PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D53

PROVIDER -
St. Francis Hospital
Wilmington, Delaware

Provider No.: 08-0003

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Highmark Medicare Services (f/k/a
Veritus Medicare Services)

DATE OF HEARING -
June 7, 2007

Cost Reporting Period Ended -
June 30, 1997

CASE NO.: 00-1081

INDEX

ISSUE:

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

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due 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 interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 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 portion 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.

Section 1887 of the Social Security Act authorizes the Secretary to determine criteria for distinguishing those services rendered in hospitals or skilled nursing facilities which constitute professional medical services that are rendered by a physician for an individual patient and which may be reimbursed as physicians' services under Part B versus those professional services that are rendered for the general benefit of patients in a hospital or skilled nursing facility and which may only be reimbursed on a reasonable cost basis. For those services that are determined to be for the general benefit of patients, §1887(a)(2)(B), as codified at 42 U.S.C. §1395xx(a)(2)(B), authorizes the Secretary to establish through regulation the "reasonable compensation equivalent" beyond which a provider may not be reimbursed. 42 C.F.R. §405.482 implements the reasonable compensation equivalent (RCE) limits for compensation of physicians by providers that is required by the statute. The issue in dispute in this appeal is whether the Intermediary applied the proper RCE limits to the Provider's hospital-based physicians.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Francis Hospital (Provider) is an acute care facility located in Wilmington, Delaware. For the fiscal period ended 06/30/97, the Provider included the compensation that it paid to its hospital-based physicians for provider services in its cost report. Highmark Medicare Services (formerly Veritus Medicare Services) disallowed portions of the claimed compensation by applying the RCE limits that were published in the Federal Register on 2/20/85 and were applicable to cost years beginning on and after 1/1/84. The single issue in dispute concerns the propriety of using the rates published on 2/20/85 for the 1997 fiscal period.

PARTIES' CONTENTIONS:

The Provider disputes the propriety of the RCE limits applied by the Intermediary to its fiscal 1997 cost report. The Provider argues that 42 C.F.R. §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 1997 year, and the Secretary's failure to update the RCE limits effectively shifted the cost of hospital-based physicians (HBPs) which should have been borne by the Medicare program to non-Medicare patients.

The Intermediary argues the Provider Reimbursement Review Board previously reviewed the application of the rates published in the Federal Register on 2/20/85 to cost reporting periods ending after 1984. In several earlier decisions,[1] the Board found that the language of the regulation does not mandate that the RCE limits be updated annually or at any other stipulated interval. The Intermediary contends that since CMS has chosen not to revise the RCE limits, the published limits are applicable and remain in effect for FY 97.

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 FYE 1997 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 fiscal year 1997 cost report. The Board reviewed the controlling regulation and the Federal

[1] Los Angeles County RCE Group Appeal v. Blue Cross Blue Shield Association/Blue Cross of California, PRRB Decision 95-D12 (December 7,1994); Rush-Presbyterian-St. Luke's Medical Center v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Illinois, PRRB Decision 97-D22 (January 15, 1997); see also Belmont Center for Comprehensive Treatment Philadelphia, Pa. v. Blue Cross and Blue Shield Association/Independence Blue Cross and Blue Shield, PRRB Decision 99-D5 and Long Beach Memorial Hospital v. Blue Cross Blue Shield Association/Empire Medicare Services, PRRB Decision 2005-D48 (July 29, 2005).

Register publication [50 FR 7123, February 20, 1985] that set the RCE limits which were ultimately applied to the Provider's HBP costs and found that the principle and scope of the enabling regulation at 42 C.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 cost incurred in compensating a physician for services rendered to the provider, and that the limits be published in a notice in the Federal Register prior to the start of the cost reporting period to which the limits will be applied. Contrary to the Provider's contentions, the Board found 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, indicated 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 updates in the regulation leads the Board to conclude that the limits published in 1985 remain in effect until such time as CMS revises them.

The Board acknowledges that commentaries in the Federal Register indicated that the Secretary originally intended to update the RCE rates annually. However, the final regulation did not include such a requirement; consequently, the Board finds no authority to suspend the application of the published 1984 RCE limits. 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 FYE 1997 HBP cost 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.
Anjali Mulchandani-West
Yvette C. Hayes

DATE: July 26, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson