IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, MERCY HEALTH MUSKEGON, CLALLAM COUNTY PUBLIC HOSPITAL NO. 2 d/b/a/ OLYMPIC MEDICAL CENTER, and YORK HOSPITAL,

Plaintiffs,

v.

ALEX M. AZAR II,
in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant.

Civil Action No. 1:18-cv-2841

DECLARATION OF JUD KNOX IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Jud Knox, hereby declare and state the following:

1. My name is Jud Knox. I am over 21 years of age and competent to testify to the facts set forth herein. I am an adult citizen of the United States. I reside in York, Maine.

2. The facts set forth in this declaration are based on my personal knowledge and upon information available to me through the files and records of York Hospital. If called upon as a witness, I could and would testify to these facts.

3. I am the President of York Hospital. I have served in this capacity since 1982. In this role, I am responsible for the performance of the entire organization. In my capacity as President, I am familiar with the impact that the clinic visit policy at issue in this lawsuit will have on York Hospital and its operations.

4. York Hospital is a small community hospital located in York, Maine that serves the surrounding area and has 50 beds in operation. Founded in 1906, York is dedicated to giving back to its community: among other things, it provides support programs and services to schools, civic organizations. and non-profit groups. runs an opiate treatment facility, and offers transportation and food to patients unable to afford them. Of York's patients, almost 54% rely on Medicare. York Hospital is a member of the American Hospital Association.

5. York Hospital has filed this lawsuit (along with its co-plaintiffs) challenging as *ultra vires* a payment reduction implemented by the Centers for Medicare & Medicaid Services (CMS) as part of the calendar year (CY) 2019 Medicare outpatient prospective payment system (OPPS) final rule (Final Rule).

6. York Hospital furnishes outpatient services at 12 excepted off-campus provider-based departments (PBDs), including three oncology clinics, four primary care practices and specialty clinics offering psychiatry, cardiovascular care, internal medicine and GYN care. York will suffer immediate and concrete harm from the payment reductions for covered outpatient services set forth in the Final Rule.

7. The ultimate reductions in payments for Medicare-funded outpatient services York Hospital faces will have a substantial impact, both economic and non-economic, on its operations and its patients and the greater community. Specifically, York Hospital estimates that the clinic visit policy set forth in the Final Rule will cause it to suffer a $1.1 million annual loss, or a .6 percent annual reduction in operating revenue.

8. Vacating the clinic visit policy portion of the Final Rule and ensuring that Medicare payments for off-campus provider based department outpatient services are made in

line with Congress's intent would help remedy the harm York Hospital faces from CMS's unlawful conduct.

9. On January 7, 2019, York Hospital submitted claims for excepted off-campus physician clinic visit services covered by the Final Rule to its Medicare Administrative Contractor. The Medicare Administrative Contractor responded to those claims on January 22, 2019. York Hospital filed a Medicare Redetermination Request on January 25, 2019. True and correct copies of these documents are attached as Exhibit A.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct.

Executed this ~~28~~ 24 day of January 2019.

By: ______________________
Jud Knox
President
York Hospital

Exhibit A

YORK HOSPITAL
15 HOSPITAL DR
YORK ME 039091011
2073634321

MED REC. # [redacted] | 0131

5 FED. TAX NO. 01-0212444 | 6 STATEMENT COVERS PERIOD FROM [redacted]19 THROUGH [redacted]19

8 PATIENT NAME [redacted]
9 PATIENT ADDRESS [redacted] ME 03904

10 BIRTHDATE [redacted] | 11 SEX M | ADMISSION 13 HR 14 | 14 TYPE 3 | 15 SRC 1 | 17 STAT 01

31 OCCURRENCE CODE 11 DATE [redacted]19

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0510	PHYSICIAN PRACTICE CLINIC	G0463 PO	[redacted]19	1	124 00	
0001	PAGE 001 OF 001	CREATION DATE	[redacted]19	TOTALS	124 00	

50 PAYER NAME: MEDICARE A AND B / HARVARD
52 REL. INFO: Y / Y | 53 ASG. BEN.: Y / Y
56 NPI 1376628398
57 OTHER PRV ID 1376628398

58 INSURED'S NAME [redacted] / [redacted] | 59 P. REL 18 / 18 | 60 INSURED'S UNIQUE ID [redacted] / [redacted]

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

67 DX: E039 | J439 | I258 | I10 | I2510 | E7800 | R911 | N281

69 ADMIT DX | 70 PATIENT REASON DX E039

76 ATTENDING NPI 1215164082 LAST JEAN FIRST NATHAN

80 REMARKS MEDICARE A AND B
PO BOX 7091
INDIANAPOLIS IN 462077091

81CC a B3 282N00000X
b B1 WHITE
c B2 M

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

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MAP1716    PAGE 06     NATIONAL GOVERNMENT SERVICES #14011       ACPFA181 01/21/19
SHN1844    SC                INST CLAIM INQUIRY                  A20191AP 11:28:46

MID ███████████  TOB 131  S/LOC P B9997  PROVIDER 200020
            MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
                CITY                     ST      ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
                CITY                     ST      ZIP
PAYMENT DATA ---  DEDUCTIBLE        82.87  COIN          CROSSOVER IND 1
PARTNER ID 000030317 P 000000060 P

PAID DATE 012219  PROVIDER PAYMENT          .00   PAID BY PATIENT
REIMB RATE    .36  RECEIPT DATE 010819  PROVIDER INTEREST
CHECK/EFT NO EFT1118593  CHECK/EFT ISSUE DATE 012219    PAYMENT CODE ACH
PIP PAY AS CASH           PRICER DATA             HOSPICE PRIOR DYS
DRG      OUTLIER AMT              TTL BLNDED PAYMT             FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT       .00   NET INL
TECH PROV DAYS       TECH PROV CHARGES
 OTHER INS ID              CLINIC CODE
37190                                                      &lt;== REASON CODES
          PRESS PF3-EXIT  PF7-PREV PAGE
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YORK HOSPITAL
15 HOSPITAL DR
YORK ME 039091011
2073634321

0131

5 FED. TAX NO. 01-0212444

6 STATEMENT COVERS PERIOD FROM 19 THROUGH 19

8 PATIENT NAME

9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX F | 12 ADMISSION DATE | 13 HR 13 | 14 TYPE 3 | 15 SRC 1 | 16 DHR | 17 STAT 01

CONDITION CODES 18–28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE 11 DATE 19

32 OCCURRENCE | 33 OCCURRENCE | 34 OCCURRENCE | 35 OCCURRENCE SPAN | 36 OCCURRENCE SPAN | 37

39 VALUE CODES | 40 VALUE CODES | 41 VALUE CODES

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0510	PHYSICIAN PRACTICE CLINIC	G0463 PO	19	1	124 00	
0001	PAGE 001 OF 001	CREATION DATE	19	TOTALS	124 00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1376528398
MEDICARE A AND B		Y	Y			57 OTHER PRV ID 1376528398
BCBS ANTHEM NEW HAMPSHI		Y	Y			

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
	18			
	18			

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: I10 | I214 | F809 | E1043 | F321 | K3184

69 ADMIT DX | 70 PATIENT REASON DX I10 | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | 75

76 ATTENDING NPI 1588739888 QUAL
LAST BRADEN FIRST TREVOR

77 OPERATING NPI QUAL
LAST FIRST

80 REMARKS MEDICARE A AND B
PO BOX 7091
INDIANAPOLIS IN 462077091

81CC a B3 282N00000X
b B1 WHITE
c B2 U

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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MAP1741              NATIONAL GOVERNMENT SERVICES #14011      ACPFA181 01/10/19
JXJ1341   SC               CLAIM SUMMARY INQUIRY              C201914F 10:11:44
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  OPERATOR ID JXJ1341    FROM DATE [REDACTED]19  TO DATE [REDACTED]19     DDE SORT
  MEDICAL REVIEW SELECT           DCN
     MID               PROV/MRN   S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
[REDACTED]                         S MOPPS   131          [REDACTED]19 [REDACTED]19  [REDACTED]19
[REDACTED]             [REDACTED]     124.00                            WW001

     PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
    PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR  PRESS PF3 TO EXIT
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                               NPI 1376528398
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     MID               PROV/MRN   S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
[REDACTED]                         S MOPPS   131          [REDACTED]19 [REDACTED]19  [REDACTED]19
[REDACTED]                 R      124.00                            WW001

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    PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR  PRESS PF3 TO EXIT
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01/10/2019 11:14:54 AM

MAP1716 PAGE 06 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/21/19
SHN1844 SC INST CLAIM INQUIRY A20191AP 11:24:35

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1ST INSURERS ADDRESS 2
CITY ST ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
CITY ST ZIP
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PARTNER ID 000000565 P

PAID DATE 012219 PROVIDER PAYMENT .00 PAID BY PATIENT
REIMB RATE .36 RECEIPT DATE 010819 PROVIDER INTEREST
CHECK/EFT NO EFT1118593 CHECK/EFT ISSUE DATE 012219 PAYMENT CODE ACH
PIP PAY AS CASH PRICER DATA HOSPICE PRIOR DYS
DRG OUTLIER AMT TTL BLNDED PAYMT FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT .00 NET INL
TECH PROV DAYS TECH PROV CHARGES
OTHER INS ID CLINIC CODE
37190 <== REASON CODES
PRESS PF3-EXIT PF7-PREV PAGE

01/21/2019 12:24:53 PM

YORK HOSPITAL
16 HOSPITAL DR
YORK ME 039091011
2073634321

0131

5 FED TAX NO. 01-0212444
6 STATEMENT COVERS PERIOD FROM 19 THROUGH 19

8 PATIENT NAME
9 PATIENT ADDRESS

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
	F		13	3	1		01

31 OCCURRENCE CODE DATE: 11 19

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0510	PHYSICIAN PRACTICE CLINIC	G0463 PO	19	1	124 00	
0001	PAGE 001 OF 001	CREATION DATE	19	TOTALS	124 00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MEDICARE A AND B		Y	Y		
MAIL HANDLERS BEN		Y	Y		

56 NPI 1376528398
57 1376528398
OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
	18			
	01			

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

67 I10 E1169

69 ADMIT DX
70 PATIENT REASON DX I10
71 PPS CODE
72 ECI

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1598640987 QUAL
LAST BURKE FIRST RACHEL
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS MEDICARE A AND B
PO BOX 7091
INDIANAPOLIS IN 462077091

81CC
a B3 282N00000X
b B1 WHITE
c B2 M
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

York Hospital

A Not-for-Profit Community
Health Care Center Since 1904.

January 17, 2019

National Government Services
Attn: Appeals Department
P. O. Box 7111
Indianapolis, IN 46207-7111

To Whom It May Concern:

On November 21, 2018, CMS published in the Federal Register a final rule with comment period reducing Medicare payment rates for clinic visit services at certain off-campus provider-based departments (excepted off-campus PBDs). As explained in comments on the proposed rule (see 83 Fed. Reg. 59-004-15), the payment reduction exceeds the ultra vires because it violates the statutory requirement that adjustments to payment rates be budget neutral and because it ignores the statutory distinction between excepted and non-excepted off-campus PBDs. The APC Wage Adjusted payment rate, for the claimed services for York Hospital Provider Number 20-0020, should be $118.38 effective for dates of service beginning 1/1/2019.

Sincerely,

Robin LaBonte, CFO

15 Hospital Drive, York, Maine 03909
Information: 207-363-4321 Toll Free. 877-363-4321
www.yorkhospital.com TTY: 207-363-7433

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MAP1716   PAGE 06    NATIONAL GOVERNMENT SERVICES #14011      ACPFA181 01/21/19
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1ST INSURERS ADDRESS 2
                CITY                  ST      ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
                CITY                  ST      ZIP
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PARTNER ID 000000060 P

PAID DATE 012219  PROVIDER PAYMENT          .00   PAID BY PATIENT
REIMB RATE    .36  RECEIPT DATE 010819  PROVIDER INTEREST
CHECK/EFT NO EFT1118593  CHECK/EFT ISSUE DATE 012219    PAYMENT CODE ACH
PIP PAY AS CASH            PRICER DATA             HOSPICE PRIOR DYS
DRG      OUTLIER AMT              TTL BLNDED PAYMT            FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT        .00   NET INL
TECH PROV DAYS       TECH PROV CHARGES
 OTHER INS ID              CLINIC CODE
37190                                                         &lt;== REASON CODES
          PRESS PF3-EXIT  PF7-PREV PAGE
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01/21/2019 12:25:56 PM

NATIONAL GOVERNMENT SERVICES, INC.
MEDICARE PART A
Payment Date: 01/22/2019

Today's Date: 01/25/2019 09:31
Page 1 of 1

Provider Number: 1376528398 YORK HOSPITAL

Patient Name / Invoice ID / Doc Ctl No	HIC No	From Date / Thru Date / Crossover Carrier Info	Days TOB / DRG Plan ID	Total Chgs / Rejected	Cov Chgs / Deductible	Non Cov / Co Ins	Prof Comp / Cont Adj	Interest / Net Reimb
[redacted]		/2019	131	124 00	124.00	0.00	0.00	0.00
[redacted]	[redacted]	/2019	MEDICARE	0 00	82.87	0.00	41.13	0.00
[redacted]		AETNA, INC.			000000060			

Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount
	CO	45	CHARGE EXCEEDS FEE SCHEDULE/M/	41.13
	PR	1	DEDUCTIBLE AMT	82.87

Claim Remarks

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                              NPI 1376528398
      MID                  PROVIDER                S/LOC           TOB
 OPERATOR ID JXJ1341       FROM DATE    19  TO DATE     19    DDE SORT
 MEDICAL REVIEW SELECT             DCN
      MID              PROV/MRN    S/LOC        TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT   TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
                                  S MOPPS    131              19       19       19
                           N       124.00                             WW001
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      MID                  PROVIDER                S/LOC           TOB
 OPERATOR ID JXJ1341       FROM DATE    19  TO DATE     19    DDE SORT
 MEDICAL REVIEW SELECT             DCN
      MID              PROV/MRN    S/LOC        TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT   TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
                                  S MOPPS    131              19       19       19
                                   350.00                             WW001
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YORK HOSPITAL
15 HOSPITAL DR
YORK ME 039091011
2073634321

CNTL #
MED. REC. #

0131

5 FED. TAX NO. 01-0212444

6 STATEMENT COVERS PERIOD FROM 19 THROUGH 19

8 PATIENT NAME
9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX F | 12 DATE | 13 HR 09 | 14 TYPE 3 | 15 SRC 1 | 16 DHR | 17 STAT 01

31 OCCURRENCE CODE 11 DATE 19

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0510	PHYSICIAN PRACTICE CLINIC	G0463 PO	19	1	124 00	
0001	PAGE 001 OF 001	CREATION DATE	19	TOTALS	124 00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MEDICARE A AND B		Y	Y		
AARP HEALTHCARE OPTIONS		Y	Y		

56 NPI 1376528398
57 1376528398
OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
	18			
	18			

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

67 DX J329

69 ADMIT DX | 70 PATIENT REASON DX J329 | 71 PPS CODE | 72 ECI

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1588840957 QUAL
LAST BURKE FIRST RACHEL

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS MEDICARE A AND B
PO BOX 7091
INDIANAPOLIS IN 462077091

81CC
a B3 282N00000X
b B1 WHITE
c B2 M
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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MAP1716   PAGE 06    NATIONAL GOVERNMENT SERVICES #14011     ACPFA181 01/21/19
SHN1844   SC               INST CLAIM INQUIRY                A20191AP 11:26:33

MID [redacted]   TOB 131  S/LOC P B9997  PROVIDER 200020
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1ST INSURERS ADDRESS 2
                CITY                  ST      ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
                CITY                  ST      ZIP
PAYMENT DATA ---  DEDUCTIBLE      82.87  COIN          CROSSOVER IND
PARTNER ID

PAID DATE 012219  PROVIDER PAYMENT          .00   PAID BY PATIENT
REIMB RATE    .36  RECEIPT DATE 010819  PROVIDER INTEREST
CHECK/EFT NO EFT1118593  CHECK/EFT ISSUE DATE 012219    PAYMENT CODE ACH
PIP PAY AS CASH          PRICER DATA            HOSPICE PRIOR DYS
DRG      OUTLIER AMT             TTL BLNDED PAYMT            FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT       .00   NET INL
TECH PROV DAYS      TECH PROV CHARGES
 OTHER INS ID            CLINIC CODE
37190                                                   &lt;== REASON CODES
           PRESS PF3-EXIT  PF7-PREV PAGE
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                            NPI 1376528398
     MID                PROVIDER                S/LOC            TOB
 OPERATOR ID JXJ1341    FROM DATE     19   TO DATE     19     DDE SORT
 MEDICAL REVIEW SELECT              DCN
     MID             PROV/MRN    S/LOC        TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
                                S MOPPS    131                 19      19       19
                              124.00                                WW001

     PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
    PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR  PRESS PF3 TO EXIT
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 OPERATOR ID JXJ1341    FROM DATE     19   TO DATE     19     DDE SORT
 MEDICAL REVIEW SELECT              DCN
     MID             PROV/MRN    S/LOC        TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
                                S MOPPS    131                 19      19       19
                              124.00                                WW001

     PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
    PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR  PRESS PF3 TO EXIT
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Remittance Header

Remittance ID: MED A | MEDICARE PART A
Provider Group: MEDICARE PART A
Today's Date: 01/25/2019 09:34

Provider Number: 1376528398 | YORK HOSPITAL
Payor Name: NATIONAL GOVERNMENT SERVICES, INC.
Page: 1 of 2

File Creation Date: 01/19/2019
File Control Number: 116300427

Payment Date: 01/22/2019

Claim Header

Invoice Number: [redacted]
Patient Name: [redacted]
Member Identificatio [redacted]
Claim Start Date: [redacted]2019
Coverage Exp Date:
Plan ID: MEDICARE | MEDICARE A & B
Claim End Date: [redacted]2019
Claim Received Date:
Rank: Primary
Invoice Type: UB
UB TOB: 131
Claim Status: Processed as Primary:
Document Ctl No: 21900800675304MEA

Outpatient Adjudication Info

Reimbursement Rate: .36
HCPCS Payable Amt:
End Stage Renal Disease Amt:

Additional Claim Information

Claim Remark Codes
MA01 N793

Medical Record Identification Number: [redacted]
Coverage Amount: 124.00
Per Day Limit: 0.36

Total Billed	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Paid Amount	Prof Comp	Interest
124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Line Items...	*Service Date*	*Billed Proc*	*Paid Proc*	*Qty*	*Billed Amt*	*Cov Chgs*	*Non-Cov*	*Rejected*	*Deductible*	*Co-Ins*	*Cont Adj*	*Payment*	*Prof Comp*	*Interest*
**	[redacted]2019	G0463 PO	G0463 PO	1	124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Ambulatory Patient Group (APG) Number: 05012
Ambulatory Payment Classification: 05012
Allowed - Actual: 124.00

Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount
	CO	45	CHARGE EXCEEDS FEE	41.13

		SCHEDULE/MAX ALL	
PR	1	DEDUCTIBLE AMT	82.87

1 YORK HOSPITAL
15 HOSPITAL DR
YORK ME 039091011
2073634321

4 TYPE OF BILL: 0131
5 FED. TAX NO.: 01-0212444
6 STATEMENT COVERS PERIOD FROM: 19 THROUGH: 19

8 PATIENT NAME
9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX: F | 12 DATE | ADMISSION 13 HR: 08 | 14 TYPE: 3 | 15 SRC: 1 | 16 DHR | 17 STAT: 01
CONDITION CODES 18–28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE: 11 DATE: 19
32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38
39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0510	PHYSICIAN PRACTICE CLINIC	G0463 PO	19	1	124 00		
0001	PAGE 001 OF 001	CREATION DATE	19	TOTALS	124 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MEDICARE A AND B		Y	Y		
BCBS ANTHEM NEW HAMPSHI		Y	Y		

56 NPI: 1376528398
57 OTHER PRV ID: 1376528398

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
	18			
	18			

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: 0
67: H6692
69 ADMIT DX | 70 PATIENT REASON DX: H6692 | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1770803439 QUAL
LAST ROBINSON FIRST ELIZABET
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS MEDICARE A AND B
PO BOX 7091
INDIANAPOLIS IN 462077091

81CC
a B3 282N00000X
b B1 WHITE
c B2 M
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

```
MAP1716   PAGE 06    NATIONAL GOVERNMENT SERVICES #14011     ACPFA181 01/21/19
SHN1844   SC               INST CLAIM INQUIRY                A20191AP 11:31:25

MID [REDACTED]   TOB 131  S/LOC P B9997  PROV DER 200020
            MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
                CITY                  ST     ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
                CITY                  ST     ZIP
PAYMENT DATA ---  DEDUCTIBLE      82.87  COIN          CROSSOVER IND 1
PARTNER ID 000030067 P

PAID DATE 012219  PROVIDER PAYMENT          .00   PAID BY PATIENT
REIMB RATE    .36  RECEIPT DATE 010719  PROVIDER INTEREST
CHECK/EFT NO EFT1118593  CHECK/EFT ISSUE DATE 012219    PAYMENT CODE ACH
PIP PAY AS CASH           PRICER DATA              HOSPICE PRIOR DYS
DRG      OUTLIER AMT             TTL BLNDED PAYMT           FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT       .00   NET INL
TECH PROV DAYS      TECH PROV CHARGES
 OTHER INS ID           CLINIC CODE
37190                                                   &lt;== REASON CODES
          PRESS PF3-EXIT  PF7-PREV PAGE
```

01/21/2019 12:31:30 PM

```
MAP1881                 NATIONAL GOVERNMENT SERVICES #14011      ACPFA181 01/10/19
JXJ1341    SC                REASON CODES INQUIRY                C201914F 10:01:53
                                                            MNT: JOB3763   010919
PLAN REAS  NARR   EFF        MSN       EFF       TERM    EMC     HC/PRO  PP    CC
IND  CODE  TYPE   DATE       REAS      DATE      DATE    ST/LOC  ST/LOC  LOC   IND
 1   WW001  E    063005                                  S MOPPS S MOPPS
 TPTP A     B    NPCD A       B       HD CPY A     B    NB ADR      CAL DY      C/L C
 ------------------------------NARRATIVE------------------------------------
THIS IS A TEMPORARY EDIT TO SUSPEND ALL CLAIMS WITH STATEMENT THRU DATE
GREATER THAN 12/31/18.
NO PROVIDER ACTION IS NECESSARY.




       PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
  PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
```

01/10/2019 11:01:59 AM

Remittance Header

Remittance ID:	MED A	MEDICARE PART A	Provider Group:	MEDICARE PART A	Today's Date. 01/25/2019 09:39
Provider Number:	1376528398	YORK HOSPITAL	Payor Name:	NATIONAL GOVERNMENT SERVICES, INC.	Page: 1 of 2
File Creation Date:	01/19/2019		File Control Number:	116300427	
Payment Date:	01/22/2019				

Claim Header

Invoice Number:	[redacted]					
Patient Name:	[redacted]					
Member Identificatio	[redacted]		Claim Start Date	[redacted]/2019	Coverage Exp Date:	
Plan ID:	MEDICARE	MEDICARE A & B	Claim End Date	[redacted]/2019	Claim Received Date:	
Rank:	Primary		Invoice Type:	UB	UB TOB:	131
Claim Status:	Processed as Primary:		Document Ctl No:	21900700897604MEA		

Outpatient Adjudication Info

Reimbursement Rate: .36
HCPCS Payable Amt:
End Stage Renal Disease Amt:

Additional Claim Information

Crossover Carrier: ANTHEM BCBS NORTHEAST REGION
Payor Identification: 000030067

Claim Remark Codes
MA01 N793 MA18

Medical Record Identification Number: [redacted]
Coverage Amount: 124.00
Per Day Limit: 0.36

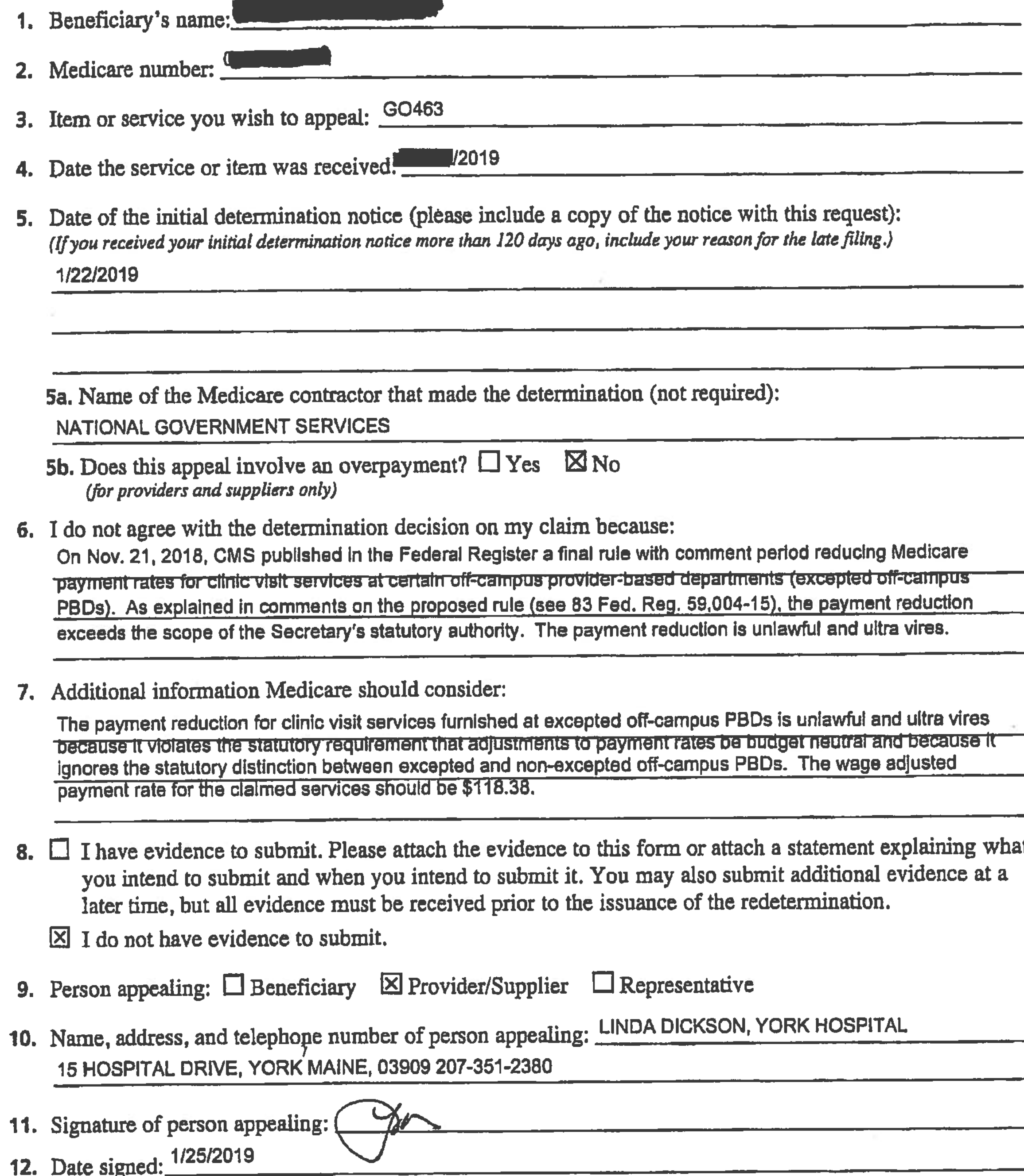
Total Billed	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Paid Amount	Prof Comp	Interest
124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Line Items...	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Payment	Prof Comp	Interest
**	[redacted]/2019	G0463 PO	G0463 PO	1	124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Ambulatory Patient Group (APG) Number: 05012
Ambulatory Payment Classification. 05012
Allowed - Actual: 124.00

Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount
	CO	45	CHARGE EXCEEDS FEE	41.13

		SCHEDULE/MAX ALL	
PR	1	DEDUCTIBLE AMT	82.87



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: [redacted]
2. Medicare number: [redacted]
3. Item or service you wish to appeal: GO463
4. Date the service or item was received: [redacted]/2019
5. Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)
1/22/2019

5a. Name of the Medicare contractor that made the determination (not required):
NATIONAL GOVERNMENT SERVICES

5b. Does this appeal involve an overpayment? ☐ Yes ☒ No
(for providers and suppliers only)

6. I do not agree with the determination decision on my claim because:
On Nov. 21, 2018, CMS published in the Federal Register a final rule with comment period reducing Medicare payment rates for clinic visit services at certain off-campus provider-based departments (excepted off-campus PBDs). As explained in comments on the proposed rule (see 83 Fed. Reg. 59,004-15), the payment reduction exceeds the scope of the Secretary's statutory authority. The payment reduction is unlawful and ultra vires.

7. Additional information Medicare should consider:
The payment reduction for clinic visit services furnished at excepted off-campus PBDs is unlawful and ultra vires because it violates the statutory requirement that adjustments to payment rates be budget neutral and because it ignores the statutory distinction between excepted and non-excepted off-campus PBDs. The wage adjusted payment rate for the claimed services should be $118.38.

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.
☒ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☒ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing: LINDA DICKSON, YORK HOSPITAL
15 HOSPITAL DRIVE, YORK MAINE, 03909 207-351-2380

11. Signature of person appealing: [signature]

12. Date signed: 1/25/2019

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54489 (2006) or at http://www.cms.gov/PrivacyActSystemofRecords/downloads/0566.pdf

Form CMS-20027 (12/10)

Remittance Header

Remittance ID:	MED A	MEDICARE PART A	Provider Group:	MEDICARE PART A
Provider Number:	1376528398	YORK HOSPITAL	Payor Name:	NATIONAL GOVERNMENT SERVICES, INC.
File Creation Date:	01/19/2019		File Control Number:	116300427
Payment Date:	01/22/2019			

Today's Date: 01/25/2019 14:54

Page 1 of 2

Claim Header

Invoice Number:	[redacted]	Claim Start Date	[redacted]/2019	Coverage Exp Date:	
Patient Name:	[redacted]	Claim End Date	[redacted]2019	Claim Received Date:	
Member Identification:	[redacted]	Invoice Type:	UB	UB TOB:	131
Plan ID:	MEDICARE / MEDICARE A & B	Document Ctl No:	21900800674204MEA		
Rank:	Primary				
Claim Status:	Processed as Primary:				

Outpatient Adjudication Info

Reimbursement Rate: .36

HCPCS Payable Amt:

End Stage Renal Disease Amt:

Additional Claim Information

Corrected Patient/Insured Name: [redacted]

Insured's Changed Unique ID Number: [redacted]

Crossover Carrier: ANTHEM NH

Payor Identification: 000000565

Claim Remark Codes

MA01 N793 MA18

Medical Record Identification Number: [redacted]

Coverage Amount: 124.00

Per Day Limit: 0.36

Total Billed	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Paid Amount	Prof Comp	Interest
124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Line Items...	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Payment	Prof Comp	Interest
**	[redacted]2019	G0463 PO	G0463 PO	1	124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Ambulatory Patient Group (APG) Number: 05012

Ambulatory Payment Classification: 05012

Allowed - Actual: 124.00

Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount
	CO	45	CHARGE EXCEEDS FEE	41.13

CO	45	CHARGE EXCEEDS FEE SCHEDULE/MAX ALL	41.13
PR	1	DEDUCTIBLE AMT	82.87

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: [redacted]
2. Medicare number: [redacted]
3. Item or service you wish to appeal: G0463
4. Date the service or item was received: [redacted]2019
5. Date of the initial determination notice (please include a copy of the notice with this request):
   (If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)
   1/22/2019

   5a. Name of the Medicare contractor that made the determination (not required):
   NATIONAL GOVERNMENT SERVICES

   5b. Does this appeal involve an overpayment? ☐ Yes ☒ No
   (for providers and suppliers only)

6. I do not agree with the determination decision on my claim because:
   On Nov. 21, 2018, CMS published in the Federal Register a final rule with comment period reducing Medicare payment rates for clinic visit services at certain off-campus provider-based departments (excepted off-campus PBDs). As explained in comments on the proposed rule (see 83 Fed Reg. 59,004-15), the payment reduction exceeds the scope of the Secretary's statutory authority. The payment reduction is unlawful and ultra vires.

7. Additional information Medicare should consider:
   The payment reduction for clinic visit services furnished at excepted off-campus PBDs is unlawful and ultra vires because it violates the statutory requirement that adjustments to payment rates be budget neutral and because it ignores the statutory distinction between excepted and non-excepted off-campus PBDs. The wage adjusted payment rate for the claimed services should be $118.38.

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.

   ☒ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☒ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing: LINDA DICKSON, YORK HOSPITAL
    15 HOSPITAL DRIVE, YORK MAINE, 03909 207-351-2380

11. Signature of person appealing:

12. Date signed: 1/25/2019

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Form CMS-20027 (12/10)

Remittance Header

Remittance ID: MED A | MEDICARE PART A
Provider Number: 1376528398 | YORK HOSPITAL
File Creation Date: 01/19/2019
Payment Date: 01/22/2019

Provider Group: MEDICARE PART A
Payor Name: NATIONAL GOVERNMENT SERVICES, INC.
File Control Number: 116300427

Today's Date: 01/25/2019 14:51
Page: 1 of 2

Claim Header

Invoice Number:
Patient Name:
Member Identificatio
Plan ID: MEDICARE | MEDICARE A & B
Rank: Primary
Claim Status: Processed as Primary:

Claim Start Date: 2019
Claim End Date: 2019
Invoice Type: UB
Document Ctl No: 21900800674004MEA

Coverage Exp Date:
Claim Received Date:
UB TOB: 131

Outpatient Adjudication Info

Reimbursement Rate: .36
HCPCS Payable Amt:
End Stage Renal Disease Amt:

Additional Claim Information

Crossover Carrier: HARVARD PILGRIM HEALTH CARE
Payor Identification: 000030317

Claim Remark Codes
MA01 N793 MA18 N89

Medical Record Identification Number:
Coverage Amount: 124.00
Per Day Limit: 0.36

Total Billed	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Paid Amount	Prof Comp	Interest
124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Line Items...	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Payment	Prof Comp	Interest
**	2019	G0463 PO	G0463 PO	1	124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Ambulatory Patient Group (APG) Number: 05012
Ambulatory Payment Classification: 05012
Allowed - Actual: 124.00

Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount
	CO	45	CHARGE EXCEEDS FEE	41.13

SCHEDULE/MAX ALL

PR | 1 | DEDUCTIBLE AMT | 82.87

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: [redacted]
2. Medicare number: [redacted]
3. Item or service you wish to appeal: GO463
4. Date the service or item was received: [redacted]/2019
5. Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)
1/22/2019

5a. Name of the Medicare contractor that made the determination (not required):
NATIONAL GOVERNMENT SERVICES

5b. Does this appeal involve an overpayment? ☐ Yes ☒ No
(for providers and suppliers only)

6. I do not agree with the determination decision on my claim because:
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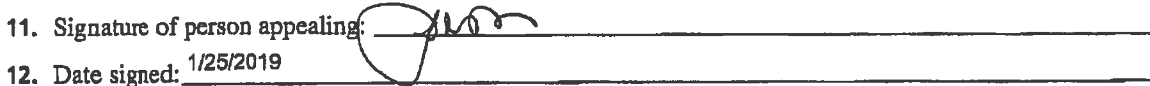
☒ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☒ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing: LINDA DICKSON, YORK HOSPITAL
15 HOSPITAL DRIVE, YORK MAINE, 03909 207-351-2380

11. Signature of person appealing:



12. Date signed: 1/25/2019

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Form CMS-20027 (12/10)

Remittance Header

Remittance ID: MED A — MEDICARE PART A
Provider Number: 1376528398 — YORK HOSPITAL
File Creation Date: 01/19/2019
Payment Date: 01/22/2019

Provider Group: MEDICARE PART A
Payor Name: NATIONAL GOVERNMENT SERVICES, INC.
File Control Number: 116300427

Today's Date: 01/25/2019 14:55
Page: 1 of 2

Claim Header

Invoice Number: [redacted]
Patient Name: [redacted]
Member Identificatio [redacted]
Plan ID: MEDICARE — MEDICARE A & B
Rank: Primary
Claim Status: Processed as Primary:

Claim Start Date: [redacted]2019
Claim End Date: [redacted]2019
Invoice Type: UB
Document Ctl No: 21900800674404MEA

Coverage Exp Date:
Claim Received Date:
UB TOB: 131

Outpatient Adjudication Info

Reimbursement Rate: .36
HCPCS Payable Amt:
End Stage Renal Disease Amt:

Additional Claim Information

Crossover Carrier: AETNA, INC.
Payor Identification: 000000060

Claim Remark Codes

MA01 N793 MA18

Medical Record Identification Number: [redacted]
Coverage Amount: 124.00
Per Day Limit: 0.36

Total Billed	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Paid Amount	Prof Comp	Interest
124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Line Items...

	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Payment	Prof Comp	Interest
**	[redacted]/2019	G0463 PO	G0463 PO	1	124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Ambulatory Patient Group (APG) Number: 05012
Ambulatory Payment Classification: 05012
Allowed - Actual: 124.00

Reason Detail...

Grp Cd	Rsn Cd	Reason Description	Amount
CO	45	CHARGE EXCEEDS FEE	41.13

		SCHEDULE/MAX ALL	
PR	1	DEDUCTIBLE AMT	82.87

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: [redacted]N
2. Medicare number: [redacted]
3. Item or service you wish to appeal: G0463
4. Date the service or item was received: [redacted]2019
5. Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)
1/22/2019

5a. Name of the Medicare contractor that made the determination (not required):
NATIONAL GOVERNMENT SERVICES

5b. Does this appeal involve an overpayment? ☐ Yes ☒ No
(for providers and suppliers only)

6. I do not agree with the determination decision on my claim because:
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☒ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☒ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing: LINDA DICKSON, YORK HOSPITAL
15 HOSPITAL DRIVE, YORK MAINE, 03909 207-351-2380

11. Signature of person appealing:

12. Date signed: 1/25/2019

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Form CMS-20027 (12/10)

Remittance Header

Remittance ID: MED A — MEDICARE PART A
Provider Number: 1376528398 — YORK HOSPITAL
File Creation Date: 01/19/2019
Payment Date: 01/22/2019

Provider Group: MEDICARE PART A
Payor Name: NATIONAL GOVERNMENT SERVICES, INC.
File Control Number: 116300427

Today's Date: 01/25/2019 14:55
Page: 1 of 2

Claim Header

Invoice Number: [redacted]
Patient Name: [redacted]
Member Identificatio [redacted]
Plan ID: MEDICARE — MEDICARE A & B
Rank: Primary
Claim Status: Processed as Primary:

Claim Start Date: [redacted]2019
Claim End Date: [redacted]2019
Invoice Type: UB
Document Ctl No: 21900800675304MEA

Coverage Exp Date:
Claim Received Date:
UB TOB: 131

Outpatient Adjudication Info

Reimbursement Rate: .36
HCPCS Payable Amt:
End Stage Renal Disease Amt:

Additional Claim Information

Claim Remark Codes
MA01 N793

Medical Record Identification Number: [redacted]
Coverage Amount: 124.00
Per Day Limit: 0.36

Total Billed	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Paid Amount	Prof Comp	Interest
124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

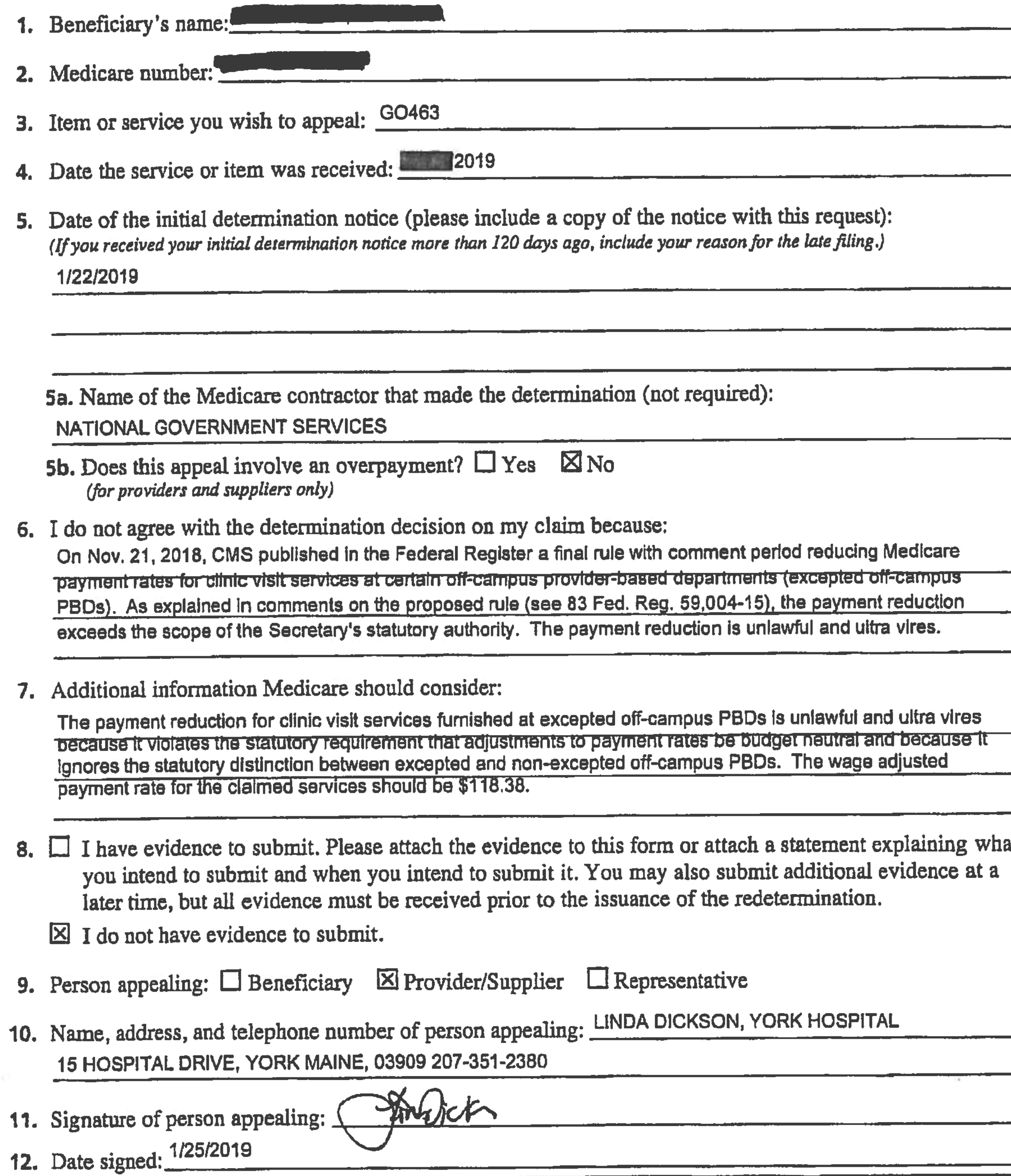
Line Items...	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Payment	Prof Comp	Interest
**	[redacted]2019	G0463 PO	G0463 PO	1	124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Ambulatory Patient Group (APG) Number: 05012
Ambulatory Payment Classification: 05012
Allowed - Actual: 124.00

Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount
	CO	45	CHARGE EXCEEDS FEE	41.13

SCHEDULE/MAX ALL

PR	1	DEDUCTIBLE AMT	82.87



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: [redacted]
2. Medicare number: [redacted]
3. Item or service you wish to appeal: GO463
4. Date the service or item was received: [redacted] 2019
5. Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)
1/22/2019

5a. Name of the Medicare contractor that made the determination (not required):
NATIONAL GOVERNMENT SERVICES

5b. Does this appeal involve an overpayment? ☐ Yes ☒ No
(for providers and suppliers only)

6. I do not agree with the determination decision on my claim because:
On Nov. 21, 2018, CMS published in the Federal Register a final rule with comment period reducing Medicare payment rates for clinic visit services at certain off-campus provider-based departments (excepted off-campus PBDs). As explained in comments on the proposed rule (see 83 Fed. Reg. 59,004-15), the payment reduction exceeds the scope of the Secretary's statutory authority. The payment reduction is unlawful and ultra vires.

7. Additional information Medicare should consider:
The payment reduction for clinic visit services furnished at excepted off-campus PBDs is unlawful and ultra vires because it violates the statutory requirement that adjustments to payment rates be budget neutral and because it ignores the statutory distinction between excepted and non-excepted off-campus PBDs. The wage adjusted payment rate for the claimed services should be $118.38.

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.
☒ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☒ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing: LINDA DICKSON, YORK HOSPITAL
15 HOSPITAL DRIVE, YORK MAINE, 03909 207-351-2380

11. Signature of person appealing: [signature]

12. Date signed: 1/25/2019

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54489 (2006) or at http://www.cms.gov/PrivacyActSystemofRecords/downloads/0566.pdf

Form CMS-20027 (12/10)

Remittance Header

Remittance ID: MED A | MEDICARE PART A
Provider Number: 1376528398 | YORK HOSPITAL
File Creation Date: 01/19/2019
Payment Date: 01/22/2019

Provider Group: MEDICARE PART A
Payor Name: NATIONAL GOVERNMENT SERVICES, INC.
File Control Number: 116300427

Today's Date: 01/25/2019 14:56
Page: 1 of 2

Claim Header

Invoice Number: [redacted]
Patient Name: [redacted]
Member Identificatio [redacted]
Plan ID: MEDICARE | MEDICARE A & B
Rank: Primary
Claim Status: Processed as Primary:

Claim Start Date: [redacted]2019
Claim End Date: [redacted]2019
Invoice Type: UB
Document Ctl No: 21900700897804MEA

Coverage Exp Date:
Claim Received Date:
UB TOB: 131

Outpatient Adjudication Info

Reimbursement Rate: .36
HCPCS Payable Amt:
End Stage Renal Disease Amt:

Additional Claim Information

Crossover Carrier: ANTHEM BCBS NORTHEAST REGION
Payor Identification: 000030067

Claim Remark Codes
MA01 N793 MA18

Medical Record Identification Number: [redacted]
Coverage Amount: 124.00
Per Day Limit: 0.36

Total Billed	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Paid Amount	Prof Comp	Interest
124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

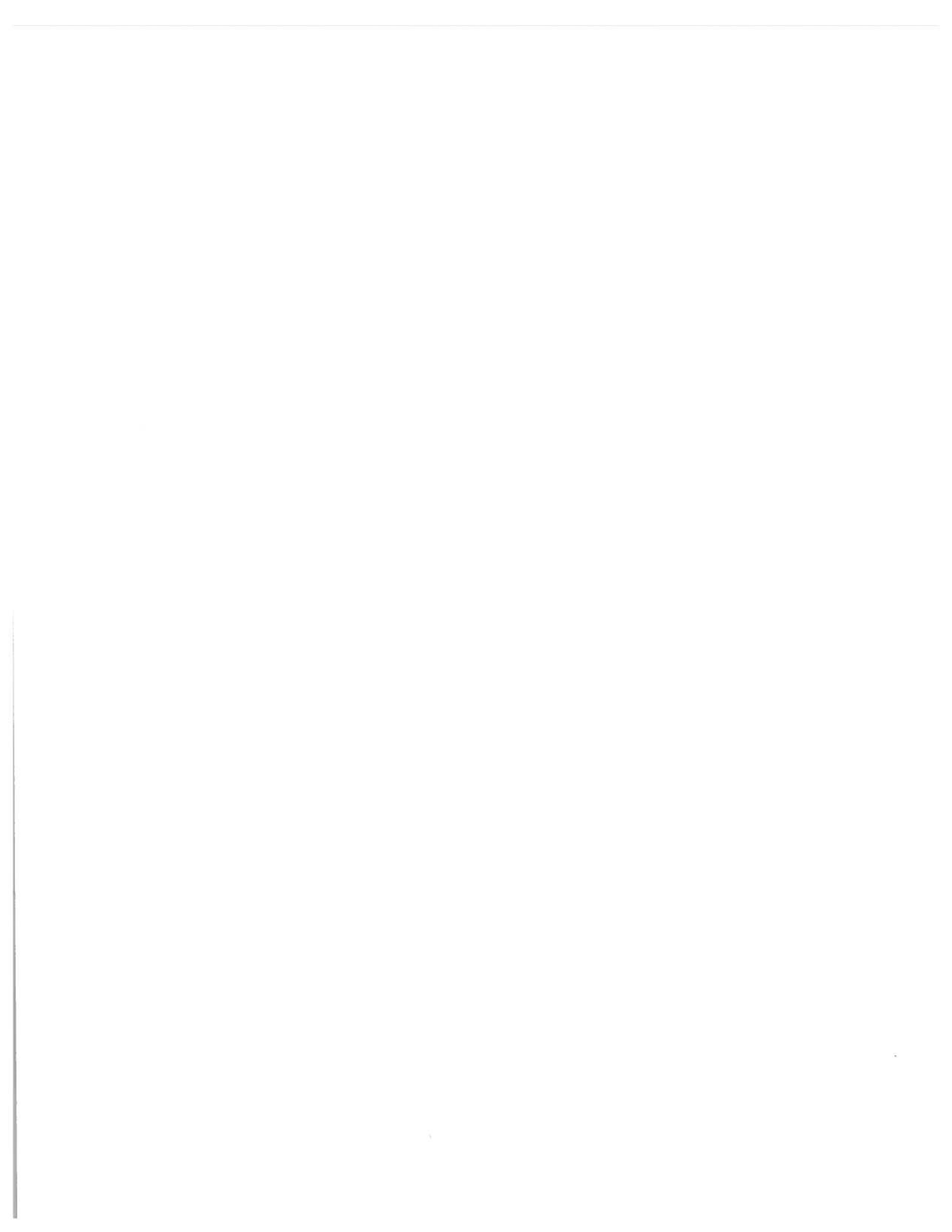
Line Items...	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Payment	Prof Comp	Interest
**	[redacted]2019	G0463 PO	G0463 PO	1	124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00	0.00

Ambulatory Patient Group (APG) Number: 05012
Ambulatory Payment Classification: 05012
Allowed - Actual: 124.00

Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount
	CO	45	CHARGE EXCEEDS FEE	41.13

SCHEDULE/MAX ALL

PR | 1 | DEDUCTIBLE AMT | 82.87



IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, MERCY HEALTH MUSKEGON, CLALLAM COUNTY PUBLIC HOSPITAL NO. 2 d/b/a/ OLYMPIC MEDICAL CENTER, and YORK HOSPITAL,	
Plaintiffs,	
v.	Civil Action No. 1:18-cv-2841
ALEX M. AZAR II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,	
Defendant.	

[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Upon consideration of Plaintiffs' Motion for Summary Judgment, the Memorandum in Support, any opposition or replies, and the arguments of counsel, it is hereby

ORDERED that Plaintiffs' motion be **GRANTED**; and it is further

ORDERED that summary judgment shall **BE**, and it hereby **IS**, **GRANTED** in favor of Plaintiffs and against Defendant on all claims; and it is further

ORDERED that the Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule for Calendar Year 2019 (the Final Rule) **BE**, and it hereby **IS,** declared unenforceable for the reasons set forth in this Court's separate opinion; and it is further

ORDERED, that the *ultra vires* portions of the Final Rule shall **BE**, and hereby **ARE**, **VACATED**; and it is further

ORDERED, that Defendant is hereby **ENJOINED** from enforcing the *ultra vires* portions of the Final Rule; and it is further

ORDERED that CMS shall conform its payment policies and conduct to the requirements of the Medicare Act; and it is further

ORDERED that CMS shall recalculate all payments made or due pursuant to the Final Rule and provide immediate payment of any amounts improperly withheld as a result of its *ultra vires* conduct to all affected hospitals (including but not limited to the Plaintiff-Hospitals and all affected members of the AHA and AAMC).

SO ORDERED, this __ day of ______ 2019.

____
The Honorable Rosemary M. Collyer
United States District Court Judge

Copies to:

Catherine E. Stetson
Susan M. Cook
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004

Bradley P. Humphreys
Justin Sandberg
U.S. Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, NW
Washington, DC 20005