PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2005-D48

PROVIDER -
Long Beach Memorial Hospital
Long Beach, NY

Provider No.: 33-0225

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Empire Medicare Services

DATE OF HEARING -
May 23, 2005

Cost Reporting Period Ended -
December 31, 1991

CASE NO.: 95-0777

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ISSUE:

Whether the Intermediary's application of the reasonable compensation equivalent limits was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Physicians often furnish services to a hospital that are for the general benefit of the hospital's patients.[1] The services are commonly referred to as "provider services," and the physicians are known as "hospital-based physicians." The reasonable cost of these services is reimbursed under Part A of the Medicare program, subject to certain limits known as reasonable compensation equivalents (RCE). 42 C.F.R. §405.482. The issue in dispute in this case is whether the Intermediary properly applied the RCE limits to the Provider's hospital-based physician services.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Long Beach Memorial Hospital (Provider) is a 179 bed acute care facility located in Long Beach, NY. It operates a 24 bed psychiatric unit and a 200 bed skilled nursing facility. For the fiscal period ended 12/31/91, the Provider included the compensation that it paid to its hospital-based physicians (HBP) for provider services in its cost report. Empire Medicare Services

[1] These services are to be distinguished from professional medical services rendered to an individual patient that are reimbursed under Part B of the Medicare program.

(Intermediary) disallowed portions of the claimed compensation by applying the RCE limits published in the Federal Register on 2/20/85 and applicable to cost years beginning on and after 1/1/84. The single issue in dispute is the propriety of using the rates published on 2/20/85 for the 1991 fiscal period.

PARTIES' CONTENTIONS:

The Provider disputes the propriety of the RCE limits applied by the Intermediary to its 1991 cost report. The Provider argues that 42 CFR §405.482(f) requires that, prior to the start of a period to which a set of cost limits will be applied, CMS will publish a notice in the Federal Register that sets forth the amount of the limits and explains how the limits were calculated. The Provider argues that the only limits that have been published through the Federal Register are specifically limited to 1983 and 1984, and that no RCE limits have been published, as required by the regulation, for the years subsequent to 1984. Consequently, the Provider contends that no RCE limits exist to apply to the fiscal 1991 year and that the Secretary's failure to update the RCE limits effectively shifted the cost of HBPs, which should have been borne by the Medicare program, to non-Medicare patients.

The Intermediary argues that the Provider Reimbursement Review Board previously reviewed the application of the rates published on 2/20/85 to a provider's 1991 operations in Belmont Center for Comprehensive Treatment Philadelphia, Pa. vs. Blue Cross and Blue Shield Association/Independence Blue Cross and Blue Shield, PRRB Decision 99-D5. In that decision the Board found that the language of the regulation does not require that the RCE limits be updated annually or on any other stipulated interval. The Intermediary contends that, since CMS has chosen not to revise the RCE limits, the already published limits are applicable and remain in effect for the December 31, 1991 cost report.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, finds and concludes that the application of the 1984 RCE limits to the Provider's hospital-based physician costs was proper.

The pivotal issue in this appeal is the application of the rates published in 1985 to the Provider's 1991 cost report. The Board conducted a comprehensive analysis of the controlling regulation and the Federal Register publication [50 FR 7123, February 20, 1985] that set the RCE limits which were ultimately applied to the Provider's HBP costs. The Board's examination indicated that the principle and scope of the enabling regulation at 42C.F.R. §405.482 require CMS to establish RCE limits on the amount of compensation paid to physicians by providers. The regulation further requires that such limits be applied to a provider's costs incurred in compensating physicians for services rendered to the provider, and that the limits be published in a notice in the Federal Register prior to the start of a cost reporting period to which the limits will be applied. Contrary to the Provider's contentions, the Board can find nothing in the regulation that mandates that the RCE limits be updated annually or on any other stipulated

interval.

The Board's examination of the February 20, 1985 Federal Register notice, which set the RCE limits in dispute, indicates that the notice made the limits applicable for cost reporting periods beginning on or after January 1, 1984. The language of the Federal Register and the absence of a specific interval for update in the regulation require the Board to conclude that the limits published in 1985 remain in effect until such time as CMS revises them. Absent such revision, the Board concludes that the rates published in 1985 apply to the Provider's 1991 cost reporting year.

The Board acknowledges that commentary in the Federal Register indicated that the Secretary originally intended to update the RCE limits annually. However, the final regulation did not include such a requirement, and consequently, the Board may not suspend the application of the published RCE rates. The Board is bound by the governing law and regulation and lacks authority in a matter specifically reserved to the Secretary.

DECISION AND ORDER:

The Intermediary's application of the 1984 RCE limits to the Provider's 1991 HBP costs was proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews-Powell, C.P.A.
Martin W. Hoover, Jr., Esquire
Anjali Mulchandani-West

DATE: July 29, 2005

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson