PerformCARE®

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

(Last update: August 2015)

August 2015

PerformCARE®

Instructions for Use

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I. Introduction

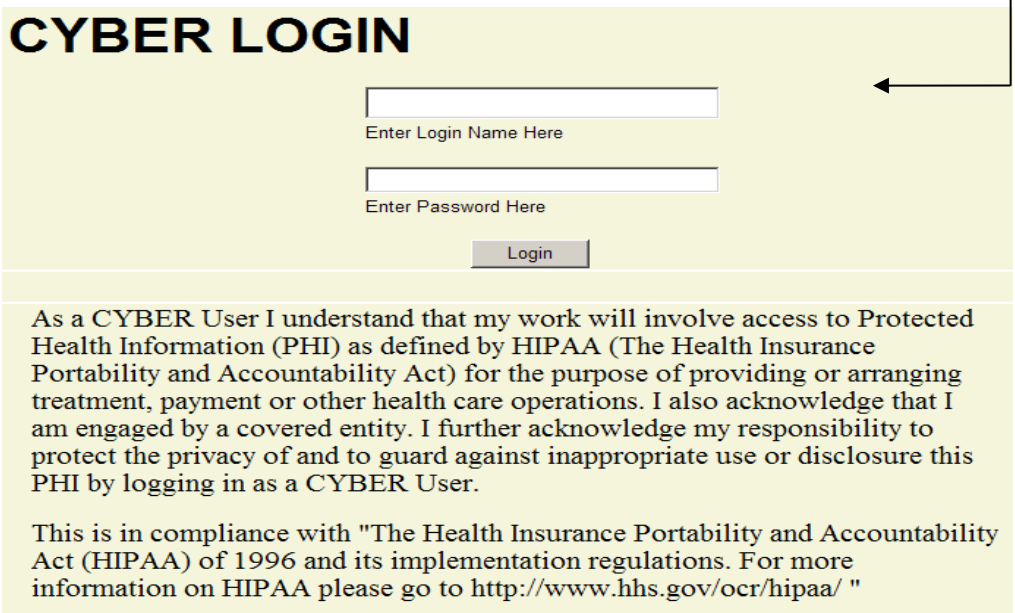
The CMS 1500 Form is available electronically in the CYBER system to those individuals with the proper security attached to their User ID. Individuals who are designated as "MGR" or Manager level users, have access to the 1500 Form and have the ability to complete and submit the Form for payment.

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 CYBER Service Desk at (1-877-736-9176/servicedesk@performcarenj.org).

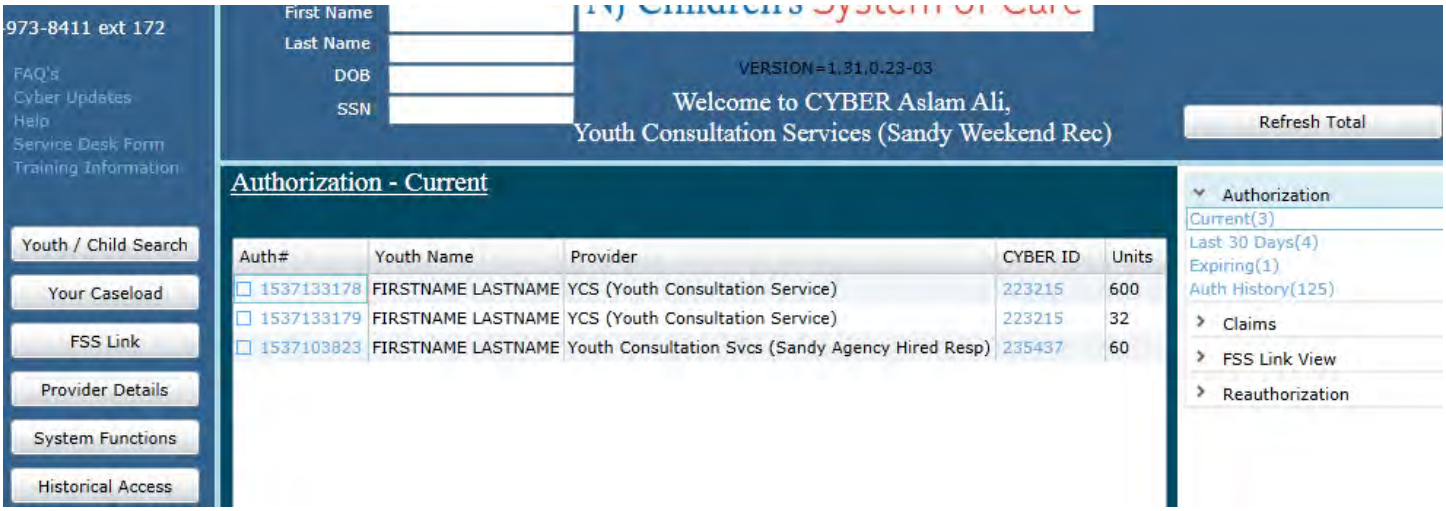
II. Accessing CYBER

Users must first log-into CYBER with their UserID and Password. The log-in screen can be found via the PerformCare website – www.performcarenj.org.



III. 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 FSS 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;

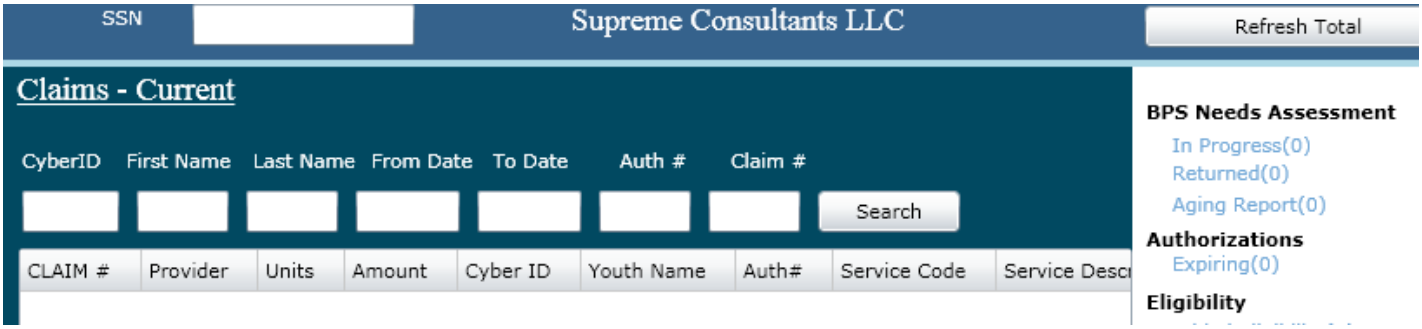
- Authorization # - will act as a hyperlink that, when clicked, will bring the user to the Authorizations Details screen which shows the authorization information and any claims submitted against it (this is where a user with the MGR designation in their profile can create and submit CMS 1500 Claim Forms)
- 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;
        - 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.
        - 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.

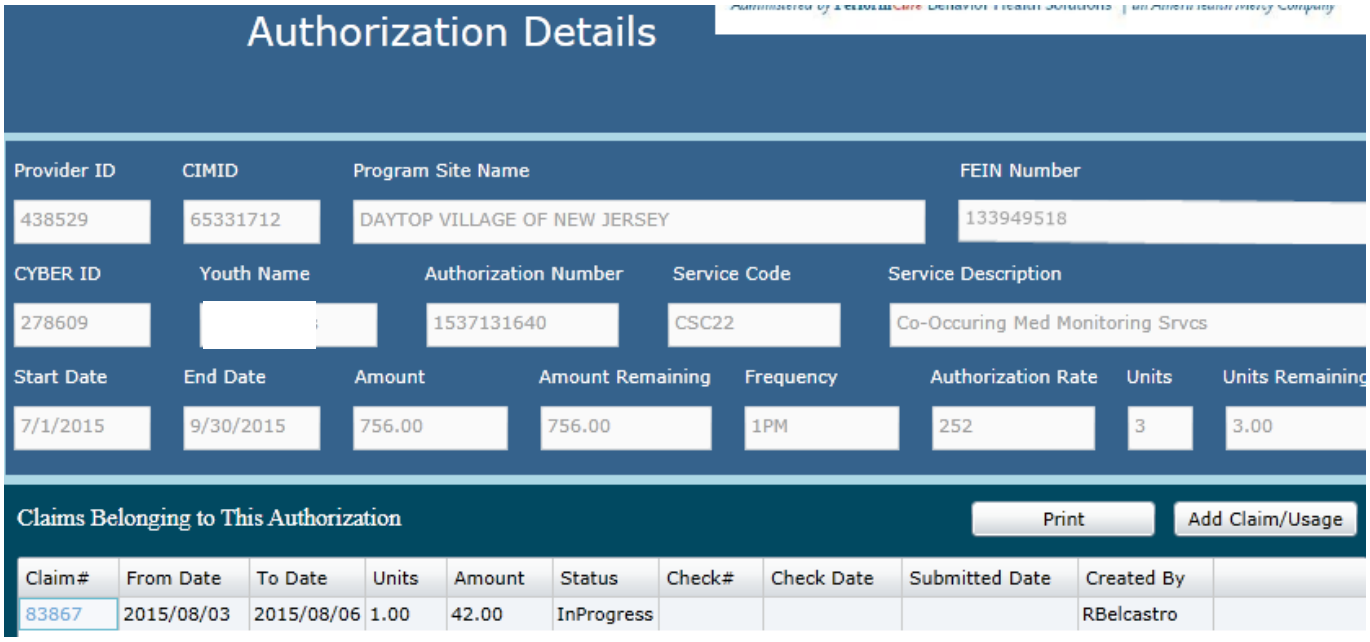


This area will allow the user to search the grid for specific information such as a specific CYBER ID, claims from a certain time-frame and specific authorizations numbers. The Claims grids will be populated with the following information;

- 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

IV. 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.

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 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.

This is an example of a new 1500 claim.

1500 HEALTH INSURANCE CLAIM FORM # 0 | Final Claim | Document Upload | Eligibility

Demographics

Training | Youth First Name
Test | Youth Last Name
MI
278609 | Youth/Child ID
24 North Street | Youth's Address
10/15/1989 | Date of Birth
609-2222222 | Telephone
M | Gender
SAYREVILLE | City
NJ | State
08871 | Zip Code

Insurance

Self | Relationship to Insured
Authorized Person's SOF
Note: Patient's or authorized person's signature is needed. Signature on file (SOF) will satisfy this requirement

Reserved for NUCC Use
Other Insured's Name
Other Insured's Policy Num
Other Reserved for NUCC Use
Other Reserved for NUCC Use
Insured Plan Name

1537131640 | Authorization #
CSC22 | Service Code
Co-Occuring Med Monitoring Srvcs | Service Description
133949518 | Federal Tax ID #
TAXID | Tax ID Type
438529 | Provider #
<M/d/yyyy> | Submitted to CSA
3 | Auth Units
3.00 | Auth Units Remaining
252 | Cost per Unit
756.00 | Auth Amount
756.00 | Auth Amount Remaining
Total Claims Against Auth

Service Details | Add Claim | 0 | Total Claim Amount

Remove Record	StartDate	EndDate	PlaceOfService	ServiceCode	DiagnosisCode	AmountBilled	Units	Check #	Check Date	Check Amount

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.

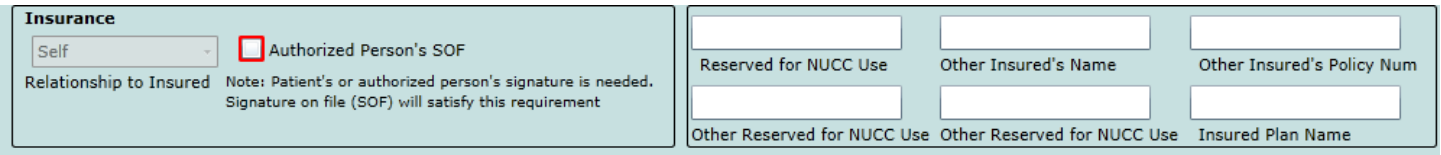
Each form will have the following buttons at the bottom;

- 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.

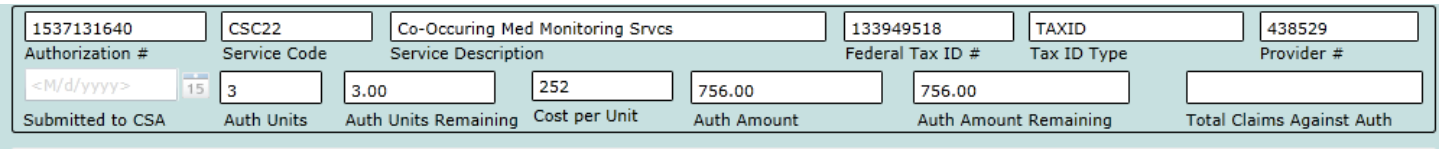
This area is automatically populated from the youth's Face Sheet of their record. If something here is incorrect, the user will need to go to the Face Sheet to make changes; the saved claim will update accordingly. Please note that changes can only be made to the Face Sheet while the user's Tracking Element is still open; if the user is completing the 1500 form after their Tracking Element 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.



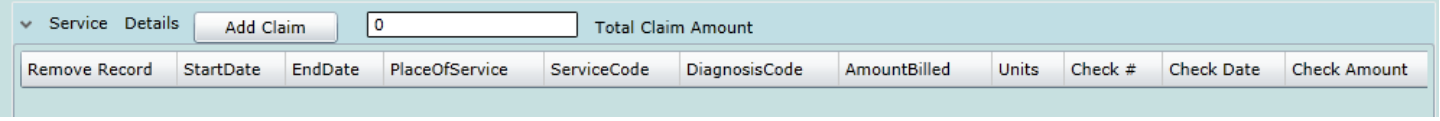
The only field here that should be used is the check-box labeled "Authorized Person's SOF (signature on file)". This is a required field (marked by the red box).

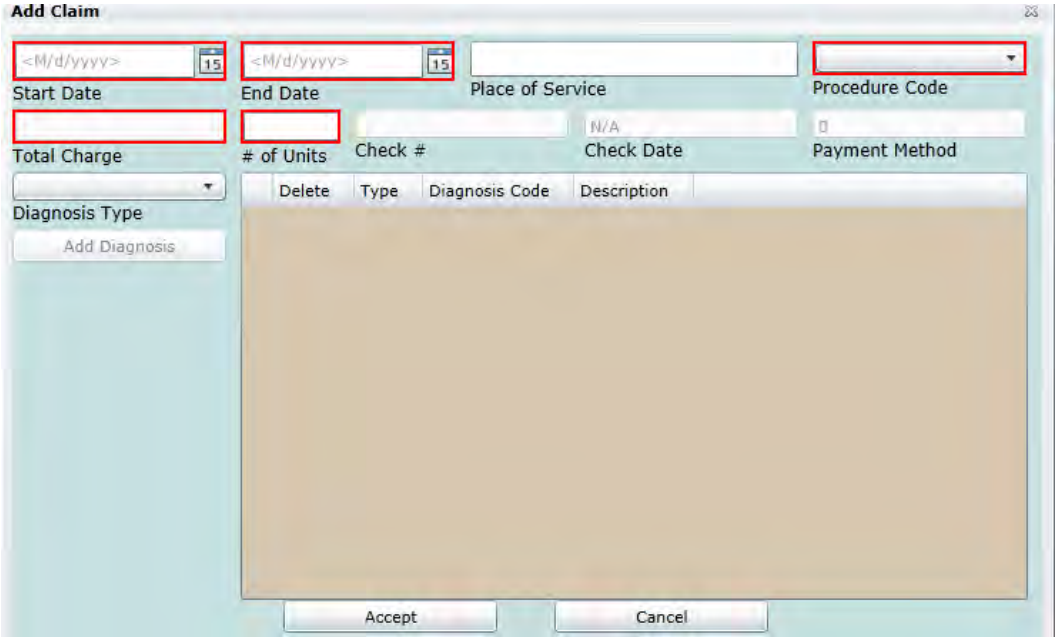
The Authorization Details/Billing area is next.



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.

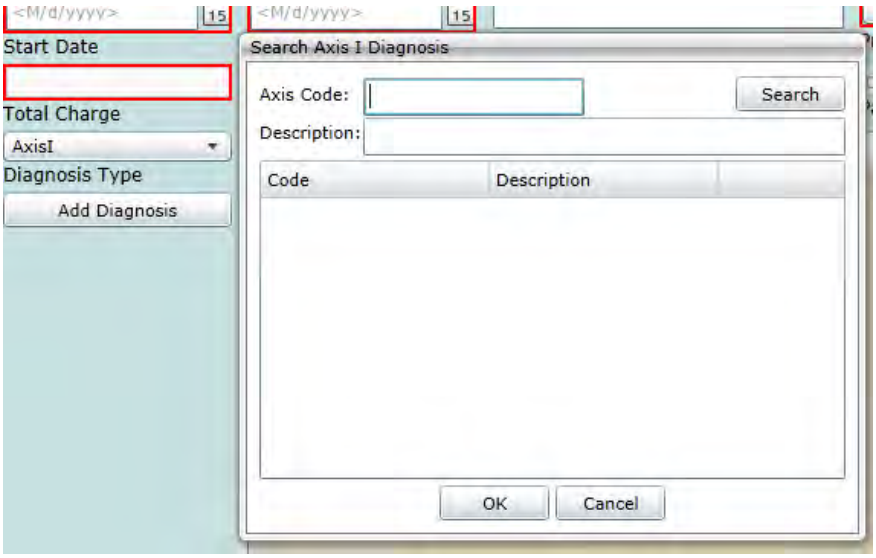
Procedure Code: A drop-down menu of the codes associated with the authorization being billed against; if the service code for the authorization is a bundled code, the user must chose the appropriate sub-code or procedure code in this menu.

Total Charge: Total charge for the individual claim being entered.

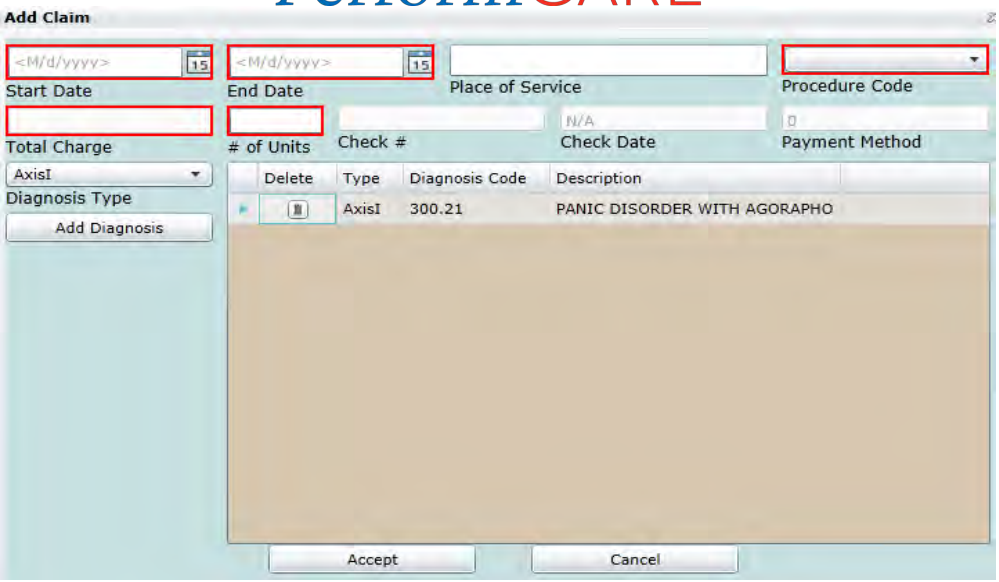
# of Units: Total number of units used during the time-frame for the claim.

There are additional fields here 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.

There is also drop-down menu for Diagnosis type; diagnosis information is no longer a required field. If the user enters it, they must first choose the type of diagnosis they are going to enter. Currently, users will select from the DSM-IV Axis'; in the future, users will be able to choose from the DSM-IV or 5 codes. Once a selection is made, the user will click on the Add Diagnosis button. Doing so will bring up the search window.



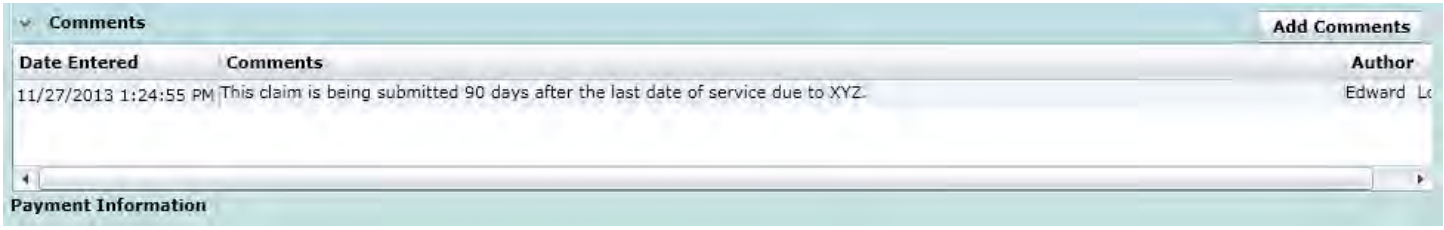
Users are encouraged to conduct a partial search unless they know the full code or description; if an incorrect data element is entered, the search will result in no matches. Once the user enters data into one or both of the fields and clicks the Search button, the results will populate the grid. Single-clicking 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 trash can icon next to the diagnosis record to delete it from the 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 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 95 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. Upon submitting the claim, it will automatically be given a status of Review so that it is flagged for PerformCare staff.

VI. Uploading Documents

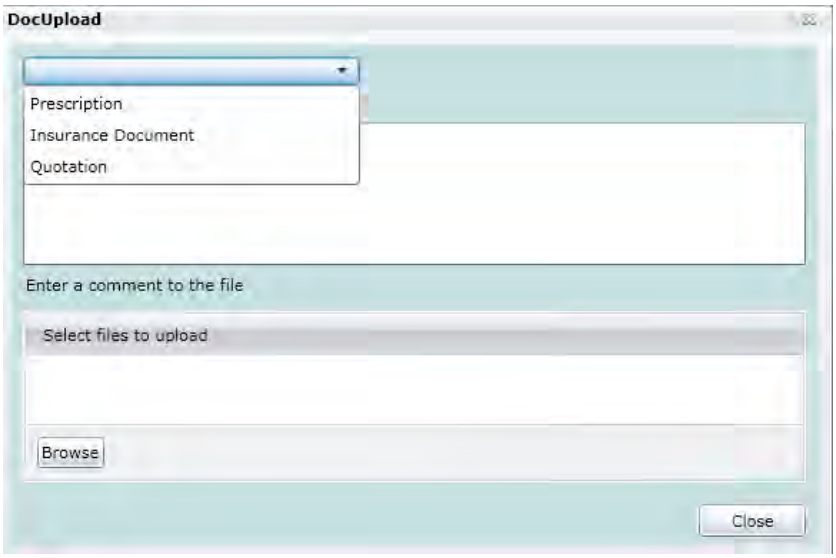
There is a Document Upload tab at the top of the screen, next to the Claims tab. This area allows a user to upload documents to the youth's record, such as insurance documents and quotations (used for vehicle modifications, assistive devices, etc). This is the area that some providers will utilize to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

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.

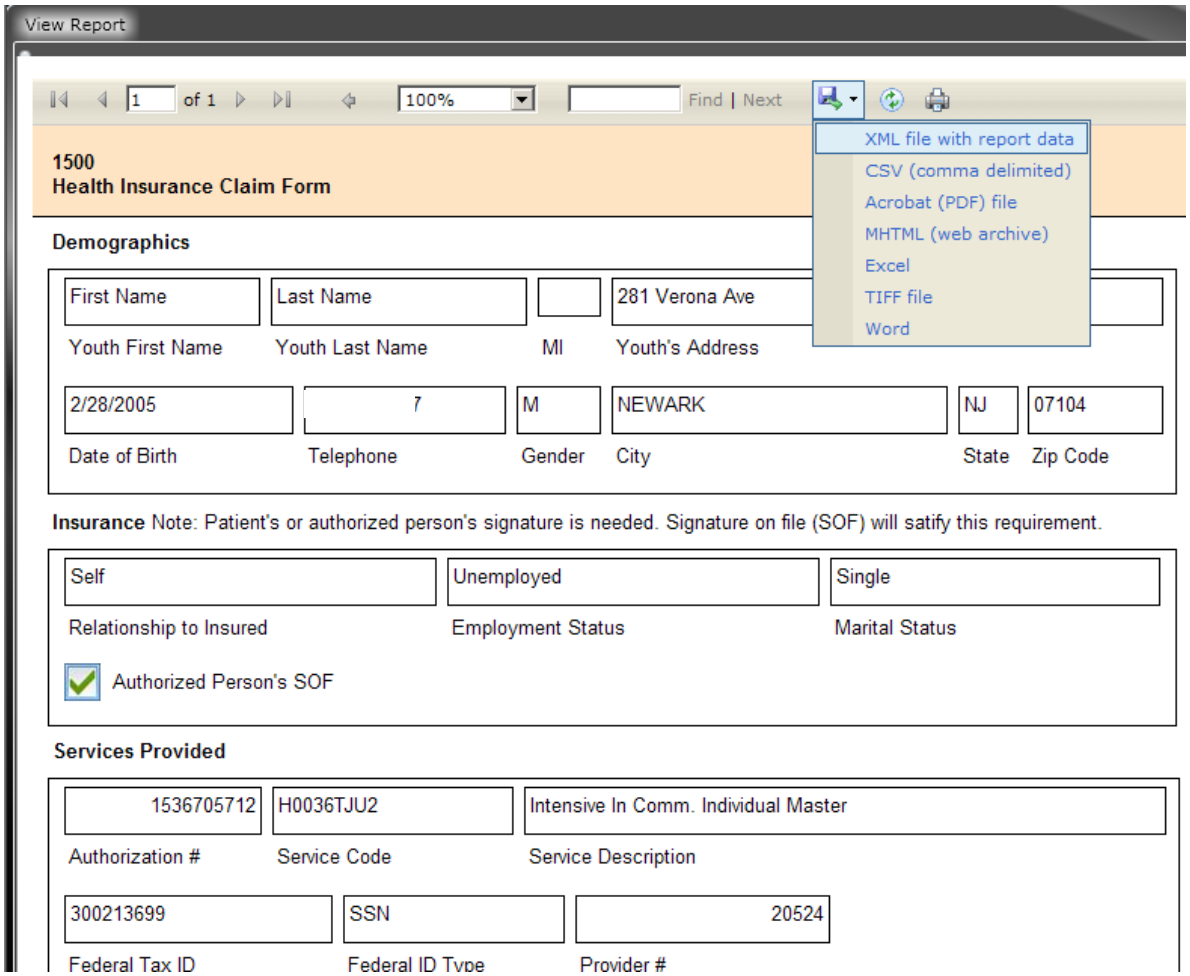


When uploading documentation, users must ensure that the document(s) does not contain PHI such as progress notes, session notes, etc. This is a HIPAA violation; the Billing & Eligibility Unit at PerformCare does not need that information to process the claim. If any of this documentation is found uploaded, 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. The user can delete the file, if necessary, by clicking on the trash can icon next to the document on the Document Upload tab.

VII. 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.