PINE ACRES NURSING AND CONVALESCENT HOME,
Petitioner,

v.

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES,
Respondent.

Decided November 21, 1979

Initial Decision

SYNOPSIS

The action of the Division of Medical Assistance and Health Services denying payment for the billing of a patient is affirmed, where the administrative law judge determined that the claim was not submitted within the prescribed time period and that petitioner had had an opportunity to present arguments for the waiver of the time period restriction.

GEIGER, ALJ:

Petitioner requests relief from the administrative determination of the Division of Medical Assistance and Health Services (DMAHS) denying payment of a patient's bill, pursuant to agency regulation contained in Long Term Care Facility Circular Letter No. 16 Amendment, dated June 19, 1975.

The matter was transmitted to the Office of Administrative Law for determination as a contested case, pursuant to N.J.S.A. 52:14F-1 et seq.

Petitioner requested a hearing on September 11, 1979. After notice to all parties, a hearing was held on October 30, 1979. The issue to be determined is the correctness of the denial of payment for the billing of one patient during the period October 1, 1977 through November 11, 1977 because of alleged untimely submittal of the claim. The agency regulation cited as the authority for the denial of payment is contained in Long Term Care Facility Letter No. 16 Amendment which reads in part as follows:

The Division of Medical Assistance and Health Services will accept all legitimately authorized charges submitted within five months from the last day of the billing month in which services were initially provided.

In exceptional cases where it was beyond the control of the Long Term Care Facility to claim reimbursement within the six month period, a written request for payment may be submitted with
documentation to the Bureau of Claims and Accounts, Division of Medical Assistance and Health Services. Retroactive claims will not be approved for payment in those instances where the claim could have been submitted or resubmitted within the time limitation as defined above.

The bookkeeper from Pine Acres Nursing and Convalescent Home presented into evidence the business records of the nursing home regarding the patient whose claim is at issue. According to the records, the patient had four separate admissions. The admission period in question, October 1, 1977 through November 11, 1977, was the third admission. In a letter dated June 16, 1978 to DMAHS, the bookkeeper stated that the billing for that particular admission period was overlooked and that the amount of the claim was $1,029.60. A response was made from the Adjustment Section of DMAHS on on July 27, 1978, stating that a “Form MCNH-7” was needed to cover the period in question in order to put through an adjustment. A letter enclosing the MCNH-7 was sent to the DMAHS Adjustment Section on August 1, 1979. It is to be noted that the copy of the Form MCNH-7 accompanying the letter dated August 1, 1979, was itself dated February 24, 1978, which would have placed it within the six-month period necessary for valid billing of the claim. A letter from DMAHS, dated August 13, 1979 to the administrator of Pine Acres Nursing and Convalescent Home, reads in part as follows, “Pursuant to Circular Letter No. 16, you may submit a written request for payment. Please state your reasons for not timely submitting the claim and provide me with supporting documentation”. Response from the Nursing Home was made in a letter, dated August 28, 1979, and states in part that the reason for the delay in pursuing the claim was personnel problems in the Bookkeeping Office. At the hearing, the bookkeeper representing Pine Acres repeated the problems that made things difficult in their office for approximately a year and a half. The response to this letter from DMAHS was dated September 5, 1979, and stated that after a review of the reasons submitted, the Adjustment Section deemed the claims were not timely submitted in accordance with Long Term Care Facility Circular Letter No. 16, and consequently the claim for payment was denied.

The agency representative observed at the hearing that the request of the Adjustment Section of DMAHS for an MCNH-7 was made in July 1978 and no response was made, nor a copy of the MCNH-7 sent until August 1979, approximately a year later. Consequently, the agency felt well within their discretion as administrators to deny waiving the time period.

Based upon the foregoing, I FIND:

1. The agency has a clearly stated policy regarding the submittal of claims
within an appropriate time period, including a mechanism by which they can administratively waive the time period in exceptional cases.

2. Petitioner's representative stated in a letter to DMAHS in June 1978, that the period in question was overlooked for billing.

3. Petitioner's representative showed a copy of MCNH-7 dated February 1978, but could provide no proof that this form had been sent at any time other than in accompaniment to the letter dated August 1, 1979.

4. The agency did provide petitioner with the opportunity to present arguments for a waiver of the time period.

Based upon the facts adduced at the hearing in this proceeding and the applicable regulations, I CONCLUDE that the agency acted in accordance with accepted policy, and it was in the framework of the policy to deny an adjustment.

Therefore, the action of the Division of Medical Assistance and Health Services in denying payment for the billing of the patient during the period October 1, 1977 through November 11, 1977 is AFFIRMED.

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After reviewing this Initial Decision, the Division of Medical Assistance and Health Services on January 10, 1980 issued the following Final Decision:

The Director, Division of Medical Assistance and Health Services, has reviewed the record in this matter including the Initial Decision of the administrative law judge. Exceptions were filed by Pine Acres Nursing Home.

The Director has reviewed the exceptions and does not find sufficient evidence to reverse the initial decision of the administrative law judge.

The Director adopts and incorporates the Findings of Fact and Conclusions and Recommendations set forth in the Initial Decision. Therefore, the decision of the Bureau of Claims and Accounts to deny payment because the billing was overaged, is affirmed.