STATE OF MICHIGAN

COURT OF APPEALS

CENTRAL HOME HEALTH CARE SERVICES, INC,

Plaintiff-Appellee,

and

KEVIN THOMAS,

Other Party,

v

PROGRESSIVE MICHIGAN INSURANCE COMPANY,

Defendant-Appellant.

FOR PUBLICATION
March 21, 2024
9:00 a.m.

No. 364653
Oakland Circuit Court
LC No. 2022-192077-NF

Before: O'BRIEN, P.J., and BORRELLO and HOOD, JJ.

BORRELLO, J.

In this action for personal protection insurance (PIP) benefits under the no-fault act, MCL 500.3101 *et seq*., defendant appeals by leave granted[1] the trial court's order denying defendant's motion for partial summary disposition under MCR 2.116(C)(10). For the reasons set forth in this opinion, we reverse and remand.

I. BACKGROUND

Plaintiff initiated this action to obtain payment for in-home healthcare services provided to defendant's insured, Kevin Thomas, to treat injuries Thomas suffered in an automobile accident.

[1] *Central Home Health Care Servs Inc v Progressive Mich Ins Co*, unpublished order of the Court of Appeals, entered 7/7/2021 (Docket No. 364653).

The healthcare services provided by plaintiff included in-home skilled nursing care and in-home physical therapy. Plaintiff alleged that there was an outstanding balance of $95,527.36 for services provided between July 31, 2021, and September 29, 2021. In its first amended complaint, plaintiff alleged that Thomas had incurred an additional $47,172.87 in charges for services provided between December 21, 2021, and January 7, 2022.

Defendant moved for partial summary disposition under MCR 2.116(C)(10), on the ground that plaintiff was precluded under MCL 500.3157(2)(a) from recouping the full amount of the claimed charges. Defendant argued that under this statute, plaintiff was limited to recovering 200% of what Medicare would have paid for the services. According to defendant's expert, Michael Strong, the total amount representing 200% of what Medicare would have paid for all dates of service at issue was $10,216.52.[2] Thus, defendant argued this was the maximum amount plaintiff could recover for its services in this action.

Plaintiff argued, however, that MCL 500.3157(2)(a) did not apply in this case because there was no "fee schedule" under Medicare for in-home healthcare services and Medicare, for purposes of the no-fault act, did not provide an amount payable for the services. Plaintiff contended that although Medicare established fee schedules for physicians and certain other types of providers, Medicare instead employed a "prospective payment system" for in-home healthcare services. Hence, according to plaintiff, its charges in this case were reimbursable under MCL 500.3157(7)(a)(*i*) at 55% of the rates identified on plaintiff's charge description master that was in effect on January 1, 2019. Additionally, plaintiff argued that Strong's report did not accurately compute that amount Medicare would have paid for the services. Plaintiff attached an affidavit by its own expert, Lindsey Grancitelli, to rebut Strong's methodology for calculating the amount Medicare would have paid.

Following a hearing at which the parties presented oral argument consistent with their written filings, the trial court denied defendant's motion. The trial court denied defendant's motion for reconsideration. This appeal followed.

II. ANALYSIS

In this appeal, we are presented with the narrow issue whether the applicable limit on plaintiff's potential reimbursement for its services under the circumstances of this case is provided by MCL 500.3157(2)(a) or MCL 500.3157(7)(a)(*i*). This issue is one of statutory interpretation.

Statutory interpretation presents an issue of law that we review de novo on appeal. *Columbia Assoc, LP v Dep't of Treasury*, 250 Mich App 656, 665; 649 NW2d 760 (2002). This Court also reviews a trial court's ruling on a motion for summary disposition de novo. *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159; 934 NW2d 665 (2019). Under MCR 2.116(C)(10), the question is whether a party is entitled to judgment or partial judgment as a matter of law because there is no genuine question of material fact. MCR 2.116(C)(10).

[2] Strong's report was attached to the motion for partial summary disposition.

"The primary goal of statutory interpretation is to ascertain the legislative intent that may reasonably be inferred from the statutory language." *Woodman v Dep't of Corrections*, 511 Mich 427, 440; 999 NW2d 463 (2023) (quotation marks and citation omitted). To discern the legislative intent, we must "focus[ ] first on the statute's plain language and examine the statute as a whole, reading individual words and phrases in the context of the entire legislative scheme." *Sunrise Resort Ass'n, Inc v Cheboygan Co Rd Comm*, 511 Mich 325, 333-334; 999 NW2d 423 (2023) (quotation marks and citation omitted; alteration in original). "While terms must be construed according to their plain and ordinary meaning, words and phrases as may have acquired a peculiar and appropriate meaning in the law, shall be construed and understood according to such peculiar and appropriate meaning." *Hannay v Dep't of Transp*, 497 Mich 45, 57; 860 NW2d 67 (2014) (quotation marks and citation omitted). "When a statute's language is unambiguous, the Legislature must have intended the meaning clearly expressed, and the statute must be enforced as written." *Sunrise Resort*, 511 Mich at 334 (quotation marks and citation omitted).

The Michigan Legislature enacted "sweeping changes" to the no-fault act in 2019 in an attempt to control no-fault insurance costs. *Andary v USAA Cas Ins Co*, 512 Mich 207, 214, 218; 1 NW3d 186 (2023). These changes took effect on June 11, 2019. See 2019 PA 21 and 2019 PA 22. The underlying automobile accident in this case occurred on December 5, 2019, and the parties agree that the 2019 amendments apply to this case.

At issue in this case is MCL 500.3157, which provides in relevant part as follows:

> (1) Subject to subsections (2) to (14), a physician, hospital, clinic, or other person that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the treatment or training. The charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance.
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> (2) Subject to subsections (3) to (14), a physician, hospital, clinic, or other person that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is not eligible for payment or reimbursement under this chapter for more than the following:
>
> (a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 200% of the amount payable to the person for the treatment or training under Medicare.
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> * * *
>
> (7) If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under subsection (2), (3), (5), or (6), the physician, hospital, clinic, or other person that renders the treatment or training is not eligible for payment or reimbursement under this chapter of more than the following, as applicable:

(a) For a person to which subsection (2) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

(*i*) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 55%.

* * *

(15) As used in this section:

* * *

(f) "Medicare" means 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 1395*lll*, 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 Subsection (2)(a), a provider that "render[ed] treatment or rehabilitative occupational training to an injured person" between July 1, 2021, and July 2, 2022,[3] "for an accidental bodily injury covered by personal protection insurance" is limited to recouping "200% of the amount payable . . . for the treatment or training under Medicare." Hence, Subsection (2)(a) clearly states that if Medicare provides coverage for the treatment or service,[4] then the provider may recover from the no-fault insurer up to 200% of the amount Medicare would pay—i.e., the "amount payable . . . under Medicare." Subsection (7), in contrast, provides the limitations cap only "[i]f Medicare *does not provide an amount payable* for a treatment or rehabilitative occupational training under subsection (2)." (Emphasis added.)

We further note that although this particular issue was not before our Supreme Court in *Andary*, the Court in *Andary* generally described the operation of MCL 500.3157 in a manner consistent with our analysis. See *Andary*, 512 Mich at 269 ("One of several tools selected by the Legislature to rein in escalating costs was the implementation of fee schedules in MCL 500.3157 for Medicare-reimbursable and non-Medicare-reimbursable services, treatment, and products."). The Legislature's intent that whether Subsection (2) or Subsection (7) applies in a given situation depends on whether Medicare covers the treatment at issue is plainly and unambiguously expressed in the statutory language and must be enforced as written. *Sunrise Resort*, 511 Mich at 334.

[3] It is undisputed that the services at issue in this case were provided within this time period.

[4] Under MCL 500.3157(k), " '[t]reatment' includes, but is not limited to, products, services, and accommodations."

Contrary to plaintiff's argument, the definition of "Medicare" in MCL 500.3157(15)(f) does not require a different conclusion. Under Subsection (15)(f), "Medicare" means "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 1395*lll*, 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."

The first clause of this definition specifically directs our attention to the federal statutes defining the Medicare program. Pursuant to 42 USC 1395c, Medicare Part A is an "insurance program" that "provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part" for eligible individuals as defined under the Social Security Act, 42 USC 301 *et seq*. Medicare Part B is "a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government." 42 USC 1395j. Medicare Part D provides qualified prescription drug coverage for eligible individuals. 42 USC 1395w-101(a)(1). Both Part A and Part B indicate that the insurance program benefits entitle the covered individual to "payment" to the individual or on the individual's behalf for certain medical services, including certain home health services. 42 USC 1395d(a); 42 USC 1395k(a).[5]

Considering the description of Medicare provided by the relevant federal statutes, it is apparent that Medicare provides "fee for service payments" as contemplated by MCL 500.3157(15)(f). Accordingly, the first clause of the definition of Medicare in MCL 500.3157(15)(f) simply states the obvious: the Legislature's use of the term "Medicare" in MCL 500.3157 means Parts A, B, and D of the federal Medicare program, which provides fee-for-service-payment coverage, akin to insurance coverage, for certain medical expenses for eligible individuals. The second clause of MCL 500.3157(15)(f) instructs that certain other adjustments may be made under Medicare for purposes of administering the Medicare program but those adjustments are not related to the actual reimbursement rates and therefore, are not to be considered for purposes of Michigan's no-fault act.

Plaintiff resists this common-sense reading of the statute by latching onto the reference in MCL 500.3157(15)(f) to "the fee schedule." Plaintiff argues that the no-fault act's definition of Medicare is limited to fee for service payments made pursuant to a "fee schedule" and that because 42 USC 1395fff provides for payment of home health services through a "prospective payment system," rather than a "fee schedule" such as is applicable to other services under Medicare, see, e.g., 42 USC 1395w-4 (physicians' services),[6] the definition in MCL 500.3157(15)(f) necessarily excludes home health services from the definition of Medicare for purposes of the no-fault act. Thus, plaintiff argues, its limitation cap on reimbursement must be governed by MCL 500.3157(7)

[5] The recent amendment to 42 USC 1395k(a)(2)(J) is not relevant to our purposes for citing this statute.

[6] This statute has been amended three times since this lawsuit was initiated, but those amendments are not implicated in the context of resolving the narrow issue before us on appeal.

because home health services are not services for which Medicare provides a payment *according to a fee schedule*.

However, we need not attempt to discern the actual difference between a fee schedule and prospective payment system under Medicare in order to resolve this appeal. As we have already stated, the simple question to answer in determining whether MCL 500.3157(2) or MCL 500.3157(7) applies is whether Medicare covers the service at issue. Nothing in either of those two subsections indicates that the method for calculating the amount Medicare would pay is relevant. Furthermore, nothing in the definition of Medicare in Subsection (15)(f) makes the method of calculation relevant for determining the application of Subsection (2) or Subsection (7) either. The second clause of Subsection (15)(f) merely states that if a fee schedule is involved and other adjustments unrelated to the rate in the fee schedule would be made under Medicare, those adjustments are not to be considered for purposes of the no-fault act. Nothing in the second clause states that there could not be another applicable method—such as a prospective payment system—for calculating the amount Medicare would pay for a service. Plaintiff asks this Court to read a limitation into the statutory definition that does not exist. Additionally, as we have been instructed by our Supreme Court, "[A] court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself." *Nickola v MIC Gen Ins Co*, 500 Mich 115, 123; 894 NW2d 552 (2017) (quotation marks and citation omitted).

We therefore hold that for purposes of MCL 500.3157, Subsection (7) does not apply if Medicare covers the treatment or service at issue because coverage under Medicare means that Medicare provides an "amount payable" for the treatment. Under the factual circumstances here, the fact the Medicare covers the service means that the limitations cap is provided instead by Subsection (2)(a). Subsection (7) only applies if there is no Medicare coverage for the treatment at issue. The trial court erred by determining that Subsection (7) was the controlling provision in this case.

Applying our holding to this case, the parties do not dispute that Medicare would cover the home health services at issue, and the parties do not dispute that the services were provided within the time period defined in MCL 500.3157(2)(a). Therefore, as previously stated, MCL 500.3157(2)(a) governs the limitations cap in this case. However, we express no opinion on whether the calculation of that amount has been properly made by either party. The parties have presented conflicting expert opinions on this matter, creating genuine questions of fact that preclude summary disposition on that issue. On remand, the parties are free to argue their positions regarding the amount that represents 200% of the amount Medicare would pay for purposes of MCL 500.3157(2)(a).

Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction. No costs are awarded. MCR 7.219(A).

/s/ Stephen L. Borrello
/s/ Colleen A. O'Brien
/s/ Noah P. Hood