Instructional Guide for Entering Claims (CMS 1500 forms) and Uploading Documentation into CYBER

(Last update: June 2018)
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I. Introduction
The CMS 1500 Form is available electronically in the CYBER system to those individuals with the proper security attached to their User ID. Individuals who are designated as “MGR” or Manager level users, have access to the 1500 Form and have 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 encounter forms); please see page 12 for more information on uploading documents and what is required.

If a user has difficulty with this functionality or have questions regarding the billing process, they should contact the PerformCare Service Desk at (1-877-736-9176/servicedesk@performcarenj.org).

II. Acronyms and Definitions:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1500 Claim</td>
<td>Center for Medicare &amp; Medicaid Services (CMS) federal claim form; used to bill indicated units for authorized service code(s).</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of Service</td>
</tr>
<tr>
<td>BPS Assessment</td>
<td>Bio-Psycho-Social/Assessment</td>
</tr>
<tr>
<td>CME</td>
<td>Care Management Entity – Either CMO or MRSS</td>
</tr>
<tr>
<td>CMO</td>
<td>Care Management Organization</td>
</tr>
<tr>
<td>CSA</td>
<td>Contract System Administrator</td>
</tr>
<tr>
<td>Eligibility</td>
<td>A youth that has coverage such as Medicaid NJ Family Care, 3560...etc.</td>
</tr>
<tr>
<td>Molina</td>
<td>Molina Medicaid Solutions is a federal state vendor that manage &amp; process Medicaid.</td>
</tr>
<tr>
<td>Medicaid Claim</td>
<td>Youth that has an active (Medicaid/NJ FamilyCare) eligibility number that covers the date of service on claim.</td>
</tr>
<tr>
<td>MRSS</td>
<td>Mobile Response and Stabilization Services</td>
</tr>
<tr>
<td>Prior Authorization Number</td>
<td>A computer generated and unique number that indicates approved service code and units; this number is required to bill for services rendered.</td>
</tr>
<tr>
<td>Service Code</td>
<td>Describe specific procedures and services in an alpha and numeric cipher (i.e. H0018TU1).</td>
</tr>
<tr>
<td>Units</td>
<td>The quantity block(s) of time approved during the prior authorization period. The total Units approved &amp; frequency are indicated in CYBER and on the NJMMIS website.</td>
</tr>
<tr>
<td>Wrap Flex</td>
<td>NJ State funds for youth enrolled in the CSOC; authorized for Behavioral/Mental health services and some Substance Use treatment.</td>
</tr>
<tr>
<td>Dx</td>
<td>Diagnosis Code is a requirement in the CYBER 1500 Claim Form- Diagnostic coding is the translation of written description of diseases illness and injuries into codes.</td>
</tr>
<tr>
<td>ICD-10</td>
<td>The International Classification of Disease, Tenth Edition (ICD-10) is a clinical cataloging system (diagnostic codes), which went into effect for the United States healthcare industry on October 1, 2015. The ICD-10 is a morbidity classification published by the United States for classifying diagnosis and reason for visits in all health care settings.</td>
</tr>
<tr>
<td>Wrap Flex Claim</td>
<td>NJ State funds for youth enrolled in the CSOC billed on Center for Medicare &amp; Medicaid Services (CMS) federal 1500 claim form; which indicates units for authorized service code(s).</td>
</tr>
</tbody>
</table>
III. Accessing CYBER

Users must first log-into CYBER with their Login Name/UserID and Password. The login screen can be found via the PerformCare website – \texttt{www.performcarenj.org}.

Each provider organization has at least one CYBER Security Administrator, and your agency's CYBER Security Administrator can set up a login for you.

Your access will be based on your login type and security levels.

**Before you log in, keep in mind....**

- There is no 'back button' use in CYBER!
- Most areas/buttons are single-click – do not double-click on a button!
- Every time you launch CYBER, you will be required to enter your Login name and Password to continue.

Below the log in area is a statement that, as a CYBER user, you acknowledge your responsibility to protect the privacy of, and to guard against, the inappropriate use of the Protected Health Information (PHI) contained within the system.

This statement will appear each time you log in.

Please also check the Providers section on the PerformCare website for the most up-to-date technical requirements (such as browser compatibility and operating systems) that a user would need to access CYBER.
IV. Welcome Page Components

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

*Please note that 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 (seen in the above example).

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. In order to get a preview of the number of items associated with the link, users will need to click on the “Refresh Totals” button that sits on top of the list of links on the right. This will prompt the system to populate the empty parenthesis on each link with a number.

The first area is for Authorizations (or 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.
The **Authorization** grids will be populated with the following information:

- **Authorization #** - will act as a hyperlink that, when clicked, 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)
- **Provider** – name of the provider or program that the authorization was opened for; will vary depending upon what programs the user is attached to
- **CYBER ID** (of the youth) – will act as a hyperlink that, when clicked, will bring the user to the youth’s Face Sheet
- **Youth Name**
- **Amount and Amount Remaining** – amount of authorization and the amount that remains
- **Units and Units Remaining** – number of units authorized and the number that remains
- **Service Code and Description**
- **Start and End Date** (of the Authorization)
- **Create Date** (of the Authorization)
- **CIMID** – an identifier used within CYBER for each provider/program

The next area is for **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** – these claim forms have been submitted to PerformCare
- **Approved** – all claims that have been approved for the agency
- **Sent** – all 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 will be denied due to the following: **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 vendor Molina for adjudication, **OR 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
- **CSOC Review** – all claims for the agency that are currently in review with CSOC
  - A claim may be in review with CSOC because it is over 90 days past the last day of service or the amount of units on the claim exceeds the number of units authorized
The Claims grids will have a search area above it that will appear once one of the links is selected.

This area will allow the user to search the grid for specific information such as a specific CYBER ID, claims from a certain time-frame and specific authorizations numbers. The Claims grids will be populated with the following information:

- Claim number
- Provider
- Units and Amount
- CYBER 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
V. The Authorizations Details Screen

This screen will appear when a user clicks on the Authorization Number hyperlink from one of the Authorization grids on the Welcome Page.

The top of the screen houses information about the individual authorization; users will find information here such as the name of the youth the authorization is for, the service code and description, as well as 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

Users have the ability to add a claim to this authorization from this screen, by clicking the Add Claim button just above the grid. Clicking here will bring up the electronic 1500 form.
VI. 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 have been made to CYBER.

*Please 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 submitted the claim in good faith.

For more details information on Wrap Flex billing claims please review the approved IIC Billing guide in the PerformCare website.

This is an example of a new 1500 Claim Form.

The form will automatically be given a Claim 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) needs to refer back to it, especially once it is submitted or approved/returned/paid, etc.

*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.

The second tab – Document Upload – is to be used by those agencies that are required to submit supporting documentation along with their claims. Please see page 13 for more information on how to utilize that functionality.

The third tab – Eligibility – will give the user access to the youth’s Medicaid coverage information, if applicable.
Each form will have the following buttons at the bottom:

- **History** – when clicked, will bring up 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 page xx for more information on 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 does not get submitted; please note that a claim that remains in this status for 365 calendar days after creation will be automatically deleted by the system
  - 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**

The Claim/1500 Form is broken into sections, the first being Demographics.

This area is automatically populated from the youth’s Face Sheet of 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.

The next area is for 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).

The Authorization Details/Billing area is next.
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 be checking 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.

(Please 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.

The next area is where users will add individual claims to the 1500; clicking the Add Claim button will bring up a new window. (Please note – the Total Claim Amount box which 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 red:

**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 of time. 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 being billed against; 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 being entered.

**# of Units:** Total number of units used during the time-frame for the claim.

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

**Add 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 diagnosis code plan, 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 (Crosswalk DSM-IV” box will be checked by default and will allow users to search for ICD-10 codes using DSM-IV search criteria). If the user de-selects the “Crosswalk DSM-IV” check box, only codes that match the search criteria will appear in the search results.
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. 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 into the first claim will carry over into any additional claims added to the 1500 Form; they will not carry over 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 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.

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 being submitted past 90 days since the last date of service, the user will receive a message from the system asking for a comment to be entered which justifies the late submission. Additionally users would need to upload an appeal letter to claim. Appeal letter should be typed in a letter head and uploaded to CYBER with supporting documentation of the dispute. Upon submitting the claim for appeal, PerformCare associate will change the status of claim to Review. PerformCare will review the appeal then make the recommendation to CSOC for a final decision.
VII. 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.). This is the area that some providers will utilize to upload the documentation that is required to be included with their claims in order for them to be processed. Please note the following:

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

Please 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 any of this documentation is found uploaded, 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 Browse 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, as well as the size of the file. Once the user clicks the Upload button, the document will be uploaded to 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 claim is incorrect, PerformCare associate will change the status of claim to Returned; which, will thereafter permit users to edit line of the claim and resubmit the amended claim to PerformCare for review.
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.