PerformCARE®

Instructional Guide for Entering Claims (CMS-1500 Claim Form) and Uploading Documentation into CYBER

December 2023 – (02089)

PerformCARE®

Instructional Guide for Entering Claims

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I. Introduction

The CMS-1500 Health Insurance Claim Form is the billing form used by the Center for Medicaid & Medicare Services for claims made by some providers of health care services through the New Jersey Children's System of Care (CSOC). This form is available for use electronically in the CYBER system to bill wrap-flex claims. Individuals with the proper security attached of "MGR" or Manager level users, have access to the 1500 Health Insurance Claim Form and the ability to complete and submit the form for (Wrap-Flex) payment.

Please note that some agencies are required to upload documentation to support their Claims, such as the Service Delivery Encounter Documentation Form (SDED) (See Uploading Documents for more information on uploading documents and their requirements).

This document describes the features and functionality of the electronic 1500 Health Insurance Claim Form in CYBER.

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II. Accessing CYBER

CYBER can be accessed via the PerformCare website – www.performcarenj.org . The link is available under the CYBER menu at the top of the home page or the button at the bottom of the page. Users must log into CYBER with their Username and Password.

Each provider organization has at least two CYBER Security Administrators, and your agency's CYBER Security Administrators can set up a login and temporary password. Access will be based upon login type and security levels.

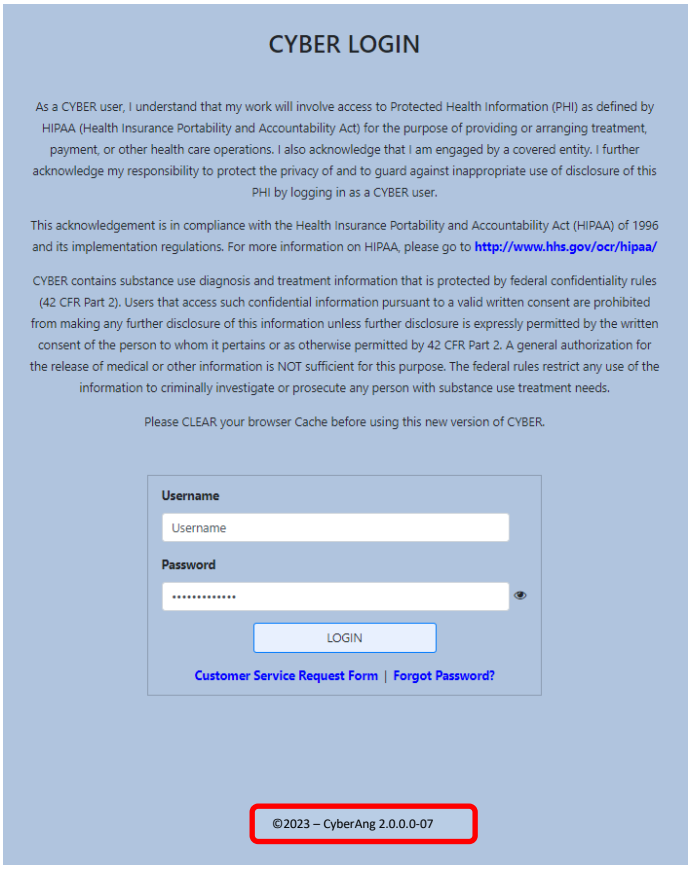
Before logging in, keep in mind…

- Every time CYBER is launched, the **Username and Password is required, then click the LOGIN button to continue**.
- Users are required to **change their password every 90 days.**

Above the login area is a statement that, CYBER users acknowledge their responsibility to protect the privacy of and to guard against the inappropriate use or disclosure the Protected Health Information (PHI) contained within the system.

This statement will appear during each log in.

Please also check the link: **CYBER Access Requirements** page on the PerformCare website for the most up-to-date technical requirements (such as browser compatibility and operating systems) needed to access CYBER.

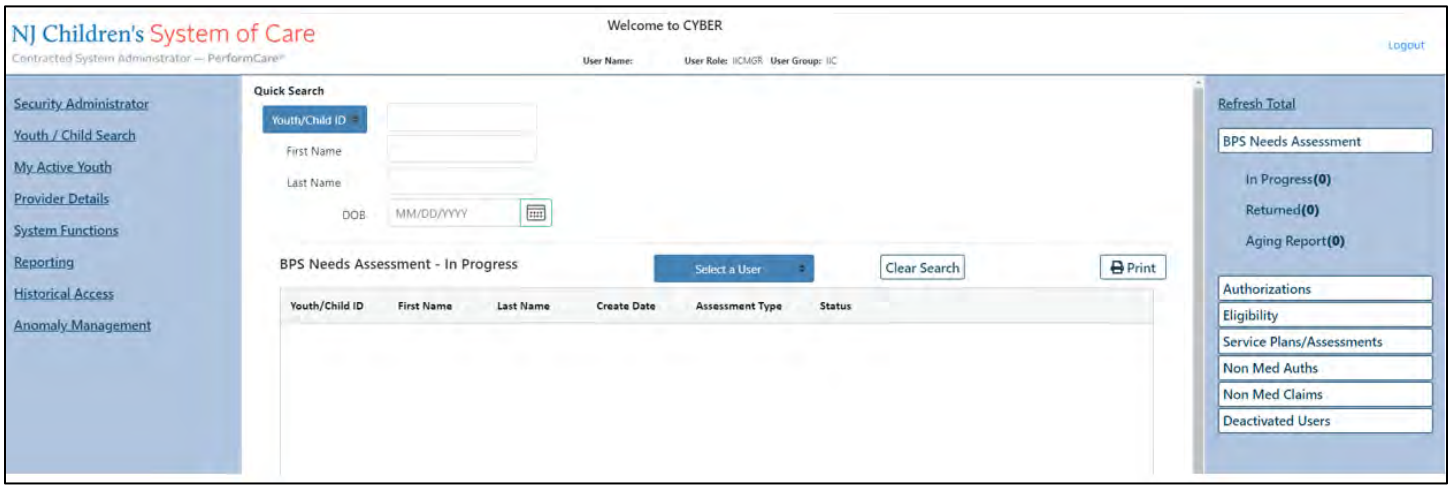


At the bottom of the login page is the version of CYBER. The server number is the last 2 digits at the end (-XX). This is helpful to note when requesting assistance.

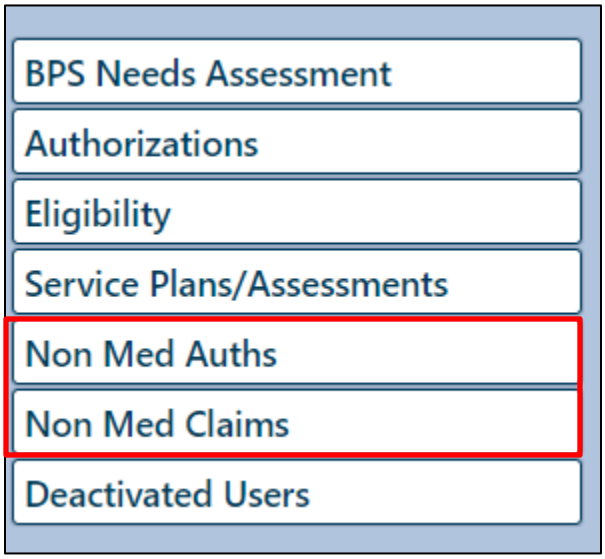
For technical support, please use the **Customer Service Request Form** link under the login.

III. Welcome Page Components

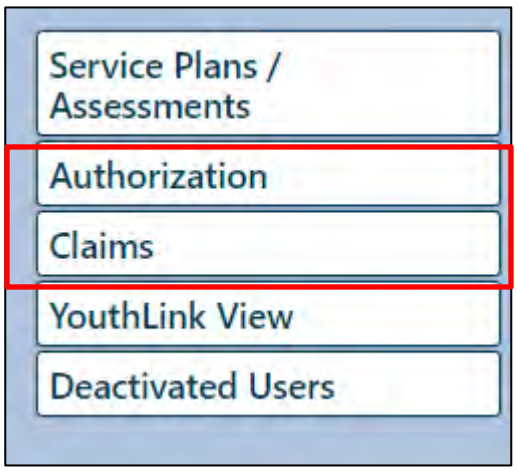
The Welcome Page includes areas and links, which will populate the center grid, that include information specifically for the claims entered electronically into CYBER and their associated authorizations. (Please note that if your agency does not submit 1500 Claim forms but completes utilization information, it will not appear on your Welcome Page.)



IIC users' links will be labeled "Non-Med Auths" and "Non-Med Claims". Other users, such as SJI providers, will see the links for Authorizations and Claims.

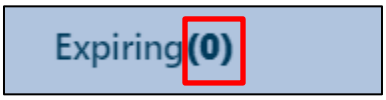


IIC user links



SJI user links

When the user clicks on one of the links from the right side of the screen, the center grid will populate with the associated information. The parenthesis next to each link, will automatically populate the number associated with the link.

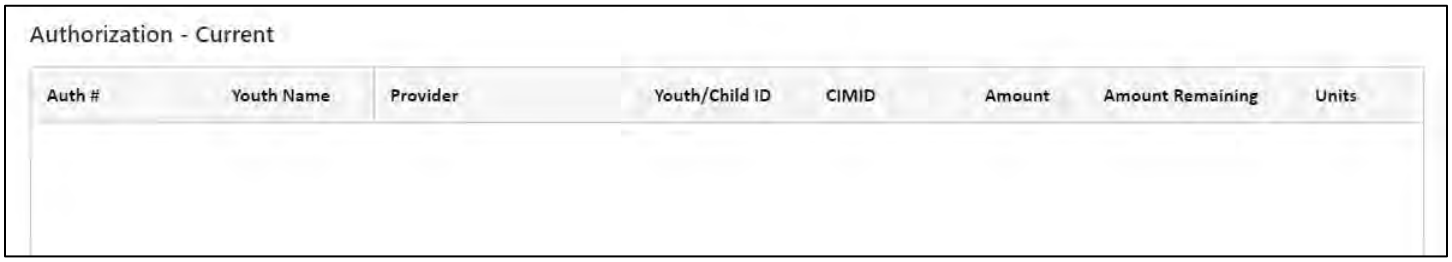


Non-Med Auths

The links will contain the following information:

- Current – the default grid will automatically populate the center grid when the user first logs in and anytime they return to the Welcome Page; will list the authorizations for the provider where the current date is equal to or after the start date of the authorization and is equal to or before the end date of the authorization.
- Last 30 days – all authorizations for the provider that have expired in the last 30 calendar days.
- Expiring – all authorizations for the provider that will expire in the next 30 calendar days.
- Auth History – all authorizations for the provider that expired between the last 31 and 365 days.

Once the user selects one of the tabs under "Non-Med Auths", the center grid will show the **Authorization** grids.



The **Authorization grid** will be populated with the following information:

- Authorization # – this hyperlink will bring the user to the Authorizations Details screen which shows the authorization information and any claims submitted against it (this is where a user with the MGR designation in their profile can create and submit CMS-1500 Claim Forms)
- Youth Name – name of the youth receiving services
- Provider – name of the provider or program that the authorization was opened for; will vary depending upon what programs the user is attached to
- Youth ID (of the youth) – hyperlink that directs user to the user to the youth's Face Sheet
- CIMID – an identifier used within CYBER for each provider/program
- Amount and Amount Remaining – monetary amount associated with the authorization and the amount that remains
- Units and Units Remaining – number of units authorized and the number that remains
- Service Code and Description – assigned HCPCS code and the service description associated with the code
- Start and End Date (of the Authorization) – date when the service period begins and the date when the service period ends.
- Create Date (of the Authorization) – date the authorization was created in CYBER.

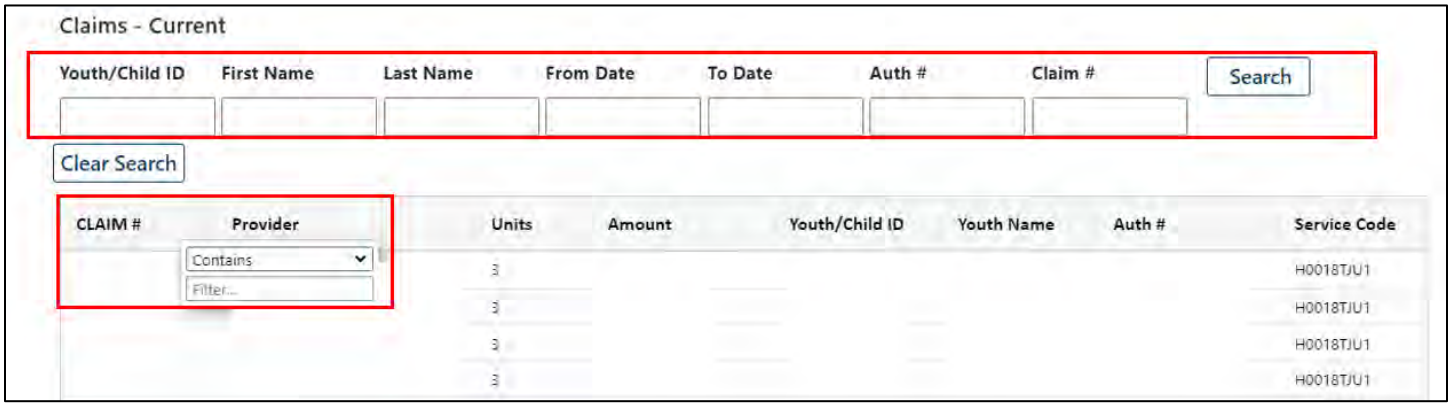
Non-Med Claims

The links will contain the following information:

- Claims – all claims for the agency will show here
- In Progress – all claim forms for the agency with an "In Progress" or draft status will appear here
- Submitted –claim forms that have been submitted to PerformCare
- Approved –claims that have been approved for the agency
- Sent – claims from the agency that have been sent by PerformCare for payment
- Paid – all claims that were paid for the agency in the last 365 days (payments are posted in CYBER no less than 30 days after the payment has been issued)
- Returned – all claims that have been returned to the agency by PerformCare
- Denied – all claims with a status of Denied; these claims have been denied by PerformCare or CSOC. A claim may be denied if:
    - Care Management requested the authorization (IIC Providers only – BPS)
    - Youth have an active Medicaid eligibility number that covers the dates of service on claim for the Intensive-In-Community/Biopsychosocial service rendered.
    - the claim must be submitted to NJ Medicaid Fiscal Agent for adjudication,
    - Duplicate Claim Submission
- Review – all claims for the agency that are currently in review with PerformCare; this includes claims that have been entered for services that fall outside of the end of the authorization by more than 90 days as well as all claims for the agency that are currently in review with CSOC

Searching within the Claims Grid

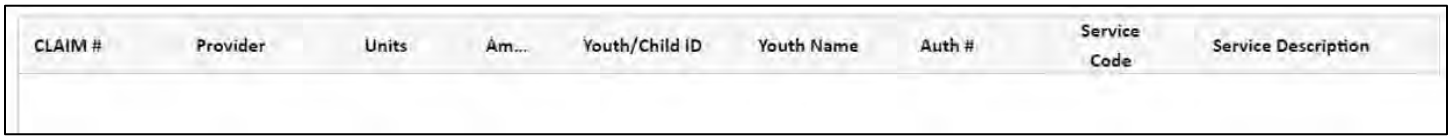
The Claims grids will have a search area above it that will appear once a user selects one of the links listed under "Non-Med Claims". Users can search within those fields. Or within the grid headings.



Users can search the grid for specific information such as a specific CYBER ID, claims from a certain period and specific authorizations numbers.

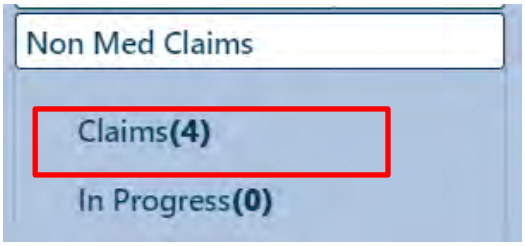
The Claims grids will be populated with the following information:

- Claim number
- Provider
- Units and Amount
- Youth ID
- Youth Name
- Authorization number
- Service Code and Description
- Start and End Date (of the authorization)
- Status (of the claim)
- Check number, Check Date (when applicable)
- Create Date
- Created by
- CIMID



IV. The Authorizations Details Screen

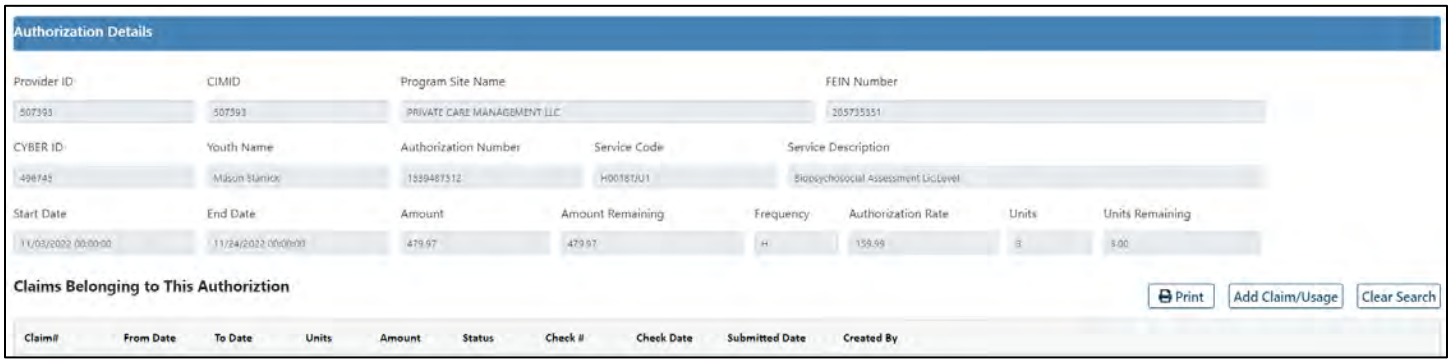
The user can access the Authorization details by selecting the Claims link under Non-Med Claims or by searching for a particular authorization using the Search claims fields.



The User may also search using any of the fields in the Current Claims Search box. Although CYBER will allow you complete multiple search fields, by searching one criterion at a time it will narrow your results.

Once you have identified the claim you want to view, then select the Authorization link. This will direct you to the Authorization Details Screen.

The top of the screen houses information about the individual authorization. Users will find the name of the youth the authorization is for the service code and description, the amount of the authorization, the amount remaining, the number of units and frequency initially authorized and the number of units that remain on the authorization.

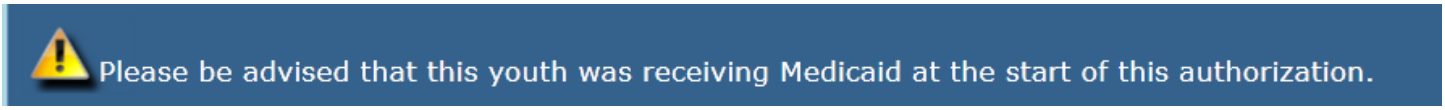


Below this area is the grid of claims that have been entered against this authorization; it will be blank if no claims have been entered.

The grid will be sorted by Claim number, descending, and will contain the following information:

- Claim number – will act as a hyperlink that, when clicked, will bring up the 1500 form. If the form is In Progress or Returned (status), it will be available for editing. If the form has any other status – Submitted, Review, Paid, etc. – it will open in read-only format.
- Start and End Dates entered on the claim
- Units
- Amount
- Status – submitted, paid, returned, denied, etc.
- Check number and date (when applicable)
- Submitted Date
- Submitted by

Note: If the Youth had Medicaid during the time of service, the user would receive an error message at the top of the CYBER Screen.



Users can add a claim to this authorization from this screen, by clicking the Add Claim button on the right of the grid. Clicking here will bring up the electronic 1500 form.

V. Entering Claims Using the 1500 Form in CYBER

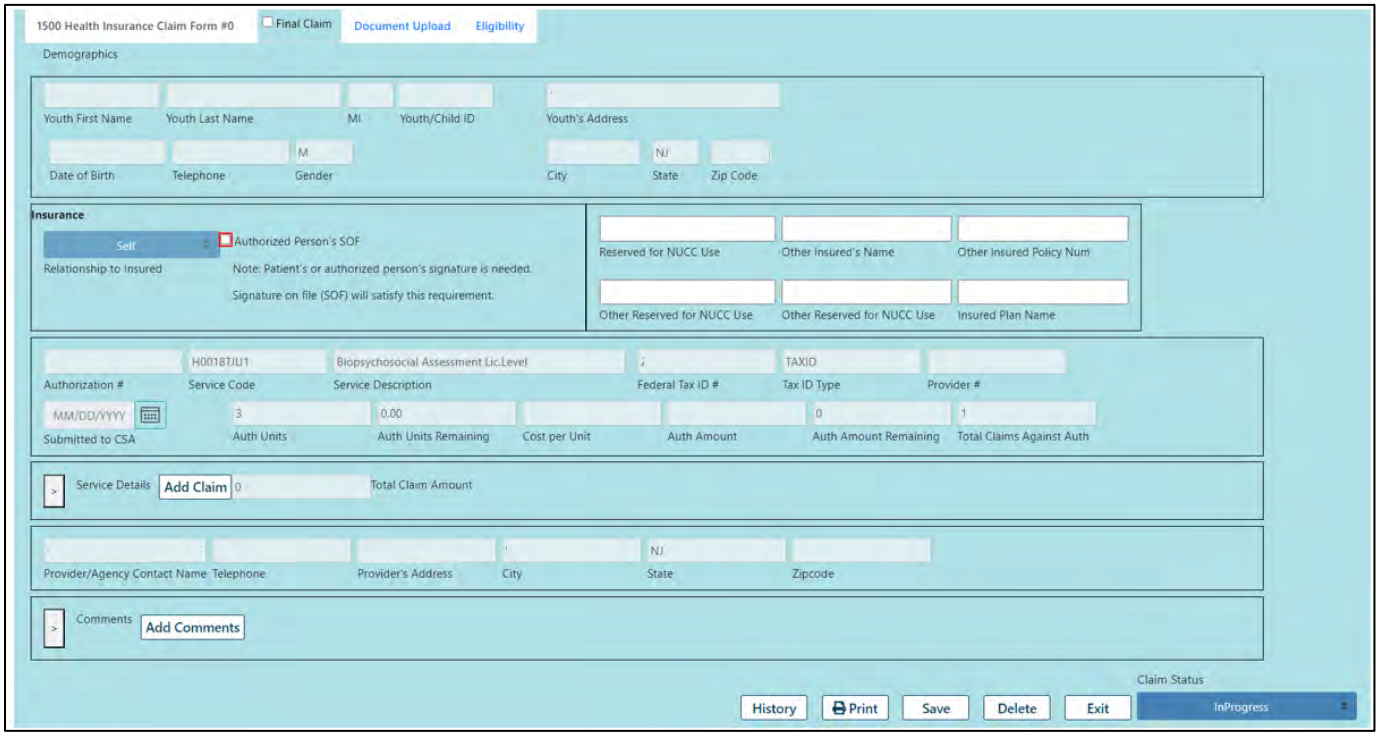
Users can submit their CMS-1500 forms via CYBER instead of using paper. The 1500 form that is in CYBER is the same form that providers are now completing on paper; the changes that were made to the form has been made to CYBER.

Note: In order to submit a claim, a user must have a Manager (MGR) user role assigned to their user profile; the Agency's System Administrator can assign the designation to the appropriate person(s) within the agency.

*Users will submit the form with an electronic signature; when the user goes to submit the claim to PerformCare, they will receive a screen that is an exact copy of the back of the existing 1500 form. This information asks the user to verify that the claim they are submitting is correct; by accepting the conditions outlined in the statement, the user is verifying that they are submitting the claim in good faith.

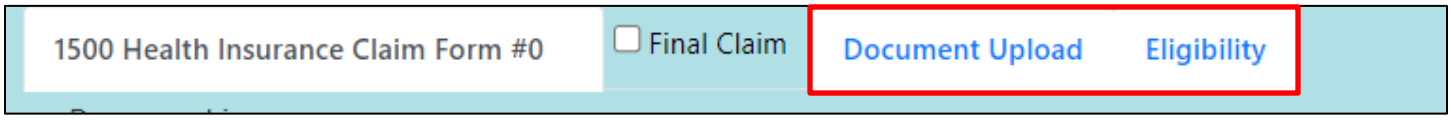
For more detailed information on Wrap-Flex billing and claims, please review the IIC Billing Guide on the PerformCare website (see References).

This is an example of a 1500 Claim Form.



The 1500 Form will automatically be assigned a **Claim Form number**, which will display in the upper left side of the form, once it is saved. This will aid in identifying the claim if the user (or Billing and Eligibility associate) needs to refer to it, especially once it is submitted or approved/returned/paid, etc.

Note: In previous versions of the electronic 1500 form, the Final Claim checkbox was available for users to select; it has been disabled so that it cannot be selected by mistake.



There are two (2) additional tabs on the 1500 Claim Form:

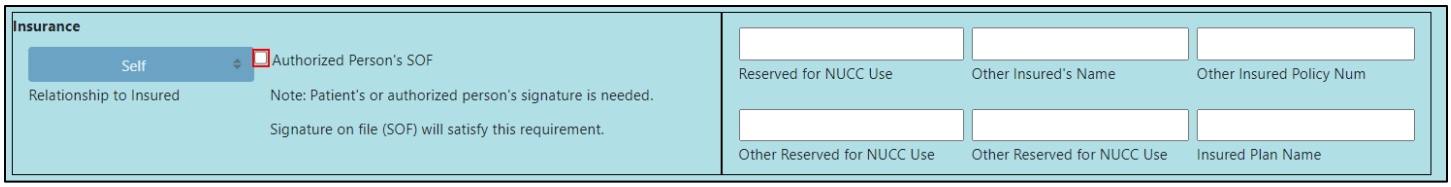
- Document Upload tab – to be used by those agencies that are required to submit supporting documentation along with their claims
- Eligibility tab – will give the user access to the youth's Medicaid coverage information, if applicable

Breakdown of the 1500 Form

Demographics

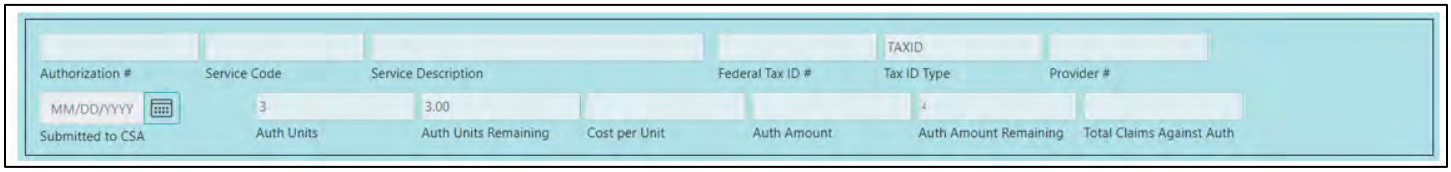
This area is automatically pre-populated from the youth's Face Sheet within their record. If something here is incorrect, the user will need to go to the Face Sheet to make changes; the saved claim will update accordingly. Please note that changes can only be made to the Face Sheet while the user's Security tab is still open; if the user is completing the 1500 form after their Security tab has closed, they will only have historical access to the record and will be unable to edit the Face Sheet.

Insurance information.



The only field here that should be used is the check box labeled "Authorized Person's SOF (Signature on File)". This is a required field (marked by the red box).

Authorization Details/Billing area

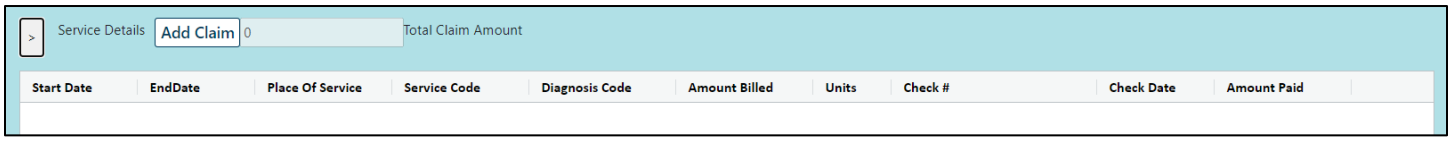


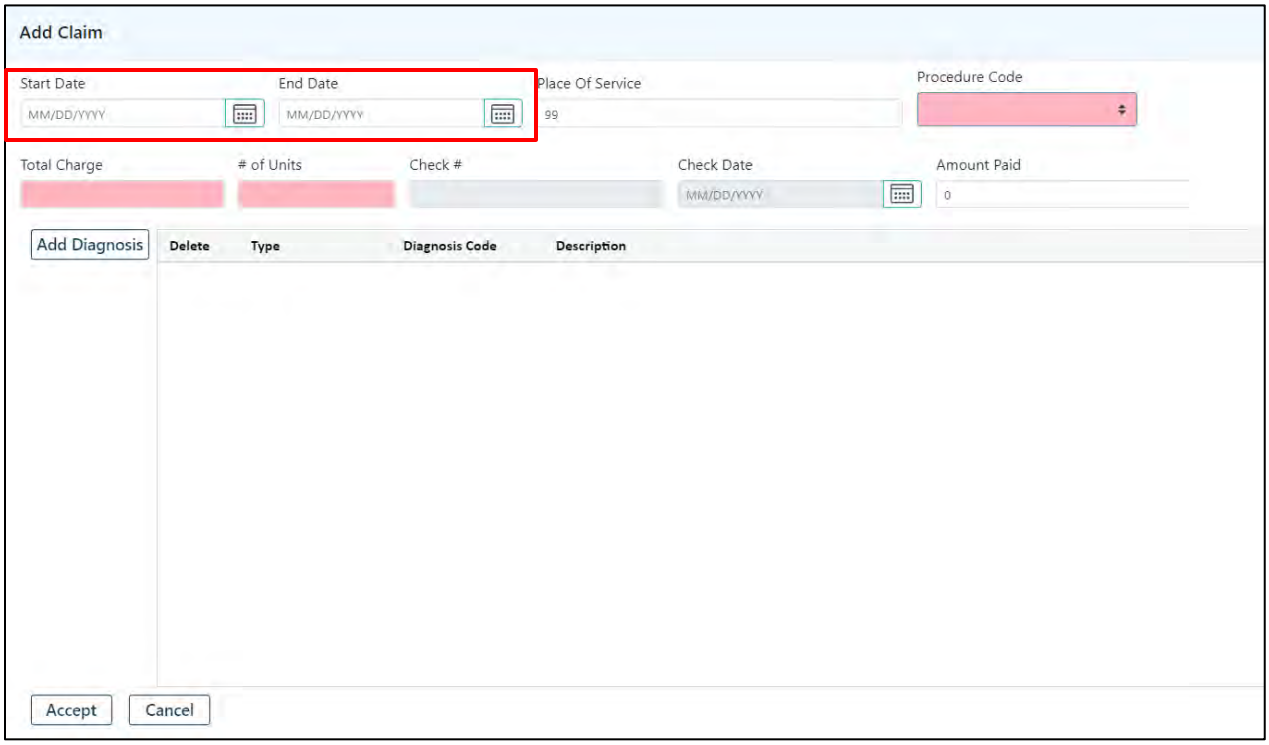
The Claim/1500 form that is being created will be submitted against the authorization that the user chose from the Welcome Page; the two rows will display details for that authorization including the service code and description, as well as the cost per unit and the amount that remains on the authorization. Users should check the Cost per Unit field to ensure it is accurate with the authorization they are billing against; rates are subject to change – an authorization that is from one month ago may have a different rate than a current authorization.

Note: If the service code is a bundled code, the user will need to select the specific procedure code when entering the claim.) The last field in this area, Total Claims against Auth, will show a total dollar amount that has been claimed to the current date on this authorization.

Entering Individual Claims

Clicking the "Add Claim" button will bring up a new window. (Please note – the Total Claim Amount box that appears next to the Add Claim button will populate with a total dollar amount of all claims entered into the 1500.)





The user must enter information into the fields that are highlighted in pink as well as a Start and End date :

Start and End Dates: Users will be unable to enter claims with overlapping or duplicate dates. In other words, each claim line must be for a unique period. If any dates entered into a claim overlap or duplicate any other claim previously entered (including those entered on previously submitted 1500 Forms), the user will receive an error message and will be unable to proceed without correcting the error. The dates must fall within the authorized period and each line must fall within the same month; the user will receive an error if either of those is entered.

Procedure Code: A drop-down menu of the codes associated with the authorization number on the claim; if the service code for the authorization is a bundled code, the user must choose the appropriate sub-code or procedure code in this menu.

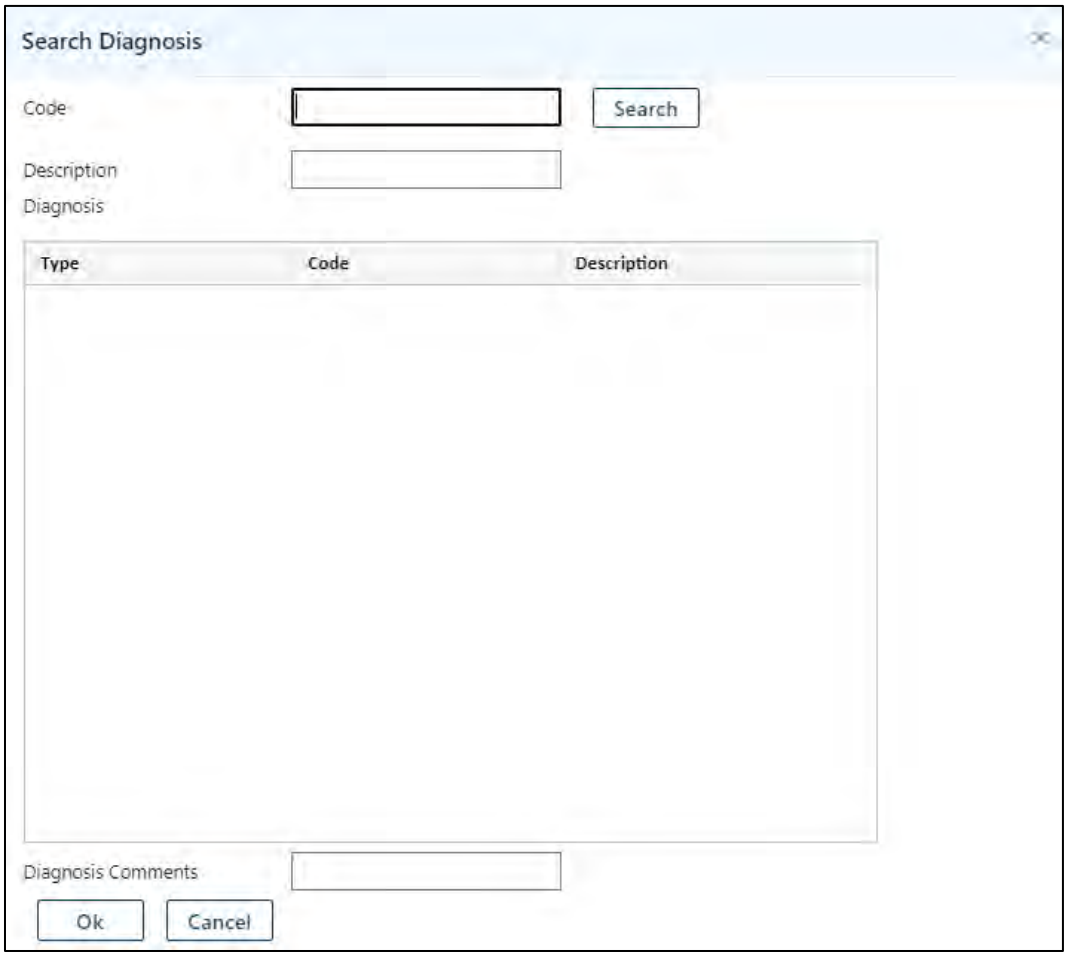
Total Charge: Total charge for the individual claim entered.

# of Units: Total number of units used during the timeframe for the claim.

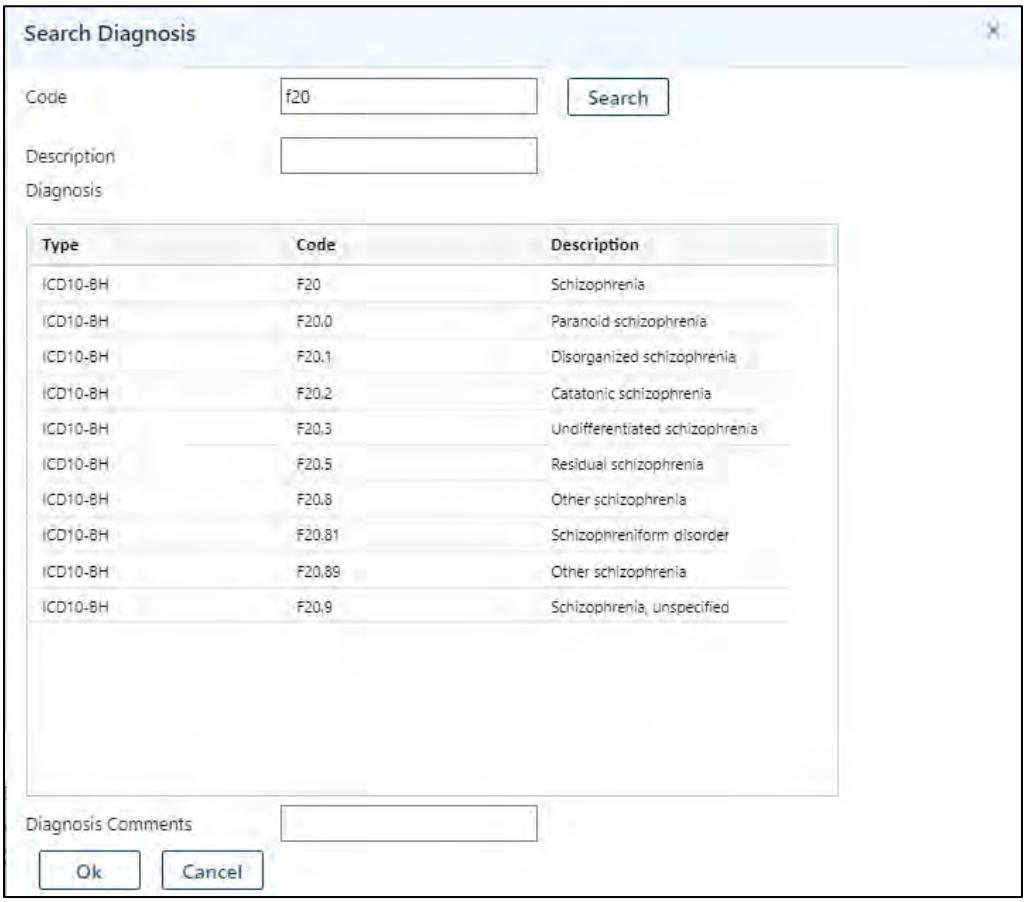
There are additional fields in the line of the claim for payment information; this will populate once the payment data is transferred into CYBER. This transfer occurs approximately 30 days after the payment have been made.

Add Diagnosis: Diagnosis (DX) information is now a required field for billing Wrap-Flex claims, except for Summer Camp providers. (For more details on how to enter the clinical diagnosis information into treatment plans and assessments, please reference the Instructional Guide for the Implementation of ICD-10 in CYBER document.)

By clicking on the Add Diagnosis button, it will bring up the Search Diagnosis window. User must first choose the type of Dx they are going to enter. Users will be able to choose from the ICD-10 codes and DSM-5 descriptions.

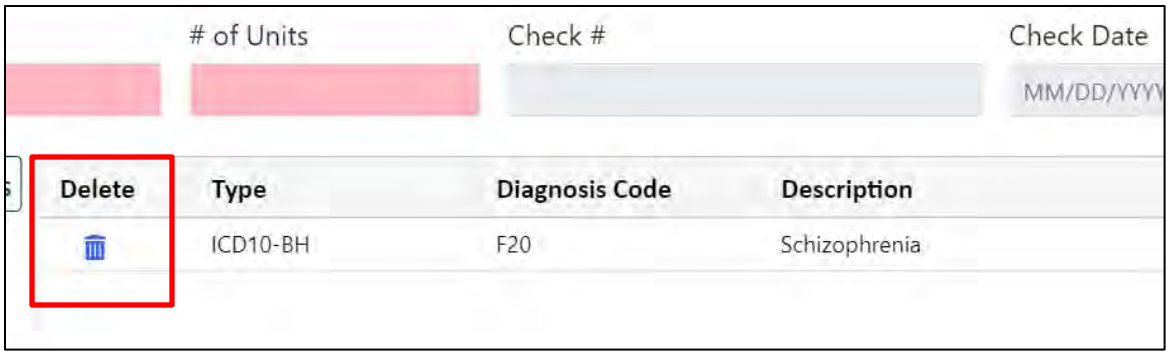


- The Type column will display ICD-10.
- The Diagnosis Code column will display the ICD-10 code.
- The Description will be the DSM-5 description; there will also be, when applicable, the ICD-9/DSM-IV code in parentheses at the end of the description for the user to cross-reference if necessary.
    - This will be useful in the cases when a user enters a DSM-IV/ICD-9 code as a search parameter.
- There is a new Diagnosis Comment field at the bottom of the window.
- Once the user single-clicks on a diagnosis record from the grid to add to the plan or assessment, they have the option of adding text into this field.
    - This field should be used for any specifying information that is not included in the ICD-10 and DSM-5 descriptor.



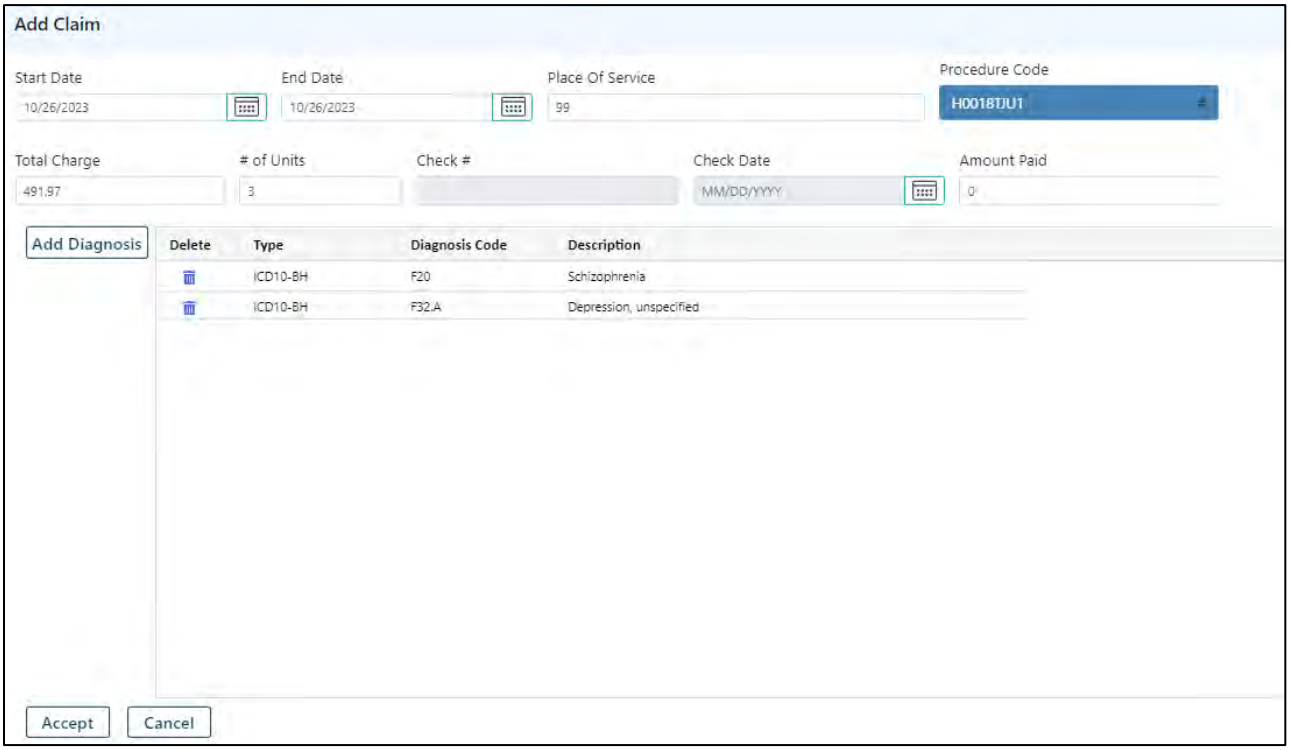
Partial searches are allowed; for example, a user can enter “F2” into the Code field and a list of all Diagnosis Codes that contain “F2” will appear in the Diagnosis grid. Users are encouraged to conduct a partial search unless they know the full code or description. If an incorrect data element is entered, the search will result in no matches.

Once the user enters data into one or both of the fields and clicks the Search button, the results will populate the grid. Single-clicking on a record and clicking the Ok button will place the diagnosis record onto the claim.



If a user incorrectly adds a diagnosis, they can select the trashcan delete button to remove the diagnosis from the grid.

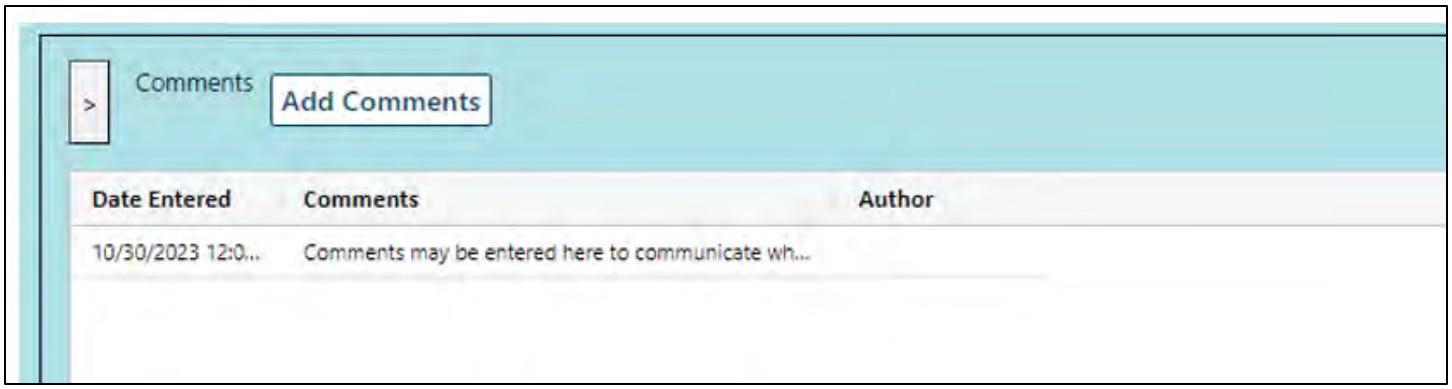
Users can add up to 12 diagnosis records onto each claim; if changes need to be made, a user can click on the line of the claim to edit/change the diagnosis code in claim. The diagnosis information that the user enters the first claim will transfer into any additional claims added to the 1500 Form; they will not transfer to a new 1500 Form.



**As on the paper version of the 1500 form, users can add up to six lines of dates of service to the 1500 Form; to add each date, the user will continue to use the Add Claim button.

The next area, Provider's Contact Information, is automatically pre-populated by the system. If any of this information is incorrect for an IIC provider, they will need to contact Medicaid (this information is automatically pulled into CYBER); if the information is for a Wrap-Flex provider, they will need to contact the PerformCare Service Desk for a correction to be made.

The Comments area will house any comments that have been entered on the Claim by either the provider or PerformCare CSA.

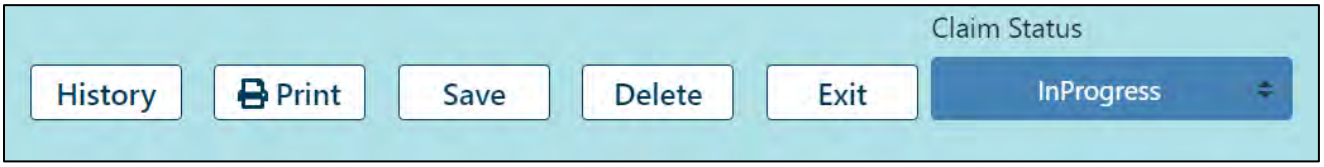


Comments may be entered here to communicate why a claim was returned; for example, if PerformCare finds that the youth was eligible for Medicaid when the services were rendered, that information will be documented here.

Please note: If the claim is submitted after 90 days from the last date of service, the user will receive a message from the system requesting a reason for or requesting justification the late submission. Additionally, users would need to upload an appeal letter to claim. Appeal letters should be typed on letterhead and uploaded into CYBER with supporting documentation. Upon submission of the claim appeal, a PerformCare Billing associate will change the status of claim to Review. PerformCare will review the appeal then make the recommendation to CSOC for a final decision.

Each 1500 form will have the following buttons at the bottom:

- History – when clicked, will populate a window that displays the history of the claim – the owners, the past and current status of the claim and the dates on which the status (or ownership) changed.
- Print – clicking here will bring up the reports window; it is recommended that users export to a PDF file before printing the claim form (see Printing). If the Claim is in draft/in progress, it will print with a "Draft" watermark; the Comments area of the claim will not print, as it is communication between the provider and PerformCare and not part of the claim itself.
- Save – it is recommended that the user saves often as they complete the form so that no information is lost should there be an interruption in internet service. The form will be saved in draft (In Progress) by default.
- Delete – only available for use when the claim is in draft or "In Progress"
- Exit – will exit the form without saving
- Claim Status – pull down menu options – In Progress/Submitted
  - In Progress – the form is in draft and is not submitted
  - Submitted – choosing this status will submit the claim to PerformCare



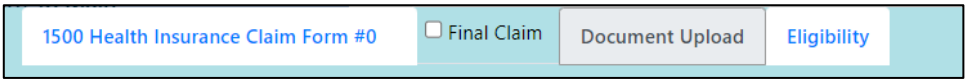
Please note – only users with a Manager (MGR) designation in their user profile can submit a claim

VI. Uploading Documents

There is a Document Upload tab at the top of the screen, next to the Claims tab. This area allows a user to upload documents to the youth's record, such as insurance documents and quotations (used for vehicle modifications, assistive devices, etc.).

Some providers will utilize this area to upload the documentation that is required to be included with their claim submission. Please note the following:

- IIC – SDED (mandatory)
- FSS – Time sheets (mandatory)
- Appeal letter (Wrap-Flex claims with DOS over 90 day)



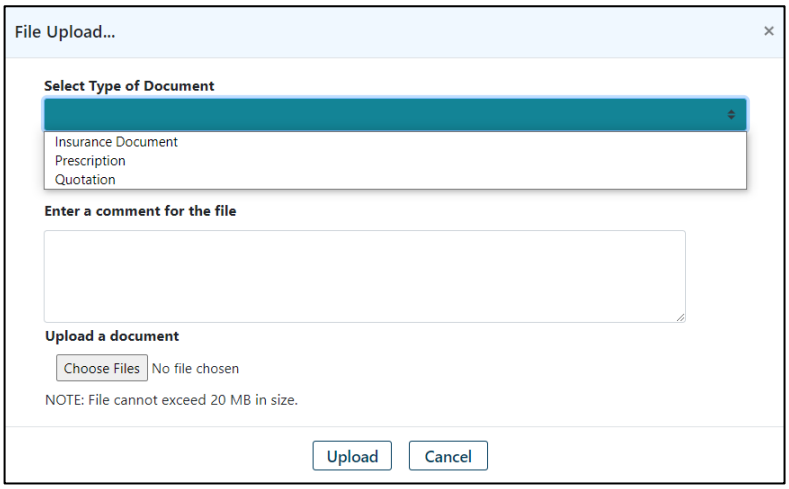
Note: In order to upload any documents to the claim, the user must first save the claim and then come to this tab to complete the upload.

If there are other documents uploaded to this Claim, they will be listed here. The user can delete documents only until the Claim has been submitted unless it has been returned.

Users can upload documents that are up to 4 MB in size; documents such as Word or PDF files, spreadsheets (Excel) and images (JPEG files) are the only file types that can be uploaded at this time. Clicking the Add New Document button will allow the user to choose the type of file to upload, and then browse for it on their system.

When uploading documentation, users must ensure that the document(s) does not contain PHI such as progress notes, session notes, etc. This is a HIPAA violation; the Billing & Eligibility Unit at PerformCare does not need that information to process the claim. If this type of documentation is uploaded along with the claim, the claim will be returned.

Once the type of document has been selected – which should be Insurance Document – the user must enter a description. It is recommended that users enter information such as the dates of service that the document includes. The user must then upload the file; clicking the "Choose File "button will bring up a window of the user's files from their computer.



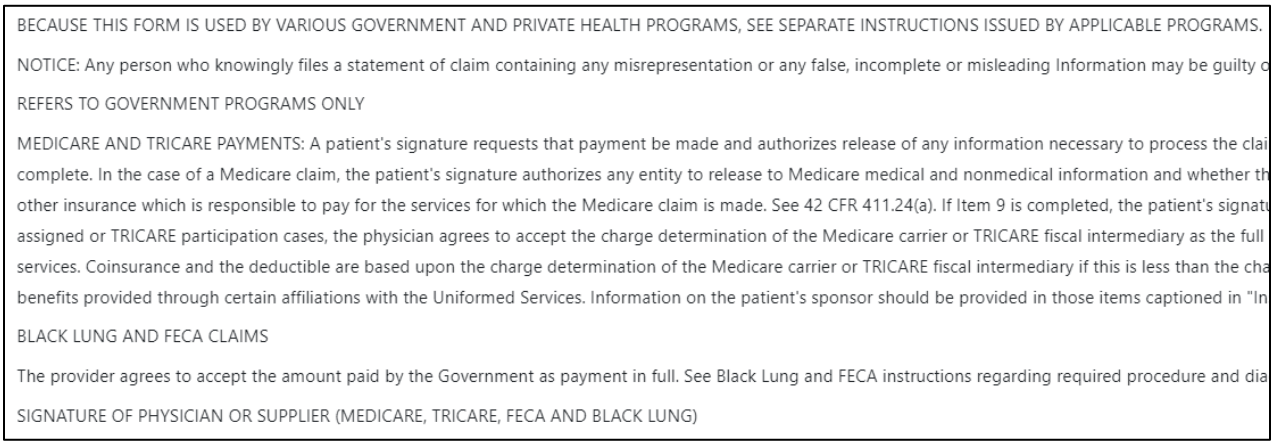
After selecting a file, the user will be able to "Upload" the file; the file name will appear. Once the user clicks the Upload button, the document uploads into the 1500 Form. In the "In Progress" status, the user can delete the claim, if necessary, by clicking the Delete button on the lower part of the claim. However, once the Wrap-Flex claim is Saved and Submitted to PerformCare, it does not allow users to delete the claim. If the claim is incorrect, a PerformCare Billing associate will

change the status of claim to Returned, which, will thereafter permit users to edit a line of the claim and resubmit the amended claim to PerformCare for review.

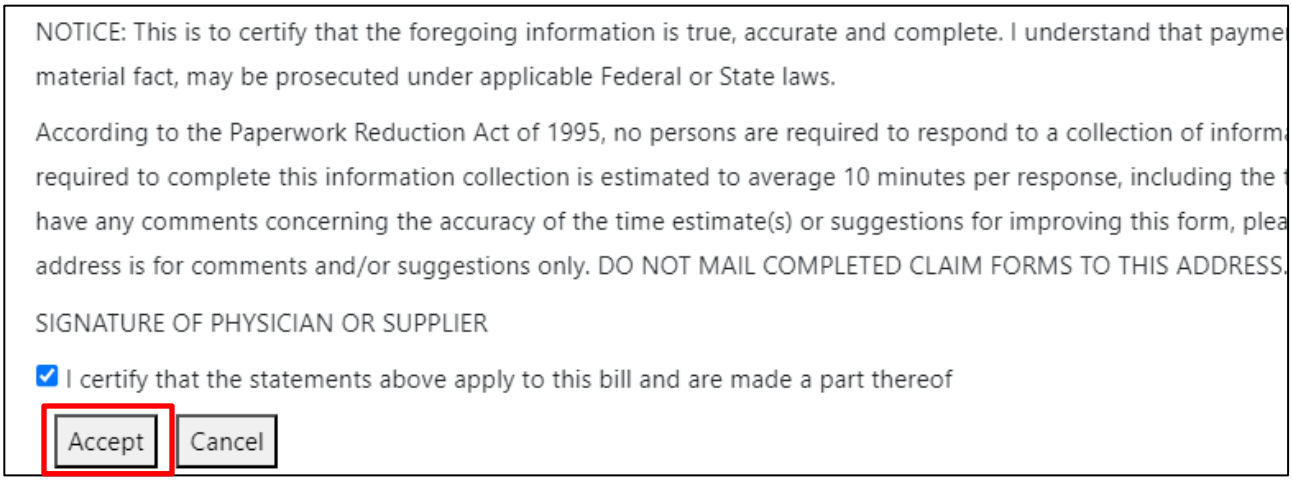
VII. Submitting Claims

Once the claim form has been completed, and documents uploaded as needed, the user can submit the claim for processing. With the 1500 Health Insurance Claim Form window activated, the user can navigate to the bottom of the window. Under the Claims Status drop down, the user can select “Submitted” from the list.

This will display the Certification window.



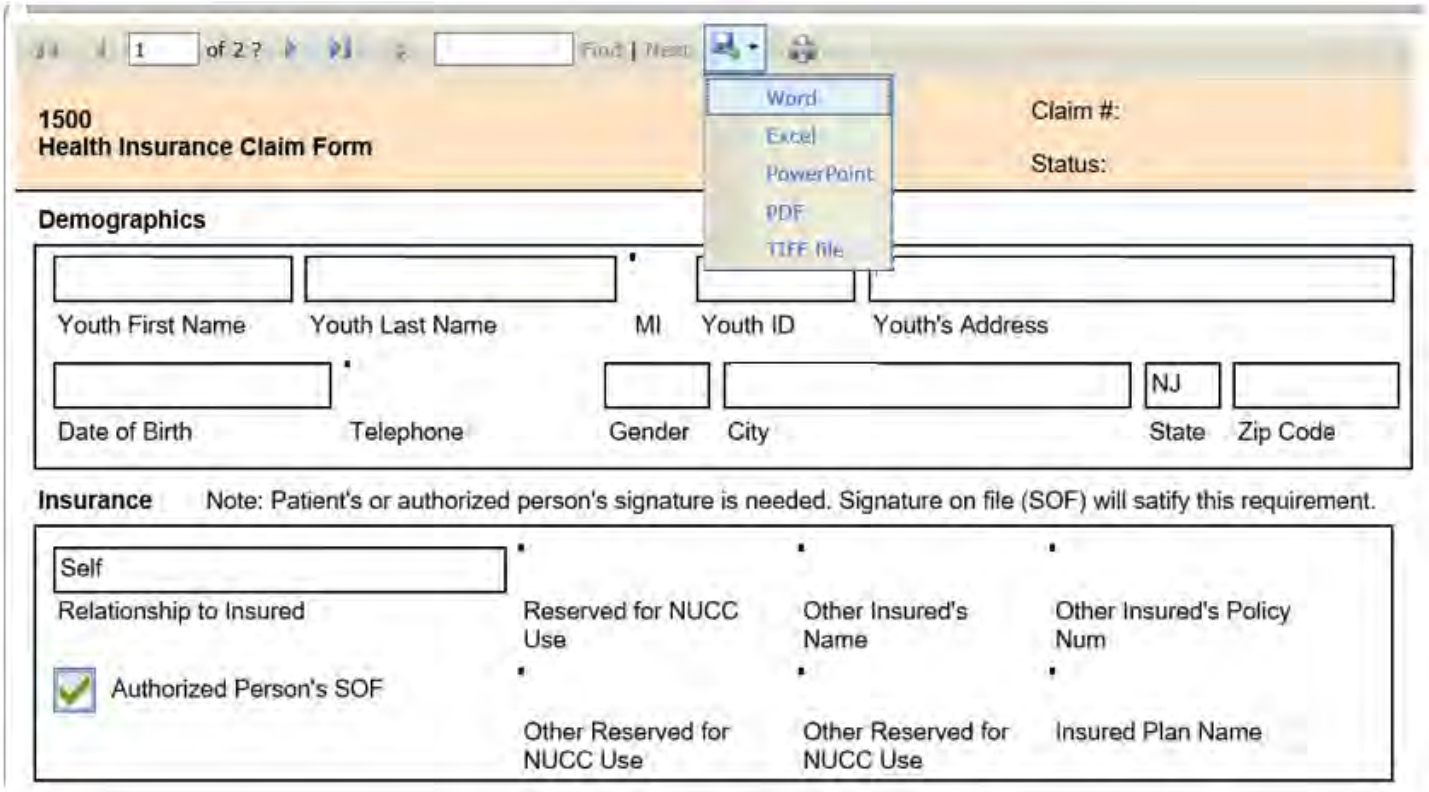
The user can scroll down to the bottom section of this document where the certification is located.



Here the user can click with the left mouse button to mark the check box. This will activate the “Accept” button which the user will click to certify the form. There is no need to save the 1500 form again. In addition, the claim will display under the Non-Med Claims () Submitted () grid when the user clicks this link on the Welcome Page.

VIII. Printing

Clicking the **Print** button at the bottom of the 1500 form will open the Reports window.



Once the report loads, the user has the option to print directly from CYBER using the print icon in the top right side of the window; it is recommended that users export to another format (typically PDF) before printing. Printing directly from CYBER can be a lengthy process.

Once the user has exported to another format, the document can then be printed or saved to the user's computer.

IX. References

PerformCare Website Training page: http://www.performcarenj.org/provider/training.aspx

Billing and Claims Training materials:

- 3560- & Third-Party Liability Data Collection in CYBER
    - http://www.performcarenj.org/pdf/provider/training/billing-claims/3560-tpl-data-collection-cyber.pdf
- IIC Billing Guide
    - https://www.performcarenj.org/pdf/provider/training/billing-claims/intensive-in-community-billing-guide.pdf

X. Appendix A

Acronyms and Definitions:

1500 Claim	Center for Medicare & Medicaid Services (CMS) federal claim form; used to submit claims against authorized service codes for services rendered.
BPS Assessment	Biopsychosocial Assessment
CME	Care Management Entity – Either CMO or MRSS
CMO	Care Management Organization
CSA	Contract System Administrator
DOS	Date of Service
DSM-5	Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5)-American Psychiatric Association
Dx	Acronym for 'Diagnosis Code'. A dx is a requirement in the CMS-1500 Claim Form. Diagnostic coding is the translation of written description of diseases illness and injuries into codes.
Eligibility	Assistance to cover services (in CYBER known as Medicaid, NJ Family Care, 3560, etc.)
ICD-10	The International Classification of Disease, Tenth Edition (ICD-10) is a clinical cataloging system (diagnostic codes). The ICD-10 is a morbidity classification published by the United States for classifying diagnosis and reason for visits in all health care settings.
Medicaid Claim	A claim that is submitted to Medicaid for services rendered when the youth has active Medicaid coverage for the authorized dates of service.
MRSS	Mobile Response and Stabilization Services
New Jersey State Medicaid fiscal agent	The organization that manages and processes Medicaid and Medicaid authorizations.
Prior Authorization Number	A computer generated, unique number that indicates an approved service code and units; this number is required to bill for services rendered.
Service Code/Procedure Code	Alphanumeric code that describes specific procedures and services (e.g. H0018TJU1).
Units	The quantity/block(s) of time approved during the prior authorization period. The total Units approved, and frequency are showing in CYBER and on the NJMMIS website.
Wrap-Flex	NJ State funds for youth enrolled in the CSOC; authorized for Behavioral/Mental health services and some Substance Use treatment.
Wrap-Flex claims	The term for non-Medicaid claims managed for youth authorized who are not enrolled in Care Management Entity. Wrap-flex claims are claims managed by the CSA for CSOC authorized services that are not Medicaid billable.

PerformCare Customer Service

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