PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD

2000-D26

PROVIDER -
Monmouth Medical Center
Long Branch, New Jersey

Provider No. 31-0075

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of New Jersey

DATE OF HEARING-
January 5, 2000

Cost Reporting Period Ended -
December 31, 1992

CASE NO. 95-1566

INDEX

ISSUE:

Was the Intermediary's failure to apply updated reasonable compensation equivalent limits proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Monmouth Medical Center ("Provider") is a 561-bed, not-for-profit, general acute care hospital located in Long Branch, New Jersey. During its calendar year ended December 31, 1992, the Provider incurred physicians' compensation costs for hospital-based physician ("HBP") services. The Provider claimed these costs on its as-filed cost report for the purpose of obtaining program reimbursement. Blue Cross and Blue Shield of New Jersey ("Intermediary") audited the Provider's cost report and applied reasonable compensation equivalent ("RCE") limits to the physicians' compensation. The RCE limits used by the Intermediary were issued by the Health Care Financing Administration ("HCFA") on February 20, 1985, and were effective with cost reporting periods beginning on or after January 1, 1984.

On September 20, 1994, the Intermediary issued a Notice of Program Reimbursement reflecting the application of the subject limits to the Provider's physicians' compensation. On March 15, 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 met the jurisdictional requirements of those regulations.[1] The amount of Medicare reimbursement in controversy is approximately $407,000.[2]

The Provider was represented by Robert L. Roth, Esq. of Michaels & Bonner, P.C. The Intermediary was represented by Eileen Bradley, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's use of the subject limits, which were established for the purpose of determining Part A physician compensation in fiscal year 1984 and, which had not been updated until 1997, is unlawful for four reasons.[3]

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[1] Provider Position Paper at 1 and 5. The Board notes that the RCE issue contained in this case was not included in the Provider's original appeal. It was, however, properly added to the Provider's original appeal in accordance with 42 C.F.R. § 405.1841(a)(1). See Provider Position Paper at 3.

[2] The Board notes that this amount appears to be the Intermediary's actual adjustment to the Provider's physicians' compensation rather than the net effect of the adjustment on the Provider's program reimbursement. See Intermediary Position Paper at 2 and Provider Position Paper 5.

[3] Provider Position Paper at 13.

First, the Provider contends that HCFA's failure to update the limits to reflect increases in physician compensation violates 42 U.S.C. §1395x(v)(1)(A), which explains that providers of inpatient services are entitled to be reimbursed for the "reasonable costs" they incur in providing health care service.[4] The statute defines "reasonable costs" as the costs actually incurred less any part found to be unnecessary in the efficient delivery of needed health services. Moreover, HCFA must determine these costs "in accordance with regulations establishing the method or methods to be used, and the items to be included" and must "take into account both direct and indirect costs of providers or services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered." Id.

With respect to these statutory provisions, the Secretary of Health and Human Services ["Secretary"] conceded that physician compensation costs increased after 1984 by representations made in 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. Luke's Medical Center v. Shalala, No. 97-C-1726, 1997 WL 543061 (N.D.ILL.)("Rush-Presbyterian"),[5] and by updating Part B physician screens available for Part B payments to physicians every year since 1983 (except 1985). Accordingly, HCFA's failure to update the RCE limits while acknowledging the increase in physician compensation costs means providers were not reimbursed their reasonable costs in violation of the statute.

HCFA's failure to update the RCE limits while acknowledging the increase in physician compensation costs also means that Medicare's share of the "reasonable cost" of HBPs after 1984 have not been borne by the Medicare program as required by 42 U.S.C. §1395x(v)(1)(A). Therefore, HCFA has under reimbursed providers for their Part A physician compensation costs and forced non-Medicare covered patients to bear these costs in violation of the statute.

The Provider asserts that HCFA's refusal to update the RCE limits also violates 42 U.S.C. §1395xx(a)(2)(B), which states that the Secretary may not recognize as reasonable any portion of a hospital's cost for "general benefit" physician services "to the extent that such costs exceed the reasonable compensation equivalent for such services." Id. In enacting this provision, Congress explicitly provided that the intent was to differentiate between Part A and Part B physician costs in order 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. S10902.)" See 47 Fed. Reg. 43,578 (Oct. 1, 1982).[6] It is inherent in this language that the Secretary must recognize all physician

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[4] Provider Position Paper at 14.

[5] Exhibit P-29.

[6] Exhibit P-30.

compensation costs within the RCE limits. Accordingly, the Secretary violated this statutory provision by failing to update the RCE limits from 1984 through 1992, even though physician compensation costs increased between these periods.

Second, the Provider contends that the Intermediary's application of the subject limits is unlawful because HCFA's failure to annually update the limits violates the program's regulations, HCFA's stated intent to update the limits annually, HCFA's manual provisions, and statutory provisions.[7] With respect to program regulations, 42 C.F.R. § 405.482(b) states that HCFA will establish "a methodology for determining annual compensation equivalents, considering average physician incomes by specialty and type of location, to the extent possible using the best available data." Id. The regulations go on to state that "[b]efore 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." 42 C.F.R. § 405.482(f)(1). Clearly, this unambiguous statement requires annual updating.

Moreover, the requirement for annual updating was confirmed in the preamble to the Notice of Proposed Rulemaking in which the RCE regulations were first proposed. In that instance, HCFA stated that it would "update the RCE limits annually on the basis of updated economic index data." 47 Fed. Reg. 43578 at 43586 (October 1, 1982).[8] The preamble to the Final Rule adopting the RCE regulations stated that the "RCE limits will be updated annually on the basis of updated economic index data" and that when new limits are calculated without a change in the methodology, a single general notice of the new limits would be published. 48 Fed. Reg. 8902 at 8923 (March 2, 1983).[9] The preamble also stated that the RCE limits will apply only to the cost year specified and not to any other cost reporting period. Id. at 8924.[10]

Also, in the RCE notice published in February 1985, HCFA again acknowledged the limited applicability of the limits and the need to update them on an annual basis, stating:

> [42 C.F.R. §] 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.

50 Fed. Reg. 7123 at 7124 (Feb. 20, 1985).[11]

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[7] Provider Position Paper at 16.

[8] Exhibit P-21.

[9] Exhibit P-23.

[10] Exhibit P-24.

[11] Exhibit P-25.

And finally, although the Secretary proposed to change the methodology of updating RCE limits from an annual basis to a "periodic" basis in 1989, this proposal was never finalized. 54 Fed. Reg. 5946 (February 7, 1989).[12] In the preamble to those proposed rules, HCFA acknowledged that annual updates are required by the regulations and that the regulations must be changed in order to avoid annual updates, by stating:

> [s]pecifically, Section 405.482(f) provides that before the start of a cost reporting period 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 . . . . Although the regulations do not specifically provide for an annual adjustment to the RCE limits, the 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.... 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 (Feb. 7, 1989).

Accordingly, because this proposal was never finalized there has been no change in HCFA's obligation to annually update the limits.

With respect to manual instructions, HCFA confirmed its commitment to use the most current data available when making annual updates to the RCE limits. The Provider Reimbursement Manual ("HCFA Pub. 15-1") §2182.6.C states:

> HCFA establishes the methodology for determining RCEs by considering average physician income by specialty and type of location. The best available data are used.

Id.

In addition, HCFA Pub. 15-1 § 2182.6.F identifies the RCE limits that were used to reduce the Provider's 1992 physician compensation costs as applying only to "1983 and 1984." Id. There are no RCE limits mentioned in the manual which actually pertain to 1992.

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[12] Exhibit P-26.

The Provider asserts that when the RCE limits were finally updated in 1997, 62 Fed. Reg. 24,483 (May 5, 1997),[13] they resulted in a dramatic increase from the 1984 levels. This makes clear that there was a programmatic need for HCFA to update the RCE limits annually, a fact that was recognized explicitly in the regulations and policies requiring annual updating. It also makes clear that HCFA, by continuing to rely upon 1979 physician income information updated for inflation in 1984, violated the RCE regulation's mandate that HCFA use "the best available data" when determining annual compensation equivalents. 42 C. F. R. §405.482(b).

The Provider argues that it is simply not credible for HCFA to deny that annual RCE limit updates are required by its regulations and policies. As stated by the court in Rush-Presbyterian:

> [b]ased on the two preambles to the regulations, it is clear that the Secretary originally intended to update the RCE limits annually. While the Secretary may not be bound by these preambles, the language of the regulations themselves also hints at this: it requires HCFA to establish a methodology for determining "annual [RCE] limits."

Rush-Presbyterian supra at 55,717.

Based on these facts, the court found that HCFA's "action or inaction in interpreting and implementing the regulations was arbitrary and capricious." Id. The court went on to state:

> [i]t is true that the Secretary is usually given a wide berth in interpreting her own regulations. However, when she acts in apparent contravention of those regulations without offering any justification whatsoever, she violates the [Administrative Procedure Act] APA's proscription on arbitrary and capricious agency action.

Id.

On this basis, the court found HCFA's decision to apply the 1984 RCE limits to costs incurred in subsequent years to be unlawful. By withdrawing their appeal in Rush-Presbyterian, HCFA should be deemed to have conceded the unlawfulness of the RCE limits.

Finally, with respect to statutory provisions, 42 U.S. C. § 1395xx(a)(2)(B) requires HCFA to establish RCE limits by regulation. Accordingly, by refusing to update the limits, HCFA essentially changed its regulations and policies without establishing new regulatory authority in violation of the Administrative Procedure Act ("APA"). And, by doing so, HCFA violated the statutory requirement that RCE limits be established by regulation.

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[13] Exhibit P-27.

The Provider's third argument is that application of the subject limits to its 1992 cost reporting period is unlawful because HCFA's failure to annually update the limits is inconsistent with basic notions of due process, i.e., given that HCFA admits that physician compensation costs increased significantly after 1984.[14] Although the enabling statute gives HCFA the authority to determine what constitutes reasonable cost, this authority is not absolute. The court in Rush Presbyterian found that HCFA "must have some basis for exercising" its authority in deciding not to update annually the RCE limits. Rush Presbyterian supra at 55,716. The court then found that HCFA's failure to offer "any explanations, either before or during this litigation, for the way in which the RCE limits were determined" constitutes "arbitrary and capricious" action under the APA. Id. On that basis, the court set aside HCFA's application of the 1984 limits to costs incurred by a provider in a year subsequent to 1984.

In addition, as discussed above, the preambles to HCFA's regulations and the regulations themselves establish that HCFA is required to update the RCE limits on an annual basis using the "best available data." Therefore, HCFA's failure to do so violates the APA because, under the APA, an agency can only change a regulation or an established policy by following the notice and comment procedures set forth in 5 U.S.C. § 553. Here, HCFA's failure to issue annual RCE updates based on the "best available data" amounts to HCFA issuing a new regulation and a new policy without publishing the change in the Federal Register and allowing an opportunity for comments to be made before a final rule is adopted. Buschmann v. Schweiker, 676 F.2d 352 (9th Cir. 1982).

HCFA acknowledges these APA requirements in 42 C. F. R. § 405.482(f)(2), which states:

> [i]f HCFA proposes to revise 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).

Clearly, HCFA established the methodology to be applied in annually updating the RCE limits using the notice and comment procedures in the APA. Furthermore, HCFA followed its regulation and the statutory requirement that Medicare pay its share of provider costs by setting RCE limits for 1982, 1983 and 1984 that properly reflected increases. However, HCFA abandoned its regulatory requirements after 1984 without providing any notice or opportunity for comment and without offering any explanation, even though HCFA admits that physician compensation costs increased after 1984. HCFA's failure to apply its published methodology constitutes a change in the methodology, which is invalid under the requirements of the APA. In addition, HCFA's failure to update the RCE limits annually was arbitrary and capricious under the APA because HCFA contravened its own regulation.

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[14] Provider Position Paper at 19.

See, e.g., Teleprompter Cable Communications Corp. v. FCC, 565 F.2d 736, 742 (D.C. Cir. 1977) (agency acted arbitrarily by failing to abide by its own regulations).

The fourth and final reason the Provider contends that application of the subject limits to its 1992 cost reporting period is unlawful is because HCFA's failure to update the limits is arbitrary and capricious in violation of the APA.[15] As discussed above, HCFA has already conceded that physician compensation costs increased after 1984, Rush-Presbyterian supra at 55,716, and also by updating Part B physician screens every year since 1983, except for 1985. Also, the Board has recognized that physician compensation costs increased after 1984, when it stated that it:

> fully considered the Provider's argument that data compiled by the American Medical Association, increases in the CPI and increases in the RCE limits issued by HCFA for 1997, clearly illustrate undisputed increases in net physician income throughout the periods spanning 1984 through the fiscal year in contention . . . [T]he 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. . . .

Albert Einstein Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D9, December 5, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,907, declined rev. HCFA Admin., January 14, 1998.[16]

Also, 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-Dl2, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,983, declined rev. HCFA Admin., January 12, 1995, aff'd. 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) ("Los Angeles") (Exhibit P-31) states:

> [c]learly, physicians' salaries were increasing during the periods in question and at least some updated RCE limit would have been necessary to assure that reimbursement to providers under the Medicare program for Part A physician services would continue to be reasonable.

Los Angeles, PRRB Dec. No. 95-D12.

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[15] Provider Position Paper at 21.

[16] Exhibit P-19.

Accordingly, HCFA's failure to update the RCE limits while acknowledging the increase in physicians' compensation costs lacks a rational basis and, therefore, is arbitrary and capricious, and should be set aside.

Concluding, the Provider argues that as a result of HCFA's failure to update the RCE limits, no valid RCE limit is applicable to its 1992 physicians' compensation costs. Therefore, the Provider asserts that it should be reimbursed for its actual 1992 physicians' compensation costs to the extent that they are otherwise reasonable and appropriate. See Action on Smoking and Health v. Civil Aeronautics Board, 713 F.2d 795, 799 (D.C. Cir. 1983); see also Abington Memorial Hospital v. Heckler, 750 F.2d 242, 244 (3rd Cir. 1984).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment restricting program payments for the Provider's 1992 HBPs' costs to the 1984 RCE limits is proper. The Intermediary asserts that RCE limits, as promulgated, must be applied to determine reasonable costs pursuant to Medicare regulations. In this regard, the Intermediary maintains that it complied with existing regulations and applied the RCE limits in effect for the subject cost reporting period. 42 C.F.R. § 405.480(c) and 405.482(a).[17]

Contrary to the Provider's position, the Intermediary contends that HCFA is not required to update the RCE limits on an annual basis. The Intermediary notes that the Board has consistently ruled that HCFA is not mandated by regulation or statute to update the RCE limits, and cites the following cases in support of its argument: 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, 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-Dl2, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,983, declined rev. HCFA Admin., January 12, 1995, aff'd. 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) ¶ 44,072, 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) ¶ 44,073, declined rev. HCFA Admin., May 1, 1996; Belmont Center for Comprehensive Treatment v. Blue Cross Blue Shield Association et al., PRRB Dec. No. 99-D5, November 16, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,142, declined rev. HCFA Admin., January 8, 1999.

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[17] Intermediary Position Paper at 4.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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

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

§ 553 et seq.	-	Rule Making

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

§ 405.480(c)	-	Limits on Allowable Costs
§ 405.482 et seq.	-	Limits on Compensation for Services of Physicians in Providers
§§ 405.1835-.1841	-	Board Jurisdiction

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

§ 2182.6C	-	Reasonable Compensation Equivalents (RCEs)
§ 2182.6F	-	Table I -- Estimates of Full-Time Equivalency (FTE) Annual Average Net Compensation Levels for 1983 and 1984

5. Case Law:

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, 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-Dl2, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,983, declined rev. HCFA Admin., January 12, 1995, aff'd. 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) ¶ 44,072, 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) ¶ 44,073, declined rev. HCFA Admin., May 1, 1996.

Belmont Center for Comprehensive Treatment v. Blue Cross Blue Shield Association et al., PRRB Dec. No. 99-D5, November 16, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,142, declined rev. HCFA Admin., January 8, 1999.

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. Luke's Medical Center v. Shalala, No. 97-C- 1726, 1997 WL 543061 (N.D.ILL.).

Albert Einstein Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D9, December 5, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,907, declined rev. HCFA Admin., January 14, 1998.

Teleprompter Cable Communications Corp. v. FCC, 565 F.2d 736 (D.C. Cir. 1977).

Action on Smoking and Health v. Civil Aeronautics Board, 713 F.2d 795 (D.C. Cir. 1983).

Abington Memorial Hospital v. Heckler, 750 F2d 242 (3rd.Cir.1994).

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

6. Other:

47 Fed. Reg. 43578 (Oct 1, 1982).
48 Fed. Reg. 8902 (March 2, 1983).

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

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

62 Fed. Reg. 24483 (May 5, 1997).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented,[18] 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 December 31, 1992. The Provider's fundamental argument regarding this application is that the limits were unlawful 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 costs 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 and program instructions indicate that HCFA 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.

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[18] The Board did not accept into evidence documentation submitted by the Provider in a letter dated September 9, 1999. This documentation consists of copies of cost reporting forms, Supplemental Worksheet A-8-2, for the Provider's 1991, 1992, and 1998 cost reporting periods, as well as a copy of a Medicare Bulletin dated May 15, 1998. The Board reviewed these materials and found them to be immaterial and irrelevant.

Finally, the Board acknowledges the Provider's argument that data compiled by the American Medical Association, increases in the CPI, and increases in the RCE limits that were issued by HCFA in 1997, clearly indicate that net physician income 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 it is bound by the governing law and regulations.

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

DECISION AND ORDER:

The Intermediary's application of the 1984 RCE limits to the Provider's physicians' compensation costs is 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

Date of Decision: March 6, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman