
Division of Medical Assistance v. Shop-Rite Pharmacy

Cite as 2 *N.J.A.R.* 369

**DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES,**

Petitioner,

v.

SHOP-RITE PHARMACY,

Respondent.

Decided April 9, 1980

Initial Decision

SYNOPSIS

Shop-Rite Pharmacy submitted prescription claims to the Division of Medical Assistance and Health Services for reimbursement under the Medicaid Program between January and December 1978. One hundred and eighty-two of these claims with missing or incorrect information were returned to the Shop-Rite while the rest continued to be processed for payment. Shop-Rite resubmitted these 182 claims in September of 1979 when they were rejected by the Agency as being submitted out-of-time.

The administrative law judge found that *N.J.A.C.* 10:51-5.30 required that any claim rejected because it lacked information must be resubmitted to the Agency within 180 days of the claimed service rendered. Since Shop-Rite's resubmission was out-of-time, the administrative law judge affirmed the denial of Medicaid reimbursement.

GOLDBERG, ALJ:

Respondent challenged the administrative determination of the Division of Medical Assistance and Health Services (DMASH) refusing to reevaluate 182 claims for Medicaid payment based upon *N.J.A.C.* 10:51-5.30. 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.*

At issue is the refusal of the DMAHS to reevaluate 182 prescription claims for payment under the Medicaid program because they were not resubmitted within the time period prescribed by regulation. The agency relied on *N.J.A.C.* 10:51-5.30 which governs the submission of missing claims. The regulations provided that:

A. Time Limitation

Missing Claims Investigations for all claims must be received by Blue Cross of New Jersey *not later* than 180 days after the last date

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of service (dispensing date) as noted on the claim(s) in question. It should be noted that the 180-day time limit does not apply to queries submitted due to patient eligibility.

B. Waiting Time

From the date of the last appearance of the claim on a voucher, a reasonable period of "waiting time" before instituting a Missing Claims Investigation is 45 days. PLEASE NOTE: 180 days is the maximum waiting time.

The facts of the matter are not disputed. Respondent submitted the claims for payment to the agency's claims agent, Blue Cross, between January and December 1978. They were screened by the computer and those with missing or incorrect information were returned to the respondent. The rest continued to be processed for payment. Respondent resubmitted the 182 claims at issue for payment in September 1979. As a matter of courtesy the Division of Medical Assistance and Health Services asked Blue Cross to conduct a random review of the claims. Thirty four claims were reviewed with the following result:

- 7 were paid or declined on vouchers
- 13 required more information
- 14 required corrected information

While respondent admitted it had the applicable regulation in its possession, respondent was not familiar with the policy for resubmitting missing claims.

Based upon the foregoing **I FIND:**

1. Respondent timely submitted all 182 claims for payment.
2. Respondent failed to initiate missing claims actions for any of the claims within the time period authorized in agency regulation.
3. A random review conducted by Blue Cross revealed that a substantial number of claims did not contain essential information or contained incorrect information.
4. Respondent has the applicable regulation which contains the policy for resubmitting missing claims for payment.

Based upon the facts adduced at the hearing and pursuant to the regulation previously cited **I CONCLUDE** that the agency's decision to deny Medicaid reimbursement for the 182 claims at issue in this matter because they were submitted out of time is correct and is therefore **AFFIRMED**.

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After reviewing this Initial Decision, the Division of
Medical Assistance and Health Services on May 7, 1980
issued the following Final
Decision:

The Director adopts and incorporates the Findings of Fact and
Conclusions and Recommendation set forth in the initial decision.