

**CHAPTER 49**

**ADMINISTRATION MANUAL**

**Authority**

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

**Source and Effective Date**

R.2008 d.230, effective July 11, 2008.  
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

**Chapter Expiration Date**

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 49, Administration Manual, expires on July 11, 2015. See: 43 N.J.R. 1203(a).

**Chapter Historical Note**

Chapter 49, Administration, was adopted and became effective prior to September 1, 1969. Subchapters 1 through 6 were amended by R.1977 d.213, effective July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c).

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1990 d.390. See: 22 N.J.R. 1512(a), 22 N.J.R. 2313(a).

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted as R.1992 d.317, effective August 17, 1992. See: 24 N.J.R. 1728(b), 24 N.J.R. 2837(a). Subchapter 19, Pre-paid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995. See: 27 N.J.R. 853(a); 27 N.J.R. 2446(b).

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1997 d.354, effective August 8, 1997. As a part of R.1997 d.354, effective September 2, 1997, Chapter 49, Administration, was renamed Chapter 49, Administration Manual; Subchapter 2, New Jersey Medicaid Recipients, was renamed Subchapter 2, New Jersey Medicaid Beneficiaries; Subchapter 9, Provider and Recipient's Rights and Responsibilities; Administrative Process, was renamed Subchapter 9, Provider and Beneficiary's Rights and Responsibilities; Administrative Process; Subchapter 17, Home and Community-Based Services Waivers, was recodified as N.J.A.C. 10:49-22, Home and Community Based Services Waiver Programs; Subchapter 18, Home Care Expansion Program, was recodified as N.J.A.C. 8:81-2, and Subchapter 18, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), was adopted as new rules; Subchapter 19, HealthStart, was adopted as new rules; Subchapter 21, Pharmaceutical Assistance to the Aged and Disabled (PAAD), was recodified as N.J.A.C. 8:81-3, and Subchapter 21, The Medicaid Managed Care Program—NJ Care, was adopted as new rules; Subchapter 22, Lifeline Programs, was recodified as N.J.A.C. 8:81-4, and Subchapter 22, Home and Community-Based Services Waiver Programs, was adopted as new rules; and Subchapter 23, Hearing Aid Assistance to the Aged and Disabled, was recodified as N.J.A.C. 8:81-5, and a new Subchapter 23, Lifeline Programs, was adopted as new rules. See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Subchapter 24, Work First New Jersey/General Assistance Claims Processing, was adopted as R.2000 d.309, effective August 7, 2000. See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

Chapter 49, Administration Manual, was readopted as R.2003 d.81, effective January 22, 2003. See: 34 N.J.R. 2647(a), 35 N.J.R. 1116(a).

Subchapter 20, The Garden State Health Plan (GSHP), was repealed by R.2003 d.82, effective February 18, 2003. See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Chapter 49, Administration Manual, was readopted as R.2008 d.230, effective July 11, 2008. As a part of R.2008 d.230, Subchapter 21, The Medicaid Managed Care Program—NJ Care 2000, was renamed The Medicaid/NJ FamilyCare Managed Care Program, effective August 4, 2008. See: Source and Effective Date. See, also, section annotations.

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received by the Medicaid Fiscal Agent within 90 days of the date of the Medicare adjudication.

iii. For Medicare/Medicaid claims where the Medicare adjudication occurs within one year from the date of service, but less than 90 days remain within the timely filing period, the provider shall submit the claim to be received by Medicaid within the one year timely filing period or 90 days, whichever is later.

iv. A combination Medicare/Medicaid claim received outside the applicable Medicaid timely submission period shall not be reimbursed by the New Jersey Medicaid program.

3. In most cases, when a beneficiary is eligible for both Medicare and Medicaid, or Medicare and NJ FamilyCare, a Medicare/Medicaid approved claim will crossover from the Medicare Carrier/Intermediary to the program's Fiscal Agent. The provider is requested to allow 45 days from Medicare adjudication for the Medicaid or NJ FamilyCare program to receive and process crossover claims. Failure to allow the 45 days for the transition from Medicare to Medicaid or NJ FamilyCare will result in claim denials due to duplicate claim errors. There are instances, however, where claims will not cross over from Medicare. In those instances, or when a Medicare/Medicaid or Medicare/NJ FamilyCare crossover is not reflected on the provider's Medicaid Remittance Advice within 45 days of the Medicare Explanation of Benefits (EOB), the provider shall follow the billing instructions in the Fiscal Agent Billing Supplement following the second chapter of the provider services manual.

(g) If additional information is required in order to process a Medicaid claim, the provider shall supply the information as soon as possible but not more than 30 days after the end of the timely submission period.

(h) Regarding a Medicaid claim submitted timely that has been adjudicated and denied, a provider may resubmit the claim within one year of the date of service or 30 days of the date of adjudication as indicated in the Remittance Advice Statement, whichever is later.

(i) If it appears that an individual is eligible for Supplemental Security Income (SSI), the Medicaid provider or a designee should, but is not required to, assist the patient in completing and submitting an application for SSI. The application for SSI shall be submitted to the Social Security Administration (SSA) so that it is received by the SSA within the time requirements for claim submission contained in (a) through (h) above. For institutional and non-institutional claims for services provided to an individual who was not found to be eligible for Medicaid as of the date of service and who thereafter is determined to be eligible for SSI (for that date of service) by the SSA, and, therefore, also eligible for Medicaid (for that date of service), the following requirements shall apply:

1. If the individual's application for SSI is received by the SSA within the time requirements for claim submission contained in (a) through (h) above, the Medicaid provider or a designee shall file a claim for services rendered to the individual so that it is received by the State's fiscal agent within the later of the following:

i. The applicable time requirements for claim submission contained in (a) through (h) above;

ii. Six months from the date of the SSI eligibility determination; or

iii. Six months from the date that the SSI/Medicaid eligibility data appears on the New Jersey Medicaid Management Information System.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted "beneficiary" for "recipient" and deleted "form" following "claim" throughout; and in (b)2, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" and inserted reference to three digit carrier/payer.

Amended by R.1997 d.520, effective January 5, 1998.  
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

Rewrote (a), inserted new (a)1 and recodified existing (a)1 as (a)2.  
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).  
See: 30 N.J.R. 713(a).

In (d), inserted references to Medicare/NJ KidCare and to NJ KidCare, and made corresponding language changes, throughout, and inserted a reference to Medicare and NJ KidCare in the first sentence of 3.  
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).  
See: 30 N.J.R. 1060(a).

In (d)3, inserted a reference to Medicare/NJ KidCare approved claims in the first sentence and deleted "Medicaid" following "provider's" in the last sentence; and in (h)2, inserted references to Medicare/NJ KidCare claims throughout, and deleted "Medicaid" following "filed."  
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.  
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.  
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.  
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.  
Amended by R.2001 d.329, effective September 17, 2001.  
See: 33 N.J.R. 1889(a), 33 N.J.R. 3334(a).

Rewrote (a)2; in (a)2ii, revised N.J.A.C. reference; in (d)3, substituted "KidCare may result in payment delays" with "FamilyCare will result in claim denials"; and substituted "Advise" with "Advice"; in (e), substituted "30" for "90"; rewrote (f); deleted (g) and (h).  
Amended by R.2003 d.82, effective February 18, 2003.  
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

In (a)2ii, inserted "that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit" following "retroactive eligibility application"; added a new (b) and (c) and recodified existing (b) through (f) as (d) through (h).  
Amended by R.2003 d.485, effective December 15, 2003.  
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

In (a), deleted the last two sentences in the introductory paragraph; rewrote (e) and (f).  
Administrative correction.  
See: 36 N.J.R. 5352(b).

Amended by R.2006 d.337, effective September 18, 2006.  
See: 38 N.J.R. 2002(a), 38 N.J.R. 3899(b).

Added (i).  
Amended by R.2008 d.230, effective August 4, 2008.  
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In the introductory paragraph of (a)2, inserted a comma following "reimbursement"; in (a)2ii, deleted "that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit" following

the first occurrence of "application" and inserted "at the appropriate eligibility determination agency"; and in (d)iv and (e)iv, substituted "Early" for "early".

Amended by R.2011 d.290, effective December 5, 2011 (operative January 1, 2012).

See: 43 N.J.R. 1129(a), 43 N.J.R. 3182(b).

Section was "Timeliness of Medicaid claim submission". Rewrote (a)1.

#### Case Notes

Evidence of provider's custom or practice of mailing reimbursement claims against New Jersey Medicaid Program fund, together with other evidence, was sufficient, under preponderance of evidence standard, to create presumption that disputed claims were mailed and received. SSI Medical Services, Inc. v. State Dept. of Human Services, Div. of Medical Assistance and Health Services, 146 N.J. 614, 685 A.2d 1 (1996).

Evidence supported finding that medical service provider timely submitted its Medicaid claims to fiscal agent for Division of Medical Assistance and Health Services: fiscal agent probably lost them. SSI Medical Services, Inc. v. State, Dept. of Human Services, Div. of Medical Assistance and Health Services, 284 N.J. Super. 184, 664 A.2d 505 (A.D.1995).

Where (1) a convalescent center provided services to a patient during January and February 1999, claims for which were initially denied while the local board of social services conducted its semi-annual review of the patient's eligibility for Medicaid benefits, (2) the patient was determined in April 1999 to be eligible for continued Medicaid benefits, and (3) the convalescent center mistakenly believed it would be automatically paid without the need to resubmit the claims, the center's resubmission of its claims for reimbursement for the January and February 1999 services in May 2001 was properly denied as being filed out of time. Mediacenter Neptune v. N.J. Dep't of Health & Senior Services, OAL Dkt. No. HLT 4363-01, 2005 N.J. AGEN LEXIS 567, Initial Decision (October 3, 2005).

Denial of reimbursement for untimely claims affirmed. Capital Nursing Center v. Department of Health and Senior Services, 97 N.J.A.R.2d (HLT) 44.

Nursing facility not entitled to Medicaid reimbursement for untimely claims. Clara Maass Continuing Care Center v. Department of Health and Senior Services, 97 N.J.A.R.2d (HLT) 26.

Denial of reimbursement for untimely claim affirmed. In the Matter of Bridgeton Nursing Center, Patients: W.G. and M.R., 97 N.J.A.R.2d (HLT) 7.

Medicaid claims submitted more than two years after services rendered rejected as untimely filed. In the Matter of Bayview Convalescent Center, 97 N.J.A.R.2d (HLT) 1.

Failure to make timely inquiry regarding denial of Medicaid reimbursement claim rendered nursing home ineligible for reimbursement. In the Matter of Meadowview Nursing Home Patients, 96 N.J.A.R.2d (DMA) 65.

Medicaid reimbursement claims were denied where insufficient proof was submitted to invoke presumption of timely receipt of claims. SSI Medical Services, Inc. v. Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 47.

Delay between claim receipt and claim processing was that of agency, not that of provider and did not warrant denial of Medicaid reimbursement for untimeliness. Bergen Pines County v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 30.

Twelve-month rule not applicable; government failed to give hospital provider number. Bergen Pines County Hospital v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 54.

Billing agent's error did not provide exception from one-year period. Pan American Pharmacy, Inc. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 32.

Mismanagement by primary insurer no reason for relaxing time frames. Newark Beth Israel Medical Center v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 27.

Failure to receive determination from primary carrier did not excuse untimely application for Medicaid. Carrier Foundation v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 17.

Medicaid claim untimely; computer-indicated error not corrected for over one year. Lincoln Park Intermediate Care Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 63.

Claims for Medicaid reimbursement not timely filed. Jewish Hospital and Rehabilitation Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 53.

Corrected copy was sufficient notice of filing of discharge in error. Courthouse Convalescent Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 43.

Claim for reimbursement not filed within one year of date of discharge. Holy Name Hospital v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 36.

Hospital's claims for Medicaid reimbursement were untimely. Holy Name Hospital v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 33.

Long term care facility's claim for payment was untimely. Leisure Chateau Care Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 31.

Medicaid reimbursement; properly completed claims timely filed after rejection of improperly submitted claims. Leader Nursing and Rehabilitation Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 21.

Home care visits could not be added to cost report in absence of timely claim. Long Branch Public Health Nursing Association, Inc. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 10.

#### 10:49-7.3 Third party liability (TPL) benefits

(a) "Third party liability" (TPL) exists when any person, institution, corporation, insurance company, absent parent, Medicare program, public, private, or governmental entity is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the cost of medical assistance payable by the Medicaid or NJ FamilyCare program.

1. It is a violation of section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services.

(b) Medicaid and NJ FamilyCare benefits are last-payment benefits. All TPL, for example, health insurance, Medicare, CHAMPUS, prepaid health plans, workers' compensation and auto insurance, shall, if available, be used first and to the fullest extent in meeting the cost of the medical needs of the Medicaid or NJ FamilyCare beneficiary, subject to the exceptions listed in (h) below.

(c) The New Jersey Medicaid program and the NJ FamilyCare program will supplement the amount paid by a third party, but the combined total paid to the provider shall not exceed the total amount payable under the program in the absence of any TPL. The following exceptions should be noted:

1. Medicare: The program will make payment in the full amount of the Medicare Part A deductible and coinsurance for inpatient hospital services, and for Part B outpatient hospital services. For services rendered on or after July 20, 1998, payment for Part B coinsurance and deductible for other non-hospital services shall be paid only up to the Medicaid or NJ FamilyCare maximum allowable.

2. Contracting practitioners: No program payments shall be made when the third party calls for a contracting or participating practitioner to accept the TPL as payment in full.

(d) Medicaid and NJ FamilyCare participating providers are prohibited from billing Medicaid or NJ FamilyCare beneficiaries for any amount, except:

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, or not covered or authorized by the Division of Medical Assistance and Health Services under this chapter or N.J.A.C. 10:74, 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;

3. For NJ FamilyCare-Plan C enrollee's contribution to care responsibility; or

4. For NJ FamilyCare-Plan D enrollee's required co-payment.

(e) When a Medicaid or NJ FamilyCare-Plan A beneficiary has other health insurance, the program requires that such benefits be used first and to the fullest extent, subject to the exceptions in (h) below. Supplementation may be made by the program, but the combined total paid shall not exceed the amount payable under the program in the absence of other coverage. The program shall not supplement covered services rendered by a participating or contracting practitioner with any private health coverage program where the private plan calls for the practitioner to accept that plan's payment as payment in full. When other health insurance is involved, supplementation claims shall not be filed with the program unless accompanied by a statement of payment, Explanation of Benefits (EOB), or denial from the other carrier. Attachment of such information will expedite Medicaid and NJ FamilyCare claim processing.

1. Medicare is a health insurance program which covers certain aged and disabled persons. When rendering Medicare-covered services to any Medicaid or NJ FamilyCare beneficiary, providers shall inquire about Medicare eligibility especially if the third digit of the Eligibility Identification Number is a 1, 2, 5, or 7. Medicaid or FamilyCare supplementation of available Medicare benefits shall be as follows:

i. Medicare (Title XVIII): For any Medicaid or NJ FamilyCare beneficiary who is covered under Medicare, responsibility for payment by the New Jersey Medicaid Agent or the NJ FamilyCare program for non-hospital Part B services shall be limited to the unsatisfied deductible and/or coinsurance to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid or NJ FamilyCare program in the absence of other coverage for services rendered on or after July 20, 1998.

(f) When a Medicaid or NJ FamilyCare beneficiary has benefits available, such as those described above or from any other liable third party, an approved Medicaid or NJ FamilyCare provider shall be authorized to sign an insurance claim for the Commissioner, based on the third party assignment of rights, in order to receive direct payment from the insurer. This is done pursuant to N.J.S.A. 30:4D-7.1(c). The following language shall be used by the provider when completing insurance claims: "(signature of authorized provider), Assignee for the Commissioner, New Jersey Department of Human Services."

(g) When recovery of benefits is sought by the Medicaid or NJ FamilyCare program from a liable third-party, the Commissioner shall authorize the Director or his designee(s) to sign the recovery demand.

(h) TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid or NJ FamilyCare payment in any of the following circumstances:

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;

2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the program;

3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay;

4. The claim involves a service for which CMS has granted a waiver of the TPL cost avoidance requirements in accordance with 42 C.F.R. 433.139(e). Waivers have been granted for services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR, and Vineland Special Hospital; or

5. Rehabilitation services provided by a local school district under a child's Individualized Education Program (IEP).

(i) In those situations where a health insurance payment is received after Medicaid or NJ FamilyCare has been billed and has made payment, the provider must reimburse the Medicaid or NJ FamilyCare payment to the Medicaid or NJ FamilyCare program and not to the Medicaid or NJ FamilyCare beneficiary. Reimbursement must be made immediately to comply with Federal regulations. In the event a provider is apprised or otherwise is on notice that a duplicate or excessive payment has been made by the Division as a result of the provider's receipt of a Medicare or health insurance payment, the provider shall have 60 days to refund such overpayments to the Division. To initiate the process, providers must submit an MMIS Claim Adjustment Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

1. In situations involving tort matters where liability has not been established at the time of billing, providers may elect to bill the Medicaid program. However, if they choose to do so, they are precluded from returning Medicaid payments for their services, and may not seek reimbursement from any proceeds resulting from the tort matter. Conversely, providers may elect not to bill the Medicaid program, and await the outcome of the tort matter. However, should the tort matter not result in an award to the beneficiary, and the deadline for timely filing of a Medicaid claim by the provider passes, the provider shall not bill either the Medicaid program or the beneficiary.

2. This subsection in no way precludes the Division from seeking reimbursement for Medicaid payments made on behalf of the beneficiary or from any third party liability source, including a tort liability recovery, which may be awarded the beneficiary.

(j) Regardless of the status of a provider's claim with other third parties, all claims for Medicaid or NJ FamilyCare reimbursement must be received by the Fiscal Agent within the time frames specified in N.J.A.C. 10:49-7.2, Timeliness of claim submission.

(k) Any individual who undertakes to legally represent any Medicaid or NJ FamilyCare beneficiary in an action for damages against any third party when medical expenses have been paid by the Division shall be required to give written notice to the Division within 20 days of filing or commencing the action.

1. The term "legal representative" shall include, but not be limited to, an attorney, administrator/administratrix, executor/executrix, conservator, guardian or guardian ad litem.

Petition for Rulemaking.  
See: 27 N.J.R. 770(b), 27 N.J.R. 1320(a).

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" throughout; in (a), substituted "by the Medicaid program" for "under this act"; in (b), inserted "the exceptions listed in"; in (e)1, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; deleted (e)1i and (e)1i(1); added (h)5; and in (i), substituted "a health insurance payment is received" for "an insurance payment is received from another payer" and "MMIS Claim Adjustment Request Form" for "Adjustment/Void Request Form".

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Inserted references to NJ KidCare throughout; in (d)1, inserted ", as amended and supplemented," following "et seq.;" and added 3; and in (e), inserted a reference to NJ KidCare-Plan A beneficiaries in the first sentence.

Amended by R.1998 d.382, effective July 20, 1998.

See: 30 N.J.R. 1255(b), 30 N.J.R. 2646(b).

In (c), inserted a reference to the NJ KidCare Program in the introductory paragraph and rewrote 1; and in (e), added a new 1i, and inserted references to NJ KidCare, Medicare and Medicaid throughout.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

Amended by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

In (h)4, deleted i; rewrote (i).

#### 10:49-7.4 Prohibition of payment to factors

(a) A "factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or deduction of a portion of the accounts receivable.

(b) Payment for any covered services furnished to any Medicaid or NJ FamilyCare beneficiary by an approved provider may not be made to or through a factor, either directly or by power-of-attorney.

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (b), substituted "beneficiary" for "recipient".

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

In (b), inserted a reference to NJ KidCare beneficiaries.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Amended by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

#### 10:49-7.5 Use of service bureau and/or management agency

(a) Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payment in the name of the provider if the agent's compensation for this service is:

1. Related to the cost of processing the billing;