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NO. A10-1930

State of Minnesota
In Supreme Court

Ronald E. Troyer,

Employee,

v.

Vertlu Management Company/
Kok & Lundberg Funeral Homes,

Employer-Relator,

and

State Auto Insurance Company,

Insurer-Relator,

and

HealthEast Care System,

Hospital-Respondent.

BRIEF OF EMPLOYER AND INSURER - RELATORS

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STATEMENT OF THE CASE

This case presents the question of whether a hospital that treats an injured employee under the Workers' Compensation Act is entitled to claim a large pass-through mark up on an implanted medical device used in an employee's surgery. This is solely a legal issue that requires the interpretation of Minn. Rule 5221.0700, subp. 2(A)(2) and Minn. Stat. 176.136, subd. 1b(b). At the administrative hearing level, workers' compensation judges have split in their interpretation of how to apply Minn. Stat. 176.136, subd. 1b(b). See Konczal v. Hage Const. Co. (slip op. March 23, 2009), Hove v. Coca Cola Bottling Co. (slip op. April 9, 2009), Gee v. Now Technologies (slip op. June 9, 2009), Jennings v. Allina Medical Clinic (slip op. April 2, 2009), Fischer v. Tehnical Serv. for Electronics, Inc. (slip op. June 8, 2009). As a result, the Office of Administrative Hearings is currently holding numerous cases involving millions of dollars on this issue in abeyance in order to allow this Court to provide the appropriate legal guidance.

The present case involves a claim by HealthEast Care System ("HealthEast") for a large pass-through mark up—likely almost \$50,000.00 above its cost—on a medical implant that it did not develop, manufacture, or keep in stock, but ordered specifically for Mr. Troyer at the direction of his treating surgeon. To achieve the broadest possible application and guidance, the parties submitted this matter to the Office of Administrative hearings on stipulated issues and facts pursuant to Minn. Stat. § 176.322.

HealthEast filed a Medical Request on March 11, 2009. Workers' Compensation Judge Gary Mesna heard the matter on December 2, 2009 and January 20, 2010.

HealthEast alleged that it was the ‘healthcare provider’ of surgical implant hardware used during Ronald Troyer’s August 27th, 2008 surgery. As a result, HealthEast claimed that it was entitled to bill the employer and insurer for those implantable devices at 85 percent of its usual and customary charge. The employer and insurer argued that Advanced Neuromodulation Systems Inc. (“ANS”), not HealthEast, was the ‘healthcare provider’ of the surgical implants pursuant to Minn. Rule 5221.0700, subp. 2(A)(2). If HealthEast was determined to be the ‘healthcare provider’ for the implant, then pursuant to Minn. Stat. 176.136, subd. 1b(b), the employer and insurer argued that the compensation judge has the authority to determine the reasonable value of the implants limited to a cap of 85 percent of the hospital’s usual and customary charge or 85 percent of the prevailing charge.

On February 3, 2010, Judge Mesna issued his Findings and Order. He determined as a matter of law that HealthEast was the ‘healthcare provider’ of the implant components used in Mr. Troyer’s surgery and thus was entitled to bill for those components (Findings No. 1, 2); that the reasonable value of the implants was 85 percent of HealthEast’s usual and customary charge, that the employer and insurer were liable for the unpaid balance due up to that percentage (Findings No. 3, 4); and that HealthEast’s Exhibits K, L, and M, as well as Employer and Insurer Exhibits 8 and 9 were irrelevant to a determination of the issues (Finding No. 5). Judge Mesna noted that he permitted the parties to make an offer of proof with respect to those exhibits in order to preserve the issue for appeal (Finding No. 5).

The employer and insurer appealed Findings No. 1, 2, 3, 4, and 5, and Orders No. 1, 2, 3, and 4 to the Workers' Compensation Court of Appeals. The W.C.C.A. affirmed Judge Mesna's decision on October 4, 2010. Troyer v. Vertlu Mgmt. Co./Kok & Lundberg Funeral Homes (W.C.C.A. October 4, 2010). The employer and insurer now appeal the W.C.C.A.'s decision that: 1) HealthEast is the 'healthcare provider' for the implant components and therefore may bill for those components under Minn. Rule 5221.0700, subp. 2(A)(2); 2) that the compensation judge does not retain the authority to determine the reasonable value of the implant components limited to a cap of 85 percent of the hospitals usual and customary charge or 85 percent of the prevailing charge pursuant to Minn. Stat. 176.136, subd. 1b(b); and that Employer/Insurer Exhibits 8 and 9 are excluded as irrelevant.

ISSUES PRESENTED

- I. Whether the W.C.C.A. committed an error of law in determining that HealthEast is the 'healthcare provider' of the surgical implant hardware used during the employee's surgery, and therefore is entitled to bill the employer and insurer for those devices pursuant to Minn. Rule 5221.0700, subp. 2(A)(2).
- II. Whether the W.C.C.A. committed an error of law in determining that the compensation judge does not have the authority to determine the reasonable value of the surgical implant hardware up to a cap of 85 percent of the hospital's usual and customary charge pursuant to Minn. Stat. 176.136, subd. 1b(b); and finding that, therefore, the reasonable value of the hardware was 85 percent of HealthEast's usual and customary charge.

STATEMENT OF FACTS

The parties submitted this matter to the compensation judge on stipulated facts pursuant to Minn. Stat. § 176.322 as follows:

1. The employee, Ronald Troyer, sustained work-related injuries to his low back arising out of and in the course and scope of his employment with Vertlu Mgt/Kok & Lundberg Funeral Homes.
2. The employer, Vertlu Mgt/Kok & Lundberg Funeral Homes, had timely notice of the work-related injury.
3. On the date of injury the employer was insured for workers' compensation liability in the state of Minnesota by State Auto Insurance.
4. The employer and insurer admitted primary liability and paid workers' compensation benefits including medical benefits.
5. The employee was hospitalized at HealthEast St. Joseph's Hospital and on August 27, 2008 he underwent a low back surgery that was reasonable and necessary to cure and relieve him from the effects of his personal injuries. The low back surgery consisted of: a) removal of an anterior RF receiver and laminectomy at the T10 level, b) removal of an epidural plate electrode, and c) implantation of an IPG spinal cord stimulator implant system.
6. The low back surgery included the implantation of components from Advanced Neuromodulation Systems, Inc. ("ANS"). These included an ANS lamitrode 44 led kit, ANS EON patient programmer, ANS EON mini 16 channel IPG, and an ANS portable charging system for the EON mini 16 channel IPG.
7. HealthEast St. Joseph's Hospital does not ordinarily keep in stock the ANS implants components utilized during the employee's surgery of August 27, 2008.
8. HealthEast St. Joseph's Hospital ordered the components from ANS per the direction [REDACTED] for this specific employee. The components were delivered on-site by personnel from ANS.

9. That it would be common practice for a representative from the manufacturer of the spinal cord stimulator implant, ANS, to be present in the operating room and, if necessary, to consult with the surgeon during the surgical procedure to implant the device, as discussed in detail by [REDACTED] in her deposition testimony which is marked as an exhibit in this case.
10. HealthEast Care System's usual and customary charge, as defined by Rule 5221.0500, subp. 2 B (1), for the ANS components totals \$73,320.00.
11. HealthEast Care System's usual and customary charge for the ANS implants includes a mark-up on the wholesale price charged by ANS to HealthEast St. Joseph's Hospital.
12. CorVel, on behalf of the employer and insurer, has requested the actual invoices for the ANS implants from HealthEast pursuant to Rule 5221.0700, subp. 2 (A) (2) in order to determine the appropriate payment for those implanted devices. HealthEast refuses to provide the invoices. The price charged HealthEast Care System by ANS for the IPG implant system used during the employee's surgery is considered by HealthEast Care System to be confidential and proprietary in nature. It contends that the price of the implants is not relevant as to its right to payment of its usual and customary charges under the Minnesota Workers Compensation Fee Schedule.
13. HealthEast St. Joseph's Hospital is a hospital with over 100 beds for purposes of application of Rule 5221.0500 and Minn. Stat. §176.136.
14. HealthEast St. Joseph's Hospital is part of the HealthEast Care System, and charges for services at HealthEast St. Joseph's Hospital are billed by and through HealthEast Care System.
15. Upon the recommendation of CorVel, the employer and insurer authorized and made payment to HealthEast for the OR charges, room and board, and all other charges as indicated by the EOR dated October 7, 2008. They also paid the following charges for the cost of the implanted devices utilized during the employee's surgery as follows:
 - \$1,395.00 for the ANS EON patient programmer;
 - \$17,995.00 for the ANS EON mini 16 channel IPG;

- \$1,350.00 for the ANS portable charging system; and
- \$3,700.00 for the ANS lamitrode 44 lead kit.

These total \$24,440.00. HealthEast cashed the check for the payment on November 3, 2009. That leaves an unpaid balance claimed by HealthEast Care Systems for said components in the amount of: $\$73,320.00 \times 85\% = \$62,322.00 - \$24,400.00 = \$37,922.00$.

Findings and Order, pp. 2-3.

STANDARD OF REVIEW

This appeal involves only questions of law. When reviewing questions of law determined by the Workers' Compensation Court of Appeals, this Court is free to exercise its independent judgment. Bruns v. City of St. Paul, 555 N.W.2d 522 (Minn. 1996).

ARGUMENT

- I. The W.C.C.A. committed an error of law in determining HealthEast is the 'healthcare provider' of the surgical implant hardware used during the employee's surgery, and therefore is entitled to bill the employer and insurer for those devices pursuant to Minn. Rule 5221.0700, subp. 2(A)(2).**

On August 27, 2008, [REDACTED] performed low-back surgery consisting of implantation of an ANS rechargeable IPG spinal cord stimulator system for Mr. Troyer at HealthEast St. Joseph's Hospital. (Findings and Order, p. 2). [REDACTED] [REDACTED] directed HealthEast to order the specific components that he then implanted. *Id.* HealthEast did not develop, test, manufacture, or keep the components in stock. *Id.* These implant components included an ANS lamitrode 44 lead kit, ANS EON patient programmer, ANS EON mini 16-channel IPG, and an ANS portable charging system. *Id.* HealthEast billed the employer/insurer and was paid without dispute for charges associated with the

surgery—except the implants. *Id.* at 3. HealthEast was paid for the operating room charge, room and board charges, and associated services. *Id.*

The Workers' Compensation Court of Appeals erroneously concluded as a matter of law that the applicable rule—Minn. Rule 5221.0700, subp. 2(A)(2)—allows HealthEast to submit its charge, rather than the actual-cost invoice from ANS for payment, because it found HealthEast to be the healthcare provider of the spinal implants. *Troyer* at 5. The employer and insurer's best evidence is that the medical implants cost \$24,440.00. Employer/Insurer Ex. 8. HealthEast charged the employer and insurer \$73,320.00 for those implant components that it merely ordered and then handed to [REDACTED] [REDACTED] Findings and Order at 3. This errant determination would allow HealthEast to tack on a probable pass-through mark up of nearly \$50,000.00 above and beyond its cost for the device.

A. Policy underlying direct billing by the healthcare provider

In affirming the compensation judge's determination that HealthEast is the 'healthcare provider', the W.C.C.A. relied on its prior decision in *Buck-Ulrick v. Tri-City Enterprise*, 68 W.C.D. 210 (W.C.C.A. May 13, 2008). In that earlier decision, the Court failed to address one of the key components needed to properly apply Minn. Rule 5221.0700, subp. 2(A)(2)—the policy underlying the rule. *Troyer* at 6. In this case, the W.C.C.A. repeated this error by applying the same analysis to those policy considerations. *Id.* The Court's analysis is incorrect.

The legislature's intent is that the Workers' Compensation Act be interpreted to "assure the quick and efficient delivery of indemnity and medical benefits to injured

workers at a reasonable cost to the employers who are subject to the provisions of this chapter.” Minn. Stat. §176.001 (2000) (Emphasis added). To implement this intent, the purpose of the rule governing Fees for Medical Services, is “... to prohibit health care providers treating employees with compensable injuries from receiving excessive reimbursement for their services.” Minn. Rule 5221.0300 (1993) (Emphasis added.) In furtherance of these mandates, the Department of Labor and Industry amended Rule 5221.0700—the rule at issue—in order to combat indirect billing that resulted in undue cost mark ups. Through enactment of subpart 2(A), the “provider actually furnishing a service, article, or supply must submit its charges directly to the payor.” Rule 5221.0700, subp. 2(A)(1993).

The Commissioner promulgated Rule 5221.0700, subp. 2(A) to curtail payor liability by precluding pass-through mark ups for certain services—including medical supplies such as the implant components at issue here—purchased for a specific employee that the hospital does not ordinarily keep in stock.

As part of the rule-making process, the Department produced a Statement of Need and Reasonableness (SONAR). Employer/Insurer Exhibit 16. This policy document provides the context for applying the rule, as it explicitly discusses the rationale for including subpart 2(A) in its revision. The SONAR states that subpart 2(A) was added to require direct billing to the payor from the service provider. It explains that, “The problem of mark-ups for services provided by another business entity but billed by the referring provider is avoided, thus reducing costs and minimizing disputes.” *Id.* at 36. The amended rule addresses the legislative intent of the Workers’ Compensation Statute

and Fees for Medical Services rule by eliminating unreasonable charges through mark ups created by a hospital's indirect billing procedures.

The Court's decision in this case frustrates that legislative intent. Here, the surgeon determines the need for surgery and chooses the specific ANS neurostimulator implant components to implant into Mr. Troyer. Stipulated Fact 6. The surgeon directs the hospital to order those components from ANS. Stipulated Fact 8. The ANS representative delivers the pre-sterilized components to the hospital, and it would have been common practice for the representative to be present in the operating room and consult with the surgeon during the implantation procedure. Stipulated Facts 8 and 9. HealthEast personnel verifies and catalogues the ANS components. Employer/Insurer Ex. 10 at 20. The circulator nurse in the operating room hands the components to the scrub nurse, who in turn hands the components to the surgeon. Id. at 21. Both nurses are included in the operating room staff and are paid for as part of the hospital's operating room charge. The ANS representative remains in the OR throughout the surgery to answer any questions by the surgeon related to the implants, to offer advice and expertise, and to provide additional or different components as needed. Id. at 24-26.

B. The W.C.C.A.'s 'totality of the surgical procedure' test is incorrect.

Following a discussion of the pertinent SONAR provisions, the W.C.C.A., in this case, acknowledged that the policy rationale set forth in the SONAR suggests that if the supply or equipment is not ordinarily kept in stock by the hospital and is ordered for a specific employee, then the healthcare provider is the supplier of that equipment. Troyer at 8. This is consistent with the intent of the Statute per section 176.001 and the intent of

the Rule per 5221.0300. Interestingly, the Court then went on to note that it does not believe this is the sole criteria for determining who is the healthcare provider, as it “would transform virtually every manufacturer of custom medical devices or surgical components not kept in stock by a hospital into healthcare providers...” Id. (citing Buck-Ulrick at 214-215). That is—in fact—precisely the point. In order to eliminate unwarranted pass-through mark ups, subpart 2(A) requires that the supplier, as the healthcare provider, submit its bill to the payor. There is no “transformation”, as the W.C.C.A. believes. Rather, the Rule provides a simple and direct means to avoid pass-through mark ups by the hospital. The alternative is manifest in this case—a pass-through mark-up of nearly \$50,000.00 by the hospital.

HealthEast admits that its usual and customary fees for the implant components are \$73,320.00. Stipulated Fact 10. It won’t say how much it paid ANS for the devices ordered by [REDACTED] [REDACTED] Id. at 12. It has refused to produce an invoice from ANS. Id. The employer and insurer paid HealthEast for its OR charges, Room and Board charges, and a comprehensive list of charges for other services that the hospital provided for Mr. Troyer’s surgery. Employer/Insurer Ex. 5. The employer and insurer also paid \$24,400.00 towards HealthEast’s medical implant charges, based upon other invoices for the same implant components. Stipulated Fact 15. The W.C.C.A. did not directly address the compensation judge’s error of law in excluding Employer/Insurer Exhibits 8 and 9¹ as irrelevant. See Findings and Order, Finding 5 and Order 3. Given HealthEast’s refusal to produce its cost for the invoices, Exhibit 8—alternate actual-cost invoices from

¹ Employer/Insurer Exhibit 9, Affidavit of [REDACTED] provides foundation for Exhibit 8.

ANS—are the best evidence available to determine whether or not the specific intent of the rule is frustrated in finding that HealthEast is the healthcare provider. They are essential to demonstrate the need for—and the intent of—the rule. Based upon the actual-cost invoices, the difference in the marked-up charge by HealthEast and the actual cost of the implants is nearly \$50,000.00. This egregious sum graphically illustrates the problem the revised rule at issue intended to address. Exhibit 8 is clearly relevant, as it provides the necessary context to demonstrate the need to apply the rule as we propose. It shows that, if upheld, the W.C.C.A.’s decision would ratify a massive windfall in this, and many other cases.

In failing to properly apply Rule 5221.0700, subp. 2(A)(2), the W.C.C.A.’s determination that ANS is not the ‘healthcare provider’ of the spinal stimulator implant components leads to the exact result that the Rule is meant to prohibit—a substantial mark up on a supply not kept in stock by the hospital, purchased for a specific employee, and provided by a separate entity.

Rather than simply apply the rule as conceived and enacted, the W.C.C.A. instead fashioned its own rule. According to that Court, in determining who is the ‘healthcare provider’ of the implants, “the dispositive factor is that the implant components manufactured by ANS had no intrinsic value standing alone and could not cure and relieve the employee from the effects of his personal injuries until used in the surgery.” Troyer at 9-10 (citing Buck-Ulrick at 214). “The implant hardware had no value to the employee until it was used at the hospital by the surgeon as part of the employee’s surgical procedure.” *Id.* at 8. Essentially, the W.C.C.A. has incorrectly chosen to reject

the plain language and intent of Rule 5221.0700, subp. 2(A)(2) and look towards the ‘totality of the surgical procedure.’

The intent of the Workers’ Compensation Act is to “assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter.” Minn. Stat. §176.001 (2000) (Emphasis added). The Rules governing Fees for Medical Services which implement this policy seek “... to prohibit health care providers treating employees with compensable injuries from receiving excessive reimbursement for their services.” Minn. Rule 5221.0300 (1993) (Emphasis added.) The W.C.C.A.’s analysis of Rule 5221.0700 allows a \$50,000.00 pass-through mark up by HealthEast on a medical device provided by ANS—directly contrary to legislative policy. Contrast this with a plain reading of the rule, which prohibits a pass-through mark up—limited to those supplies and equipment not kept in stock by the hospital and ordered for a specific patient.

In applying its newly-created rule in both Buck-Ulrick and the present matter, the Court failed to consider two points. First, as the implant is one of the key elements to the employee’s treatment, its design, development, and manufacture are valuable and necessary parts of that same overall treatment. These services must be considered when determining who has provided value to the employee, contrary to the W.C.C.A.’s new rule. While the hospital provided an operating room with trained personnel, it charged and was paid for those services. ANS designed, developed, and manufactured a sophisticated medical device. ANS provided personnel to deliver the device and advise the surgeon. The crux of the Rule at issue is that the hospital should not be paid a

\$50,000.00 mark up over ANS's charge. "The problem of mark ups for services provided by another business entity but billed by the referring provider is avoided, thus reducing costs and minimizing disputes." SONAR at 36.

Second, the 'totality of the surgical procedure' test fashioned by the W.C.C.A. improperly assumes that individual supplies and services cannot be delineated as separate services to the employee. Rather, the surgery—including the implants—is one all-encompassing service that cannot be scrutinized to determine whether individual components are charged at a reasonable amount. This is incorrect.

The W.C.C.A.'s analysis would allow a \$50,000.00 mark up on the implants provided by ANS because those components are part of an indivisible medical service performed at the hospital. However, the hospital has no difficulty assigning a charge—or value—to each item and service involved. Employer/Insurer Ex. 5. The hospital's line-item billing statement shows 48 separate charges for supplies and services to the employee—from specific medications to a broader surgical level-3 charge that encompasses use of the operating room and associated personnel. *Id.* It is disingenuous to argue that each of these charged services cannot be viewed on their own, yet then bill the employer/insurer for each independently.

The hospital charges for each medication, room charge, anesthesia charge, et cetera that it provides, for which it accrues operating and overhead expenses. But this does not apply to those specific services encompassed by Minn. Rule 5221.0700, subp. 2(A)(2). The Rule addresses several situations where pass-through mark ups are prohibited:

- (1) Diagnostic imaging, laboratory, or pathology testing not actually performed by the healthcare provider who ordered the test;
- (2) Equipment, supplies, and medication not ordinarily kept in stock by the hospital or other healthcare provider facility, purchased from a supplier for a specific employee;

Id.

Under the W.C.C.A.'s new rule, each of the above has "no intrinsic value standing alone." An MRI scan has no value until interpreted by a medical professional and incorporated to help direct treatment. A lab test has no value until its results are used to make a diagnosis or help direct treatment. If the W.C.C.A.'s analysis is upheld, a hospital should be able to farm out these services and charge a mark up as they only have value once incorporated into the overall treatment of the injured worker. Rule 5221.0700 would be meaningless. The Rule clearly bars pass-through mark ups and its plain language should be applied.

The Court's 'totality of the procedure' test is premised on the idea that only when the medical implant is incorporated into the entire surgery, is a service provided to the employee. To look at it another way, the actual value to the patient would arise only when a sophisticated medical device is developed, tested, and manufactured; and then performs its function in the patient's body following implantation through the expertise of the surgeon. Under this analysis, the surgeon would most closely be the 'healthcare provider' of the device by implanting it. The surgeon's skill and knowledge is the crux of the treatment. But the surgeon bills separately, and does so for applied expertise—not for the device. This is appropriate. HealthEast is no more the 'healthcare provider' for

the implants than it is for the surgeon's expertise under the Court's test. It has not added value for which it has not been paid.

The W.C.C.A. held that the Rule is not "the sole criteria" to determine whether HealthEast can bill a \$50,000.00 pass-through mark up, but it failed to apply any portion of that Rule in its new 'totality of the surgical procedure' test. The Court's test is logically unsound, and renders Minn. Rule 5221.0700, subp. 2(A)(2) meaningless. The W.C.C.A.'s analysis should be rejected.

C. ANS is the 'healthcare provider' of the medical implants

In order to determine which entity is "actually furnishing the service, article, or supply" to the employee under the Rule, this Court should reject the W.C.C.A.'s 'totality of the procedure' analysis and compare specifically what HealthEast and ANS did to add value to the implants for the employee. This analysis, taken together with underlying policy considerations and the intent of Minn. Rule 5221.0700, subp. 2(A)(2), avoids "the problem of mark-ups [by the hospital] for services provided by another business entity [ANS]..." SONAR at 36. This comparison leads to the conclusion that ANS is the 'healthcare provider' of the implant components intended by the Rule.

The Workers' Compensation Statute defines a 'healthcare provider' as:

"...a physician, podiatrist, chiropractor, dentist, optometrist, osteopath, psychologist, psychiatric social worker, *or any other person who furnishes a medical or health service* to an employee under this chapter, but does not include a qualified rehabilitation consultant or approved vendor." Minn. Stat. §176.011, subd. 24 (2000) (Emphasis added.)

While the definition lists neither medical implant manufacturers nor hospitals, it implicitly contemplates both. With regards to what constitutes a medical service, as set forth above, Rule 5221.0405, subd. 15 defines it as:

“...any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing or relieving an injured worker from the effects of a compensable injury...” (Emphasis added.)

ANS developed, tested, and manufactured the medical implant component (i.e. “supply, product”) used to cure or relieve Mr. Troyer’s injury. (Findings and Order, p. 2) ANS provided the implants. HealthEast does not regularly keep the implant components in stock, and it purchased those components—along with the services of the ANS representative—from ANS specifically for Mr. Troyer at the direction of the surgeon. *Id.* It then passed on its cost and its mark up over cost to the employer and insurer. *Id.* at 3. These facts fall squarely within the plain language—and the policy considerations—of Rule 5221.0700. Where supplies such as implant components are not kept in stock by HealthEast, but are specially ordered for a specific patient at the direction of the surgeon, HealthEast would only be the ‘healthcare provider’ for the implants to the extent that [REDACTED] chosen medical device passed through its hands—albeit briefly—just prior to implantation. The hands of the circulator nurse and scrub nurse assisting [REDACTED] [REDACTED] are already charged and paid for in the hospital’s OR fees. This certainly does not justify an additional \$50,000.00 mark up. A closer comparison of the roles of HealthEast and ANS with regards to the implants demonstrates this.

1. The extent of HealthEast's services with regards to the surgical implants

Despite the fact that the Workers' Compensation Court of Appeals' rule appears to require no comparison of the relative roles of HealthEast and ANS (*see* Troyer at 9-10), the W.C.C.A. ran through a summary list of those respective roles in support of finding HealthEast the 'healthcare provider.' In doing so, it erred in its analysis of the extent of the hospital's contact with—or added value to—the implants. The Court noted:

- A HealthEast employee ordered the implant components at the request of ██████████ ██████████ Troyer at 9.
- HealthEast was responsible for insuring the correct device was implanted in the correct patient and that sterility was maintained. *Id.*
- HealthEast supplied the facility, equipment, and supplies for the surgery, and except for the surgeon provided all necessary staff. *Id.*

A thorough reading of the deposition testimony of HealthEast St. Joseph's clinical manager of its operating rooms—██████████—shows that the Court's discussion of HealthEast's role with regards to the implants overemphasizes the hospital's importance. The testimony reinforces the fact that HealthEast has already been compensated for the services it provided.

While HealthEast ordered the implant from its pre-approved list, Ms. ██████████ acknowledged that the surgeon specifies what particular implant—including size and make/model number—is required. *Employer/Insurer Ex. 10* at pg. 18-19. The surgeon, rather than the hospital, selects the manufacturer. Ms. ██████████ testified that these particular

implants arrive pre-packaged and sterilized—no additional maintenance or processing is required of HealthEast. Ex. 10 at pg. 20. The components were delivered on-site by personnel from ANS. Stipulated Fact 8, Findings and Order pg. 2. Receipt of a pre-packaged, sterilized device provided on-site by the manufacturer does not justify a \$50,000.00 mark-up.

The Court's reference to insuring that the procedure is performed on the correct patient, and requiring establishment and maintenance of a sterile field in the operating room is equally unpersuasive. As in any other surgery performed in an operating room, proper identification of the patient is necessary, and a sterile field is required. These services were paid as part of the undisputed operating room charge, and have nothing to do with the ANS spinal implants. Employer/Insurer Ex. 7. Most importantly, the operating room staff at HealthEast St. Joseph's (i.e. scrub nurse, non-sterile staff, and circulator nurse) would have been present even if no implants were used in the surgery. Employer/Insurer Ex. 10 at 15. The employer and insurer paid for the services of each of these individuals and their services without dispute as part of the operating room charge. Employer/Insurer Ex. 7. To allow HealthEast to mark-up an implant by \$50,000.00 for providing services for which it was already paid defies logic.

In sum, Ms. [REDACTED] clinical manager for the operating rooms at St. Joseph, testified that HealthEast personnel's contact with the spinal implants was limited to:

- Non-sterile staff circulator receives the device;
- Non-sterile staff verifies the device by reading the packaging information to the surgeon that it is the correct implant;

- Non-sterile staff opens the outer packaging and hands the pre-sterilized device to the scrub nurse; and,
- The scrub nurse places the implant in the sterile field for the surgeon.

Employer Ex. 10 at 18-20

What did HealthEast do—what value is added to the implants by passing them through the hands of a scrub nurse already accounted for in the OR charge? What alchemy transforms the ordering and receipt of a spinal stimulator into a justifiable \$50,000.00 mark-up? To find that verifying a few numbers, opening a pre-sterilized outer package, and then handing the implant to the surgeon somehow bestows upon HealthEast the right to tack on a \$50,000.00 increase over cost of the implant is absurd. More to the point, how is this not indirect billing through a pass-through mark up? It results in exactly the undue costs that the Department of Labor and Industry specifically sought to eliminate through amendment of Rule 5221.0700, subpart 2(A). The W.C.C.A.’s flawed analysis of the policy underlying the rule, coupled with its incorrect ‘totality of the surgical procedure’ test is manifestly evident.

2. The extent of ANS’ services with regards to the surgical implants

In attempting to dispense with ANS as the ‘healthcare provider’ of the implants, the W.C.C.A. makes two flawed determinations. First, it minimizes ANS’ role in the surgical procedure, and second states that even that analysis is unnecessary as no matter the level of ANS’ involvement, it would not be the ‘healthcare provider’ due to

application of the Court's misguided 'totality of the surgical procedure' rule. Troyer at 9-10. Application of this manufactured rule is nonsensical.

The hospital's significant role in Mr. Troyer's surgery is clear. It provided a sophisticated medical facility as the site of the procedure and subsequent care. It provided skilled personnel to assist the surgeon in the operating room. As demonstrated by its extensive, itemized billing, it both charged for and was paid for these services. Employer/Insurer Ex. 7. The hospital also seeks to bill a separate charge for the medical implant itself. Its role in providing this device, not already accounted for by other services and charges, is miniscule. ANS' role as to the implants—the design, testing, and manufacture; along with ANS' role in Mr. Troyer's surgery is large by comparison. This is another basis upon which this Court can determine who is the 'healthcare provider' of the medical device.

Contrast HealthEast's extremely limited role as it relates to the implants with that of ANS. HealthEast did not develop, test, manufacture, or even select the spinal implant. ANS developed, tested and manufactured it. Additionally, HealthEast St. Joseph's clinical manager of surgery testified that, as in any other surgical implantation of a spinal stimulator, an ANS representative would have been present in the operating room prepared to assist the surgeon with any questions on implantation of the device, and to provide alternate-sized equipment for implantation. Employer/Insurer Ex. 10 at 24-26. She testified:

Q. And what is that representative doing while the surgery is taking place, if you know?

- A. They could be just standing there waiting.
- Q. Okay.
- A. And once the decision is made for the device, then they'll know what the surgeon is needing, and then anticipating questions.
- Q. So there may be some dialog that takes place?
- A. Right.
- Q. The surgeon may have some questions. Would there be any conversations between the circulator and the scrub nurse and the representative, or is it pretty much between the surgeon and the representative?
- A. There might be a conversation between the rep and the tech, if there was a question on a piece when they opened it up, opened up the packaging, just for clarification on something.
- Q. What sort of thing—conversation would there be between the surgeon and the rep, what would be some things the surgeon may ask?
- A. “Does it go this way?”
- Q. Okay.
- A. It's very difficult to say, you know, there's a myriad of questions that they...I'm not sure.

Id.

The W.C.C.A. attempted to diminish ANS' significant efforts in providing time, ingenuity, and economic resources. Additionally, it disregarded ANS's service of providing trained personnel to assist the surgeon, by adopting the Compensation Judge's notation that “there is no evidence describing what the ANS representative actually did...” Troyer at 9. This statement misses the point.

Consider the analogy of the firefighter. A firefighter stands ready to respond to a call anytime—day or night. Under the W.C.C.A.'s rationale, the only time a firefighter

provides a service to the public is if he/she is actually fighting a fire. The preparation, training, and time spent at the firehouse between fires—ready to respond when his/her skills are needed—are apparently meaningless. Obviously this is absurd. The presence of trained personnel to assist the surgeon specifically with regards to the implant, if necessary, is not irrelevant. ANS provided a service to Mr. Troyer by not only producing the devices required to cure or relieve the effects of his injury; not only by bringing the device selected by the surgeon on-site, but by training and providing personnel to assist the surgeon in the operating room. ANS personnel stood ready to provide advice, expertise, and even additional devices if needed by the surgeon.

A brief summary of the relevant undisputed facts demonstrates that ANS—not HealthEast—is the healthcare provider for the medical implants:

- HealthEast did not develop, test, manufacture, choose, stock, or sterilize the implants used in Mr. Troyer’s surgery.
- The surgeon, [REDACTED] not HealthEast—selected the specific implant components, directed HealthEast to order them for Mr. Troyer’s surgery, and then implanted them.
- The employer/insurer paid [REDACTED] [REDACTED] for his services.
- The employer/insurer paid HealthEast for providing the location of Mr. Troyer’s surgery and skilled nursing care through OR and room and board charges. The hospital was paid for the facility it provided.

- The circulator and scrub nurse are normal personnel in the OR, not special additions for the implant surgery. The hospital was paid for the staff that it provided.
- The employer and insurer paid HealthEast for other supplies used in the procedure on which the hospital incurs overhead costs—as contemplated by the rule. The hospital was paid for the supplies it provided.
- ANS—not HealthEast—manufactured and provided the implant components.
- ANS’ representative was present in the operating room to consult and assist by answering any questions that the surgeon had about the device, its placement, and performance.

All of the hospital’s services in conveying the implant from ANS to the surgeon have been paid. The hospital has imparted no additional value to the implant for the employee. The OR services, OR personnel, and surgical preparation and sterilization procedures would have been the same if implants were not a part of the surgery. All of those services—the facility, supplies, and staff—have been paid for by the employer and insurer. By any measure of comparison, ANS—not HealthEast—is the healthcare provider actually furnishing the spinal stimulator implant system. ANS’ charge—the cost of the implant (\$24,400.00, not \$73,320.00)—is the basis for what is payable.

II. The Court committed an error of law in determining that the compensation judge does not have the authority to determine the reasonable value of the surgical implant hardware up to a cap of 85 percent of the hospital's usual and customary charge pursuant to Minn. Stat. 176.136, subd. 1b(b); and in finding that the reasonable value of the hardware was 85 percent of HealthEast's usual and customary charge.

The W.C.C.A. determined that the plain language of Rule 5221.0700 does not apply, and that HealthEast—rather than ANS—was the healthcare provider able to bill for the spinal implants. The Workers' Compensation Court of Appeals then adopted HealthEast's argument that the employer and insurer must pay 85 percent of HealthEast's usual and customary charge for the medical device, and that the compensation judge does not have authority to determine a reasonable value of the implanted devices at an amount less than 85 percent of the hospital's charge. Troyer at 11-12. This determination is incorrect as a matter of law. The W.C.C.A. ignored the policy considerations of Minn. Stat. 176.136. It disregarded the fact that all provisions under this section which regulate and assure reasonable medical costs require independent judicial oversight in order to further those policy considerations. And, it misinterpreted the plain language of the statute.

A. The consistent provision for independent judicial review throughout Minn. Stat. 176.136 furthers the policy of ensuring reasonable costs to employers for medical benefits to injured workers.

The legislature set out its intent in the first section of the Workers' Compensation Act: the statute is to be interpreted to “assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter.” Minn. Stat. 176.001 (2000) (emphasis

added). Section 176.136 of the Act deals with provision of medical services at a reasonable cost to employers. Through this section, the legislature set out different methods to regulate and assure reasonable medical costs.

Minn. Stat. 176.136, subd. 1a sets up a Relative-Value Fee Schedule. Here, within the limits imposed by the statute, the Commissioner determined the reasonable value of specific services, articles, or supplies through the rule-making process. Independent judicial review is provided by an administrative law judge as part of the rule-making process.

In Minn. Stat. 176.136, subd. 2, the legislature barred payment of certain medical charges altogether, deeming and listing them ‘Excessive.’ It included a provision to allow the Commissioner to implement and further clarify what is excessive through the rule-making process—again with independent judicial oversight by and ALJ as part of that process.

Minn. Stat. 176.136, subd. 1c addressed charges for Independent Medical Examinations.

Minn. Stat. § 176.136, subd. 1b—the provision at issue here—specifically limits payor liability for services not covered by the relative-value fee schedule. It carves out separate limits for services that are not covered by subdivisions 1a (Relative-Value Fee Schedule), 1c (Independent Medical Exams), or subdivision 2 (Excessiveness). Subdivision 1b(a) controls for small hospitals. Judicial oversight guarantees the reasonable cost of medical benefits at small hospitals. The Commissioner or a

compensation judge may review those charges to determine whether they are unreasonably excessive. *Id.*

Subdivision 1b(b) controls for large hospitals with more than 100 beds like HealthEast St. Joseph's. It reads:

“The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a or 1c or paragraph (a) shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph.” Minn. Stat. § 176.136, subd. 1b(b).

Under subd. 1b(b), there is a specific mechanism to ensure that medical services to injured workers at large hospitals are provided at a reasonable cost as the legislature intended. As with subdivisions 1a (Relative-Value Fee Schedule), subdivision 1b(b) (Small Hospitals), and subdivision 2 (Excessiveness), this mechanism specifically allows for judicial review in order to ensure that billing practices by large hospitals comply with the legislative directive to provide care a reasonable cost. This provision grants authority and discretion to the commissioner or compensation judge to determine the reasonable value of services, articles, or supplies. *Id.* The policy underlying this grant of authority is to provide an independent judicial check against unreasonable charges by hospitals for services not covered by the fee schedule.

Subdivision 1b(b) also provides a possible alternative to direct judicial review for reasonableness. As with subdivision 1a, the commissioner, by rule, may establish the reasonable value of the medical service in lieu of the 85 percent limitation. *Id.* Under that option, there would be transparency during the rule-making process to determine specific reasonable charges, with independent judicial review as part of that process. No such rule has been implemented. Therefore the safety catch remains direct judicial review of large hospital charges for reasonableness.

By way of comparison, the language granting a compensation judge the authority to determine the reasonable value of a service covered by the Fee Schedule is not explicitly provided in subd. 1a. The explanation for this is elementary—the Commissioner regulates allowable fees for various medical services through the rule-making process. Judicial review has already taken place. The reasonable value of the service or item has been established through the rule-making process by the Commissioner. The rules specifying those values were scrutinized by an administrative law judge as part of the rule-making process. In other words, the Commissioner—subject to judicial review in the rule-making process—acts as an independent safeguard to assure the reasonableness of any charges under the fee schedule.

For large hospitals, the statute caps, rather than specifies, the reimbursement amount. It does so at 85 percent of the hospital's usual and customary charge or 85 percent of the prevailing charge. The legislative policy contemplates the fact that these larger institutions—with their significantly larger economies of scale and revenue streams—can absorb reimbursement at less than their full charge. This is exemplified by

the language in Minn. Stat. 176.136, subd. 1b(a), which pertains to small hospitals.

There, the statute reads:

“The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a small hospital shall be the hospital’s usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive.” Id.

This section mandates payment at 100 percent of a small hospital’s charges, yet still provides oversight by the commissioner or compensation judge to ensure that the charges are not unreasonably excessive. By enacting subdivision 1b(a), the legislature furthers its policy of ensuring that a smaller institution with less economy of scale and a less-certain revenue stream is adequately protected. It guarantees that institution 100 percent of its usual and customary charge—so long as that charge is not unreasonable—per independent review by the commissioner or a judge. This is consistent with having independent review for reasonableness.

By granting a judge the authority to review certain charges for large hospitals with more than 100 beds, subd. 1b(b) acts as a check on any unreasonable ‘usual and customary’ charge by an individual hospital, or ‘prevailing charge’ determined by compiling charges from multiple hospitals. Otherwise, the only basis to determine a reasonable charge for a large-hospital service or item outside the fee schedule is whatever the hospitals choose to set as a charge. Both the ‘usual and customary’ and ‘prevailing charge’ fees are set by hospitals without oversight.

The ‘prevailing charge’—without independent judicial review—cannot be the safeguard intended by the legislature to protect against unreasonable ‘usual and customary’ billing. The hospitals alone set the fee without scrutiny or review. The very hospitals from which data is gathered to set a ‘prevailing charge’ are likely passing on significant mark-ups. As indicated in the Statement of the Case, this matter is one of many currently pending on the issue of pass-through mark-ups on implantable medical devices. Many of those other cases involve the same hospitals—likely engaged in the same mark-up practices—that HealthEast’s charges must be compared to under the ‘prevailing charge’ theory.

In its decision, the Workers’ Compensation Court of Appeals failed to address the Act’s consistent requirement for judicial review to ensure delivery of medical benefits to employees at a reasonable cost to employers. If upheld, only large hospitals would have no effective judicial review of their charges. Only large hospitals would be free from independent oversight. This inconsistency advocated by the W.C.C.A. cannot be overstated. Charges under the Relative-Value Fee schedule and charges by small hospitals are all subject to judicial scrutiny. Only large hospitals would have carte blanche. If a large hospital chose to charge \$1,000,000.00 as a ‘usual and customary’ charge for the devices implanted by [REDACTED] or if a number of large hospitals chose to charge \$1,000,000.00 for that same device under a ‘prevailing charge’, there would be no basis to challenge the amount. This is directly contrary to the intent of the legislature set out in the first sentence of the Act.

B. The Relative-Value Fee Schedule is not at issue

Rather than address the consistency of allowing for judicial review throughout Minn. Stat. 176.136, the W.C.C.A. instead briefly noted that the “legislature directed the Commissioner to enact a relative-value medical fee schedule which ‘must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect.’” Troyer at 10 (citing Minn. Stat. 176.136, subd. 1a). While the Court failed to expand on this statement, it appears to attempt to tie the directive of a 15 percent reduction under the fee schedule then in effect directly to the 85 percent ‘usual and customary’ or ‘prevailing charge’ provisions of subd. 1b(b). In other words, 85 percent must be the mandatory reimbursement percentage—rather than a cap—as it would result in a 15 percent reduction from the previous fee schedule. This analysis fails for two reasons.

First, the Relative-Value Fee schedule is not at issue in this case. Reference to the legislative directive in Minn. Stat. 176.136, subd. 1a—the Relative-Value Fee Schedule—is irrelevant. As discussed above, in order to regulate and assure reasonable medical costs, the legislature carved out separate subdivisions under section 176.136. Subdivision 1a—the section cited by the Court noting the directed 15 percent reduction—does not pertain to large hospital charges under subd. 1b. Subdivision 1a required the Commissioner to fashion a new relative-value fee schedule in which he set specific non-hospital charges through a judicially-reviewed, annually adjusted, conversion factor. Minn. Stat. 176.136, subd. 1b—the provision at issue in this case—specifically limits payor liability for services not covered by that Relative-Value Fee Schedule.

Second, the Fee Schedule determines the reasonable value of certain charges with regulated annual adjustments. Under the W.C.C.A.'s analysis, a hospital—or hospitals under the 'prevailing charge'—could set their charge for medical implants without review. There would be nothing to stop charges with mark ups from jumping 25 percent to 500 percent from year to year. How would allowing hospitals to collect 85 percent of those unregulated increases accomplish the legislative direct to reduce overall costs by 15 percent? To equate the directed 15 percent reduction under subd. 1a—the Relative-Value Fee Schedule—which has undergone judicial oversight, with a mandatory 85 percent payment to hospitals under subd. 1b(b) without allowing independent judicial review is absurd.

C. The plain language of Minn. Stat. § 176.136 does not mandate payment at 85 percent of the 'usual and customary' rate

If the meaning of a statute is unambiguous, the Court must interpret the statute according to its plain language. Molloy v. Meier, 679 N.W.2d 711, 723 (Minn. 2004). The plain language of Minn. Stat. 176.136, subd. 1b demonstrates that the legislature intended to grant the Commissioner or compensation judge the authority to determine the reasonable value of a large hospital's charges limited to a maximum cap of 85 percent of the 'usual and customary' or 'prevailing charge.'

Consider the compulsory nature of subd. 1b(a), which controls for charges of small hospitals.

“The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a small hospital shall be the hospital's usual and customary charge, unless the charge is determined

by the commissioner or a compensation judge to be unreasonably excessive.”

Minn. Stat. § 176.136, subd. 1b(a)

“The liability of the employer...shall be the hospital’s usual and customary charge...”

Id. (Emphasis added.) ‘Shall be’ expresses “compulsion” or “obligation.” Webster’s New World Dictionary at 568 (1996.) The plain language requires payment at 100 percent—while maintaining the compensation judge’s authority to determine whether or not that charge is unreasonably excessive.

Contrast this with the controlling clause of subd. 1b(b):

“The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a or 1c or paragraph (a) shall be limited to 85 percent of the provider’s usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph.”

Minn. Stat. § 176.136, subd. 1b(b).

The key clause reads “... shall be limited to 85 percent of the hospital’s usual and customary charge, or... prevailing charges...” Id. (Emphasis added.) To ‘limit’ is to “draw a boundary”, or is the “greatest amount allowed.” Webster’s at 360. Subdivision 1b(a) says ‘shall be’. Subdivision 1b(b)—the provision at issue—says ‘shall be limited to’. ‘Limited to’ has no meaning if not to provide a cap. By capping payor liability at 85 percent for large hospitals, the legislature set the upper limit—not a conclusive percentage for reimbursement. It then subjected this limit to the authority and scrutiny of

the Court to determine the reasonable value of treatment, articles, or supplies. Minn. Stat. § 176.136, subd. 1b(b).

If the legislature had intended 85 percent to be the fixed amount for reimbursement of large hospitals, it would have used the same obligatory language employed in subd. 1b(a)—‘shall be’ 85 percent. It did not do so. Any attempt to equate ‘shall be limited to’ with ‘shall be’—particularly within the same statute—is unpersuasive. Such an interpretation would subject small hospitals to examination for potentially unreasonable charges while cloaking large hospitals’ billing under impenetrable secrecy. For them there would be no transparency or scrutiny of any charge they choose to set.

The W.C.C.A. correctly rejected the trial court’s baffling explanation² of the use of the word ‘limited’ twice in subd. 1b(b) as a potential explanation for why 85 percent is a mandated amount. But it developed an equally unpersuasive argument in an attempt to reconcile the legislature’s use of ‘shall be’ and ‘shall be limited to.’ Troyer at 12. The Court agreed that the legislature’s use of ‘shall be limited to’ was intentional and that the amount owed by an employer and insurer might be less than 85 percent of the ‘usual and customary’ or ‘prevailing charge.’ *Id.* Incredibly, the W.C.C.A. then reasoned that no comparison need be made regarding ‘shall be’ with ‘shall be limited to’, despite the fact that they occur in the same place—in parallel clauses—of subdivisions related to hospital charges. *Id.* Under the Court’s confused analysis, ‘shall be limited to’ is instead tied to the Commissioner’s authority to “establish the reasonable value of a service, article, or

² See Findings and Order, Memorandum at 7.

supply in lieu of the 85 percent limitation in this paragraph” in the last sentence of subd. 1b(b). Id. In other words, while ‘shall be limited to 85 percent’ is not a mandated amount according to the W.C.C.A., it is only a cap insofar as it relates to the Commissioner’s authority to establish a separate reasonable value by rule. This tortured attempt to explain the plain language 85 percent cap in subd. 1b(b) makes no sense.

If subd. 1b(b) read ‘shall be’ rather than ‘shall be limited to’ the Commissioner could still establish a different reasonable value by rule. The power of the Commissioner is not contingent upon ‘shall be limited to.’ The statute sets a cap on large hospital fees. It provides the safety catch for a judge to review those fees within the cap to make sure they are reasonable—consistent with the intent of the legislature in section 176.001. As an alternative, the Commissioner can establish the reasonable value through rule-making—as he did in the Fee Schedule—subject to judicial review as part of that process.

The correct analysis does not require semantic gymnastics. The statute should be read by its plain language—that ‘shall be’ and ‘shall be limited to’ cannot have the same meaning. The first sets an absolute percentage, while the second sets an upper limit. This is particularly persuasive given that they address the same subject matter—the liability of the employer and insurer for the charge—and occur in parallel provisions of the statute that deal with small and large hospitals, respectively.

D. A determination that Minn. Stat. § 176.136, subd. 1b mandates payment at 85 percent of a hospital’s usual and customary charge leads to an absurd result

In analyzing a statute, the language of the legislature should not be interpreted to lead to absurd or contradictory results. Fink v. Cold Spring Granite Co., 115 N.W.2d 22,

30-31 (Minn. 1962). If the statute mandates payment at 85 percent of the hospital's charge, it leads to an internally inconsistent result by rendering an entire clause superfluous. Under the W.C.C.A.'s interpretation, the clause that reads, "...the compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount," is meaningless. The judge's only function is to rubber stamp the hospital's charge. According to the W.C.C.A.'s failed analysis, subdivision 1b(b) is the only section of Minn. Stat. 176.136—the provision for ensuring medical services are provided to employees at a reasonable cost to employers—that does not allow for independent judicial scrutiny of charges.

The correct interpretation of Minn. Stat. 176.136, subd. 1b(b) sets the upper limit for reimbursement at 85 percent—yet within that limit, reason may compel a lesser charge. In this case, HealthEast seeks to impose a \$50,000.00 mark-up above the cost of a medical implant device which literally just passed through its hands. On its face, adding \$50,000.00 on top of the cost of the implant components for passing it on to the surgeon seems questionable at best and patently unreasonable at worst. The statute provides the compensation judge with the ability to at least examine the circumstances to see if all or part of such a charge is reasonable. Employer/Insurer Exhibit 8 again is relevant as it provides the necessary context to correctly analyze subd. 1b(b). The actual-cost invoices, taken together with the hospital's bills, show a mark-up of nearly \$50,000.00. If the compensation judge does not have the authority to determine the

reasonable value of the implants, capped at 85 percent, then the hospital reaps a windfall on an implant that OR personnel merely handed to a surgeon.

If the Workers' Compensation Court of Appeals' decision is correct, and the phrase 'shall be limited to...' does not create a cap under which a compensation judge may determine the reasonableness of hospital charges. Then, only two options remain to limit to those charges:

- Whatever the hospital says the charge is under its 'usual and customary' billing; or,
- Whatever other hospitals say the charge is under the 'prevailing rate'.

That this is the 'basis' on which a compensation judge determines reasonableness simply does not make sense. How does this require a determination? In other words, if the clause granting the judge authority "...to determine the reasonable value..." simply means to point out the lower of two numbers—both set by hospitals without oversight—no determination is necessary. The clause is rendered meaningless and leads to an absurd result. The statute could have been written to read, "On this basis, the reasonable value *shall be* the lesser of 85 percent of the usual and customary, or 85 percent of the prevailing rate." It does not. Rather, "...the Commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount." Minn. Stat. 176.136, subd. 1b(b).

The Workers' Compensation Court of Appeals disregarded both the unambiguous plain language, and ignored an entire clause granting review authority—authority inherent in every other pertinent provision of Minn. Stat. 176.136. It may be that upon

review of the factual evidence at a full evidentiary hearing, a court may find that a portion, or even all, of the mark-up is reasonable. But certainly the Court has the power to scrutinize.

In sum, the W.C.C.A.'s analysis of the statute leads to an absurd result. It recognizes that there is a problem with allowing unregulated charges for medical implants by large hospitals. Troyer at 12-13. It discounts the plain language of the statute and the consistent provision of independent judicial review. It constructs a framework which prevents scrutiny for reasonableness. Then, it laments that the statute provides no remedy for the problem of unregulated medical implant charges and soughs off responsibility to solve the problem on to the Commissioner. The W.C.C.A. concludes that rules can be made to solve the problem, yet earlier discounted the very rule—5221.0700—enacted to do so. This is an absurd and contradictory result.

Conclusion

The facts, statutory analysis, and underlying principles of this case are simple. HealthEast attempts to collect a \$50,000.00 mark-up on the implant components that it merely passed from ANS's representative to [REDACTED] [REDACTED] for Mr. Troyer's surgery. HealthEast cannot be allowed to reap a windfall in these circumstances. Through powers delegated by the legislature, the Commissioner promulgated Rule 5221.0700 in order to eliminate unwarranted pass-through mark-ups caused by indirect billing. ANS manufactured the device and provided a service to Mr. Troyer by being present to provide the surgeon guidance, advice, and other implantable components, if needed. The W.C.C.A.'s 'totality of the surgical procedure' test first set forth in Buck-Ulrick, and

relied upon in this matter should be abandoned. ANS is the healthcare provider of the spinal implant components. The employer and insurer respectfully request that this Court reverse the decision of the W.C.C.A. ANS, rather than HealthEast is the healthcare provider of the implant components.

If the Court determines that Rule 5221.0700 does not apply and that HealthEast is the healthcare provider, the employer and insurer respectfully request that this Court reverse the W.C.C.A.'s decision on the second issue. The compensation judge has the authority and discretion to decide the reasonable value of the implant components—capped at 85 percent—under Minn. Stat. § 176.136. This Court should then remand this case to the trial court for an evidentiary hearing to determine the reasonable value of the implanted medical devices.

AAFEDT, FORDE, GRAY, MONSON & HAGER, P.A.

Dated: November 30, 2010

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Certification

I hereby certify that this brief conforms to the requirements set forth in Minn. R. App. P. 132.01, subd. 3 with regards to number of pages, word count, and lines of text. The length of the brief is 10, 136 words, and 38 pages.

A copy of this certificate has been served with the brief on the Court and all parties.

Dated: 11.30.10



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