45-2-0165

NOT FOR PUBLICATION WITHOUT THE
APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
A-5219-97T3

NEW YORK HOSPITAL,

Plaintiff-Respondent,

v.

BEVERLY ROBINSON,

Defendant-Appellant.

Submitted[1]: April 28, 1999 - Decided: MAY 28 1999

Before Judges King and Fall.

On appeal from the Superior Court of New Jersey, Law Division, Special Civil Part, Passaic County.

Madeline L. Houston, attorney for appellant.

Hayt, Hayt & Landau, attorneys for respondent (Carey A. Aquilina, on the brief).

PER CURIAM

Defendant, Beverly Robinson, appeals from denial of her motion to vacate a default judgment entered against her on November 4, 1987 on a hospital bill relating to medical treatment due to complications in the birth of her son on April 22, 1982. At the time of the treatment, defendant was a recipient of public assistance and covered for medical expenses under Medicaid. We reverse.

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[1]Originally scheduled for oral argument on this date, both counsel agreed to waive oral argument.

I

Defendant gave birth to her son Frank Robinson April 22, 1982, in St. Joseph's Hospital in Paterson. At the time defendant was a Medicaid recipient. A few days after his birth, it was determined defendant's son had a hole in his heart and would need to have an operative procedure performed to correct it. St. Joseph's transported Frank to New York Hospital where the procedure was performed in May 1982.

Plaintiff, New York Hospital, submitted a claim for the cost of treatment to New Jersey Medicaid which was denied. While the basis of that denial is not contained in the record before us, Frank's date of birth was mistakenly recorded by the Passaic County Board of Social Services as May 11, 1982, instead of April 22, 1982. This discrepancy apparently resulted in denial of the claim. Plaintiff issued a bill to defendant in 1985 in the amount of $2,584.00 for the services rendered in 1982. According to defendant, this is the only medical bill incurred by her son which was denied by Medicaid, including a stay at New York Hospital in 1984 for heart surgery.

Upon receipt of the bill from plaintiff, defendant certifies she called the billing department at New York Hospital and was told the bill had been submitted to Medicaid and not paid, but that it would be resubmitted. Upon receiving a subsequent bill from plaintiff, defendant called plaintiff's billing department again and was told Medicaid was not paying and the hospital would hold

her responsible for the charges. Defendant certifies she then contacted Medicaid and also attempted to explain the error to plaintiff's counsel, from whom she started to receive collection letters.

On or about August 4, 1987, plaintiff filed a complaint against defendant seeking $2,584.00 plus an additional $1,260.42 in interest. Plaintiff's proof of service indicates defendant was served September 17, 1987. Upon receiving the complaint, defendant claims she contacted Medicaid and was told the claim was denied by mistake and that it would be taken care of. Based on this exchange, defendant believed she did not need to answer the complaint. Default judgment was entered against defendant November 4, 1987, in the amount of $3,844.42.

Plaintiff sent defendant a letter dated May 18, 1988, advising her of the judgment and requesting payment. Upon receipt of the letter, defendant telephoned plaintiff's law firm May 23, 1988, and advised them she was not responsible for the hospital bill as she was covered by Medicaid. According to plaintiff, defendant was again contacted November 27, 1990, regarding the judgment by an employee of plaintiff's law firm. Thereafter, plaintiff's counsel was unable to locate defendant's address or place of employment until 1996.

In October 1996, nine years after entry of the default judgment, defendant's wages were garnished. Defendant filed a pro se motion to vacate the default judgment November 18, 1996, maintaining Medicaid was responsible for the hospital bill.

Defendant's motion was heard and denied on January 24, 1997. The judge found defendant's motion was filed out of time, and that proper service was made upon defendant. However, the judge indicated defendant should seek the assistance of an attorney. Defendant sought the assistance of the Passaic County Legal Aid Society which brought a motion to vacate the default judgment on October 23, 1997.

In her certification in support of the motion to vacate judgment, defendant asserts she and her son lived in the same apartment since 1990 and had qualified for Section 8 housing. Defendant has been off Medicaid and Aid For Dependent Children (AFDC) since approximately 1985, and has held the same job with the North Jersey Developmental Center since June 1992. Prior to the wage garnishment, defendant's take home pay was approximately $560 every two weeks. Subsequent to the wage garnishment, her take home pay is approximately $480 every two weeks. According to defendant, since Section 8 counts the tenant's share of the rent based on the tenant's income prior to any deductions for items such as wage garnishments, she could no longer afford the rent for her apartment. She and her son now live in one room that plaintiff rents in a private house. Defendant also asserts she sought a night job with a bank doing encoding in order to make ends meet, but was denied employment, as the bank would not hire someone with a wage garnishment in effect.

A different judge heard oral argument on defendant's motion March 13, 1998, and placed his decision on the record April 3,

1998. The judge outlined the history of the case, and concluded defendant did not bring the motion within a reasonable amount of time. The judge also found defendant had not presented "truly exceptional circumstances" warranting relief, noting,

> Rather, I find that defendant was aware of the bills in 1985, had conversations with the hospital regarding Medicaid and its declamation prior to the initiation of the lawsuit, had discussions with plaintiff's counsel prior to the initiation of a lawsuit, chose not to answer the complaint in 1987, was notified of the judgment against her in May 1988, spoke with the plaintiff counsel's law firm shortly after notification in May, 1988 and did nothing until her wages were garnished in November of 1996.
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> To take her first step in the judicial process nine years after entry of judgment was too late and unreasonable under the circumstances. Given the notice she admittedly received prior to a lawsuit in which plaintiff proved by credible evidence that she received within one year after judgment. If she had consulted with counsel or at least taken some action in 1988 when she became aware of the judgment, this would most likely be a different result.

As of March 13, 1998, $2,319.00 had been collected through the wage garnishment. On appeal, plaintiff contends the judge erred in denying her motion to vacate the default judgment pursuant to R. 4:50-1(f) on the basis she has a meritorious defense, and the public policy behind the Medicaid law requires vacating the judgment.

II

A court should view "the opening of default judgments . . . with great liberality," and should tolerate "every reasonable

ground for indulgence . . . to the end that a just result is reached." Mancini v. EDS, 132 N.J. 330, 334 (1993), citing, Marder v. Realty Constr. Co., 84 N.J. Super. 313, 319 (App. Div.), aff'd, 43 N.J. 508 (1964). The decision whether to grant the motion is left to the sound discretion of the trial court, and will not be disturbed absent an abuse of discretion. Mancini, 132 N.J. at 334, citing, Court Inv. Co. v. Perillo, 48 N.J. 334, 341 (1966). All doubts, however, should be resolved in favor of the parties seeking relief. Mancini, 132 N.J. at 334, citing, Arrow Mfg. Co. v. Levinson, 231 N.J. Super. 527, 534 (App. Div. 1989).

Plaintiff asserts the judge correctly denied defendant relief, as she was unable to establish the elements necessary for vacating a default judgment – excusable neglect and a meritorious defense. Marder, 84 N.J. Super. at 318. "Carelessness may be excusable when attributable to an honest mistake that is compatible with due diligence or reasonable prudence." Mancini, 132 N.J. at 330. While defendant did not act through proper legal channels to resolve the dispute over the hospital bill, she did act in other ways. Upon receipt of the bill, she immediately called the hospital to point out the mistake. Upon receipt of a subsequent bill, defendant again called the hospital and was advised she would be held responsible for the amount, as Medicaid denied the claim. Defendant then contacted both Medicaid and plaintiff's counsel in an attempt to resolve the matter. Upon receipt of the complaint in 1987, defendant again contacted Medicaid, and was informed that the denial was a mistake and it would be taken care of. When defendant

received a collection letter from plaintiff informing her of the default judgment and seeking payment, defendant called plaintiff's law firm and informed them she was not responsible for the bill as it had been incorrectly denied by Medicaid. Nine years later when plaintiff acted on the default judgment by garnishing defendant's wages, defendant immediately responded by moving pro se to have the default judgment vacated. Upon denial of her request, she sought legal assistance. In light of these factors, we find defendant's neglect in responding to the complaint is excusable, as she exercised due diligence in attempting to resolve the dispute over the bill through direct contact with plaintiff and Medicaid.

Even if defendant were unable to demonstrate excusable neglect, she is not precluded from relief under R. 4:50-1(f). That subsection authorizes relief from judgments in "exceptional situations." Baumann v. Marinaro, 95 N.J. 380, 395 (1984). "No categorization can be made of the situations which would warrant redress under subsection (f)." Court Inv. Co., 48 N.J. at 341, quoted in Baumann, 95 N.J. at 395, and Palko v. Palko, 73 N.J. 395, 398 (1977). "[T]he very essence of (f) is its capacity for relief in exceptional situations. And in such exceptional causes its boundaries are as expansive as the need to achieve equity and justice." Ibid. For relief under subsection (f), "strict bounds should never confine its scope." Hodgson v. Applegate, 31 N.J. 29, 41 (1959).

Here, the motion judge did not find defendant demonstrated "exceptional circumstances," instead finding the nine-year delay

between entry of the default judgment and defendant's motion to vacate unreasonable under the circumstances. The judge noted, "[i]f she had consulted with counsel, or at least taken some action on her own in 1988 when she became aware of the judgment, this would most likely be a different result." However, contrary to these observations, as outlined above, defendant did take action on her own in 1988; she continued to call plaintiff's counsel in an attempt to resolve the dispute over payment of the bill. In addition, defendant's response to plaintiff's actions on the default judgment was timely; once plaintiff began collecting on the default judgment through wage garnishment, defendant immediately moved to vacate the judgment.

Plaintiff argues this case is most like Garza v. Paone, 44 N.J. Super. 553 (App. Div. 1957), where we found defendant's four-year delay in applying for relief from a void judgment was not "within a reasonable time," noting defendant did not move for relief until he felt "the pinch of the need for a driving license." Id. at 559. Similarly here, plaintiff argues, defendant did not move to vacate the judgment until she felt the pinch of the wage garnishment and her delay of nine years should not be considered reasonable. However, Garza is distinguishable from these facts. First, unlike the defendant here, the defendant in Garza consulted with an attorney prior to entry of the default judgment, who explained to defendant his rights and inquired of plaintiff's counsel concerning an extension of time to file an answer. Id. at 556. The defendant's attorney was never authorized to proceed

further. Ibid. Second, the co-defendant in Garza had died, and we determined this fact, coupled with the amount of time that had elapsed since the accident, might preclude a fair retrial of issues of liability. Id. at 558-559. Here, plaintiff brought the action to collect on the unpaid bill. It follows that any proofs to establish defendant's obligation on this claim would be in plaintiff's exclusive possession, and any lapse in time between the entry of judgment and a retrial should not prejudice plaintiff. Finally, in contrast to the defendant in the present case, the defendant in Garza, upon learning of his rights and obligations on the claim, took no action to resolve the matter until four years later. Here, contrary to plaintiff's assertion that defendant "took no action for almost ten years," defendant took a proactive stance and attempted to resolve the claim through direct contact with both plaintiff and Medicaid. See Almodovar v. Beese, No. A-007721-95 (App. Div. Feb. 6, 1998) (relief should have been granted under subsection (f) where defendant had a meritorious defense to the matter, had consulted with an attorney within one year of the default judgment and retained counsel when financially able; court found defendant was not "dilatory" in her actions).

In Mancini, the Court granted relief from a default judgment under subsection (f), finding the circumstances "sufficiently exceptional to entitle EDS to relief." Mancini, 132 N.J. at 336. There, the Court found defendant's neglect in responding to plaintiff's complaint and requests for arbitration, while inexcusable, was neither willful nor calculated. Ibid. The Court

based its grant of relief on the failure of plaintiff to conduct the arbitration proceeding consistent with the provisions of the arbitration act, N.J.S.A. 2A:24-1 to -11. Ibid.

Similarly here, even if defendant's neglect was inexcusable, the circumstances surrounding this case are such that relief should be granted under subsection (f). Not only did defendant act within a reasonable time in light of plaintiff's delay of nine years in enforcing the default judgment, defendant presented a meritorious defense to plaintiff's claim. Since defendant's son was a Medicaid recipient at the time the hospital services were rendered, plaintiff was legally barred from ever having brought suit against defendant. The judge did not address this issue, and the failure to grant relief on this claim under subsection (f) was error.

III

Medicaid providers are prohibited from billing Medicaid beneficiaries except in limited circumstances. N.J.A.C. 10:49-7.3(d) outlines the circumstances under which a provider may seek payment from a recipient:

> Medicaid and NJ KidCare participating providers are prohibited from billing Medicaid or NJ KidCare beneficiaries for any amount, except:
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> 1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.), as amended and supplemented, if the beneficiary elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized;

> 2. For payments made to the beneficiary by a third party on claims submitted to the third party by the provider; or
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> 3. For NJ KidCare-Plan C enrollee's contribution to care responsibility.
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> [N.J.A.C. 10:49-7.3(d).]

Providers who participate in the Medicaid program must accept the amount paid by the agency, including any deductible, coinsurance, or copayment required by the individual, as payment in full. 42 C.F.R. § 447.15. A child born to a woman receiving Medicaid is deemed automatically eligible for such assistance on the date of birth and remains eligible for a period of one year, so long as the woman remains eligible for such services. 42 U.S.C.A. § 1396a(e)(4). Here, it is undisputed defendant was receiving Medicaid and AFDC. Thus, her son was automatically covered under Medicaid. The record does not reflect the basis for Medicaid's denial of defendant's claim, however the services provided to the infant were services which clearly appear covered under Medicaid. See N.J.S.A. 30:4D-6(a)(1) (inpatient hospital services is a classification under which the department "shall provide medical assistance to qualified applicants"); see also N.J.A.C. 10:52-1.5 (covered inpatient and outpatient services); N.J.A.C. 10:52-1.3 (inpatient services excluded from coverage).

Plaintiff asserts the "not covered or authorized" language of N.J.A.C. 10:49-3(d)(1) includes all denied claims, thus permitting plaintiff to bill defendant directly for the services. This interpretation is not supported by the plain language of the

regulation. In addition, N.J.S.A. 30:4D-6(c) contradicts plaintiff's interpretation of N.J.A.C. 10:49-3(d)(1). N.J.S.A. 30:4D-6(c) prohibits a provider from seeking payment from the recipient even where the reimbursement was denied because the services were medically unnecessary, unless the recipient elected to receive the services with the knowledge that they were not authorized. N.J.S.A. 30:4D-6(c) (emphasis supplied). Here, defendant's infant son was born with a hole in his heart. There is nothing in the record to suggest the services rendered by the hospital were medically unnecessary, or that defendant sought out the services with the knowledge that they were not authorized.

Even assuming plaintiff could establish the "not covered or authorized" language of N.J.A.C. 10:49-7.3(d)(1) included denied claims, so that the first prong of the regulation was met, plaintiff cannot establish the second prong of the regulation – that defendant "elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized." Therefore, plaintiff was barred from billing defendant for these services, and defendant has offered a meritorious defense to plaintiff's claim. See also 42 U.S.C.A. § 1396a(a)(18); 42 U.S.C.A. § 1396p(a)(1), ("No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except . . . pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, ..."); N.J.S.A. 30:4D-7.2 (permitting a lien to be

filed against an estate of a recipient in certain limited circumstances).

Allowing a Medicaid provider to recover directly from a recipient would circumvent the purpose behind the program. "Medicaid is a program whose principal aim is that of 'enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance [to] individuals whose income and resources are insufficient to meet the costs of necessary medical services . . . .'" Monmouth Medical Center v. State, 80 N.J. 299, 302, cert. denied, 444 U.S. 942, 100 S. Ct. 297, 62 L.Ed. 2d 308 (1979), citing, 42 U.S.C.A. § 1396. The stated purpose behind the New Jersey Medicaid statute, N.J.S.A. 30:4D-1 to -35, is "to provide medical assistance, insofar as practicable, on behalf of persons whose resources are determined to be inadequate to enable them to secure quality medical care at their own expense . . . ." N.J.S.A. 30:4D-2. Permitting a provider, such as plaintiff, to recover from a recipient circumvents this statutory scheme and thwarts the purpose behind Medicaid, as persons needing medical assistance who are economically disadvantaged will be reluctant to seek treatment for fear of being held responsible for the charges incurred.

In an analogous case, Hospital Center at Orange v. Cook, 177 N.J. Super. 289, 303 (App. Div. 1981), we found a hospital's failure to comply with the notice requirements of the Hill-Burton Act, 42 U.S.C.A. §§ 291 to -291o and 42 U.S.C.A. §§ 300s to -300s-

6, precluded it from collecting on its bill.[2] The defendant in Hospital Center was a mother whose sole income for the year proceeding her son's hospital treatment was Social Security survivor's benefits. Hospital Center, 177 N.J. Super. at 292. Defendant subsequently received a bill in the amount of $2,060.50 which she was unable to pay. Ibid. The hospital brought suit against her, and defendant attempted to amend her answer to include, by way of an affirmative defense that she was an intended beneficiary of the Hill-Burton Act and the hospital failed to perform its contractual obligations to her by failing to give her appropriate notice of the availability to her of free or reduced-cost hospital service. Id. at 293.[3]

In determining the hospital's failure to comply with notice requirements of the Hill-Burton Act constituted an absolute bar to recovery, we noted,

> We regard the notice requirements imposed upon hospitals by state and federal imperatives to be the fundamental technique for assuring fulfillment both of the federal legislative purpose and of the hospital's

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[2] The underlying purpose of the Hill-Burton Act is to make federal funds available for construction and modernization of hospitals and other state facilities. The provision of a reasonable amount of uncompensated services to those medically indigent is the Hospital's quid pro quo for its receipt of capital funds under the act. Hospital Center, 177 N.J. Super. at 294-295.

[3] 42 C.F.R. § 53.111(f) requires a written determination of eligibility [under the Hill-Burton Act] to be made by the hospital prior to rendering services except where emergency services are rendered. In the case of emergency services, the bill rendered is required to contain the eligibility information prescribed by the notice provisions of section (i). See 8 N.J.R. 182 (b) (1976); Hospital Center, 177 N.J. Super. at 297.

> compliance with assurances which they have given the state as a condition of capital funding. Because failure of a hospital to comply with its notice obligations so clearly constitutes a mechanism by which the legislative intent may be defeated, the dictates of public policy demand that they be subject to the strictest possible enforcement. Our courts have heretofore steadfastly refused to enforce private contractual rights if enforcement would do violence to overriding concerns of public policy; consequently, violation of public policy is a traditionally cognizable and viable affirmative defense to a contract action.
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> [Id. at 303 (citations omitted).]

Similarly here, while no notice provisions were violated, allowing plaintiff to pursue a claim against defendant for services which should have been covered by Medicaid, allows the legislative intent of providing services to persons unable to afford medical treatment to be circumvented. In addition, allowing plaintiff's claim to stand is contrary to the plain language of N.J.A.C. 10:49-7.3(d). As such, defendant has presented a viable defense to plaintiff's action and the failure to address the merits of this defense under R. 4:50-1(f) was error.

Guidance can be found in New York cases dealing with similar issues. In Amsterdam Memorial Hospital v. Cintron, 384 N.Y.S.2d 225, 227 (App. Div. 1976), the court held recipients of Medicaid or Social Services "cannot be held responsible for payment in any form compatible with the appropriate provisions of the Social Services Law when the patient is eligible for such service."

Amsterdam involved an action by the plaintiff, Amsterdam Memorial Hospital, to recover for services rendered to defendant's wife. Defendant set forth as an affirmative defense plaintiff's failure to make a timely claim for services from the local agency. Id. at 225. At the time of admission, defendant signed a form agreeing to pay for services rendered, and the wife was eligible for Medicaid benefits. Ibid. The hospital did not request payment from the Social Services agency, and while the Social Services Law in New York does not specifically address the rights of a Medicaid vendor to recover from the recipient, compare N.J.A.C. 10:49-7.3(d), the court found the legislative intent behind the Social Services Law of "making available to everyone regardless of . . . economic standing, high-quality medical care," precluded a "shifting of payment from [the Social Service agency] to the recipient." Id. at 227 (citing Social Services Law § 363). See Shaw v. Tait, 431 N.Y.S.2d 247, 248 (Sup. Ct. 1980) (defendants demonstrated meritorious defense where part of debt to hospital should have been paid by Medicaid; while defendants did not apply for Medicaid, at time of services defendants were eligible for Medicaid and hospital had an obligation to ascertain whether they were eligible or take steps to see that they applied for Medicaid when defendants were unable to pay their bill).

In Mount Sinai Hospital v. Kornegay, 347 N.Y.S.2d 807 (Civ. Ct. 1973), the court held where the defendant applied for Medicaid, but the application was incomplete, the hospital, upon receipt of the unexecuted application forms had a clear duty to

ascertain what had happened. The forms were returned to the hospital, which took no action with regard to them, instead billing the defendant for the services some years later. Id. at 809. In evaluating the hospital's obligations under Social Service Law § 363, the court noted,

> Although the responsibilities of the hospital are not defined with adequate clarity in the statute or accompanying regulations, I am satisfied that the situation set up by the statutory pattern imposes on the hospital the duty to ascertain the possible eligibility of the patient or family, give adequate directions and information, and maintain a sufficient continuing interest to insure that eligible patients or family file the required applications and that appropriate actions is taken. These responsibilities follow inexorably from the obvious reality that specialized hospital personnel are almost certain to be far more knowledgeable about the legal requirements than the average patient and also to have an ongoing relationship with the Department that permits ready correction of misunderstandings or points of confusion.
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> . . . .
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> Surely, the hospitals have a very direct interest in being compensated through medical assistance rather than pursuing poor people for money they do not have.
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> I am satisfied that if the hospital had made such inquires the problem, whatever it was, would have been straightened out . . . and this lawsuit would never have come to pass. The failure to make such inquires, or even inform the Defendant or her mother promptly that an application had to be executed, seems to me to require the dismissal of this action. It would completely frustrate the intended purpose of the Medicaid statute to permit a hospital to default so completely on

> its obligation in a way that forestalled the Medicaid payment and then sue the needy patient or family for the cost of the medical services.
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> [Id. at 809-810 (emphasis supplied).]

While the court did not consider the consequences of a failure by the Department to authorize payment because of an error in evaluating the facts correctly, id. at 810, as is present in the instant case, the underlying rationale is the same. Plaintiff, because of its unique and on-going relationship with Medicaid, was in a position to inquire into the reasons behind Medicaid's denial of defendant's claim. This inquiry would likely have revealed the administrative error and allowed the mistake to have been corrected, without the necessity of legal action some five years after the services were rendered.

While plaintiff maintains it did not have a duty to appeal Medicaid's denial of defendant's claim, as noted by the court in Mount Sinai, plaintiff was in a superior position to ascertain the reasons behind the denial and to straighten out any administrative errors forming the basis of Medicaid's denial of defendant's claim. In addition, while plaintiff may not have had an obligation to appeal the denial of defendant's claim, in the instant case, the right to appeal the decision of the agency rested squarely with plaintiff. N.J.A.C. 10:49-10.3(a) and (b) impose twenty-day time limits for appealing claim denials upon both providers and claimants. Here, the record does not reflect the date plaintiff received notice of the denial of defendant's claim, or if defendant ever received notice from Medicaid of the

denial, however, considering the three years which passed between the rendering of services and plaintiff's subsequent billing, it is reasonable to assume the twenty-day window had elapsed. See N.J.A.C. 10:49-10.3(a)(3) (twenty-day notice period for providers starts from date on the Remittance Advice Claims Status); (b)(3) (claimants shall have twenty days from the date of notice of Medicaid Agent (agency/department)). As plaintiff had control over the notice provided to defendant, by way of its decision to bill defendant three years after the service was performed, it is reasonable to impose on plaintiff, if not an obligation to appeal the decision, at least an obligation to inform defendant of her right to appeal the denial of her claim.

IV

Plaintiff asserts equity and justice require the default judgment entered in this action remain intact, as public policy requires that there be some finality of judgment. Defendant maintains here, the interests of justice weigh heavily in favor of vacating the judgment.

The principle of finality of judgments dictates that "litigation must eventually be ended and that at some point the prevailing party be allowed to rely confidently on the inviolability of his judgment. But it is not an absolute rule, and must be weighed in the balance with the equally salutary principle that justice should be done in every case." Hodgson v. Applegate, 31 N.J. at 43. The power to set aside judgments "should doubtless be freely exercised when the enforcement of a

judgment would be unjust, oppressive or inequitable as to the party moving to vacate it." Wilford v. Sigmund Eisner Co., 13 N.J. Super. 27, 33 (App. Div. 1951).

"A court typically vacates a judgment because . . . the relief granted did not adequately take into account the prevailing equities." Housing Authority of Town of Morristown v. Little, 135 N.J. 274, 289 (1994). "[T]he rule is designed to provide relief from judgments in situations in which, were it not applied, a grave injustice would occur." Ibid. Here, the trial court did not take into account the prevailing equities, i.e., that defendant presented a meritorious defense to plaintiff's claim. While plaintiff maintains even if defendant was able to present a meritorious defense to the action, her failure to move within a "reasonable time" to vacate judgment precludes her from seeking relief, the issue raised by defendant is of public importance, and should not be dismissed on a technical procedural ground. See Bauer v. Griffin, 104 N.J. Super. 530, 541 (Law Div. 1969), aff'd, 108 N.J. Super. 414 (App. Div.), certif. denied, 56 N.J. 245 (1970) (where infant moved to set aside judgment on novel grounds, under R.R. 4:62-2 (a) and (f) (current R. 4:50-1 and -2), court refused to avoid reaching merits of plaintiff's claim based on procedural grounds though five years had passed between entry of judgment and plaintiff's motion).

Plaintiff further argues the judge did not abuse his discretion in refusing to vacate the judgment, as defendant was well aware of the action and chose not to defend against it.

Plaintiff relies on our decision in Woodrick v. Jack J. Burke Real Estate, Inc., 306 N.J. Super. 61 (App. Div. 1997), in support of its claim. In Woodrick, the defendant chose not to defend against an action, arguing that it "reasonably believed that [corporate successor liability] was not a valid theory against it." Id. at 77. The defendant in Woodrick made a decision not to defend itself because it felt confident it was insulated from liability. Ibid. We found no abuse of discretion in the trial court's refusal to vacate to default judgment against defendant, noting that defendant presented no "exceptional circumstances" warranting relief; the legal theory relied on by defendant had been called into question as early as 1976; and even if defendant was able to present a meritorious defense, no excusable neglect was demonstrated. Id. at 77-78. Here, in contrast, defendant has demonstrated both a meritorious defense and "exceptional circumstances" sufficient to warrant relief. In addition, this is not a case where defendant chose to ignore the claim against her based upon reliance on a legal theory insulating her from liability. Here, defendant reached out to the entity she knew was responsible for the bill and relied on their representation that they would "take care of it."

Allowing this judgment to stand would be unjust, as plaintiff was precluded from seeking reimbursement from defendant in the first instance; defendant was not dilatory, as she made efforts to resolve the dispute over the bill with both plaintiff and Medicaid; plaintiff was in a superior position to resolve the

dispute with Medicaid which would have likely brought the clerical error to light, eliminating the need for a lawsuit; and allowing plaintiff to collect from defendant circumvents the legislative purpose behind the Medicaid statute.

Reversed and remanded.