

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.

REPLY BRIEF OF EMPLOYER AND INSURER- RELATORS

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ARGUMENT

I. As this case involves questions of law, the Court is free to exercise its independent judgment as the standard of review.

The employer and insurer-relators and HealthEast Care System-respondent agree that this Court is free to exercise its independent judgment in this matter as it involves questions of law. (Relator Brief at 6; Respondent Brief at 10). Unfortunately, *amicus* Fairview Health Services attempts to smudge the agreed-upon standard of review by drawing the Court into a lower substantial evidence standard. (Fairview Brief at 2, 7). Fairview reveals its motives for doing so by stating, “It is important to note that the Workers’ Compensation Court of Appeals, a specialized agency of the executive branch, having particular experience and expertise in workers’ compensation matters, has now considered this issue twice and arrived at the same conclusion.” *Id.* at 3. In short, Fairview asks this court to cede its review of this case to the judgment of the W.C.C.A., because they are the experts. (Fairview Brief at 2-3).

Fairview’s attempt to blur the standard of review fails to consider that this case involves only legal issues. The facts are not in dispute. This Court has the expertise to interpret statutes and analyze the intent and appropriate application of rules. This case requires focused legal determinations on how Minn. R. 5221.0700, subp. 2(A)(2) and Minn. Stat. 176.136, subd. 1b(b) are to be applied. Therefore, this Court is free to exercise its independent judgment. Bruns v. City of St. Paul, 555 N.W.2d 522 (Minn. 1996).

II. The plain language of Minnesota Rule 5221.0700, subp. 2(A)(2) prohibits HealthEast from submitting its marked-up for the neurostimulator implants through indirect billing.

Substantial portions of the prior briefing on this matter have involved arguments over which entity is the ‘healthcare provider’ of the implants, and whether or not a ‘service’ has been ‘furnished’ to the employee. This has been in response to the W.C.C.A.’s interpretation of the rule in its prior decisions. (See Buck-Ulrick v. Tri-City Enterprise, 68 W.C.D. 210 (W.C.C.A. May 13, 2008) and Troyer v. Vertlu Mgmt. Co./Kok & Lundberg Funeral Homes (W.C.C.A. October 4, 2010)). There, the W.C.C.A. ignored the plain language of the rule. Instead, it wove its ‘totality of the surgical procedure’ test out of whole cloth. (Relator App. At A-8).

An examination of the plain language of the rule demonstrates that it is unambiguous, self-contained, and by its own definition includes the very charges at issue in this case. Minn. R. 5221.0700, subp.2(A)(2) reads:

A. 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:

- (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. (emphasis added).

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). Consistent

with the rules of statutory construction, language in rules and statutes must be read in conjunction to give meaning and purpose to all parts. Minn. Stat. 645.16.

The focal point here—the controlling phrase—states, “This includes, but is not limited to the following...” Minn. R. 5221.0700, subp. 2(A). (Emphasis added). In other words, the plain language specifically requires that if equipment, supplies, and medications are not ordinarily kept in stock by the hospital and are purchased from a supplier for a specific employee, then they must be included in the billing procedure in the first clause of subp. 2(A). By the rule’s own definition, the ‘supplier’ in subp. 2(A)(2) is necessarily the ‘healthcare provider furnishing the supply’ under subp. 2(A). The rule determines which entity is the healthcare provider furnishing the supply by defining it in subp. 2(A)(2).¹ Any other interpretation neuters the ‘This includes’ language. What would be the purpose of listing definitive criteria that the directive includes—“...supplies...not ordinarily kept in stock by the hospital...purchased from a supplier for a specific employee”—if those criteria do not apply? Under this

¹ Fairview points out that ‘healthcare provider’, as defined in Minn. Stat. 176.011, subd. 24 does not include ‘manufacturer’. (Fairview Brief at 4). It also does not include ‘hospital’. Minn. Stat. 176.011, subd. 24. In a second attempt at misdirection, Fairview states that ‘service’ as defined in Minn. R. 5221.0100, subp. 15 does not include a manufacturer providing an implantable medical device. (Fairview Brief at 4). Again, it does not include hospital. More importantly, it does include a ‘supply’ or “product...provided for the purpose of curing or relieving an injured worker from the effects of a compensable injury...” Minn. R. 5221.0100, subp. 15.

interpretation, the language cannot be read “in conjunction to give meaning and purpose to all parts” of the rule—directly contrary to Minn. Stat. 645.16.

In order to correctly apply Minn. Rule 5221.0700, subp. 2(A)(2), the Court need answer the following questions:

- Are the implant components equipment, supplies, or medications?
- If so, does HealthEast ordinarily keep those implant components in stock?
- If not, are they purchased from a supplier for a specific employee?

If the preceding criteria are met, the supplier must submit its charges for the implant components to payer. HealthEast concedes each fact under this test in the employer and insurer’s favor. (Relator Brief at 4-5). Necessarily, ANS’s charge—not HealthEast’s mark up of nearly \$50,000.00—must be submitted to the payer. This is not only consistent with the self-contained plain language of Minn. R. 5221.0700, but is supported by the policy rationale set forth in the SONAR for revising subp. 2(A) in the first place. (Employer/Insurer Ex. 16 at 36). Additionally, it helps “assure the quick and efficient delivery of ... medical benefits to injured workers at a reasonable cost...” and “...prohibits healthcare providers treating an employee with compensable injuries from receiving excessive reimbursement for their services.” Minn. Stat. 176.001 (2000); Minn. R. 5221.0300 (1993) (Emphasis added).

III. ANS—not HealthEast—is the healthcare provider furnishing the medical implants to the employee.

Rather than apply the plain language, the W.C.C.A. fashioned its own convoluted ‘totality of the surgical procedure’ rule—ignoring the clear directive of Minn. R. 5221.0700.² Troyer at 8-10 (citing Buck-Ulrick at 214). In applying this new rule, it incorrectly determined that HealthEast was the ‘healthcare provider’ that ‘furnished a service’—specifically with regards to the implants—to the employee. Aside from the self-contained definition within the rule, by any measure of comparison ANS—not HealthEast—is the healthcare provider that furnished the implant components to the employee.

A. HealthEast added no value to the employee related to the implants for which it was not compensated.

In an effort to justify its egregious \$50,000.00 mark up for the implant components, HealthEast provides a summary of what went into the employee’s surgery. (Respondent Brief at 5-9)³. Nothing cited in those five detailed pages describes a service to the employee for which HealthEast hasn’t already been paid. (Employer/Insurer Ex.

² Fairview cautions this Court against ‘judicially legislating’ and ‘re-writing the law’ no less than four times. (Fairview Brief at 16, 17, and 19). Interestingly, that is precisely what the W.C.C.A. did here. As advocated by HealthEast and Fairview, it jettisoned the plain language of Minn. R. 5221.0700. Instead, it judicially crafted a ‘totality of the surgical procedure’ test that re-writes the rule.

³ Fairview inaccurately states that HealthEast *determined* the necessary implants per the surgeon. (Fairview Brief at 6). This makes no sense, as the surgeon determined what implants to use, per the stipulated facts. (Relators Brief at 4).

7). From the preparation of the OR for surgery and maintenance of a sterile field to any actions performed by a circulator or scrub nurse—all these services were paid for as part of the undisputed operating room charge. (Employer/Insurer Ex. 7; Ex. 10 at 15).

These services would be provided as part of any surgery and are included in the OR charge. Whether hospital staff perform different tasks from one surgery to another makes no difference. If the surgery takes more time or more hospital resources, the OR charge is higher. (Employer Ex. 10 at 7-8). To allow HealthEast to mark up medical implants to which it added no uncompensated value—no service—to the employee by \$50,000.00 is ludicrous.

B. 'Direct contact' is not the test to determine who is the healthcare provider

HealthEast attempts to distinguish whether or not a service was provided by relying on 'direct contact' with the employee. (Respondent Brief at 17-18; Fairview Brief at 4). This illusionary distinction is easily dispelled. Many staff members in the hospital have no direct contact with the employee, such as the non-sterile circulator and the nurse in the OR. A lab tech performing testing on a blood or tissue sample may never see the patient. By HealthEast's logic, the services of these individuals should not be compensable. As a corollary, HealthEast asks the Court to ignore the fact that ANS provided two trained representatives that were in the OR for Mr. Troyer's surgery. (Respondent Brief at 9). These representatives were prepared to consult with and address any of the surgeon's questions related to the implants. (Employer/Insurer Ex. 10 at 51-53). According to HealthEast, the distance from the patient—rather than the expert

knowledge and availability to provide that knowledge—is the determinative factor on whether or not a service was provided to the employee. If the ANS representatives were in the sterile field, or had touched the employee, apparently ANS would have been magically transformed into a healthcare provider.

Here's another way of looking at it. If HealthEast had to consult with an outside expert on how to handle this specific neurostimulator during surgery, and that expert then billed HealthEast, any attempts to mark-up that consultation bill and pass it on to the employer and insurer would clearly be prohibited. The consultant provided a service to the employee, despite not having had any 'direct contact'. The consultant would be entitled to bill the payer for this service. Here, ANS provided a sophisticated neurostimulator along with two trained representatives in the OR to answer questions and to provide additional components, if necessary. ANS is entitled to bill the payer for this device and these services.

C. 'Referral' is not the test for determining whether or not a charge results in indirect billing prohibited by the rule.

HealthEast and Fairview next attempt to shift the focus away from a \$50,000.00 pass-through mark up by focusing on a second, illusory distinction—whether or not the employee was 'referred' to ANS. (Respondent Brief at 20; Fairview Brief at 9). HealthEast and Fairview argue that since Mr. Troyer wasn't 'referred' to ANS, the entire policy underlying prohibitions on indirect billing should be disregarded. *Id.* This 'missing the forest for the trees' analysis fails to address the material issue. Fairview and

HealthEast ask this Court to swallow the argument that the Commissioner revised Minn. R. 5221.0700 to prohibit indirect pass-through mark ups on a \$40.00 ankle brace, yet not to address a \$50,000.00 mark-up on a neurostimulator. The fact that ‘referrals’ are discussed in the SONAR does not make them some talismanic incantation necessary to prohibit a pass-through mark up. Rather, they are one example of the type of billing practice that the rule seeks to extinguish. Another example is a \$50,000.00 mark-up on an implant ordered for a specific employee that the hospital does not keep in stock.

IV. Concepts of ‘direct’ and ‘indirect’ billing

HealthEast sets out a simple and effective comparison of direct and indirect billing procedures that demonstrates how to properly analyze the core issue here. (Respondent Brief at 10-11). Below is HealthEast’s example, compared with the facts in this case:

Assume that a doctor does not own x-ray equipment.

The doctor sends the patient to an outside entity that employs its own technicians and imaging equipment.

That entity sends the results of the x-rays back to the doctor, who incorporates them into his treatment

Assume that a HealthEast does not own/keep in stock the neurstimulator.

The surgeon specifies a particular medical implant provided by and outside entity—ANS. HealthEast orders this neurostimulator for the specific patient from ANS.

ANS provides the neurostimulator and trained personnel to answer

plan.⁴

If the outside entity bills the payer \$100.00 for the x-rays, it is engaged in direct billing.

If the outside entity bills the doctor's office \$100.00, the doctor pays the \$100.00 charge, and then includes his own billing statement to the payer for a charge of \$125.00, he is "engaged in indirect billing." *Id.*

questions of the surgeon. The surgeon implants the devices as part of his surgery to treat the patient.

If ANS bills the hospital \$24,400.00, HealthEast pays the charge and then includes its own billing statement to the payer for a charge of \$73,200.00, then it is "engaged in indirect billing."

The policy underlying the revision of Minn. R. 5221.0700, subp.2 set forth in the SONAR is clear—the rule was drafted to halt the problem of mark ups for services through 'indirect billing' procedures. (Employer/Insurer Ex. 16 at 36). The rule's language effectively resolves this issue. If equipment, supplies, or medication are not ordinarily kept in stock by the hospital, but are purchased from a supplier for a specific employee, the hospital cannot submit its marked up charge. Minn. R. 5221.0700, subp.2(A)(2). The purported tests of 'direct contact' and 'referral', the references to a 'manufacturer' as opposed to a 'healthcare provider', the deconstruction of whether or not a 'service' was 'furnished' to the employee—this is all sophistry created to circumvent the intent and plain language of the rule. These illusory factors have been sewn together by HealthEast and Fairview to support the W.C.C.A.'s judicially-created

⁴ Note that the x-rays—standing alone—have value to the patient according to HealthEast. They did not become a service once incorporated into the overall treatment plan. HealthEast concedes that this is an example of 'direct billing.' *Id.*

‘totality of the surgical procedure’ rule. They should be rejected and the Court should apply the plain language of the rule to the facts of this case. The hospital’s indirect billing and mark up for medical implants should be denied.

V. The compensation judge has the authority to determine the reasonable value of the surgical implant up to a cap of 85 percent of the hospital’s usual and customary charge.

The Court need only address this issue if it determines that HealthEast is the healthcare provider of the ANS neurostimulator implant. Here, the hospitals attempt to distract the Court by injecting irrelevant complexities into this argument. First, they claim that analysis of Minn. Stat. 176.136, subd. 1b(b) involves interpretation of the language and legislative history of the Relative Value Fee Schedule, and that this leads to the conclusion that 85 percent of a large hospital’s charge is the mandated payment amount. Second, they manipulate the plain language of the statute to carve out a rule that allows large hospitals—and only large hospitals—to avoid judicial scrutiny of their charges. Third, they invoke hidden hospital administrative procedures and vague economic principles to obfuscate the straight-forward determination of what would go into determining a reasonable charge for the implants. Finally, they appeal to fear, arguing that application of the rule will cause the sky to fall, lead to uncertainty, and cause gridlock in the workers’ compensation courts. Each of these arguments was crafted to obscure the fact that the compensation judge’s authority to determine the reasonable value of the ANS neurostimulator—capped at 85 percent—is the only safeguard that

prevents the hospital from reaping a windfall of nearly \$50,000.00 for a device that it added little to no value.

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

This case does not involve interpretation or analysis of the Fee Schedule, contrary to extensive arguments by HealthEast. (Respondent Brief at 24-26, 37-38). Minn. Stat. 176.136, subd. 1b—the provision at issue—is entirely separate from the Fee Schedule. This provision specifically limits payer liability for services not covered by the relative-value fee schedule. It sets separate limits for services, such as for large and small hospitals, that are not covered by subdivisions 1a (Relative-Value Fee Schedule), 1c (Independent Medical Exams), or subdivision 2 (Excessiveness.) Subdivision 1b(b) limits large hospital charges—subject to judicial review for reasonableness—to a cap at 85 percent of the hospital’s usual and customary charge. Despite this, HealthEast argues that the 1993 changes to the Relative Value Fee Schedule support its argument that an 85 percent cap on large-hospital charges is, instead, a mandated amount.

HealthEast strays into 176.136, subd. 1a, which is not at issue in this case.

HealthEast contends that as part of the rule-making process in enacting the fee schedule, the Commissioner selected a conversion factor that sought to accomplish a 15 percent overall reduction from the prior fee schedule. (Respondent Brief at 25). This is true. HealthEast then mistakenly argues that this goal to reduce costs by fifteen percent extends to a mandatory payment of 85 percent of a hospital’s usual-and-customary charge

under Minn. Stat. 176.136, subd. 1b(b). *Id.* at 26-27. This argument has two fatal flaws: 1) the relative-value fee schedule is not at issue in this case; and, 2) extending the directed 15 percent overall fee-schedule reduction to an 85 percent mandatory payment to large hospitals in Minn. Stat. 176.136, subd. 1b(b) does not allow for any review of large hospital charges. This would grant hospitals *carte blanche* to increase charges and frustrate the directed 15 percent reduction.

By way of brief summary⁵, the Workers' Compensation Act carves out different methods to regulate and assure reasonable medical costs. Minn. Stat. 176.136, subd. 1a sets up a Relative-Value Fee Schedule. In that provision, the Commissioner has determined the reasonable value of specific services, articles, or supplies through the rule-making process. Independent judicial review by an administrative law judge provided transparency as part of the process. Minn. Stat. 176.136, subd. 1b—the provision at issue in this case—specifically limits payor liability for services not covered by the relative-value fee schedule. It sets separate limits for services, such as for large and small hospitals, that are not covered by subdivisions 1a (Relative-Value Fee Schedule), 1c (Independent Medical Exams), or subdivision 2 (Excessiveness.) Specifically, subd. 1b(b) limits large hospital charges—subject to judicial review for reasonableness—to a cap at 85 percent of the hospital's usual and customary charge.

⁵ For a more thorough analysis, see Relators' Brief at 24-31.

The second flaw is that equating the directed 15 percent overall fee-schedule reduction with the 85 percent cap on hospital charges in subdivision 1b(b) does not allow for judicial review nor result in the cost reduction that HealthEast claims supports its argument. HealthEast argues that the overall policy goal was to reduce costs by 15 percent, yet claims the compensation judge has no authority to determine the reasonable value below 85 percent of the usual and customary charge or the prevailing rate. If this is the case, a hospital—or hospitals under the prevailing rate—can increase their mark-ups on implantable devices from year to year without scrutiny—while allowing the hospitals to collect 85 percent of those increases. In essence, HealthEast proposes a reading that lets hospitals hide dramatic jumps in charges without fear of discovery. According to HealthEast, so long as they are collecting only 85 percent of those cloaked increases, they're accomplishing the legislative directive to reduce overall costs by 15 percent. This is absurd. HealthEast's argument is littered with references to the Fee Schedule (*See* Respondent Brief at 23-28, 33, 35, 37-38, 43-45. These references should be disregarded. Minn. Stat. 176.136, subd. 1b(b)—which grants a compensation judge the authority to determine the reasonable value of a service at a large hospital capped at 85 percent—not the Fee Schedule, is at issue in this case.

B. HealthEast and Fairview's reading of Minn. Stat. 176.136, subd. 1b(b) leads to an absurd result.

All parties can second guess the statutory language that could or should have been implemented in order to clarify the issue currently before the Court. With that said, the hospitals' interpretation renders the clause "On this basis, 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,” meaningless. The only determination for a judge to make under the hospitals’ ‘plain reading’ is which number is lower—the usual and customary charge or the prevailing charge—both of which are set by the hospitals without judicial review. This is no ‘basis’ for a determination. The hospital sets its usual and customary charge. There is nothing for the judge to determine. For the prevailing rate, while a judge may compare time windows for billing statements, types of medical facilities, and whether enough billing statements have been submitted, in the end a simple number is generated—is it higher or lower than the usual and customary charge? Under the hospitals’ argument, this is the determination for a compensation judge to make in subd. 1b(b). (Respondent Brief at 42).

The ‘basis’ for the compensation judge’s determination is the 85 percent cap. In other words, this is to be used as the cap or ceiling percentage for reimbursement—the judge cannot grant a greater amount. While this percentage will generally suffice, specific facts—such as a \$50,000.00 mark up on a medical implant that the hospital added no value to—may lead the compensation judge to conclude that a lesser amount is warranted. The statute explicitly grants the judge the authority to make that determination.

Equally unpersuasive is HealthEast’s claim that the employer and insurer’s position is directly contrary to Minn. R. 5221.0500 and Minn. R. 5221.0600. *Id.* at 35-36. Contrary to HealthEast’s assertions, we do not advocate a “third alternative” for

determining the reasonable value of a specific medical service, article, or supply. *Id.* Rather, the grant of judicial scrutiny is a check on the capped limitations (usual and customary; prevailing rate) set forth in both Minn. R. 5221.0500 and Minn. Stat. 176.136, subd. 1b(b). It is not a third, separate path to making a determination, but a check—the only check—on unreasonable large-hospital charges. The language in Minn. R. 5221.0500, subd. 2D parrots the language of the statute. HealthEast’s fixation on the fact that it does not contain the specific clause granting judicial review is irrelevant, as a rule specifically refers back to the statute. Minn. R. 5221.0500, subd. 2D begins, “Under Minnesota Statutes, section 176.136, subdivision 1b, paragraph b, payment...”. This language makes it clear that the rule is based upon, and therefore subject to, the statute.

As to Minn. R. 5221.0600, that provision sets forth specific grounds upon which a payer may deny payment of a medical charge. In this case, the employer and insurer are not denying payment of a medical charge. The employer and insurer seek a judicial ruling on who is the appropriate party to-be-paid under Minn. R. 5221.0700; and if that entity is determined to be HealthEast, whether or not the employer and insurer must pay exactly 85 percent of the usual and customary charge without scrutiny or independent review for reasonableness

C. A determination that Minn. Stat. 176.136 caps, rather than requires payment of 85 percent will not result in a flood of complicated litigation.

HealthEast and Fairview argue that recognizing the Court’s power of review to determine the reasonable value of the implant charges will “eviscerate the fee schedule”

and “result in a flood of litigation over what constitutes economically reasonable charges...” (Respondent Brief at 37; Fairview Brief at 18). This hyperbole should be ignored.

First, Minn. Stat. § 176.136, subd. 1b is limited in scope. It applies only to services not contemplated in the extensive relative-value fee schedule. It strikes the correct balance by limiting those hospital charges outside of the fee schedule to a reimbursement cap that is virtually higher than every other source of payment, yet still subject to judicial review.⁶ To be clear, Minn. Stat. 176.136, subd. 1a—the Fee Schedule—does not provide for independent review at an administrative conference or hearing before a compensation judge of each charge in the fee schedule. This is because the Commissioner has determined the reasonable charges for each item in the schedule independently by rule. HealthEast and Fairview’s statements that the employer and insurer’s position could be expanded throughout the statutory and rule scheme enacted in 1992—including the Relative-Value Fee Schedule—are false. (Respondent Brief at 37-38; Fairview Brief at 17). In Friel v. Gibson’s Construction Enterprises, Inc., (W.C.C.A. December 23, 2003), the Court stated that where the Commissioner, by rule, has determined the reasonable value of a service, article, or supply in lieu of the 85 percent

⁶ This is obvious as most every disputed workers compensation case with medical treatment involves multiple intervenors with Spaeth balances. The providers have been paid by other sources, yet are still entitled to additional payment under the worker’s compensation system. Spaeth v. Cold Spring Granite Co., 56 W.C.D. 136 (W.C.C.A. 1996) *aff’d in part, rev’d in part*, 560 N.W.2d 92 (Minn. 1997).

limitation, the more-specific rule applies. *Id.* at 6. In the fee schedule, the Commissioner determined the reasonable value of a whole list of medical services, articles, and supplies. He has not done so with large hospital charges.

Second, Fairview and HealthEast claim that employers and insurers will “be free to deny unilaterally the charges on virtually any pretext...forcing hospitals to prove otherwise before a compensation judge...” (Fairview Brief at 17). Fairview and HealthEast have employed a scare tactic that ignores the safeguards against frivolous challenges. It also disregards the economic unfeasibility of litigation to Minnesota employers and insurers. In challenging a charge, the employer and insurer could still be subject to penalties and interest if the charges are determined to be reasonable or if improperly challenged. Minn. Stat. 176.225. Additionally, Minnesota employers and insurers are subject to the same financial constraints as the hospitals—it simply would not be economically viable to initiate litigation over small charges. This tactic to divert the Court’s attention from a \$50,000.00 mark up on one medical device should not be allowed to succeed.

Third, HealthEast and Fairview claim that the employer and insurer offer no framework upon which a compensation judge can determine a reasonable charge. (Respondent Brief at 39-40; Fairview at 19). That is not at issue here. This case is limited to a determination as to whether a hospital can bill a mark up at all; and if so, can the judge determine whether the charge is reasonable, capped at 85 percent of the hospital’s usual and customary charge. Fairview’s consistent effort to redefine

‘reasonableness’ as ‘economic reasonableness’ is misleading. It is an attempt to cause hesitation by invoking the potential for some arcane economic analysis.

A straightforward approach would be for the compensation judge to examine the cost of an implanted medical device, the charge for the device by the hospital, and what—if anything—the hospital did to justify the difference for which it hasn’t already been paid. The first two pieces of information are available from the hospital. What the hospital did to justify the difference, if anything, and how much that service is worth would involve witness testimony as to what service was performed, and expert testimony as to the value of that service.

Workers’ compensation judges routinely hear expert evidence and make determinations on complex medical issues—from causation of injuries and diseases to the reasonableness and necessity of surgery. Why should we assume they would be incapable of determining a reasonable charge for a hospital’s services that haven’t already been paid elsewhere? In sum, the role of the compensation judge is to make determinations on disputed issues such as those in this case. Minn. Stat. § 176.011, subd. 7a(3). HealthEast and Fairview make an overly-broad argument that seeks to strip the compensation judge of his or her authority and responsibility to decide disputed issues, and replace them with a rigid, unthinking percentage. The Courts have summarily rejected similar arguments.

In Weber v. City of Inver Grove Heights, 461 N.W.2d 918 (Minn. 1990), this Court rejected the interpretation that compensation judges no longer had the discretion to assign a reasonable permanent partial disability rating, following the adoption of Minn. Stat. 176.101, subd. 2a. Compensation judges could do so within a framework outlined by this Court.

This Court also rejected imposition of a rigid percentage scheme that sought to strip compensation judges of their authority and discretion to determine the reasonable value of attorney's fees in Irwin v. Surdyk's Liquor, 599 N.W.2d 132 (Minn. 1999), following the amendment of Minn. Stat. 176.081(1). On remand, the W.C.C.A. outlined a framework that preserved authority and discretion for compensation judges to decide the reasonable value of those issues. Irwin v. Surdyk's Liquor, slip op. (WCCA May 25, 2000.) Reason and intent overrode imposition of a rigid percentage.

HealthEast and Fairview argue that the "uniformity" and "predictability" of payment will no longer exist without guidance as to what constitutes a reasonable charge. (Respondent Brief at 40; Fairview Brief at 19-20). Aside from the fact that this "uniformity" currently allows hospitals to unilaterally charge as much as they like for implants, a framework can be established—as in Weber and Irwin—that outlines factors to be considered in determining the reasonable value of charges.

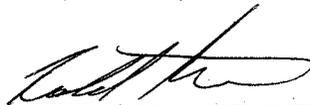
CONCLUSION

Through their unfounded arguments, the hospitals seek to throw open the floodgates, hoping the deluge will conceal or divert attention away from this basic fact—HealthEast charged \$50,000.00 above the cost of the ANS neurostimulator. This is an unjustifiable windfall. Minn. R. 5221.0700 intends to prohibit this. In the alternative, Minn. Stat. 176.136, subd. 1b(b) grants a compensation judge the ability to scrutinize this possible windfall. HealthEast has overreached and brought to light exactly the practice the rule and statute are in place to prevent. The hospitals claim that the employer and insurer are attempting to rewrite the law simply because we do not like it. (Fairview at 20). What we do not like is a billing practice resulting in windfalls to hospitals at the expense of Minnesota employers. The statute intends to prevent this. Minn. Stat. 176.001. The rule at issue seeks to prevent this. Minn. R. 5221.0700, subp. 2A(2). And Minn. Stat. 176.136, subd. 1b(b) opens the practice to scrutiny. It took awhile to be discovered, but it's time for the windfalls to stop. The rule and statute provide clear language and intent to do that.

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

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