



## STATEMENT OF FACTS

The Defendant, \_\_\_\_\_, is a 40 year old woman who has been totally disabled due to a psychiatric disability for approximately the past twenty (20) years. As a result of this disability, the Social Security Administration has determined her to be totally disabled and provides her with \$477.00 per month in Supplemental Security Income (SSI) Benefits plus Medicaid **Benefits**. This is her only source of income.

Ms. \_\_\_\_\_ had been a patient of Dr. Martin **Skalar** for about six (6) years when she went to him complaining of abdominal **pain** on May 31, 1991. Dr. **Skolar** diagnosed her condition and scheduled her for an elective **cholecystectomy** (gallbladder removal). **However**, prior to the scheduled date, her **symptoms** worsened **and** the surgery was performed at South **Amboy Memorial Hospital** on June 14, 1991.

Ms. \_\_\_\_\_ had been a Medicaid recipient for approximately seventeen (17) years at the time and had no reason to believe the surgery **would** not be covered. Medicaid was billed for the costs of the surgery and **hospital stay**. Medicaid denied the claim citing as the reason for denial that a second opinion was required for this procedure to be authorized and covered by Medicaid. I fowever, Ms. \_\_\_\_\_ was **unaware of** this requirement and the urgent nature of the procedure further prevented her from determining the necessity of and obtaining a second opinion. As a result of the Medicaid denial, the hospital shifted its efforts to obtain reimbursement for the surgery **and** related medical costs to the patient, Ms. **Lestuck**. When Ms \_\_\_\_\_ was unable to pay the bill, it was turned over to a collection agency, American Trading Company, which is presently attempting to collect the debt from Ms. \_\_\_\_\_ as an assignee of South **Amboy Memorial f Hospital**.

## LEGAL ARGUMENT

### Joint

**THE FACTS IN THIS MATTER ARE NOT  
IN DISPUTE AND THIS CASE IS THEREFORE  
APPROPRIATE FOR DISPOSITION BY  
SUMMARY JUDGMENT YURSUANT TO  
R.4:46-2**

R.4:46-2 provides that a Motion for **Summary** Judgment shall be granted where " . . . there is no genuine issue as to any material fact challenged and that the moving party is entitled to a Judgment as a matter of **law.**" **The** burden is on the moving party to exclude any reasonable doubt as to the existence of a genuine issue of material fact . . . all emphasis of doubt are drawn against the **movant** in favor of the opponent of the Motion. **Judson vs. Peoples Bank and Trust Company of Westfield**, 17 N.J. 67, 74 ( 1954); **Gilborges vs. Wallace**, 153 N.J. Super 121, 131(App. Div. 1977), **Aff'd & Rev'd in part**, 78 N.J.342 (1978).

The facts in this case are undisputed. On June 14, 1991, **South Amboy Memorial Hospital** (the hospital) provided services to the **Defendant**, . . . At the time those services were provided, **Defendant** was a recipient of Medicaid. The hospital submitted its bill for services to Medicaid for payment. Medicaid denied payment\_ indicating **that** a second opinion was required prior to the provision of services. The hospital now seeks to recover payment for services from the Defendant through it's assignee, American Trading Company.

The issue for the Court is whether a provider of medical services can recover **payment for services** from a Medicaid recipient after agreeing to accept as payment in full

whatever reimbursement Medicaid gives to the provider in accordance with N.J.S.A. 30:4D-6(c).

## **Point II.**

### **A MEDICAL PROVIDER IS PROHIBITED BY N.J.S.A. 30:4D-6(c) FROM RECOVERING REIMBURSEMENT FROM A MEDICAID PATIENT FOR SERVICES RENDERED.**

#### **a. Introduction**

In order for a State Medicaid Program to receive Federal funding, it must provide “such methods of **Administration** . . . found by the Secretary [of **Health** and **Human Services**] to be necessary for the **proper and efficient operation** of the plan.” (42 U.S.C.A. 51396 a(a)(1)(A)). The Code of Federal **Regulations** provides specific administrative methods determined to be necessary **and** proper **and** therefore required from the State Medicaid Plans seeking Federal funding. 42 **C.F.R. §447.15** requires that State plans “provide that the Medicaid Agency must limit the participation in the Medicaid **Program** to providers who accept, as payment in full, the amounts paid by the agency . . . .” The New Jersey Medicaid Statutes, in compliance with the **Federal** Guidelines, include a requirement that reimbursement from the State Medicaid Program “ . . . shall constitute payment in full to the provider **on** behalf of the recipient. Every provider making claim for payment pursuant to this act shall **certify** in writing on the claims submitted that no additional amount will be charged to the recipient . . . .” N.J.S.A. 30:4D-6(c).

**b. A Medical Provider is Precluded from recovering from a Medicaid Recipient even where Medicaid refuses to reimburse for the services.**

Plaintiff, ii medical services provider, should be precluded from recovering medical payments from the Defendant, , since she was (and is) a Medicaid eligible individual even though Medicaid refuses to reimburse the provider for any portion of the services provided. The Code of Federal Regulations requires State Medicaid Plans to "limit participation in the Medicaid Program to providers who accept as payment in full the amounts paid by the agency." 42 C.F.R. 5447.15. This "payment in full" requirement has been interpreted to include situations "where a State Agency refuses payment as well as situations where reimbursement is made according to established rates." Banks vs. Secretary of Indiana Family and Social Services, 997 F.2d 231, 244(7th Cir. 1993). New Jersey Statutes similarly require that the amount reimbursed to the medical provider by Medicaid "shall constitute payment in full to the provider on behalf of the recipient. Every provider making claim for payment . . . shall certify in writing on the claim submitted that no additional amount shall be charged to the recipient . . ." N.J.S.A. 30:4D-6(c). Where the provider makes a claim to Medicaid, he has effectively agreed to accept whatever amount Medicaid reimburses as payment in full for the services rendered. Where that claim is denied, it is the provider's responsibility to proceed against the Medicaid Administration for payment through further inquiry or hearings. Banks, supra, at 243-244. Although there is a lack of New Jersey case law on this point, there have been multiple New York cases addressing the application of the payment in full requirement. The similarities in the State Medicaid Legislation, the Federal Regulation which directs the State's statute in this area,

**and common** public policy considerations are factors which dictate **the** application of New York case law to interpret this New Jersey case involving the payment in full issue. Specifically, see **Mount Sinai Hospital vs. Kornegay**, 347 N.Y.S. 2nd 807 (N.Y. Civil Ct. 1973) and **Knickerbocker Hospital vs. Downing**, 3 17 N.Y.S. 2nd 688, 689, 65 MISC. 2nd 278( Civil Ct. 1970).

In **Knickerbocker**, a hospital submitted a claim for an ineligible patient to Medicaid which was denied as “disapproved insurance.” **The** hospital attempted to seek payment from the recipient **and** the Court held **that** the provider **should** have proceeded against the Medicaid Administration. **The fact that the time limit** to proceed against the Medicaid denial had expired did **not** allow the **hospital** to hold the recipient responsible for the debt. **Knickerbocker**, at 690-691. Once the claim is submitted to Medicaid, it is **no** longer the patient’s obligation regardless of the **amount**, if **any**, of reimbursement received from Medicaid.

**In** the instance case, the **medical** provider made a claim for reimbursement to Medicaid. At that point, the debt ceased to be the recipient’s obligation. **The** medical provider, South **Amboy Memorial Hospital**, is bound by Federal **and** State **law** to accept whatever amount of reimbursement Medicaid provides as payment in full for the medical care provided. When Medicaid denied the hospital’s claim for reimbursement, the hospital should have pursued the claim against the State Medicaid Agency, but it is precluded by New Jersey Statutes, as well as Federal Law, from seeking reimbursement from the Medicaid eligible patient.

**CONCLUSION**

In view of the above, it is respectfully submitted **that** Federal and State Law prohibit the Plaintiff from recovering payment from the Defendant for services rendered when such payment was submitted to and denied by Medicaid. Therefore, it is respectfully requested that Defendant's Motion for Summary Judgment be granted and that the Complaint in this matter be dismissed.

**MIDDLESEX COUNTY LEGAL SERVICES CORPORATION**

DATED: 1/6/95



**RUSSELL GALE, ESQ.**

Attorney for Defendant