# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D34

**PROVIDER –**
Porter Hospital
Middlebury, Vermont

Provider No.: 47-0006

**vs.**

**INTERMEDIARY –**
Blue Cross and Blue Shield Association/
National Government Services

**DATE OF HEARING -**
September 25, 2012

Cost Reporting Period Ended -
September 30, 2004

**CASE NO.:** 07-2753

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ISSUE:

Whether the Provider documented that it experienced in a cost-reporting period compared to the previous cost-reporting period a decrease of more than 5 percent in its total number of patient discharges due to circumstances beyond its control in accordance with 42.U.S.C. § 1395www(d)(5)(D)(ii).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare administrative contractors (MAC). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit a cost report annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the fiscal year and the proportion of those costs to be allocated to the Medicare program.[3] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues a Notice of Program Reimbursement (NPR).[4] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[5]

Part A of the Medicare program covers "inpatient hospital services." As part of the Social Security Amendments of 1983,[6] Congress changed hospital reimbursement under the Medicare program by establishing the prospective payment system for inpatient hospital services (IPPS). Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments based on hospital-specific factors.[7] The statutory provisions addressing the IPPS are located in 42 U.S.C. § 1395ww(d) and they contain a number of provisions that adjust payment based on hospital-specific factors.[8]

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] 42 C.F.R. § 413.20.
[4] 42 C.F.R. § 405.1803.
[5] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 - 1837.
[6] Social Security Amendments of 1983 § 601, Pub. L. No. 98-21, 97 Stat. 65, 149-163 (1983).
[7] *See id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).

One of these hospital-specific adjustment factors applies only to sole community hospitals (SCHs). Specifically, 42 U.S.C. § 1395ww(d)(5)(D)(ii) provides for a low volume adjustment for qualifying SCHs as follows:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

The regulations implementing this statutory provision are located at 42 C.F.R. § 412.92 and state in pertinent part:

> (d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals*— . . . .
> (3) *Adjustment to payments*. A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section.
> (e) *Additional payments to sole community hospitals experiencing a significant volume decrease*. (1) For cost reporting periods beginning on or after October 1, 1983, the intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. . . .
> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement–
> (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and
> (ii) Show that the decrease is due to circumstances beyond the hospital's control.

And lastly, additional guidance exists as follows in the instructions located in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2810.1:

A. Criteria for Determining Eligibility for Additional Payments.—In addition to being approved as an SCH for at least a part of the cost reporting period in question, the basic criteria for approval of additional payment for SCHs involve two issues, i.e., circumstances beyond the hospital's control and decrease in discharges.

1. Circumstances Beyond the Hospital's Control.—In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects.

2. Decrease in Discharges.—In order to qualify for additional payments, an SCH must experience a decrease in discharges of more than 5 percent. In making the comparison of discharges, the number of discharges in a cost reporting period is compared to the immediately preceding cost reporting period only. Thus, if a hospital experiences an occurrence toward the end of a cost reporting period that does not result in a total 5 percent decrease in discharges throughout the cost reporting period, additional payments are not made to the hospital. Similarly, if a hospital experiences an occurrence that results in a sustained decrease in cases, an adjustment is made only for the cost reporting periods where the change resulted in a decrease of 5 percent of the discharges. An adjustment is not made during a subsequent period unless discharges decreased another 5 percent.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Porter Hospital (Provider) is a 45-bed not-for-profit hospital located in Middlebury, Vermont. The Provider has been classified as an SCH pursuant to 42 C.F.R. § 412.92 since December 5, 1989.[9] National Government Services, Inc. is the Provider's designated intermediary (Intermediary).

On August 7, 2006, the Provider submitted an SCH low volume exception request with supporting documentation to the Intermediary requesting an additional payment of $1,425,923 for the Provider's fiscal year ending September 30, 2004 (FY 2004).[10] The exception request documented that the Provider experienced a decrease of 9.35 percent in inpatient discharges as compared to its fiscal year ending September 30, 2003 (FY 2003).[11]

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[9] Provider's Final Position Paper at 1; Intermediary's Final Position Paper at 1.
[10] *See* Provider Exhibit P-7 at 15.
[11] Provider's Post-Hearing Brief at 1; Provider Exhibit P-7 at 6.,

The Intermediary reviewed the Provider's request and supporting documentation and on November 28, 2006 sent a letter to the Provider stating that the request was incomplete due to lack of documentation. The letter instructed the Provider to submit additional documentation by December 28, 2006 to support the SCH volume adjustment requirement that the decrease resulted from an unusual situation or occurrence externally imposed on the Hospital and beyond its control.[12]

The Provider responded to the additional documentation request on December 22, 2006.[13] The Intermediary reviewed this submission and found that the Provider failed to submit any new documentation. As a result, the Intermediary denied the Provider's request for a low volume adjustment by letter dated June 19, 2007.[14]

The Provider filed a timely appeal of the Intermediary's determination to the Board on August 8, 2007.[15] The Provider was represented by William H. Stiles, Esq., of Verrill Dana LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

STIPULATION OF FACTS:

The Provider and the Intermediary stipulated to the following pertinent facts:

- The Provider had 1,486 total inpatient discharges for its fiscal year ended September 30, 2003 ("FY 2003"). Provider Exhibit P-7, p. 6. The Provider reported 1,478 total discharges on the fiscal year ended September 30, 2003 cost report.

- The Provider had 1,347 total inpatient discharges for its fiscal year ended September 30, 2004 ("FY 2004"). Provider Exhibit P-7, p. 6. The Provider reported 1,330 total discharges on the fiscal year ended September 30, 2004 cost report.

- The Provider experienced a decrease of more than 5% in its total number of inpatient discharges in FY 2004 as compared to the previous cost reporting period (FY 2003).

- The Provider experienced a 9.35% decrease in its total number of inpatient discharges for its fiscal year 2004 when compared to FY 2003. Provider Exhibit P-7, p. 6. Utilizing the number of inpatient discharges reported by the Provider in its fiscal year ended September 30, 2003 and 2004 cost reports, the decrease in discharges is 10.01%.[16]

PROVIDER'S CONTENTIONS:

The Provider contends that it satisfied the two criteria necessary to qualify for the SCH low volume adjustment. The first criterion is that the Provider must have experienced a decrease of

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[12] Provider Exhibit P-8.
[13] Provider Exhibit P-9.
[14] Provider Exhibit P-5.
[15] Provider Exhibit P-10.
[16] Provider Exhibit P-29 (Stipulation of Fact (Sept. 21, 2012)).

more than 5 percent in its total number of inpatient discharges. In this appeal, there is no dispute that the Provider experienced a decrease of more than 5 percent in its total number of inpatient cases from FY 2003 to FY 2004. As demonstrated in the Provider's low volume adjustment request, total discharges decreased from 1,486 in FY 2003 to 1,347 in FY 2004, for a difference of 139 discharges, or 9.35 percent. The Intermediary has stipulated that the decrease represented either 9.35 percent as calculated by the Provider using detailed discharge records, or 10.01% using the discharge figures from the Medicare cost report.[17]

In addition, the Provider contends that it satisfied the second criterion necessary to qualify for a low volume adjustment, namely that the decrease in volume resulted from an unusual situation or occurrence externally imposed on the hospital and beyond its control. The Provider asserts that the following circumstances are the three primary reasons that led to the volume decrease: (1) the loss of a physician from Little City Family Practice, an independent family group practice; (2) reduced demand for general inpatient surgery among the patients of the independent surgeons, Drs. Fuller and Petri; and (3) reduced demand for inpatient services among the patients of Middlebury Family Health, an independent family group practice.[18]

In support of the first circumstance, the Provider documented that a physician, Dr. Newman, resigned her position at Little City Family Practice effective February 21, 2003. The physician's decision to relocate away from an independent physician group is not within the Provider's control. The Provider did what was within its control and assisted the independent physician group with the recruitment of a replacement physician. The Provider documented its good faith efforts to assist in finding a replacement physician, as well as the fact that a suitable replacement was actually named within a reasonable period of time.[19]

The Provider notes that Dr. Newman practiced in an independent group practice and, as a result, the impact of the departing physician must be measured on a group basis. The physicians remaining in Little City Family Practice were attempting to retain and cover for Dr. Newman's patients after she relocated, recruit a suitable replacement, and maintain their own panel of patients. Accordingly, the departure of a physician from a group practice clearly disrupts those physicians remaining with the group practice. The Provider argues that when viewed properly, the effect of Dr. Newman's departure on Little City Family Practice was a net loss of 26 discharges. Dr. Newman's departure, the recruitment of a replacement, and the ensuing transition of incorporating the replacement into the group affected the entire group practice. This cascade of events triggered by the physician's departure contributed to reduced inpatient admissions from the group practice as a whole. The Provider argues that this circumstance was beyond the hospital's control.[20]

In support of the second circumstance, the Provider documented a significant, but temporary drop, in general inpatient surgery during FY 2004. As described in the Provider's low volume adjustment request, independent general surgeons Dr. Fuller and Dr. Petri had 31 and 13 fewer discharges from the Provider in FY 2004, respectively. Through discussions with the practice

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[17] *See* Provider's Post Hearing Brief at 9.
[18] *See id.* at 10.
[19] *See* Exhibit P-7, p. 9-10 .
[20] *See* Provider's Post Hearing Brief at 10-11.

managers of the physician group practices for these surgeons, the Provider established that there were no significant changes in either of the surgeons' practices from FY 20003 to FY 2004, *i.e.*, there was no unusual time off, no change in office hours, and no changes in the types of services that the practices provided. The practice managers described FY 2004 as a year when there were fewer emergency surgeries and fewer patients who required inpatient surgical procedures as compared to historical years. The practice managers' statements were corroborated by a review of the surgeons' schedules as well as an examination of the surgeons' total revenue for FYs 2003, 2004 and 2005. The revenue data showed a significant drop for inpatient services from FY 2003 to FY 2004, and then a rebound in FY 2005.[21] The Provider asserts that the reduction of 44 inpatient general surgeries in FY 2004 was beyond the Provider's control.

In support of the third circumstance, the Provider documented a significant drop in inpatient discharges from Middlebury Family Health, an independent family practice group. The Provider's low volume adjustment request documented that discharges from this practice fell from 101 in FY 2003 to 76 in FY 2004, for a decrease of 25 discharges. In his testimony, the President of the Provider noted that his frequent discussions with physicians from the area indicated that the physicians were seeing fewer patients, and the patients they were seeing were healthier and not in need of inpatient services. In addition, the President's discussions with physicians admitting to the Provider suggested no dissatisfaction with the Provider or the services it offered.[22] This circumstance was beyond the hospital's control.

Additionally, the Provider contends that, during FY 2004, the demand for hospital inpatient services was down throughout its service area, throughout the Middlebury zip code, and throughout the State of Vermont. Data from the State of Vermont revealed that the total number of patients living in the Provider's service area who sought inpatient care at any hospital fell from a net total of 3,435 in FY 2003 to 3,284 in FY 2004, a difference of 151. The same data showed an increase of 360 discharges in FY 2005. In other words, the total demand for inpatient services dropped in FY 2004, and then rebounded to normal levels in FY 2005.[23]

An almost identical pattern presented itself in the Middlebury zip code which is the zip code from which the Provider draws the largest percentage of its patients. The total number of residents in the Middlebury zip code who sought inpatient care at any hospital decreased from 729 in FY 2003 to 691 in FY 2004 (5.2 percent decrease), and rebounded to 722 in FY 2005 (4.4 percent increase). This evidence proves that fewer residents of the Middlebury zip code required inpatient care in FY 2004. There were simply fewer participants in the market.[24]

Further evidence supplied by the Provider included data provided by the State of Vermont that showed that total inpatient discharges in Vermont decreased from 59,035 in calendar year ("CY") 2003 to 57,999 in CY 2004, a decrease of 1,036 (1.75 percent). This demonstrates that some factor was causing a general decreased demand for inpatient services throughout the State

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[21] *See* Provider's Post Hearing Brief at 11-12.
[22] *See* Provider's Post Hearing Brief at 12-13; Transcript ("Tr.") at 48, 51-52.
[23] *See* Provider's Post Hearing Brief at 13; Provider Exhibit P-25 at 1.
[24] *See* Provider's Post-Hearing Brief at 14; Provider Exhibit P-25 at 2.

of Vermont[25]. Thus, the phenomenon of decreased demand for inpatient services was not limited to the Provider's service area, and necessarily could not have been within the Provider's control.

And lastly, the Provider contends that there was no change in the types of services it provided throughout this time period. The Provider performed an analysis of the top 30 DRGs for its FYs 2003, 2004 and 2005 to further demonstrate the decreased demand for inpatient services among patients residing in the Provider's service area. These services make up the Provider's core services. During FYs 2003, 2004 and 2005, the same 30 DRGs made up approximately 66% of the Provider's inpatient discharges. These top 30 DRGs remained the same during FYs 2003, 2004 and 2005 which demonstrates that the Provider continued to offer the same core services throughout this time period.[26]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that while the Provider has abundant evidence that the number of the Provider's inpatient discharges decreased generally in many practice areas, and even in a number of hospitals in Vermont, the Provider is unable to show the particular facts that give rise to the circumstances resulting in the decrease of discharges at the Provider. The Intermediary believes that the record reflects that the Provider simply does not know why the level of inpatient discharges declined in FY 2004.[27]

The Intermediary argues that the Provider must show the particular facts and circumstances beyond its control, to be granted a low volume adjustment request. The Intermediary contends that the Provider makes no effort to link the decreases in discharges to specific facts. For example, how was the market different in FY 2004 than FY 2003? Was there an economic downturn? Was there a lower incidence of illness and injury? As an example, there is no study regarding the incidence of illness or injury that might explain fewer patients, fewer inpatient admissions, and then fewer discharges.[28]

The Intermediary also contends that the Provider's argument with respect to the decreased demand for inpatient hospital services in its service area, in the Middlebury ZIP code and throughout the State of Vermont is not definitive. The documentation submitted by the Provider shows that some Vermont hospitals experienced a decrease in discharges while others experienced an increase in discharges.[29]

The Intermediary argues that the Provider's low volume adjustment request was denied for lack of supporting documentation. The Provider failed to provide any specific information that could be audited as to the specific facts giving rise to the circumstances allegedly resulting in the decrease in inpatient discharges at the hospital. The Provider was only able to cite to a decrease

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[25] *See* Provider's Post-Hearing Brief at 14; Provider Exhibit P-20.
[26] *See* Provider's Post-Hearing Brief at 14-15.
[27] Intermediary's Post-Hearing Brief at 1.
[28] Intermediary's Post-Hearing Brief at 2.
[29] Intermediary's Post-Hearing Brief at 12-13.

in inpatient discharges but could not provide any documentation describing the circumstances and facts giving rise to the circumstances.[30]

In summary, the Intermediary contends that, although the Provider's inpatient discharges declined by more than 5 percent, the Provider failed to meet its burden of demonstrating that the circumstances or reasons for the decline were beyond its control. Absent the identification of the reasons in some reasonable detail, it is not possible to determine whether those reasons were beyond the control of the Provider.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider is entitled to a low volume payment adjustment for its FY 2004, as it experienced a decrease of more than 5 percent in its total number of inpatient cases from FY 2003, due to circumstances beyond its control.

The Board finds that the wording of the low-volume exception adjustment in 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92 essentially agree. Both contain the phrase "circumstances beyond its control" as the foundation for additional payments for SCHs. The Board concludes that PRM 15-1 § 2810.1(A), which the Intermediary used as its basis to deny the Provider's low volume payment adjustment request, requires demonstration of two criteria – (1) circumstances beyond the hospital's control and (2) a greater than 5 percent decrease in discharges.

This hearing focuses on the first criterion, *i.e.*, whether the circumstances giving rise to the decrease in discharges is beyond the Provider's control. In that regard, PRM 15-1 § 2810.1(A)(1) states:

> In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects.

The Board notes that, in establishing that a circumstance is beyond the provider applicant's control, the provider applicant need not prove what caused the circumstance but only that the circumstance was "externally imposed . . . and beyond its control."

As explained below, the Board finds that the Provider has established that the circumstances giving rise to the 9.35 percent decrease in discharges was "externally imposed . . . and beyond its control." First, the Provider could not control the loss of a physician from Little City Family Practice, whose departure, as well as the ensuing recruitment of a replacement and transition,

[30] Intermediary's Post-Hearing Brief at 9.

contributed to reduced inpatient admissions from the practice. The record shows that the Provider was diligent and timely in seeking to replace and finding an actual replacement for that physician.[31] The Board agrees with the Provider that, as a group practice, the Little City Family Practice has to be viewed as a whole to determine the impact of a departing physician because the departure of a physician disrupts the whole group (*e.g.*, the remaining physicians have to retain and cover for patients of the departing physician while concurrently maintaining their own panel of patients).

Likewise, the evidence of record shows that the Provider could not control the reduced demand for general inpatient surgery among the patients of the independent surgeons Drs. Fuller and Petri. As part of the process to confirm this, the Provider's consultant interviewed the practice managers for each of these surgeons and reviewed the surgeons' schedules.[32] Through this interview and document review, the Provider confirmed that the independent surgeons had no unusual time off (*e.g.*, vacations, illness, injury), had no change in the office hours, had no change in the types of services furnished, and were neither dissatisfied with the Provider nor sending patients elsewhere.[33]

And lastly, the Provider could not control the reduced demand for inpatient services among the patients of the independent physician group practice Middlebury Family Health. As part of the process to confirm this, the Provider's consultant interviewed the practice administrator for this independent group practice.[34] Through this interview, the Provider confirmed that no one at the independent group practice was aware of anything in particular that may have resulted in fewer admissions to the Provider and that they were not dissatisfied with the Provider or sending patients elsewhere.[35]

Testimony from the Provider witnesses established that the Provider reviewed the following potential factors for the decline in discharges during the time at issue and ruled them out:

1. Other than the one physician leaving Little City Family Practice, the active staff for the Provider was constant.[36]

2. The Provider did not close any departments or units, discontinue any services, did not change outpatient complement or capacity, and did not undertake any construction projects.[37]

3. The Provider did not change its admitting practice or make any other changes in operations.[38]

4. The Provider did not turn away or transfer patients.[39]

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[31] *See* Tr. at 53-54, 90-92 (replacement efforts included search firms and advertising).
[32] Tr. at 92-95.
[33] *See* Tr. at 92-95, 97; Provider Exhibit P-9 at 4, 8-9.
[34] Tr. at 96-97.
[35] Tr. at 96-97; Provider Exhibit P-7 at 14, 27.
[36] Tr. at 48.
[37] Tr. at 48-49, 74, 89-90.
[38] Tr. at 49.

5. There was no change in length of stay, intensity of services, or case mix.[40]

6. Physician and patient satisfaction remained good based on management discussions with physicians, nurses and other caregivers and the reviews done by the consultant, Press Ganey.[41]

7. There was no evidence that physicians were sending their patients to other hospitals.[42]

8. Patient satisfaction remained good based on management discussion with staff and patients as well as patient satisfaction surveys conducted by an independent third party annually (including for the year at issue).[43]

9. The Provider did not suffer bad publicity.[44]

10. The economy in Vermont was improving.[45]

Based on these circumstances, the Board concludes that the statute and related regulations were established to grant relief to hospitals that experienced patient volume declines as did the Provider. The additional payments made to SCHs are necessary to help them maintain viability as rural hospitals during periods of reduced admissions.

The Board further finds that there were aberrations in market place conditions both throughout the Provider's service area[46] and throughout the State of Vermont during FY 2004,[47] evidencing a general decreased demand for inpatient services. The Intermediary asserts that the evidence addressing the Provider's service area shows that some hospitals had experienced increases in inpatient services. However, even if all of these increased inpatient services were attributed to the Provider, the Provider still would have experienced more than a 5 percent decrease in services.[48] As a result, the Board finds that the Provider was subjected to environmental market conditions, externally imposed and not within the Provider's control.

The Board finds the Intermediary's interpretation of the regulations and program instructions to be overly restrictive. The Intermediary's main argument is that the Provider failed to provide any specific information supported by auditable documentation as to the specific facts that resulted in the decrease in inpatient discharges at the hospital. The Board concludes that the Provider has met its burden of proof to establish that: (1) circumstances existed that were externally imposed and beyond the Provider's control; and (2) it experienced a reduction in

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[39] Tr. at 49.
[40] Tr. at 77. *See also* Provider Exhibit P-24.
[41] Tr. 44-47, 59-60.
[42] Tr. at 97.
[43] Tr. at 44-47, 59-60.
[44] Tr. at 49.
[45] Tr. at 61.
[46] *See, e.g.*, Provider Exhibit P-25.
[47] *See, e.g.*, Provider Exhibit P-20.
[48] *See* Exhibit P-25 at 1.

inpatient discharges of greater than 5 percent. Contrary to the Intermediary's position, PRM 15-1 § 2810.1(A)(1) does not require that the Provider explain the reason for the decrease.

DECISION AND ORDER:

The Board finds that the Provider is entitled to a low volume payment adjustment for its FY 2004 as it experienced a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control. The Intermediary's denial of the Provider's low volume payment adjustment request is reversed. The Provider's request is remanded to the Intermediary to perform the appropriate calculation for the low volume adjustment.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
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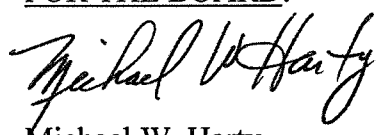
FOR THE BOARD:



Michael W. Harty
Chairman

DATE: AUG 29 2013