

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,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 1:18-cv-2841
)	
ALEX M. AZAR II,)	
in his official capacity as SECRETARY OF)	
HEALTH AND HUMAN SERVICES,)	
)	
<i>Defendant.</i>)	

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 ²⁴~~25~~ day of January 2019.

By: _____

Jud Knox
President
York Hospital

Exhibit A

YORK HOSPITAL 15 HOSPITAL DR YORK ME 039091011 2073634321		UNITED STATES 5 MED REG. #		STATEMENT COVER PERIOD FROM 19 THROUGH 18		0131
PATIENT NAME		PATIENT ADDRESS		STATE		ZIP
10 BIRTHDATE		11 SEX		12 DATE		13
14		15		16		17
18		19		20		21
22		23		24		25
26		27		28		29
30		31		32		33
34		35		36		37
38		39		40		41
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / NPPS CODE		45 SERV. DATE
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64 INSURED'S NAME		65 PREL		66 INSURED'S UN DUE ID		67 GROUP NAME
		18 18				
68 TREATMENT AUTHORIZATION CODES		69 DOCUMENT CONTROL NUMBER		70 EMPLOYER NAME		
E039 J438 I258 I10 I2510 E7800 R911 N281						
71 ADMIT DATE		72 PATIENT REASON DN		73 ICD-9-CM PROCEDURE		74 ICD-9-CM PROCEDURE
E039						
75 ATTENDING		76 OPERATING		77 OTHER		78 OTHER
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79 REMARKS		80 ICD-9-CM		81 ICD-9-CM		82 ICD-9-CM
MEDICARE A AND B		B3 282N00000X		B1 WHITE		B2 M
PO BOX 7091						
INDIANAPOLIS IN 462077091						

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 F

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

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SEL LAST NAME FIRST INIT TOT CHG PROV REIMB PD DT CAN DT REAS NPC #DAYS
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SEL LAST NAME FIRST INIT TOT CHG PROV REIMB PD DT CAN DT REAS NPC #DAYS
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MAP1716 PAGE 06 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/21/19
SHN1844 SC INST CLAIM INQUIRY A20191AP 11:24:35

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 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

18 HOSPITAL DR YORK 2073834321										STATE ME 038091011										0131 01-0212444 19									
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BIRTHDATE [REDACTED]										ADMISSION 13 HR 14 TYPE 18 ERG 19 3 1										STAT 01									
OCCURRENCE DATE 19										OCCURRENCE DATE [REDACTED]										OCCURRENCE DATE [REDACTED]									
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SERV. DATE 19										SERV. UNITS 1										TOTAL CHARGE 124.00									
0001										PAGE 001 OF 001										CREATION DATE 19									
PAYER NAME MEDICARE A AND B MAIL HANDLERS BEN										HEALTH PLAN ID [REDACTED]										PRIOR PAYMENTS Y Y									
INSURED NAME [REDACTED]										INSURED'S UNIQUE ID 18 01										GROUP NAME [REDACTED]									
TREATMENT AUTHORIZATION CODES [REDACTED]										DOCUMENT CONTROL NUMBER [REDACTED]										EMPLOYER NAME [REDACTED]									
ICD-9 110										ICD-10 E1169										ICD-9 [REDACTED]									
ADMIT 110										TIPOS [REDACTED]										ECN [REDACTED]									
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534 045-1422

APPROVED CLAIMS AND CREDIT

NUCC

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



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,

A handwritten signature in black ink, appearing to read 'Robin LaBonte'.

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

MAP1716 PAGE 06 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/21/19
SHN1844 SC INST CLAIM INQUIRY A20191AP 11:25:48

MID ██████████ TOB 131 S/LOC P B9997 PROVIDER 200020
MSP ADDITIONAL INSURER INFORMATION

1ST INSURERS ADDRESS 1
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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 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

<== REASON CODES

PRESS PF3-EXIT PF7-PREV PAGE

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

Today's Date: 01/26/2019 09:31
 Page 1 of 1

Provider Number: 1376528398 YORK HOSPITAL

Patient Name	From Date	Days TOB	Total Chgs	Cov Chgs	Non Cov	Prof Comp	Interest	
Invoice ID	HIC No	Thru Date	DRG Plan ID	Rejected	Deductible	Co Ins	Cont Adj	Net Reimb
Doc Ctl No	Crossover Carrier Info							
[REDACTED]	[REDACTED]	[REDACTED]/2019	131	124.00	124.00	0.00	0.00	0.00
[REDACTED]	[REDACTED]	[REDACTED]/2019	MEDICARE	0.00	82.87	0.00	41.13	0.00
[REDACTED]	AETNA, INC.		000000080					
Reason Detail...	Grp Cd	Rsn Cd	Reason Description	Amount				
	CO	45	CHARGE EXCEEDS FEE SCHEDULE/MF	41.13				
	PR	1	DEDUCTIBLE AMT	82.87				

Claim Remarks

MAP1741 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/10/19
JXJ1341 SC CLAIM SUMMARY INQUIRY C201914F 10:13:24
NPI 1376528398
MID [REDACTED] PROVIDER S/LOC TOB
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] N 124.00 WW001

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT
MAP1741 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/10/19
JXJ1341 SC CLAIM SUMMARY INQUIRY C201914F 10:13:55
NPI 1376528398
MID [REDACTED] PROVIDER S/LOC TOB
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] 350.00 WW001

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

YORK HOSPITAL 15 HOSPITAL DR YORK ME 039091011 2073634321		CNTL# 15060991000001 S. DED. REC. # [REDACTED] 8 FED. TAX NO. 01-0212444 9 STATEMENT COVER PERIOD FROM 18 THROUGH 19		0131
PATIENT NAME [REDACTED]		PATIENT ADDRESS [REDACTED]		
10 B RTNDATE	11 SEX	12 DATE	13 ADM BELGN	14 TYPE
	F	08 3 1		01
31 OCCURRENCE DATE	32 OCCURRENCE TIME	33 OCCURRENCE DATE	34 OCCURRENCE TIME	35 CODE
11				
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / NIPPX CODE	45 REV. DATE	46 SERV UNITS
0810	PHYSICIAN PRACTICE CLINIC	G0483 PO	19	1
				17 TOTAL CHARGES
				124.00
				48 NON-COVERED CHARGES
0001 PAGE 001 OF 001		CREATION DATE 18		TOTALS 124.00
50 PAYER NAME		51 HEALTH PLAN ID	52 REL. INFO	53 ACC. BEN.
MEDICARE A AND B AARP HEALTHCARE OPTIONS			Y	Y
			Y	Y
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI
				1376628398
				57 OTHER PRV ID
				1376628398
58 INSURED 3 NAME		59 REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
[REDACTED]		18	[REDACTED]	
[REDACTED]		18	[REDACTED]	
62 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		66 EMPLOYER NAME
68 ADMIT DATE		69 PATIENT REASON DX	70 ICD9 CODE	71 ICD9 CODE
J329		J329		
72 PRINCIPAL PROCEDURE DATE	73 OTHER PROCEDURE DATE	74 OTHER PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 ATTENDING NPI
				1588840957
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI
79 OTHER NPI		80 OTHER NPI		81 OTHER NPI
82 REMARKS		83 ICD9 CODE		84 ICD9 CODE
MEDICARE A AND B		B3 282N0000X		
PO BOX 7081		B1 WHITE		
INDIANAPOLIS IN 482077091		B2 M		

3974051250

APPROVED ON 08/06/09

NUBC

THE PORTION OF THIS RECEIPT THAT APPLIES TO THE BILL IS MADE A PART OF THE BILL

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

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

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

<== REASON CODES

PRESS PF3-EXIT PF7-PREV PAGE

MAP1741 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/10/19
JKJ1341 SC CLAIM SUMMARY INQUIRY C201914F 10:14:19
NPI 1376528398

MID	PROVIDER	S/LOC	TOB											
OPERATOR ID JKJ1341	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]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	S MOPPS	131	[REDACTED]	19	[REDACTED]	19	[REDACTED]	[REDACTED]	19
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	124.00	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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

MAP1741 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/10/19
JKJ1341 SC CLAIM SUMMARY INQUIRY C201914F 10:14:42
NPI 1376528398

MID	PROVIDER	S/LOC	TOB											
OPERATOR ID JKJ1341	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]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	S MOPPS	131	[REDACTED]	19	[REDACTED]	19	[REDACTED]	[REDACTED]	19
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	124.00	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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

Remittance Header

Remittance ID: MED A
 Provider Number: 1376528398
 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 09:34
 Page: 1 of 2

Claim Header

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

Claim Start Date: 2019
 Claim End Date: 2019
 Invoice Type: UB
 Document CI No: 21900800676304MEA

Coverage Exp Date: [REDACTED]
 Claim Received Date: [REDACTED]
 UB TOB: 131

Outpatient Adjudication Info

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

Additional Claim Information

Claim Remark Codes
 MA01 N793

Line Items...	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj Paid Amount	Prof Comp	Interest
**	2019	50463 PO	50463 PO	1	124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00
Ambulatory Patient Group (APG) Number: 05012													
Ambulatory Payment Classification: 05012													
Allowed - Actual: 124.00													
Reason Detail... GP Cd 45 Rsn Cd 45 Amount 41.13													
CHARGE EXCEEDS FEE													

PR	1	SCHEDULE/MAX ALL DEDUCTIBLE AMT	82.87
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MAP1716 PAGE 06 NATIONAL GOVERNMENT SERVICES #14011 ACPFA181 01/21/19
SHN1844 SC INST CLAIM INQUIRY A20191AP 11:31:25

MID ██████████ 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 <== REASON CODES
PRESS PF3-EXIT PF7-PREV PAGE

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

PR SCHEDULE/MAX ALL
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: _____
2. Medicare number: _____
3. Item or service you wish to appeal: GO463
4. Date the service or item was received: /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

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (e)(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>

Remittance Header

Remittance ID: MED A MEDICARE PART A Today's Date: 01/25/2019 14:54
 Provider Number: 1376528398 YORK HOSPITAL Provider Group: NATIONAL GOVERNMENT SERVICES, INC. Page: 1 of 2
 File Creation Date: 01/19/2019 Payor Name: NATIONAL GOVERNMENT SERVICES, INC.
 Payment Date: 01/22/2019 File Control Number: 116300427

Claim Header

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

Outpatient Adjudication Info

Reimbursement Rate: [REDACTED] .36
 HCPCS Payable Amt: [REDACTED]
 End Stage Renal Disease Amt: [REDACTED]
 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:
 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
Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj	Payment	Interest
124.00	0.00	0.00	0.00	82.87	0.00	41.13	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 [REDACTED] 30463 PO [REDACTED] 1 124.00 0.00 0.00 0.00 82.87 0.00 41.13 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
 [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] 41.13

44	PR	STORAGE CASUALTY FEE	41.13
45	1	SCHEDULE/MAX ALL	
		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: _____
- 2. Medicare number: _____
- 3. Item or service you wish to appeal: GO463
- 4. Date the service or item was received: 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

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/PrivacyAct/SystemofRecords/downloads/0566.pdf>

Remittance Header
 Remittance ID: MED A
 Provider Number: 1376528398
 File Creation Date: 01/19/2019
 Payment Date: 01/22/2019
 Provider Group: MEDICARE PART A
 Payor Name: YORK HOSPITAL
 File Control Number: 116300427
 Today's Date: 01/25/2019 14:51
 Page: 1 of 2

Claim Header
 Invoice Number: [REDACTED]
 Patient Name: [REDACTED]
 Member Identification: [REDACTED]
 Plan ID: MEDICARE
 Rank: Primary
 Claim Status: Processed as Primary
 Claim Start Date: [REDACTED]
 Claim End Date: [REDACTED]
 Invoice Type: UB
 Document Ctl No: 21900800674004MEA
 Coverage Exp Date: 2019
 Claim Received Date: 2019
 UJ TOB: 131

Outpatient Adjudication Info
 Reimbursement Rate: .36
 HCPCS Payable Amt: [REDACTED]
 End Stage Renal Disease Amt: [REDACTED]
 Additional Claim Information
 Crossover Carrier: HARVARD PILGRIM HEALTH CARE
 Payer Identification: 000030317

Claim Remark Codes
 MA01 N793 MA18 N89

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
Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj Payment	Prof Comp	Interest
124.00	0.00	0.00	0.00	82.87	0.00	41.13	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	00463 PO	1	124.00	0.00	0.00	0.00	0.00	82.87	0.00	41.13	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													
		CC	45	CHARGE EXCEEDS FEE							41.13		

PR	1	SCHEDULE/MAX ALL DEDUCTIBLE AMT	82.87
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

- 1. Beneficiary's name: _____
- 2. Medicare number: _____
- 3. Item or service you wish to appeal: GO463
- 4. Date the service or item was received: 1/22/2019
- 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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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

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>

Remittance Header
 Remittance ID: MED A
 Provider Number: 1376528398
 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 Identification: MEDICARE
 Plan ID: Primary
 Rank: Processed as Primary
 Claim Status: [REDACTED]
 Claim Start Date: 2019
 Claim End Date: 2019
 Invoice Type: UB
 Document CII No: 21900800674404MIEA
 Coverage Exp Date: [REDACTED]
 Claim Received Date: [REDACTED]
 UB TOB: 131

Outpatient Adjudication Info
 Reimbursement Rate: [REDACTED]
 HCPCS Payable Amt: [REDACTED]
 End Stage Renal Disease Amt: [REDACTED]
 Additional Claim Information
 Crossover Carrier: AETNA, INC.
 Payor Identification: 000000060

Claim Remark Codes
 MA01 N793 MA18

Line Items...	Service Date	Billed Proc	Paid Proc	Qty	Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj Paid Amount	Prof Comp	Interest
**	2019	00463 PO	00463 PO	1	124.00	124.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00
Ambulatory Patient Group (APG) Number: 05012													
Ambulatory Payment Classification: 05012													
Allowed - Actual: 124.00													
Reason Detail... GP Cd Rsn Cd Reason Description Amount													
CC 45 CHARGE EXCEEDS FEE 41.13													

PR	1	SCHEDULE/MAX ALL DEDUCTIBLE AMT	82.87
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

- 1. Beneficiary's name: _____
- 2. Medicare number: _____
- 3. Item or service you wish to appeal: GO463
- 4. Date the service or item was received: 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

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/PrivacyAct/SystemofRecords/downloads/0566.pdf>

PR	1	SCHEDULE/MAX ALL DEDUCTIBLE AMT	82.87
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NATIONAL GOVERNMENT SERVICES
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Remittance Header

Remittance ID: MED A
 Provider Number: 1376528398
 File Creation Date: 01/19/2019
 Payment Date: 01/22/2019

MEDICARE PART A
 YORK HOSPITAL

Provider Group: MEDICARE PART A
 Payer 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 A & B
 Rank: Primary
 Claim Status: Processed as Primary:

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

Coverage Exp Date: 2019
 Claim Received Date: 2019
 UB TOB: 131

Outpatient Adjudication Info

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

Additional Claim Information
 Crossover Carrier: ANTHEM BCBS NORTHEAST REGION
 Payer Identification: 000030067

Claim Remark Codes
 MA01 N793 MA18

Medical Record Identification Number: [REDACTED]

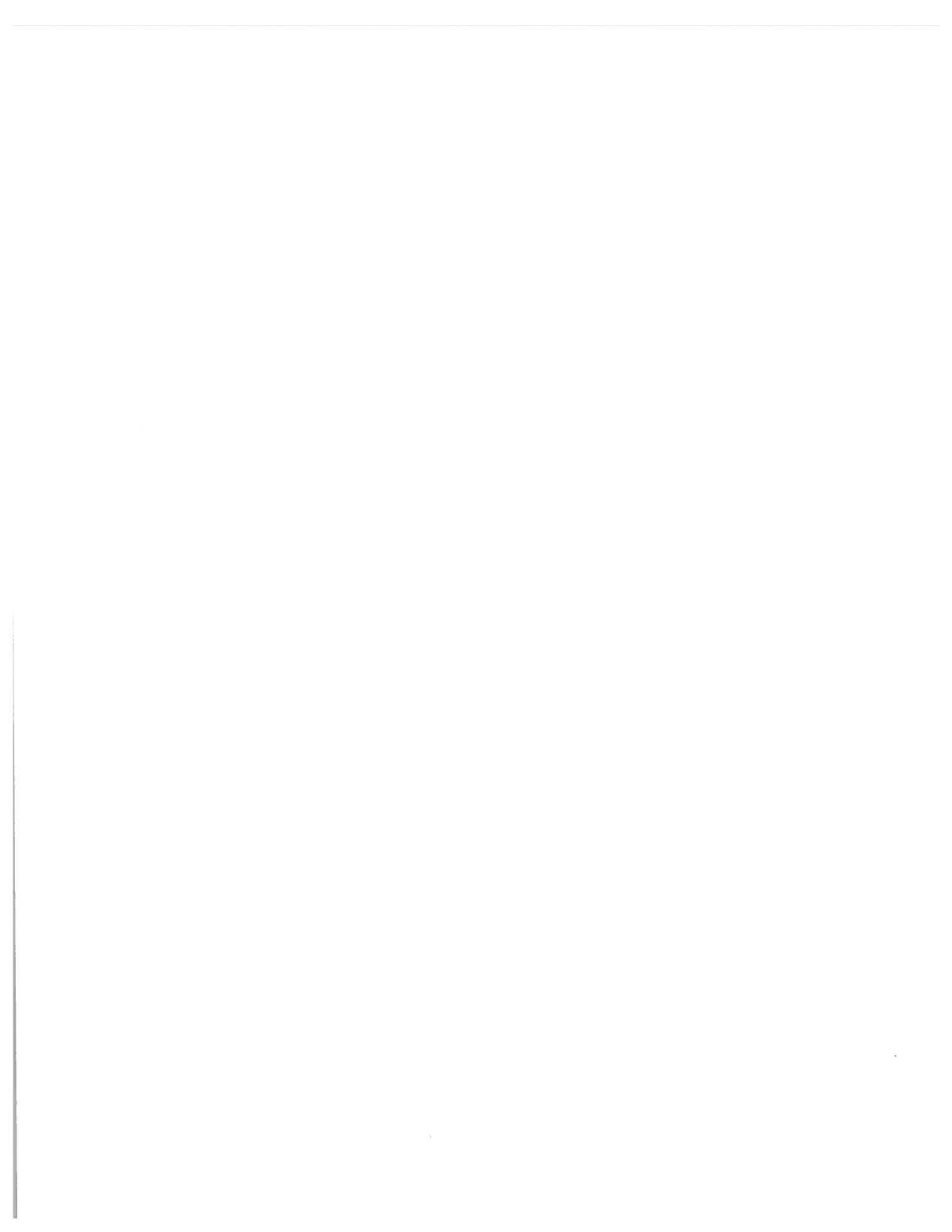
Coverage Amount: 124.00
 Per Day Limit: 0.36

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
Billed Amt	Cov Chgs	Non-Cov	Rejected	Deductible	Co-Ins	Cont Adj Payment	Prof Comp	Interest
124.00	0.00	0.00	0.00	82.87	0.00	41.13	0.00	0.00

Line Items... Service Date: 2019
 Billed Prog: 60463 PO
 Field Proc: 60463 PO
 Qty: 1
 Ambulatory Patient Group (APG) Number: 05012
 Ambulatory Payment Classification: 05012
 Allowed - Actual: 124.00

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

PR	1	SCHEDULE/MAX ALL DEDUCTIBLE AMT	82.87
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

<hr/>)
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,))
))
<i>Plaintiffs,</i>))
))
v.)	Civil Action No. 1:18-cv-2841
))
ALEX M. AZAR II,))
in his official capacity as SECRETARY OF))
HEALTH AND HUMAN SERVICES,))
))
<i>Defendant.</i>))
<hr/>)

**[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