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Instructional Guide
for
Intensive In-Community (IIC)
Billing

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Instructions for IIC Billing

Table of Contents

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I. Introduction and Background

The New Jersey Children's System of Care (CSOC) services are authorized by the **Contracted System Administrator (CSA),** PerformCare New Jersey. Each service code is assigned a unique prior authorization number for billing purposes. This instructional guide is customized for Intensive In-Community (IIC) providers to assist in billing the rendered authorized CSOC services. There are two types of prior authorizations that IIC providers may potentially bill: Medicaid authorization(s) and non-Medicaid authorizations. Both Medicaid and non-Medicaid authorizations are required to be submitted for reimbursement on a 1500 Health Insurance Claim form. This guide will provide the following instructions:

- Reviewing the prior authorization information,
- Verifying youth's eligibility,
- Handling and differentiating between Medicaid claim(s) and non-Medicaid claim(s),
- Billing 1500 Claim forms properly.

Included is a hyperlink to the instructional guide on how to submit the electronic 1500 Claim form via CYBER, an outline on uploading the Service Delivery Encounter Documentation (SDED) form, and the definition of each 1500 Claim form status for users to track their completed claim form within CYBER Management Information System (MIS). Additionally, this document discusses how to register with the NJ Department of Treasury, as well as the procedure for locating payment & appeal information.
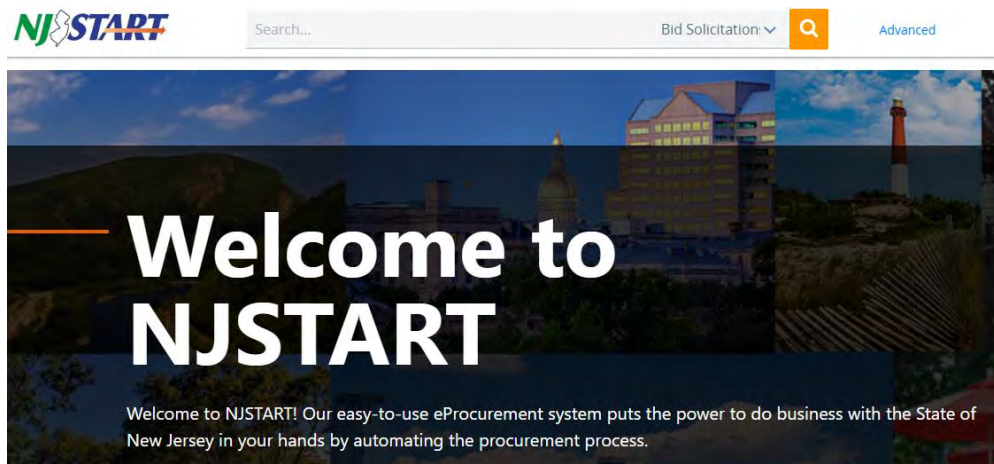
Acronyms and Definitions:

3560	Medicaid 'look-alike' that acts just as a NJ FamilyCare Medicaid eligibility number; **Except,** it only covers authorized services for youth active in CSOC. 3560 is payer of last resort and only a Care Management Entity (CMO/MRSS) can apply for 3560 number.
3560-5xxx	This eligibility number ONLY covers FSS services for Developmentally Disabled (DD) determined youth.
1500 Claim	Center for Medicare & Medicaid Services (CMS) federal claim form; used to bill indicated units for authorized service code(s).
DOS	Date of Service
BPS Assessment	Biopsychosocial/Assessment
CME	Care Management Entity – Either CMO or MRSS
CMO	Care Management Organization
CSA	Contracted System Administrator
Eligibility	A youth that has coverage such as Medicaid (NJ Family Care) or 3560 eligibility number…etc.
FSS	**Family Support Services** – Services available to youth who determined DD Eligible. Services included assistive technology, educational advocacy, and respite.
Medicaid Fiscal Agent	The New Jersey Medicaid fiscal federal agent
MRSS	Mobile Response and Stabilization Services
NJ FamilyCare	An insurance program for youth & low-income families in New Jersey
Medicaid Claim	Youth that has an active (Medicaid/NJ FamilyCare) eligibility number that covers the date of service on claim.
NJ Start.Gov	New site to be established in the Treasury Registration system. In lieu of the W-9 form new providers must register NJ Start.Gov for payment of Wrap Flex/non-Medicaid claims.
Non-Med	Non-Medicaid youth that do not have Medicaid coverage and may potentially qualify for Wrap Flex funds
PA	**Prior Authorization Number** - A computer generated and unique number that indicates approved service code and units; this number is required to bill for services rendered.
Service Code	Describe specific procedures and services in an alpha and numeric cipher (i.e. H0018TJU1).
Turn-Back	Cancellation of authorized service (i.e. unable to staff prior authorization BPS assessment).

Units	The quantity block(s) of time approved during the prior authorization period. The total Units approved & frequency are indicated 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.

Provider Setup Process

For checks to be issued from the Department of Treasury, providers **must be established on the State of New Jersey Accounting System.** Providers must register with the DCF State of New Jersey Accounting System by completing registration or updating information in NJ START.Gov website and obtain a vendor ID#. In lieu of the W-9 form, providers can register at https://www.njstart.gov/bso/. Also, providers may setup Direct Deposit in NJ START.Gov.
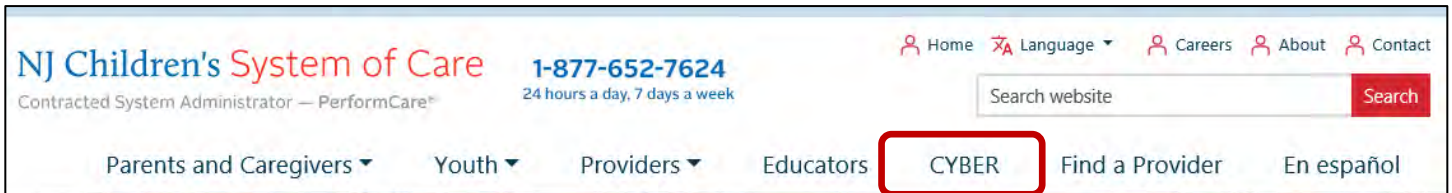
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Any further assistance on **NJ Start.Gov** can be received at the technical support hotline (609) 341-3500.

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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.

NJ Children's System of Care
Contracted System Administrator — PerformCare®

1-877-652-7624
24 hours a day, 7 days a week

Home | Language ▾ | Careers | About | Contact

Search website | Search

Parents and Caregivers ▾ | Youth ▾ | Providers ▾ | Educators | CYBER | Find a Provider | En español

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.

Providers
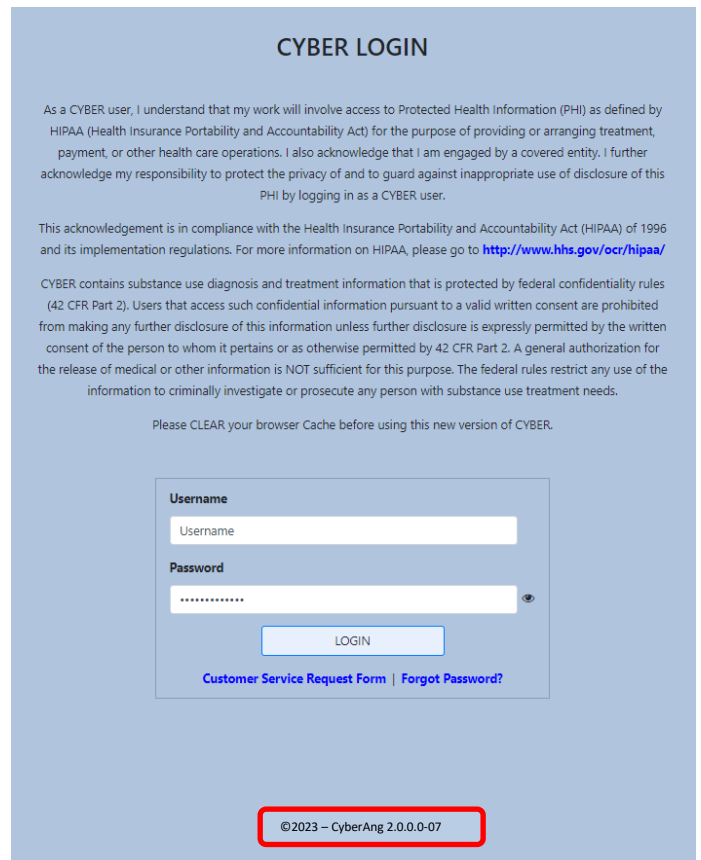
Launch CYBER

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.

CYBER LOGIN

As a CYBER user, I understand that my work will involve access to Protected Health Information (PHI) as defined by HIPAA (Health Insurance Portability and Accountability Act) for the purpose of providing or arranging treatment, payment, or other health care operations. I also acknowledge that I am engaged by a covered entity. I further acknowledge my responsibility to protect the privacy of and to guard against inappropriate use of disclosure of this PHI by logging in as a CYBER user.

This acknowledgement is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementation regulations. For more information on HIPAA, please go to **http://www.hhs.gov/ocr/hipaa/**

CYBER contains substance use diagnosis and treatment information that is protected by federal confidentiality rules (42 CFR Part 2). Users that access such confidential information pursuant to a valid written consent are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any person with substance use treatment needs.

Please CLEAR your browser Cache before using this new version of CYBER.

Username

Username

Password

LOGIN

Customer Service Request Form | Forgot Password?

©2023 – CyberAng 2.0.0.0-07

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

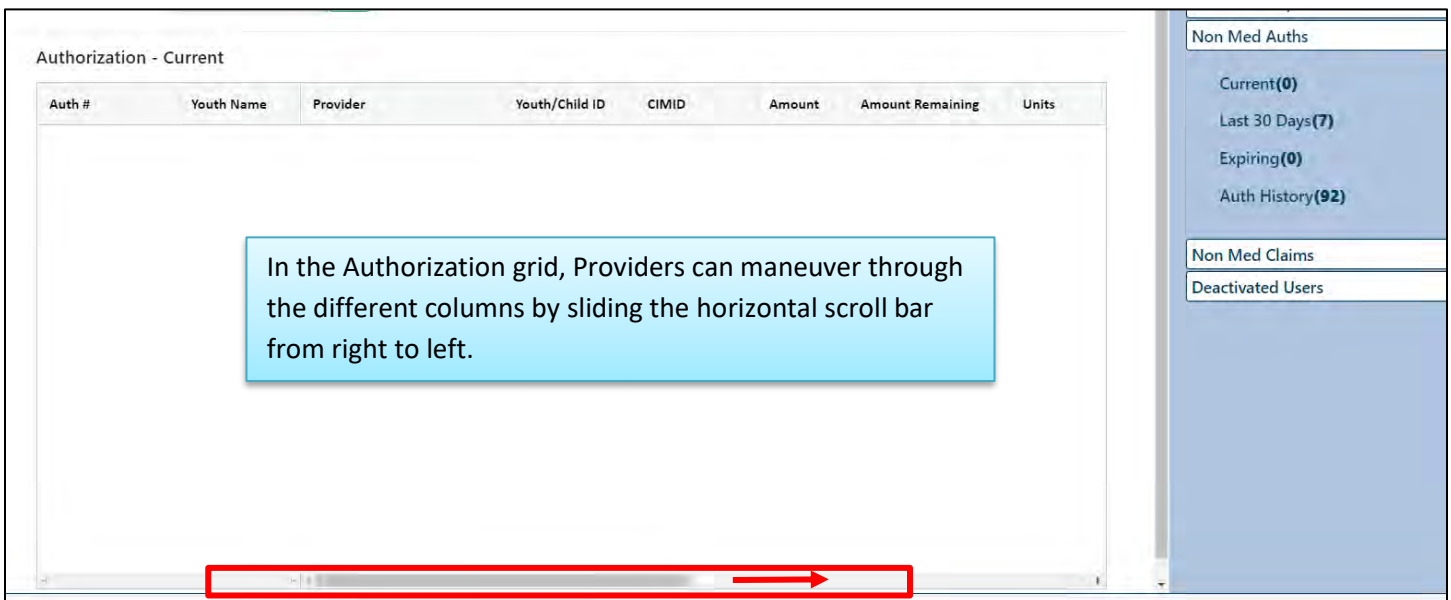# III. Prior Authorizations, Modifications and Suspensions

Prior Authorization Information

All New Jersey Intensive In-Community (IIC) services (i.e. behavioral health, biopsychosocial assessments, developmental & intellectual disability) require a Children System of Care (CSOC) prior authorization number that must be approved by the CSA **PerformCare New Jersey**.

IIC providers may refer to the CYBER **Welcome Page** to see all the currently approved non-Medicaid and Medicaid prior authorization numbers. From the Welcome Page under the **Non-Med Auths** users must click on the '**Current**' hyperlink for a list of approved non- Medicaid prior authorization number(s). The center grid will populate with this information.
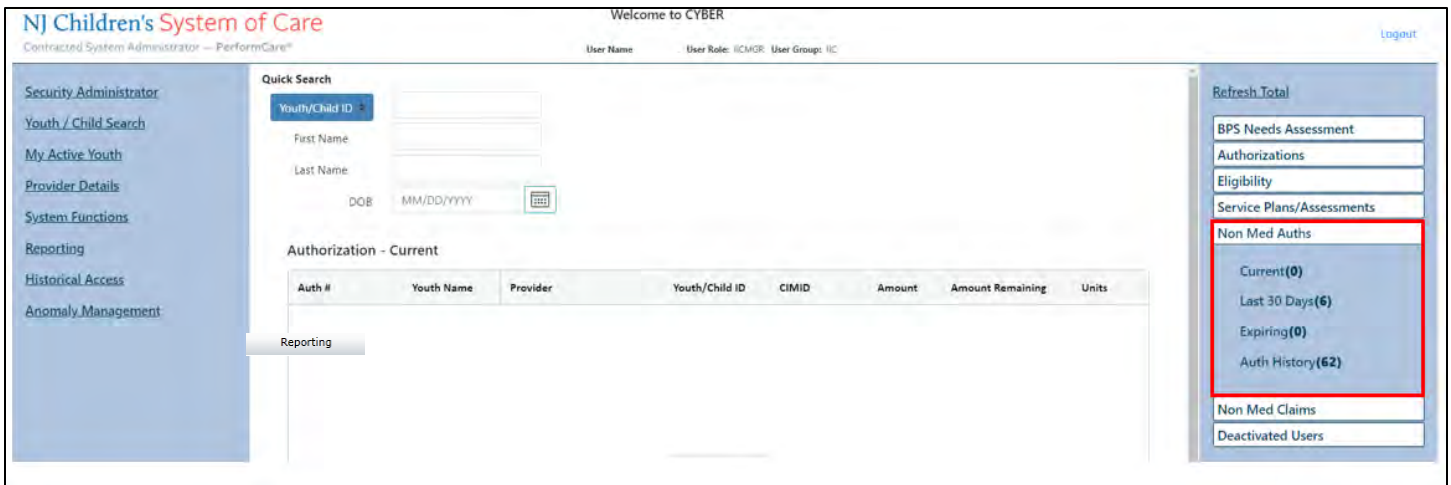
The **Auth#** is a hyperlink to connect to the **Authorization Details** window, which displays details of the approved service code.

In the Authorization grid, Providers can maneuver through the different columns by sliding the horizontal scroll bar from right to left.

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Level 3 Security Access users may view approved Medicaid (only) authorizations using the '**Reporting**' button located on the bottom left side of the Welcome Page.

Security Administrator

Youth / Child Search

My Active Youth

Provider Details

System Functions

Reporting

Historical Access

Once the user selects the program and the report **0060 -NJ1199 _Provider Authorizations** then clicks View Report the Medicaid authorizations will be displayed. *Note: Only users with **Level 3** security access can see this area of CYBER.*

The user can then select the date range for the authorizations they would like to view. "**NJ1199- Provider Authorizations**" report shows Medicaid Prior authorizations in the same categories as the Welcome Page (Current, Last 30 Days, Expiring and Auth History).

Once PerformCare has authorized a service, the IIC provider/agency may conduct that service as warranted.

The specific prior authorization information including service codes and its description are in CYBER for providers' view. In addition, an approval letter with authorization details will be mailed to the family.

6

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Prior Authorization Status (AUTHSTATUS)

The provider can check for the prior authorization number status (AUTHSTATUS) within the Authorizations on File grid of the youth's record in CYBER. To access the Authorizations on File, click on the CYBER ID# hyperlink (blue) from the Welcome Page in CYBER, and it will connect to the youth's Face Sheet; then click the Authorizations button on the left side of CYBER screen. In the Authorizations on File grid users are able to view authorization details and Auth Status.

Auth Status indicates whether the prior authorization number (with Medicaid eligibility) was transmitted and accepted by the NJMMIS (New Jersey Medicaid Management Information System). This also displays the non-Medicaid prior authorization status, which is viewed as UNSENT in CYBER. If the Medicaid authorization still has not been sent after 7 days from the authorization creation date, please submit your request using the Customer Service Request Form.

(AUTHNUM) - The Prior Authorization number (...ie.153xxxxxx)

AUTH STATUS – Medicaid Prior Authorization number status in CYBER.

Prior Authorization Numbers Status Types in CYBER

'**PENDING**' - the prior authorization is in the process of transmittal to Medicaid fiscal agent. It takes one to two business days for the system to process the prior authorization, which will then appear in CYBER as either 'accepted' or 'rejected.'

'**ACCEPTED**' - the prior authorization transmitted to the Medicaid fiscal agent has been accepted into the 'Medicaid PA' file. Claims can be submitted against the prior authorization immediately.

'**REJECTED**' - the prior authorization was transmitted to the Medicaid system, in which it will appear in CYBER with three-digit rejection code (such as REJECTED 402) that may indicate potential discrepancy, such as, an issued prior authorization number that has dates overlapping with another existing prior authorization numbers.

'**UNSENT**' - the prior authorization number did not transmit into the Medicaid system due to lack of Medicaid eligibility number at the start of the authorization period.

Providers should allow up to seven business days from the prior authorization number creation date for **ANY AND ALL** authorization(s) to transmit into the Medicaid fiscal agent. PerformCare transmits authorizations to the Medicaid fiscal agent on Tuesdays and Thursdays ONLY.

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Authorization Modification Process

In the event that a prior authorization needs to be modified, the IIC provider should submit a request to the entity (for example, CMO/MRSS) that completed the plan of care for the youth and requested the service. If the requester of the service was PerformCare, please submit your request using the <u>Customer Service Request Form</u> with the following information:

- Provider name and ID.
- Prior authorization number.
- What you are requesting to be modified (example dates, unit amounts).
- Reason for this request.

If a modification of a BPS authorization is needed, for example the assessment was unable to be completed within the authorization period; the provider is unable to make that request. In these circumstances, the family must outreach to PerformCare to complete a new triage. Based on information gathered, if the BPS Assessment is still the most appropriate service, a new BPS assessment will be authorized.

Suspension of Authorization Process

An authorization suspension is the cancellation that makes the authorization invalid for billing.

<u>PerformCare will suspend an authorization based on the following criteria:</u>

- Overlap authorization
- Duplicate authorization
- Services not provided
- Turn-Backs

In the event an agency is authorized a BPS assessment that they are unable to staff, they are to turn back the referral within **three (3) business days** so the family may select a different agency and receive a timely assessment. The agency may request a turn-back by calling PerformCare at 877-652-7624 or calling/emailing PerformCare's Service Desk (877-736-9176/servicedesk@performcare.org). The agency will need to provide the youth's CYBER ID and indicate their inability to deliver a timely BPS. Additionally, the provider must also enter a progress note in CYBER verifying that they are unable to staff the referral and they have contacted PerformCare via phone or email for advisement.

IV. Determining Eligibility

The first step of the claims process is determining whether the youth has active eligibility coverage such as a Medicaid (NJ FamilyCare), 3560 number and/or is enrolled with CMO/ MRSS during the approved authorization period. It is important to verify the youth eligibility with every prior authorization receipt. The youth may potentially be eligible for Medicaid; however, not every approved authorization assigned to a youth may have Medicaid coverage. As a result, all youth with prior authorizations should be checked for eligibility.

The youth must have eligibility coverage at the start of the prior authorization period) in order to be considered a **Medicaid** authorization. The prior authorization number(s) that have Medicaid eligibility are auto transmitted from PerformCare NJ to Medicaid fiscal agent for adjudication and payment of claims.

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The provider/agency can verify if the youth has Medicaid eligibility by calling the **Recipient Eligibility Verification System (REVS)** at 800-676-6562. Provider should follow prompts and have the following information available: Provider's 7-digit Medicaid ID number, the youth's date of birth (8-digit format), social security number and the dates of service (6-digit format). The REVS will state the youth's first & last name, Medicaid eligibility number and indicate the specific dates of Medicaid coverage.

For further details on Medicaid eligibility information (i.e., NJ FamilyCare, 3560 number, etc.), providers can also confirm eligibility by logging into the **New Jersey Medicaid Management Information System (NJMMIS)** website. If the youth have an active Medicaid number, the NJMMIS website will show and specify: the youth first & last name, type of coverage, total approved units, its frequency, Medicaid eligibility number and the eligibility segment effective date and end date. In order to log into **www.njmmis.com** website providers should reference the enrollment notice from DMAHS's fiscal agent for the provider **username** and **password**, which will allow providers to review claims and youth Medicaid eligibility.
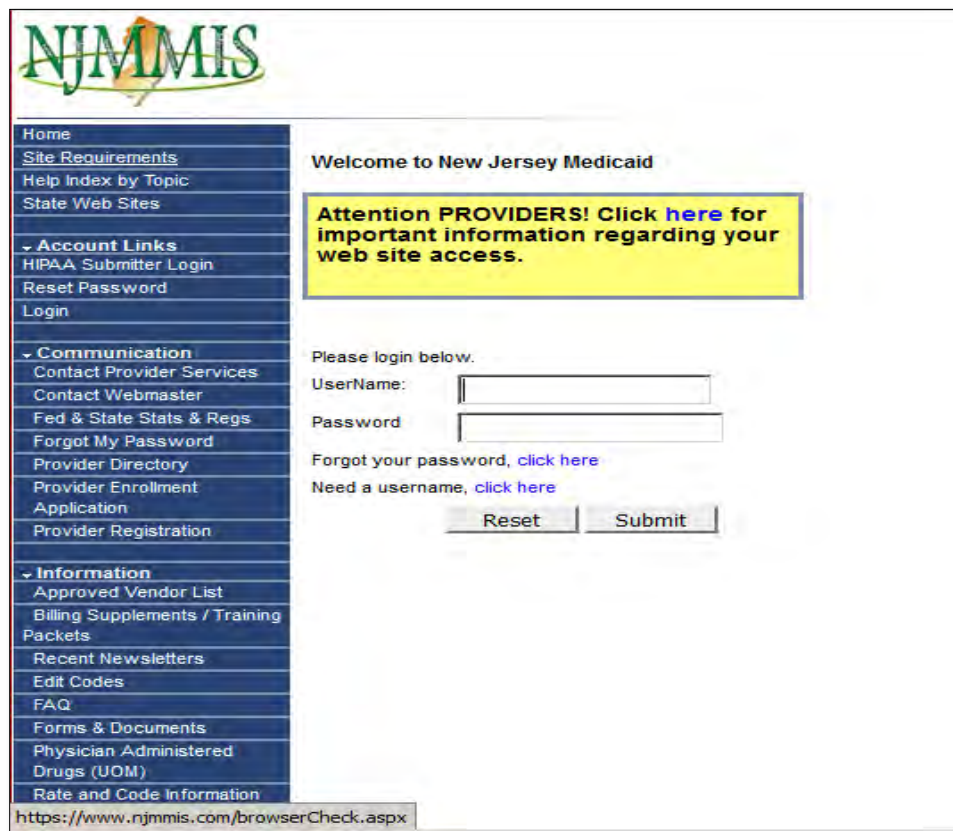
Once eligibility is established and the dates of service are covered on claims, providers can bill the Medicaid claims for payment. In addition, the provider should view the authorization status in CYBER to assure when the prior authorization number was transmitted into the Medicaid system (refer to page 6).

When youth does not have Medicaid eligibility and is active with CMO/MRSS, the Care Management Entity (CME) is responsible for obtaining coverage for the youth. The IIC provider should contact the CME to apply for coverage such as Medicaid (NJ FamilyCare) or payer of last resort 3560 number.

If there is no active Medicaid eligibility, number found in the NJMMIS website or REVS this suggests that youth does not have Medicaid eligibility coverage for the period of the authorization number. This designates the prior authorization

9

number as a **non-Medicaid**. Therefore, non-Medicaid prior authorization numbers without an active CMO/MRSS should be billed to PerformCare. Upon appropriate rendering of the authorized service, such as a (H0018TJU1- License level) BPS, the provider may begin the claims process.

V. Submitting Claims

The 1500 Health Insurance Claim Form is a Center for Medicare & Medicaid Services (CMS) federal claim form to allow reimbursement of authorized rendered services.

ICD-10CM Information the International Classification of Disease, Tenth Edition Clinical Modification (ICD-10CM) is required for all Intensive In-Community services including needs assessments on a 1500 Claim form. ICD-10CM is a clinical cataloging system (diagnostic codes), which went into effect for the U.S. health care industry on October 1, 2015.

The ICD-10CM is a morbidity classification published by the United States for classifying diagnoses and reasons for visits in all health care settings and is an updated version of the ICD-9CM code sets. Please note ICD-10CM codes are updated annually.

'The ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. WHO has authorized the development of an adaptation of ICD-10 for use in the United States for U.S. government purposes'
https://www.cdc.gov/nchs/icd/icd10cm.htm.

Submitting Medicaid Claims

Provider can submit the **Medicaid claim(s)** for youth (with Medicaid eligibility that covers date of service) to the Medicaid Fiscal Agent, for payment. IIC providers can reference the enrollment notice from Medicaid, which will give providers a username and password to the **www.njmmis.com** website to review claims and recipient eligibility. The Medicaid fiscal agent conducts Medicaid billing training that is available for providers, by contacting Provider Relations at **1-800-776-6334**.

Claim 'Rejections' from Medicaid

Only submit your remittance advice (RA) with the following error codes to PerformCare Billing Unit for review. Contact PerformCare Service Desk and provide the youth's CYBER ID and the prior authorization number in your email or have it available when you call. PerformCare will research and may be able to resolve the following rejection codes:

- 774 — Prior authorization not on file.
- 775 — Prior authorization record on file is not active.
- 779 — Medicaid prior authorization number invalid.
  All other error codes **must** be directed to Medicaid system **first** for resolution.

Wrap Flex (non-Medicaid) Funded Claim

Non-Medicaid authorizations (i.e. BPS/Mentor/Interpreter services) may qualify for NJ State Wrap Flex funds, which are formally known as Wrap Flex claims. Wrap Flex claims are billed to PerformCare for youth that does NOT have CMO/MRSS and/or an active Medicaid (NJ FamilyCare/3560) coverage. Providers can electronically submit to PerformCare a virtual 1500 Claim form for Wrap Flex funds thru CYBER.

Only seasonal providers are exempt from electronic billing, such as summer camp and one-to-one aides; these providers can send Wrap Flex (non-Medicaid) paper 1500 Claim forms to PerformCare by mail (specific billing instructions are sent via email to these qualified summer camp providers).

Please note: a maximum of two biopsychosocial needs assessments (H00TJ18U1) per youth can be billed per rolling period of 365 days.

Submitting 1500 Claim Form to PerformCare via CYBER

Once established that youth does not have Medicaid coverage and the claim is a Wrap Flex funded, the provider can submit a 1500 Claim form to PerformCare via CYBER. This 1500 Claim form is simulated into the CYBER Management Information System for individuals (such as providers with the proper security (Manager) attached to their User ID) to have the availability to submit the Wrap Flex funded claims electronically via CYBER.

Individuals who are designated as 'MGR' or Manager level users in CYBER have access to the 1500 Claim form and the ability to complete and submit the Form for payment. *Note: IIC providers are required to upload documentation to support their claims (for example, the encounter forms).*

To bill non-Medicaid Wrap Flex claims through CYBER, please follow this check list:

☐	1. Please assure that all required fields of the 1500 Claim form are complete as described in the Instructional guide.
☐	2. Upload the **Invoice/SDED form** (as required) to the electronic 1500 Claim form. See the following section for information on the SDED.
☐	3. Click on claim status **'Submitted'** to successfully send 1500 Claim form electronically to PerformCare via CYBER.
☐	4. Submit to PerformCare your billing within 90 calendar days of the last date the services were rendered. (Claims over 90 days from the last date of service needs to follow the appeal process)

Do not wait several months before submission of billing.

Specific steps on how to get to the Instructional Guide for Entering Claims (1500 forms) into CYBER:

1. From the PerformCare website**: http://www.performcarenj.org/**
2. Click the Providers Tab to access the Providers page and then click the Training hyperlink in the left side of page
3. On the Training page, click the Billing and Claims section, and then click the View Session & Documents link
4. Click the 'Entering Claims (PDF)' link - *Instructional Guide for Entering Claims (CMS 1500 forms)*

You can find the Instructional Guide for Entering Claims (1500 forms) into CYBER using the following link: http://www.performcarenj.org/pdf/provider/training/billing-claims/instructional-guide-entering-claims.pdf

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Encounter Forms: Service Delivery Encounter Documentation (SDED)

The Service Delivery Encounter Documentation form (informally known as Encounter form) is required for all IIC claims. The SDED form is available through the Children's System of Care (CSOC) state website.

For Wrap Flex claims, the two-page SDED form must be completed and uploaded into the electronic 1500 claim form via CYBER for review. Please note all the dates on the SDED form must match the date of service on claim.

The following is an example Service Delivery Encounter Documentation (SDED) form:

The following hyperlink will take users to the **instructions on how to complete a Service Delivery Encounter Documentation (SDED) form:** https://www.state.nj.us/dcf/providers/csc/ServiceDeliveryDocumentation.pdf.

Access to CYBER 1500 Claim Form

To access the electronic 1500 claim form users may click on the **Non Med Authorizations** section on the right side of the CYBER Welcome Page. Click on the **Current** link in order to view a list of approved prior authorization numbers that are available for billing.

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Completed 1500 Claim Form in CYBER

1500 Claim form number
(i.e. Claim#)

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Authorization Details Screen

Once the claim is submitted successfully through CYBER to the PerformCare Billing Unit for review; users can track a claim status via the links in the **Claims** area on their Welcome Page and on the Authorization Details window.

Selecting the **Authorization #** hyperlink, will bring the user to the Authorization Details screen

The Authorization Details screen will show all the created and/or submitted claims belonging to the authorization. Thus, multiple claim numbers may appear in the Authorization Details window. i.e., for every new electronic 1500 claim form created, a different number will be assigned to claim.

Authorized Units and Frequency

Check# and **Check Date**

This posting payment information shows the Check number and Check date, which is also indicated on each line of the **'Paid'** 1500 Claim form in CYBER.

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1500 Claim Form Status

Wrap Flex (Non–Medicaid) 1500 Claim Form Status Definitions in CYBER

Keep track of Wrap Flex CYBER 1500 Claim form statuses. *(Once claim is submitted via CYBER successfully the following Status occurs).* Please view below the following electronic claim status in CYBER:

- **In Progress** - Already started and saved 1500 claim but not submitted through the CYBER MIS for processing; still in draft/saved with the provider agency *(Providers must click on the 'Submitted' status and 'Saved' button at the bottom of the 1500 form to send the electronic claim successfully; otherwise, it remains in the user's queue as a draft, under In-Progress status).*

- **Submitted** – This status permits the completed 1500 Claim form to be sent by provider electronically to PerformCare, via CYBER. The claim is electronically recorded with the date receipt and ready for claim to be processed accordingly.

- **Approved** - Electronic 1500 claim forms that are adjudicated and accepted by a PerformCare Billing Unit associate; however, awaiting to be sent to DCF Office of Accounting for payment.

- **Sent** - PerformCare approved the 1500 claim form and sent it with the electronic claims spreadsheet report to DCF Office of Accounting (OOA) for payment processing *(The turn-around for DCF OOA to process payment is 10 business days from the date 'Sent').*

- **Paid -** These are approved 1500 claims that have been paid (*waged*) and posted in CYBER (*This status displays the payment posting information, which is viewed on each line of electronic claim and on the Authorization Details screen in CYBER MIS. Payment posting is automatically updated into CYBER by PerformCare's IT department approximately every 60 days. Please note, this status 'Paid' is only managed by PerformCare users but visible to providers in Authorization Details screen and provider's Welcome Page. Also, be advised that PerformCare does not adjudicate payment of claims.*

- **Returned -** Erroneous 1500 claims that are returned electronically to the provider's CYBER MIS queue for corrections *(Providers may reference the comment section of the electronic 1500 claim to view the error and reason for the status return; along with specific instructions).*

16

- **Denied** - 1500 claims are denied (rejected) if the youth is determined to have an active NJ FamilyCare/3560 eligibility number or if it is a duplicate claim submission. Claims may also be denied for reasons not listed here; details will be listed in the Comments section of the 1500 claim form.

Payment Information

IIC Providers can search payment information by registering through www.state.nj.us (click on **Register** and follow the prompts). Using their Federal Identification Number, provider will be able to search for payments that were issued to them or provider's agency for a selected period.

Direct Deposit can be setup and viewed in the NJ Start.Gov website.

Please note that checks issued by the Department of Treasury will have a check stub (remittance advice) that will list the following information: authorization number, service date(s), dollar amount, and a telephone number to contact DCF should a provider have any questions about the payment.

Also, as a reminder, in CYBER status **'Paid'** displays the payment posting information. It is visible to providers in the Authorization Details screen and Welcome Page. Payment posting is automatically updated into CYBER by PerformCare IT department approximately every 60 days.

*To view **immediate** status of a payment, provider can register through the State of New Jersey website* (www.state.nj.us) and NJ Start.Gov for status updates.

Timely Filing/Returned Claims

All 1500 claim forms returned to providers for error correction must be resubmitted to PerformCare within 90 days from the first date of service (DOS). Turn around process for PerformCare to review claims is approximately 10 business days from the receipt date. PerformCare will reject all Wrap Flex claims submitted to them for reimbursement that have service dates older than 90 days.

Wrap Flex Appeal Process

If there is a dispute on a claim that is over 90 days from the first DOS or a resubmitted claim that arrived after the 90 days of the first DOS, an appeal letter is required. Providers should submit a written appeal letter for denied claim(s) and resubmit corrected claim(s) to PerformCare along with supporting documentation.

The written appeal letter needs to be uploaded into CYBER with supporting documentation of the dispute. in addition to an explanation in the comment section of the electronic 1500 claim. PerformCare will review the appeal with supporting documentation and send to CSOC for final determination.

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VI. Important Contact Information for CSOC Providers

Medicaid Fiscal Agent Provider Relations • Medicaid billing questions • Setting up Medicaid billing training • Medicaid error codes resolution	**1-800-776-6334**
PerformCare New Jersey • CYBER Access • Technical Questions • Questions regarding the DCF Wrap Flex billing process • If available, have the youth's CYBER ID and/or prior authorization number available for reference. • Instructions on entering 1500 Claim form into CYBER.	**www.performcarenj.org** **1-877-736-9176** **servicedesk@performcarenj.org** **www.performcarenj.org/pdf/provider/training/billing-claims/instructional-guide-entering-claims.pdf**
New Jersey Department of Treasury • Providers must register to receive payment of non-Medicaid Wrap Flex claims • To view payment information	**www.njstart.gov/bso/** **1-609-341-3500** **www.state.nj.us https://www20.state.nj.us/TYM_VPI/**
New Jersey Medicaid Management Information System • Medicaid billing questions • Setting up Medicaid billing training	**www.njmmis.com**
Recipient Eligibility Verification System (REVS)	**1-800-676-6562**
New Jersey Children's System of Care • SDED (Encounter) Forms and instructions	**www.state.nj.us/dcf/providers/csc/ServiceDeliveryDocumentation.pdf** **www.nj.gov/dcf/documents/behavioral/providers/SDEDFInstructions.pdf**

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VII. References

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

Billing and Claims Training materials: http://www.performcarenj.org/provider/training.aspx#billing

- 3560 & Third Party Liability Data Collection in CYBER
    - http://www.performcarenj.org/pdf/provider/training/billing-claims/3560-tpl-data-collection-cyber.pdf

PerformCare Service Desk is available 24/7/365:

Service Desk Request Form:
https://apps.performcarenj.org/HelpDesk/csareqajax.aspx/

Phone: **1-877-652-7624**

19