Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Provider Forum March 12, 2025

Questions & Answers Provider Forum

1. **What can we do/who we can speak with when TCM schedules meetings with members and does not include provider. When TCM is asked why the provider was not invited they say the member did not ask for provider to be there.**

   A member may not choose to have a provider be a part of their care team. I suggest you use the list shared to outreach the TCM Provider to ask to be involved.

2. **I have reached out to the TCM providers to provide care, and they have not responded. What is my next step?**

   Please ensure you've used the contact list we've provided to ensure you're reaching out to the appropriate staff at the TCM Provider agency.

3. **Will we be getting a copy of this presentation?**

   The PowerPoint will be posted on our website. The forum recording and presentation can be found at https://www.trilliumhealthresources.org/provider-forum.

4. **What are the guidelines regarding timelines of ISPs so we can submit TARs in a timely manner? When are ISPs due to agencies so that we can submit TARs in the minimum two-week requirement?**

   UM can respond to questions about ISP timelines, but you can also reference the TCM Provider Manual. Plans are reviewed with TAR submission. Policy says within birth month. Please reach out to the care manager for further timeframes.

5. **What are the guidelines regarding input in care manager documentation? We were told during a PPR review that we were responsible for ensuring certain info be added in ISPs, but if care managers write the ISP, how are we accountable for that info?**

   Collaborate with TCM providers to ensure you have input into an ISP.

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6. **We are struggling with Care Managers not completing the 1915(i) Assessment annually, resulting in members' services lapsing. What can we as a provider agency do to avoid that from occurring?**

   Reassessments need to be completed 60 days before eligibility expiration to allow enough time for Carelon to respond/determine eligibility. If you see a date is approaching, remind the TCM Provider of this. We routinely remind them it is their responsibility to do reassessments to avoid lapses.

7. **What is the info listed in your provider list about our agency is incorrect- who to contact to fix it?**

   Your agency's TCM Consultant can correct it for you.

8. **What is the expectation for TCM providers to get the plan done and services started. we are waiting months- seems some TCMs are not well trained**

   Please reference the TCM Provider Manual for timelines. If you have a concern about a TCM Provider, please feel free to submit a provider concern to Trillium.

9. **We are unable to see when a TAR is submitted by a Care Manager, is there any way to change this, so we can view the TAR? Asking as we are struggling with TARs being keyed in timely and accurately and we want to be able to look behind the CM**

   Authorizations are viewable by service providers, however TARs submitted by care managers are not.

10. **How do I make a correction for a TCM provider?**

    You can contact your Trillium TCM Consultant if the contact info is incorrect. We routinely verify it is correct in our routine meetings with TCM Providers.

11. **Can members receive 1915(i) Respite and CLFS 1 in lieu of service since they are considered different funding sources?**

    Please review service definitions for these services.

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12. Some TCMs are stating that they cannot give us a copy of the 1915(i) assessment, that we must get them from the families but often, families do not have them. Where can we get a copy?

I do not believe the family would have a copy of the 1915(i) assessment. Are you referring to the 1915(i) eligibility determination letter? If so, that is not required for anything.

13. Can members receive 1915(i) Respite and CLFS 1 in lieu of service since they are considered different funding sources?

Please review service definitions for these services.

14. Service definition states a member can only receive 1915(i) but TCMs are telling families they can receive both, looking for clarification.

If they are living with family in CLFS level 1 - Please review service definitions for these services.

15. Can providers access the portal where TCMs are entering Authorization requests to check status and approval/denial? Providers are waiting for TCMs to let us know what is going on and are asking us to take their word that something is approved without showing us the actual authorization.

Authorizations are viewable to service providers in Provider Direct.

16. We are receiving denials for service not authorized. How do we manage these denials when the TARs are submitted by care managers?

Work with the TCM Provider closely. I think you can see authorizations for your agency in Provider Direct, no matter who entered them.

17. Who do you contact to become account manager both Trillium and CCH are sending me to one another?

For Behavioral Health:

- *Email your assigned Provider Relations Coordinator or NetworkServicesSupport@TrilliumNC.org.*

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For Physical Health:

- *Email your assigned Provider Engagement Administrator or ProviderEngagement@cch-network.com to establish the first account manager for your TIN. Please also view: Portal Administrator Guide (PDF)*

18. In PD we can see authorizations that were directly requested internally. I am not seeing any of the care managers when using the search TARs feature.

Care Managers add documentation in a separate area of Provider Direct which has limited access.

19. We are unable to see when a TAR is being submitted by a Care Manager. We can see when an authorization is approved but it would be beneficial to know when a TAR is submitted.

Care Managers add documentation in a separate area of Provider Direct which has limited access.

20. Can the benefit plan be updated to clarify that 1915(i) Respite can be provided in conjunction with CLFS 1 when member resides with family?

UM will take this into consideration

21. When EVV was initially launched there was CLS "ALL Services Code" for authorizations. This code does not appear to be available anymore. Is this going to be reinstated?

There are no plans to reinstate the CLS "ALL Services Code" anytime in the near future.

22. We are experiencing claim denials for behavioral health E&M services and being told that these need to be submitted as physical health claims. Are you able to assist with this?

For assistance on determinations between Behavioral Health and Physical Health claims, we encourage visiting our website under For Providers, Provider

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Documents & Forms, Claims/Finance Information & Forms. Here you can locate the Tailored Plan & Medicaid Direct Claims Submission Protocol.

Along with the Departments PHP Billing Guide:

- Health Plan Billing Guidance | NC Medicaid

For additional assistance and questions please submit a ticket to the Trillium Claims Team by submitting an email to ClaimsSupport@TrilliumNC.org. Please include 'Provider Forum' in the subject line in the email and please also include, the name of your agency, NPI, Tax ID, summary of your issue, and return contact information.

23. Should there be one or two plans for 1915(i) CLS? Some TCMs are stating they write an ISP and then provider should write a separate plan for short range goals and interventions. Other TCMs include short range goals an intervention.

There should be one plan - the TCM provider creates the plan and the provider providing the CLS services are responsible for the short-range goals.

24. Who is supposed to sign the service order for 1915(i) services that can be ordered by a QP? Some TCMs are signing the service order, others are stating the Provider must sign the service order.

The care plan does not have a specific signature place for service orders but a service order is required for 1915(i) ISP and ITS. Per the TCM manual both the care manager and service provider should be signing the care plan so either signature would meet the service order requirement if QP or other accepted licensure.

CCP

5.4 Service Order A Service order is a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be completed by one of the following; a. qualified professional; b. licensed behavioral health clinician; c. licensed psychologist; d. physician; e. nurse practitioner; or f. physician assistant per their scope of practice.

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Page 88:

iv. Perform additional responsibilities related to developing and monitoring implementation of the Care Plan/ISP for members obtaining 1915(i) services beyond those required for other individuals engaged in Tailored Care Management.

1. *Incorporate the results of the independent assessment into the Care Plan/ISP.*
2. *Complete the Care Plan/ISP so that the Tailored Plan / LME/MCO receives it within 60 calendar days of 1915(i) eligibility determination.*
3. *As part of developing the Care Plan/ISP:*
    a. *Explain options regarding the services available, and discuss the duration of each service;*
    b. *Include a plan for coordinating waiver services;*
    c. *Ensure the enrollee provides a signature (wet or electronic) on the Care Plan or ISP to indicate informed consent, in addition to ensuring that the Care Plan/ISP includes signatures from all individuals and providers responsible for its implementation.*

25. Some care managers from Trillium are not getting annual ISP's completed in time, having incorrect or missing info on an ISP, etc. What is their case load? Is there a shortage of CM's? Are CM Extenders assisting? Providers should not be expected to "routinely remind" them.

Care Management teams are working daily to meet the needs of the members identified for support. If a provider is having an issue with a specific region or Care Manager, they can outreach the program directors for assistance. If the issue is related to the Innovations Wavier team the provider can outreach Becky Arnette. If the issue is related the team supporting 1915(i) waiver or Medicaid Direct they can outreach Katina Dial-Scott.

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26. There are several questions involving Innovations Services that were asked last month and are asked again this month and there are still no answers. When can we have an Innovations specific conversation about Trillium's plan process and authorizations.

The recording, slide deck and Q&A for the February 12th forum is posted online https://www.trilliumhealthresources.org/provider-forum

27. What if Medicaid is cut? Will clients be allowed to enroll in IPRS? Will IPRS be able to cover the cost?

Please review the NC Medicaid Managed Care Provider Playbook Fact Sheet for North Carolina's Transition of 1915(b)(3) Benefits to 1915(i)

28. Can PD notify provider when an auth is approved? Can PD notify provider when a1915(i) auth submitted by a TCM is approved?

Currently, there is no feature available that will send a notification.

29. For 1915(i) members, is there a way to transition ISP effective dates to coincide with member birthdates so authorizations align just like Innovation member annual rhythms? It would help from a planning perspective to have consistency in authorization rhythms.

The plans should run consistently with the birth month for the member identified. Example: if a member's birth month is May their plan year should be June 1-May 31.

30. We are a behavioral Health Provider that have Nurse Practitioners on staff. We are repeatedly told that their claims must be submitted as physical health claims. All documentation states a COMBINATION of taxonomy and diagnosis

According to the Behavioral Health vs Physical Health Claims Guidance from NCDHHS found in the link below, the taxonomy code for Nurse Practitioner falls out in Level 5 and considered Physical Health.
https://medicaid.ncdhhs.gov/health-plan-billing-guide-version-29-jan-10-2025/download?attachment

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31. Is anyone at Trillium tracking how many lapses in services are occurring because TCMs are not completing plans and getting Authorizations in a timely manner?

Almost all our members on 1915(i) are having weeks of lapses.

Innovations Waiver and 1915(i) members who receive a combination of community living and support (CLS) services T2013 and T2012, how to handle these codes in terms of billing and Electronic Visit Verification (EVV)? When the provider submits a TAR for CLS services, you submit for the full CLS unit amount for each code based on the ISP/Budget. For example, if a member receiving 30 hours of CLS weekly split between two codes, you can submit the CLS TARs for 30 hours each. The budget and ISP will reflect.