

Frequently Asked Questions for Billing and Claims

What should I do if my claim was denied?

Submit your Remittance Advice (RA) with the following error code(s) to PerformCare Billing Unit for review. PerformCare will research and may be able to resolve the following rejection codes:

774 – PA not on file

775 – PA record on file is not active

779 – Medicaid PA number invalid

Please contact the Service Desk by email at servicedesk@performcarenj.org or by telephone at **1-877-736-9176**. Provide the youth's CYBER ID and the Prior Authorization number in your email or have it available when you call.

All other error codes **must** be directed to the Molina Medicaid Solutions system **first** for resolution by calling **1-800-776-6334**.

What does it mean when the status of a Prior Authorization in CYBER shows as PENDING, ACCEPTED or REJECTED?

CYBER PENDING status means the Prior Authorization was transmitted to the Molina Medicaid Solutions system. It takes one to two business days for processing and will then appear in CYBER as either ACCEPTED or REJECTED.

CYBER ACCEPTED status means the Prior Authorization transmitted to Molina Medicaid Solutions system has been accepted into the MEDICAID PA file. Claims can be submitted against the Prior Authorization immediately.

CYBER REJECTED status means the Prior Authorization transmitted to the Molina Medicaid Solutions system has discrepancies, such as an incorrect NJ FamilyCare (Medicaid) number for youth or a prior authorization issued to a provider at a different location.

Please contact the Service Desk by email at servicedesk@performcarenj.org or by telephone at **1-877-736-9176**. Please provide the youth's CYBER ID number and the Prior Authorization number in your email or have it available when you call.

What should I do if the NJ FamilyCare/3560 number is not attached to the Prior Authorization?

First, check the eligibility tab to confirm the correct number is showing with the correct start and end dates to cover the prior authorization. Next, check the prior authorization to view the authorization

status. Please note that it takes seven to 10 business days for the NJ FamilyCare/3560 number to attach to the authorization. PerformCare feeds authorizations to Molina on Tuesdays and Thursdays.

If the authorization still has not been sent after 10 days from the first day of service, please contact servicedesk@performcarenj.org.

What should I do if the Prior Authorization is attached to an inactive NJ FamilyCare/3560 number?

NJ FamilyCare/3560 benefit numbers (active and inactive) are cross-referenced in the Molina Medicaid Solutions system. Please submit your claims for payment using the active NJ FamilyCare/3560 number and contact PerformCare **only** if your claims are denied.

How do I request a Prior Authorization modification and how long it will take?

The provider should submit his or her request to the entity that completed the plan of care for the youth and requested the service. However, if the requester of the service was PerformCare, please forward your request to servicedesk@performcarenj.org with the following information:

- a) Provider name and ID.
- b) Prior Authorization number.
- c) What you are requesting to be modified (example dates, unit amounts).
- d) Justification for this request.

How can I obtain a retroactive authorization or service change?

A retroactive authorization is any service request not previously submitted through the appropriate and approved Treatment Plan or Assessment or with a start date more than seven business days earlier than the submitted date. If the youth is enrolled in a Care Management Organization (CMO) or Mobile Response Stabilization Services (MRSS) entity, then the provider should send his or her request to that care management entity.

If the youth was not enrolled with a CMO or MRSS, then the provider should submit the request to PerformCare at servicedesk@performcarenj.org for resolution. For any Prior Authorization that exceeds seven days, the requester must also provide an explanation for the lateness.

What should I do if the youth's NJ FamilyCare/3560 number does not appear in the Eligibility tab?

This means that when the youth was registered, the NJ FamilyCare/3560 number was not attached in the CYBER Management Information System (MIS). If you have the youth's NJ FamilyCare/3560 number, you may contact the Service Desk by email at servicedesk@performcarenj.org or by telephone at **1-877-736-9176**. Please provide the youth's CYBER ID in your email or have it available when you call.

If you do not have the number when you call or email, PerformCare can still attempt to locate the NJ FamilyCare/3560 number by reviewing the youth's eligibility information using the youth's name and date of birth.

How do I verify a youth's NJ FamilyCare/3560 number?

Contact the Molina Medicaid Solutions Recipient Eligibility Verification System (REVS) at **1-800-676-6562**. You should have available your seven-digit provider Medicaid ID number, the youth's date of birth and Social Security number, and the dates of service.

What is the procedure to submit non-NJ FamilyCare claims for youth who are not enrolled with a CMO or MRSS?

PerformCare will no longer process 1500 claim forms submitted on paper. To ensure prompt processing and payment of claims, please enter your claims through PerformCare CYBER MIS. You can find the instructional guide for entering claims into PerformCare CYBER MIS using the following link:

www.performcarenj.org/pdf/provider/training/billing-claims/instructional-guide-entering-claims.pdf

Only seasonal providers, such as Summer Camp and One-to-One Aides can send paper 1500 claim forms to PerformCare (specific billing instructions are sent via email to aforementioned providers).

Where can I print the Service Delivery Encounter Documentation (SDED) forms?

The SDED form is available through the Children's System of Care (CSOC) state website:

www.nj.gov/dcf/providers/csc/index.html

Do I need to complete an Electronic Data Interchange (EDI) request?

Providers are only required to complete the EDI request if they purchase software that will be used for claims submission. Per Molina Medicaid Solutions, the software company should inform the provider that they need an EDI authorization for submitting claims as part of their purchase. Providers cannot submit claims without this agreement with Molina in place. Please note that providers are not required to purchase software, as they can enter data directly through the New Jersey Medicaid Management Information System (NJMMIS).

What claims are paid out of PerformCare WrapFlex Funds?

Currently, PerformCare WrapFlex funds are used to pay claims for youth who are not enrolled in a CMO or MRSS entity. For youth who are not enrolled with a care management entity, PerformCare WrapFlex pays for services such as a therapeutic needs assessment and some Substance Use (SU) treatments for any youth who does not have a NJ FamilyCare/3560 number. It also reimburses entities for non-therapeutic interventions, such as translation or summer camp.

What is the 90-day rule for Wrap Flex claims submitted to PerformCare for reimbursement?

All claim forms with service dates older than 90 days will be rejected by PerformCare.

How long do I have to resubmit my returned claim?

All claim forms returned to providers for error correction must be resubmitted to PerformCare within the original 90 days from the earliest service date on the form. Late resubmissions will be rejected.

If my claim(s) are denied for late submission, how can I make an appeal?

Providers may submit a written appeal for denied claim(s) to PerformCare along with supporting documentation. Please upload into PerformCare CYBER MIS the written appeal in a letterhead format, along with an explanation in the Comment section of the electronic claim. PerformCare will review the appeal with supporting documentation and make a recommendation to CSOC for a final determination.

What claims are paid out of Substance Use (SU) Wrap Flex funds?

SU Wrap Flex funds are used to pay for Enhancement and Co-Occurring services for those youths who are not enrolled in an Out of Home (OOH) treatment facility.

What is the process for receiving a Wrap Flex payment?

For the Department of the Treasury to issue checks, providers must first submit a completed and signed W-9 Vendor Questionnaire to the New Jersey Department of Children and Families (DCF). The W-9 form is accessible online at www.state.nj.us/treasury/omb/forms/

The form must be mailed or faxed to:

DCF — Office of Accounting
P.O. Box 717
Trenton, New Jersey 08625

Fax: **1-609-633-8519**

PerformCare typically processes these claims 10 business days after submission by the provider. Approved WrapFlex invoices and claims information is forwarded to the New Jersey DCF Office of Accounting (OOA) for payment processing.

To view the status of a payment, providers can register through the State of New Jersey website. Go to www.state.nj.us. Click on "Register" and follow the prompts. When the provider has completed registration, he or she can log in to the website with their log-on ID and password, and the Vendor Payment Inquiry should appear on the "MY New Jersey" home page.

Using their provider federal identification numbers, providers can search for payments issued for a selected time period. To match the payments to the youth by the reference used by the Office of Accounting, just add the PerformCare authorization number and dates of services, e.g., 153xxxxxx 070113.

What should I do if I cannot locate a 3560 number in CYBER after the 3560 eligibility application has been approved?

The 3560 number should appear in the CYBER eligibility tab within five to seven business days after the approval date on the 3560 application. If the number does not appear in the eligibility tab after seven business days, please contact PerformCare at servicedesk@performcarenj.org with the provider name and ID and the youth's CYBER ID number.

How can I obtain a 3560 number to cover an eligibility gap for youth newly referred to CMO or MRSS?

PerformCare may issue a 3560 number to cover a gap of one to 30 days in eligibility at the beginning of the referral period to CMO or MRSS. The provider of the service should contact the CMO or MRSS to assist the provider in obtaining this eligibility gap coverage. Any additional gaps in coverage require the CMO or MRSS entity to complete a new 3560 application.

How can I be paid for Outpatient Services when the 3560 number is terminated?

Outpatient services can only be billed against an active 3560 number. When Outpatient Services are approved as a part of the Transition plan as the youth is closing to CMO or MRSS services, the Care Management Entity (CME) must ensure that the plan is sustainable and that the payment source is defined. If there is an approved authorization in CYBER MIS for Outpatient Services and the youth transitions before that end date, the Outpatient provider will only be able to bill on that authorization until the 3560 is closed, at which time the provider and family will need to identify a different payment source.

What is the process for requesting a Missing Days Authorization?

A Missing Days authorization is one that covers up to a five-day period where a youth has left an Out of Home Care program. The authorization allows the provider to keep a bed open for that same youth to return within the five-day period. Any Out of Home Care provider can request a Missing Days Authorization.

- i. The program must enter a progress note in CYBER confirming the date the youth left the facility.
- ii. The request may be called in to Member Services at **1-877-652-7624** or emailed to servicedesk@performcarenj.org by the facility. The authorization should be requested on the day the youth returns or on the end of the fifth day after the youth leaves the facility, whichever is less. This allows PerformCare to create the Missing Days Authorization with the correct number of days needed.
- iii. If the youth does not return to the program, the Out of Home Care provider can discharge the youth after the end of the fifth day.
- iv. The program should communicate the authorization request to billing staff so it may be billed appropriately. The Missing Days Authorization service code is **H2020HA**.

How many Biopsychosocial Assessments are billable per year?

A maximum of two Biopsychosocial Assessments per beneficiary are billable per rolling period of 365 days.

What is ICD-10?

The International Classification of Disease, Tenth Edition, (ICD-10) is a clinical cataloging system (diagnostic codes), which went into effect for the U.S. health care industry on October 1, 2015. The ICD-10 is a morbidity classification published by the United States for classifying diagnoses and reasons for visits in all health care settings.

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10 Clinical Modification (ICD-10-CM): the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare & Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

Are ICD-10 codes required in my claims?

Yes. Please note that ICD-10 is an updated version of the ICD-9 code sets.

What is the 35605 number?

35605 is a NJ FamilyCare (Medicaid) look-alike number to be used only by Family Support Service (FSS) providers for respite services when submitting claims to Molina Medicaid Solutions. You can identify the 35605 by the fifth digit, which will always be the number 5.

What does the 35605 number cover?

The 35605 number **only** covers respite services for youth (up to age 21) who are determined to be Intellectual/Developmentally Disabled (I/DD) and accessing the Children's System of Care (CSOC). Please note, the 35605 number does not include a medical package (e.g. hospital, physician, dental, vision, or prescriptions). Additionally, the 35605 number does not cover WrapFlex services such as CMO, MRSS, OOH, or certain Substance Use (SU) treatment services.

PerformCare operates 24 hours a day, 7 days a week, and 365 days a year. For billing inquiries, please submit a work order via servicedesk@performcarenj.org and it will be assigned and researched by a Billing and Claims associate.