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March Provider Forum

ACCREDITED NCQA HEALTH PLAN INTERIM

Today's Agenda

01 Welcome and Overview of Trillium's Tailored Plan

02 Tailored Care Management Providers
Communication with TCM Providers

03 Care Management
Requesting a Care Manager's Name

04 1915(i) Services

05 Physical Health Portal and Other Topics

06 Electronic Visit Verification

07 Provider Manual

08 Questions

1 Welcome and Overview of Trillium and the Tailored Plan

Linda Hawley Isbell, MA, CI
Associate VP of Provider Relations and Engagement and Provider Support Services

Chauncey Dameron, MBA, & Kimberly Wagner, MBA
Provider Relations and Engagement Managers

About Trillium Health Resources

Trillium HEALTH RESOURCES
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- Trillium Health Resources is a Tailored Plan and Managed Care Organization (MCO) that manages serious mental health, substance use, traumatic brain injury, and intellectual/developmental disability services in North Carolina.
- For individuals receiving Medicaid through the Tailored Plan, we cover physical health care and pharmacy services as well.
- We also help uninsured individuals through state-funded services.

Regional Information

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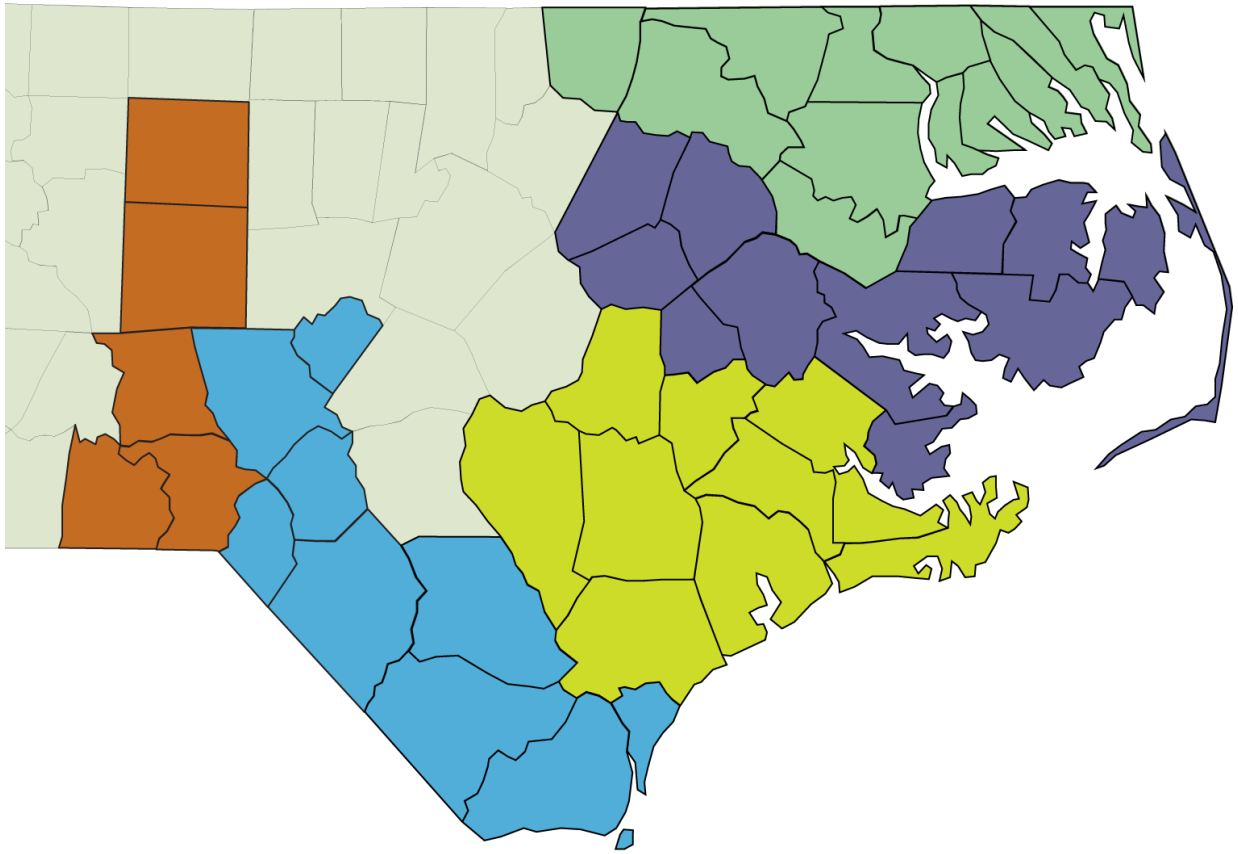
46 Counties

Land mass: 28,977 sq mi
Percentage of land mass in NC: 59.61%

Total Population: 3,152,058
Percentage of NC pop: 30%



Network

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- Physical health providers: 54,105
- Behavioral health providers: 14,103
- Vision providers: 452
- Pharmacy and medical supplies: 2,788
- Counties covered by providers: 100

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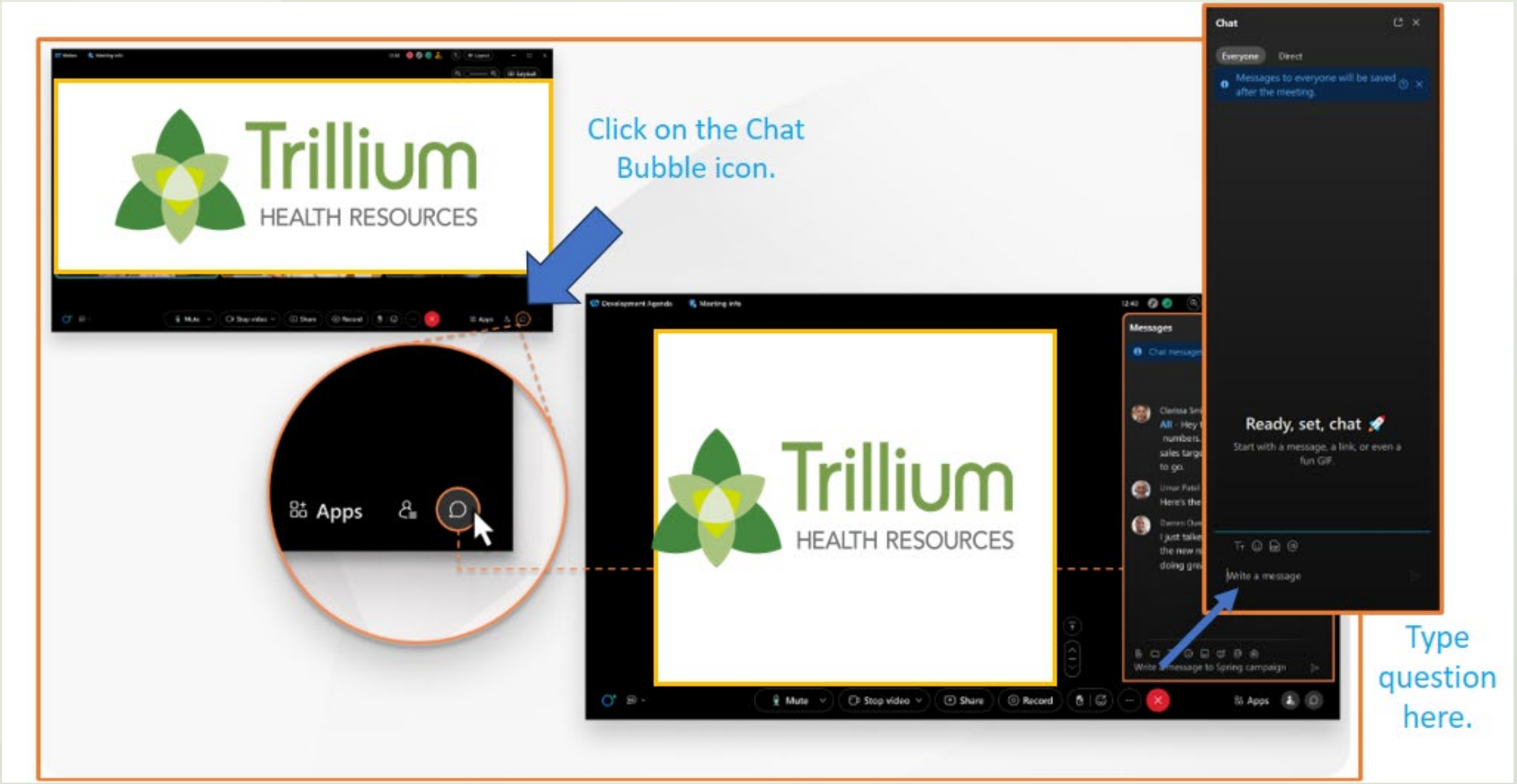
Question & Answer and Live Discussion

Use the Q&A throughout the meeting and allotted time for the Q&A section at the end of the presentation.

Submit your questions using during the meeting. We will have Subject Matter Experts responding in the chat to questions throughout the meeting.

If there are questions that require more research, we will review them and provide the answer in the Frequently Asked Questions Document (FAQ) that is posted on our website.

Accessing the Q&A feature in WebEx.



Provider Forums

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- During the fall of 2024 we conducted a survey to collect data on the topics that you, our provider network would like to receive technical assistance and education on.
- Top 7 Topics
  1. Claims Denials
  2. Review of the Trillium Tailored Plan
  3. How to Add or Remove Services
  4. Personal Care Services
  5. TBS Set Up
  6. Questions about the Physical Health Portal through Carolina Complete Health
  7. A Demo of the Provider Directory
- There are many other topics that were identified in the survey that we would include in upcoming forums along with other hot topics as they come up.

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Tailored Plan Partnerships

Trillium's Tailored Plan Partners

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Carolina Complete Health (CCH):

Trillium's Standard Plan Partner; responsible for our Physical Health Network including Primary Care, Specialty Care, Durable Medical Equipment (DME), Vision, Long-Term Services and Supports (LTSS) Non-Emergency Medical Transportation (NEMT), and Non-Emergency Ambulance Transportation (NEAT).

Centene Vision Services:

Trillium's Vision partner (formerly Envolve), through our agreement with CCH; responsible for our Optometry Network.

PerformRx:

Trillium's Pharmacy Benefit Manager partner; responsible for our Pharmacy Network.

Modivcare:

Trillium's NEMT partner, through our agreement with CCH; responsible for our NEMT Network.

NC Department of Health and Human Services:

Trillium's oversight entity; responsible for managing the delivery of health and human-related services for all North Carolinians.

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Resources for Providers

- All Behavioral Health contracted providers are assigned a Provider Relations and Engagement Coordinator as your first point of contact for any questions.
- Call the Provider Support Service Line (PSSL) at (855) 250-1539
  - PSSL is available Monday through Saturday from 7 a.m. to 6 p.m. including federal holidays.
- Email Provider Relations and Engagement at NetworkServicesSupport@TrilliumNC.org
- Review the Trillium Health Resources website www.TrilliumHealthResources.org

2

Tailored Care Management Providers

Miriam Godwin

TCM Provider Network Manager

Tailored Care Management (TCM) in Trillium's Network

50 TCM Providers serve our members with:

- Mental Health and Substance Use Disorder (child and/or adult)
- Intellectual and/or Developmentally Disability
- Innovations Waiver
- Co-occurring (MHSU/IDD) (child or adult)

Communicating with TCM Providers

- Use the contact list for TCM we maintain on our website, found here: https://www.trilliumhealthresources.org/sites/default/files/docs/TCM-For-Providers/Trillium-TCM-Providers-List.pdf
- TCM Providers are not required to have a live person answer the phone, so you may have to leave a detailed voicemail.
- Please encourage members you serve to work with their TCM Providers.
- Release of Information not required for coordination of care.
- TCM Providers are responsible for completing 1915i assessments, completing Care Plan or ISP, and submitting Treatment Authorization Requests (TARs) for most 1915i services. For all other services, it is the service provider's responsibility to submit any needed TARs.
- We strongly encourage collaboration between service providers and TCM Providers.

Can you add the TCM service to your contract?

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Only after a provider completes certification and Readiness Review for TCM through NCQA will we add the service to your contract and start the TCM onboarding process.

Questions about the TCM certification and Readiness Review process, managed fully by NCDHHS and NCQA, can be directed to Medicaid.TailoredCareMgmt@dhhs.nc.gov

3 Care Management Requesting a Member's Care Manager Name or Assignment Process

Katy Eads, LPA
Clinical Support Services Director

Tailored Care Management

PCP/Provider Request for a Care Manager Name or Assignment Process

- Trillium Health Resources developed a new process for when a Primary Care Physician Office or Behavioral Health Provider needs to obtain the name of a member's Care Manager or Care Management assignment.
- The process was developed so there is a streamlined process for PCPs/Providers/Office Administrative staff to use to outreach to care management.
- The process is started by the Primary Care Physician Office or Behavioral Health Provider going to NC Tracks and verifying the member's Managed Care Organization/Tailored Plan (MCO/TP) and the assigned Tailored Care Management Entity. It is important the listed MCO/TP is Trillium Health Resources, and the Tailored Care Management Entity is Trillium Health Resources.
- Contacting Provider Support Services by phone or email and Provider Support Services will provide the provider with the link to the PCP/Provider Request for Care Manager Name or Assignment Referral Form, **or**
- Locating the form directly on the Trillium Health Resources Website under "For Providers, Resources, Provider Documents & Forms, Links and Resources, Trillium Health Resources"
- Link to form: PCP/Provider Request for Care Manager Name or Assignment Referral Form (smartsheet.com)

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PCP/Provider Request for a Care Manager Name or Assignment Process (cont.)

- After the referral form is submitted, the clinical support team will review the PCP/Provider Request for a Care Manager Name or Assignment referral and provide a response within three business days.
- The response received will depend on if the member is assigned to Trillium Health Resources or a Provider Based Care Management Entity for Tailored Care Management.
- If the member is assigned to a Provider Based Care Management Entity (AMH+ or CMA), the clinical support team will provide the name and contact information of the Provider Based Care Management Entity to the individual who submitted the referral email.
- If the member is assigned to Trillium Health Resources and has an assigned care manager, the clinical support team will provide the name of the care manager. The clinical support team will alert the care manager of the request from the PCP/Provider.

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PCP/Provider Request for a Care Manager Name or Assignment Process (cont.)

- If the member is assigned to Trillium Health Resources but does not yet have an assigned care manager, the clinical support team will submit the referral for care management services. The clinical support team will alert the referring individual a referral has been submitted.
- The time frame from the clinical support team's submission of the referral for care management to assignment of a care manager is 3-5 business days. If a care manager is assigned the clinical support team will contact the referring individual and provide the name of the care manager. It is important to note, the care manager will outreach to the member prior to outreach to the individual who submitted the referral.
- If a care manager is not assigned, the clinical support team will alert the referring person the referral for tailored care management was declined.
- If the member situation is emergent or urgent member where it is felt a care management assignment needs to be expedited, or you are a hospital and need to refer a member on an inpatient unit or ED, please contact the Member & Recipient Services line at 1-877-685-2415.

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PCP/Provider Request for a Care Manager Name or Assignment Process Helpful Tips

- It is recommended you alert the member of the submission of the PCP/Provider Request for a Care Manager Name or Assignment referral form. Informing the member of the submission and can assist the TCM Entity with member engagement.
- If you do not receive an initial email response to your PCP/Provider Request for a CM Name or Assignment within 3 Business days, check your spam/junk folder. All emails which have PHI/PII are sent encrypted.
- If you have a Personal Care Services question or need, please refer to Trillium Health Resources website for information: https://www.trilliumhealthresources.org/personal-care-services-pcs
- NC DHHS and Trillium Health Resources Website has a lot of helpful information on Tailored Care Management for providers and members/recipients.
  - NC DHHS TCM information website link: https://medicaid.ncdhhs.gov/tailored-care-management
  - Trillium provider TCM information website link: https://www.trilliumhealthresources.org/for-providers/tailored-care-management-for-providers/tailored-care-management-resources
  - Trillium member/recipient TCM information website link: https://www.trilliumhealthresources.org/members-recipients/tailored-care-management

4 1915(i) Home and Community Based Services

Katina Dial-Scott
Associate VP of Operations, I/DD and LTSS Services

What are 1915(i) Services?

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- The 1915(i) Home and Community Based Services (HCBS) services are free for members who receive Medicaid and want support to live in their home communities.
- These services are non-medical behavioral health services
- They are provided at a member's residence or community and are not for members living in an institution.
- 1915(i) services replaced 1915 (b)(3) services which are no longer available as of 12/31/2024.
- Federal conflict-free care management requirements state a provider cannot provide Tailored Care Management (TCM) and 1915(i) services to the same member.
- Individuals who are enrolled in Community Alternatives Program for Children (CAP/C) or Community Alternatives Program for Adults (CAP/DA) can receive some 1915i(i) services. Members cannot received Respite or Community Transition but are eligible to receive all other services.

1915(i) Services

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- Community Living and Support (CCP 8H-5): Members learn skills to help them live independently at home and participate in the community. Members learn to manage eating, bathing, dressing, personal care, hygiene and other daily activities. Life skills such as shopping and banking and extra support for health and safety.
- Community Transition (CCP 8H-6): Members can get up to $5,000 in credit to help them move from an institution or approved setting to their own home. Approved settings can be a state-operated health care facility, a foster or group home, a psychiatric residential treatment facility, a community intermediate care facility (ICF-IID) and more. Funding can be used for security deposit for an apartment or house, essential home furnishings, like furniture, kitchen utensils and linens, moving expenses, and set-up fees for utilities (like phone, internet, gas).
- Individual and Transitional Support (ITS) (CCP 8H-3): Members get personalized support for their recovery from mental health issues or substance use disorders. Members participate and guide their recovery process, have access to transportation, help to find housing, manage their finances, and continue their education.
- Respite (CCP 8H-4): Gives caregivers a break, while knowing that their loved one is cared for. Overnight, weekend, and emergency care for the member could be provided in or out of the home.
- Supported Employment for IDD and TBI (CCP 8H-1): Members learn skills to find, get and keep a job that's right for them. They receive help with career planning and discovery, résumé assistance, job interview practice, support with assigned job tasks, and transportation services.
- Individual Placement and Supports for Mental Health & Substance Use (IPS)(CCP 8H-2): Members with severe mental illness find competitive, community employment and provides ongoing, individualized services with a focus on employment. Services include personalized counseling to understand how work may affect a member's benefits, ongoing treatment to help manage medications, symptoms, and other BH needs. An employment specialist and peer support help members to succeed on the job and advance professionally.

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Eligibility for 1915(i) services?

Eligible

- NC Medicaid Direct, Tailored Plans, EBCI Tribal Option and The Children and Families Specialty Plan (upon launch).
- Members on the waitlist for Innovations Services may be eligible to receive 1915(i) services while they wait.
- Members are not required to meet an institutional level of care to be eligible for 1915(i) services.

Not Eligible

- Recipients of Standard Plan, the NC Innovations or TBI Waiver are not eligible for 1915(i) services.

NC Medicaid's Member Eligibility for 1915(i) Services

Eligibility for 1915(i) services varies on a benefit-by-benefit basis and is determined after an assessment is approved. Eligible populations must have a NC Medicaid health plan managed by an LME/MCO and include individuals with I/DD, SED, SMI, SPMI, SUD, and TBI.

1915(i) Services	I/DD (Intellectual/Developmental Disability)	SED (Serious Emotional Disturbance)	SMI and/or SPMI (Serious Mental Illness)/ Severe and Persistent Mental Illness)	SUD (Severe Substance Use Disorder)	TBI (Traumatic Brain Injury)
Community Living and Support	✓ All Ages				✓ All Ages
Supported Employment	✓ Ages 16+				✓ Ages 16+
Individual Placement and Support Services		✓ Ages 16+	✓ Ages 16+	✓ Ages 16+	
Respite Care	✓ Ages 3+	✓ Ages 3-20		✓ Ages 3-20	✓ Ages 3+
Individual and Transitional Support		✓ Ages 16-21	✓ Ages 18+	✓ Ages 16+	
Community Transition	✓ All Ages		✓ All Ages	✓ All Ages	✓ All Ages

Courtesy of NCDHHS and AHEC

1915(i) Process Flow

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- **Identification:** Member is identified by PCP, BH, IDD or other provider to need 1915(i) services
- **Independent Assessment**: TCM completes the 1915(i) assessment and submits it to Carelon for review. This can be completed and submitted by the TCM before the CMCA is completed. This is required for all members where there is a prior authorization or not.
- **Independent Evaluation**: Carelon reviews the 1915(i) assessment to determine if the member needs the needs-based eligibility criteria. Carelon's timeframe for when a decision is rendered is 2 weeks. After 2 weeks the submitter can request a status update from Carelon.
- **Care Plan/ISP:** TCM assists the member in identifying a 1915(i)-service provider, develops the plan, and ensures the plan reflects the member's needed services and supports, preferences for the delivery of services and name of service provider. Must be completed within 60 calendar days of TCM consent for all new members with 1915(i) goals. TCM and 1915(i) providers should collaborate to develop the member's Care Plan/ISP and share a copy of the plan once completed together to ensure accuracy and there are no barriers to the member receiving 1915(i) services.
- **Prior Authorization:** TCM submits a completed Care Plan/ISP for review, UM conducts prior authorization of 1915(i) services. Providers should not bill 1915(i) services until a member has been deemed eligible and authorized for services unless there is no prior authorization required.
- **Service Delivery and Care Coordination:** TCM and 1915(i) service provider will work to implement the authorized services according to the plan. TCM provides ongoing care coordination.

Note: If a member has opted out of TCM, Care Coordination staff can complete these tasks.

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Authorization of 1915(i) Services

Effective 1/1/2025, Clinical Communication Bulletin #70 released 12/20/2024 for Mental Health Parity updates, flexibilities ending and authorization changes need. This CCP effected the following two 1915(i) services:

- 1915(i) Individual Placement and Support (IPS) for MH & SA (8H-2)
  - Remove prior authorization, initial authorization, reauthorization, and UM requirements
  - Remove completing authorization requests form program assistant activities
- 1915(i) Individual and Transitional Supports (ITS) (8H-3)
  - Removed that this service may be provided up to 60 hours per month for rehabilitation
  - Remove prior authorization, initial authorization, reauthorization, and UM Requirements
  - Remove Medicaid can cover up to remove 240 units of service per month. Initial authorization of services cannot exceed 180 calendar days.
  - Remove Medicaid may cover up to 240 units of service per month for 90 calendar days for reauthorization periods.

Note: 1915(i) assessment is required for all members whether they need prior authorization or not

2024-2025 Medicaid 1915(i)-Option Set of Services - Prior Authorization

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- **Community Living and Support (CCP 8H-5):** School-aged Members Up to 15 hours (60 units) a week when school is in session and up to 28 hours (112 units) a week when school is not in session. Members aged 22 and up: Up to 28 hours (or 112 units) a week.
- **Community Transition (CCP 8H-6):** Available up to 3 months in advance of a member's move to an integrated living arrangement, and up to 90 consecutive days post move in date.
- **Respite (CCP 8H-4):** No more than 1200 units (300 hours) can be provided in a Plan year.
- **Supported Employment for IDD and TBI (CCP 8H-1):**
  - **Pre-employment and Employment Stabilization Phase:** A maximum of 20 hours (80 units) per week for up to 180 days of services for initial job development, training, and support. If the member obtains employment and their schedule and support needs require more than 20 hours a week of services, additional hours can be authorized.
  - **Employment Stabilization Phase:** Based on the members' work schedule and support needs, not to exceed 40 hours a week (160 units). Services can be authorized for up to 365 days if the work schedule/ needs are not anticipated to change.
  - **Long-Term Supported Employment Phase:** For a member who is stable in their employment and has minimal support needs, a maximum of 10 hours (40 units) per month may be approved annually for periodic long-term support. If there is an increased support need, additional hours may be authorized. For a member with ongoing support needs, SE may be authorized for the number of hours necessary to support the member to remain stable in their employment; not to exceed 40 hours (160 units) a week.
- Trillium-Medicaid-1915i-Option-Set-Benefit-Plan.pdf

2024-2025 Medicaid 1915(i)-Option Set of Services - No Prior Authorization

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- **Individual and Transitional Support (ITS) (CCP 8H-3):** The duration and frequency must be based on member need and progress made by the member toward goals outlined in the care plan. It is expected that the service intensity titrates down as the member demonstrates improvement.

- **Individual Placement and Supports for MH & SUD (IPS)(CCP 8H-2):**
  - Service does not have a hard limit.
  - The duration and frequency at which IPS is provided must be based on medical necessity and progress made by the member toward goals outlined in the Career Profile.
  - Services are based on the level of intensity required to acquire stable employment or interventions required for continued employment.
  - Individuals with sole IDD or TBI diagnoses would not qualify for IPS-SE.
- Trillium-Medicaid-1915i-Option-Set-Benefit-Plan.pdf

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What are the 1915(i) Service billing codes?

- Providers should not bill 1915(i) services until a member has been deemed eligible for 1915(i) services (which happens after the 1915(i) assessment has been completed) and the member's 1915(i) services have been authorized by the member's Tailored Plan or LME/MCO.
- When submitting 1915(i) service claims ensure you are using the correct codes and site location for services.

The following codes can be leveraged after the member has been authorized for 1915(i) services:

Code	Modifier(s)	1915(i) Service
H0043	U4	Community Transition
H0045	U4	Respite
H0045	HQ U4	Respite Group
H2023	U4	Supported Employment Initial
H2023	HQ U4	SE Initial Group
H2026	U4	SE Maintenance
H2026	HQ U4	SE Maintenance Group
T1019	U4	Individual and Transitional Support (subject to EVV)
T1019	U4 TS	Individual and Transitional Support (non-EVV, only in the community)
T2012	U4	Community Living and Supports (only in the community, non-EVV)
T2013	TF HQ U4	Community Living and Supports Group (subject to EVV)
T2012	GC U4	Community Living and Supports relative as provider lives in home (non-EVV)
T2013	TF U4	Community Living and Supports Individual (subject to EVV)
T1017 T1017	HT U4	TCM for 1915(i) *(Two separate lines on the same claim are required)*

Courtesy of the NC Medicaid Managed Care Provider Playbook

Care plans/ISP Trainings and Templates

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- Individual Support Plan (ISP) development Templates
  These are templates that can be utilized for the Individual Support Plan (ISP)development. Please make sure to follow the appropriate Clinical Coverage Policies for 1915i or Innovations Waiver to make sure all required elements are on the ISP that is developed.
  - Tailored Care Management Providers Forms and Training | Trillium Health Resources

- TCM Training Resources and Links: To ensure provider success, TCM Providers contracted with Trillium can access TCM specific trainings and support tools at their convenience. The Provider My Learning Campus, Trillium's web-based training platform, houses TCM specific trainings offered by Trillium and the Mountain Area Health Education Center (MAHEC).
  - **Step 1**: Provider - My Learning Campus User Agreement Form
  - **Step 2**: Provider - My Learning Campus Click Provider Login
  - **Step 3**: TCM providers can find pertinent trainings in the **"Tailored Care Management Tailored Plan"** category, as well as **All TCM Provider Forum** recordings in the **"Network Trainings"** category.
- Accessing trainings through MAHEC: NC MAHEC hosts a helpful web portal which contains a wealth of resources for TCM providers, including slideshows used in past Learning Collaborative meetings.

1915(i) Provider Resources

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- 1915(i) Clinical Coverage Policies
  - 8H-1, 1915 (i) Supported Employment for I/DD and TBI
  - 8H-2, 1915(i) Individual Placement & Support (IPS) for Mental Health & Substance Use
  - 8H-3, 1915(i) Individual and Transitional Support (ITS)
  - 8H-4, 1915(i) Respite
  - 8H-5, Community Living and Supports
  - 8H-6, 1915(i) Community Transition
- Medicaid Benefit Plan: Medicaid 1915(i) - Option Set of Services
- Trillium Rate Sheet: https://www.trilliumhealthresources.org/for-providers/billing-codes-rates-check-write-schedule
- TCM Provider Manual: https://medicaid.ncdhhs.gov/tcm-provider-manual-012025/download?attachment.
- 1915(i) Services: Medicaid Home and Community-Based Services: Medicaid.NC.Gov/1915i.
- PCP/Provider Request for Care Manager Name or Assignment Referral Form: PCP/Provider Request for Care Manager Name or Assignment Referral Form
- For TCM Assignment: Providers can refer to NC Tracks to determine TCM assignment. Just click on the enrollment tab, scroll down and click on the current date range. The enrollment detail box will pop up, then click on the Tailored Care Manager NPI numbers in blue to see the assigned TCM. If Trillium is the TCM, the PCP/Provider Request for Care Manager Name or Assignment Referral Form (PCP/Provider Request for Care Manager Name or Assignment Referral Form (smartsheet.com) can be submitted to identify the Trillium TCM staff assigned to the member.

5

Physical Health Portal and Prior Authorizations

Gaines Carey

Education and Training Coordinator

Carolina Complete Health

Creating a New Account

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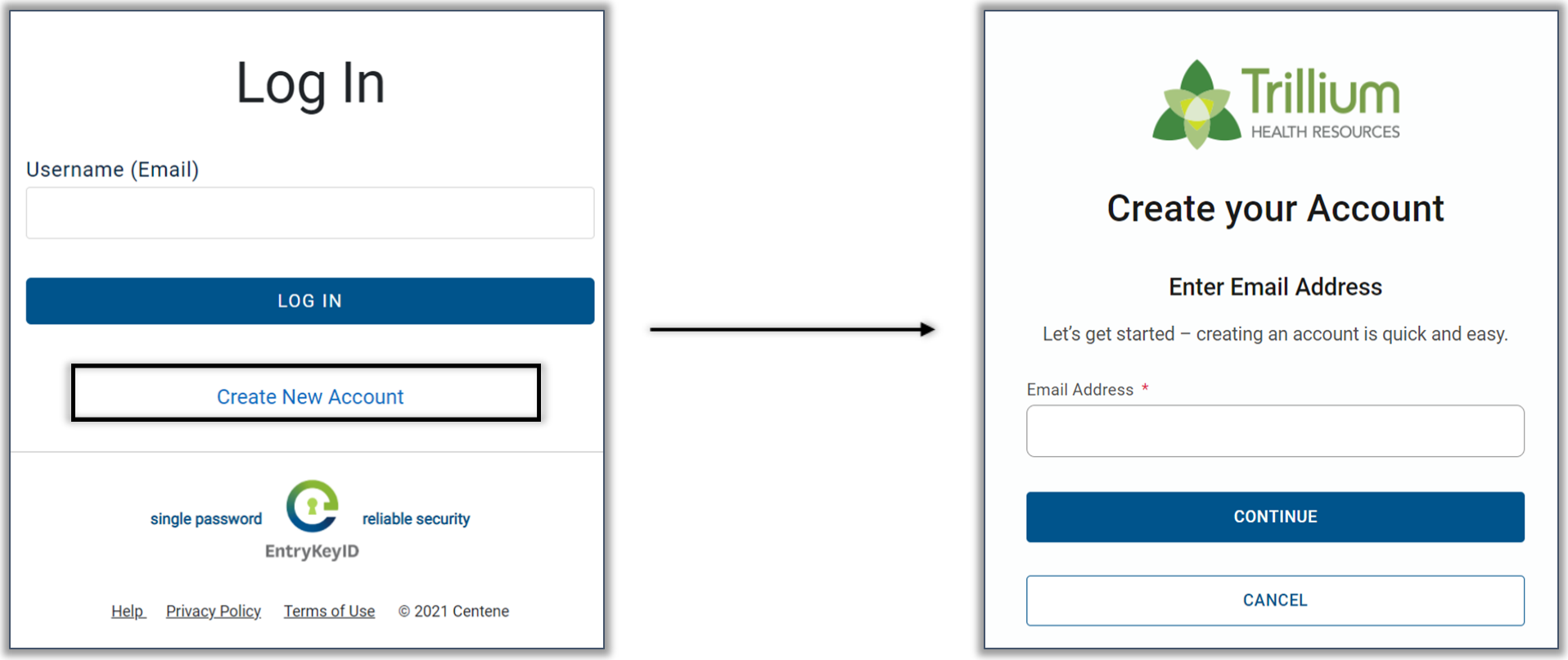
- Visit https://provider.trilliumhealthresources.org/
- Tip: Add no-reply@mail.entrykeyid.com to your email contacts



Initial Portal Registration

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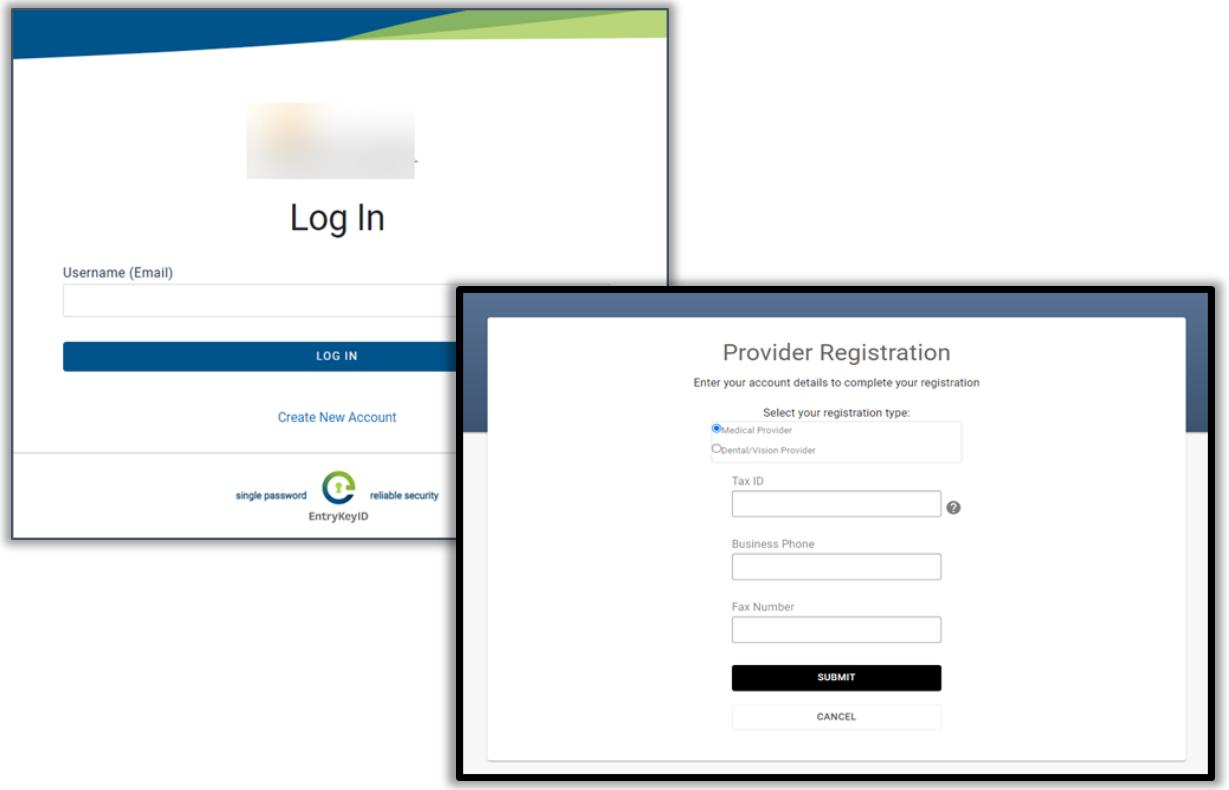
- Portal Registration: Once the EntryKeyID account setup is completed, the portal user will log in with their Username and password. The Portal Registration page will display.
- Once you have completed registration, your portal Account Manager can verify your access.
- If an Account Manager is not yet established, that individual should reach out to CCHN Provider Engagement for set-up.



Tip: To register for the portal, the provider organization's TIN ***must*** be loaded in our back-end system(s).

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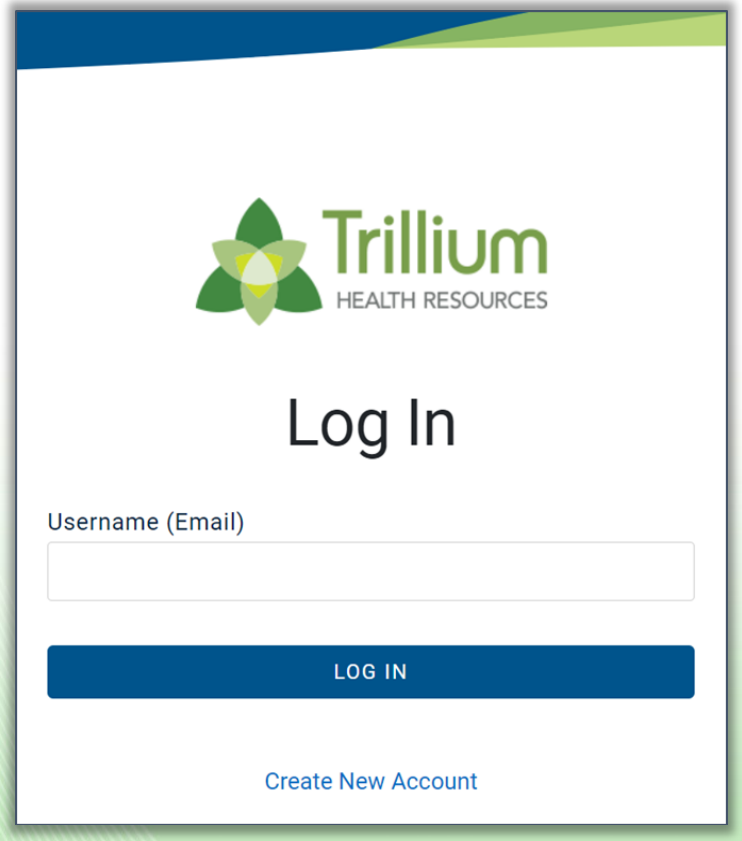
Overview: Physical Health Portal Set-up



Secure Portal address: https://provider.trilliumhealthresources.org/

1. **Assign Portal Account Manager:** To access the Trillium Physical Health Portal, in-network contracted providers must identify one individual who will serve as the Portal Account Manager. The Account Manager will be responsible for managing all other users for that provider organization.
2. **Create an account:** Visit provider.trilliumhealthresources.org to create a new account associated with your email address.
3. **Verify email:** Verify your email address by entering the one time code sent by EntryKeyID.
4. **Register TIN:** Under the 'Success!' message, click continue to enter the Tax ID for the contracted entity, business phone and fax. Click 'Submit.'
5. **Email Provider Engagement:** After registering, email your assigned Provider Engagement Administrator to request verification of your portal registration request and assignment as Portal Account Manager. **CCHN Is responsible for verifying/setting up the first Account Manager.**

Note: Providers should not use the Carolina Complete Health Standard Plan portal to submit Tailored Plan claims.

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Portal Account Manager

Portal Account Manager

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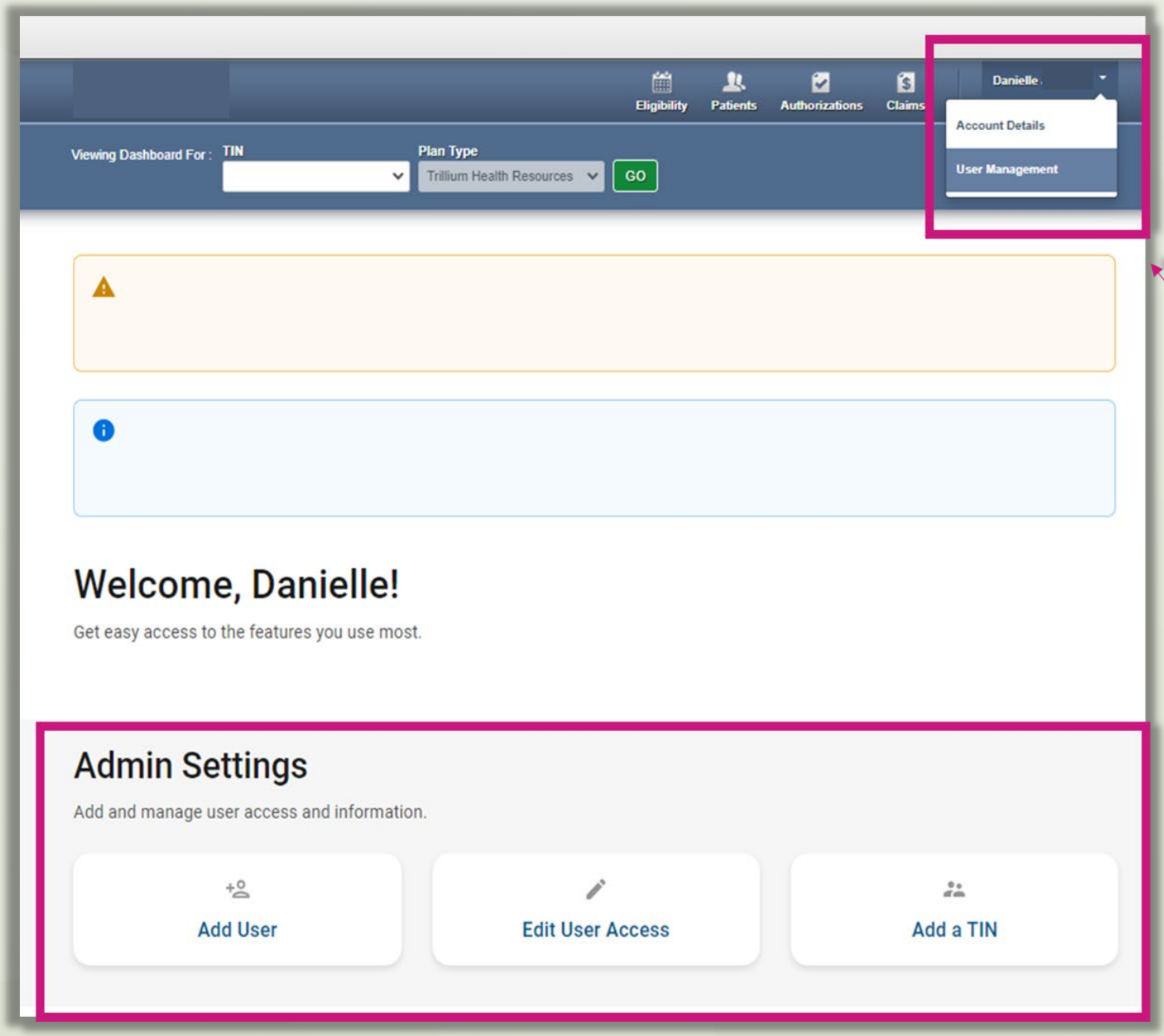
- A Portal Account Manager is a role assigned to a primary contact within a provider organization.
- The Account Manager is responsible for the day-to-day support of all Secure Provider Portal user accounts that are registered under the same TIN.
- Email your assigned Provider Engagement Administrator or ProviderEngagement@cch-network.com to establish the first account manager for your TIN.


Eligibility
Patients
Authorizations
Claims
Danielle
Account Details
User Management
Viewing Dashboard For :
TIN
Plan Type
Trillium Health Resources
GO
Welcome, Danielle!
Get easy access to the features you use most.
Admin Settings
Add and manage user access and information.
Add User
Edit User Access
Add a TIN
1

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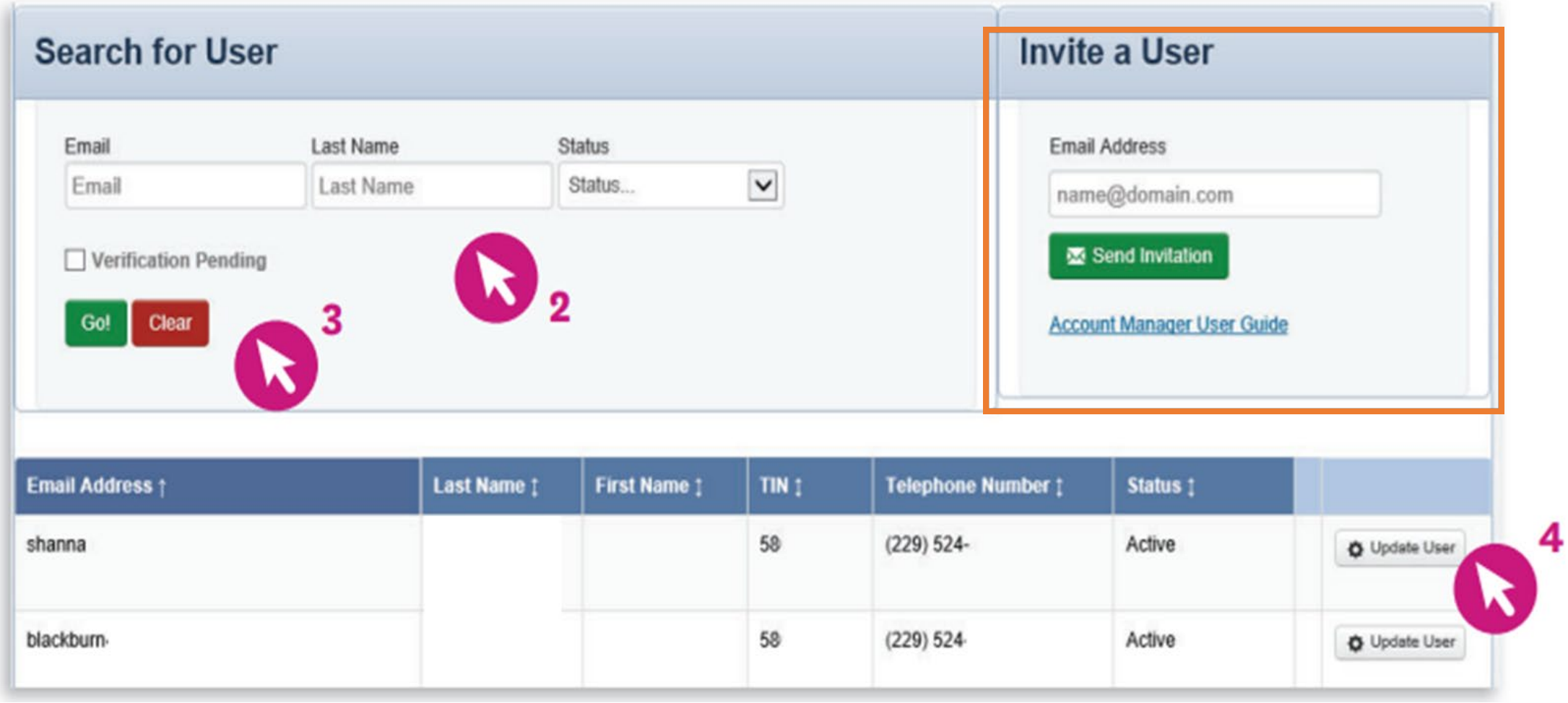
User Management



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Portal Account Manager Tips

- Each TIN should have at least two Account Managers
  - For large organizations, it is recommended to have at least two Account Managers per department.
  - There is no limit on the number of Account Managers allowed under a TIN
- Account Managers should *regularly* log into the portal to:
  - Verify new portal registrations
  - Send password reset email to users whose portal account is locked due to inactivity
  - Disable / Enable a user's portal access
  - Modify portal permissions based on the user's role within your organization
- Account Managers **cannot** manage their own portal account

Tip: Always disable portal users, who no longer need portal access, especially when they leave your company.

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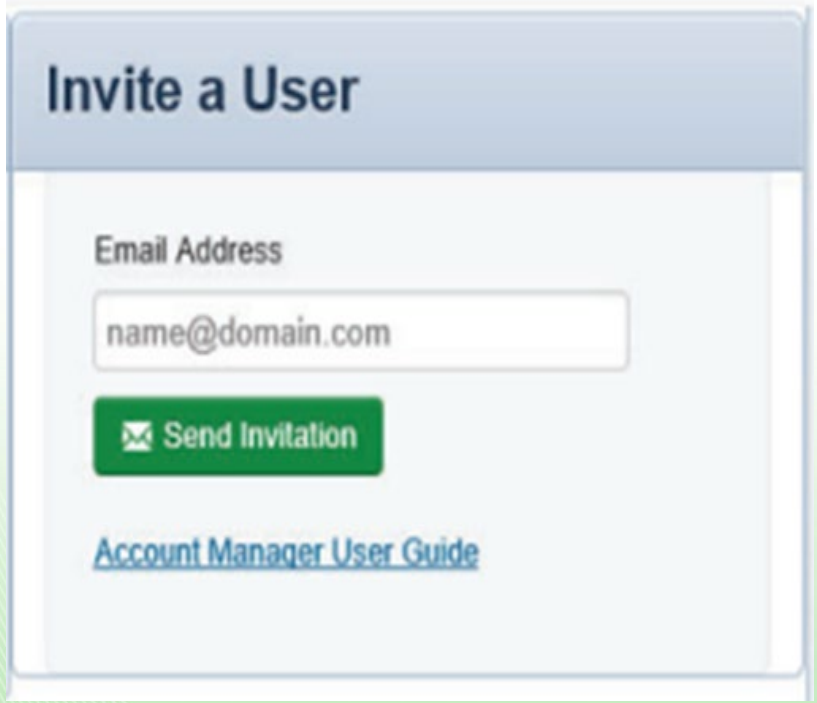
Portal Access for Third-party Billers



- Third-party billing entities supporting Trillium providers third-party have accounts to the Secure Provider Portal when validated by the practice's **Portal Account Manager.**
- The Account Manager should Invite a User by sending an invitation to the email address for the third-party biller.
- This generates an email link to the Trillium PH Secure Provider Portal.
- User should continue to Create an Account, verifying their email, then returning to enter TIN, Phone, and Fax.
- **After this point, the third-party biller should contact the Portal Administrator at the practice to verify their account request.**
- Upon verification, the user will be able to login to the portal and have functionality to submit and view claims.

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How to Secure a Prior Authorization

Emergency services, family planning, post stabilization services, and tabletop x-rays do not require prior authorization.

Electronic Submission (Preferred)	Manual Submission
Secure Provider Portal: Provider.trilliumhealthresources.org	Phone: 1-855-250-1539 Connect with Trillium Provider Support Service Line and request a transfer to the Physical Health Utilization Management Team
Availity Essentials https://www.availity.com/providers/	Fax Use the Trillium PA Fax Form (PDF) and submit to one of the following: Outpatient: 833-875-0930 Inpatient medical: 833-875-0650 Concurrent review: 833-875-2264 Transplant: 866-753-5659 Physician Administered Drug Program (PADP): 833-754-0251

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Is Prior Authorization Needed?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Will be available on the provider section of the Carolina Complete Health website

carolinacompletehealth.com/trillium-preauth.html

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DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Behavioral Health Services need to be verified using Trillium's Prior Auth Lookup Tool

Vision Services need to be verified by Centene Vision (Formerly Envolve)

Dental Services need to be verified by the State.

Complex imaging, MRA, MRI, PET, and CT scans need to be verified by Evolent (Formerly NIA)

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Are Services being performed in the Emergency Department or Urgent Care Center or Family Planning services billed with a Contraceptive Management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are services being rendered for pain management?	○	○
Are anesthesia services being rendered for dental procedures?	○	○
Are oral surgery services being provided in the office?	○	○
Is the member receiving hospice services?	○	○

To submit a prior authorization Login Here.

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Services Requiring Prior Authorization

All out-of-network (non-par) services and providers require prior authorization, *excluding emergency services, family planning, post stabilization services, and table top x-rays*

Ancillary Services

- Air Ambulance Transport (non-emergent fixed wing airplane)
- DME purchases costing $500 or more or rental of $250 or more
- Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy
- Orthotics/Prosthetics billed with an "L" code costing $500 or more or rental of $250 or more
- Hearing Aid devices including cochlear implants
- Genetic Testing

Inpatient Services

- All elective/scheduled admissions at least 14 business days prior to the scheduled date of admit (including deliveries) Note: Normal newborns do not require an authorization unless the level of care changes or the length of stay is greater than normal newborn
- All services performed in out of network facility
- Hospice care
- Rehabilitation facilities
- Skilled nursing facility
- Transplant related support services including pre-surgery assessment and post-transplant follow up care
- Notification for all Urgent/Emergent Admissions:
- Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes

Procedures/Services

- All procedures and services performed by out-of-network providers (except ER, urgent care, family planning, and treatment of communicable disease)
- Potentially Cosmetic including but not limited to:
    - bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures
- Experimental or investigational
- High Tech Imaging (i.e. CT, MRI, PET)
- Hysterectomy
- Oral Surgery
- Pain Management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Surgical Authorizations: Necessary Information

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- Beneficiary Name& ID number
- Providers Name, telephone number, &Taxonomy/ NPI number
- Facility name, if the request is for an inpatient admission or outpatient facility services (also include Taxonomy/NPI numbers)
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, **planned surgical procedures, surgery date**)
- Relevant clinical information (e.g. past/proposed treatment plan, **surgical procedure**, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans

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Authorization Tips

- Always check the member's eligibility before submitting an authorization request
  - A web authorization cannot be submitted on an ineligible member
- Web authorizations generally load in processing queue within seconds of submission
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request
  - This is the only way a portal user will see a web authorization error
  - Web authorization errors are uncommon, but when an error is encountered the web authorization request will not load, and thereby will not be processed
    - Please submit the authorization request by phone or fax
    - Notify the Health Plan and provide the web authorization confirmation number for research

Authorization Determination Timelines

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Authorization Type	Timeline for Request, Notification and Decision	Additional Details:
Standard Service Authorization	Request PA at least 14 days prior. The decision will be made within 14 calendar days.	Prior authorization required at least 14 business days before scheduled admission or as soon as service need is identified.
Surgery Authorization (Planned, non-emergent)	Request PA at least 14 days prior. The decision will be made within 14 calendar days.	Necessary clinical information, including diagnostic testing or second opinions, must be submitted to avoid administrative denial.
Emergent Inpatient Admission	Providers must notify within 1 business day.	Required for ongoing concurrent review and discharge planning.
Urgent/Expedited Requests	A decision and notification is made within seventy-two (72) hours of the receipt of the request.	Decision and notification within 72 hours of request receipt.

Claims and Payment

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- Contracted providers have 365 calendar days from the date of service (professional) or date of discharge (hospital) to file first time claim or claim corrections.
- Trillium physical health claim payments are issued weekly. Check run is Wednesday with payment issued to providers the following day. Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim.

Definitions

Paid in Full	The claim has been adjudicated, processed and reimbursed in accordance and with the executed provider contract on file including the coordination of benefits, as applicable per claim.
Clean Claim	A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Submission Methods for Physical Health Submit Claims

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Secure Provider Portal

- Provider.trilliumhealthresources.org
- Individual claims (professional and institutional) and batch claim submission

Availity Essentials

- https://www.availity.com/providers/

Clearinghouse/EDI

- Use Payer ID 68069
- The preferred clearinghouse is Availity. If the provider's clearinghouse connects to Availity, the claim can be passed on to CCH.

Mail

- Paper claim submission and claim correspondence (i.e. reconsiderations and grievances) can be mailed on the appropriate form to:
  PO Box 8003 Farmington, MO 63640-8003

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Portal Functionality

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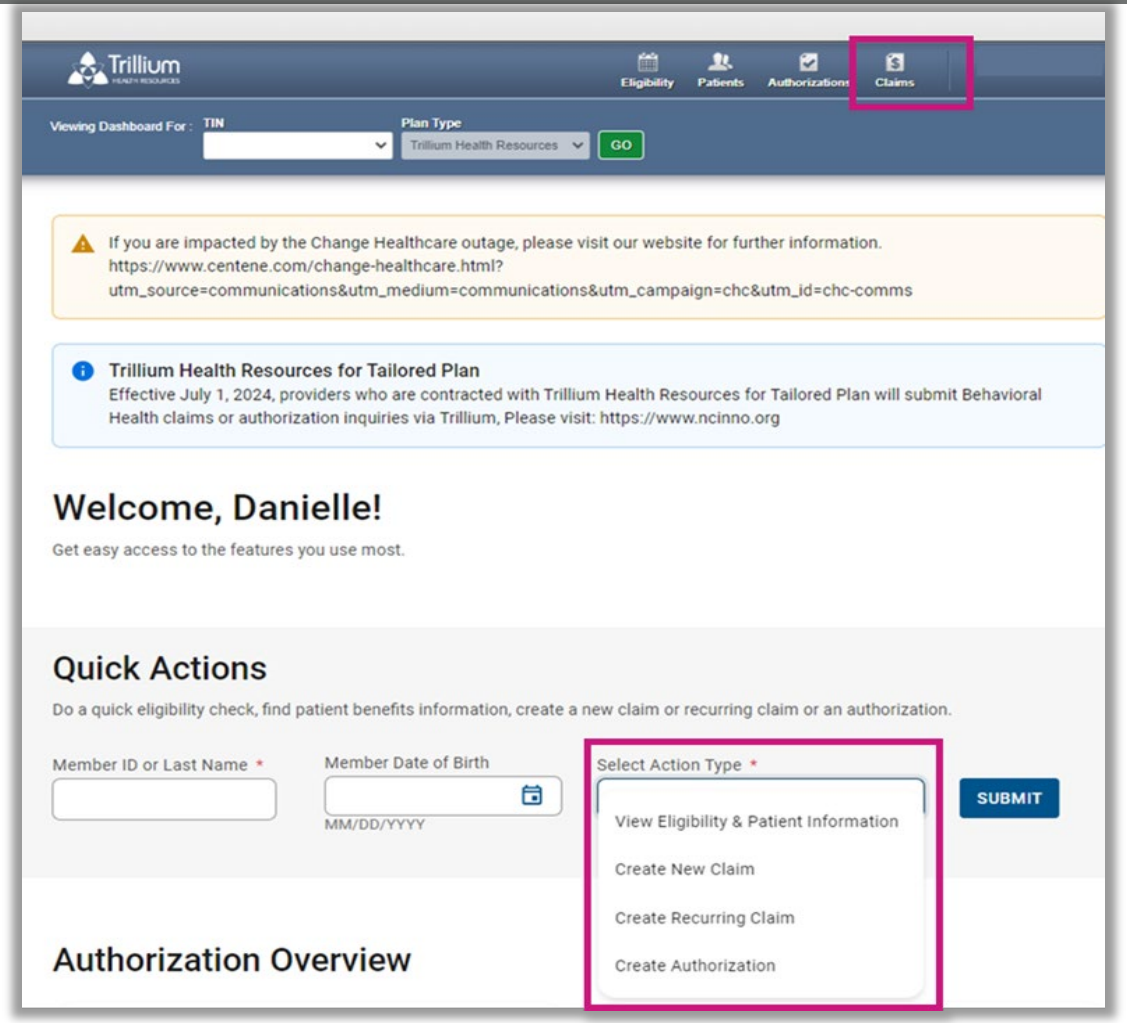
Claims

The Claims section displays claim-related information and is divided into a series of tabs.



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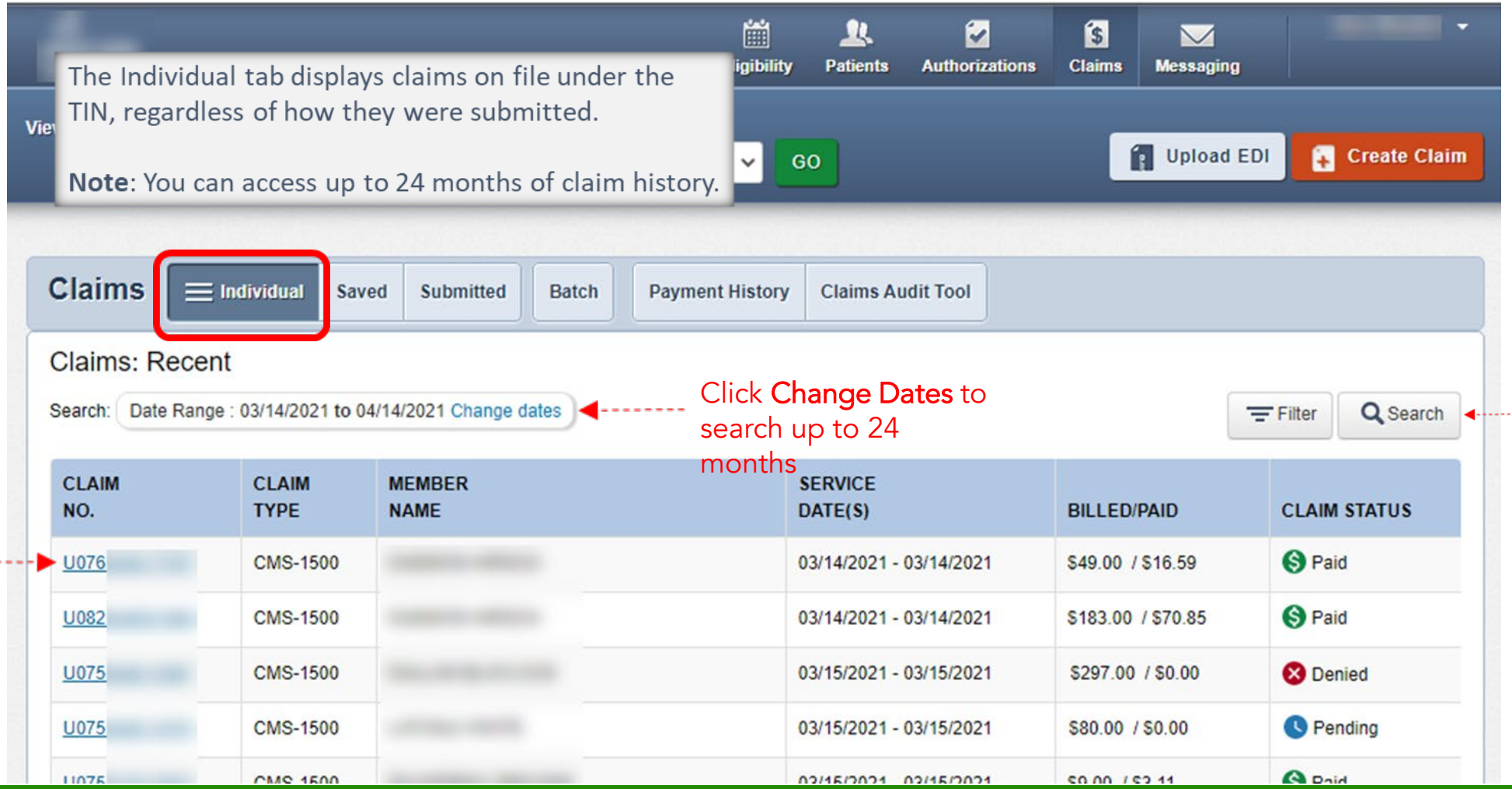
Claims – Individual



Click Claim Number to view claim details

Click **Change Dates** to search up to 24 months

Click **Filter** and/or **Search** for additional options

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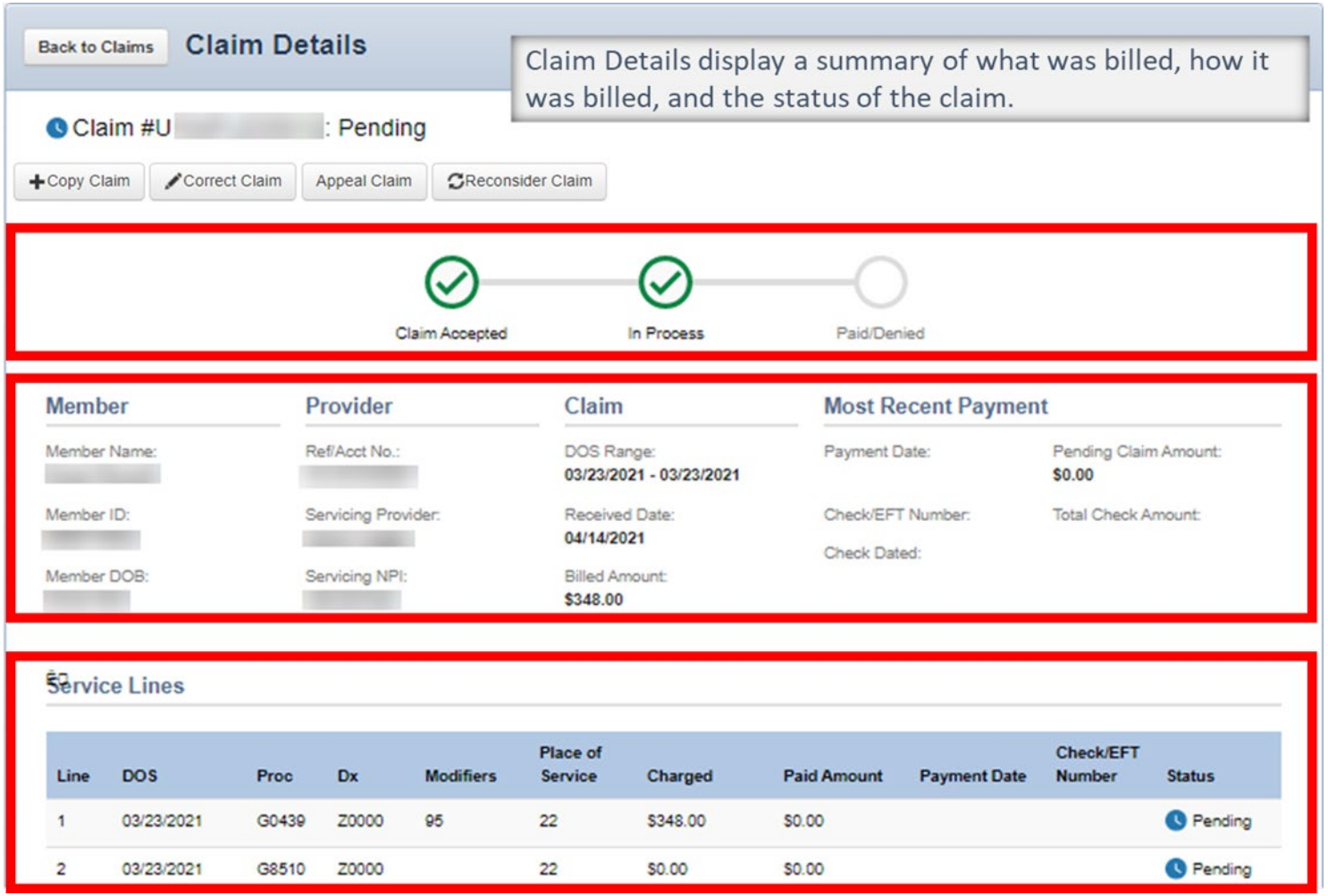
Claim Details

Claim Action Buttons

Claim Information

Claim Status Tracking

Claim Service Line(s)



Claim Details – Finalized

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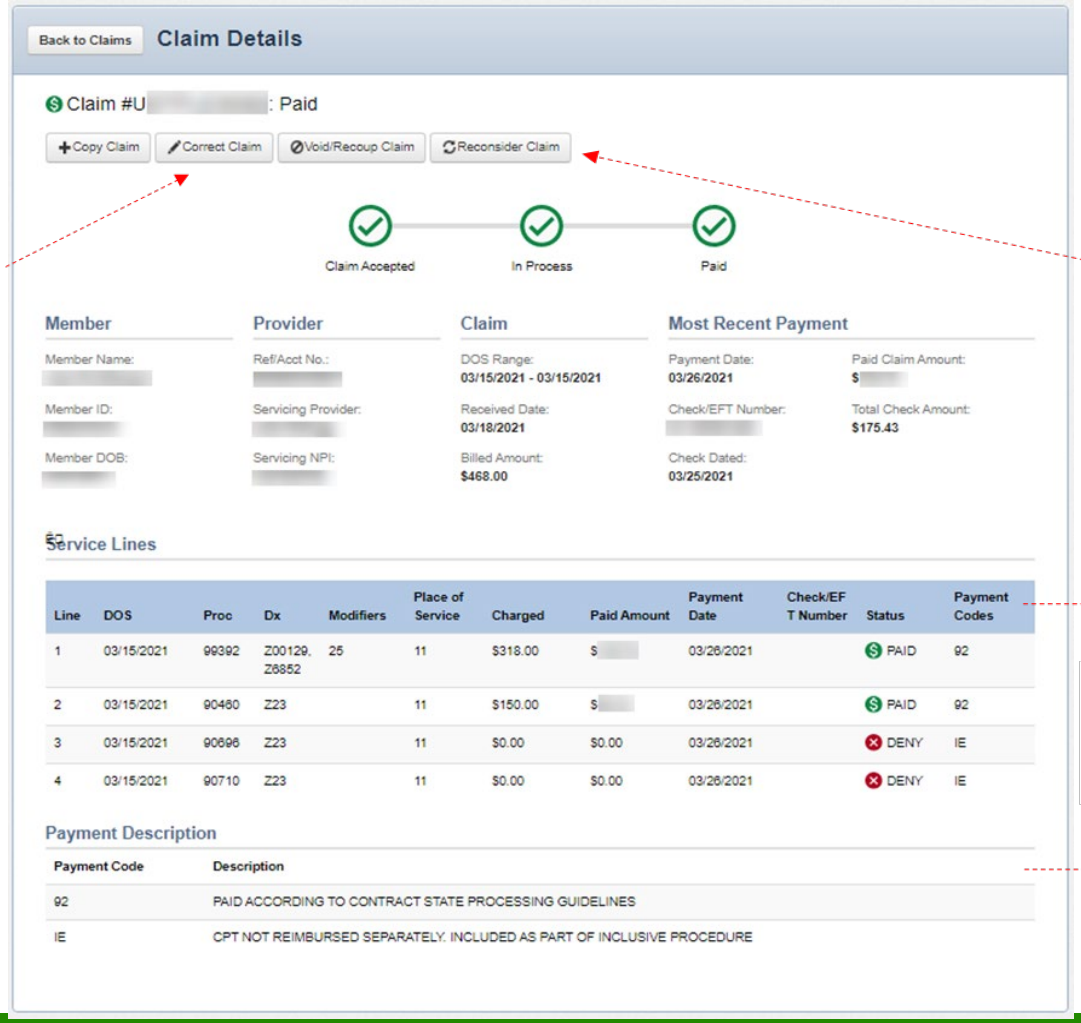
Click **Correct Claim** to correct a finalized claim



Click **Reconsider Claim** to submit reconsideration request

Payment Codes and **Payment Description** display on finalized claims

Claims – Saved

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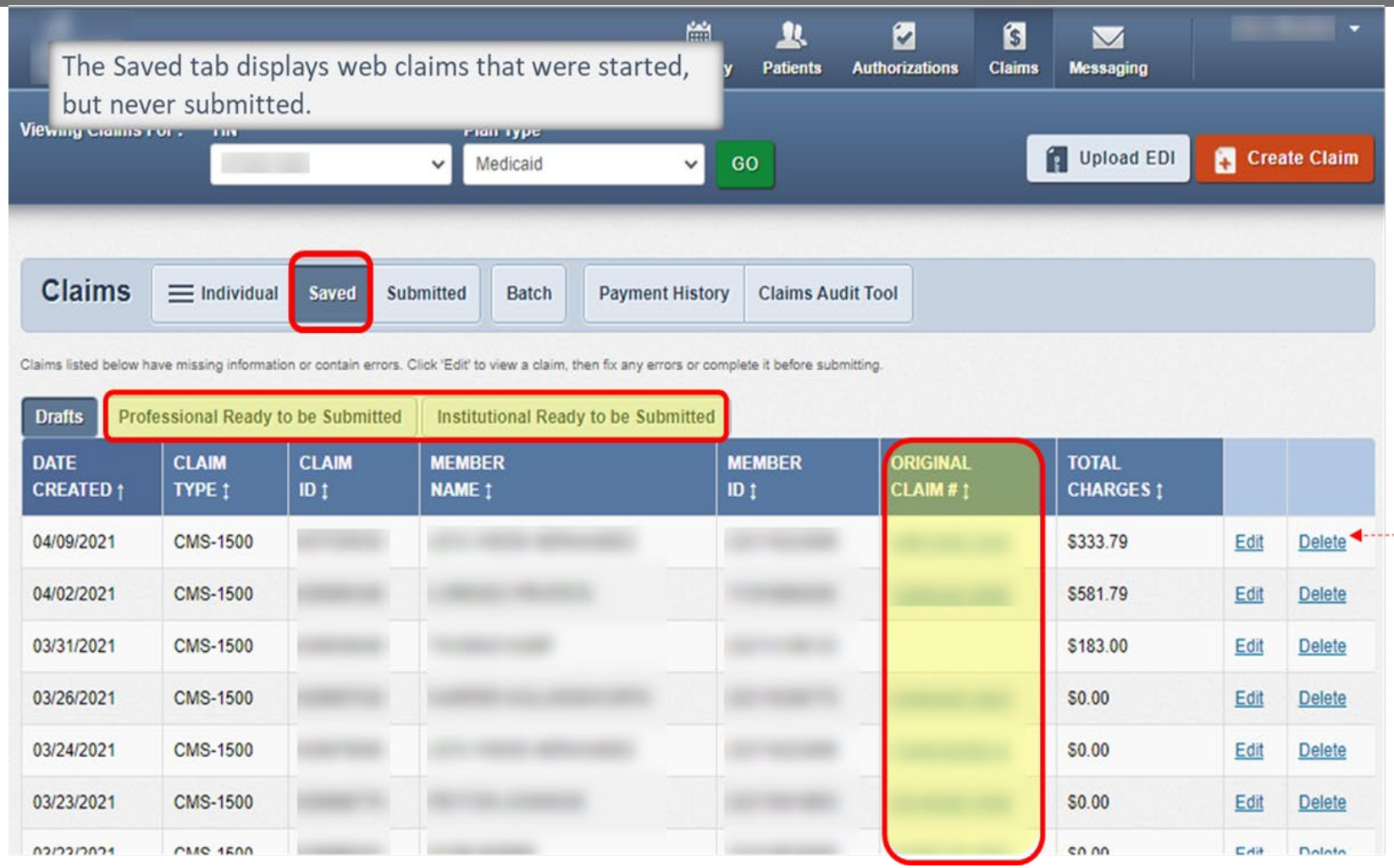

Click **Edit** to resume, complete, and submit web claim

Click **Delete** to delete the web claim draft

Tip: A Claim Number in the Original Claim # column, indicates it is a corrected claim draft.

Claims – Submitted

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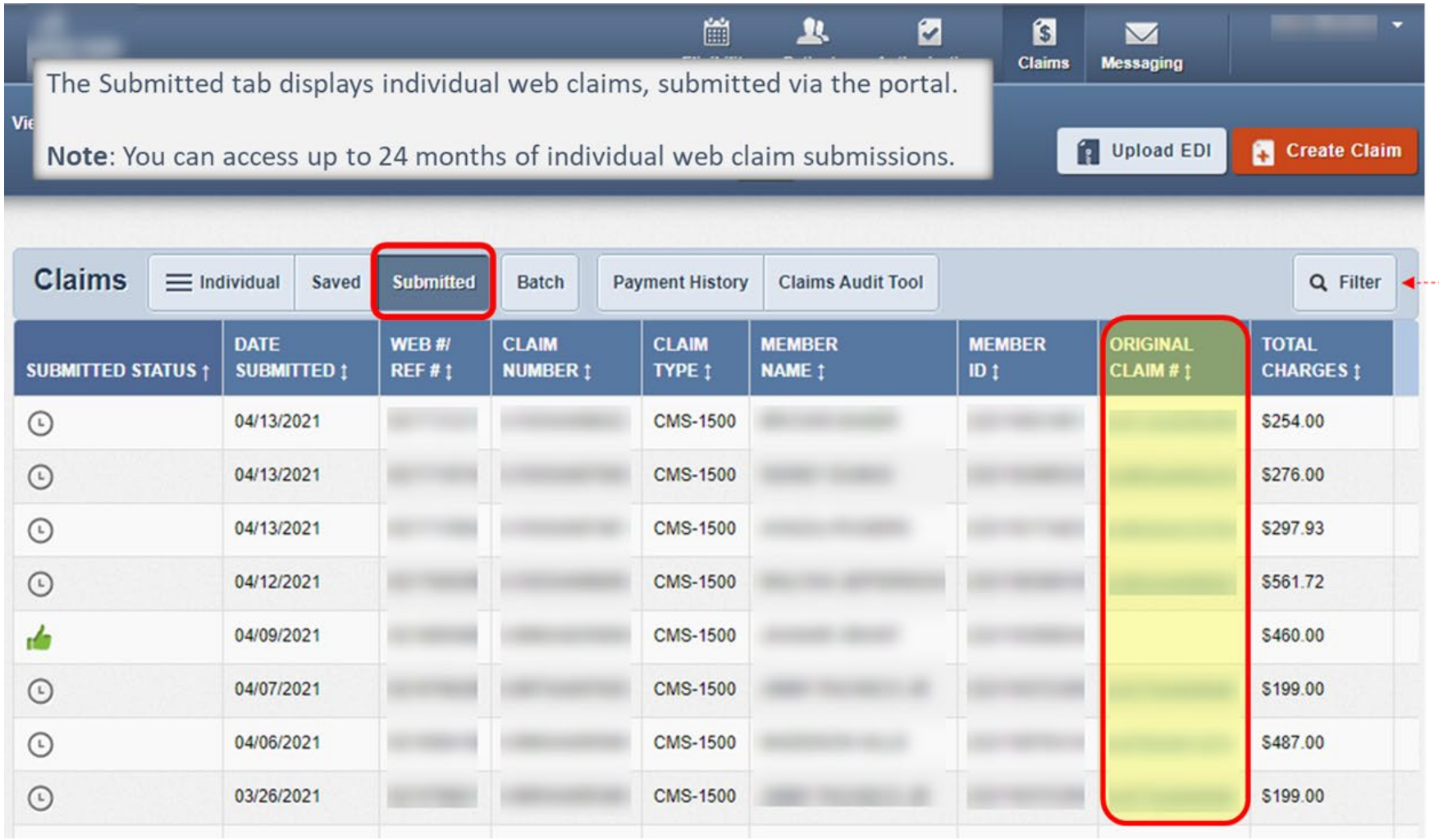

Click **Filter** for additional search options

Tip: A Claim Number in the Original Claim # column, indicates it is a corrected claim submission.

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Portal Functionality: Claim Submission

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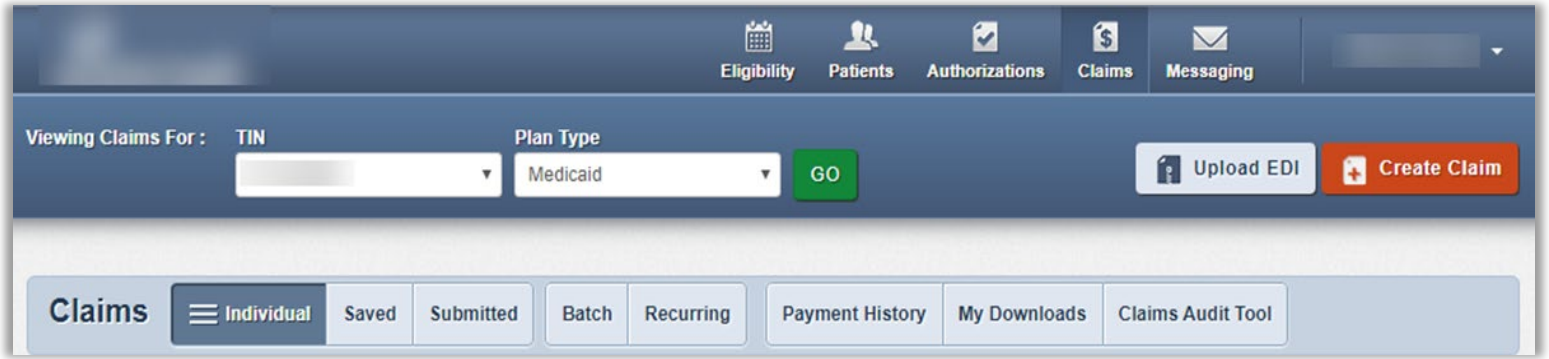
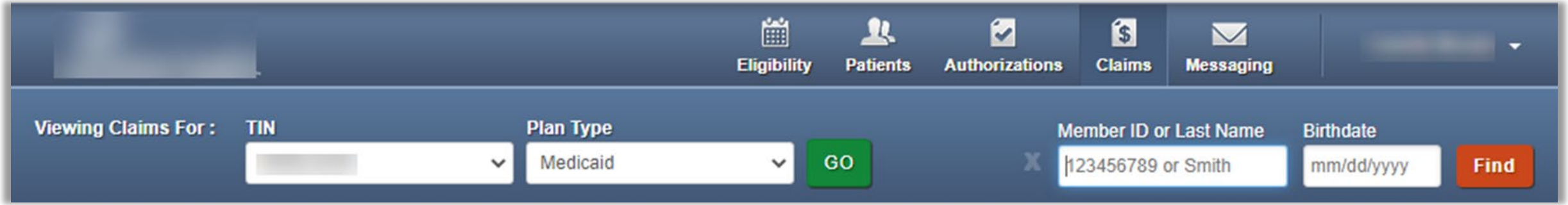
Claim Submission – Create Claim (Individual Web Claim)

To begin an individual web claim:

1. Click **Claims**
2. Click **Create Claim**
3. Enter **Member ID or Last Name**
4. Enter **Member's Birthdate**
5. Click **Find**





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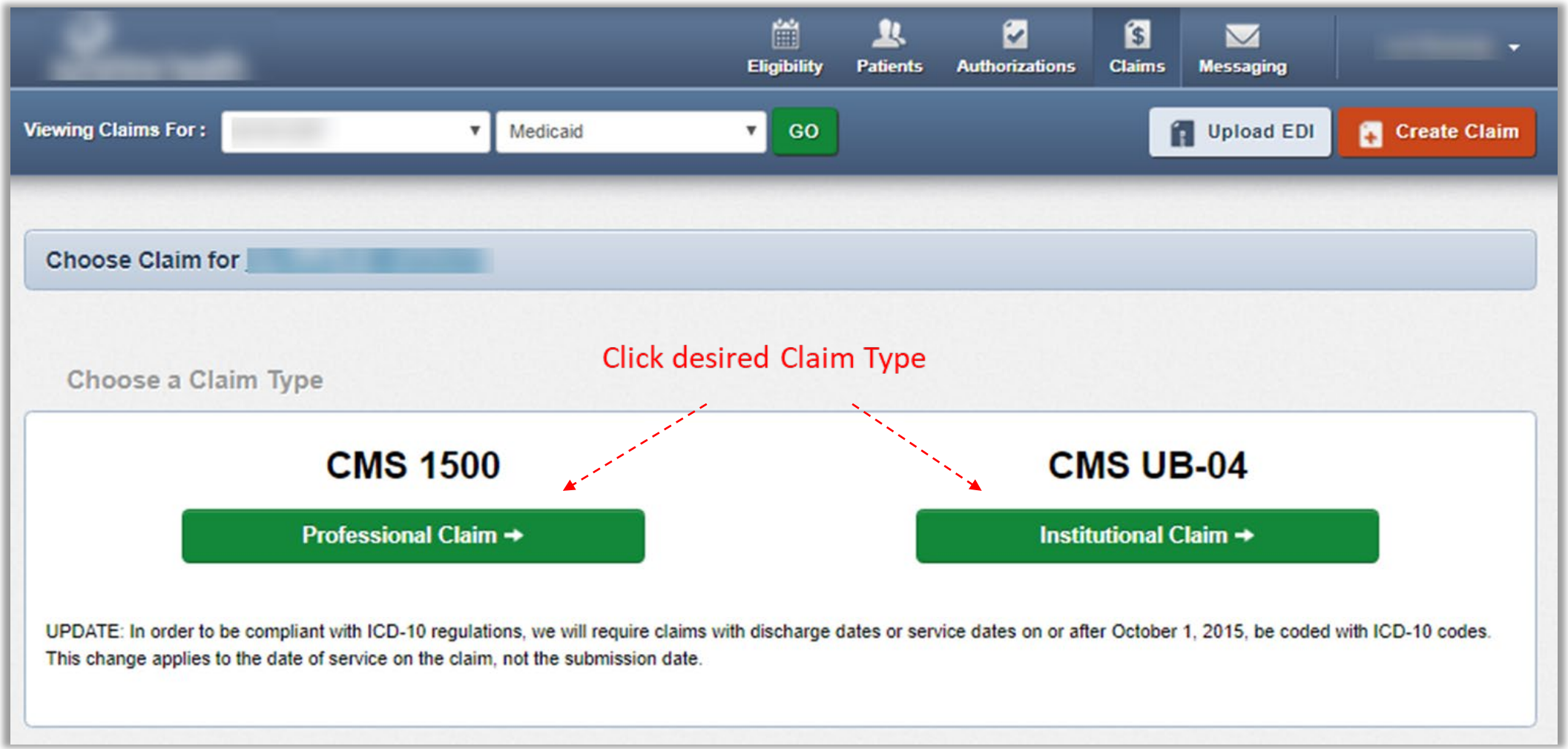
Create Claim – Claim Type Selection



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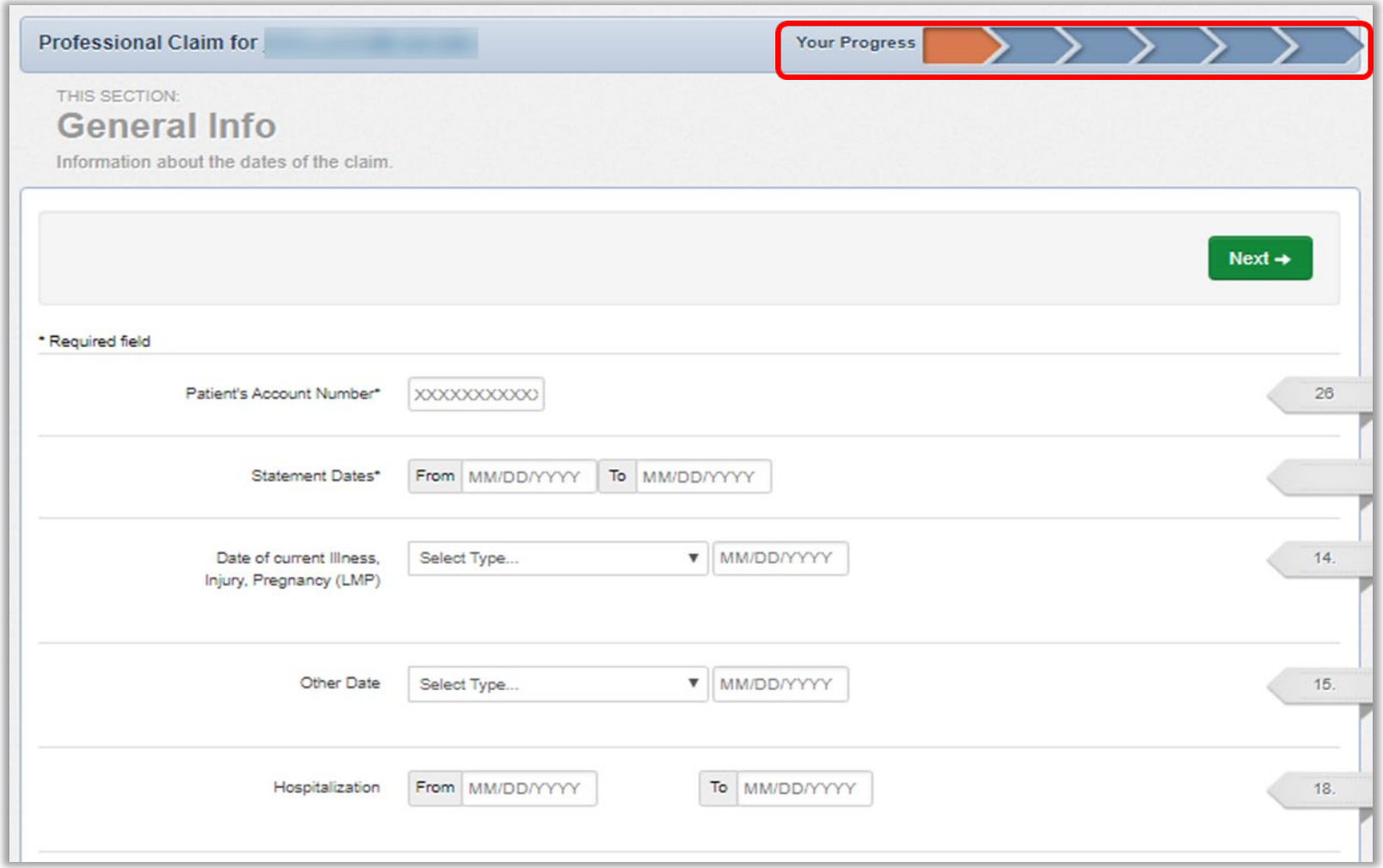
Create Claim – General Information



Hover mouse over tabs for additional information

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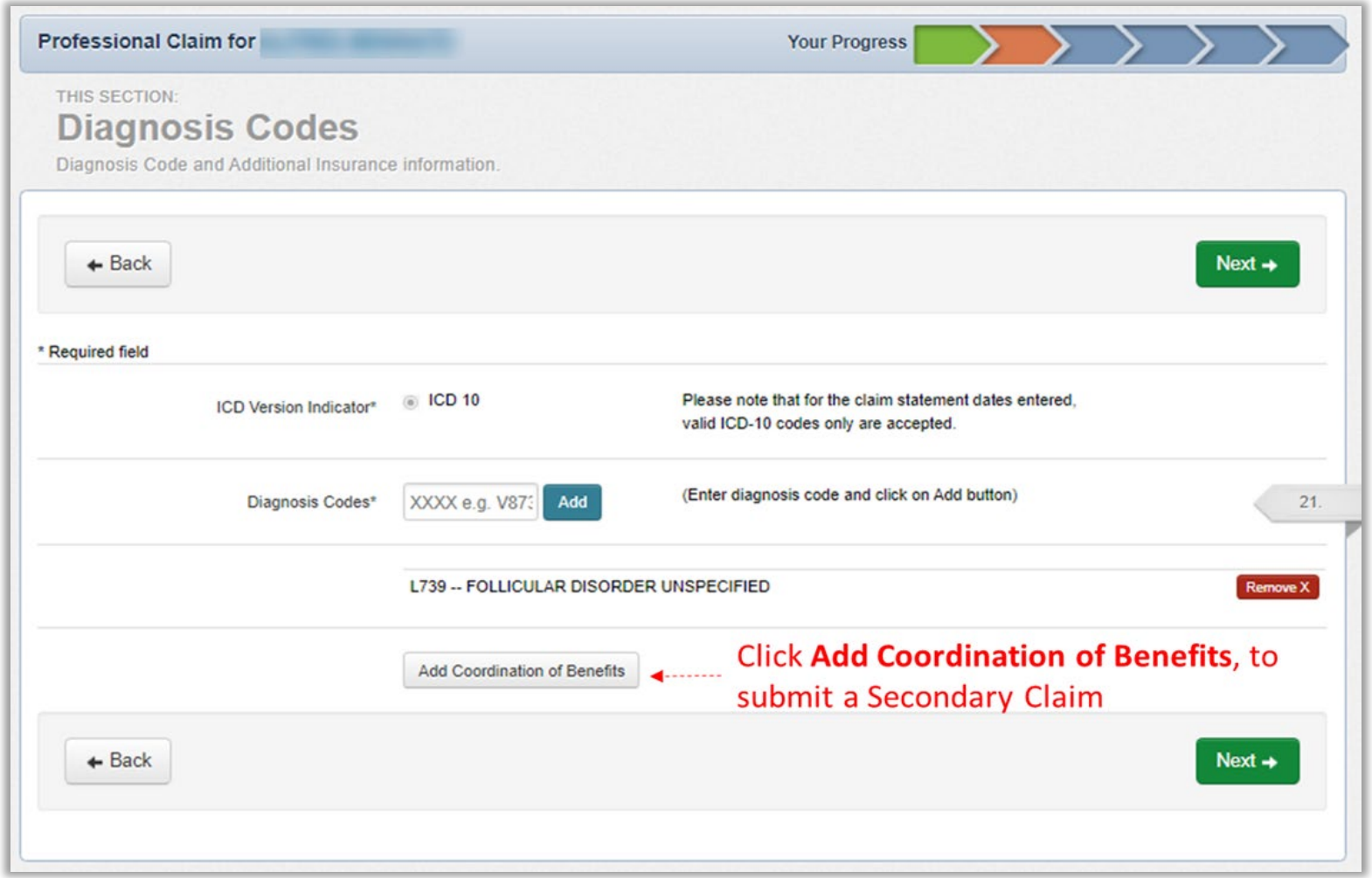
Create Claim – Diagnosis Codes



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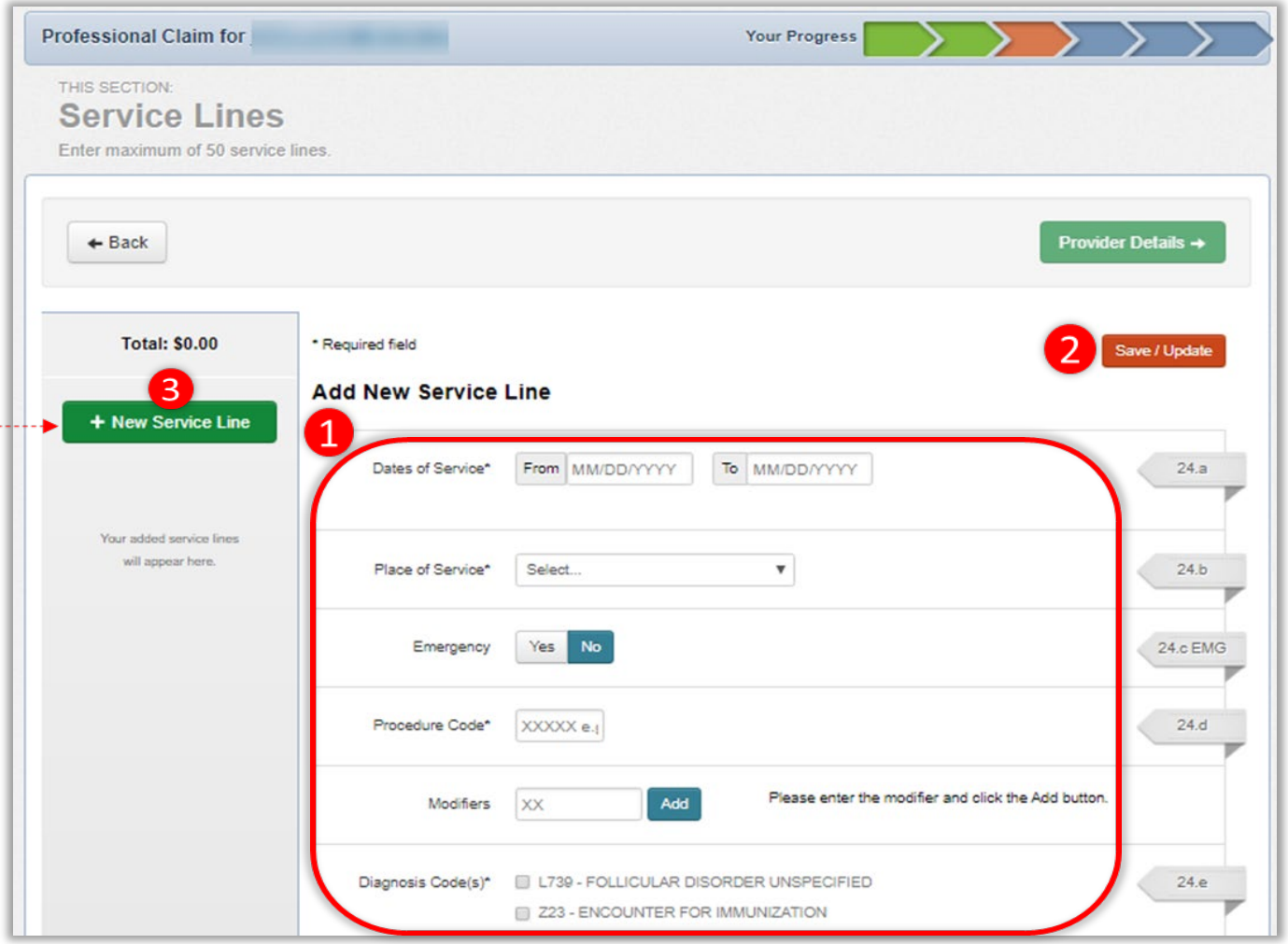
Create Claim – Service Lines

Click **+ New Service Line** to enter additional Service Line(s).



After entering or editing a Service Line, click **Save/Update**.

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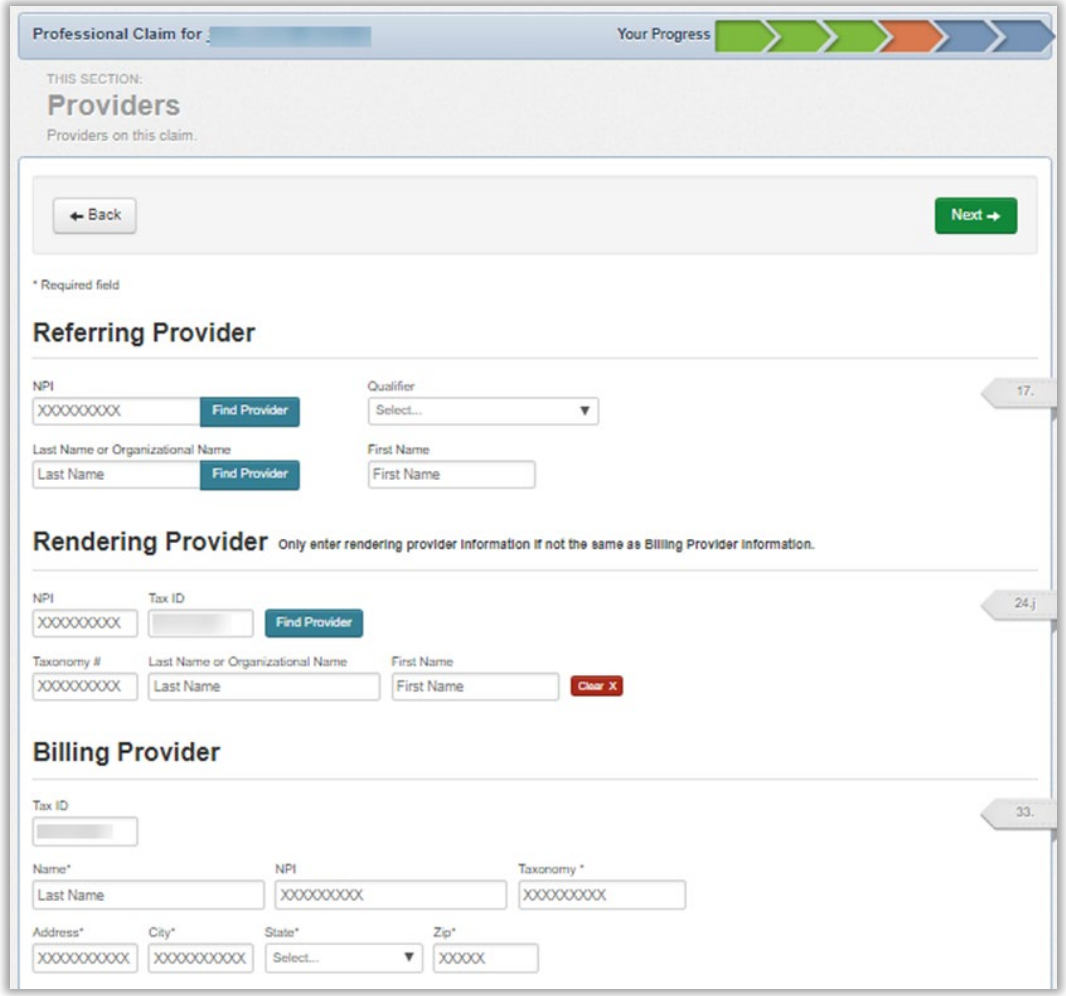
Create Claim – Providers



Tip: Missing Taxonomy is a common cause of processing delays and denials.

For more information, view our Claims Submission Reminder Guide (PDF)

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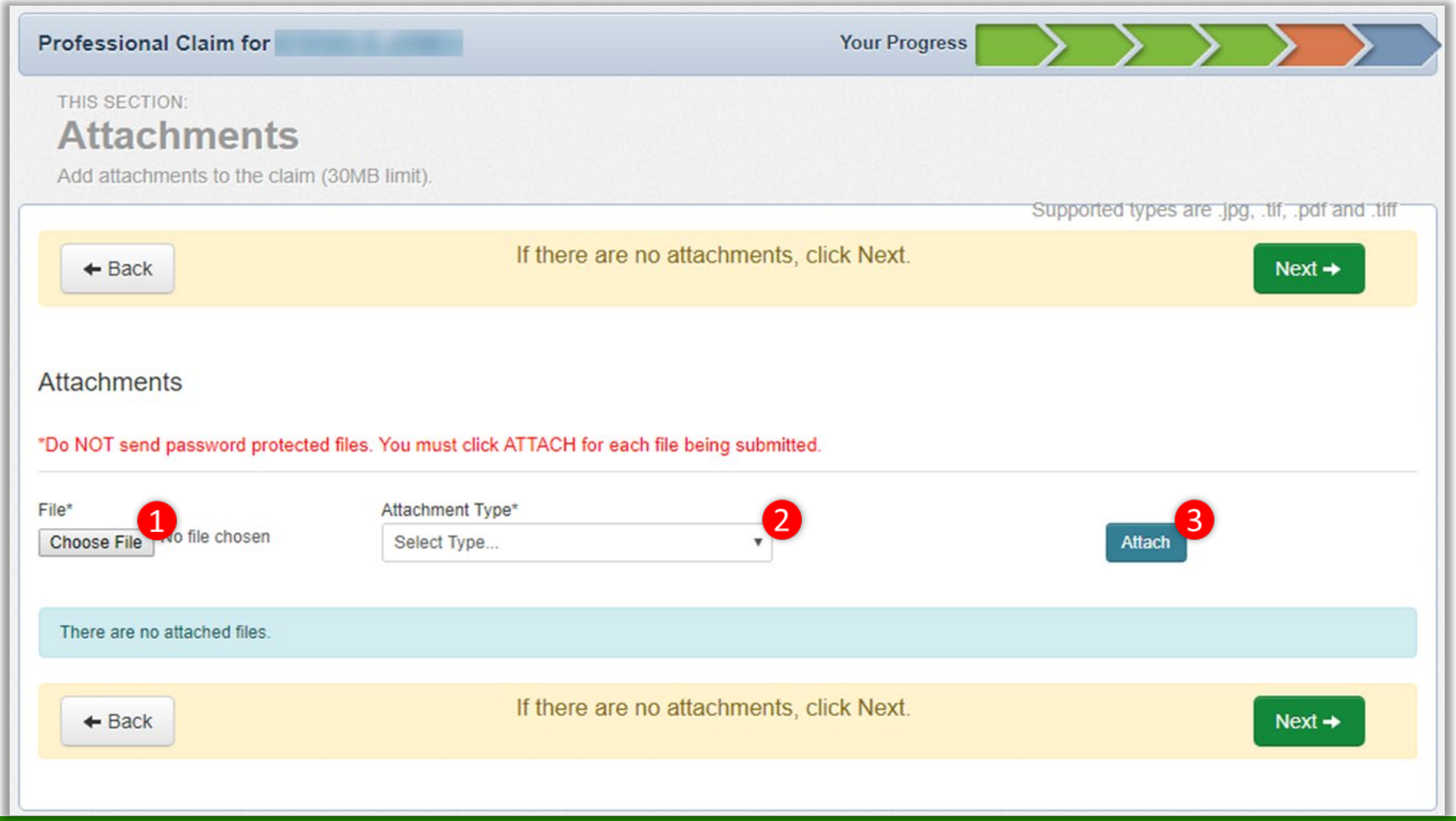
Create Claim – Attachments



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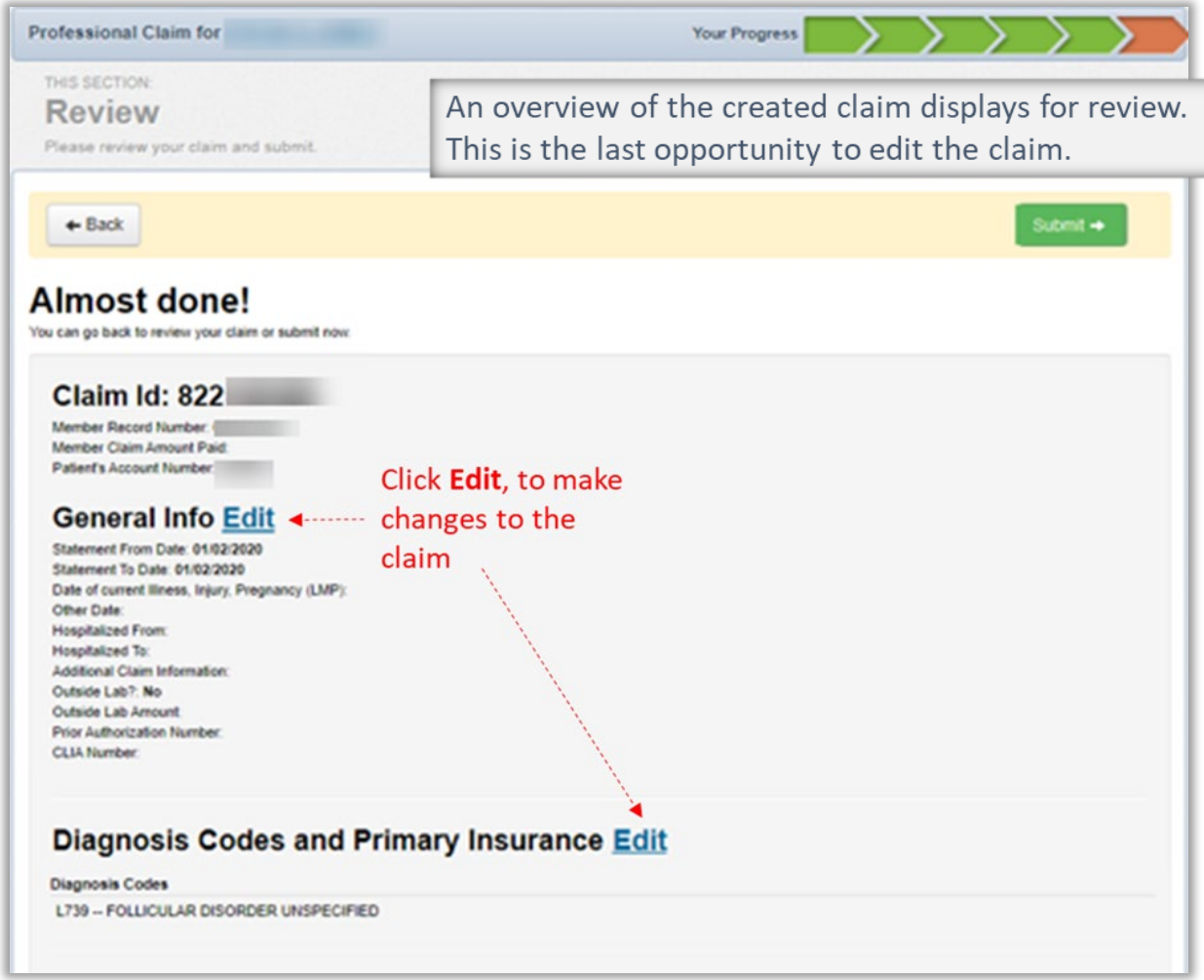
Create Claim – Review and Submit



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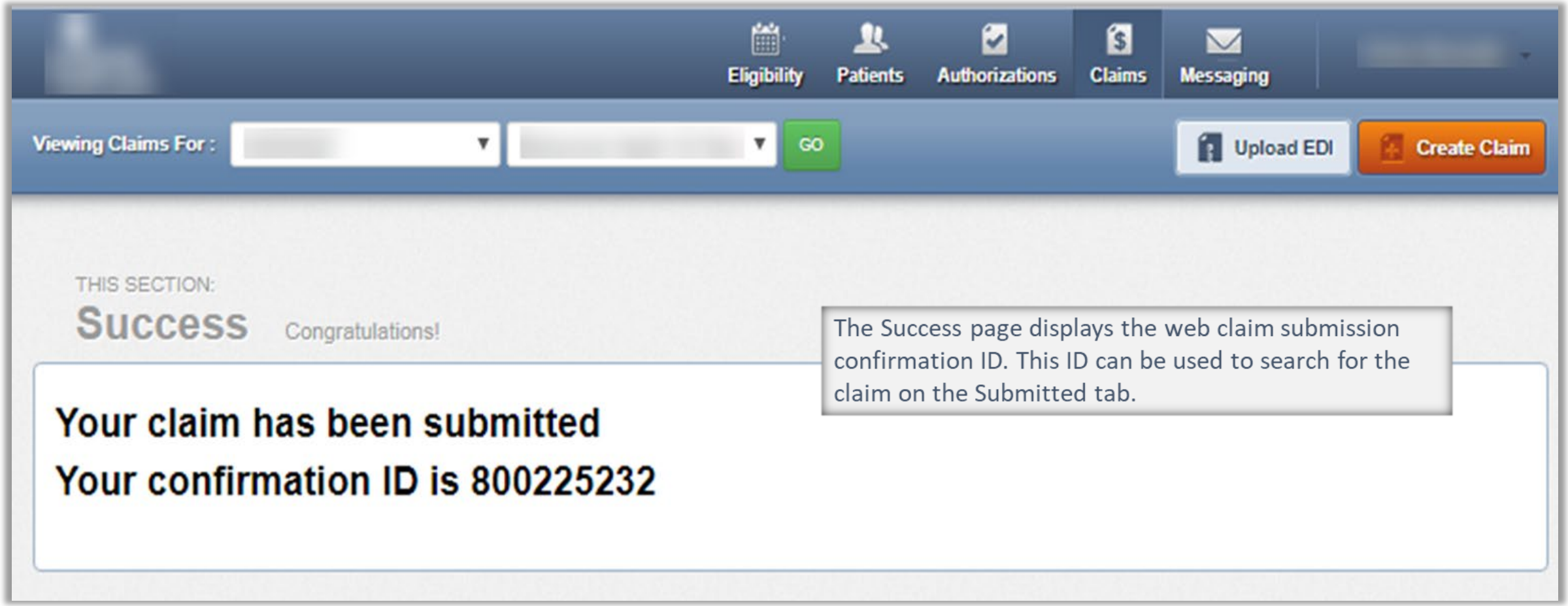
Create Claim – Submission Confirmation



The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab.

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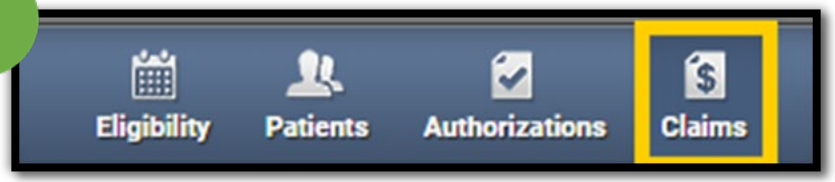
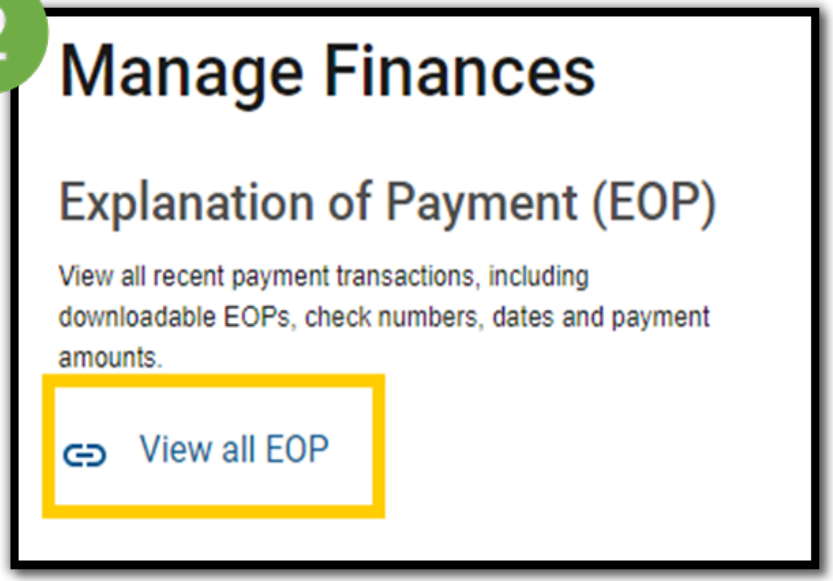
Access EOPs in Physical Health Portal

1



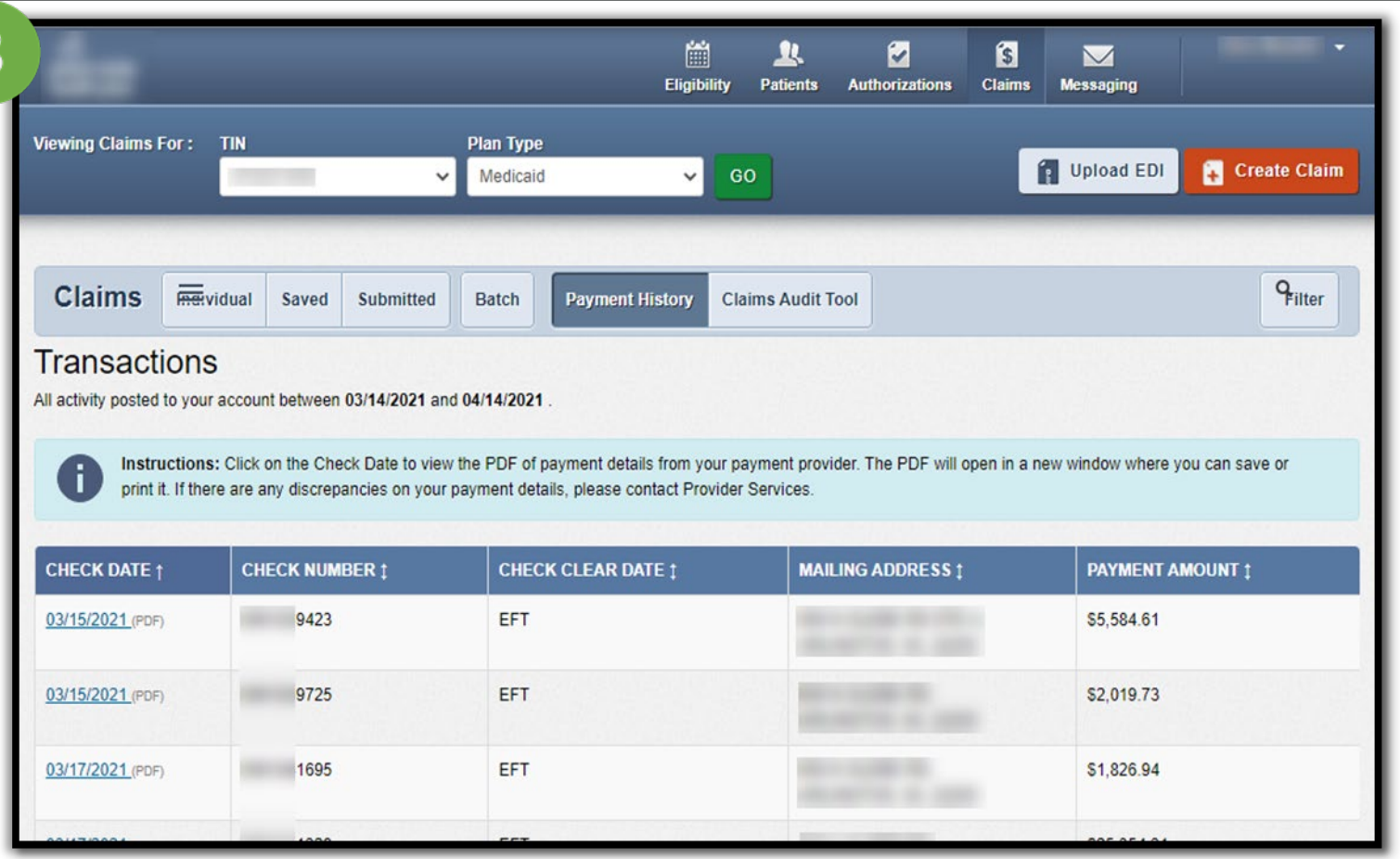
Click ‘Claims’ in the header menu

2



Scroll down and click ‘View all EOP’

3



Click the Check Date links which will download a PDF of the EOP

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Self Audits

- Providers should conduct periodic, voluntary **self audits** to identify incorrect payments. Self audits ensure compliance with participating Provider Agreement and State & Federal requirements.
- Providers must monitor and report findings of fraud, waste, & abuse.
- Report and return any **overpayments made within 60 days** of identification by:
  - Notifying CCH's Network Support Specialist team at NetworkRelations@cch-network.com
    OR
  - Ethics and Compliance Helpline at 1-800-345-1642 or www.centene.ethicspoint.com

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Key Contacts and Resources

Trillium Member Support Line	1-877-685-2415
Trillium Provider Support Line	1-855-250-1539
Technical support for the Trillium Physical Health Portal	CCHN Provider Engagement Team: ProviderEngagement@cch-network.com
General Questions/Support	Trillium Provider Support Service Line: 1-855-250-1539 *(Have your TIN and NPI ready for provider verification)
CCHN Provider Relations	NetworkRelations@cch-network.com (once you are connected with your assigned rep, they can be your single point of contact for claims and contracting questions)

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Trainings Available

- Personal Care Services Provider Training (PDF)
  - Recording
- Trillium Physical Health Provider Orientation Register in Advance
- Network Carolina Complete Health – Trillium Tailored Plan Provider Resources

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Additional Resources

- Covered services view the Clinical Coverage Policies: Network Carolina Complete Health – Clinical Policies
- Provider Manual: Updated 2/25/25 (PDF)
- Tailored Plan Billing with Partners and Trillium for Physical Health Providers (PDF)
- CCH Billing Guides
- CCH Billing Manual

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Questions

6 Electronic Visit Verification

Stacy Lassiter

Claims Manager, Claims - Analysis

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What Is EVV?

- EVV stands for Electronic Visit Verification. It is a method used to verify home healthcare visits to ensure members receive the services
- Section 12006(a) of the 21st Century Cures Act mandates that states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider.
- This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver.
- Trillium EVV webpage link https://www.trilliumhealthresources.org/for-providers/evv
  - EVV Terms and Acronyms
  - EVV Q&A
  - EVV Tip Sheet

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HHAeXchange

- Trillium contracts with HHAeXchange (HHAx) for the EVV software
- Onboarding Form Link North Carolina Home Health HHAeXchange Provider Enrollment Form
- LME Provider Portal Questionnaire
- HHAeXchange Knowledge Base
  HHAeXchange job aids and resources link
- Billing Watch billing videos to learn more about the billing process
- HHAeXchange Knowledge Base Home for Providers with 3rd Party EVV Vendors
- If using a 3rd party vendor to submit to HHA, your vendor should send the appropriate HHAx Payer ID on the visit files.
  - PCS services use Trilliums PH payer ID# 27076
  - HH services use Trilliums PH payer ID# 57541
  - BH services use Trilliums BH payer ID# 27076

EVV Services

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- PCS Services - Hard launch guidelines effective 7/1/2024
  - All provider are expected to be fully compliant with EVV requirements.
  - EVV data must be validated prior to claims adjudication.
  - Claims without the required EVV criteria will deny.
- HH Services – Currently under Soft launch. Possible Hard Launch 7/1/2025
  - HHCS providers are encouraged to submit EVV visit information to HHAx through the soft launch period to ensure all systems are operating as intended for a successful hard launch.
  - If experiencing challenges with claims submission during soft launch, providers are able to submit claims outside of HHAx while working collaboratively with Trillium and HHA to resolve barriers.
  - EVV data elements through HHAx are still required even if utilizing the Direct Bill option.

EVV Services (cont.)

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- The Authorization required functions has been turned off in HHA for Trillium. That means you are able to submit billing even if there is no auth showing in HHA. If the service is an auth required service, the auth must be in Trilliums billing software but not in HHA for claims submission. Visit will show RED and warn you there is no auth but you can still submit billing.
- Services subject to EVV elements
- For assistance with claims denials and/or questions send to claimssupport@trilliumnc.org

7 Provider Manual

Gregg Conover

Network Auditing Manager, Network Management - Network Accountability

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Provider Manual

- The Provider Manual is available on the Trillium Health Resources (Trillium) Provider Direct portal and website.
- The Provider Manual outlines how to do business with Trillium. It includes the processes and procedures we expect from you and tells you what you can expect from us in return.
- It is our intent for the Provider Manual to be a living document that serves as a resource for Trillium staff and our provider network
- Trillium regularly reviews and updates this Provider Manual annually, with submission due on July 1st, or upon request by the Department to reflect changes to applicable federal and state laws, rules and regulations, Department or Trillium policies, procedures, bulletins, guidelines or manuals, or Trillium business processes as necessary
- Trillium keeps the provider network apprised of new information and procedural changes on an ongoing basis to ensure providers are up-to-date and understand revised expectations as they happen. We send timely messages through our email distribution via Constant Contact so please be sure at least one staff person in your office signs up to receive these updates.

Provider Manual

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- A printed copy of the information posted on the website is available upon request by calling Trillium at the Provider Support Service Line 1-855-250-1539
- The Trillium Provider Manual can be located at the following locations
  - Trillium Provider Direct-under “Resources”
  - Trillium Website-under “For Providers-Provider Documents and Forms”
- Here is a direct link to the Provider Manual from the website https://www.trilliumhealthresources.org/sites/default/files/docs/Provider-documents/Provider-Manual/Trillium-TP-Provider-Manual.pdf

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8 Next Steps & Questions

Chauncey Dameron, MBA, and Kimberly Wagner, MBA

Provider Relations and Engagement Managers

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Upcoming Provider Forums

- Our Provider Forums will be held the 2nd Wednesdays of the month from 10 a.m. until 12 p.m. and they will be virtual.
- Our next Provider Forum will be held on April 9, 2025, from 10 a.m. until 12 p.m.

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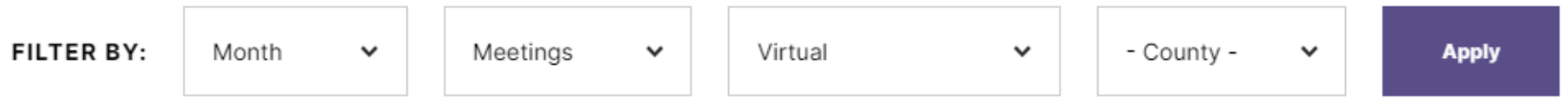
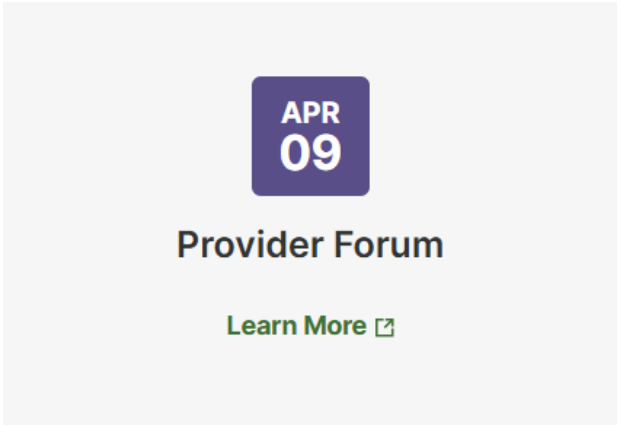
Provider Forum Registration

- Visit our website and register for monthly Provider Forums: https://www.trilliumhealthresources.org/events



- Filter by the month to view the registration link
- Click "Learn More"
- Click "Register today for this month's forum"



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Questions from today's forum?