

not propose to change the methodology used to determine the limits. We indicated that, in accordance with § 415.70(f), we are allowed to publish the revised RCE limits in a final rule without prior publication of a proposed rule for public comment. Furthermore, indicated our belief that publication of the revised RCE limits in a proposed rule with opportunity for public comment was unnecessary, and that we found good cause to waive the procedure.

Comment: One commenter was encouraged to learn of our proposal to publish updated RCE limits and suggested that these updates occur on an annual basis.

Response: We will continue to review the RCE limits on a regular basis by applying the most recent economic index data and publish updates as necessary.

3. Application of RCE Limits

This section, as well as the two following sections, is not describing new policy, but rather is simply a discussion of a continuation of the existing policies with respect to the application of and exceptions to the RCE limits and the geographic area classifications used for purposes of establishing the RCE limits. We will continue to use the RCE limits to compute Medicare payments when a physician is compensated by a provider that is subject to the RCE limits in some or all of its areas. We also will use these limits when the physician is compensated by any other related organization for physician administrative, supervisory, and other provider services paid under Medicare. In applying the RCE limits, the intermediary will assign each compensated physician to the most appropriate specialty category. If no

specialty category is appropriate (for example, in determining the reasonable cost for an emergency room physician), the fiscal intermediary will use the RCE level for the "Total" category, which is based on income data for all physicians. The fiscal intermediary will determine the appropriate geographic area classification given in Table 9 of the addendum of this final rule.

If the physician's contractual compensation covers all duties, activities, and services furnished to the provider and to its patients and the physician is employed full-time, the appropriate specialty compensation limit will be used and adjusted by the physician's allocation agreement to arrive at the program's share of allowable costs as physician compensation costs. In the absence of an allocation agreement, we generally will assume that 100 percent of the compensation was related to services paid under the physician fee schedule and that there are no allowable costs for the physician's services to the provider.

If a physician's compensation from the provider represents payment only for services that benefit patients generally (that is, the physician bills fees for all services furnished to individual patients), the appropriate specialty compensation limit will be used. If a physician is employed by a provider to furnish services of general benefit to patients on other than a full-time basis, the RCE amount will be adjusted upward or downward to reflect the percentage of time his or her actual hours related to a full work year of 2,080 hours.

4. Exceptions to the RCE Limits

Some providers, particularly but not exclusively small or rural hospitals, may be unable to recruit or maintain an adequate number of physicians at a

compensation level within the prescribed limits. In accordance with section 1887(a)(2)(C) of the Act, if a provider is able to demonstrate to the intermediary its inability to recruit or maintain physicians at a compensation level allowable under the RCE limits (as documented, for example, by unsuccessful advertising through national medical or health care publications), the intermediary may grant an exception to the RCE limits established under these rules.

5. Geographic Area Classifications for RCE Limits

We adjust the RCE limits to account for differences in salary levels by location as well as by specialty. Under our methodology for establishing limits, and in the limits set forth below, we have classified geographic areas into three types: nonmetropolitan areas, metropolitan areas less than 1 million, and metropolitan areas greater than 1 million.

As we do for purposes of the IPPS and the physician fee schedule, we use the most current MSA designations for purposes of establishing the RCE limits. In New England, we use the NECMAS for this purpose. Tables 4A and 4B of the Addendum to this final rule includes information that identifies, by type of location (urban and rural), the geographic areas affected; that is, they list all MSAs and their constituent counties and identifies whether their population are classified as large urban. Any county not listed in the tables and all other affected U.S. possessions and territories not part of a State are considered rural areas. This information will enable providers, physicians, Medicare fiscal intermediaries, and other members of the public to determine which RCE limit level will apply in specific areas.

ESTIMATES OF FTE ANNUAL AVERAGE NET COMPENSATION LEVELS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JANUARY 1, 2004 *

Specialty	Nonmetropolitan areas	Metropolitan areas less than one million	Metropolitan areas greater than one million
Total	159,800	171,400	177,200
General/Family Practice	142,500	136,700	138,700
Internal Medicine	150,200	154,100	165,600
Surgery	182,900	204,100	208,000
Pediatrics	130,900	152,100	140,600
OB/GYN	200,300	194,500	196,400
Radiology	217,600	231,100	225,300
Psychiatry	138,700	142,500	154,100
Anesthesiology	167,500	200,300	200,300
Pathology	208,000	219,500	215,700

*All figures are rounded to the nearest \$100.