

NO. A10-1930

State of Minnesota
 In Supreme Court

Ronald E. Troyer,

Employee,

vs.

Vertlu Management Company/
 Kok & Lundberg Funeral Homes and
 State Auto Insurance Company,

Employer and Insurer-Relators,

and

HealthEast Care System,

Hospital-Respondent.

**BRIEF OF AMICUS CURIAE
 INSURANCE FEDERATION OF MINNESOTA**

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I.

INTRODUCTION

The Insurance Federation of Minnesota, (hereinafter “IFM”) was granted leave to participate as Amicus Curiae by Order of the Supreme Court dated November 19, 2010. The IFM joins in the position of Relators in asking this Court to reverse the Workers' Compensation Court of Appeals and remand for determination consistent with their position.

The IFM is a non-profit state insurance trade association representing approximately 50 insurance companies and several other related organizations.¹

The IFM asks to participate as *amicus curiae* not only for its own membership, but for every employer in the state of Minnesota that is obligated to provide workers' compensation benefits to its injured employees. Besides those involved in a typical insurance agreement, this would include the many self-insured private employers and governmental entities, including the state of Minnesota.

The issues before this Court go to the very heart of the workers' compensation system. Like many insurers that provide a health benefit, the increase in the cost of medical care and treatment has been dramatic. Within the workers' compensation system of the state of Minnesota, of every benefit dollar paid, the cost of medical care and treatment rose from 52 cents in 1997 to 57 cents in 2007.²

The experience of SFM Mutual Insurance Company, the author of this brief, is that currently almost 60 cents of every dollar paid in the workers' compensation system is for medical care and treatment.

¹ Pursuant to RCAP 129.03, the Brief on behalf of the IFM is being authored and the cost underwritten by SFM Mutual Insurance Company, a member of the IFM.

² Minnesota Department of Labor and Industry Workers' Compensation System Report 2008, published July 2010.

The IFM feels strongly that the Legislature and the Department of Labor and Industry have acted to address the staggering cost of medical care and treatment, and the decision of the Workers' Compensation Court of Appeals in the matter before the Court frustrates that very legitimate and appropriate goal.

II.

STATEMENT OF THE CASE

Amicus IFM adopts Relator's Statement of the Case.

III.

STATEMENT OF THE FACTS

Amicus IFM adopts Relator's Statement of the Facts.

IV.

STANDARD OF REVIEW

Amicus IFM adopts Relator's position as to the Standard of Review.

V.

ARGUMENT

I. **The Workers' Compensation Court of Appeals erred in determining that HealthEast is the healthcare provider of the surgical implant hardware, and thus entitled to bill the employer and insurer pursuant to Minn. Rule 5221.0700 (2) A(2).**

IFM joins in Relator's position that the Minnesota Workers' Compensation Court of Appeals erred in its interpretation of Minn. Rule 5221.0700 and M.S. 176.136.

Relator has very succinctly outlined the stipulated facts and legal issue before the Court, and Amicus IFM joins in their position that ANS is a healthcare provider, and by any reasonable review, the healthcare provider that actually furnished the service, article or supply to the injured worker.

The crux of this matter has to do with the interpretation of Minn. Rule 5221.0700, subpart (2) A(2). The history of this rule requires examination for resolution. Initially, Rule 5221.0700 (1991), in relevant part, reads as follows:

Subpart 1: Usual charges. No provider shall submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensation injuries.

Subsequently, the statute was amended in 1993, and specifically addressed how to limit excessive billing created by indirect billing procedures. As part of that process, the Department of Labor and Industry promulgated the Statement Of Need And Reasonableness (SONAR), employer and insurer Exhibit 16. The SONAR addressed the exact circumstance before this Court under the heading "indirect billing for services," which reads as follows:

Some providers include on the billing statement the service and charges provided by another healthcare provider under referral from the treating doctor. This combined billing creates difficulties for the payer in determining the reasonable payment for that outside service. For example, **charges for a**

lumbar brace prescribed by the treating provider and ordered from a separate business entity may be billed by the ordering facility. The bill charge may include the cost of the brace to the provider plus a markup of up to 40 percent. (Emphasis added.) (Employer and insurer Exhibit 16, pages 34, 35.)

Item A of Exhibit 16 discusses the proposed remedy. The remedy contemplates the direct billing by the healthcare provider actually providing the services.

Billing the payer directly allows the payer to review the charge for a service or supply and assess the reasonableness of the charge or compare the charge with other similar services. **The problem of markup for services provided by another business entity but billed by the referring provider is avoided, thus reducing costs and minimizing disputes.** (Emphasis added.)
Id. page 36.

Item A goes on to address the type of charges likely to be directly billed under this provision.

...this item applies, but is not limited to, charges for services, supplies or articles that are often referred out, including diagnostic imaging, lab and pathology testing performed by other than the ordering healthcare provider; **equipment, supplies, and medication not ordinarily kept in stock and ordered specifically for a patient from another entity.** (Emphasis added.)
Id.

As a result of that review, the rule applicable in this matter, 5221.0700 2 (A) was adopted in 1993, and reads as follows:

Charges for services, articles and supplies must be submitted to the payer directly by the healthcare provider actually furnishing the service, article or supply. This includes but is not limited to the following: Sub. 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.

It is undisputed that the ANS' implants and components, the subject of this litigation, were:

1. Not ordinarily kept in stock by the hospital; and
2. Purchased from a supplier for a specific employee.

The inquiry then must turn to the Workers' Compensation Court of Appeals' determination that ANS is not a healthcare provider, which they found dispositive.

The Workers' Compensation Court of Appeals is an administrative agency and the scope of its authority is strictly confined to the jurisdiction granted to it by the Legislature, Quam v. State, 391 N.W.2d 803, (Minn. 1986). It does not have the power to invalidate rules duly promulgated by another agency. 391 N.W.2d at 809. Unfortunately, it appears they have done just that in determining whether ANS is not a healthcare provider.

“Healthcare provider” as used in Rule 5221.0405 subd. 12, is defined pursuant to Minnesota Statutes 176.011, subd. 24, as follows:

“Healthcare provider” means 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 vendor. (Emphasis added.)

Service or treatment is defined per Rule 5221.0405, subp. 15 as follows:

...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 under M.S. 176.135, subd. 1. (Emphasis added.)

The WCCA specifically expressed concern that this definition “would transform virtually every manufacturer of custom medical devices or surgical components not kept in stock by a hospital in to healthcare providers.” (Troyer at 8.)

As stated by the Relator, “that is [in fact] precisely the point.”

There can be no reasonable reading of the rules without determining that a manufacturer or supplier of such a product, specifically not kept in stock in the normal stock of the hospital and

ordered specifically for a patient, is a healthcare provider pursuant to M.S. 176. The Court of Appeals must be reversed in determining that ANS is not a healthcare provider.

IFM does not suggest this is dispositive of the issue. Mr. Troyer was attended by three distinct healthcare providers as defined by M.S. 176; the hospital, the surgeon, and ANS, the provider of the spinal cord stimulator implant system.

The question then becomes, which healthcare provider “actually furnished the service, article or supply?”

The Workers' Compensation Court of Appeals has determined that because 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,” ANS could not be a healthcare provider. While this may be technically true as to the implant components, it is irrelevant to the statutory definition of service or treatment per 5221.0115. If this definition is adopted, it would essentially eliminate any application of 5221.0700 to any “supply, product or other thing,” which are clearly contemplated by the Rules.

It must be emphasized that this is not a circumstance where a hospital has special ordered a product for a specific patient, and then engages in extensive preparation of that product, such as sterilizing, assembling, and transporting, prior to its being provided or applied to a particular patient. Rather, per the stipulated facts, the components were delivered on-site by personnel by ANS, and it would be common practice for this representative of the manufacturer, ANS, to be present in the operating room and, if necessary, consult with the surgeon during the surgical procedure (Facts 8 and 9).

Relator has aptly characterized the Workers' Compensation Court of Appeals' determination as the "totality of the surgical procedure assessment." Carried to its logical extension, the operating room of the hospital, absent the surgeon has "no intrinsic value standing alone and would not cure and relieve the employee from the effects of his personal injuries until used in the surgery." Under this rationale, the surgeon, and only the surgeon, who brings together the expertise, the equipment of the emergency room, and the implant components, would be the billing agent, and the only billing agent.

The SONAR and the rules compel the conclusion that the "mischief to be remedied"³ is the excessive markup of special order products under circumstances where the hospital has little or no involvement with the products, preparation or delivery. Such is the case in the matter before the Court. In this circumstance, the surgeon should bill for his or her services, the hospital for the operating room and attending personnel, and ANS, for the provision of the implant components to Mr. Troyer, each as an independent and separate healthcare provider.

Such a determination would appropriately compensate providers for services rendered. The clear intention of the Legislature was to provide a fair system of providing services to injured workers that reasonably compensates the healthcare providers without excessive or exploitive markups. This benefits not only every employer, private and public, but every consumer and taxpayer by lowering the costs of the most significant benefit under the workers' compensation law. Such an interpretation embraces the plain reading of the statute, rules, and the administrative history

³ M.S. 645.16.

contained in the SONAR, all of which presume that the Legislature intends to favor the public interest as against any private interest.⁴

II. The Workers' Compensation Court of Appeals committed an error of law in finding the compensation judge does not have the authority to determine the reasonable value of surgical implant hardware subject to the cap of 85% contained in M.S. 176.136(1)b(b).

IFM joins the Appellants urging this Court to accept the plain meaning of the language ... “shall be limited to...” contained in M.S. 176.136 (1)b(b) as a boundary or ceiling. This is entirely consistent with the longstanding statutory cannon of construction that “words and phrases are construed according to rules of grammar and according to their common and approved usage; ...”⁵, and the presumption that the Legislature intends to favor the public interest as against any private interest.⁶

Perhaps Amicus IFM is uniquely qualified to argue for this interpretation. Amicus IFM asks this Court to take judicial notice of the fact that the economics of healthcare in the state of Minnesota is not tied to price, whether you call that usual and customary charge or prevailing charge, but rather to reimbursement as defined by a healthcare insurance contract.

Almost all health insurers have contracted with providers for a specific reimbursement rate, and have that ability, through the bargaining power based on the numbers in their covered population. Employers in Minnesota have no such luxury or power in the workers’ compensation arena. They cannot direct treatment to a particular provider or facility unless in a managed care plan pursuant to M.S. 176.1351. The vehicle to protect the employers who do not have this ability to

⁴ M.S. 645.17.

⁵ M.S. 645.08 (1).

⁶ M.S. 645.17 (5).

bargain is the fee schedule, pursuant to M.S. 176.136(1), which sets, in effect, the “rate of reimbursement” as in private insurance contracts.

This safeguard is eliminated when that rate is tied to a percentage of a level that is unilaterally set by the provider, such as “usual and customary or prevailing charge.” As emphasized by Relator, this can be set at virtually any figure, and as long as that is the charge presented to each and every insurer, most of whom have contracts for a much lower reimbursement, it can legitimately be represented as the usual and customary charge. The net result, however, is that the employer community, whether in the private or public sector, will continue to pay this extraordinary markup with no remedy unless there is the inherent judicial power to make a determination of reasonableness pursuant to M.S. 176.001, M.S. 176.135, and M.S. 176.136.

It is this bedrock of judicial review that is necessary to assure the goals of the workers’ compensation law of providing reasonable care and treatment on a cost-effective basis. Amicus IFM urges this Court to find the language of M.S. 176.136.(1)b(b), “not exceeding,” to be a ceiling or a boundary, allowing judicial review of services provided by those hospitals as to the statutorily required reasonableness of care and treatment provided under the Minnesota Workers' Compensation Act.

VI.

CONCLUSION

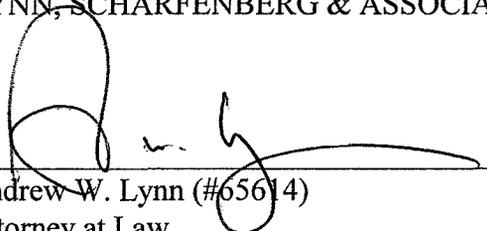
The Workers' Compensation Court of Appeals erred in determining that ANS is not a health care provider pursuant M.S. 176. The facts of this matter are uniquely within the scope of Minn. Rule 5221.0700, and consistent with that rule, ANS is the provider of these surgical components to Mr. Troyer, and should be the billing agent.

Should HealthEast be upheld as the health care provider that provided these articles to the employee, the Workers Compensation Courts retain the power to determine the reasonable value of that service, subject to the ceilings of M.S. 176.136(1)b(b).

Respectfully Submitted,

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DATED: 12-8-10


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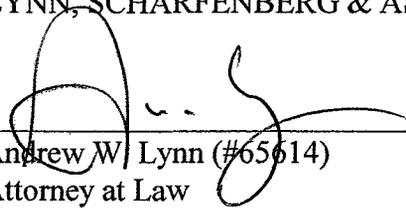
CERTIFICATION OF BRIEF LENGTH

I hereby certify that this Brief conforms to the requirements of Minn. R. Civ. App. P. 132.01, subs. 1 and 3, for a brief produced with a monospaced font. The length of this brief is 380 lines and 2,786 words. This brief was prepared using Microsoft Word Office 2000.

Respectfully Submitted,

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