( Hospitals Letter Head)

## NJ Medicaid Utilization Review Program

### Continued Stay Review Approval Letter

Date:

**Hospital:**
**Patient:**
**M.R. #:**

**Physician Name:**
**Medicaid ID #:**
**Admission Date:**

Dear:
Re: **(Patient Name)**

The ***(insert hospital name here)*** has reviewed your record for the current hospitalization. The guidelines used for reviews are **(Facility)** Care guidelines as well as guidelines from the New Jersey Division of Medical Assistance and Health Services (DMAHS) has approved, in accordance with 42 CFR part 456 and N.J.A.C. 10:52. After careful review of the above medical record, the following has been determined and is to be reflected on the claim submitted for payment.

Determination: Approved
No. of Days Approved:
Reinstate at the acute level of care effective:
Social Necessity Approval Dates: Date:

**RATIONALE:**



Sincerely,

***(Insert Physician's name here),*** M.D.
***(Title)***

**RIGHT TO APPEAL**
**FIRST LEVEL**

The patient, and/or hospital designee have the right to appeal this decision to ***(insert Hospitals Name),*** use internal process for appeal.
***(Insert the following)***

***Hospital Name***
***Hospital Appeal Contact***
***Address***
***Phone***

If you have any questions, please contact ***(insert your Facility's Utilization Review Contact here, phone number)***

**Second Level**

The second level of appeal will be in writing, within 60 days of receipt of the notice to Permedion, the State of NJ vendor for Utilization Review. Upon appeal, please provide a copy of the complete medical record and any clinical information that may not have been present on the initial appeal. This appeal process can be used after the first level has been completed.

**Address all correspondence for Second Level Appeal to:**

Permedion
Attn: Linda Freites
1 Quakerbridge Plaza, Suite 3
Mercerville, N.J. 08619

c: Attending Physician
DMAHS
Hospital Billing
Patient
Compliance Officer

*( Hospital letter head )*

## NJ Medicaid Utilization Review Program

### Admission Review Denial Letter

Date:

**Hospital:**
**Patient:**
**M.R. #:**

**Physician Name:**
**Medicaid ID #:**
**Admission Date:**

Dear:
Re: (Patient Name)

The ***(insert hospital name here)*** has reviewed your record for the current hospitalization. The guidelines used for reviews are **(Facility)** Care guidelines as well as guidelines from the New Jersey Division of Medical Assistance and Health Services (DMAHS) has approved, in accordance with 42 CFR part 456 and N.J.A.C. 10:52. As a delegated provider after review of the medical records, the following has been determined.

***(Please use date in the area below)***

Determination: Denied

Admission denied effective date:

**RATIONALE FOR DENIAL:**



Sincerely,

***(Insert Physician's name here),*** M.D.
***(Title)***

**RIGHT TO APPEAL:**

**FIRST LEVEL**

The patient, and/or hospital designee have the right to appeal this decision to ***(insert Hospitals Name),*** use internal process for appeal.

***(Insert the following)***

***Hospital Name***
***Hospital Appeal Contact***
***Address***
***Phone***

If you have any questions, please contact ***(insert your Facility's Utilization Review Contact here, phone number)***

**Second Level**

The second level of appeal will be in writing, within 60 days of receipt of the notice to Permedion, the State of NJ vendor for Utilization Review. Upon appeal, please provide a copy of the complete medical record and any clinical information that may not have been present on the initial appeal. This appeal process can be used after the first level has been completed.

**Address all correspondence for Second Level Appeal to:**

Permedion
Attn: Linda Freites
1 Quakerbridge Plaza, Suite 3
Mercerville, N.J. 08619



c: Attending Physician
DMAHS
Hospital Billing
Patient
Compliance Officer

*(Hospital letter head )*

## NJ Medicaid Utilization Review Program

### Combined Review Denial Letter

Date:

**Hospital:**
**Patient:**
**M.R. #:**

**Physician Name:**
**Medicaid ID #:**
**Admission Date:**

Dear:
Re: (Patient Name)

The ***(insert hospital name here)*** has reviewed your record for the current and previous hospitalizations. This admission has occurred within 7 days of the previous discharge. The guidelines used for reviews are **(Facility)** Care guidelines as well as guidelines from the New Jersey Division of Medical Assistance and Health Services (DMAHS) has approved, in accordance with 42 CFR part 456 and N.J.A.C. 10:52. As a delegated provider after review of the medical records, the following has been determined.

***(Please use date in the area below)***

Previous Stay – Admission Date: Discharge Date:

Determination: Denied – stays are combined

**RATIONALE:**

Sincerely,

***(Insert Physician's name here),*** M.D.
***(Title)***

**RIGHT TO APPEAL:**

**FIRST LEVEL**

The patient, and/or hospital designee have the right to appeal this decision to ***(insert Hospitals Name),*** use internal process for appeal.

***(Insert the following)***

***Hospital Name***
***Hospital Appeal Contact***
***Address***
***Phone***

If you have any questions, please contact ***(insert your Facility's Utilization Review Contact here, phone number)***

**Second Level**

The second level of appeal will be in writing, within 60 days of receipt of the notice to Permedion, the State of NJ vendor for Utilization Review. Upon appeal, please provide a copy of the complete medical record and any clinical information that may not have been present on the initial appeal. This appeal process can be used after the first level has been completed.

**Address all correspondence for Second Level Appeal to:**

Permedion
Attn: Linda Freites
1 Quakerbridge Plaza, Suite 3
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c: Attending Physician
DMAHS
Hospital Billing
Patient
Compliance Officer

*( Hospital letter head)*

## NJ Medicaid Utilization Review Program

### Continued Stay Review Denial Letter

Date:

**Hospital:**
**Patient:**
**M.R. #:**

**Physician Name:**
**Medicaid ID #:**
**Admission Date:**

Dear:
Re: **(Patient Name)**

The ***(insert hospital name here)*** has reviewed your record for the current hospitalization. The guidelines used for reviews are **(Facility)** Care guidelines as well as guidelines from the New Jersey Division of Medical Assistance and Health Services (DMAHS) has approved, in accordance with 42 CFR part 456 and N.J.A.C. 10:52. After careful review of the above medical record, the following has been determined and is to be reflected on the claim submitted for payment.

Determination: Denied

Continue stay denied effective:

Carve out effective:

**LEVEL OF CARE IDENTIFIED:**

SNF effective:

Residential effective:

**RATIONALE:**

Sincerely,

***(Insert Physician's name here),*** M.D.

***(Title)***

## RIGHT TO APPEAL

### FIRST LEVEL

The patient, and/or hospital designee have the right to appeal this decision to ***(insert Hospitals Name),*** use internal process for appeal.
***(Insert the following)***

***Hospital Name***
***Hospital Appeal Contact***
***Address***
***Phone***

If you have any questions, please contact ***(insert your Facility's Utilization Review Contact here, phone number)***

### Second Level

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