

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,

Respondent.

BRIEF OF RESPONDENT HEALTHEAST CARE SYSTEM

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STATEMENT OF THE CASE

This case involves HealthEast Care Systems' ("HealthEast") attempt to collect a nearly \$38,000 past due balance for a hospitalization and surgery performed on Ronald Troyer as a result of admitted low back injuries he sustained during the course and scope of his employment with the employer on November 14, 1995, March 29, 1999 and January 14, 2002.

It is undisputed that the employee's low back injuries are work related, that the hospitalization and surgery in issue were medically reasonable and necessary to cure and relieve Mr. Troyer of his admitted injuries, that the hospital's charges in issue are their usual and customary charges for said services, that there is no claim that those usual and customary charges exceed a prevailing charge and there is no claim that the charges are excessive as defined by Minnesota statute and rule.

The employee's surgery occurred on August 27, 2010 and payment was due within 30 days under applicable statute and rule. Yet, full payment has yet to be made two and a half years after the medical services were provided to the employee at St. Joseph's Hospital (which is owned and operated by HealthEast Care System).

Relators-Employer and Insurer ("employer/insurer") only partially paid the medical charges for the surgical implant hardware used during the

employee's surgery based upon two arguments. First, employer/ insurer contended that the medical supplier that sold the surgical implant hardware to HealthEast was the "medical provider" of the surgical hardware to the employee, as opposed HealthEast; therefore HealthEast was not entitled to bill the employer/insurer for the surgical implant hardware.

Second, employer/insurer contended that as to each of the 28 line item charges on HealthEast's bill, including those charges for the surgical implant hardware, a compensation judge has jurisdiction to make an independent factual determination of the "reasonable value" for each medical service, article and supply provided by a hospital to its patient.

The employer/insurers arguments represent a fundamental disagreement with the clear and unambiguous provisions of the Minnesota Workers Compensation Medical Fee Schedule. Rather than seek modification of the see schedule through the legislative and rule-making processes, employer/inurer seek to judicially rewrite the fee schedule on a case-by-case basis.

HealthEast Care System ("HealthEast") filed a Medical Request on March 11, 2009 seeking payment of its outstanding hospital charges arising out of the employee's low back surgery performed at St. Joseph's Hospital. The matter was heard before Compensation Judge Gary P. Mesna on December 2, 2009 and January 20, 2010 pursuant to Minn.Stat. §176.322

based upon stipulated facts. Judge Mesna issued a Findings and Order on February 3, 2010 finding that: 1) HealthEast was the health care provider that furnished the implant hardware to the employee during the surgery and therefore was entitled to bill for that hardware; 2) a compensation judge's determination of the "reasonable value" of charges of HealthEast was limited to either the lesser of 85% of HealthEast's usual and customary charge or 85% of a lower prevailing charge. Because there was no attempt by the employer/insurer to establish a lower prevailing charge, Judge Mesna awarded payment equal to 85% of HealthEast's usual and customary charges.

The employer/insurer appealed those findings to the Workers Compensation Court Of Appeals. On October 4, 2010 the Workers Compensation Court of Appeals issued a decision affirming the compensation judge. The Workers Compensation Court of Appeals determined that HealthEast was the healthcare provider of the surgical implant hardware and was entitled to bill the insurer for the implant device.

The Workers Compensation Court of Appeals also held that under the plain language of the applicable rules and statutes, the employer/insurer's liability for charges at a large hospital are 85% of the hospital's usual and customary charge or 85% of the prevailing charge unless the Commissioner of the Minnesota Department of Labor and Industry, by rule, establishes a lesser charge. The authority to reduce the employer's liability to less than

85% is limited to the Commissioner through the rulemaking authority. The Workers Compensation Court of Appeals held that the statute does not provide implicit or explicit authority to a compensation judge to reduce the employer's liability below the 85% limitation.

STATEMENT OF ISSUES

- I. Whether HealthEast is the "health care 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 per Minn. Rule 5221.0700, subp. 2.A. (2).**

The Workers Compensation Court of Appeals held in the affirmative.

- II. Whether the compensation judge may determine the reasonable value of the surgical implant hardware in an amount less than 85% of the hospital's usual and customary charge per Minn. Stat. §176.136, subd. 1b (b) in the absence of an asserted, lower prevailing charge.**

The Workers Compensation Court of Appeals held that the compensation judge may not determine a reasonable value of the surgical implant hardware at a rate less than 85% of the hospital's usual and customary charge and therefore the hospital, as a matter of law is entitled to payment in an amount equal to 85% of the hospital's usual and customary charges for the surgical hardware.

STATEMENT OF FACTS

HealthEast agrees with the recitation of the parties' stipulated facts set forth in the brief of employer/ insurer.

Much of employer/insurer's argument centers on the role of HealthEast and Advanced Neuromodulation Systems, Inc. ("ANS") regarding the surgical implant hardware HealthEast purchased from ANS for use in the employee's surgery. A HealthEast representative, [REDACTED] testified that the following actions typically would occur during a surgery such as the employee's from the time a surgeon decides to perform surgery on the patient, through the completion of the surgery at St. Joseph's Hospital.

The surgeon (in this case, [REDACTED]) determines the need for surgery and the surgical hardware to be used during surgery. Exhibit 10 at 16.¹ The surgeon's office then contacts the hospital to schedule the surgery and confirms what the doctor needs for the surgery, including surgical hardware. *Id.* at 17-18. If the hospital does not routinely keep the specific surgical hardware in its inventory (as was the case with the Troyer surgical implant hardware), hospital personnel contact the hardware company (in this case, ANS) to notify it of the surgery and to order the hardware to be used for the patient's surgery. *Id.* at 18-19.

¹ The exhibits identified by number refer to those of Employer/Insurer. The exhibits identified by letter refer to those of HealthEast.

The hardware company delivers hardware to the hospital, either on day of surgery or at some point prior to surgery; *Id.* at 19. In this case, the record is silent as to whether ANS representatives personally delivered the surgical hardware the hospital on the day of surgery, or whether ANS delivered the hardware to the hospital at some point prior to the day of surgery. *Id.*

On the day of surgery, the following then takes place. The hospital's operating room is prepared for surgery. *Id.* at 19. Either a company representative or a member of the hospital surgery team brings the medically sterilized surgical hardware to the operating room. *Id.* at 27.

The patient is brought to the operating room, and a sterile surgical field within the operating room is created. *Id.* at 19-20. The sterile field within the operating room suite is the sterile area in operating room within which the surgical instruments, supplies and equipment that are going to be touching the patient during the surgery are contained. *Id.* at 46-47. Only people who are properly attired are allowed to enter this area. The instrumentation, supplies, implant hardware, and other surgical equipment that may be used during the surgery enter the sterile field according to an established medical protocol that is maintained and monitored by hospital personnel. *Id.* All equipment that is used in the sterile field, including surgical hardware to be used during the surgery, must remain in a sterilized condition. Hospital personnel are responsible for maintaining the sterile condition of the surgical

hardware. *Id.*

Among the hospital personnel present during the surgery are the surgical team members. One surgical team member is the "circulator," who assumes possession and control over the surgical hardware while it is still outside the sterile surgical field. *Id.* at 21-22. Also part of the hospital's surgical team is either a registered nurse or a surgical technician. *Id.* at 15. This person (hereinafter "scrub nurse") then "scrubs in" to become part of the surgery team, which is allowed within the sterile surgical field during the surgery. *Id.* In this case, [REDACTED] a physician employed by HealthEast, assisted [REDACTED] during the surgery by. *Id.* at 36-37.

The patient is prepped for the surgery and brought into the sterile surgical field by hospital personnel. *Id.* at 20. The surgeon begins the surgery and at the appropriate time requests the surgical hardware, piece by piece. *Id.* At that point, the circulator inspects each piece of surgical hardware, and verifies with the surgeon that it is the appropriate hardware required by the surgeon. *Id.* Then, while still outside the sterile surgical field, the circulator begins unpacking the sterile hardware pursuant to established hospital protocol in order to maintain the medical sterility of the hardware. The circulator passes each piece of the surgical implant hardware into the sterile field with the hardware still in a partially unpackaged (but still sterile condition). *Id.*

The scrub nurse from within the sterile surgical field takes the hardware from the circulator and brings each piece of the hardware into the sterile surgical field. *Id.* 48. The scrub nurse then completes the unpacking process and performs any remaining necessary preparation of the hardware, such as irrigation of catheters or application of lubricants to the hardware. *Id.* at 49. Then, the scrub nurse hands the hardware to the surgeon, and if necessary assists the surgeon during the insertion of the hardware into the patient. *Id.* at 21, 49-50.

In this case, following the implantation of the new spinal cord stimulator implant, the circulator and the scrub nurse brought a programming device into the sterile field, placed it over the stimulator implant and confirmed that it was operating correctly. *Id.* at 21-22. Finally, after confirmation that the stimulator was operating correctly, the programming device was removed, the surgery cavity was secured, irrigated, closed, and surgical dressings applied. *Id.* Then, the patient was woken up and taken to the recovery room. *Id.*

Representatives from the supplier/manufacturer of the surgical hardware are sometimes, but not always, present in the operating room during surgery. *Id.* at 29. If present, the representatives are required to remain outside of the sterile surgical field. *Id.* at 49. Once the circulator has possession and physical control over the surgical hardware, the

representative has no further physical contact with the packaged hardware. *Id.* at 49. The representative, if present, may or may not consult with the surgeon or hospital representatives during the surgery regarding questions about the hardware. In this case, two representatives from ANS were present during the surgery. There is no evidence in the records as to whether any actual conversation between the ANS representative, the surgeon or hospital personnel during employee's surgery.

ARGUMENT

I. The Workers' Compensation Court Of Appeals Properly Affirmed The Compensation Judge's Determination That HealthEast Is The "Health Care 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 Per Minn. Rule 5221.0700, Subp. 2.A. (2).

Employer/insurer contend that HealthEast was not the provider of the implant hardware because HealthEast did not keep these components in stock but instead purchased them specifically for employee's surgery. Rather, employer/insurer contend that ANS was the health care provider that furnished the implant hardware to the employee within the meaning of the statute and rules. To allow HealthEast to bill the employer/insurer for the components at a markup, is, Relators assert, is contrary to Minn. R. 5221.0700, subp. 2.A. (2).

The Workers Compensation Court of Appeals found that HealthEast was the health care provider which furnished to the employee the spinal cord stimulator implant hardware used in the employee's surgery, and was entitled to bill the employer/insurer for the hardware, notwithstanding the fact that HealthEast did not keep the surgical hardware in stock and ordered it specifically for the employee's surgery.

This appears to be a mixed question of fact and law. As such, a lower court ruling does not bind this Court, and this Court can independently review the ruling on appeal. *Meyering v. Wessels*, 383 N.W. 2nd 670 (Minn., 1986).

A. Concepts of Direct and Indirect Billing by Medical Providers

The issue of indirect billing arises when a medical service, test, or supply is ordered by one medical provider, but is actually provided to the patient by a second medical provider.

For example, assume hypothetically that a doctor orders an x-ray for a patient. If the x-ray is performed in the doctor's own office, using equipment owned by that doctor's practice, then the doctor's practice has provided the x-ray to the patient. When that doctor then bills the payer for the x-ray test, he is engaged in direct billing. The fact that the doctor's charge for the x-ray test includes the cost of the x-ray film itself and also a "mark up" for the x-ray

equipment and other overhead expenses does not change the fact that the doctor is still engaged in *direct* billing to the payer, because his practice provided the x-ray test directly to the patient.

Assume instead that the doctor's medical practice does not own x-ray equipment and the doctor refers the patient to Acme Diagnostic Imaging, a separate medical entity that employs its own x-ray technicians and owns the equipment used to perform the testing. The patient goes to Acme and has the x-ray performed by Acme technicians, who use equipment owned by Acme. Then, Acme sends the results of the x-ray back to the doctor who originally ordered the test. The doctor then meets with his patient to discuss the results of the x-ray and treatment options. In this instance, when Acme bills the payer for the x-ray testing, Acme is engaged in *direct* billing because it provided the testing directly to the patient.

However, what if instead of sending its bill to the payer directly, Acme sends its bill of \$100 for the x-ray to the doctor's office. The doctor pays \$100 to Acme and then includes on his own billing statement to the payer a charge of \$125 for the x-ray test. By doing so, the doctor is engaged in *indirect* billing.

The reason that this constitutes *indirect* billing is not because the doctor marked up the cost of the x-ray test by 25%. Rather, this constitutes

indirect billing is because the doctor billed the payer for a medical test that was provided to the patient by a different medical provider (i.e. Acme).

B. Minnesota Rule 5221.0700, subp. 2.A. (2) Prohibits Indirect Billing by Medical Providers to Workers Compensation Payers

In cases where an injured employee is treated at a hospital with more than 100 beds (such as HealthEast), a workers' compensation payer is liable for payment at "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." Minn. Stat. §176.136, subd. 1b(b).

Minnesota Rule 5221.0700 sets forth the obligations of a medical provider in the billing of an employer/insurer in connection with medical services provided to an injured employee. The rule includes a prohibition against indirect billing by a one medical provider for medical services provider to the patient by a different medical provider. Minn. R. 5221.0700, subp. 2.A. (2) provides:

A. Charges for services, articles, and supplies must be submitted to the payer directly by the health care 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 health care provider facility, purchased from a supplier for a specific employee.

For purposes of chapter 5221 of the Minnesota rules, a “health care provider” is defined by Minn. Stat. § 176.011, subd. 24, 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.” Minn. R. 5221.0100, subp. 15, defines “service” 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).

The Workers Compensation Court of Appeals considered the intent and history of Minn. R. 5221.0700, subp. 2.A. (2) by examining the Statement of Need and Reasonableness (SONAR) promulgated by the Department and Labor and Industry before the passage of the rule. Exhibit 16. The Workers Compensation Court of Appeals quoted the SONOR as follows:

The SONAR explanation for the amendments to subpart 2 of the rule states, in part:

Indirect billing for services. Some providers include on their billing statements, the services and charges provided by another health care 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 billed charge may include the cost of the brace to the provider, plus a mark-up of up to 40 percent.

The SONAR further provides that item A of the rule:

[r]equires direct billing to the payer from the health care 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 mark-up for services provided by another business entity but billed by the referring provider is avoided, thus reducing costs and minimizing disputes. Prompt payment is facilitated by direct billing because the bill is not sent first to another health care provider, or the employer or employee to be forwarded to the payer. This item applies, but is not limited to, charges for services, supplies or articles that are referred out, including: diagnostic imaging, lab and pathology testing performed by other than the ordering health care provider; equipment, supplies, and medication not ordinarily kept in stock and ordered specifically for a patient from another entity.

Addendum at 8.

C. Minn. R. 5221.0700, subp. 2.A. (2) Does Not Limit The Amount That A Hospital May Charge or be Paid for Surgical Hardware Which It Provides To a Patient During Surgery

Relators argue that Minn. R. 5221.0700, subp. 2.A. (2) prohibits mark ups by a hospital for surgical hardware that the hospital purchases for a specific surgery by prohibiting the hospital from billing a payer for the hardware. The Workers Compensation Court of Appeals correctly held that this argument simply misconstrues the plain language of the rule:

No evidence was submitted as to the manner in which HealthEast determines the amount of its charges or how it priced the facilities, equipment, services, and supplies necessary for the employee's surgery. The amount of any markup was not an issue before the compensation judge nor is it an issue here. Minn. R. 5221.0700, subp. 2.A., does not prohibit a markup on medical supplies purchased by a hospital nor does it set a limit on the amount of a markup. Rather, the rule requires direct billing to the payer from the health care provider actually furnishing the article to the patient. In applying the rule, the amount of any markup is not legally significant. Furthermore, whatever the percentage of markup, the appellants stipulated it was HealthEast's usual and customary charge.

Addendum at 9.

This is correct. Minnesota Rule 5221.0700, subp. 2.A., does not limit the amount that a medical provider may charge a payer for services that it has provided directly to the injured employee. Instead, the rule simply restricts *which healthcare provider may direct bill* a payer for a given medical service—only the healthcare provider providing the service directly to the employee may bill the payer for the service.

Minn. R. 5221.0500, subp. 1.B., establishes *the amount that a healthcare provider may charge* an employer and insurer for its services.²

² **5221.0500 EXCESSIVE CHARGES; LIMITATION OF PAYER LIABILITY.**

Subpart 1. **Excessive health care provider charges.** A billing charge for services, articles, or supplies provided to an employee with a compensable injury is excessive if any of the conditions in items A to I apply to the charge. A payer is not liable for a charge which meets any of these conditions.

* * *

B. the charge exceeds the provider's current usual and customary charge, as specified in subpart 2, item B, for the same or similar service, article, or supply in cases unrelated to workers' compensation injuries;

Minn. Stat. § 176.136, subd. 1b (b) and Minn. R. 5221.0500, subp. 2 establish *the percentage of the provider's charge which is payable* in cases involving workers compensation injuries. This statute and rule discussed in detail later in this brief.

D. HealthEast Was the Healthcare Provider Which Actually Furnished the Surgical Hardware to Employee.

Read together, Minn. R. 5221.0700, subp. 2.A., and Minn. R. 5221.0100, subp. 15 establish this general rule: *Charges for medical services must be submitted to a payer by the "health care provider" who "actually furnished" those services directly "to the employee."* Minn. R. 5221.0700, subp. 2.A. (2) specifically states that this general rule applies when a hospital must special order equipment, supplies and medications for a specific patient because the hospital does not ordinarily keep the equipment, supplies and medications in stock.

Accordingly, as to equipment, supplies and medications not ordinarily kept in stock by a hospital but ordered for a specific patient, the critical determination to be made is *whether the hospital actually furnished the specially ordered equipment, supplies and medication directly to the patient.* If so, then the hospital may directly bill the payer for its charges for the equipment, supplies and medications. This is precisely the determination

that was made in favor of the hospital in this case by the compensation judge and the Workers Compensation Court of Appeals.

The compensation judge and the Workers Compensation Court of Appeals agreed that the evidence establishes that ANS was a medical vender that sold to HealthEast the surgical implant hardware used during the employee's surgery; ANS did not provide a medical service *to the employee*.

ANS had no contact with the employee and provided no treatment or supplies to the employee. HealthEast, on the other hand, performed all of the actions set forth in detail in the factual recitation above in connection with the employee's surgery and the implantation of the surgical hardware. The compensation judge noted:

The evidence also does not suggest that the manufacturer's representative participated in the employee's surgery. All the evidence shows is that there was a representative present in the operating room during the surgery, but that she would not have been permitted to enter the sterile zone, where the surgery was taking place. A reasonable inference from this is that the representative never touched the employee during the surgery. There was no testimony from anyone who was present during the surgery so there is no way to determine what the representative actually did during the surgery.

Findings and Order, Appendix at p. A10

The compensation judge further explained:

...the employer/insurer apparently would like the court to infer that the manufacturer's representative participated in a significant way in this particular employee's surgery... The court does not find that such an inference would be reasonable based on the facts presented in this case. [REDACTED] [REDACTED] did not testify that the surgeon always had significant

questions about the device or that the surgery could not have proceeded without the assistance of the representative. In this particular case, the manufacturer's representative may have done nothing at all during the surgery. The mere presence in the operating room is not necessarily significant.... In the absence of any evidence of what actually transpired in the operating room, it seems no more likely that the representative was present provide vital instruction to [REDACTED] [REDACTED] then she was present to obtain information from [REDACTED] [REDACTED] regarding the development of the product. The fact is, we simply do not know what took place in the court does not choose to make an inference one way or the other.

In any event, even if the representative did answer questions or furnish instructions to [REDACTED] [REDACTED] during the surgery, it would not convert the manufacturer into a healthcare provider. In this case, as in *Buck-Ulrick*, the manufacturer's representative had no direct contact with the employee. The employee was not referred to ANS and no one from ANS examined the employee or determined what ANS product was right for the employee. It was a surgeon who made that determination.

Id. at A10-A11.

The Workers Compensation Court of Appeals agreed with the compensation judge that the role of ANS in manufacturing, testing and delivering the implant hardware to the hospital, and the presence of ANS representatives at the surgery, did not establish the ANS provided the implant hardware to the employee:

There is no dispute ANS manufactured, developed, tested, and delivered the implant to St. Joseph's Hospital. The compensation judge, however, noted the evidence did not establish the device was brought to the operating room by ANS's agent. Nor, the compensation judge noted, did the evidence establish the agent participated in the surgical procedure in any manner. Finally, there is no evidence describing what the ANS representative actually did in this case, if anything.

Addendum at 8.

The Compensation Judge and the Workers Compensation Court of Appeals agreed that the evidence established that HealthEast was the healthcare provider furnishing the surgical implant hardware to the employee during, and as part of, the employee's surgery. The compensation judge stated:

The evidence in this case does not establish that the hospital was a mere conduit whose role involved nothing more than taking the device from the representative and handing it to the surgeon...In any case, the hospital had the responsibility to make sure that the correct device was ordered, the correct device was delivered, the device was installed in the correct patient, and that sterility was maintained. It was the hospital that provided the facility, equipment, and supplies for the surgery, and except for the surgeon, it provided the staff for the surgery including the assistant surgeon.

Findings and Order, Appendix at A10.

The Workers Compensation Court of Appeals agreed with the compensation judge:

It is undisputed a HealthEast employee ordered the implant components from ANS at the request of [REDACTED] the surgeon. HealthEast was responsible for insuring the correct device was implanted in the correct patient and that sterility was maintained. HealthEast supplied the facility, equipment, and supplies for the surgery and, except for the surgeon, provided all necessary staff, including the assistant surgeon.

Addendum at 9.

The plain language of the statutes and rules at issue shows that HealthEast was entitled to bill employer/insurer directly for the services it furnished to employee, including the surgical implant hardware. HealthEast was not attempting to submit indirect markups for medical services from other health care providers. HealthEast did not refer the employee out to have the surgical hardware implanted by a different provider. Rather, HealthEast ordered the surgical hardware from its manufacturer as a part of the employee's overall surgical procedure.

Minn. R. 5221.0700, subp. 2.A. (2) contemplate services, equipment, and supplies provided by health care providers *to the employee*. In the context of a surgical procedure, manufacturers of surgical implant hardware such as ANS cannot be considered such a health care provider because it has furnished nothing to the employee. Rather, ANS was a medical supply vender which sold medical equipment *to a hospital*.

ANS relinquished physical and legal control of the hardware to the hospital upon deliver. After the hospital assumed control over the hardware, ANS had not further contact with the hardware. It did not inventory the hardware, inspect the hardware, unpack the hardware, introduce the hardware into the sterile surgical field or physically assist the surgeon with the implantation of the hardware.

In short, HealthEast and [REDACTED] [REDACTED] controlled every aspect of the medical service provided to the employee during his surgical procedure. As a part of that procedure, HealthEast worked with a surgeon to implant surgical implant hardware purchased by HealthEast from a medical supply vender. In contrast, ANS did not have any direct contact with the employee during the surgery. It was not allowed in the sterile surgical field, and there is no evidence the ANS representative physically touched the employee in any manner during the surgery. This is not the situation that Minn. Stat. § 176.011, subd. 24 prohibits, namely one health care provider marking up charges for services provided by another health care provider.

In addition, as both the compensation judge and the Workers Compensation Court of Appeals recognized, surgical hardware such as that in this case is not a stand-alone medical supply capable of “curing or relieving an injured worker” as contemplated under Minn. R. 5221.0100, subp. 15 until incorporated by a hospital and a surgeon into a surgical procedure. The Workers Compensation Court of Appeals stated:

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. Accordingly, HealthEast was the health care provider under Minn. R. 5223.0700, subp. 2.A.(2), and was entitled to bill the insurer for the implant device.

Addendum at pp. 9-10.

In this case, the “service” contemplated under Minn. R. 5221.0100, subp. 15 furnished by the hospital to the employee was the surgery itself. The surgical hardware used during the surgery is best described as an individual “ingredient” in the final product—the operation.

The surgical hardware HealthEast purchased in this case provided no benefit to the employee in terms of curing or relieving him from the effects of his injury until HealthEast’s skilled medical staff and [REDACTED] [REDACTED] entered the operating room and performed the surgical implantation of the spinal stimulator hardware. This surgical hardware is not like a knee or ankle brace prescribed by an orthopedic specialist, which the patient personally picks up from an independent medical supply company whose personnel fit the patient for the brace.

The back surgery performed by HealthEast was the actual “service” that was “furnished to the employee” to cure or relieve him from the effects of his injury, i.e., a successful back surgery. The surgical implant hardware can only be considered one part of the final service. Because the surgical procedure was the medical service provided to the employee, HealthEast was entitled to bill Relators Employer and Insurer directly for all of its usual and customary charges for that service under Minnesota law.

Employer/insurer accuse the trial court of ignoring ANS’ “significant efforts providing time, ingenuity and economic resources” in the design and

manufacture of the surgical hardware. Employer/insurer Brief at 14. This is incorrect. These efforts of ANS are the same as any manufacture of any type of medical supply. Any manufacturer of a medical supply expends resources in the effort to create, manufacture and sell medical supplies to medical providers. Those efforts, however, do not transform the manufacturer into the healthcare provider who ultimately furnishes the surgery, (including its individual components such as medications, equipment and supplies) to the employee for purposes of the workers compensation medical fee schedule.

ANS did not furnish a medical or health service to the employee when it sold its surgical hardware to HealthEast. Neither HealthEast nor [REDACTED] referred the employee to ANS. ANS had no contact whatsoever with the employee during the surgery.

The surgical implant hardware, standing alone, had no value to the employee when it arrived at the hospital; as merely one small part of the employee's surgical procedure, the hardware cannot reasonably be considered an independent medical service that was actually "furnished" to an employee as contemplated by Minn. Stat. § 176.011, subd. 24, and Minn. R. 5221.0100, subp. 15. Rather, the hardware was sold by ANS to HealthEast for use by trained personnel in a hospital setting. Accordingly, HealthEast remained the health care provider "actually furnishing" the hardware to the employee under Minn. Rule 5221.0700, subp. 2A. (2).

II. A Compensation Judge Does Not Have Jurisdiction to Determine The Reasonable Value Of The Surgical Implant Hardware In An Amount Less Than 85% Of HealthEast's Usual And Customary Charge Absent A Lower Prevailing Charge.

The employer/insurer argue that while the fee schedule provides a ceiling cap of 85% usual and customary or 85% prevailing as to the inpatient charges for a large hospital, the fee schedule also allows a compensation judge to make an independent valuation of each large hospital charge, and to order payment of the charge at a rate lower than either 85% usual and customary or 85% prevailing.

HealthEast agrees with relators that this is a question of law and the standard of review set forth in relators' brief.

Relators argue that a hospital can never be paid more than 85% usual and customary charges, but a hospital could have its charges paid at any lower rate initially deemed "reasonable" by a compensation judge following an evidentiary hearing.

In this case the hospital's bill for the employee's surgery consists of 28 separate charges. Under the approach advocated by the employer/insurer, any or all of these 28 individual charges could be challenged on the basis that they are in an "unreasonable" amount, thereby requiring a full evidentiary hearing as to the reasonable value for each challenged medical service.

The position of the employer/insurer is wrong for the following reasons:

1. It is contrary to the legislative history of the applicable statutes and rules;
2. It is contrary to the plain language of Minn. Stat. § 176.136, Subd. 1b;
3. It is contrary to the clear language of Minn. R. 5221.0500 and Minn. R. 5221.0600;

4. It is contrary to the intent and goals of the fee schedule, and if adopted, would ultimately eviscerate the fee schedule by making it mandatory for hospitals but optional for employers and insurers.

A. 1992-93 Statutory/Rule Changes To Payer Liability For Medical Charges Resulted In A Reduction Of 15 Percent; Calls By The Insurance Industry For Steeper Reductions Were Rejected As Contrary To Legislative Intent

The present limitations on payer liability for medical charges were added to Minn. Stat. §176.136, Subd. 1b(b), in 1992, and to the corresponding rules in 1993.

Before 1992, the limitation of liability for payment of medical charges was set forth in Minn. Stat. §176.135, Subd. 3, (1990). (Exhibit B). The liability of payers was limited "to the charges therefore as prevail in the same community for similar treatment. On this basis the commissioner or compensation judge was allowed to determine the reasonable value of all such services, and the liability of the employer was limited to the amount so determined." *Id.*

Minn. Rule 5221.0500, B, (1990) provided that if a charge was not specified in the medical fee schedule, then the charge was excessive if "the charge exceeds that which prevails in the same geographic community for similar treatment or services." Exhibit C. Thus, before the 1992 changes, a payer's liability for hospital charges was equal to 100% of the prevailing charge of medical treatment in question.

In 1992 the Workers Compensation Act was substantially revised. Among the stated goals of the changes were to reduce workers compensation costs and reduce litigation. As a part of the process, the legislature directed the commissioner to enact a relative value medical fee schedule which resulted in a 15 percent over all reduction from the relative value fee schedule most recently in effect. Exhibit B. (Minn. Stat. §176.136, subd. 1a (1992))

called for the development of a Relative Value Fee Schedule whose conversion factors must reasonably reflect a 15 percent over all reduction from the medical fee schedule most recently in effect).

As to charges of large hospitals, the 1992 statutory changes reduced a payer's liability for from 100 percent of the prevailing charge to *85 percent of prevailing or usual and customary charges, whichever is lower*. Minn. Stat. §176.136, subd. 1b(b) (1992). Exhibit B.

Pursuant to the legislature's directive, the commissioner in 1993 enacted changes to the Relative Value Fee Schedule and Minn. R. 5221.0500, including the definition of "excessive charges" and the limitation of payer liability. As part of the statutory rule making process, the commissioner set forth its SONAR and engaged in an extensive rule making process, which included surveys of the various parties in the workers compensation system. Various drafts of rules were circulated among 25 different groups, and comments were incorporated into the final draft where appropriate. Exhibit 16 at 2. *See also* Exhibit G at 2, 4 (Second Report of the Chief Administrative Law Judge, October 18, 1993).

During the rule making process, the insurance industry requested that the proposed conversion factor for the Relative Value Fee Schedule be lowered because the proposed rates were substantially higher than what was paid under Medicare. In effect, the insurance industry argued that it should not have to pay medical charges at a rate higher than what is used in Medicare.

The Commissioner responded "that it selected the single conversion factor of \$52.05 in order to accomplish a *fifteen percent over all reduction, as mandated by the Legislature*. The approach urged by the AIA [American Insurance Association] and Kemper [National Insurance Company] would

bring about a much more severe cost reduction that would not be consistent with the governing statute." Exhibit G at 18 (Emphasis Added). The ALJ agreed with the rules proposed by the Commissioner, which limited the medical fee reduction to 15 percent rather than the larger reductions urged by the insurance industry. *Id.* at 19.

In this case the employer/insurer urge an interpretation of the fee schedule that would provide for payer liability in amounts substantially lower than either 85% prevailing charges or 85% usual and customary charges. Such a result was urged by the insurance industry during the 1993 rulemaking process and was rejected by both the Commissioner, and the ALJ who approved the applicable rules.

B. The Position Of The Employer and Insurer Is Contrary To The Plain Language Of Minn. Stat. § 176.136, Subd. 1b

1. Overview

The liability of an employer for charges related to inpatient treatment at small and large hospitals is set forth in Minn. Stat. § 176.136, Subd. 1b³.

³ Minn. Stat. § 176.136, Subd. 1b **Limitation of liability:**

(a) 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*. A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds. (emphasis added)

(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

Minn. Stat. § 176.136, Subd. 1b establishes two alternate standards for payment of charges arising from inpatient hospitalizations at small and large hospitals. Small hospitals are entitled to payment of 100% of their usual and customary charge unless the charge is determined by the commissioner or a compensation judge to be “unreasonably excessive.” Thus, for small hospitals, an independent judicial determination of a charge’s “unreasonable excessiveness” is *explicitly* provided by the legislature as a safeguard to charges by a small hospital.

However, for the charges of large hospitals, a different payment rate is established, and a different payer safeguard is provided. The normal payment rate is benchmarked to the specific hospital’s usual and customary rate—at 85% however, instead of 100% of the hospital’s usual and customary charge. As a safeguard against usual and customary charges that might be too high, an employer can establish and make payment at a lower rate of 85% prevailing charge, which is benchmarked to the comparable charges at comparable hospitals.

Finally, in regard to the inpatient charges of large hospitals, the legislature explicitly authorized the commissioner to establish by rule the reasonable value of a service, article, or supply in lieu of the 85% limitation contained in the rule. *Id.*

2. ‘On This Basis ‘ Language

The employer contends that the second sentence of Minn. Stat. § 176.136, Subd. 1b(b) (see footnote 3, *supra*) gives a compensation judge the authority

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. (emphasis added)

to make an independent determination of the reasonable value as to any individual charge of a large hospital for inpatient treatment, even at a level below the 85% "usual and customary" or "prevailing" charge of that hospital.

Thus, the employer/insurer contend there are three possible roads for determining the payment amount for large hospital inpatient charges: (1) 85% usual and customary; (2) 85% prevailing; or (3) whatever "reasonable value" is placed on a medical service, supply or article by a compensation judge following an evidentiary hearing.

The Workers Compensation Court of Appeals correctly held that this argument is directly contrary to the plain language of Minn. Stat. § 176.136, subd. 1b (b) and basic principles of statutory construction:

Minn. Stat. § 176.136, subd. 1b.(a), establishes the liability of the employer for treatment at a small hospital at 100 percent of the hospital's usual and customary charge "unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive." This subdivision of the statute, therefore, specifically provides for review, by a compensation judge, of a small hospital's usual and customary charge. In contrast, Minn. Stat. § 176.136, subd. 1b.(b), establishes the liability of an employer for treatment at a large hospital at 85 percent of either the hospital's usual and customary charge or 85 percent of the prevailing charge, whichever is lower. For a large hospital, therefore, the jurisdiction of a compensation judge is limited to determining which charge is less, 85 percent of the provider's usual and customary charge or 85 percent of the prevailing charge. [citation omitted] That legislative intent is evidenced by the language of the statute which states that "[o]n this basis, the commissioner or a 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 phrase "on this basis" can refer only to the two alternate standards for the liability of the employer.

Addendum at 11-12.

The first sentence of Minn. Stat. §176.136, subd. 1b (b) provides that an employer is liable for payment of a charge at a large hospital for inpatient

treatment at the lower of 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charge. The second sentence, which immediately follows, provides:

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. (Emphasis added)

Minn. Stat. §176.136, Subd. 1b (see footnote 3, supra).

The critical, dispositive language is contained in the qualifying three words "*On this basis*." This language links judge's award payment of medical charges to the alternate methods set forth in the immediately preceding sentence (i.e. 85 percent of "usual and customary" or "prevailing" charge). The words "On this basis" were placed in the statute for a reason—to confirm that the commissioner and compensation judges are to award payment of medical charges of large hospitals at either 85% usual and customary or 85% prevailing, whichever is lower.

Two basic canon of statutory construction, which have been codified into Minnesota law, are as follows:

1. [G]eneral words are construed to be restricted in their meaning by preceding particular words.

Minn. Stat. §645.08.

2. Provisos shall be construed to limit rather than to extend the operation of the clauses to which they refer. Exceptions expressed in a law shall be construed to exclude all others.

Minn. Stat. §645.19.

Under these principles of statutory construction, the language "the commissioner or compensation judge may determine the reasonable value of

all treatment, services, and supplies” is restricted by the preceding language of “on this basis” and the provisions of the preceding sentence which provides only two alternatives for determining the “reasonable value” of large hospital charges—85% of the hospital’s usual and customary charge, or 85% of a “prevailing charge.”

Moreover, the proviso “on this basis” *is to be construed to limit* the language “the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies” rather extend the operative language (as is urged by the employer).

To adopt the interpretation advocated by the employer would require that the qualifying language “On this basis” be ignored in violation of Minn. Stat. §645.08 and Minn. Stat. §645.19.

The employer/insurer argue that this interpretation of the phrase "on this basis" renders the second sentence of the rule meaningless because there is nothing left of substance for the Commissioner or compensation judge to determine. Employer/insurer Brief at 35.

This is incorrect. A compensation judge must determine whether an asserted charge is actually the hospital’s usual and customary charge for a given medical supply or service.

Then, if the employer/insurer assert a lower prevailing charge, the alleged prevailing charge must be analyzed using the criteria of Minn. Rule 5221.0500, subp. 2 B. These criteria include the timeliness of applicable billing statements from other providers, comparison of the types of medical facilities whose billing statements are being compared, whether the billing statement reflect charges for similar types of treatment or supplies, whether enough billing statements have been compiled from the required number of different providers, and the calculation of the prevailing charge itself.

Clearly, the determination of a prevailing charge does require the exercise of discretion by the commissioner or a compensation judge.

3. 'Liability Limited To' Language

The employer argues that Minn. Stat. 176.136, Subd. 1b(b) only sets a ceiling, but not a floor, on a payer's liability for a hospital's charges because it provides that the liability of a payer is "limited to" 85% usual and customary or 85% prevailing charge.

The Workers Compensation Court of Appeals rejected this position and held that this language indicates a legislative intent to provide the commissioner of the Department of Labor and Industry the authority to enact specific rules providing for payment of specific charges at a rate less than either 85% Usual and Customary or 85% Prevailing. The Workers Compensation Court of Appeals stated:

Nor do we agree with the appellants' argument that the 85 percent limitation is an upper limit only. We agree the legislature's use of the phrase "shall be limited to" was intentional and contemplates that the liability of an employer for treatment at a large hospital might be less than 85 percent of the usual and customary charge or 85 percent of the prevailing charge. We do not agree, however, that a compensation judge has jurisdiction to make that determination. The last sentence of Minn. Stat. § 176.136, subd. 1b.(b), provides that "[t]he commissioner may by rule establish a reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph." The plain meaning of the statute is that the employer's liability for charges at a large hospital are 85 percent of the hospital's usual and customary charge or 85 percent of the prevailing charge unless the commissioner, by rule, establishes a lesser charge. The authority to reduce the employer's liability to less than 85 percent is limited to the commissioner through the rule making authority. Nowhere in the statute do we find any implicit or explicit authority granted to a compensation judge to reduce the employer's liability below the 85 percent limitation.

Addendum at 11.

The Workers Compensation Court of Appeals is correct. The language “shall be limited to” contemplates the possibility that the Commissioner of the Department of Labor and Industry through the rulemaking process may enact specific rules which establish a “reasonable value” for a specific medical service at a rate less than what is otherwise provided by the medical fee schedule.

Minn. Stat. § 176.136, subd. 1b.(b) gives the commissioner the authority to “by rule establish a reasonable value of a service, article, or supply in lieu of the 85 percent limitation” is set forth in. This allows the Commissioner to use the rulemaking process to “fine tune” the medical fee schedule via the scalpel of specific, limited, individual rules rather than the bludgeon advocated by the employer/insurer.

If the position of the employer/insurer is adopted in connection with the “limitation” language so that the existing fee schedule creates only a ceiling but not a floor, then every single charge from every medical provider, even those explicitly encompassed by the Relative Value Fee Schedule, will be subject to independent judicial valuation at the request of the employer/insurer. This is because that portion of the statute dealing with the Relative Value Fee Schedule also speaks in terms of “limiting” the employer’s liability for services included in the fee schedule to the lesser of what is provided under the schedule of the providers actual fee, whichever is less. ⁴

⁴ Minn. Stat. 176.136, Subd. 1a. Relative value fee schedule. (a) The liability of an employer for services included in the medical fee schedule *is limited* to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower.

4. The Legislature Created Separate Statutory Safeguards As To Payer Liability For The Charges Of Large And Small Hospitals

Had the legislature intended to give a compensation judge an additional, alternate standard to determine if a large hospital's charges are "unreasonably excessive", it would have explicitly provided for such a determination *as it did in with respect to the inpatient 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*. A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds. Minn. Stat. 176.136, Subd. 1b (a) (Emphasis added).

For example, as to the liability for payment of charges from a large hospital, the legislature could have mandated that a judge shall award 85 percent of the usual and customary or prevailing charge *unless both charges are determined by the commissioner or a compensation judge to be unreasonably excessive*. The fact that the legislature did include such language in the large hospital provision but did not include it in the small hospital provision makes it clear that it intended to establish separate and distinct standards for small and large hospital inpatient charges.

Had the legislature intended to provide for the same safeguard (judicial determination of unreasonable excessiveness) for large hospital charges as it did for small hospital charges, it would have explicitly so stated. Instead, a different safeguard was chosen—the prevailing charge benchmark. Thus under the framework established by the legislature, if the employer believes that HealthEast is guilty of price gouging as to its surgical hardware, the remedy is for the employer to show through the prevailing charge mechanism

the lower, more reasonable charge used by other comparable hospitals.

C. The Position of the Employer/Insurer is Directly Contrary to Minn. Rule 5221.0500 and Minn. Rule 5221.0600.

The legislature assigned to the Department of Labor and Industry the to duty of enacting rules concerning the payment of medical bills and controlling excessive charges. Minn. Stat. §176.136, Subd. 1.(a) and Minn. Stat. §176.83.

Accordingly the commissioner enacted Minn. Rule 5221.0500, subp. 1, which sets forth nine categories of excessiveness, any one of which can disqualify a charge from payment under the fee schedule. This rule also mandates that if a charge is not excessive under one of these nine specific categories, then “a payer’s liability is limited as provided in Minn. Rule 5221.0500, Subp. 2., A to F.

As to large hospital charges, Minn. Rule 5221.0500, Subp. 2. D explicitly provides:

D. Under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (b), payment for services, articles, and supplies provided to an employee who is an inpatient at a hospital with more than 100 licensed beds shall be limited to 85 percent of the hospital's usual and customary charge as defined in item B, or 85 percent of the prevailing charge as defined in item B, whichever is lower. ...

Minn. Rule 5221.0500, subp. 2.D does not contain a “third alternative” to either 85% usual and customary or 85% prevailing charge options under which a commissioner or a judge can ascertain a lower “reasonable value” of a specific medical service, article or supply.

Importantly, Minn. Rule 5221.0500, subp. 2.C, which pertains to inpatient charges at small hospital, DOES retain the safeguard that provides

for a compensation judge's independent determination of "unreasonable" excessiveness:

C. Under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (a), payment for services, articles, and supplies provided to an employee while an inpatient or outpatient at a hospital with 100 or fewer licensed beds shall be 100 percent of the usual and customary charge as defined in item B, *unless the charge is determined by the commissioner or compensation judge to be unreasonably excessive*. The payer's liability for services provided by a nursing home that participates in the medical assistance program shall be the rate established by the commissioner of human services (emphasis supplied).

Further support for the position of HealthEast is found in Minn. Rule 5221.0600, subps. 2 and 3. This rule makes it clear that a payer has only specific, limited grounds upon which it can deny payment of a medical provider's charges. Those limited grounds are as follows:

1. The injury is not compensable. S
2. The charge is excessive or non-compensable under Minnesota Stat. §176, subdivision 2; or Minn. R. 5221.0700, subparts 1 and 2 (none of which allow an insurer to deny a bill because its charge is "unreasonably high").
3. The charges are not submitted on the appropriate billing form prescribed in part 5221.0700.

No other basis for denial of a charge is allowed under this rule. There is no denial allowed because the insurer believes that the amount of a charge is "unreasonable."

D. The Position of the Employer/Insurer is Contrary to the Intent of the Fee Schedule and Effectively Eviscerates the Fee Schedule

The intent of the medical fee schedule is to balance the need for controlling excessive medical charges with the need “to encourage providers to develop and deliver services for rehabilitation of injured workers” and “to ensure that quality hospital care is available to injured employees.” Minn. Stat. 176.136, Subd. 1.

In regard to large hospital inpatient charges, this balance is achieved with the alternate 85 percent “usual and customary” and “prevailing” standards. If there is a concern that a hospital’s usual and customary charges are out of line with similar charges of similar hospitals in same medical community, an employer may demonstrate that fact by establishing a prevailing charge, which is based on charges for similar services at similar hospitals.

The employer in this case has not availed itself to the “prevailing charge” safeguard. The employer/insurer apparently believe that its liability would not change significantly under a comparison of HealthEast’s charges against those of other comparable hospitals.

The result urged by the employer would have the practical effect of converting the 85% usual and customary/prevailing charge limits set forth in Minn. Stat. § 176.136, Subd. 1b (b) from a *mandatory* payment provision into an *optional* payment system under which employers and insurers could withhold payment as to *any charge related to an inpatient hospitalization at a large hospital* by simply asserting the charge is not reasonable.

Also, as discussed above, the rationale advanced by the employer/insurer could also be used to deny the “reasonableness” of any charge explicitly set forth in the relative value fee schedule, such as a

surgeon's bill, an office visit, or an x-ray.

The employer would wish that this court only focus on the large charges for surgical implant hardware involved in this case. However, the arguments advanced by the employer (that the fee schedule represents a ceiling but not a floor) would apply to all charges of large hospitals—large and small.

For each and every charge on a medical provider's bill, be it large hospital, small hospital, doctors office, or laboratory, an employer could deny any or all the charges on the basis that it is seeking a court's determination as to a "reasonable charge" at a level less than what would otherwise be provided under the fee schedule (which for large hospitals is the lesser of 85% usual and customary or 85% prevailing). Then, medical conferences and trials would be required to determine as to each contested charge whether the provider's usual and customary charge is reasonable, or whether a lower, court-determined amount should be awarded. In reality, insurers and their medical bill review services will simply attempt to capitalize on the fact that many providers don't have the time or resources to pursue such judicial review.

Even on those cases where a judge finds primary liability, a court's typical order that medical bills be paid "pursuant to the fee schedule" will have no force or effect, since an insurer can always contend that what is provided by the fee schedule represents only a ceiling, but not the actual definition of a reasonable charge.

Additionally, the approach advocated by the employer/insurer would render the prevailing charge safeguard meaningless. *Why would an insurer ever avail itself to a prevailing charges analysis when it can simply deny any charge based on the general assertion that the charge is unreasonable and not*

payable until a reasonable charge is judicially ascertained?

Under the approach advocated by the employer, how would a compensation judge determine a "reasonable value" of medical services or supplies? Indeed, the employer offers no criteria or standards as to what evidence that a compensation judge would consider in determining a "reasonable value" for a medical charge beyond a purported "invoice price" from a medical supplier to a hospital. What factors would a court employ in such an analysis?

In the case of medical supplies, the employer apparently would have the court focus solely upon the whole price paid by a provider for a given medical supply (apparently to the exclusion of any other factors). Medical providers would likely offer testimony from hospital administrators, clerks, medical suppliers, medical bill review services, and experts as to hospital pricing methodologies, business necessity, and a comparison of the hospital business realities vs. a non-hospital entity. Conflicting testimony and evidence as to product mark up, profit margins, overall hospital business needs would be presented. Each case would likely turn into a mini-MBA seminar as to a hospital's business practices and medical service pricing procedures.

How would a court then evaluate all of the other costs involved in a hospital supplying medical care to its patients? Would a judge hear testimony from hospital management or expert witnesses as to a particular hospital's balance sheet, pricing structure, overall profitability, extent to which a hospital provides medical care to other patients at a loss? Would a judge compare the so-called mark up of one hospital to another, or the mark up of a hospital to a non-medical business entity such as a business providing rehabilitation services? Would a compensation judge weight argument from

hospitals such as HealthEast that they are non-profit entities whose pricing structure is designed to allow hospitals to remain in business under very thin margins of operating costs vs. operating revenues?

This would flood the courts with additional litigation over medical bills related to inpatient, outpatient, large hospital, small hospital and doctor's office bills. Uniformity and predictability of results would be thrown out the window. Medical providers in general, and large hospitals in particular would face additional denials and delays of payments from employers on admitted work injury cases, thereby putting at risk a hospital's ability to care for injured workers. Large hospitals would have no predictability as to what amount they will be paid as to any given bill. Hospitals would be discouraged from, rather than encouraged, to treat workers compensation patients if they knew they faced prolonged, expensive litigation as to each large bill related to an injured worker's hospitalization.

Indeed, these are the types of trials that would be required under the approach advocated by the employer/insurer in this case.

If an employer feels that the charges of a large hospital for surgical hardware are too high, the remedy provided in the rules is for the employer to show through the "prevailing charge" mechanism that other comparable hospitals have lower charges for the hardware in question.

In reality, employer/insurer argue that high hospital charges are systemic, and that the "prevailing charge" remedy is no longer effective. However, as pointed out by the Workers Compensation Court of Appeals, if employers and insurers do not believe this is sufficient remedy (and as the employer has argued in this case), then they can seek a specific rule change from the Commissioner that would pertain to the charges for surgical hardware. The legislature has explicitly granted the Commissioner such rule

making authority. Minn. Stat. §176.136, subd. 1b(b). The Workers Compensation Court of Appeals noted:

We acknowledge the appellants' argument that substantial markups on surgical hardware implants by large hospitals contribute to the high cost of medical care. But this court cannot ignore the statute in order to fashion a remedy. The liability of an employer for treatment at a large hospital is statutorily established at 85 percent of either the provider's usual and customary charge or the prevailing charge. The appellants have not sought to establish the prevailing charge and have stipulated to HealthEast's usual and customary charge. To the extent a systemic problem may exist related to markups on surgical hardware implants, that problem is best addressed by the commissioner through the department's rule making authority.

Addendum 11-12.

The Workers Compensation Court of Appeals is correct. The rule making process is the correct forum to debate and possibly enact such a rule because the formalized rule making process ensures participation by all of the interested players in the workers compensation system.

While cost containment is one of the goals of the medical fee schedule, it is only one of the schedule's goals. Other goals need to be balanced with cost containment, including the encouragement of medical providers to develop and deliver services for injured workers, and to ensure that quality hospital care is available to injured employees. Minn. Stat. §176.136, Subd. 1(a). Indeed, The specific rules contemplate efficient delivery medical service and prompt payment of medical bills. See Minn. Rule 5221.0600 (payment, denial or clarification of medical charges must be done within 30 of receipt of medical bill).

The approach advocated by the employer/insurer will delay in the payment of medical bills (in this case the charges were incurred in August 2008), foster litigation, promote uncertain results and force medical providers

to retain counsel simply to obtain payment at the rate of 85% of its usual and customary charges. Faced with such litigation, will medical providers always continue to be willing to supply ongoing medical treatment to injured employees? Already, some doctors have elected to refrain from treating persons involved in workers compensation.

E. The Position Advocated By HealthEast Does Not Unduly Restrict The Discretion Afforded The Department And Compensation Judges

The Minnesota workers compensation system provides for the payment of scheduled benefits to or on behalf of injured employees. The schedules for these benefits, by their fundamental nature, place limitations on the discretion of the department or compensation judge as to the award of benefits.

For example, minimum and maximum benefit rates are established as to the various wage loss benefits. Payment rates are established for the QRC services. The permanent partial disability schedule establishes categories and ratings for various functional disabilities. And, the medical fee schedule provides payment rates for the charges of various medical providers in the workers compensation system.

The fact that these various schedules create minimum and maximum benefit rates and categories of disability do not them invalid because they restrict the discretion of compensation judges. Instead, these minimums and maximums strike a balance among the various competing interests in the workers compensation system. These schedules are the result of a political and a rulemaking process after much deliberation by the legislature and input from the various participants in the workers compensation system.

As to the charges for inpatient treatment at large hospitals, the department and the courts are given limited discretion within the framework

of the rules. Specifically, the department and the courts are given the discretion to determine a usual and customary charge for a given medical service or supply. They are also given the discretion to determine if there is a lower prevailing charge based upon the charges at comparable medical providers. Then, the department or the courts are given the discretion to determine which is lesser and award payment accordingly.

In reality, the medical fee schedule-imposed limitations on a compensation judge's jurisdiction is no different than a compensation judge being required to limit an applicant's award of TTD benefits to 2/3's of the employee's AWW and the statutory maximum in place on the date of injury, regardless of whether a judge believes that a higher amount is warranted in that particular case.

CONCLUSION

No decision from either the Workers Compensation Court of Appeals or the Minnesota Supreme Court has ever suggested that that the approach advocated by the employer/insurer is allowed under Minn. Stat. Sec 176.136.

The employer/insurer claim that there is a systemic problem in the medical fee schedule in regarding the charges of large hospitals. The employer/insurer clearly disagree with the Legislature's decision to provide different payment levels and safe guards regarding the charges of large and small hospitals.

HealthEast and other hospitals contend that the problem, in fact, is insurers who choose to ignore the plain provisions of the medical fee schedule and use delay and litigation to club medical providers into taking less for their service than is provided by the fee schedule.

These are complicated policy issues that spill over into the larger

societal debate over the healthcare debate that exists in society as a whole. This debate must include all of the participants and stakeholders in the workers compensation system.

However, the places for those debates are the legislative and the rule making processes. This allows these issues to be considered in a fair, uniform manner following input from all interested parties. Possible changes to the medical fee schedule (including those sought by both the business and the medical communities) are properly addressed through the legislative or rulemaking process with input from the commissioner, as well as “insurers, associations and organizations representing medical and other providers of treatment services and other groups.” Minn. Stat. 176.136, Subd. 1(a) (“The commissioner shall by rule establish procedures for determining whether or not the charge for a health service is excessive. In order to accomplish this purpose, the commissioner shall consult with insurers, associations and organizations representing the medical and other providers of treatment services and other appropriate groups.”).

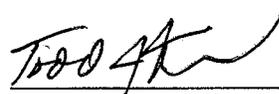
The solution is not to ask compensation judges to rewrite the fee schedule via the litigation process on a case-by-case basis.

Indeed, Minn. Stat. §176.136, Subd. 1b(b) gives the commissioner the authority to enact specific rules to establish the reasonable value of a service, article or supply in lieu of the 85% rates discussed herein. So, if there is an alleged systemic problem related to surgical hardware implants, as contended by the employer, then the solution is to not gut the entire fee schedule—the solution is for the legislature and commissioner to seek input the players in the workers compensation system and then consider whether, and to what extent, the existing rules require modification.

This is the process used to create the medical fee schedule in the first place, and this is the process to be used if further changes to the fee schedule are required. Indeed, this is the process that is being pursued at this time by the Department of Labor and Industry in its discussions with all of the competing interests. At such a process, employers and insurers can air their concerns and medical providers can provide their concerns as well.

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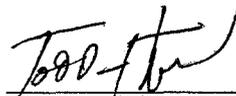
Certification

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 11,594 words and 45 pages.

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

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