PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D43

PROVIDER -
Lloyd Noland Hospital
Fairfield, Alabama

Provider No. 01-0068

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Alabama

DATE OF HEARING-
March 21, 2000

Cost Reporting Period Ended -
June 30, 1993

CASE NO. 96-0527

INDEX

ISSUE:

Was the Intermediary's adjustment disallowing portions of compensation paid to physicians based on the application of the 1984 reasonable compensation equivalents proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Lloyd Noland Hospital ("Provider") is an acute-care, non-profit hospital located in Fairfield, Alabama. For the fiscal year in contention, the Provider incurred physicians' compensation costs for hospital-based physician ("HBP") services which it claimed on its as-filed Medicare cost report for the purpose of obtaining program reimbursement. Blue Cross and Blue Shield of Alabama ("Intermediary") reviewed the Provider's cost report and applied the reasonable compensation equivalent ("RCE") limits to the physicians' compensation pursuant to the regulatory provisions of 42 C.F.R. § 405.482 ff. In calculating the Provider's Medicare reimbursement for physician compensation for fiscal year 1993, the Intermediary applied RCE limits developed by the Health Care Financing Administration ("HCFA") for the 1984 federal fiscal year.

On June 21, 1995, the Intermediary issued a Notice of Program Reimbursement reflecting the application of the RCE limits which disallowed $826,780 of the Provider's Part A HBP costs not attributable to the interns and residents cost center. On December 14, 1995, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $322,000. The Provider was represented by Leslie Demaree Goldsmith, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary's representative was Bernard M. Talbert, Associate Counsel for the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly disallowed portions of the compensation paid to its HBPs for the fiscal year at issue because the adjustments were based on the obsolete RCE limits applicable to the 1984 cost year. Since the RCE limits used have not been updated since 1984, this constitutes a violation of the governing regulations at 42 C.F.R. §§405.482 (b), (f)(1) and (f) (3) (1992, 1993), which require HCFA to update these limits on an annual basis. The Provider cites 42 C.F.R. §405.482 which states:

> (b) HCFA will establish a methodology for determining reasonable annual compensation equivalents, considering average physician incomes by speciality and type of location, to the extent possible using the best available data.
>
> (f)(1) Before the start of a cost reporting period to which limits established under this section will be applied, HCFA will publish a notice in the

> Federal Register that sets forth the amount of the limits and explains how the limits were calculated.
>
> (f)(3) Revised limits updated by applying the most recent economic index data without revision of the limit methodology will be published in a notice in the Federal Register without prior publication of a proposal or public comment period.

42 C.F.R. § 405.482(b), (f)(1) and (f)(3) (emphasis added).

In addition to the plain language of the regulation, the Provider notes that HCFA's interpretation of its own regulations requires annual updating of the RCEs on the basis of updated economic index data. Specifically, in 1982, when HCFA proposed the RCE limits, it stated: "[w]e propose to update the RCE limits annually on the basis of updated economic index data", (emphasis added) 47 Fed. Reg. 43577 at 43586 (October 1, 1982).[1] Then, in 1983, when HCFA adopted the final regulations it affirmed the need to annually update the RCE limits by stating: "[t]he RCE limits will be updated annually on the basis of updated economic index data" (emphasis added) 48 Fed. Reg 8902 at 8923 (March 2, 1983).[2]

The Provider also points out that HCFA complied with its own regulations and annually updated the initial RCE limits for the first two years following their establishment. In each case, the revisions resulted in an increase in the RCE limits. Moreover, with the promulgation of the final rule HCFA simultaneously published RCE limits applicable to Medicare provider's fiscal years commencing in 1982 and 1983, respectively. In part, HCFA stated:

> [t]he applicable schedule of annual RCE limits is determined by the beginning date of the provider's cost reporting period. That is, if the provider's cost reporting period begins during calendar year 1982, the 1982 RCE limits apply to all compensation for physicians in that portion of the period occurring on or after the effective date of these regulations. For provider's cost reporting period beginning in the calendar year 1983, the 1983 RCE limits will be applied.

48 Fed. Reg. 8902 at 8924 (March 2, 1983) (emphasis added).

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[1] See Provider Exhibit P-10.

[2] See Provider Exhibit P-5.

Also, when HCFA published new and revised RCE limits for providers' cost reporting periods beginning in 1984, 50 Fed. 7123 (Feb. 20, 1985),[3] it again acknowledged the limited applicability and annual nature of each year's RCE limits, as follows:

> [o]n March 2, 1983, we published in the Federal Register (48 F.R. 8902) the RCE limits . . . that are applicable to cost reporting periods beginning during calendar years 1982 and 1983. . . More specifically, § 405.482 (f) requires that before the start of a period to which a set of limits will be applied, we will publish a notice in the Federal Register that sets forth the limits and explains how they were calculated. If the limits are merely updated by applying the most recent economic index data without revising the methodology, then revised limits will be published without prior publication of a proposal or public comments period . . . Thus, because we are calculating the 1984 limits using the same methodology that was used to calculate the limits published on March 2, 1983, we are now publishing these revised limits in final.

50 Fed. Reg. 7123 at 7124 (Feb. 20, 1985) (emphasis added).

The Provider asserts that nowhere in this regulatory language, or anywhere else including the rule itself, does HCFA state or imply that the 1984 limits would or could apply to any cost reporting period other than one beginning during the 1984 calendar year.

The Provider maintains that the consistency of HCFA's interpretation of its own regulation is further evidenced by a proposed rule published in 1989.[4] In the preamble, HCFA indicates the desire that annual updates to the RCE limits would no longer be required. HCFA also expresses its clear belief that in order to discontinue annual updates, properly, it would have to amend the RCE regulation in order to effectuate its intent to only update the RCE limits if a significant change is warranted. In part, HCFA states:

> [s]pecifically, Section 405.482(f) provides that before the start of a cost reporting to which a set of limits will be applied, we must publish a notice in the Federal Register that sets forth the limits and explains how they were calculated . . . The latest notice that updated the RCE limits was published in the Federal Register on February 20, 1985 (50 F.R. 7123) and was effective for cost reporting periods beginning on or after January 1, 1984 . . . Although the regulations do not specifically provide for an annual adjustment to the RCE limits, the

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[3] See Provider Exhibit P-6.

[4] See Provider Exhibit P-11.

> preamble to the March 2, 1983 final rule, which described the updating process, indicated that the limits would be updated annually. (48 F.R. 8923). In addition, Section 405.482(f)(1) requires that the limits be published prior to the cost reporting period to which the limits apply. We believe that publishing annual limits, an administratively burdensome procedure, has become difficult to justify. Therefore, we are proposing to make some changes in current Section 405.482 . . .Since we believe that annual updates to the RCE limits will not always be necessary, we propose to revise current Section 405.482(f) to provide that we would review the RCE limits annually and update the limits only if a significant change in the limits is warranted.

54 Fed. Reg. 5946 at 5956 (February 7, 1989) (emphasis added).

The Provider asserts, therefore, that HCFA's current statement that the existing regulations do not require annual updates is clearly disingenuous and self-serving in light of its expressed desire to change the existing regulation so that annual updates are no longer required. Moreover, HCFA implemented its interpretation that the regulations require it to annually update the RCE limits when it set limits for each of the years 1982, 1983 and 1984. In the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2182.6C, HCFA clearly indicates that the 1984 RCE limits apply only to providers' cost reporting periods beginning in 1984. In part, the manual states:

> [t]he RCE limits are always applied to the hospital's entire cost reporting year, based on the calendar year in which the cost reporting year begins.

HCFA Pub. 15-1 § 2182.6C.

The Provider asserts that the program instructions are indicative of HCFA's interpretation of the regulation. The Provider refers to the Seventh Circuit which, in reference to HCFA, stated:

> [a]s the Administration is an arm of HCFA, the [Provider Reimbursement] Manual is best viewed as an administrative interpretation of regulations and corresponding statutes, and as such it is entitled to considerable deference as a general matter.

Davies County Hospital v. Bowen, 811 F. 2d 338 (7th Cir. 1987).[5] See also Shalala v. Guernsey Memorial Hospital, U.S. 115 S. Ct. 1232 (1995).[6]

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[5] See Provider Exhibit P-13.

[6] See Provider Exhibit P-14.

Finally, with respect to the requirements of 42 C.F.R. § 405.482, the Provider asserts that three internal HCFA memoranda also substantiate that the RCE limits must be updated each year. The document dated July 27, 1983, indicated that HCFA will publish a notice in the Federal Register setting forth the amounts of Reasonable Compensation Equivalents (RCE) for hospital cost reporting periods beginning in the following calendar year." See Provider Exhibit P-15 at (C). The document dated October 7, 1983, clearly suggest that HCFA was aware of the requirement that RCE limits be updated annually and that updated limits be published even if the RCE limit setting methodology is unchanged. See Provider Exhibit P-15 at (A). The last document dated May 5, 1983, is one in which HCFA recognizes the fact that providers, in negotiating physician contracts, rely on the Secretary of Health and Human Services' ("Secretary') expressed acknowledgment of her duty to update the RCE limits on an annual basis. See Provider Exhibit P-15 at (B).

The Provider contends that HCFA's failure to update the 1984 RCE limits violated the intent of the enabling statute and Congress. Pursuant to 42 U.S.C. § 1395xx(a)(2)(B), program reimbursement for Medicare Part A physician costs must be "reasonable." Accordingly, HCFA does not have unlimited authority to simply set limits. Rather, limits established by the HCFA must be set at a "reasonable" level to be valid. In this regard, the subject limits are not valid. Clearly, any conjecture that no upward revisions to the limits were necessary to assure reasonable compensation after 1984 is refuted by the following:

- Information compiled by the American Medical Association demonstrates that a rapid escalation of physicians'salaries across specialities and locations occurred during the latter half of the 1980s and early 1990s. For example, in 1983, the mean physician net income (in thousands of dollars) of all physicians was 104.1. This amount increased to 164.3 in 1990. See Provider Exhibit P-9.

- HCFA updated physician screens for Part B payments to physicians every year since 1983 except for 1985. These fee screens are based on the Medical Economic Index which is both readily available and used by HCFA. See 51 Fed. Reg. 42007 (November 20, 1986).[7]

- HCFA's methodology for updating the limits requires an update corresponding with the increase in the Consumer Price Index ("CPI"). HCFA's stated rationale for implementing this particular methodology was that the CPI is the best estimate of the increases in physician income and should thus be accounted for in setting the RCE limits. 48 Fed. Reg. 8902 at 8923 (March 2, 1983). In this regard, the CPI increased from 1984 through 1993. For example, the CPI for all urban consumers for all items in 1980 was 82.4. In 1985, it increased to 107.6. In 1993, the CPI soared to 145.8. See Provider Exhibit P-5.

The Provider maintains that HCFA had annual economic data relating to physician compensation increases and physician fee increases, but failed to utilize this data to update the RCE limits. This failure

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[7] See Provider Exhibit P-17.

is inconsistent with program instructions at HCFA Pub. 15-1 § 2182.6C, which states that the "best available data are [to be] used . . . [and] [t]he RCE limit represents reasonable compensation for a full-time physician."[8]

Also, Congress expressly stated that the intent in differentiating between Part A and Part B physicians' costs was to:

> assure the appropriate source of payment, while continuing to reimburse physicians a reasonable amount for the services they perform. Our intention was not to penalize but rather to create some equity between the way we pay physicians generally and the way we pay those who are hospital based. (Congressional Record, vol. 128, No. 15, August 19, 1982. S 10902).

47 Fed. Reg. 43,577 at 43,579 (October 1, 1982) (emphasis added).[9]

Application of the 1984 RCE limits to the Provider's 1993 fiscal year will not result in reasonable reimbursement for the Provider's HBP costs. A dissenting opinion in Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D12, Dec 8, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,983 ("Los Angeles"), explains that application of the 1984 limits to the 1989 cost year will not result in reasonable HBP reimbursement. The dissenting opinion notes:

> [c]learly, physicians' salaries were increasing during the periods in question and at least some updated RCE limits would have been necessary to assure that reimbursement to providers under the Medicare program for Part A physician services would continue to be reasonable. The Intermediary proffered no evidence to the contrary, including any evidence which could have suggested that on a national or regional basis, Medicare providers' Part A physician costs were static during the cost reporting periods in question in this appeal.

Los Angeles at Medicare & Medicaid Guide (CCH) ¶42,983.[10]

The Provider maintains that no valid RCE limits have been established for its 1993 cost reporting period and, consequently, the Provider must be reimbursed for its actual Part A physicians' costs. Abington Memorial Hospital v. Heckler, 750 F.2d 242, 224 (3rd Cir. 1984) (the court ruled that

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[8] See Provider Exhibit P-12.

[9] See Provider Exhibit P-10.

[10] See Provider Exhibit P-18.

where a particular rule or method of reimbursement is held not to apply, the prior method of reimbursement must be utilized).

The Provider contends that HCFA's failure to apply annual CPI updates violates the Administrative Procedure Act("APA") and the RCE regulation.[11] Before HCFA may establish a legal standard, the APA requires that a notice of the proposed standard be published in the Federal Register and that interested persons be afforded the opportunity to participate by means of written comment or oral presentation. A final rule can be adopted only after consideration of public comments pursuant to 5 U.S.C. § 553. See Buschmann v. Schweiker, 676 F. 2d 352, 355-56 (9th Cir. 1982).[12]

In compliance with the APA's notice and comment requirement, HCFA established the methodology that was to be applied in annually updating the RCE limits. HCFA, complying with this methodology, set the RCE limits for 1982, 1983 and 1984 cost years. For each year, application of this methodology resulted in an increase in the limits in accordance with data on average physician specialty compensation and updated economic index data. However, without providing any notice or opportunity for comment, and without offering any explanation for departing from its prior practice of annually updating the RCE limits in compliance with the published methodology, HCFA abruptly stopped updating the RCE limits even though inflationary changes mandated an update. Accordingly, the change in the RCE methodology is invalid for noncompliance with the requirements of the APA.

The Provider asserts that HCFA's failure to update the RCE limits, which constitutes a substantive change in the RCE methodology, is also inconsistent with 42 C.F.R. § 405.482 (f)(2), which provides:

> [i]f HCFA proposes to change the methodology by which payment limits under this section are established, HCFA will publish a notice with opportunity for public comment to that effect in the Federal Register. The notice would explain the proposed basis for setting limits, specify the limits that would result, and state the date of implementation of the limits.

42 C.F.R. § 405.482 (f)(2) (emphasis added).

The Provider maintains that HCFA's failure to update the RCE limits in compliance with its published methodology constitutes a change in methodology which is invalid because it violates the express requirements of the quoted subsection; the change was not preceded by prior notice and opportunity for public comment. The Provider cites Morton v. Ruiz, 415 U.S. 199, 235 (1974), where the Supreme Court noted that an agency must comply with its own procedures.[13] Therefore, the Board is

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[11] See Provider Exhibit P-20.

[12] See Provider Exhibit P-21.

[13] See Provider Exhibit P-22.

foreclosed from giving effect to a change in methodology that violates the clear wording of the RCE regulation and the APA.

The Provider also contends that HCFA's failure to update the RCE limits violates Congress' prohibition against cost shifting.[14] Statutory provisions at 42 U.S.C. § 1395x(v)(1)(A) direct HCFA to assure through regulations that providers'cost of providing Medicare services are reimbursed and that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by such individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . ."Id. See also 42 C.F.R. § 413.5. [15] Respectively, the Provider argues that HCFA's failure to continue updating the RCE limits from 1984 through 1997 has caused Medicare providers to be under-reimbursed for their Medicare Part A physicians' costs. The failure to update consequently resulted in non-Medicare patients bearing increased Part A physician costs, which should have been borne pro rata by the Medicare program. This is contrary to the direct instructions of Congress.

The Provider contends that the case law to date is not applicable because it is unpersuasive and distinguishable. Specifically, the issue of whether or not HCFA is bound to annually update the RCE limits has, to date, been raised in a number of appeals. In Good Samaritan Hospital and Health Center v. Blue Cross and Blue Shield Association/Community Mutual Ins. Co., PRRB Dec. No 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶41,399,[16] the Board, in a two-to-one decision, concluded that the RCE regulation promulgated by HCFA did not mandate that the RCE limits be updated annually. The Board majority came to the same conclusion in Los Angeles.[17] However, the Board majority, while conceding that HCFA was not required to annually update the RCE limits, stated:

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[14] See Provider Exhibit P-3.

[15] See Provider Exhibit P-23.

[16] See Provider Exhibit P-24.

[17] See also Palomar Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D21, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,073 (See Provider Exhibit P-26); Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D19, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,071 (See Provider Exhibit P-27); Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D20, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,072 (See Provider Exhibit P-28); Rush Presbyterian St. Luke's Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 97-D22, January 15, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,037 (See Provider Exhibit P-32).

> [t]he Board majority fully considered the physician compensation study published by the American Medical Association which illustrates undisputed increases in mean physician net income spanning the period from 1984 to the fiscal year in contention. While the majority of the Board finds the Provider's argument persuasive in demonstrating that the applied RCEs may be unreasonable in light of the increased compensation during this time period, the Board majority is bound by the governing law and regulations.

Los Angeles, CCH ¶42,983.

In all of these cases, the HCFA Administrator declined to review the Board's decisions. The providers in Los Angeles appealed to the district court for the District of Central California. County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx)(C.D. Cal. 1995) (Dec. 13, 1995).[18] The district court, in an unpublished decision, ruled in favor of the Secretary. The district court concluded that the plain meaning of the regulation did not mandate annual updates of the RCE limits despite the fact that HCFA itself had interpreted the regulation to require annual updating. The district court refused to give any weight to HCFA's discussion of the RCE updates promulgated in 1989, 54 Fed. Reg. 5946,[19] or to two intra-agency memoranda proffered by the plaintiffs that clearly demonstrate the agency's commitment to annually update the RCE limits. The preamble and the memoranda were excluded from the court's consideration on the ground that they had not been placed in evidence before the PRRB.

Even if the reasoning in these cases is adopted, the Provider argues that they are in any event, distinguishable. The issue in these cases was whether or not the regulation promulgated by HCFA, bound it to annually update the RCE limits. The Board majorities and the district court did not opine as to:

(1) Whether HCFA, by failing to annually update the RCE limits, acted contrary to the Congressional mandate that only costs found to be unreasonable by virtue of application of valid RCE limits be disallowed;

(2) Whether HCFA's failure to annually update the RCE limits constitutes a change in the published methodology and is void for noncompliance with the notice and comment requirement of the APA; and

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[18] See Provider Exhibit P-25.

[19] See Provider Exhibit P-11.

(3) Whether or not HCFA's failure to annually update the RCE limits resulted in "cost shifting" in violation of Congress' prohibition against program costs being borne by non-Medicare patients;

In summary, the Provider contends that it is clear from HCFA's Federal Register discussions, its own actions in initially setting and then updating the RCE limits on an annual basis for three consecutive years, and three HCFA intra-agency memoranda, that the RCE limits were intended to, and should have been updated annually. The RCE limits published to date were specifically limited to the years indicated; therefore, they do not apply to the subject cost reporting period at issue. Since the Supreme Court has long held that an agency may not violate its own regulation, Morton v. Ruiz, 415 U.S. 199, 235 (1974),[20] no valid RCE limits apply to the fiscal year at issue. Consequently, the Provider must be reimbursed its actual Part A physicians' costs so long as they are otherwise reasonable. Abington Memorial Hospital v. Heckler, 750 F2d 242, 244 (3rd. Cir. 1984), where the court ruled that where a particular rule or method of reimbursement is invalidated the prior method of reimbursement must be utilized.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the regulatory provisions of 42 C.F.R. § 405.482(b) allow HCFA to establish a methodology for determining RCEs on the amount of compensation paid to physicians by providers. The Intermediary's adjustment implements the regulatory provisions of 42 C.F.R. § 405.482 as they existed at the time the established RCE limits were applied to physicians' compensation reported by the Provider. Paragraph (b) of the regulation grants HCFA the authority for determining reasonable compensation equivalents by taking into consideration average physician incomes by specialty and type of location, and using the best available data to the extent possible. If a change in methodologies and payment limits is proposed by HCFA, paragraph (f) sets forth the notification procedures which will be followed to execute such changes. With regard to the notification procedures, the regulation at 42 C.F.R. § 405.482 (f) (3) states that:

> (3) Revised limits updated by applying the most recent economic index data without revision of the limit methodology will be published in a notice in the Federal Register without prior publication of a proposal or public comment period.

42 C.F.R. § 405.482 (f)(3).

Contrary to the Provider's contentions, this regulation does not mandate that the RCEs used to limit allowable physician compensation be updated annually, but merely establishes the notification procedure to be followed. Accordingly, the Intermediary is correct in using the latest RCEs published

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[20] See Provider Exhibit P-22.

by HCFA, and that the limits must be applied to all physician compensation not paid under the prospective payment system ("PPS") as required by 42 C.F.R. §405.482 (a) (2).

The Intermediary concludes that its adjustment disallowing portions of compensation paid to physicians based on the application of the 1984 reasonable compensation equivalents (RCEs) was proper and should be affirmed by the Board.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395xx et seq.	-	Payment of Provider-Based Physicians and Payment Under Certain Percentage Arrangements

2. Law - 5 U.S.C.:

§ 553 et seq.	-	Administrative Procedure Act

3. Regulations - 42 C.F.R.:

§ 405.482 et seq.	-	Limits on Compensation for Services of Physicians in Providers
§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5	-	Cost Reimbursement: General

4. Program Instructions-Provider Reimbursement Manual (HCFA Pub. 15-1):

§ 2182.6C	-	Reasonable Compensation Equivalents (RCEs)

5. Case Law:

Good Samaritan Hospital and Health Center v. Blue Cross and Shield Association/Community Mutual Ins. Co, PRRB Dec No. 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399, declined rev. HCFA Admin., May 21, 1993.

Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec No. 95-D12, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶42,983, declined rev. HCFA Admin., January 12, 1995, affd. County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal. 1995), aff'd. County of Los Angeles v. Secretary of Health and Human Services, 113 F.3d 1240, (9th Cir. 1997).

Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D19, March 13, 1996, Medicare and Medicaid Guide (CCH) § 44,071, declined rev. HCFA Admin., May 1, 1996.

Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D20, March 13, 1996, Medicare and Medicaid Guide (CCH) §44072, declined rev. HCFA Admin., May 1, 1996.

Palomar Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D21, March 13, 1996, Medicare and Medicaid Guide (CCH) § 44073, declined rev. HCFA Admin., May 1, 1996.

Rush-Presbyterian-St. Lukes Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 97-D22, January 15, 1997, Medicare & Medicaid Guide (CCH) ¶45,037, declined rev. HCFA Admin., February 25, 1997, rev'd. Rush-Presbyterian-St. Lukes's Medical Center v. Shalala, No. 97-C- 1726, 1997 WL 543061 (N.D. ILL).

Morton v. Ruiz, 415 U.S. 199 (1974).

Abington Memorial Hospital v. Heckler, 750 F.2d 242 (3rd Cir. 1984).

Buschmann v. Schweiker, 676 F.2d 352 (9th Cir. 1982).

Davies County Hospital v. Bowen, 811 F.2d 338 (7th Cir. 1987).

Shalala v. Guernsey Memorial Hospital, U.S. 115 S. Ct. 1232 (1995).

6. Other:

47 Fed. Reg. 43577 (Oct 1, 1982).

48 Fed. Reg. 8902 (March 2, 1983).

50 Fed Reg. 7123 (Feb. 20, 1985).

51 Fed. Reg. 42007 (Nov. 20, 1986).

54 Fed. Reg. 5946 (Feb. 7, 1989).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

The Intermediary applied RCE limits published in the Federal Register on February 20, 1985, and effective with cost reporting periods beginning on or after January 1, 1984, to the Part A physicians' compensation paid by the Provider for its fiscal year ended June 30, 1993. The Provider's fundamental argument regarding this application is that the limits were obsolete and not applicable to the subject cost reporting period, i.e., because HCFA failed to update them on an annual basis as required by the enabling regulation.

The principle and scope of the enabling regulation, 42 C.F.R. § 405.482(a)(1), require HCFA to establish RCE limits on the amount of compensation paid to physicians by providers, and that such limits "be applied to a provider's cost incurred in compensating physicians for services to the provider. . ." (emphasis added). However, contrary to the Provider's contentions, the Board finds that this regulation does not mandate that the RCE limits be updated annually or on any other stipulated interval.

The Board agrees with the Provider that language used in Federal Register notices, internal HCFA memoranda, and program instructions indicate that HCFA had intended to update the limits on an annual basis. However, the Board concludes that the pertinent regulation is controlling in this instance and, as discussed immediately above, it does not require annual updates.

Finally, the Board acknowledges the Provider's argument that net physician income clearly increased throughout the period spanning 1984 through the fiscal year in contention. While the Board finds this argument persuasive in demonstrating that the subject RCE limits may be lower than actual market conditions would indicate for the subject cost reporting period, the Board concludes that is bound by the governing law and regulations.

In sum, the Board continues to find, as it has in the previous cases, that the application of the 1984 RCE limits to subsequent cost reporting periods is proper.

DECISION AND ORDER:

The Intermediary's adjustment disallowing portions of compensation paid to physicians based on the application of the 1984 reasonable compensation equivalents was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: April 5, 2000

FOR THE BOARD

Irvin W. Kues
Chairman