PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D75

PROVIDER -Miami Heart Institute
Dade County, Florida

Provider No. 10-0060

vs.

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

DATES OF HEARING-
December 5-8, 1995
May 1-2, 1996

Cost Reporting Period Ended -
December 31, 1985, December 31, 1987 and December 31, 1988

CASE NO. 88-1339

INDEX

ISSUE:

Did the Intermediary correctly apply the lower of cost or charge limit?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Miami Heart Institute ("Provider") is a short-term acute care hospital located in Dade County, Florida. The sole issue in dispute in this appeal is whether Blue Cross of Florida ("Intermediary") correctly applied the lower of cost or charge limit ("LCC").[1] The Provider maintains that in applying the LCC, the Intermediary failed to compare the costs of its unlicensed interns and residents in a non-approved program with the Provider's customary charges for these services. The Provider maintains that the services of its unlicensed interns and residents in a non-approved program were routine services. Under the Medicare Program, the Provider was entitled to reasonable cost reimbursement under Part B for the costs of these services, i.e. on the outpatient side of the cost report, even though the unlicensed interns and residents provided services to inpatients. See 42 C.F.R. § 405.523 and Provider Reimbursement Manual, Part 1 (HCFA Pub.15-1) § 2120(B). The Intermediary did not disallow any of these costs through audit.[2] The Provider asserts, however, that the Intermediary did not reimburse the Provider for these costs because of LCC. The Provider's Part B costs exceeded its Part B charges. The Provider maintains the Part B costs exceeded the Part B charges because the costs for unlicensed interns and residents in a non-approved training program were included in Part B, while the charges for these services were billed to Part A as part of its room charge. The Provider maintains it properly billed for these services as part of its Part A room charge, however, the cost report mechanism requires these costs to be included and reimbursed through Part B. According to the Provider, this room charge was the only customary charge that the Provider made for the services of its unlicensed interns and residents in a non-approved program. The Provider did not bill a separate Medicare Part B

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[1] There has been a significant amount of litigation regarding the jurisdiction of the Provider Reimbursement Review Board ("Board") to hear this appeal. The Intermediary made several attempts to convince the Board to dismiss this appeal, and the Board, on at least three separate occasions, refused to dismiss this case. In light of the determinations that the Board had jurisdiction to hear the Provider's appeal, a pre-hearing conference was held. All necessary papers and briefs were filed. A six day hearing was held in two parts. Four days of hearing were held beginning on December 5, 1995, with two subsequent days of hearing held beginning on May 1, 1996. In addition, lengthy procedural/discovery disputes have all been resolved. See Record Volumes I-IV. The Board has also ruled that the Intermediary, by failing to respond to the Provider's August 23, 1994 "Request for Admissions", by the Board ordered date of July 1, 1995, has admitted these matters. See Record Volume III, No. 135.

[2] The Intermediary argues in its brief that a failure to adjust costs does not mean such costs are allowable. See Tr. at 1194.

charge for these services. As a result, the LCC comparison reflected Part B costs but no corresponding Part B charges. The Provider maintains this is a mismatch. The Intermediary maintains it refused to reclassify the Part A charges for the unlicensed interns and residents services to Part B charges for purposes of the LCC computation because the Provider failed to provide documentation that these charges were included in the room rate. Accordingly, the Provider maintains the Intermediary improperly applied the LCC.

Background

Since the early 1980's and through the years in dispute, fiscal years 1985, 1987, and 1988, the Provider employed unlicensed interns and residents in a non-approved program ("Unlicensed Physicians") to provide services to its inpatients. The Provider's Unlicensed Physicians were composed primarily of foreign medical school graduates, who were not licensed in this country. The services performed by these unlicensed physicians included performing histories and physicals, insertion of nasal gastric tubes, responding to codes blue, assisting on the regular floors, the ICU and the CCU, and assisting in the operating room ("Unlicensed Physician Services"). The Unlicensed Physician Services were similar to the services provided by nurses and other non-physician employees at the Provider. The Provider maintains the use of Unlicensed Physicians to perform these Unlicensed Physician Services was a common practice in South Florida.

Due to the nature of the Unlicensed Physicians Services, the Provider treated them as routine services. As such, the Provider contends it billed for these services in its room charge. Every patient that was admitted to the Provider was billed the same room charge, which included the Provider's Unlicensed Physician Services. The Provider maintains its billing practice was consistent with all other hospitals in the State of Florida that employed Unlicensed Physicians. According to the Provider, all hospitals in the State of Florida treated the services of Unlicensed Physicians as routine services and billed for them as part of their room charge. The Provider did not bill any other charge to any payor of the Unlicensed Physician Services. The room charge was uniformly billed to all payors.

Prior to the disaggregation of LCC, all of the Provider's costs of its Unlicensed Physician Services were compared to its customary charge for these services; however, as a result of disaggregation of the LCC, the Part B costs of Provider's Unlicensed Physicians are not compared to the Provider's customary charges, which are included in Part A. Therefore, the Provider contends the amount that its Unlicensed Physicians costs exceed its total Part B customary charges is related to the costs of Provider's Unlicensed Physicians. The Intermediary has, however, refused to reclassify a portion of the Provider's room charge to Part B.

The Provider maintains that this was an error. The Provider believes it correctly characterized the services of its unlicensed interns and residents in a nonapproved program as routine services and correctly billed all of its routine services in one room charge. The Provider

argues that the regulations and manuals unequivocally require a provider to bill for all of its routine services in its room charge. Thus, the Provider contends it correctly billed for the services of its unlicensed interns and residents in a non-approved program in its single room charge. Based upon its interpretation of the regulations, this was the Provider's customary charge for its unlicensed interns and residents in a non-approved program.

It is the Intermediary's position that the Provider should have developed a charge based upon costs to be used solely for the LCC comparison. The Provider, however, maintained that this charge could not be imposed on any patients, it was not in the Provider's charge master, it was not a charge that was used for Program reimbursement, and it was not a charge that was capable of being collected from a substantial percentage of Provider's patients. Thus, the Provider concluded it was not a customary charge. The Provider argues that even if it had billed the charge required by the Intermediary, it would not have been a customary charge and the Intermediary would not have been permitted to use it for the LCC comparison. Thus, the Provider believes the Intermediary applied the LCC in a manner that was inconsistent with the regulation.

The Board has determined the Provider's appeal has met the jurisdictional requirements of the regulations in 42 C.F.R. § 405.1835-.1841. The Medicare reimbursement effect of the LCC application is approximately $1,000,000.[3] The Provider was represented by Joanne A. Erde of Steele, Hector & Davis. The Intermediary was represented by Michael Berkey of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that in applying the LCC, the Intermediary failed to compare the costs of Provider's Unlicensed Physician Services with the Provider's customary charges for these services. The Provider maintains that the services of its Unlicensed Physician Services were routine services; as such, the Provider billed for these services in its room charge along with its other routine services.[4] The Provider made this determination based upon the nature of the services and the definition of ancillary and routine services set forth in the Manual. The Provider contends the type of services rendered by its unlicensed interns and residents in a nonapproved program were routine services and, as such, they were included within its room charge.[5] The Provider also points to Admission No. 5, in which the Intermediary admitted that the charges for the Provider's unlicensed interns and residents in a nonapproved program

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[3] Intermediary Exhibits I-38 & I-44.

[4] Transcript ("Tr.") at 630, 677, 944.

[5] Tr. at 77, 555, 627, 630, 875,892, 1009.

were included in its room charge and billed to Part A.[6] The Provider maintains it consistently treated them as routine and consistently followed this treatment with all patients. The Provider contends it never treated these services as ancillary services. The Provider further contends that every patient that entered its facility was billed the same room and board charge, which included the services of its unlicensed interns and residents in a non-approved program.[7] The Provider believes its treatment of these services as routine services was consistent with all of the hospitals in Florida that employed unlicensed interns and residents in a non-approved program.[8] The Provider maintains that all of these hospitals treated the services of their unlicensed interns and residents in a non-approved program as routine services and billed for them as part of the room charge.[9] This room charge was the only customary charge that the Provider made for its Unlicensed Physician Services.

The Provider maintains that based upon these facts, it correctly treated the services of its unlicensed interns and residents in a non-approved program as routine services. This position is based upon the definitions of routine and ancillary services in the regulations and the Manual.[10] The Provider interprets these definitions to mean that if it is customary in a provider's State to treat the services as routine, then the services will be routine. And, conversely, if it is customary to bill a separate charge for a service in the provider's state, then the service will be ancillary.[11] In that it is not customary to bill a separate charge for unlicensed interns and residents in a non-approved program in the State of Florida, and it is customary to include these services as routine services in the room charge, under the definitions in the Manual and regulation, the Provider maintains that its Unlicensed Physician Services are routine services. The Provider points out that reading these two regulatory definitions together, a "cost not recognized as an ancillary service under section 2202.8 is a routine service cost unless 2203 permits ancillary allocation."[12] National Medical Enterprises, Inc. v. Shalala, 43 F 3d 691 (DC Cir 1995) ("National Medical").

HCFA Pub. 15-1 § 2303 provides:

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6 Tr. at 1167, Record Volume III, No. 135.

7 Tr. at 632.

8 Tr. at 126, 893, 1028-1029.

9 Id.

10 See definitions in 42 C.F.R. § 413.53(b); HCFA Pub. 15-1 §§ 2202.6 & 2202.8.

11 Provider Post Hearing Brief at 9-10.

12 Provider Post Hearing Brief at 8.

> A separate ancillary charge for a particular item or service other than those listed in § 2202.2 is not recognized, and the cost of the item or service is not included in an ancillary cost center, where the common or established practice of providers of the same class . . . in the same State is to include the item or service in the routine service charge. Where there is no common or established classification of an item or service as routine or ancillary among providers of the same class in the same state, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program.

Id.

The Provider contends the National Medical decision is consistent with the long standing position of the Medicare Program. The Provider also references the Administrator's decision in Twinbrook Convalescent Center v. BCBSA, PRRB Dec. No. 77-D26, April 20, 1977, Medicare & Medicaid Guide (CCH) ¶ 28,455, rev'd HCFA Adm. June 16, 1977, Medicare and Medicaid Guide (CCH) ¶ 28,579, ("Twinbrook"). The Provider maintains that the services of unlicensed interns and residents in a nonapproved program are not ancillary services under HCFA Pub. 15-1 § 2202.8, and that HCFA Pub. 15-1 § 2203 not only does not permit ancillary allocation, it confirms that the services of unlicensed interns and residents in a non-approved program are not ancillary services.

The Provider contends this position has been adopted by the United States Court of Appeals for the Eleventh Circuit in Charter Peachford Hospital Inc. v. Bowen, 803 F 2nd 1541 (11th Cir. 1986)[13] and the United States Court of Appeals for the Eight Circuit in Creighton Omaha Regional Health Care Corp. v. Bowen, 822 F 2d 785 (8th Cir. 1987).[14]

The Provider maintains that based upon the definition of ancillary services set forth in HCFA Pub. 15-1 § 2202.8 and the interpretation of its application in HCFA Pub. 15-1 § 2203, the services of its unlicensed interns and residents in a non-approved program are not ancillary services. Accordingly, under the standard set forth by the U.S. Court of Appeals in National Medical, since the services of unlicensed interns and residents in a non-approved program are not ancillary services, they are routine services. This determination of the Court of Appeals is also consistent with the specific language of the definition of routine services set forth in the regulation and the Manual. Therefore, the Provider contends that the services of unlicensed

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[13] The Provider points out it is located in the Eleventh Circuit. Thus, it contends the Board and HCFA are bound to follow the standard that if it is customary in the provider's state to treat a cost as routine, then it will be routine for purposes of reimbursement.

[14] Provider Post Hearing Brief at 10.

interns and residents in a non-approved program are routine services and were correctly included it its room charge.[15]

In support of this position, the Provider contends that HCFA Pub. 15-1 § 2202.6 directs a provider to bill for all of its routine services in its room charge. The Provider maintains it is uncontroverted that the room charge is the mechanism for billing a patient for routine services.[16] See also, Twinbrook; Ortonville Municipal Hospital v. BCBSA/Blue Cross of Minnesota, PRRB Dec. No. 77-D92, December 8, 1977, Medicare & Medicaid Guide (CCH) ¶ 28,855, rev'd HCFA Adm., February 6, 1978, Medicare & Medicaid Guide (CCH) ¶ 28,920, ("Ortonville"). The Provider notes that the Manual provides that routine services are "[t]hose services included by the provider in a daily service charge--sometimes referred to as the 'room and board' charge." HCFA Pub. 15-1 § 2202. Therefore, the Provider contends that in light of the fact that the services of Provider's unlicensed interns and residents in a non-approved program were routine services, the only place in which the Provider could have billed for these services was in the room charge.[17]

The Provider notes the Board is of the opinion that a provider is limited to one room charge per patient per day. See Ortonville and Twinbrook. The Provider contends it could not have billed one room charge for all routine services except Unlicensed Physicians Services and a separate charge for these services. The Provider believes the HCFA Administrator made this clear in the early years of the program. Therefore, the Provider maintains it could not have billed a separate room charge for the Unlicensed Physicians Services.

The Provider further points out this is also required by Medicare Intermediary Manual ("MIM")
§ 3617. MIM § 3617, the predecessor of MIM § 3669, is premised upon the assumption that a provider bills for its unlicensed interns and residents in a non-approved program in its room charge.[18] It clarifies that this is the correct and expected way for a provider to bill for the services of its unlicensed interns and residents in a non-approved program.[19] The Provider argues that it is written as a directive that does not allow for any other type of billing arrangement and is a mandatory instruction that the provider bill in this manner. Thus, from as early as 1967, providers were required by the Program to bill for the services of their unlicensed interns and residents in a nonapproved program in their room charge. Indeed, the

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15 Provider Post Hearing Brief at 10.

16 Tr. at 195, 319, 891.

17 See Provider Post Hearing Brief at 5.

18 Provider Exhibit P-2.

19 Tr. at 875.

manual provision is written in such a manner that if a provider were to bill in some other way, it would be penalized in those instances where its inpatients have Part B and no Part A.[20]

The Provider rejects the Intermediary's assertion that MIM § 3617 and its successor MIM § 3669 required it to bill a separate and individual charge for its unlicensed interns and residents in a non-approved program. The Provider contends this manual reference, which the Intermediary is relying on, is in direct conflict with the Intermediary's position. The Provider points out that the language of MIM § 3617 makes it clear that the sole purpose of MIM § 3617 and its successor MIM § 3669 was to offer providers a mechanism to receive interim reimbursement when an inpatient did not have Part A coverage, but did have Part B. The scope of these provisions is specifically limited to interim reimbursement, as follows:

> [N]o special indication is requested on SSA-1453 bills since the interim reimbursement rates for those hospitals which provide Part B residents and interns services will include 80 percent of the cost of these Part B services and Part B deductible liability is not determined. The interim reimbursement for these inpatient costs is made under Part A for simplicity; however, the ultimate source of the payments will be the Part B trust fund.

MIM § 3669.1

The Provider maintains that the above paragraph addresses normal inpatient billing on a SSA-1453 when patients have both Part A and Part B coverage. It clearly states that a provider does not have to include any special indication on the inpatient bill to reflect that the services of unlicensed interns and residents in a non-approved program are being rendered. This is due to the fact that the provider's Part A interim reimbursement will automatically include interim reimbursement for the costs of a provider's unlicensed interns and residents in a non-approved program without the provider taking any further action. The Provider contends this was confirmed by the Intermediary's witness, who testified that "[f]or inpatients on a 1453 you don't have to bill anything because the interim reimbursement will be included in Part A interim reimbursement rate."[21] The Intermediary's witness also testified that Part A interim reimbursement automatically included the costs of unlicensed interns and residents in a non-approved program.[22] In addition, an Intermediary witness testified that except for the LCC issue, the Provider's reimbursement for the services of unlicensed interns and residents in a non-approved program would not be impeded because it did not bill for these services.[23]

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20 Provider Post Hearing Brief at 14.

21 Tr. at 1007.

22 Tr. at 566-567.

23 Tr. at 162.

Thus, the Provider contends that MIM § 3617 clearly provides that no billing, other than normal inpatient billing, is required when the patient has both Part A and Part B coverage.

Finally, in addition to the Provider being precluded from imposing charges created pursuant to MIM § 3617 and its successor MIM § 3669 by State law, the Provider believes it is also precluded from imposing these charges created under MIM § 3617 and its successor MIM § 3669 by federal law pursuant to the False Claims Act and the Civil Monetary Penalties provisions. 31 USC § 3802; 42 USC § 1320a-7a. Both of these provisions prohibit claiming payment for services that are not rendered. The Provider argues that under the Intermediary's interpretation of MIM § 3617 and its successor MIM § 3669, the Provider must calculate a per diem for the services of unlicensed interns and residents in a nonapproved program and bill this per diem to each patient for each and every day that the patient is in the hospital.[24] The Provider, however, contends that each patient does not receive the services of unlicensed interns and residents in a non-approved program every day that the individual is in the hospital. The Provider points out that the Intermediary's witness testified that the patient had to be billed for this service regardless of whether the service is received.[25] The Provider believes this is a correct interpretation, however, it would then be required to bill for services that are not rendered.[26] The Provider contends this would fall squarely within the federal preclusion set forth in both the False Claims Act and the Civil Monetary Penalties provisions of the Social Security Act.

The Provider also points out that it was not permitted under Florida law to bill any individual in the State of Florida a separate charge for the services of unlicensed interns and residents in a non-approved program.[27] The Provider notes the Intermediary has admitted this very fact. Specifically, the Intermediary has admitted, in response to the Provider's Request for Admissions, that Florida law prohibits billing an individual charge for unlicensed physician services.[28] The Intermediary's Admission is as follows:

7. Florida law prohibits billing for physician services, if the physician is unlicensed.

Therefore, the Provider concludes it was precluded by Florida law from billing a separate charge to any patient for the services of its unlicensed interns and residents in a non-approved program.

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24 Tr. at 633.

25 Tr. at 200-201.

26 Provider Post Hearing Brief at 23.

27 Provider Post Hearing Brief at 19-20.

28 Id., See Also Record Volume II, No. 135.

The Provider points out in Twinbrook, the Administrator made it crystal clear that a provider was only permitted to bill one room charge, stating "only a single charge for routine services is recognized by the program." The Provider contends the Administrator arrived at this position based upon the HCFA Pub. 15-1 §§ 2202.6 & 2203, stating "[t]hese cited portions of sections 2202.6 and 2203 highlight the program's intent to recognize only a single provider charge for all costs classified as routine by the program." To enforce this, the Administrator later stated in the decision that "[h]ence, providers are required to include only a single, uniform routine charge on bills submitted to the program .... Therefore, the provider may only include a single routine charge on the bills submitted to the program and this charge is the customary charge because it is made to both beneficiaries and other paying patients. . ." Twinbrook at ¶ 28,579.

The Provider also makes note of a HCFA Administrator Decision the following year. See HCFA Adm. Dec. in Ortonville. The Administrator stated the exact same principle, e.g. "only a single charge for routine services is recognized by the program." Id. And, pointing to HCFA Pub 15-1
§§ 2202.6 & 2203, the Administrator again stated that "[t]hese cited portions of sections 2202.6 and 2203 highlight the program's intent to recognize only a single provider charge for all costs classified as routine by the program." Id. However, the Administrator went one step further and stated that the additional per diem charge that the provider was attempting to include as a customary charge for purposes of the LCC could not be used as a "customary charge for the purposes of the lower of costs or charges limitation." Id. Thus, not only could the Provider not have billed an additional room charge for the routine services of its unlicensed interns and residents in a non-approved program, it also could not have used such a charge for the LCC comparison.[29]

The Provider contends that this single room charge was its customary charge for its Unlicensed Physician Services in accordance with 42 C.F.R. § 413.13 & 42 C.F.R. § 413.53. The Provider notes that Medicare rules and regulations require that the LCC limit compare a provider's reasonable cost to its customary charge. The Medicare regulations that govern the application of the LCC limit are set forth at 42 C.F.R. § 413.13(b). This regulation provides that a provider shall be paid the lesser of its reasonable cost or its customary charge for the same service. The Provider contends that the Intermediary has intermittently attempted to substitute a billed charge in lieu of the requirement of a customary charge. The Provider argues that this is clearly not correct.[30] The Statute, regulation and manual provisions all require that the comparison be between reasonable costs and customary, not billed, charges. The Provider contends that in testimony at the hearing, the Intermediary has acknowledged that it must be a customary charge. See Tr. at 125, 350, 352. The LCC regulation states, as follows:

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[29] Provider Post Hearing Brief at 15.

[30] Provider Post Hearing Brief at 16.

> [e]ffective with cost reporting periods beginning on or after January 1, 1974, hospitals, . . . are paid the lesser of the reasonable cost of covered services furnished to beneficiaries or the customary charges, as defined in paragraph (e) of this section, made by the provider for the same services.

42 C.F.R. § 413.13(b).

The Provider contends that to apply this regulation, there must be a comparison of a provider's customary charge with its reasonable costs for each like service. The Provider notes that the regulation defines a customary charge, as follows:

> [T]he charges for services, as defined in § 413.53(b), furnished to beneficiaries. These charges must be recorded on all bills submitted for program reimbursement.

42 C.F.R. § 413.13(e).

The charges for services are defined at § 413.53(b), as follows:

> . . . .[t]he regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services.

Id.

Therefore, the Provider concludes that the regulations provide that a customary charge for purposes of the LCC calculation is the charge for a given service that is charged to both Medicare and non-Medicare patients alike. Accordingly, a charge that is not uniformly applied to all payor classes would not be a customary charge.[31]

The Provider points out that this regulatory definition is further interpreted in HCFA Pub. 15-1
§ 2604.3. It defines a customary charge, as follows:

> Customary charges are those uniform charges listed in provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement. . . . in order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of patients liable for payment on a charge basis. Such charges must also be recognized for program reimbursement.

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[31] Provider Post Hearing Brief at 17.

Id.

The Provider explains that the Manual provision literally echoes Senate Finance Committee Report No. 92-1230 which gave the Committee's understanding of customary charges. This Report defined a customary charge, as follows:

> "customary charges" shall mean (1) the charges listed in an established charge schedule (if the institution has only a single set of charges applied to all patients), or (2) the most frequent or typical charges imposed (if the institution uses more than one charge for a single service). However, in order to be considered the "customary charge," a charge would have to be one that was actually collected from a substantial number of individuals. A charge set up in name only, perhaps primarily to avoid the effect of this provision, is not intended to determine Medicare reimbursement.

Hillhaven Group Appeal v. Ætna Life, PRRB Dec. No 82-D74, May 21, 1982, Medicare & Medicaid Guide (CCH) ¶ 31,912, rev'd HCFA Dep. Adm. Dec., May 26, 1982, Medicare & Medicaid Guide (CCH) ¶ 32,023 ("Hillhaven") at 9952.

Thus, the Provider argues that based on the above, in order to be a customary charge for the LCC comparison, the charge must be in the provider's charge schedule, it must be imposed upon both Medicare and non-Medicare patients, it must be collected from a substantial percentage of patients liable on a charge basis and it must be recognized for Program reimbursement.[32] The Provider asserts that failing to comply with one of these criteria would be sufficient to render the charge not a customary charge. The Provider contends the aforementioned are not charges that can be used for Program reimbursement, nor are they capable of being collected from a substantial percentage of patients liable on a charge basis.[33] The Provider also points out that the Intermediary's witnesses testified and confirmed that a provider did not have to bill a separate charge for the services of unlicensed interns and residents in a non-approved program in accordance with MIM § 3617 and its successor MIM § 3669 to receive reimbursement of its costs for those services.[34] Thus, even though the Provider did not need to bill a separate charge for interim reimbursement, had the Provider had billed this charge, it would not have been a customary charge for the LCC comparison. The Provider maintains that the charge that would be created under MIM § 3617 and its

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[32] The Provider points out that the Board has recently recognized that this is the definition of a customary charge in Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association, PRRB Dec. 96-D29, April 26, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,168 at p. 48,935.

[33] Tr. at 194, 413-421, 465, 891.

[34] Tr. at 162, 702-703.

successor MIM § 3669 would not be a customary charge in accordance with the regulations and Manual provisions set forth above.

The Provider also rejects the Intermediary's assertion in its closing remarks[35] that the costs of its unlicensed interns and residents in a non-approved program were unnecessary. The Provider also rejects the Intermediary's contention that the costs of unlicensed interns and residents in a non-approved program working in an operating room should be disallowed. The Intermediary's witness testified that there was no legal basis or authority for disallowing these costs.[36] The Provider believes the Board is subject to the same limitation. The Provider argues that the issue in this appeal is the application of LCC, not a dispute regarding the allowability of costs. The Provider contends the Intermediary did not make any adjustments to the subject costs for the years in question. The Provider points to the Intermediary Admission to this effect, as follows:

> 3. The Intermediary did not disallow any of the costs of the Provider's unlicensed interns and residents in a non-approved program.

Record Volume III, No. 135.

The Provider rejects the Intermediary's assertion that the costs of unlicensed interns and residents in a non-approved program were unaudited and that the Board should deny these costs for lack of auditable documentation.[37] The Provider points to testimony whereby the Intermediary's witnesses testified the costs of unlicensed interns and residents in a non-approved program were audited in 1985 and 1988 and no adjustments were made.[38]

The Provider also rejects the Intermediary's argument that it is entitled to go back and make adjustments to the costs of the Provider's unlicensed interns and residents in a non-approved program for all of the Provider's years in dispute.[39] The Provider maintains, as a matter of law, that the Intermediary is now time barred from making any adjustment regarding the allowability of the Provider's unlicensed interns and residents in a non-approved program. The Provider points to Bethesda Lutheran Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 96-D23, April 4,

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35 Tr. at 1176.

36 Tr. at 727-728.

37 Provider Position Paper at 45.

38 Provider's Post Hearing Brief at 55-56, Tr. at 100-102, 724-727, 884-886 Provider Exhibit P-4.

39 Provider's Post Hearing Brief at 57, Intermediary Position Paper at 45.

1996, Medicare & Medicaid Guide (CCH) ¶ 44,132, ("Bethesda"). In Bethesda, the Board concluded that an Intermediary is not permitted to make adjustment to a provider's cost report more than 3 years after the date of the NPR. Moreover, the Board concluded that the Board did not have this power either. Thus, the Provider contends there is no basis upon which the Intermediary could be permitted to reaudit the
costs of the Provider's unlicensed interns and residents in a non-approved program and make an adjustment disallowing these costs.[40]

The Provider notes the Intermediary's contention that the only reason for a provider to bill for unlicensed interns and residents in a non-approved program is if a provider had a LCC problem.[41] The Provider also points to the Intermediary's closing remarks at the hearing in which the Intermediary acknowledged that there was no obligation for a provider to bill a charge under MIM § 3617 and its successor MIM § 3669, unless the provider felt that it would like charges for the LCC.[42] Based on the above, the Provider asserts that billing a charge that is solely for the purposes of the LCC renders the charge not customary. As noted above, the Senate Finance Committee Report specifically provides that "[a] charge set up in name only, perhaps primarily to avoid the effect of this provision [LCC], is not intended to determine Medicare reimbursement." See Hillhaven.

The Provider also notes in the record that in January 1980, the Intermediary issued a directive,[43] the Medicare Digest, advising Florida providers that they only had to submit a separate bill for the services of licensed interns and residents in a non-approved program[44] (emphasis added in original). The Provider contends the article, entitled "Billing for House Physicians", makes it clear that no billing was required for the services of unlicensed interns and residents in a non-approved teaching program.[45]

The Provider's primary contention is that its single "room and board"charge was its customary charge for its Unlicensed Physician Services in accordance with 42 C.F.R. §§ 413.13 & 413.53. In support, the Provider argues that this was a charge that was imposed uniformly on all of the Provider's patients, it was included in the Provider's charge master, it was used for Program reimbursement, and it was collected from a substantial percentage of

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40 Provider Post Hearing Brief at 54.

41 Tr. at 702.

42 Tr. at 1184-1185.

43 Provider Exhibit P-3.

44 Provider Post Hearing Brief at 50-51.

45 Provider Position Paper at 16-18.

charge paying patients. Thus, it was the Provider's customary charge for its Unlicensed Physician Services. And, it was the customary charge that the Provider and the Intermediary historically used for the LCC comparison. Upon the disaggregation of the application of the LCC, however, the Provider's Part A room charge was no longer compared to the costs of Provider's Unlicensed Physician Services, which were in Part B. As a result, the LCC no longer compared the reasonable costs of the Provider's Unlicensed Physician Services to the Provider's customary charges for the same service. This caused the Provider's Part B costs to exceed its Part B customary charges when the disaggregated LCC comparison was performed.

The Provider maintains that the Intermediary's failure to reclassify a portion of its Part A room charge to Part B for purposes of the LCC is inconsistent with the regulations and manuals set forth above. The Provider asserts it would also violate one of the most basic principles of the Medicare program, the matching principle. The Provider points out that under the Program, revenue and expense must be matched. By leaving the customary charge of Provider's Unlicensed Physician Services in Part A and the costs in Part B, the revenue and expense are mis-matched.

In summary, the Provider contends that it correctly characterized its Unlicensed Physician Services as routine services and correctly billed all of its routine services, including Unlicensed Physician Services, in one room charge. This room charge was the Provider's customary charge for its Unlicensed Physician Services. The Provider maintains that the Intermediary's failure to reclassify a portion of this charge to Part B for the LCC comparison was inconsistent with the regulations and the Manuals. Moreover, the Intermediary's assertion that the Provider should have billed some additional charge solely for LCC purposes was clearly erroneous. The Provider contends that this separate charge would not have been a customary charge, and would not, therefore, have been able to be used in the LCC comparison. The Intermediary's refusal to reclassify a portion of the room charge to Part B for purposes of the LCC comparison is erroneous. The Intermediary has applied the LCC in a manner that was inconsistent with the regulations.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that based on Medicare Program regulations and policy, the Provider should have billed Part B for the services of unlicensed interns and residents in a non-approved program.

Pursuant to 42 C.F.R.§ 405.523, the costs of Interns and Residents services not in approved training programs, are reimbursable costs. The regulation states:

> [F]or purposes of this section, such services shall be deemed to include services of a physician employed by the hospital who is authorized to practice only in a hospital setting. Even where such services are rendered to inpatients, the cost of the services is not an allowable cost under the hospital insurance program

> but is allowable under the supplementary medical insurance program.

42 C.F.R. § 405.523(a)

The Intermediary also points to 42 C.F.R. § 405.523(b) which stipulates:

> [I]n this connection reimbursement under the health insurance program for services discussed in paragraph (a) of this section will be to the hospital in an amount of 80 percent of the cost of services rendered to the beneficiaries after recognition of the deductible. The beneficiary will incur the expense of the deductible and coinsurance amounts as determined on the basis of the hospital's charges to the beneficiary for its services that are covered under the supplementary medical insurance program.

Id.

The Intermediary contends it is clear from the language of the regulation that the reimbursement will be subject to:

a) 80% of the cost of the services

b) after the recognition of deductibles

c) beneficiary will incur the cost of deductibles and coinsurance.

d) based on the hospital charges to beneficiary

e) services that are covered under the supplemental insurance program.

The Intermediary also notes that the Medicare Intermediary Manual ("MIM") is direct to the point that a provider must bill for these services. Section 3669 of the MIM states:

> [t]he provider determines that part of the inpatient charges which represents the cost of the services of residents and interns who are not under approved teaching programs and bills these separately under Part B, using type of bill code 121 and revenue code 96X, 97X, or 98X as applicable.

Id.

To accomplish the requirement of billing, the MIM provision sets specific procedures for the provider and the intermediary. Regarding the Intermediary procedure, Section 3669 C. states:

> Intermediary Procedures.--Assist the provider in arriving at the inpatient per diem rate for the cost of services covered under Part B provided by residents and interns. (See Provider Reimbursement Manual, Part 1, § 2120 for apportioning costs between inpatient and outpatient per diem and § 2406 for establishing interim rates.) The normal interim reimbursement rate applied to other provider services applies to Part B residents' and interns' services.

Id.

Based on the above regulatory and manual requirements that a provider must bill for these services, the Intermediary maintains the it was the Provider's choice not to bill for the services.[46]

Additionally, the Intermediary points out that the Program's participation in the cost of I/R services must be limited to those beneficiaries who have Part B coverage. Patients not enrolled under Part B are liable for the entire cost of the I/R services. The Intermediary contends that it would be improper to assume that all of the Medicare patients receiving the I/R services have coverage under Part B. The Provider must furnish information to the Intermediary as to which patients receiving I/R services have Part B coverage. Otherwise, costs which are the responsibility of the patient would be improperly transferred to the Medicare program. The Intermediary maintains this violates cross subsidization provisions of Social Security Act, Section 1861(v)(1)(A).

The Intermediary also notes that Provider Reimbursement Manual, Part 1 (HCFA Pub. 15-1) § 2120 requires that ". . .[t]he Provider must maintain a record of the inpatient days of these individuals (not having Part B coverage), so that this cost may be excluded from the amount of program obligation, at the time of the retroactive cost adjustment." The Intermediary maintains that information about individuals with Part B coverage would be obtained from the Provider's billing of I/R services to the Intermediary (not the carrier). Since the billing was not done, there is no record upon which to base the allocation of cost. The Intermediary asserts that the Provider's request to impute charges violates the basic requirement of documentation. The Intermediary contends that the Provider did not provide enough documentation to support its contention that the charges for its unlicensed interns and residents in a non-approved program were included in its room and board charge.[47]

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[46] The Intermediary noted in its closing remarks that its statement on Page 11 of its position paper regarding billing to Medicare patients was a mistake. Tr. at 1174. The Provider contends that since the Intermediary's counsel was not a sworn witness, it's statement regarding the mistake was inappropriate. Provider Post Hearing Brief at 24.

[47] Tr. at 1190-1191, See also Intermediary Position Paper 13-16.

The Intermediary notes that during a June, 1992 meeting, the Intermediary specifically asked the Provider to provide detailed documentation to support its contention that charges for its unlicensed interns and residents in a non-approved program were included in its room and board charge.[48] Various methods of documentation were also discussed, such as how the charges were developed and reported to the Health Care Cost Containment Board (HCCCB). The Intermediary contends the emphasis was, the more detailed and conclusive, the better. In response to this request, the Provider submitted a letter dated August 10, 1992 (Intermediary Exhibit I-5). The Intermediary contends that since this letter did not support the contention that I/R charges were in the room charges, it communicated the need for detailed documentation several times.

On October 10, 1992, the Provider faxed one sheet of information (Intermediary Exhibit 1-6) that the Intermediary regarded as inadequate to support its contention.[49] The Intermediary notes there were several subsequent attempts on the Provider's part to support its contention, however, none of the information was acceptable to the Intermediary.[50] The Intermediary maintains that it is still willing to review evidence that could conclusively demonstrate that the charges for the unreimbursed interns and residents costs were included in the room and board charge.

The Intermediary asserts that the overwhelming regulatory and manual requirements do not provide authority to accede to the Provider's request that the outpatient charges be imputed from the room and board charges. To do so, the Intermediary contends it would have to both neglect its duty and exceed its authority.

It is the Intermediary's overall position that the LCC principle was correctly applied in this case in accordance with 42 C.F.R. § 413.13.[51] The Intermediary notes that § 413.13(e) of the Medicare regulations defines customary charges as:

> [t]he charges for services, as defined in § 413.53(b), furnished to beneficiaries. These charges must be recorded on all bills submitted for program reimbursement.

Id.

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48 Intermediary Position Paper at 22.

49 Intermediary Position Paper at 23.

50 The Intermediary notes that the documents submitted by the Provider related to FYE 1988. The unreimbursed cost, however, relates to periods from 1984 to 1987.

51 Tr. at 241-264, 1175.

The Intermediary maintains the Provider did not bill for the services of I/R; therefore, there are no customary charges to include for the LCC comparison.

The Intermediary also contends the majority of the costs were unnecessary and believes that a contributing factor for excessive costs were that too many people were in the operating rooms.[52]
The Intermediary believes that in addition to the Provider having unnecessary costs in the unlicensed intern and resident areas, the Provider also had excessive costs both in Part B[53] and other hospital areas. The Intermediary contends that overall excessive costs were allocated to Part B through the step-down process. The Intermediary's witness testified that the Provider had regular routine cost limit exception requests[54] and had consistent operating deficits.[55] The Intermediary contends that the previous statements could all be valid reasons as to why the Provider had an LCC problem.

Finally, the Intermediary asserts that the LCC problem was foreseeable and correctable by the Provider.[56] The Intermediary contends that when the law changed regarding the disaggregation of charges, the Provider should have foreseen that it was going to have a problem. The Intermediary argues that although the Provider did not bill for the unlicensed interns and residents in a non-approved program, its excess Part B costs might also be due to the fact that the Part B charges that were billed, were too low.[57] The Intermediary contends that to alleviate its LCC problem, the Provider should have increased its charges.

The Intermediary rejects the Provider's argument that it could not bill for its unlicensed interns and residents because of Florida law. The Intermediary contends the law does not apply since it applies only to unlicensed doctors billing for services in their own name. The Intermediary contends the Provider should have followed the procedures in MIM § 3669 and submitted bills in the hospital's name for its unlicensed interns and residents in a non-approved program.[58]

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52 Tr. at 1176.

53 Tr. at 129-130, 143, 145, 244-246, 253-254.

54 Tr. at 248.

55 Intermediary Exhibit I-91-34.

56 Tr. at 1179, see also Intermediary testimony in Tr. at 156-157, 270-272, 291-295.

57 Tr. at 1177, see also Tr. at 247, 312-315, 365-369, 450.

58 Tr. at 1181.

The Intermediary also takes exception to the Provider's argument that since there were no audit adjustments to the costs of its unlicensed interns and residents in a non-approved program, the costs were therefore allowable. The Intermediary argues that a failure to adjust costs does not mean they are allowable.[59] The Intermedairy also points out that the audit scope for 1985 and 1987 did not include interns and residents costs.[60]

In its closing statement at the hearing, the Intermediary also asked the Board that it be allowed to go back to 1985 and 1987 and fix standby and health and welfare costs that it audited and fixed in the 1988 fiscal year. The Intermediary explains that by the time the 1988 audit was completed, it was too late to reopen 1985 and 1987. The Intermediary argues, however, that those years are currently before the Board and the changes made in 1988 are related to the unlicensed interns and residents in a non-approved program.[61]

In summary, the Intermediary asserts that the Provider choose to ignore the regulatory requirements to bill for the services of unlicensed interns and residents in a non-approved program. The Intermediary maintains that in view of the clear language of the statute and regulation, there is no authority to impute customary charges. The Intermediary maintains the Provider's request to impute charges should be denied.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A)	-	Reasonable Cost

2. Laws - 31 U.S.C.:

§ 3802	-	False Claims Act

3. Laws - 42 U.S.C.:

§ 1320a-7a	-	Civil Monetary Penalties

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

§ 405.523 et seq	-	Interns and Residents Services not in approved Teaching Programs

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59 See Tr. at 1193 for Transcript references on this subject..

60 Tr. at 268-269, 1194.

61 Tr. at 1176-1177, See also Intermediary Position Paper at 11-12, 44-45.

§ 405.1835-.1841	-	Board Jurisdiction
§ 412.113 et seq	-	Payments Determined on a Reasonable Cost Basis
§ 413.13	-	Amount of Payment in Customary Charges for Services Furnished are Less than Reasonable Costs
§ 413.53	-	Determination of the Cost of Services to Beneficiaries

5. Program Instructions-Provider Reimbursement Manual, Part I, HCFA Pub. 15-1:

§ 2120 et seq	-	Reimbursement for Costs of Interns and Residents
§ 2202 et seq	-	Determination of the Cost of Services to Beneficiaries-Definitions
§ 2203	-	Provider Charge Structure as Basis for Apportionment
§ 2604 et seq	-	Lower of Cost or Charges-Definitions

6. Medicare Intermediary Manual, MIM:

§ 3669 (formally § 3617)	-	Residents and Interns not under Approved Teaching Programs

7. Cases:

National Medical Enterprises, Inc. v. Shalala, 43 F 3d 691 (DC Cir 1995).

Charter Peachford Hospital Inc. v. Bowen, 803 F 2nd 1541 (11th Cir. 1986).

Creighton Omaha Regional Health Care Corp. v. Bowen., 822 F 2d 785 (8th Cir. 1987).

Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association, PRRB Dec. 96-D29, April 26, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,168.

Bethesda Lutheran Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 96-D23, April 4, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,132.

Twinbrook Convalescent Center v. BCBSA, PRRB Dec. No. 77-D26, April 20, 1977, Medicare & Medicaid Guide (CCH) ¶ 28,455, rev'd HCFA Adm.. June 16, 1977, Medicare and Medicaid Guide (CCH) ¶ 28,579.

Ortonville Municipal Hospital v. BCBSA/Blue Cross of Minnesota, PRRB Dec. No. 77-D92, December 8, 1977, Medicare & Medicaid Guide (CCH) ¶ 28,855, rev'd HCFA Adm., February 6, 1978, Medicare & Medicaid Guide (CCH) ¶ 28,920.

Hillhaven Group Appeal v. Aetna Life, PRRB Dec. No 82-D74, March 26, 1982, Medicare & Medicaid Guide (CCH) ¶ 31,912, rev'd HCFA Dep. Adm. Dec., May 21, 1982, Medicare & Medicaid Guide (CCH) ¶ 32,023 ("Hillhaven").

8. Other:

Senate Finance Committee Report No. 92-1230

Medicare Digest, January, 1980

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and the Provider's Post Hearing Brief, finds and concludes that the Intermediary correctly applied the lower of cost or charge principle to the Provider's cost reports at issue in this case. Based on the above, the Board concludes that the Intermediary was correct in refusing the Provider's request to reclassify a portion of the Provider's Part A room charge to Part B for purposes of LCC comparison.

The Board finds that the following regulations are paramount to this case. Pursuant to 42 C.F.R. § 405.523, the costs of interns and residents services in a non-approved training program are reimbursable Part B costs. The regulation states:

> [F]or purposes of this section, such services shall be deemed to include services of a physician employed by the hospital who is authorized to practice only in a hospital setting. Even where such services are rendered to inpatients, the cost of the services is not an allowable cost under the hospital insurance program but is allowable under the supplementary medical insurance program.

42 C.F.R. § 405.523(a)

In concert with the above regulation, the Board finds that 42 C.F.R. § 405.523(b) indicates that the services of interns and residents in a non-approved program should have been billed under Part B. 42 C. F. R. § 405.523(b) states:

> [I]n this connection reimbursement under the health insurance program for services discussed in paragraph (a) of this section will be to the hospital in an amount of 80 percent of the cost of services rendered to the beneficiaries after recognition of the deductible. The beneficiary will incur the expense of the deductible and coinsurance amounts as determined on the basis of the hospital's charges to the beneficiary for its services that are covered under the supplementary medical insurance program.

42 C.F.R. § 405.523(b) (emphasis added)

The Board interprets this regulation to imply that charges must be available by beneficiary.

The Board also finds that the regulations clearly provide that a provider shall be paid the lesser of reasonable cost or customary charge for the same service. 42 C.F.R § 413.13(b).

The Board finds that the "matching" principle of aligning costs and charges on the cost report applies in this case assuming matching information is available. The Board finds that the Provider did not provide the Intermediary with sufficient matching information in the form of charges for its unlicensed interns and residents in a non-approved program. Without charge data for the Provider's unlicensed interns and residents in a non-approved program, the Intermediary was prevented from matching the Part B costs of these services with the Part B charges.

The Board finds there were two potential methods for billing for these services and both the Board and Intermediary would have accepted either one in determining the outcome of this case. The Board notes that the Provider could have:

(1) billed Part B separately for the services of its unlicensed interns and residents in a non-approved program as indicated in MIM 3669, or

(2) created a separate Part A charge by patient for the services of interns and residents in a non-approved program.

As an example of item 2 above, the Board refers to evidence in the form of testimony[62] and the Intermediary's Exhibit I-78 which indicates that there was in fact another Florida hospital billing Part A separately for these services. Therefore, the Board finds that in either case there had to have been itemized billing available which would have produced charges for LCC.

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62 Tr. at 301-303.

Using either of these methods would have enabled the Intermediary to "match", for LCC purposes, the costs and charges of the Provider's unlicensed interns and residents in a non-approved program.

The Board finds that since no itemized billing was available, the Intermediary could not determine the charges for the unlicensed interns and residents in a non-approved program. Therefore, the Board concludes that the Intermediary was correct in its application of the LCC principle.

The Board notes the Provider's contention that MIM § 3617, the predecessor of MIM 3669, is premised upon the assumption that a provider bills for its unlicensed interns and residents in a non-approved program in its room charge. The Board disagrees with the Provider's contention. The Board finds that according to MIM § 3669:

> [T]he provider determines that part of the inpatient charges which represents the cost of the services of residents and interns who are not under approved teaching programs and bills these separately under Part B, using type of bill code 121 and revenue code 96X, 97X, or 98X as applicable.

MIM § 3669

Therefore, the Board notes that this section does not direct a provider to bill for its unlicensed interns and residents in a non-approved program in its room charge.

Regarding the Provider's contention that the Intermediary failed to compare the costs of Provider's Unlicensed Physician Services with the Provider's customary charges for these services, the Board finds this was not feasible for the Intermediary because of lack of documentation on the Provider's part. The Board notes that the Intermediary made several attempts to make a comparison, however the Provider was not able to adequately support its contention that the charges for its unlicensed interns and residents in a non-approved program were included in its room and board charge.

The Provider maintained that based upon the facts of the case, it correctly treated the services of its unlicensed interns and residents in a non-approved program as routine services. The Board agrees with the Provider that the services could have been considered routine, however, as stated above, the Provider did not provide the Intermedairy with enough information to support its claim that the charges for these services were included in its room and board charge.

The Board also notes that the Provider contends that HCFA Pub. 15-1 § 2202.6 directs a provider to bill for all of its routine services in its room charge. The Board finds that HCFA Pub. 15-1 § 2202.6 does not direct a provider to bill for all of its routine services in its room charge.

The Board also notes the Provider's contention that based upon the definition of ancillary services set forth in HCFA Pub. 15-1 § 2202.8 and the interpretation of its application in HCFA Pub. 15-1 § 2203, the services of its unlicensed interns and residents in a non-approved program are not ancillary services. The Board finds there is not enough evidence in the record to comment on this contention.

The Board also notes the Provider's contention that it was not permitted under Florida law to bill any individual in the State of Florida a separate charge for the services of unlicensed interns and residents in a non-approved program. The Board agrees with the Intermediary that the law applies to unlicensed doctors billing for services in their own name as opposed to billing in the hospital's name.

Finally, the Board notes that the Provider's contention that an article in the Intermediary's publication, Medicare Digest, entitled "Billing for House Physicians", makes it clear that no billing was required for the services of unlicensed interns and residents in a non-approved teaching program. If the Board were to put weight on this item, it notes that it was in fact silent as to the billing requirements for unlicensed interns and residents in a non-approved teaching program.

Regarding the Intermediary's argument that the Provider's costs for its unlicensed interns and residents in a non-approved teaching program were unnecessary, the Board finds there was not sufficient evidence in the record to comment on this subject.

Also, the Board does not agree with the Intermediary's request to reopen the 1985 and 1987 cost reports and reaudit the costs on the Provider's Unlicensed Physician Services based on the Intermediary's audit of the 1988 cost report. The Board finds it was well beyond the time limit for reopening the cost reports.

DECISION AND ORDER:

The Intermediary was correct in not reclassifying a portion of the room and board charge from Part A to Part B for purposes of the LCC calculation. The Board affirms the Intermediary's position. The Intermediary may not reaudit the costs of the Provider's Unlicensed Physician's Services for the 1985 and 1987 fiscal years.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: July 27, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman