

KRISTEL C. BUCK-ULRICK, Employee, v. TRI CITY ENTERS. and SFM MUT. INS. CO.,
Employee-Insurer/Appellants, and FAIRVIEW HEALTH SERVS., Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
MAY 13, 2008

No. WC07-284

HEADNOTES

MEDICAL TREATMENT & EXPENSE - SURGERY; STATUTES CONSTRUED - MINN. STAT. 176.011, SUBD. 24; RULES CONSTRUED - MINN. R. 5221.0700, SUBP. 2.A.(2). Where the implant surgically installed in treatment of the employee's work injury was provided by the manufacturer for use by trained personnel in a hospital setting and the employee had no direct personal contact with the manufacturer, the respondent hospital remained the health care provider actually furnishing the service or supply to the employee under Minn. R. 5221.0700, subp. 2.A.(2), and the entity who furnishes the service under Minn. Stat. 176.011, subd. 24, and the compensation judge properly declined to order that the manufacturer should have billed the insurer directly for the implant, rather than billing the hospital, which in turn billed the insurer.

Affirmed.

Determined by: Pederson, J., Rykken, J., and Johnson, C.J.
Compensation Judge: Danny P. Kelly

Attorneys: Mark J. Fellman, St. Paul, MN, for the Respondent Employee. Andrew W. Lynn, Lynn, Scharfenberg & Assocs., Bloomington, MN, for the Appellants. Gregory G. Heacox, Heacox, Hartman, Koshrl, Cosgriff & Johnson, St. Paul, MN, for the Respondent Intervenor.

OPINION

WILLIAM R. PEDERSON, Judge

The employer and insurer appeal from the compensation judge's determination that the manufacturer or supplier of an artificial disc implanted during the employee's surgery is not a health care provider as defined by Minn. Stat. 176.011, subd. 24, so as to require the manufacturer or supplier to submit its charges for the article or supply directly to the insurer, rather than through the hospital. We affirm.

BACKGROUND

On February 28, 2003, and April 22, 2004, Kristel Buck-Ulrick [the employee] sustained injuries arising out of and in the course of her employment with Twin City Enterprises [the employer]. On both dates the employer was insured for its workers' compensation liability by SFM Mutual Insurance Company [SFM].

On December 12, 2006, the employee underwent an anterior spinal stabilization procedure with Prodisc arthroplasty performed by Dr. John Sherman at Fairview Southdale Hospital [Fairview].^[1] The artificial disc used during the employee's surgery was manufactured by Synthes Spine. Fairview did not keep disc implants in stock and specifically ordered the ProDisc for the employee's surgery from Synthes Spine.

Fairview subsequently sent a bill to SFM for its medical services, which included a \$14,926.00 charge for supply implants. SFM does not dispute the reasonableness or necessity of the employee's care and treatment, nor that the charge represented Fairview's usual and customary charge for the service rendered. SFM contends, however, that Fairview was not entitled to bill SFM for the disc implant actually supplied by Synthes Spine. Consequently, SFM has refused to pay Fairview for its charges relating to the implant.

On May 11, 2007, SFM filed a Medical Request seeking a determination as to its obligation to pay Fairview for the artificial disc. An Administrative Conference was held before a mediator/arbitrator on June 15, 2007, and, by decision issued June 18, 2007, the mediator/arbitrator determined that, pursuant to Minn. R. 5221.0700, the medical supplier, and not the medical facility where the surgery took place, is responsible for billing the insurer directly for the medical supplies at issue in this case. Fairview filed a Request for Formal Hearing on July 18, 2007.

The parties' dispute came on for hearing before a compensation judge on October 5, 2007, and the record closed on October 29, 2007, upon the submission of written closing arguments. The issue identified for determination by the judge was whether Fairview was entitled to submit charges directly to SFM for the artificial disc implanted during Fairview's treatment of the employee's back injury.

The only testimony at trial was provided by Mr. Robert McCoy, vice president of revenue management at Fairview. Mr. McCoy testified that Fairview is a licensed health care provider responsible for all of the services and supplies provided to patients within its facilities. As such, Fairview contracts with manufacturers for various articles used by Fairview in providing medical care to its patients, including the ProDisc implant used in this case. With regard to back surgeries such as the employee's surgery, Mr. McCoy explained that once the surgery is scheduled, the surgeon chooses the artificial disc to be implanted from Fairview's list of pre-approved manufacturers. Fairview then procures the disc from the manufacturer and pays the manufacturer directly. At the conclusion of Fairview's service, that is, the surgery, Fairview submits a bill to the payer for all charges involved with the service. Fairview's bill includes the cost of the artificial disc to Fairview plus a markup of an undisclosed amount.

In a Findings and Order issued November 27, 2007, the compensation judge determined that Synthes Spine is a supplier and not a health care provider under the statute and rules. He further found that Fairview, the health care provider in this case, was entitled to bill SFM for the employee's disc implant. Consequently, the judge found that Fairview may bill for its usual and customary charges, and he ordered SFM to make payment accordingly. The employer and SFM appeal.

DECISION

In cases where an injured employee is treated at a hospital with more than 100 beds, such as Fairview Southdale, a workers' compensation payer is liable for payment of 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). SFM concedes that Fairview submitted its usual and customary charge but contends that the compensation judge erred as a matter of law in his interpretation of Minn. R. 5221.0700, governing provider responsibilities.

Minn. R. 5221.0700, subp. 2A(2), provides:

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, medication not ordinarily kept in stock by the hospital or healthcare provider facility, purchased from a supplier for a specific employee.

For purposes of Chapter 5221 of the Minnesota Rules, the term health care provider is defined by Minn. Stat. 176.011, subd. 24, which provides that A>Health care provider' means a physician, podiatrist, chiropractor, dentist, optometrist, osteopath, psychologist, psychiatric social worker, or any other person who furnishes a medical or health service to an employee under this chapter. (Emphasis added.) Minn. R. 5221.0100, subp. 15, defines service or treatment 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. . . .

The compensation judge found that the artificial disc, ProDisc, is not ordinarily kept in stock by Fairview and that Fairview ordered the disc from Synthes Spine specifically for the employee. But he also found that Synthes Spine is a supplier and not a health care provider. As such, he concluded that Fairview was entitled to bill SFM directly for the disputed artificial disc and was entitled to payment of 85% of its usual and customary charge.

SFM argues that when Minn. Stat. 176.011, subd 24, and Minn. R. 5221.0100, subp. 15, are read together, it is clear that Synthes Spine qualifies as a health care provider, because Synthes Spine furnished a medical service (i.e., a supply) for the purpose of curing or relieving the employee from the effects of her compensable injury. As such, because the ProDisc used in this case was not ordinarily kept in stock by Fairview, and because it was purchased specifically for the employee, the plain language of Minn. R. 5221.0700, subp. 2A(2), requires Synthes Spine to submit its charges directly to SFM. In fact, SFM contends, the instant case presents exactly the circumstances contemplated by the rule. Therefore, SFM maintains, the judge's order requiring payment to Fairview must be reversed. We are not persuaded.

One of the purposes of Minn. R. 5221.0700 is to prevent a health care provider from including on its billing statement the services and charges provided by another health care provider under referral from the treating doctor, thus avoiding the problem of markup for services provided by another business entity but billed by the referring provider. Subpart 2A(1) and (2) of the rule then provide examples of the types of charges for services, supplies, and articles that are often referred out. SFM contends that subparagraph (2) of the rule precisely covers the case before us.

We acknowledge that subparagraph (2) of the rule might appear to apply to the charge at issue in this case. However, that provision must be read in conjunction with subpart 2A, which specifies that the charges are to be submitted by the health care provider actually furnishing the service. Here, Synthes Spine did not furnish any medical or health service to the employee when it sold its ProDisc implant to Fairview, and Fairview did not refer the employee to Synthes Spine. In fact, as the manufacturer of the implant, Synthes Spine has no contact whatsoever with Fairview's patients. The ProDisc implant, or supply, standing alone, had no value to the employee when it arrived at Fairview from the manufacturer; as merely one small part of the employee's surgical procedure, the ProDisc implant cannot reasonably

be considered an independent medical service that was actually furnished to an employee as contemplated by Minn. Stat. 176.011, subd. 24. Rather, this implant was provided by the manufacturer for use by trained personnel in a hospital setting. Given these circumstances, Fairview remained the health care provider actually furnishing the service or supply under Minn. R. 5221.0700, subp. 2A(2).

Our acceptance of SFM's position in this case would transform virtually every manufacturer of custom medical devices into health care providers, subject to the rules and responsibilities of the workers' compensation system. In the absence of more explicit direction, we decline to interpret the rule in this manner. Because Synthes Spine did not furnish this disc implant to the employee within the meaning of the statute and rules - - Fairview did - - the compensation judge properly concluded that Fairview was entitled to bill SFM for the device, and we affirm.

^[1] The intervenor/respondent in this case is Fairview Health Services, and our use of Fairview throughout this decision refers to Fairview Health Services and its facilities, including Fairview Southdale Hospital.

ROBIN LEHTO, Employee, v. COMMUNITY MEM'L HOSP. and ROYAL & SUN ALLIANCE INS./CAMBRIDGE INTEGRATED SERVS., Employer-Insurer/Appellants, and LAKEWALK SURGICAL CTR., Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
JANUARY 30, 2008

No. WC07-188

HEADNOTES

MEDICAL TREATMENT & EXPENSE - FEE SCHEDULE; RULES CONSTRUED - MINN. R. 5221.0500, subp. 2.B. To establish a prevailing charge a payer must base its computation on a database that meets the criteria set forth in Minn. R. 5221.0500, subp. 2.B. That is, the database must include at least 20 billings (1) for the service, article or supply, (2) from the previous calendar year, and (3) from at least three different Minnesota providers of the same provider type. The appellant insurers in these consolidated cases failed to prove, on the record submitted, that the databases relied upon complied with the rule.

MEDICAL TREATMENT & EXPENSE - FEE SCHEDULE. The compensation judge's award of payment to Lakewalk Surgery Center at 85% of its usual and customary charges for medical services provided to the employees is, on the record here, supported by the evidence.

Affirmed.

Determined by: Thomas L. Johnson, C.J., Wilson, J., and Stofferahn, J.
Compensation Judge: Gregory A. Bonovetz

Attorneys: Dennis W. Hagstrom, Svingen, Hagstrom, Karkela & Kline, Fergus Falls, MN, for the Appellants. Michael I. Cohen, Orman Nord Spott & Hurd, Duluth, MN, for Respondent Lakewalk Surgery Center.

OPINION

THOMAS L. JOHNSON, Judge

These consolidated appeals involve claims by Respondent Lakewalk Surgery Center, a medical provider, for payment of 85% of its usual and customary charges for services provided to injured employees pursuant to Minn. R. 5221.0500, subp. 2.B.^[1] The employers and insurers reduced the amounts paid to Lakewalk, asserting the provider's bills exceeded the prevailing charge for the services provided. In each case, the compensation judge found the employers and insurers failed to meet the criteria set forth in Minn. R. 5221.0500, subp. 2.B.(2), and could not, therefore, avail themselves of the prevailing charge limitation on liability for medical expenses. The judge, accordingly, ordered payment to Lakewalk of the outstanding balances. We affirm.

BACKGROUND

These cases involve appeals by the employers and insurers in three medical fee disputes.^[2] The Lehto, Spawn and Stemper cases were jointly heard by a compensation judge (along with two cases not before

us) on the motions of Lakewalk Surgery Center for judgment awarding payment of medical bills based on 85% of its usual and customary charges. The cases were submitted on stipulated Statements of Facts, with attached documents, individual to each case (Jt. Exs. 1), along with the January 10, 2007, deposition of R. William von Sydow (Er Ex. 1), limited to deposition testimony included in the stipulated facts.^[3] (Tr. at 50-51.)

Bill Review/Qmedtrix

Lakewalk Surgery Center is an ambulatory surgical center, as defined by Minn. R. 5221.0100, subp. 1a, located in Duluth, Minnesota. In each of these cases, the appellant insurers requested review of Lakewalk's charges by Qmedtrix, a workers' compensation facility bill review service. Qmedtrix examines medical bills submitted by workers' compensation carriers for coding errors and re-prices the submitted charges based on a state's medical fee schedule where the schedule provides for payment based on a usual or customary rate. Qmedtrix is paid based on a percentage of the savings to the insurer on provider bills.

Medical providers submit their charges to workers' compensation insurers on a prescribed billing form.^[4] The insurers send provider billings to Qmedtrix in paper form, by facsimile scan, or in electronic format. Qmedtrix captures the billing data using its proprietary software, BillChek, which converts the billing information into a computer-readable file. Once the billing data has been added to Qmedtrix's computer database, the original billing is either returned to the insurer or destroyed. After Qmedtrix processes a billing, it makes a payment recommendation to the insurer. In each of these cases, the insurer reduced the payment made to Lakewalk based on a billing review provided by Qmedtrix, and paid Lakewalk less than 85% of its usual and customary charge for the procedure, service or supply billed.

The Cases

I.

The Lehto case involves a single medical procedure performed on December 7, 2005. On that date, the employee underwent a selective nerve root block, right L4, at Lakewalk Surgery Center. Lakewalk submitted a bill to the insurer, Royal & Sun Alliance Insurance/Cambridge Integrated Services, for \$988.38, including \$968.00 for the procedure, CPT code 64483, a \$1.00 charge for providing a medical record in support of the bill, and \$19.38 representing the 2% MinnesotaCare provider tax.

The insurer requested review of the bill by Qmedtrix. The service recommended payment of \$781.32, which was paid by the insurer to Lakewalk. Counsel for the insurer later asserted the prevailing charge for the procedure was actually \$714.00. On March 13, 2006, Lakewalk filed a Medical Request seeking payment of an additional \$58.80, based on 85% of its usual and customary charge, that is, \$840.12, or proof that the database requirements allowing a reduced payment, pursuant to Minn. R. 5221.0500, subp. 2, had been met.

II.

The Spawn case involves two medical services provided to the employee at Lakewalk on two different occasions:

On February 7, 2005, the employee underwent an intrathecal narcotic test dose. Lakewalk's bill, submitted to the insurer, Self-Insurer's Security Fund/Sedgewick James, was \$988.38, including \$968.00 for the procedure, CPT code 62311, a \$1.00 charge for providing a medical record in support of

the bill, and \$19.38 for the 2% MinnesotaCare provider tax. The bill was reviewed by Qmedtrix which recommended payment of \$699.12 for the procedure, which was paid to Lakewalk by the insurer.

On March 14, 2005, the employee underwent surgery at Lakewalk consisting of placement of an intrathecal catheter, InDura Model #8709, and implantation of a programmable Medtronic synchroMed pump Model #8637-40. The total bill was \$23,139.21, including \$1,010.00 for the catheter procedure, CPT code 62350 51, \$4,027.00 for implantation of the pump, CPT code 62362, and \$17,647.50 for IV Therapy / INFSN pump, CPT code E0783. Qmedtrix reviewed the bill and the insurer paid \$12,100.13. The parties stipulated the insurer and Qmedtrix relied upon a Medtronic invoice dated March 14, 2005, for a synchroMed II pump, model #8637, with a unit price of \$11,200.00 to reduce the infusion pump charge. (Stipulated Facts 9.)

On December 20, 2005, Lakewalk filed a Medical Request seeking payment of an additional \$7,739.21 for both dates of service, based on 85% of its usual and customary charge.

III.

The Stemper case involves four medical services provided to the employee at Lakewalk on three different dates:

On February 11, 2005, the employee underwent an intrathecal narcotic trial at Lakewalk Surgery Center. The total bill for the procedure, presented by Lakewalk to the insurer, Sedgwick Claims/CNA, was \$988.38, including \$968.00 for the procedure, CPT code 62311, a \$1.00 charge for providing a medical record in support of the bill, and \$19.38 for the 2% MinnesotaCare provider tax. The bill was reviewed by Qmedtrix which recommended payment of \$699.12 for the procedure, which was paid to Lakewalk by the insurer.

On March 8, 2005, the employee underwent surgery at Lakewalk consisting of placement of an intrathecal catheter and implantation of an infusion pump. The total charge for the surgery was \$23,289.03, including \$1,010.00 for the catheter procedure, CPT code 62350 59 50, \$4,027.00 for implantation of the pump, CPT code 62362, and \$17,775.00 for the pump itself. Qmedtrix initially recommended payment of \$10,563.76, and, later, an additional payment of \$288.01, on the basis that the charge reflected secondary services at 50% of the usual and customary allowance. In an Amended Medical Response, counsel for the insurer stated that \$12,434.26 had been paid to Lakewalk.

On August 3, 2005, the employee received an increase in dosage for the implanted pump and an SI joint injection. The charge for the increased pump dosage was \$964.00, CPT code G0260; the insurer paid \$818.75 to Lakewalk for the procedure. The charge for the SI joint injection was \$192.00, CPT code 76005. After review of the billing by Qmedtrix, the insurer paid Lakewalk \$94.62.

On December 19, 2005, Lakewalk filed a Medical Request seeking an additional \$9,183.49 for all three dates of service, based on 85% of its usual and customary charges. The parties subsequently stipulated that Lakewalk's billings for services provided on February 11, 2005, and August 3, 2005, were reduced because of alleged unbundling of services.

The Databases - Excessive Charges

The insurers submitted three databases provided by Qmedtrix that they assert establish a prevailing charge less than Lakewalk's usual and customary charge, as provided for in Minn. R. 5221.0500, subp. 2.B.(2). The documentation for each database consists of a one-page summary with 20 entries, each

entry listing a single procedure, along with a computer print screen for each included billing. The summary includes a BillTrak number, the provider name, the CPT code, the date of service and the amount charged for each procedure listed. The print screens are abstracts of billing data for the 20 entries, as captured by Qmedtrix's BillChek software, and include the state, provider type, adjudication type, date received, diagnostic codes, date of service, and for every procedure included in the billing, the HR code, the CPT code and any modifiers, and the amount charged for the procedure. Copies of original billings were provided for some of the entries. CPT refers to a numeric coding system used to identify a specific medical service, article or supply. The system is copyrighted by the American Medical Association which publishes the Current Procedural Terminology Coding System manual.^[5]

The database provided in the Spawn case (Spawn Ex. F:1-20) and one of two databases submitted in the Stemper case (Stemper Ex. L:34-70) are identical. Database entries numbers 7 through 20 in Lehto are identical to entries 1 to 14 in Spawn and this Stemper database. These databases include CPT procedure codes 62311, 64475, 64480, 64483, 64484 and 64510. The other database in the Stemper case (Stemper Ex. L:1-33) includes CPT procedure codes 62273, 64472 and 64476. All of the databases include billings from calendar years 2004 and 2005. All of the databases include services provided by ambulatory surgical centers, hospitals and other providers.

In the Spawn case, the parties stipulated the database provided was for the February 7, 2005, date of service only. They further stipulated the payment for the March 14, 2005, date of service was not reduced based on a database created by Qmedtrix, and that no database, screen prints or medical bills were provided as support for that reduction of payment. Similarly, in the Stemper case, the parties stipulated the database provided was for the February 11, 2005, date of service only, and that no database had been provided for CPT codes 62350, 62362, E0783, G0260 or 76005. They further agreed that payment for the March 8, 2005, date of service was not reduced based upon a database created by Qmedtrix.

In the Spawn case, the appellant asserted that Lakewalk's billings for the surgical insertion of a catheter and implantation of an infusion pump were properly paid at 85% of Lakewalk's usual and customary charges after identification and correction of billing errors and excessive charges. With respect to the pump itself, a copy of an invoice was submitted showing a cost of \$11,200.00 for a Medtronic SynchroMed II pump. The insurer reduced the \$17,647.50 charge for the pump to reflect the actual invoiced cost of the device, citing Minn. R. 5221.0500, subp. 1.A.^[6]

The Findings

Following a hearing on April 3, 2007, the compensation judge issued a Findings and Order in each case. The judge found, in all of the findings and orders, that to avail itself of the prevailing charge provision of Minn. R. 5221.0500, subp. 2.B.(2), the payer must base its computation on a database that meets the criteria listed in that rule. Specifically, the court found the database must include, only Minnesota providers, the providers must be of the **same type**, there must be at least 20 billings for **the service** and the 20 billings are from the **previous calendar year**. (Lehto finding 18, Spawn finding 23, Stemper finding 26.)

The compensation judge made a finding in each case, not appealed, that a number of the providers included within the 20 required billings were not ambulatory surgery centers and were not the same provider type. Specifically, some of the providers are hospitals which may use the line-item billing method, a billing method not used by Lakewalk Surgery Center. (Lehto finding 21, Spawn finding 25, Stemper finding 29.)

The compensation judge also found, in each case, that the database provided by the employer and insurer did not include at least 20 billings for the same service. (Lehto finding 23, Spawn finding 27, Stemper finding 31.) In Lehto, the judge additionally found that several of the 20 billings included in the database did not reflect the service provided, that is, selective nerve root block, right L4, with a CPT code of 64483. (Finding 22.) The compensation judge similarly found in Spawn that the employee had an intrathecal narcotic test dose in his lumbar spine with a CPT code of 62311, but the database used by the employer and insurer contained only three entries for the same type of injection. The remaining entries reflect different CPT codes for other services. And in Stemper, the judge found that although the rule requires at least 20 billings for the service, article or supply, the billings submitted by the insurer reflect services that were not the same as those provided to the employee on February 11, 2005, March 8, 2005, and/or August 3, 2005.

In each case, the judge also determined, in unappealed findings, that the rule specifically requires that billings included in the database be from the previous calendar year and although the employees' procedures occurred in 2005, a substantial number of the billings do not reflect dates of service in calendar year 2004. (Lehto finding 20, Spawn finding 28, Stemper finding 28.)

Additionally, the compensation judge found that a substantial number of the 20 billings submitted were, in fact, not billings but rather copies of computer print screens. The judge found the rule requires the use of billings in creating the database, and that because of the paucity of information contained in the computer print screens they do not contain sufficient information to be a suitable substitute for a billing. (Lehto finding 24, Spawn finding 29, Stemper finding 32.)

In the Spawn case, the compensation judge further found that although the employer and insurer asserted that Lakewalk's charges for the placement of a programmable Medtronic synergy pump on March 14, 2005, were excessive, the evidence introduced did not meet any of the conditions for excessive provider charges listed in Minn. R. 5221.0500, subp. 1. Nor, the judge found, was evidence introduced which would bring the employer and insurer's calculations under the prevailing charge aspect of Minn. R. 5221.0500, subp. 2.B.(2).

In each case, the compensation judge found the database submitted by the employer and insurer did not meet the criteria specified by Minn. R. 5221.0500, subp. 2.B.(2), and the employers and insurers could not, therefore, avail themselves of the prevailing charge computation method. The judge concluded the employers and insurers' liability for payment of the charges submitted by Lakewalk was 85% of the provider's usual and customary charges, and ordered payment to Lakewalk of the outstanding balances. The employers and insurers appeal.

DECISION

These consolidated cases involve claims by Lakewalk Surgery Center for payment of 85% of its usual and customary charge for medical services provided to the employees. The appellant insurers made reduced payments asserting Lakewalk's bills exceeded the prevailing charges for the services provided. Under Minn. Stat. 176.136, subd. 1.(a), [t]he commissioner shall by rule establish procedures for determining whether or not the charge for a health service is excessive. Subparagraph 1.(b) of this statute further provides:

The procedures established by the commissioner must limit, in accordance with subdivisions 1a, 1b, and 1c, the charges allowable for medical,

chiropractic, podiatric, surgical, hospital and other health care provider treatment or services, as defined and compensable under section 176.135.

Minn. Stat. 176.136, subd. 1b.(b) provides:

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

The Commissioner of the Department of Labor and Industry enacted chapter 5221 of the Minnesota Rules pursuant to this statutory authority. The stated purpose of the chapter is to prohibit health care providers treating employees with compensable injuries from receiving excessive reimbursement for their services. Minn. R. 5221.0300. The liability of a workers' compensation insurer (referred to as a payer)^[7] is specifically set forth in Minn. R. 5221.0500, entitled Excessive Charges; Limitation of Payer Liability. Subpart 1 of the rule defines excessive health care provider charges^[8] and states a payer is not liable for a charge that meets any of the nine listed conditions. If a charge is not excessive under subp. 1, a payer's liability for payment is limited as set forth in subpart 2.^[9] The payers' liability in these cases is governed by Minn. R. 5221.0500, subp. 2.B.^[10] Under this subpart a payer's liability is limited to either 85% of the provider's usual and customary charge or 85% of the prevailing charge for similar treatment, whichever is lower. To establish a prevailing charge, the payer must base its computation on a database that meets the criteria of the rule. That is, the database must include at least 20 billings (1) for the service, article, or supply, (2) from the previous calendar year, and (3) from at least three different Minnesota providers of the same provider type. Minn. R. 5221.0500, subp. 2.B.(2)(a-c). The appellants contend the databases submitted do comply with the rule, and assert the compensation judge's decision should be reversed.

1. Twenty Billings from Previous Calendar Year

Minn. R. 5221.0500, subps. 2.B.(2) and 2.B.(2)(b), require a minimum of 20 billings for the service in question and these 20 billings must be from the previous calendar year. The compensation judge found the appellants' databases contain billings for a period of 12 months prior to the date of service in question rather than billings from the calendar year prior to the date of service, and do not comply with this portion of the rule. The appellants did not appeal and do not contest this finding. Accordingly, on this basis alone, the appellants have failed to satisfy all of the criteria necessary to establish a prevailing charge under Minn. Stat. 176.136, subd. 1b.(b).

2. Same Provider Type

The compensation judge found the Minnesota providers included in the databases were not of the same type as Lakewalk and that the databases did not meet the criteria in Minn. R. 5221.0500, subp. 2.B.(2)(a). Essentially three Qmedtrix databases were submitted in these cases.^[11] Each database contains 20 entries, the minimum number of billings required under subpart 2.B.(2)(b). Each database

includes providers that appear to be ambulatory surgery centers, the same type of provider as Lakewalk Surgery Center.^[12] Each database, however, also includes hospitals. If the hospital listings are removed, each database contains fewer than the required 20 billings and, thus, would fail to comply with the rule.

Subitem (2)(a) specifies the database may include only identifiable providers of the same provider type. The appellants contend the rule does not require the database be limited to billings from providers exactly identical in type to Lakewalk, citing Minn. R. 5221.4033, subp. 1a. That rule provides, in part, [e]xcept where the facility fee is precluded from payment in subpart 1, fees for ambulatory surgical center and hospital outpatient surgical center are paid in accordance with part 5221.0500, subpart 2. Based upon this rule, the insurers contend ambulatory surgery centers and hospital outpatient surgical centers are the same provider type for the purposes of the rule. Accordingly, the appellants argue charges from hospitals are properly included in each database. We disagree.

Lakewalk Surgery Center is an ambulatory surgical center defined by Minn. R. 5221.0100, subp. 1a, as a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization . . . or is an outpatient surgical center as defined in part 4675.0100, subpart 8, and licensed by the Minnesota Department of Health. Part 4675.0100, subpart 8, defines an outpatient surgical center as a freestanding facility organized for the specific purpose of providing elective outpatient surgery for pre-examined, prediagnosed, low-risk patients. Admissions shall be limited to procedures which utilize local or general anesthesia and which do not require overnight inpatient care. There is nothing in the Statements of Facts or attached documents that establishes the hospitals listed meet the criteria of a freestanding facilit[y] providing elective outpatient surgery of the kind specified in the rule, or that the hospitals listed were licensed as outpatient surgical centers by the Department of Health. There is simply no evidence that the hospitals listed are outpatient surgical centers of any kind.^[13]

The Department of Health licensing rules define a hospital as an institution . . . providing services, facilities and beds for the reception and care for a continuous period longer than 12 hours for one or more nonrelated persons requiring diagnosis, treatment, or care for illness, injury, or pregnancy; and regularly making available clinical laboratory services, diagnostic x-ray services, and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent. Minn. R. 4640.0100, subp. 5. Clearly, ambulatory surgical centers and licensed outpatient surgical centers are much more limited in the services they can provide, and it is evident that an ambulatory surgical center could never qualify as a hospital. Based upon their definitions, ambulatory surgical centers and hospitals are not the same provider type.

Moreover, even accepting the appellant insurers' assertion that the hospitals listed in the databases are hospital-based day surgery centers, the evidence does not support the appellants' contention that hospital outpatient facilities and ambulatory surgical centers, such as Lakewalk, are equivalent provider types for the purposes of determining a prevailing charge.

Gloria Roy is a certified Professional Coder - Hospital for Lakewalk Surgery Center. In an affidavit, Ms. Roy stated, [c]omparing hospital facility billed charges on a claim, even on an outpatient basis, to an ambulatory surgery center facility billed charges on a claim is not an appropriate or like comparison of facility charges due to the different methodology of line item vs. flat fee bill. (Spawn Jt. Ex. RA.83-84.)

The parties stipulated that Minnesota hospitals and hospital-based day surgery centers may line item bill, meaning a hospital can charge separately for services and supplies. A hospital line item billing charge

for a procedure identified by a particular CPT code does not include pharmaceutical, laboratory, supply or radiologic fees in the charge for the procedure. These charges are listed separately on the bill.^[14]

Lakewalk Surgery Center, as an ambulatory surgical center, may not use the line item billing method.^[15] Under Minn. R. 5221.4033, subp. 1a.A., eight specified services and supplies provided by an ambulatory surgical center must be included in a single facility fee and an ambulatory surgery center may not bill separately for these services and supplies. These items include the use of the facility, nursing and related services, drugs or pharmaceuticals, surgical dressings and supplies, and diagnostic or therapeutic services directly related to the provision of a surgical procedure. Thus, for a procedure identified by the same CPT code, services and supplies that must be included in a single charge when billed by an ambulatory surgical center may, when provided by a hospital facility, be broken out and charged separately, in addition to the charge for the procedure.

For example, Jt. Ex. F-7 in the Spawn database is a billing from Landmark Surgery Center with a single charge of \$726.30 for a procedure identified by CPT code 64483. Jt. Ex. F-15 is a billing from Miller-Dwan Medical Center, a hospital, including a \$463.00 charge for a procedure also designated by CPT code 64483. In addition, Miller-Dwan charged separately for pharmacy, \$67.49, pharmacy incidental to radiologic service, \$38.51, sterile supplies, \$81.50, and diagnostic x-ray, \$462.50. Thus, the total charges from Miller-Dwan to perform the same procedure were considerably more than the \$463.00 listed in the Qmedtrix database.

The appellants failed to prove, on the record in these cases, that the hospitals included in the Qmedtrix databases were the same provider type as Lakewalk Surgery Center, or equivalent thereto, and we affirm the finding that the databases relied upon by the insurers did not meet the criteria in Minn. R. 5221.0500, subp. 2.B. in this respect.

3. Same or Similar Service

Minn. R. 5221.0500, subp. 2.B.(2)(b), requires that a database contain at least 20 billings for the service, article or supply. The compensation judge found, for each database, that some of the services included were not the same service as that provided to the employee by Lakewalk and did not, therefore, comply with the rule.

Lakewalk's bills and the Qmedtrix databases identify a service or procedure by its CPT code. A CPT code is a numeric code included in the Current Procedural Terminology Coding System manual A CPT code is used to identify a specific medical service, article or supply. Minn. R. 5221.0100, subp. 4.B. The CPT Manual is incorporated by reference into chapter 5221. Minn. R. 5221.0405, subp. D. There is no dispute that not all of the 20 billings in any given database are the same as the CPT code for the service provided to the employee by Lakewalk. Thus, if the rule requires that a database include only the same CPT code as the procedure billed by Lakewalk, the databases do not comply.

Citing subparts 2.B. and 2.B.(2)(a) of Minn. R. 5221.0500, which refer to similar services or treatment,^[16] the appellants contend, however, that the services included in a database need not be exactly the same as those provided to an employee, rather, they need only be similar. Accordingly, the appellants assert the databases comply with the rule.

The Lehto case involves a single procedure identified by CPT code 64483. Relevant portions of the Current Procedural Terminology Coding System Manual were not provided to the court, so the compensation judge could not, nor can we, refer to it for the code definitions. In her Affidavit, Ms. Roy

included a chart with the numerical code and a CPT code description for each of the codes included in the Spawn database. She averred the CPT codes and definitions were accurate. The chart includes multiple procedures, including CPT code 64483, with a code description of [i]njection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level. The Lehto database contains seven entries for CPT code 64483, the remaining 13 entries list different CPT codes. Six of the 13 entries are for CPT code 62311, a procedure which Ms. Roy listed as an [i]njection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal). Five entries in the Lehto database are CPT code 64475 which Ms. Roy includes as an [i]njection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level. One entry is CPT code 64480 which is [i]njection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic and one entry is CPT code 64510 which is injection, anesthetic agent; stellate ganglion (cervical sympathetic).

In the Spawn and Stemper cases, the parties stipulated the database provided was for a single date of service - - February 7, 2005, in Spawn and February 11, 2005, in Stemper - - and for CPT code 62311 only.^[17] The Spawn database contains three entries for CPT code 62311. The remaining 17 entries include CPT codes 64475, 64480, 64483 and 64510. Each of these CPT codes, as defined above, involve injections to the spine. There are two databases in evidence in Stemper. The first contains three CPT codes, 62273, 64472 and 64476. None of these codes are identical to the service received by Connie Stemper nor are these codes defined or described in any evidence submitted to the court. In addition, the database appears to include a number of duplicate bills. The second database is identical to the Spawn database.

Each CPT code in the Lehto, Spawn and Stemper databases identifies a procedure described as an injection. Beyond that, however, there is no evidence the procedures are similar, whatever that word may mean in the context of the rule. The injections involve different levels and areas of the spine and different agents. Without further evidence, there is no factual basis for the compensation judge or this court to conclude the procedures in the database are similar to the procedure provided to Lehto, Spawn or Stemper.

The appellants had the burden of establishing by a preponderance of the evidence that the services included in the databases were the same or, as they contended, at least similar or equivalent to the services provided to the employees. At best, we can conclude the CPT codes in the databases involve injections as do the procedures provided to the employees in these cases. But whether one type of injection is similar to another is a subject for expert testimony which is not present here. We conclude the appellants have failed to prove the databases contain at least 20 billings for the service, article or supply. Absent proof that the databases include the minimum number of similar services, we need not decide the issue of whether the services described in the databases need only be similar or must be the same as those provided the employees.

4. Billings for Services

Minn. R. 5221.0500, subp. 2.B.(2)(b), requires that a database contain at least 20 billings for the service, article or supply. The documentation for each database submitted into evidence by the appellants consists of a one page summary with 20 entries and a computer print screen for each included charge. Copies of original bills from providers are included for some but not all of the 20 entries. For those entries for which there is no bill from the provider, the only support is the computer print screen. The print screen is an abstract of the bill as captured by Qmedtrix's BillChek software and includes the state,

provider type, diagnostic codes, date of service, CPT code and the amount charged for the procedure. The compensation judge found the computer print screen was not a substitute for a bill and the databases did not contain 20 billings as required by the rule. The appellants contend this finding is unsupported by the evidence.

The rule requires a bill for each service included in the database.^[18] The word bill is unequivocal and does not include a summary or abstract of the bill. Absent the original bill from the provider, it is not possible to verify the accuracy of the Qmedtrix abstract of the bill. We affirm the compensation judge's finding that the databases do not comply with Minn. R. 5221.0500, subp. 2.B.(2)(b).

5. Bill for Infusion Pump

The employee in Spawn underwent surgery at Lakewalk in March 2005 consisting of placement of an intrathecal catheter and implantation of an infusion pump. The bill included a \$1,010.00 charge for the catheter procedure, CPT code 62350 51, \$4,027.00 for implantation of the pump, CPT code 62362, and \$17,647.50 for IV Therapy / INFSN pump, CPT code E0783. Qmedtrix reviewed the bill and the insurer ultimately paid \$12,100.13. The compensation judge found that although the employer and insurer asserted Lakewalk's charges for the infusion pump were excessive, the evidence introduced did not meet any of the conditions for excessive provider charges listed in Minn. R. 5221.0500, subp. 1. Nor, the judge found, was evidence introduced which would bring the employer and insurer's calculations under the prevailing charge aspect of Minn. R. 5221.0500, subp. 2.B.(2). We agree.

The insurer asserted the services performed on March 14, 2005, were paid at 85% of the usual and customary charges after correction of billing errors and excess charges. More specifically, the appellant contended Lakewalk's bill included duplicative facility fees for the surgery involved, and was excessive under Minn. R. 5221.0500, subp. 1.A. This rule states that a payer is not liable for a charge that wholly or partially duplicates another charge for the same service, article or supply. Relying on a Medtronic invoice for a Model #8637-40 pump with a unit price of \$11,200.00, the insurer and Qmedtrix marked down the bill by approximately \$6,000.00. The appellant asserts the \$17,647.50 bill reflects a duplication of charges included in the CPT procedural codes, and there is no justification by way of unbilled facility costs for such a substantial markup.

The invoice submitted in the Spawn case (Jt. Ex. RA.91) consists of a copy of a page from the internet showing a 2006 box price of 11200 for a Medtronic SynchroMed II Pump, part number 863740. Nothing was submitted, by either party, establishing the fees and costs that were, in fact, included in the infusion pump bill or incorporated in the surgical procedure charges. Neither party submitted any evidence providing an explanation or full description of the CPT codes included in the bill, that is CPT code 62350 51, CPT code 62362, or CPT code E0783, nor how these codes were, or would be, applied to determine the proper charge(s) for the services, articles or supplies included in the bill. No database was provided in support of the reduction.

The appellant had the burden of establishing that Lakewalk's charges for the surgery on March 14, 2005, were excessive within the meaning of Minn. R. 5221.0500, subps. 1.A. or 2.B. Any such finding, on the record here, would be speculative. We, therefore, affirm the compensation judge's finding.

6. Unbundling

The appellant insurer in Stemper, on appeal, makes no argument regarding the reduction of charges for the March 3, 2005, date of service, other than the database arguments made in all of the cases. There is

no database that includes CPT codes G0260 or 76005, and no argument is made specifically regarding these procedures. Nor was any argument made or evidence presented regarding unbundling of services. We therefore affirm the compensation judge's award of reimbursement at 85% of Lakewalk's usual and customary charge for these services.

In summary, we conclude the compensation judge's award of payment to Lakewalk at 85% of Lakewalk's usual and customary charges for medical services provided to the employees herein, is, on the record before us, supported by the evidence, and must be affirmed.

SEPARATE OPINION

DEBRA A. WILSON, Judge

To the extent that no grounds exist to grant the appellants any relief, I concur with the majority. However, in my opinion, the appeals do not present a justiciable controversy.

In their briefs, the appellants concede that the Rule requires that the database consist of billings covering the calendar year predating the year and date of the service in question, and it is undisputed that this condition was not satisfied in any of the cases now before us. Having acknowledged that the necessary criteria to establish a prevailing charge under the applicable rules have not been fulfilled, the appellants have also acknowledged, at least implicitly, that their obligation to pay Lakewalk as ordered by the compensation judge will be unaffected by this court's disposition of the contested issues. In fact, the appellants have not requested reversal of the compensation judge's orders for payment, only reversal of the judge's interpretations as to certain elements of the rules.

Under the doctrine of mootness, the requisite personal interest in a controversy must exist throughout the course of the litigation. See Chaney v. Minneapolis Cmty. Dev. Agency, 641 N.W.2d 328, 332 (Minn. Ct. App. 2002). If a court cannot grant effectual relief, the issue will be deemed moot. Id. At this point in these proceedings, there are simply no concrete interests at stake with respect to these particular appeals. Simply put, the appellants cannot win and in fact do not hope to do so. I understand that the parties desire guidance for purposes of handling other cases, involving Lakewalk, that are currently pending in the system. However, appellate courts are to hear only live controversies and will not pass on the merits of a particular question merely for the purpose of setting precedent. In re Inspection of Minn. Auto Specialties, Inc., 346 N.W.2d 657, 658 (Minn. 1984). Well reasoned and thorough though it may be, the majority's opinion is advisory, and, therefore, impermissible. See, e.g., Herrly v. Walser Buick, Inc., 47 W.C.D. 670, 675 (W.C.C.A. 1992) (the W.C.C.A. has no authority to issue advisory opinions). Because these appeals are clearly moot, dismissal is the only appropriate disposition.

^[1] See infra p. 9.

^[2] The compensability of the employees' injuries was not in issue, nor was the reasonableness and necessity of the medical treatment provided to the employees.

^[3] Mr. von Sydow is the Director of National Dispute Resolution for Qmedtrix.

^[4] See, e.g., Minn. Stat. 176.135, subd. 7; Minn. R. 5221.0700.

^[5] See Minn. R. 5221.0100, subp. 4.B., and Minn. R. 5221.0405.

^[6] Finding 24 in the Stemper case, in which the judge concluded that the employer and insurer failed to establish that Lakewalk's charge for the infusion pump was excessive, was *not* appealed. Thus, on appeal, the infusion pump billing remains at issue in the Spawn case only.

^[7] See Minn. R. 5221.0100, subp. 11.

^[8] A charge is defined as the payment requested by a provider on a bill for a particular service. Minn. R. 5221.0100, subp. 3.

^[9] Under subpart 2.A., a payer's liability is limited to the medical fee schedule, if the fee schedule applies to the charge at issue. In the cases before us, there is no argument that any of the disputed charges should have been paid pursuant to the fee schedule.

^[10] Minn. R. 5221.0500, subp. 2.B., provides:

B. Except as provided in items C to F, if the maximum fee for service, article, or supply is not limited by parts 5221.4000 to 5221.4070, the payer's liability for payment shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charge for similar treatment, articles, or supplies furnished to an injured person when paid for by the injured person, whichever is lower.

(1) A usual and customary charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraphs (a) and (b), means the amount actually billed by the health care provider to all payers for the same service, whether under workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system.

(2) A prevailing charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (b), is the 75th percentile of the usual and customary charges as defined in subitem (1) in the previous calendar year for each service, article, or supply if the database for the service meets all of the following criteria:

(a) the database includes only Minnesota providers, with at least three different, identifiable providers of the same provider type, distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service, or provider of other similar service, article, or supply;

(b) there are least 20 billings for the service, article, or supply; and

(c) the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the database or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings.

^[11] Two databases were submitted in the Stemper case, one in the Spawn case and one in the Lehto case. One of the Stemper databases was identical to the Spawn database. See supra p. 6.

^[12] The Qmedtrix print screens contained in Spawn Jt. Ex. F.1-20, for example, code providers such as Landmark Surgery Center, the Ambulatory Surgery Center in Thief River Falls, and Willmar Surgery

Center as SC, which we assume means ambulatory surgical center. None of the Statements of Facts or the attached documents, however, interpret or explain the various Qmedtrix print screen codes.

^[13] Additionally, in the Lehto case, included in the minimum 20 billings are charges from St. Francis Medical Center. Based on the copy of the original bill (Ex. G, RA 59) this facility is a hospital with less than 100 beds, which the appellants appear to concede is not the same provider type. See Minn. R. 5221.0500, subp. 2.C.

^[14] See Affidavit of Gloria Roy (Spawn Jt. Ex. RA-84); Deposition of R. William von Sydow (Er. Ex. 1, pp. 61, 64); Spawn Stipulated Facts 12-15; Stemper Stipulated Facts 23, 25.

^[15] See Affidavit of Gloria Roy, id., Sydow Deposition, id.

^[16] Service or treatment means 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. Minn. R. 5221.0400, subp. 15.

^[17] The parties in Spawn further stipulated the payment for the March 14, 2005, date of service (placement of an intrathecal catheter and programmable pump, CPT codes 62350 and 62362) was not reduced based on a database created by Qmedtrix, and that no database, screen prints or medical bills were provided as support for that reduction of payment. (Spawn Stipulated Facts 8-9.) Similarly in Stemper, the parties stipulated that no database had been provided for CPT codes 62350, 62362, E0783, G0260 or 76005, and agreed that payment for the March 8, 2005, date of service was not reduced based upon a database created by Qmedtrix. (Stemper Stipulated Facts 14-15.)

^[18] Bill or billing means a provider's statement of charges and services rendered for treatment of a work related injury. Minn. R. 5221.0100, subp. 2.