health care service involving a complicating factor to an emergency patient described in section 24507(1)(a) or (c) may file a claim with a carrier for a reimbursement amount that is greater than the amount described in section 24507(2). The claim must be accompanied by both of the following:

(a) Clinical documentation demonstrating the complicating factor.

(b) The emergency patient's medical record for the health care service, with the portions of the record supporting the complicating factor highlighted.

(2) A carrier shall do 1 of the following within 30 days after receiving the claim described in subsection (1):

(a) If the carrier determines that the documentation submitted with the claim demonstrates a complicating factor, make 1 additional payment that is 25% of the amount provided under section 24507(2)(a).

(b) If the carrier determines that the documentation submitted with the claim does not demonstrate a complicating factor, issue a letter to the nonparticipating provider denying the claim.

(3) If a carrier denies a claim under subsection (2), beginning July 1, 2021, the nonparticipating provider may file a written request for binding arbitration with the department on a form and in a manner required by the department. The department shall accept the request for binding arbitration if the department receives all of the following from the nonparticipating provider:

(a) The documentation that the nonparticipating provider submitted to the carrier under subsection (1).

(b) The contact information for the emergency patient's health benefit plan.

(c) The denial letter described in subsection (2).

(4) If the request for binding arbitration under subsection (3) is accepted by the department, the department shall notify the carrier. Within 30 days after receiving the department's notification under this subsection, the carrier shall submit written documentation to the department either confirming the carrier's denial or providing an alternative payment offer to be considered in the arbitration process.

(5) The department shall create and maintain a list of arbitrators approved by the department who are trained by the American Arbitration Association or American Health Lawyers Association for purposes of providing binding arbitration under this section. The parties to the arbitration shall agree on an arbitrator from the department's list. The arbitration must include a review of written submissions by both parties, including alternative payment offers, and the arbitrator shall provide a written decision within 45 days after receiving the documentation submitted by the parties. In making a determination, the arbitrator shall consider documentation supporting the use of a procedure code or modifier for care provided beyond the usual health care service and any of the following:

(a) Increased intensity, time, or technical difficulty of the health care service.

(b) The severity of the patient's condition.

(c) The physical or mental effort required in providing the health care service.

(6) The nonparticipating provider and the carrier shall each pay 1/2 of the total costs of the arbitration proceeding. A nonparticipating provider participating in arbitration under this section shall not collect or attempt to collect from the patient any amount other than the applicable in-network coinsurance, copayment, or deductible.

(7) This section does not limit any other review process provided under this article.

(8) As used in this section, "complicating factor" means a factor that is not normally incident to a health care service, including, but not limited to, the following:

(a) Increased intensity, time, or technical difficulty of the health care service.

(b) The severity of the patient's condition.

(c) The physical or mental effort required in providing the health care service.

History: Add. 2020, Act 234, Imd. Eff. Oct. 22, 2020.

Popular name: Act 368