Trillium
HEALTH RESOURCES

Welcome to the September Provider Forum

Chauncey Dameron, MBA
Provider Relations and Engagement Manager

ACCREDITED NCQA HEALTH PLAN ACCREDITED

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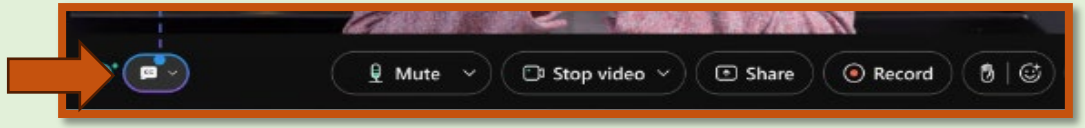
Please Engage With Us

Engaging with our Subject Matter Experts. Options to ask questions: 1) raise your hand and we will call on you, 2) unmute and ask your question, and 3) add your question within the Q&A Bubble.

Questions that require more research, we will review them and provide the answer in the Frequently Asked Questions document (FAQ) posted on our website.

Accessibility features – Closed Captions



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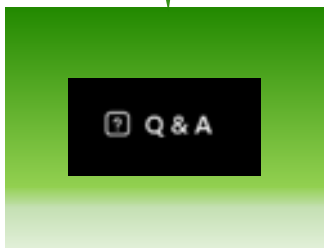
Click on the Q&A icon



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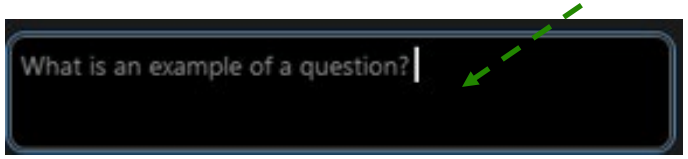

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September Forum Agenda

01 Welcome and Overview of Trillium's Tailored Plan

02 1915(i) Updates

03 PCP/Provider Request for CM Name or Assistance Process

04 Utilization Management

05 Treatment Authorization Request (TAR)

06 Upcoming Trainings

07 Claims

08 Housing

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September Forum Agenda

09 Network Development

10 CCH

11 Provider Forum Upcoming Meetings

12 Resources, Questions, and Answers

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Welcome and Overview of Trillium and the Tailored Plan

Chauncey Dameron, MBA
Provider Relations and Engagement Manager

About 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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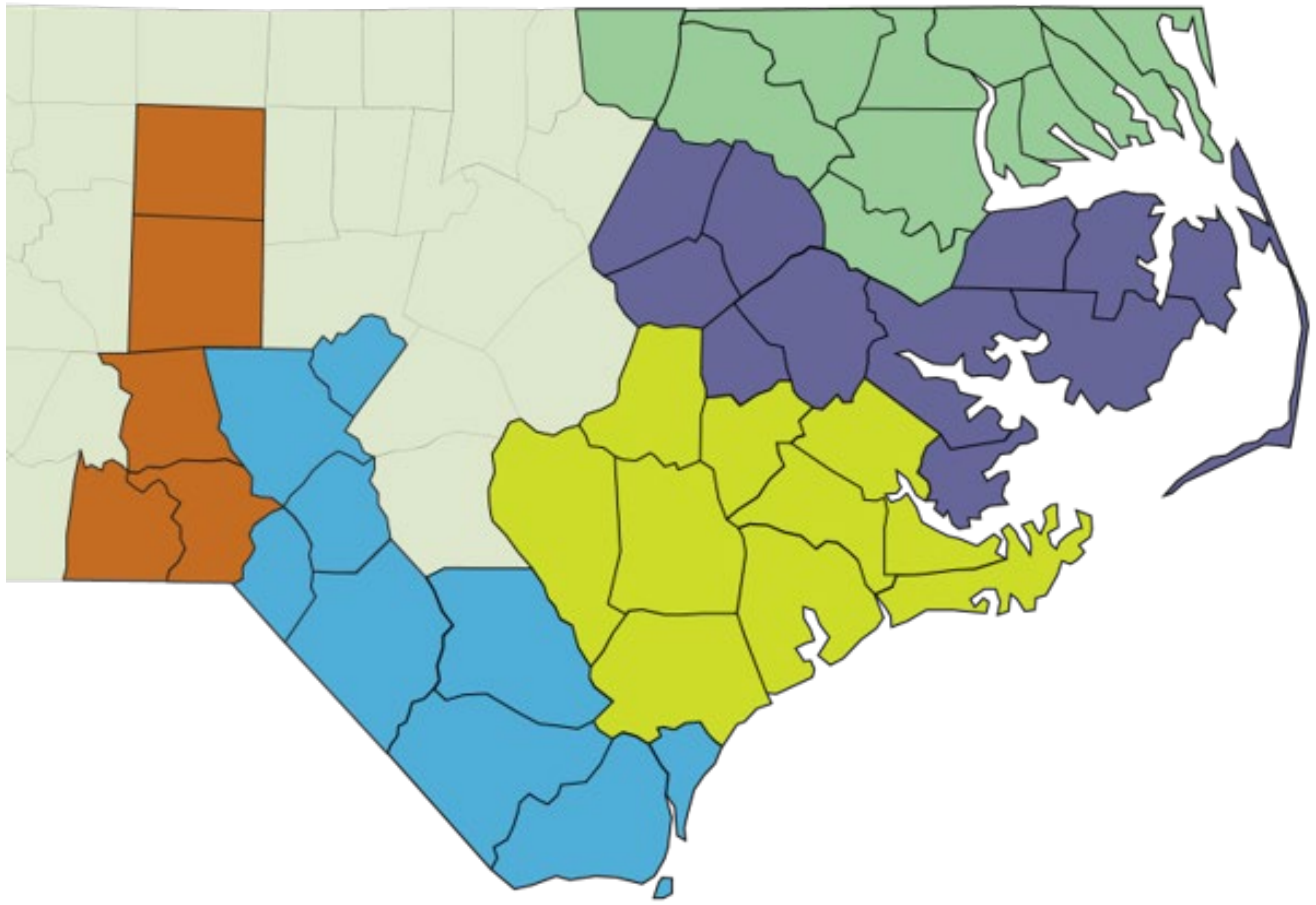
46 Counties

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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Tailored Plan Partnerships

Trillium's Tailored Plan Partners

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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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 for members who receive Medicaid and want support to live in their home communities. These services are non-medical behavioral health services.
- These services are used to support members with serious mental illness, severe substance use disorders, traumatic brain injuries or intellectual/developmental disabilities. Members can receive these services while on the Registry of Unmet Needs for Innovations.
- They are provided at a member's residence or community and are not for members living in an institution.
- 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 1915(i) services. Members cannot receive Respite or Community Transition but are eligible to receive all other services.

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Eligibility for 1915(i) services?

Eligible

- Must have eligible NC Medicaid Health plan:
  - NC Medicaid Direct, Tailored Plans, EBCI Tribal Option and The Children and Families Specialty Plan (upon launch).
  - (Trillium Medicaid Insurance Active: Medicaid B, TP Medicaid)
- 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

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1915(i) Services

Supported Employment for IDD and TBI (CCP 8H-1)

Prior Authorization Required

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 behavioral health needs. An employment specialist and peer support help members to succeed on the job and advance professionally.

Restrictions:

- Members must have gone through services by Employment and Independence for People with Disabilities (EIPD) before they can get Supported Employment.
- 1915(i) SE and CLS may not exceed a combined limit of 40 hrs. per week.
- SE may not be provided by family members who live in the same household as the member.
- May not be provided if the service is otherwise available under a program funded under the Rehabilitation Act of 1973 or under the Individuals with Disabilities Education Act.
- May not be provided to a member living in an ICF-IID
- **Pre-employment and Employment Stabilization Phase**: A **maximum of 20 hours 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**. 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 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 a week.**
- See the benefit plan for more details.
  8H-1, 1915 (i) Supported Employment for I/DD and TBI

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1915(i) Services

Individual Placement and Supports for Mental Health & Substance Use (IPS)

(CCP 8H-2)

Prior Authorization Not Required

Helps members find, get, and keep a job that is right for them. A specialist will help them with career planning and discovery, resume help and job interview practice. Help with learning assigned job tasks and how to get to work

(Effective 1/1/2025, Clinical Communication Bulletin #70 released 12/20/2024 for Mental Health Parity updates, flexibilities ending and authorization changes need.)

Restrictions:

- 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.
- Must have gone through services by Employment and Independence for People with Disabilities (EIPD) before you can get Individual Placement and Support.
- Services must not be provided during the same auth period as ACT.
- 1915(i) SE and CLS may not exceed a combined limit of 40 hrs. per week
- Even though this service is under a NPA all documentation is still required for the services to include:
  - 1915(i) Assessment
  - CMCA
  - Care Plan
- See the benefit plan for more details.

8H-2, 1915(i) Individual Placement & Support (IPS) for Mental Health & Substance Use

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1915(i) Services
Individual and Transitional Support (ITS)
(CCP 8H-3)
Prior Authorization Not Required

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.

(Effective 1/1/2025, Clinical Communication Bulletin #70 released 12/20/2024 for Mental Health Parity updates, flexibilities ending and authorization changes need.)

Restrictions:

- 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.
- Cannot be provided during the same authorization period as ACT, CST, IIH, MST, PSR, or those ages 16-21 who reside in Medicaid funded group residential treatment facility or any other duplicative service.
- Cannot be provided if the service is otherwise available under the Rehabilitation Act of 1973 or under the Individuals with Disabilities Education Act.
- Family members or LRP are not eligible to provide this service.
- Cannot be provided during the same time as another direct support Medicaid service.
- This service may not be provided in a group.
- Even though this service is under a NPA all documentation is still required for the services to include:
  - 1915(i) Assessment
  - CMCA
  - Care Plan
- See the benefit plan for more details.

8H-3, 1915(i) Individual and Transitional Support (ITS)

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1915(i) Services
Respite (CCP 8H-4):
Prior Authorization Required

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.

Restrictions:

- Respite must not be provided by any person or legal guardians if they live in the same home as the member.
- No more than **1200 units (300 hours)** can be provided in a plan year.
- Respite may not be billed on the same day as Residential Supports.
- Emergency care applies to family emergencies and does not include out of home crisis.
- This service may not be used as a regularly scheduled daily service for individual support.
- Respite may not be used for members who are living alone or with a roommate.
- Members enrolled in the CAP/C or CAP/DA waiver are not eligible for Respite services.
- See the benefit plan for more details. 8H-4, 1915(i) Respite

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1915(i) Services

Community Living and Support (CCP 8H-5)

Prior Authorization Required

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.

Restrictions:

- Relatives who live in the same home as a member who is under 18 years old may not provide CLS.
- Members who are in school eligible for up to 15 hours per week when school is in session and up to 28 hours per week when school is not in session.
- Members 22 years of age and older may be eligible up to 28 hours per week.
  - Members 18 years of age or older that have graduated per CCP may be eligible for over age 22 limits.
- 1915(i) CLS and SE may not exceed a combined limit of 40 hrs. per week.
- Transportation to and from the school setting is not covered.
- Individuals who are enrolled in the Innovations or TBI waiver are not eligible for 1915(i) services.
- This service may not be provided during the same time as any other direct support Medicaid service.
- Relatives who live in the same primary residence as member, who is over 18 years old, can provide CLS if the relative meets the required staffing qualifications.
- See the benefit plan for more details.

8H-5, Community Living and Supports

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1915(i) Services
Community Transition (CCP 8H-6)
Prior Authorization Required

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).

Restrictions:

- 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.
- Has a limit of $5,000 per individual during a 5-year period.
- Only covers the actual items purchased, not the time spent helping the member to purchase them.
- May be provided only in a private home or apartment with a lease in the individual's/legal guardian's/ representative's name or a home owned by the individual.
- May not be provided by family members.
- Services cannot duplicate items that are currently available from a roommate.
- Furnished only to the extent that the member is unable to meet such expenses, or when the support cannot be obtained from other sources or services.
- May not be provided to members enrolled in the CAP/C or CAP/DA wavier.
- May not be provided to a member residing in an Institution for Mental Disease (IMD) regardless of the facility type.
- See the benefit plan for more details.

8H-6, 1915(i) Community Transition

Process for Accessing 1915(i) Services

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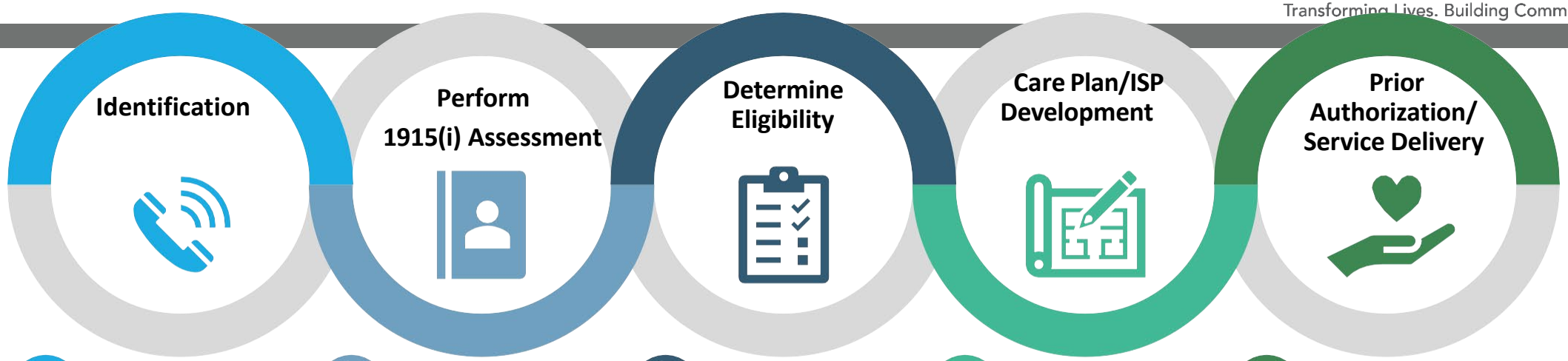

1. Member is identified by PCP, BH, IDD or other provider to need 1915(i) services

2. Care Manager will complete a 1915(i) assessment and submit to Carelon for review.

3. Carelon will review and determine eligibility for 1915(i) services.

4. Upon confirmed eligibility for 1915(i) services, the Care Manager will work with the member to identify the right service provider(s) and develop a personalized Care Plan/ISP. Required 60 days from TCM Consent

5. Care Manager submits the Care Plan/ISP for review. Once authorized, collaboration with service provider(s) to deliver services outlined in member's Care Plan/ISP and ongoing care.
NPA: *IPS and ITS*

1915(i) assessments are conducted annually or when circumstances or needs change significantly. These assessments determine continued eligibility for 1915(i) services.

*The Department uses different names for this plan according to a person's need (Care Plan for people with behavioral health-related needs and an ISP for people with I/DD or TBI).

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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)*

Who can you contact at Trillium?

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- Providers should email UM@trilliumnc.org for questions related to utilization management of 1915(i) services.
- Providers can reach out to their TCM consultant by phone or email if they have difficulty finding contact information for members so their TCM consultant can look in Trillium's system.
- For questions related to contracting, providers should email networkservicessupport@trilliumnc.org
- Providers can contact the PSSL at (855) 250-1539 or via email at NetworkServicesSupport@trilliumnc.org with any questions The PSSL is open Monday through Saturdays from 7 a.m. to 6 p.m.
- 1915(i) service providers can refer to NC Tracks to determine TCM assignment by clicking on the Enrollment tab, scroll down and click on the current date range, enrollment Detail box will pop up and click on the Tailored Care Manager NPI numbers in blue to see the assigned TCM.
- Trillium also has a link on our website located under "For Provider", then under "How do I…?". Providers can submit questions on the following topics by clicking 1915(i) Question Submission Form
  - Who is the assigned Trillium TCM staff, Contact information for member, 1915(i) insurance eligibility coverage, 1915(i) assessment needed, ISP/Care Plan needed, Service authorization needed, Claims/Billing need and 1915(i) service code issue

Care Plan/ISP

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TCM and 1915(i) providers must work together to ensure the ISP/Care Plans are completed in a timely manner and are fully completed with the correct information on them to avoid issues.

- TCM will Incorporate the results of the independent assessment into the Care Plan/ISP.
- TCM will complete the Care Plan/ISP within 60 calendar days of 1915(i) eligibility determination.
- Explain options regarding the services available and discuss the duration of each service.
- Include a plan for coordinating waiver services
- CM will complete long-range goals, and 1915(i) service provider will complete the short-range goals.
- Ensure the member 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 members and providers responsible for its implementation.
- Plans must align with the birth month. Dates: Initial Start Date through last day of member's birth month. Example: Birthday is in May the end date of the plan would need to be May 31st.
  - **Primary IDD or TBI Diagnosis > ISP**
  - **Primary MH Diagnosis > Care Plan**
- **Care Plan/ISP for CLS:** There should be one Care Plan/ISP for the member. The TCM provider creates the plan and the provider providing the CLS services are responsible for the Short-range goals.
- **Service Order Signatures**: 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 another accepted licensure. (CCP 5.4 Service Order)

Care Plan/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

Frequently Asked Questions

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- **What constitutes a service order with the 1915i services?** UM is reviewing the CM QP signature as the service order for 1915i. Provider agency would need to ensure they have a copy of the members Care Plan/ISP that includes the, service codes, long range goals and this signature pages. As the provider agency, they should be getting a copy of this plan when providing services.

- **Is a traditional CCA required for services such as CLS and ITS?** For CLS this is an IDD specific service, member would a psychological evaluation that provides diagnostic impressions. As it relates to ITS documentation of a qualifying diagnosis would be needed, you could use the CCA for this MH service)

- **Is there a way providers can see 1915i CLS authorizations?** Service providers should be able to view authorizations through Provider Direct.

- **Why is there a continued problem with continuation for 1915i services, or getting authorizations and different care managers following processes for plan development?** Please continue to work with your care manager. If you have concerns, please reach out to Trillium to discuss authorization.

Frequently Asked Questions Continued

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- **Can members receive 1915(i) services and CLFS in lieu of service since they are considered different funding sources?** Members receiving CLFS are excluded from receiving Medicaid State Plan Care or other Medicaid benefits included in CLFS bundled service. Those members receiving CLFS level 1 in their home may be eligible for 1915(i) Respite. See service definitions for these services.

- **Where can providers see 1915(i) authorizations?** Authorizations are provided “Provider Direct” however if the services is under a NPA no authorization is required and would not be shown.

- **Change in assigned Tailored Care Manager (TCM):** TCM may change if a member changes TCM providers or opts out of TCM, staffing changes, reassignment from the department or due to member support needs. For example, if a member is assigned to a provider that offers TCM and 1915(i) services, the member would need a new TCM assignment or a referral to another 1915(i) service provider since both services cannot be provided by the same provider.

1915(i) Provider Resources

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- **Medicaid Benefit Plan:** Medicaid 1915(i) - Option Set of Services
- **TCM Provider Manual**: TCM Provider Manual
- **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.
- **1915(i) Question Submission Form** (Located under For Providers > How do I?) 1915i Question Submission Form
- **Trillium Rate Sheet**: Billing Codes & Rates | Check Write Schedule | Trillium Health Resources
- **HHA issues with 1915i members not set up contact:** Claimssupport@trilliumnc.org, if including PHI Zixmail Secure for Providers

3

PCP/Provider Request for CM Name or Assistance Process

Katy Eads, LPA
Clinical Support Director • Clinical Operations - Population Health

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

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- To provide a clear pathway for providers to connect with Care Management/Care Coordination, Trillium Health Resources developed a streamlined process for when a Primary Care Physician (PCP) Office, Behavioral Health or Physical Health Provider needs to obtain the name of a member's Care Manager or request Care Management assignment.
- First step is for the PCP or Behavioral Health/Physical Health Provider to verify Trillium is the member's assigned Managed Care Organization/Tailored Plan/Prepaid Inpatient Health Plan (MCO/TP/PIHP) in NC Tracks.
- Once determined the member is a Trillium member, PCP/Provider submit a referral via the PCP/Provider Request for CM Name or Assignment Referral Form.
- Link to form: PCP/Provider Request for Care Manager Name or Assignment Referral Form (smartsheet.com)
- The link can also be obtained by contacting Provider Support Services by phone or email and Provider Support Services or going to Trillium Health Resources Website under "For Providers, Resources, Provider Documents & Forms, Care Coordination Forms"

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

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- After the referral form is submitted, the Clinical Support Team (CST) 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)**:
  - CST provides the name and contact information for the assigned Provide Based Care Management entity to the individual who submitted the referral.
  - CST notifies the Provider-Based Care Management Entity of the referral and outreach request.

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

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- **If the Member is Assigned to Trillium Health Resources and has an assigned Care Manager/Care Coordinator (CM/CC)**:
  - If a CM/CC is already assigned, the clinical support team (CST) provides the name of the CM/CC to the individual who submitted the referral.
  - The clinical support team alerts the CM/CC of the referral request.
- **If the Member is Assigned to Trillium Health Resources and does not have an assigned Care Manager/Care Coordinator (CM/CC)**:
  - The clinical support team will submit a referral for care management assignment. CST will alert the referring individual the referral was submitted.
  - Assignment Timeframe: 3-5 business days from CST referral submission. The clinical support team alerts the care manager of the referral request.
    - If the referral is assigned a CM/CC, the CST will contact the referring individual and provide the name of the CM/CC. It is important to note, the care manager will outreach to the member to obtain TCM Consent prior to outreach to the individual who submitted the referral.
    - If a CM/CC is not assigned, the clinical support team will alert the referring person the referral for tailored care management was declined.

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

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- The process is for routine care management requests. If the member situation is **emergent or urgent** and 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.
- Please 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 have a Personal Care Services question, 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

Utilization Management

Dr. Shiela E. Lee, Ed.D., LCMHC, NCC
UM Manager - Child Mental Health/Substance Use

Utilization Management Objectives

When Prior Authorizations Are Required

Types of Review & The Review Process

Role of Clinical Coverage Policies

Where to Find Benefit Plans

When Are Prior Authorizations Required?

Every service has authorization guidelines.
These are posted on the benefit plans.

Prior Authorization | | No Prior Authorization

Examples requiring Prior Authorization

Inpatient/Residential
Acute psychiatric- after 72 hours
Residential treatment / PRTF

All State-funded Services
RB-BHT effective 10/1/25

Types of Review

Types of Review

- **Initial:** Before service delivery
- **Concurrent:** During ongoing treatment

Decision Factors

- Medical necessity criteria
- Evidence-based guidelines
- Plan coverage limitations
- Clinical documentation quality quality

The Review Process

Provider Submission

☑ Submit TAR via Provider Direct with clinical documentation

Clinical Review

☑ UM team evaluates against clinical coverage policies & evidence-based criteria

☑ Request for additional information

Determination Outcomes

☑ Approved, Unable to Process (UTP), Exceeds Benefit Plan (EBP) denial

☑ Clinical Peer Review (CPR)

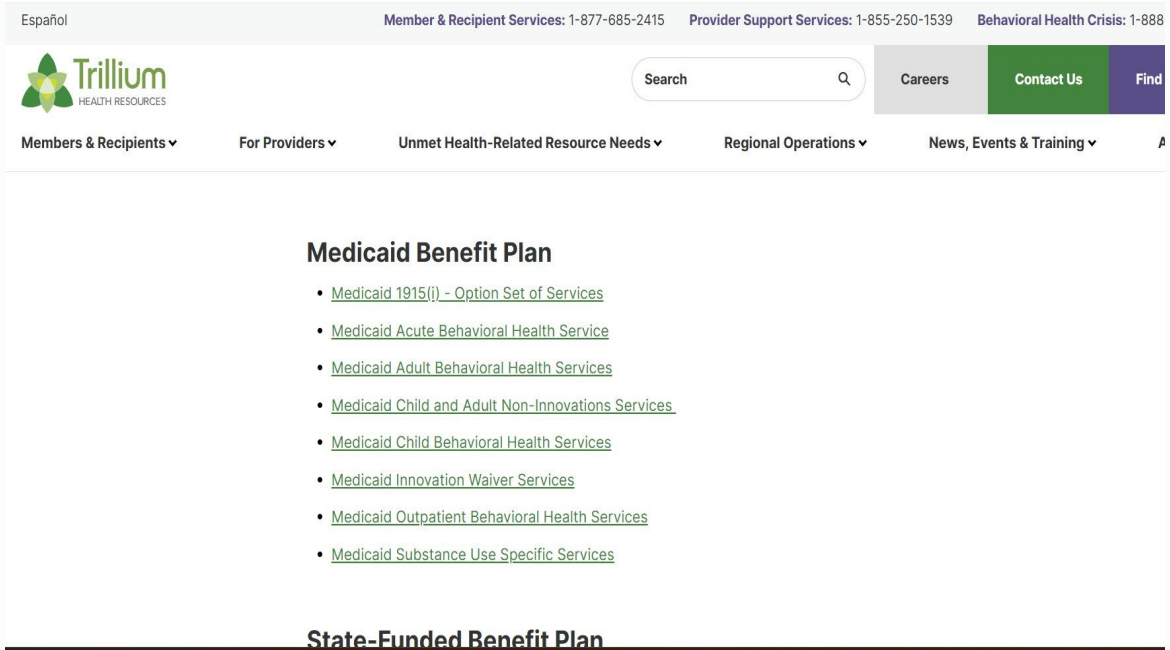
The Role of Clinical Coverage Policies

Evidence-Based

Standards outlining criteria for medical necessity

Medicaid & State-Funded Compliant

Where to find the Benefit Plans



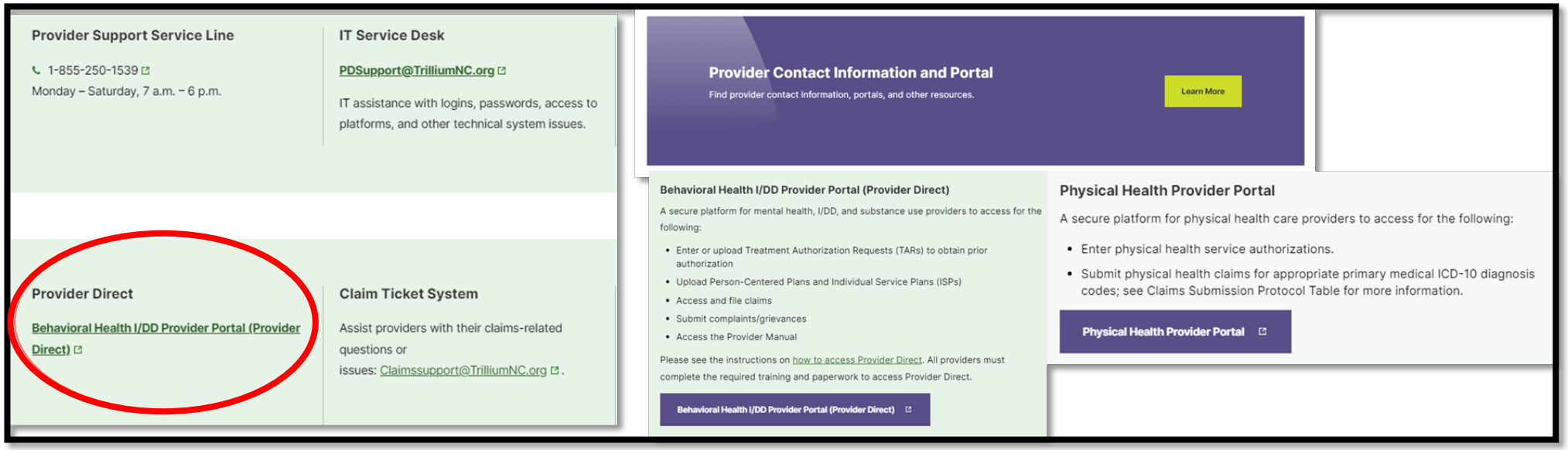
5

Treatment Authorization Request (TAR)

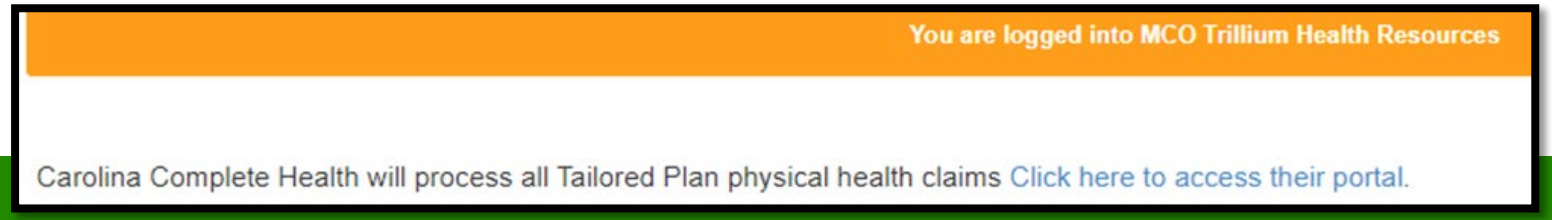
Stacey Henderson
Director of IT Programs – Business Systems

Accessing the BH I/DD Provider Portal - Provider Direct

- To access the secure provider portals, please visit trillium's website at www.trilliumhealthresources.org and select "For Providers"
- Hyperlink to Provider Direct is displayed mid-way down on the "For Providers" page OR you can click on "Provider Contact Information and Portal"

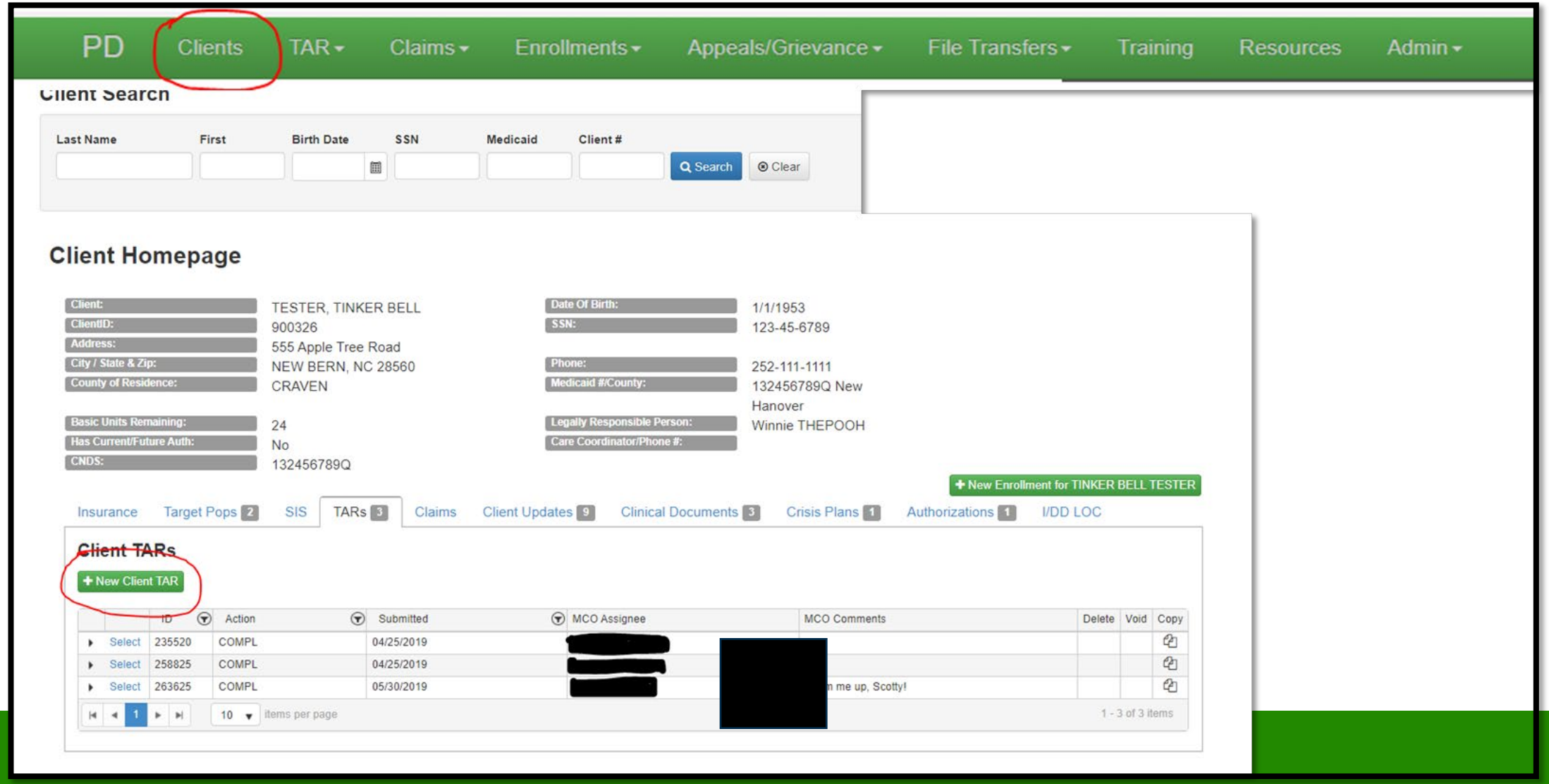


- In addition, a direct link to Carolina Complete Health's provider portal is available within each screen within Trillium's Provider Direct portal

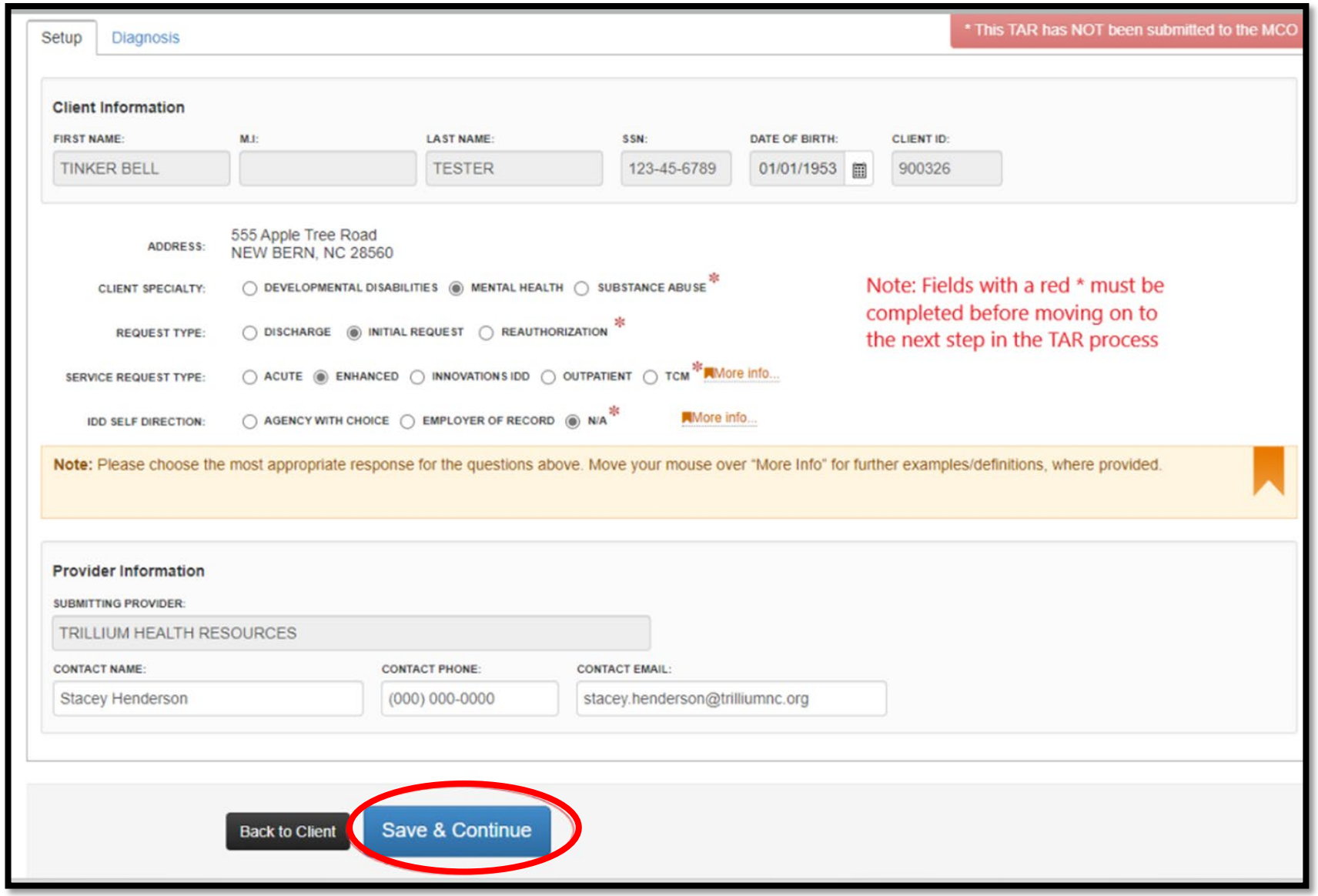


Treatment Authorization Request (TAR) Process

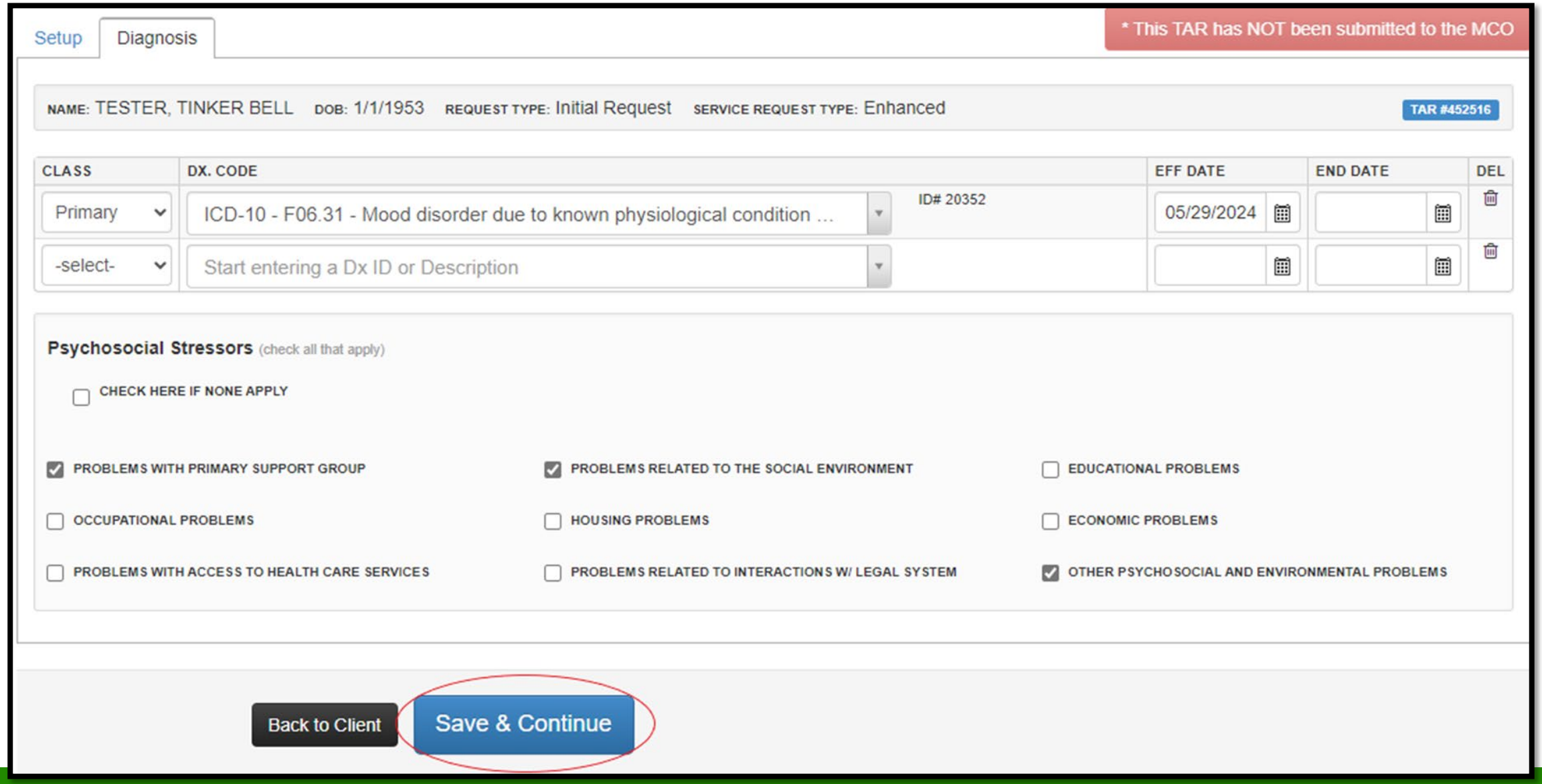
- A Treatment Authorization Request (TAR) can be completed within Provider Direct to request an authorization for service for a member.



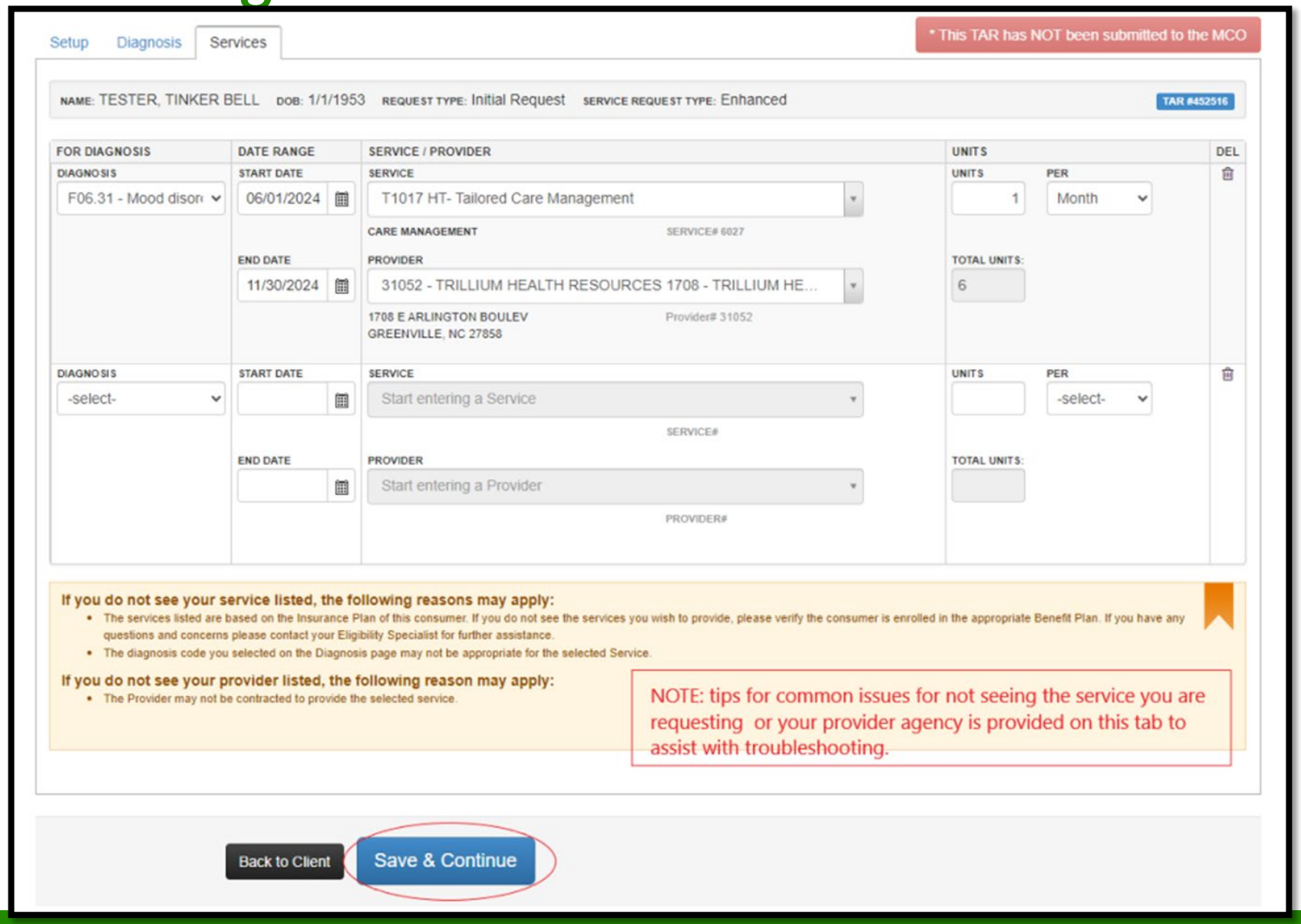
Initial Setup Tab of the TAR Process



Entering Diagnosis Information in the TAR



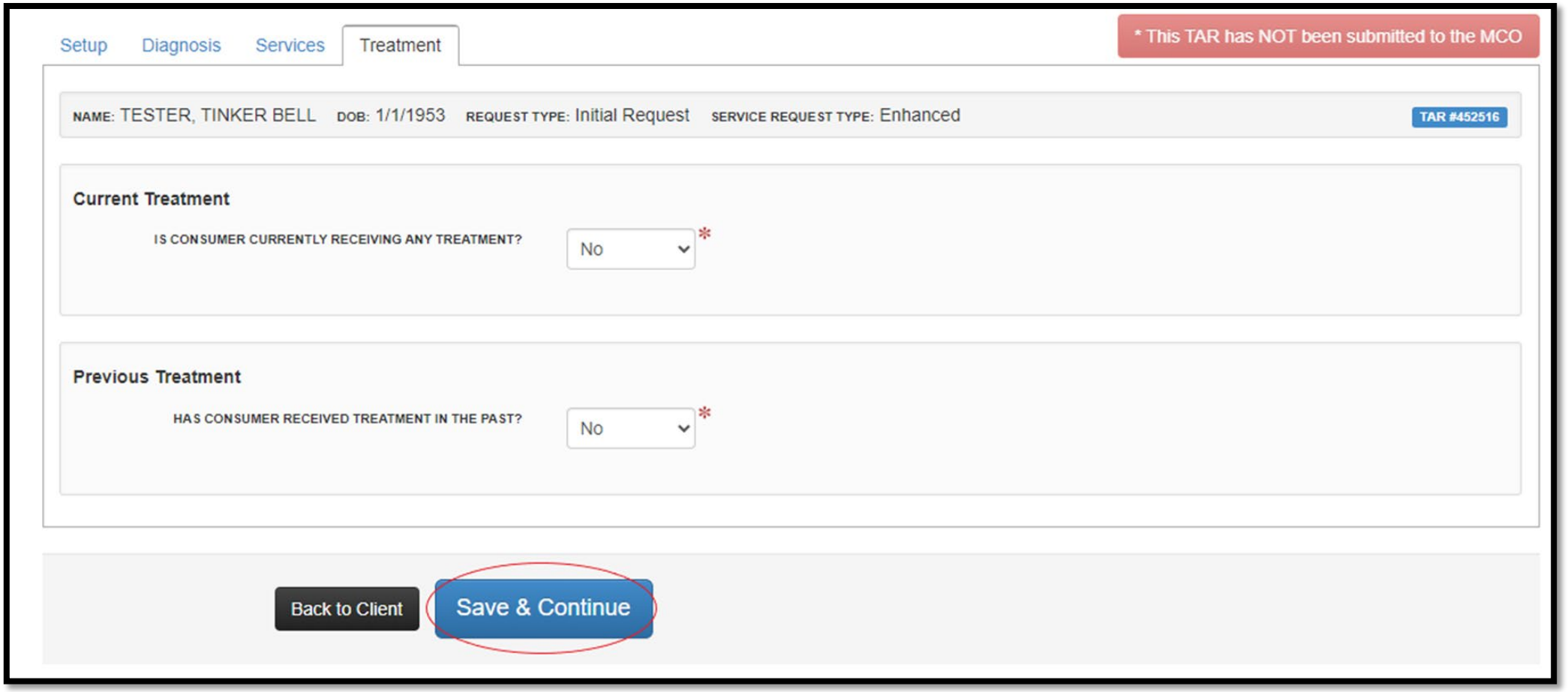
Adding Services to the TAR



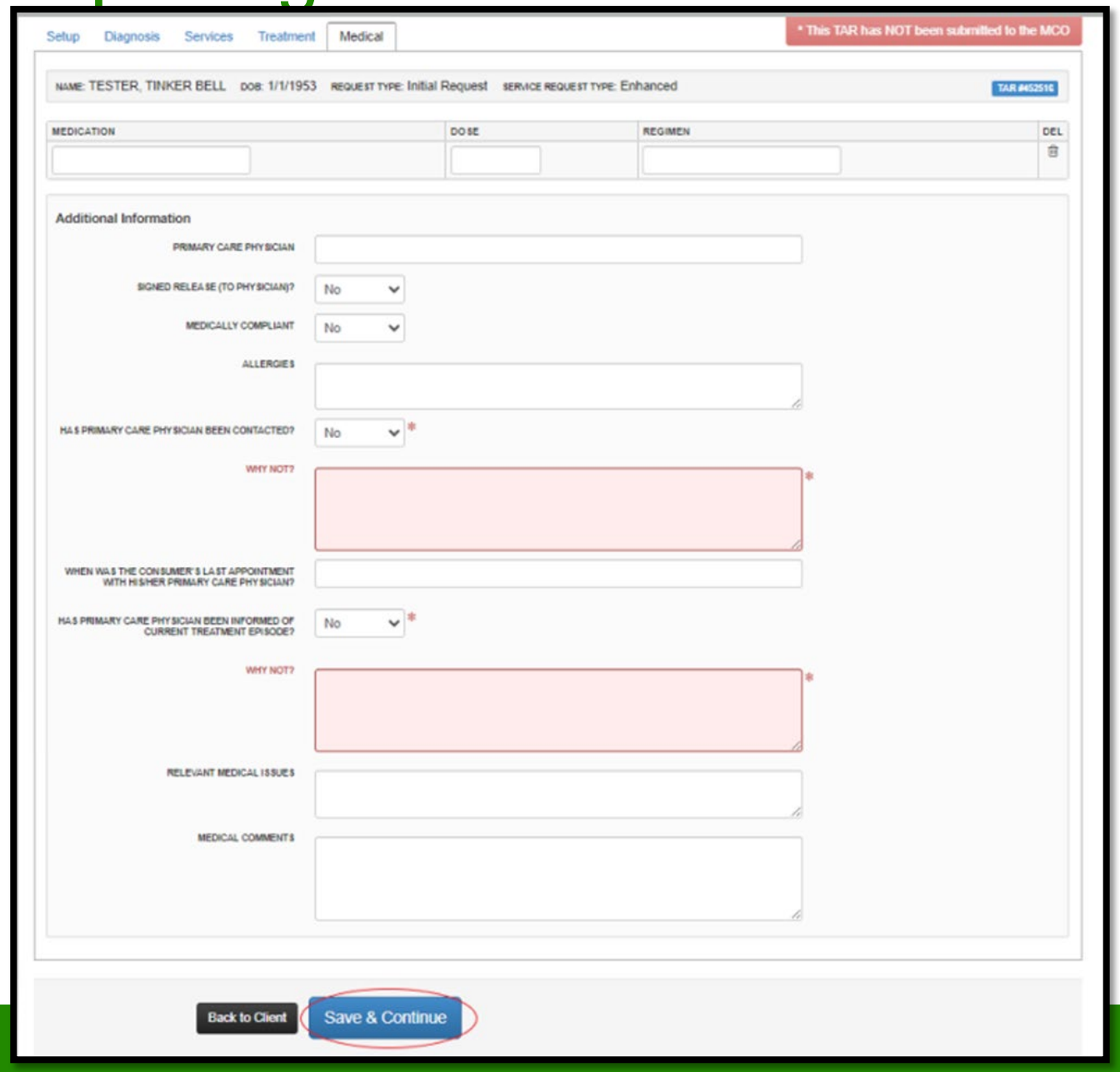
A common reason for not being able to find the service you are requesting in the drop down is that the end date for the time period requesting exceeds the members eligibility span. You can check the member's eligibility on the client home page under the insurance tab.

Additionally, if you are able to select the service but you are not seeing your provider agency in the provider drop down, that service may not be in the your contract for that funding type.

Entering Treatment History for the Member in the TAR



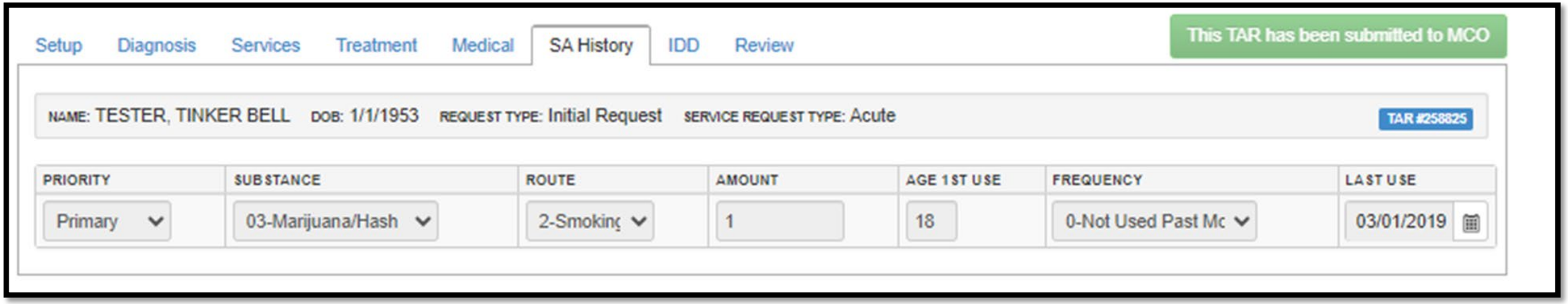
Completing Medical Information in the TAR



Note: If you select NO for either of the drop downs with a red * and hit "Save & Continue" an error message will show. This is simply prompting you to put in a reason for selecting NO in the drop down before continuing to the next step of the TAR process.

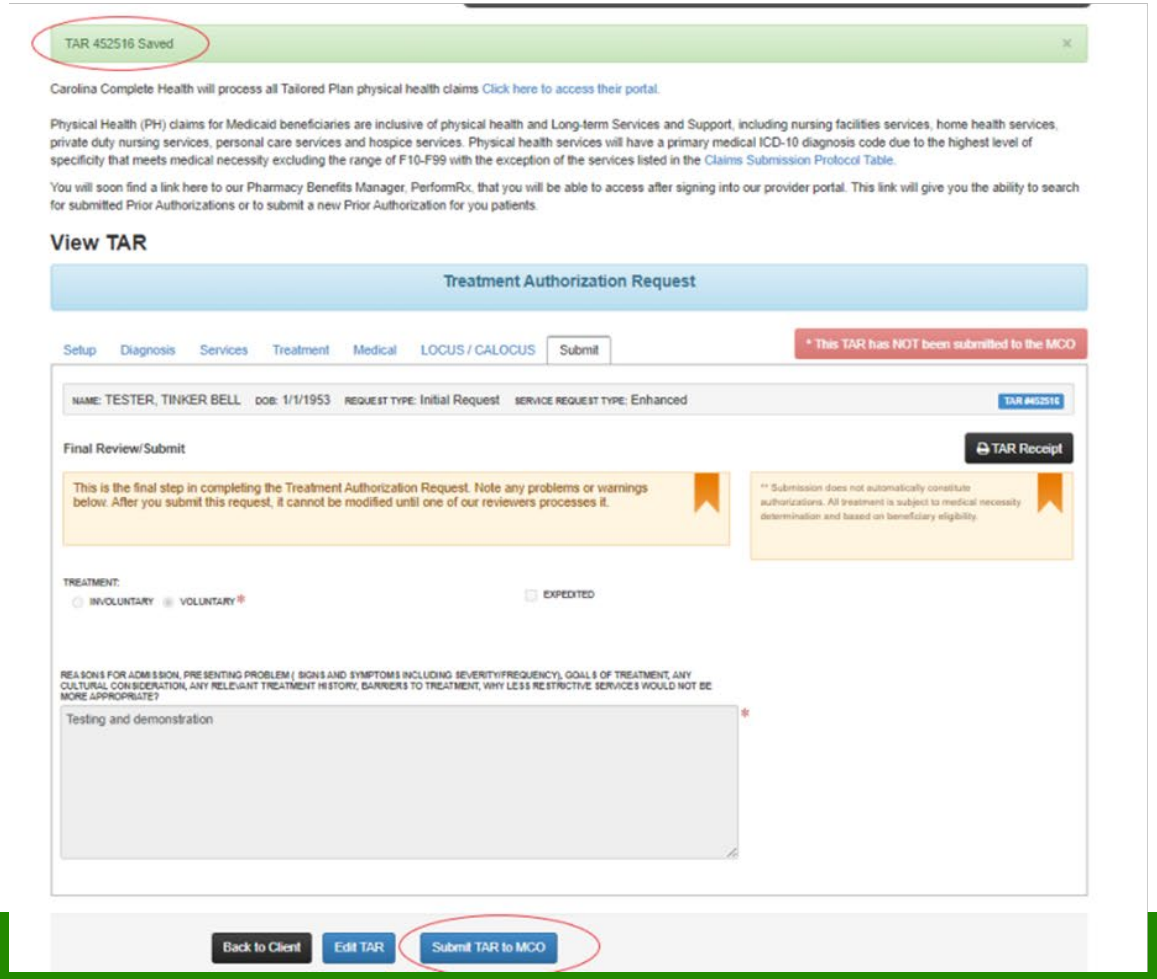
SA History (Situational Information)

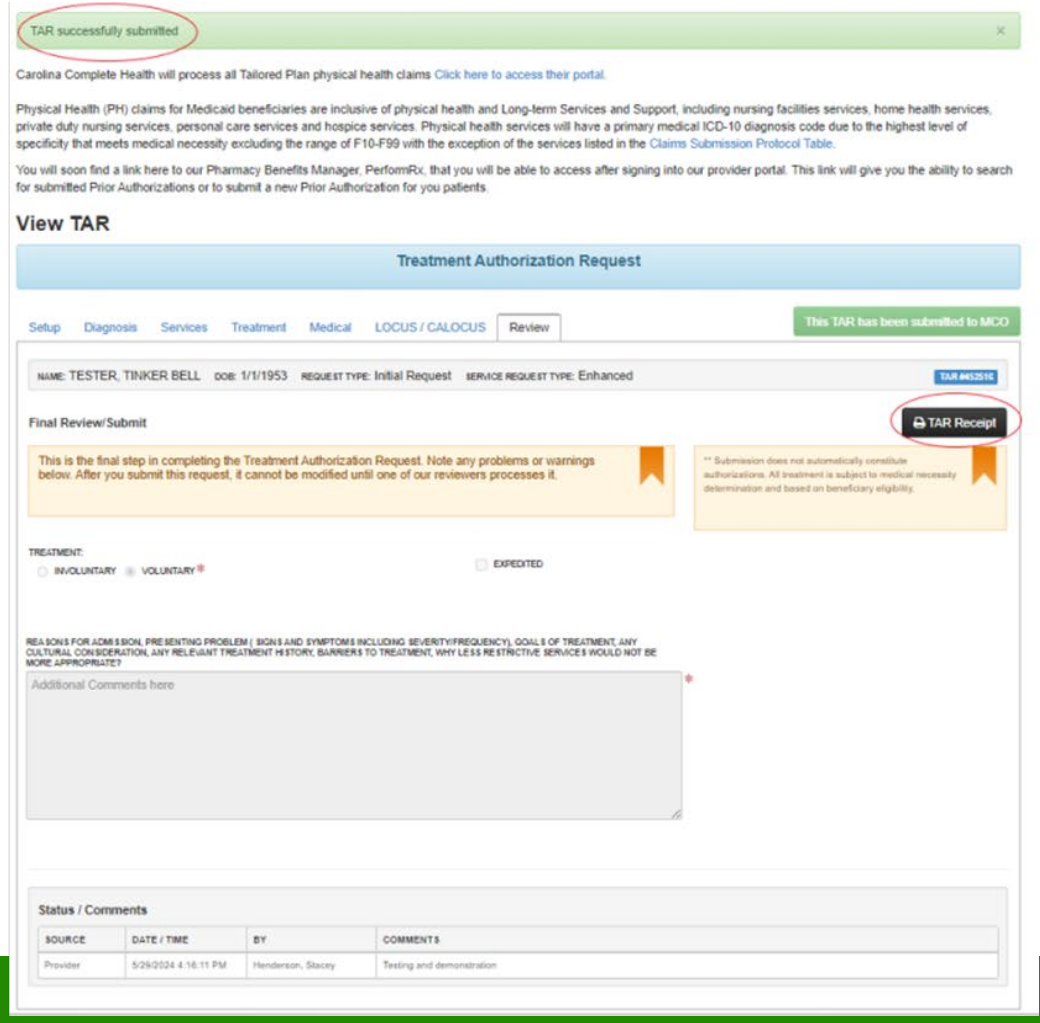
- The SA History is a situational tab: If you put in a Substance Use diagnosis on the diagnosis tab, you will be prompted to complete the SA History page.



Reviewing, Saving and Submitting the TAR

- On the final tab, after you hit “Save & Continue” the system generated TAR number will be displayed in the green bar at the top of this screen. This has SAVED the TAR but has not submitted it to Trillium. You must click on “Submit TAR to MCO” for the TAR to be submitted for review by Trillium Utilization Management staff.





Viewing the Authorization

Once the request has been processed and approved by Trillium's Utilization Management staff, you can see the members service authorizations via the Client Home page OR though the Print Authorizations functionality.

Client Homepage

Client:	TESTER, TINKER BELL	Date Of Birth:	1/1/1953
ClientID:	900326	SSN:	123-45-6789
Address:	555 Apple Tree Road		
City / State & Zip:	NEW BERN, NC 28560	Phone:	252-111-1111
County of Residence:	CRAVEN	Medicaid #/County:	132456789Q New Hanover
Basic Units Remaining:	24	Legally Responsible Person:	Winnie THEPOOH
Has Current/Future Auth:	No	Care Coordinator/Phone #:	
CNDS:	132456789Q		

+ New Enrollment for TINKER BELL TESTER

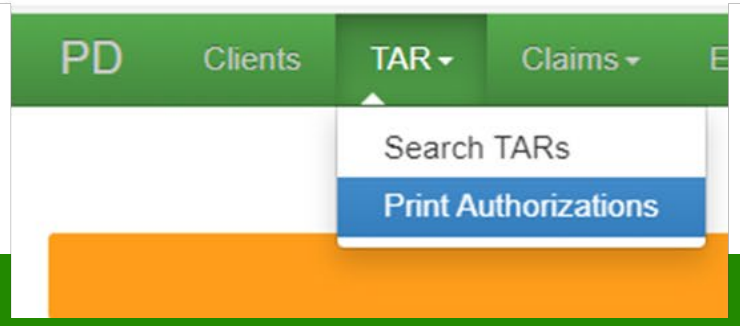
Insurance | Target Pops 2 | SIS | TARs 3 | Claims | Client Updates 9 | Clinical Documents 3 | Crisis Plans 1 | Authorizations 1 | I/DD LOC

Authorizations

Print Authorization for ALL items on this page

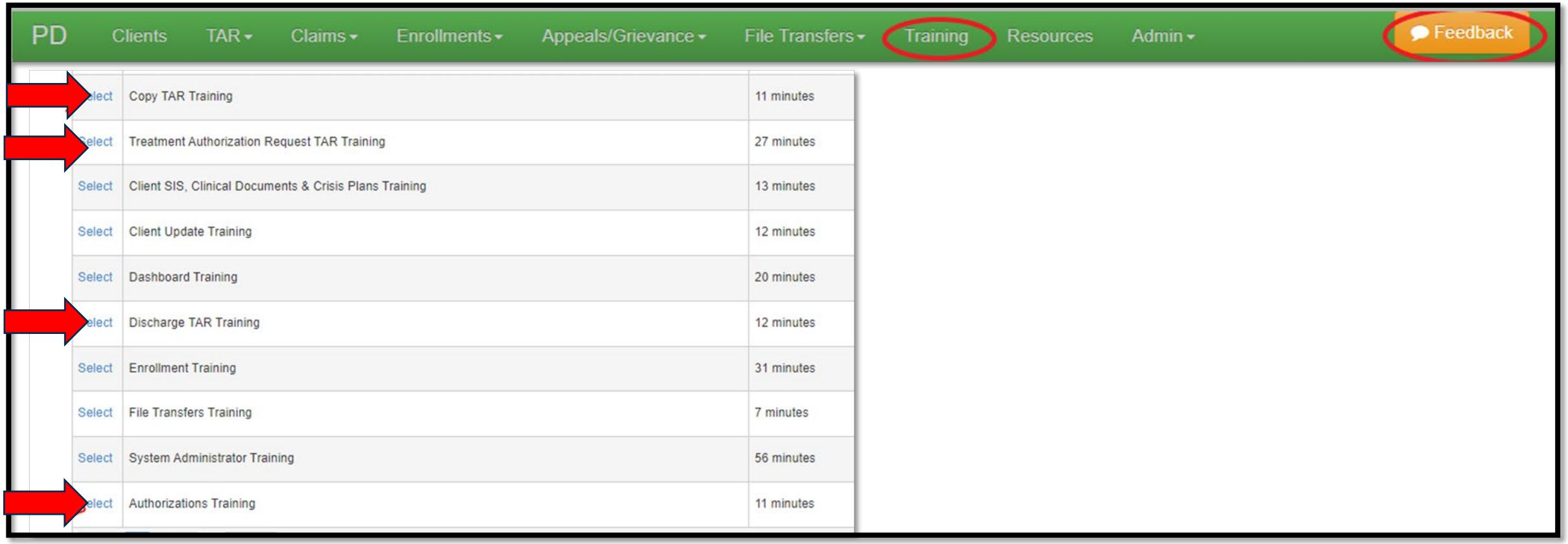
Auth #	Service Definition	Serv. Code	Auth Date...	Auth Units	Auth Effe...	Auth End	TAR #	Revised	
1904233449	B3 SERVICES	H0043 U4	04/25/2019	12	11/02/2018	11/07/2018	235520		

1 10 items per page 1 - 1 of 1 items



Training Resources within Provider Direct

- Training Materials can be found within Provider Direct for quick access
- Training resources are available for many Provider Direct functionalities, including several related to treatment/service authorization requests
- If you need technical assistance, you can reach out to PD Support via the FEEDBACK button within Provider Direct or email pdsupport@trilliumnc.org



6

Upcoming Events

Brooke Mickelson, B.S.
Director of Program Coordination

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Program Coordination

Post Disaster Simulations

October 2- Brunswick County, Bolivia
https://registration.socio.events/e/brunswickpds

October 21- Onslow County, Jacksonville
https://registration.socio.events/e/onslowpds

Working with UNC Wilmington to schedule for 2026

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Program Coordination

Reentry Simulations

October 30- Edgecombe County, Tarboro
https://registration.socio.events/e/edgecomberes

November 5- Dare County, Nags Head
https://registration.socio.events/e/dareres

2026 Events:
January 13- Lee County, Sanford
https://registration.socio.events/e/leeres

January 22- Beaufort County, Washington
https://registration.socio.events/e/beaufortcores

January 29- Pasquotank County, Elizabeth City
https://registration.socio.events/e/ecsu2026res

February 10- Pamlico County, Grantsboro
https://registration.socio.events/e/pamlicores

In Process for 2026:
February TBD-Scotland County
March 24-Bertie County
April 7-Northampton County
May TBD-Lenoir County

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Supporting Children Early Simulations

September 23- Guilford County, High Point
https://registration.socio.events/e/guilfordsces

November 13- Sampson County, Clinton
https://registration.socio.events/e/sampsonsces

December 4- Edgecombe County, Tarboro
https://registration.socio.events/e/edgecombesces

2026 Events-
March 10- Brunswick County, Bolivia
registration coming soon

April 14- Anson County, Wadesboro
registration coming soon

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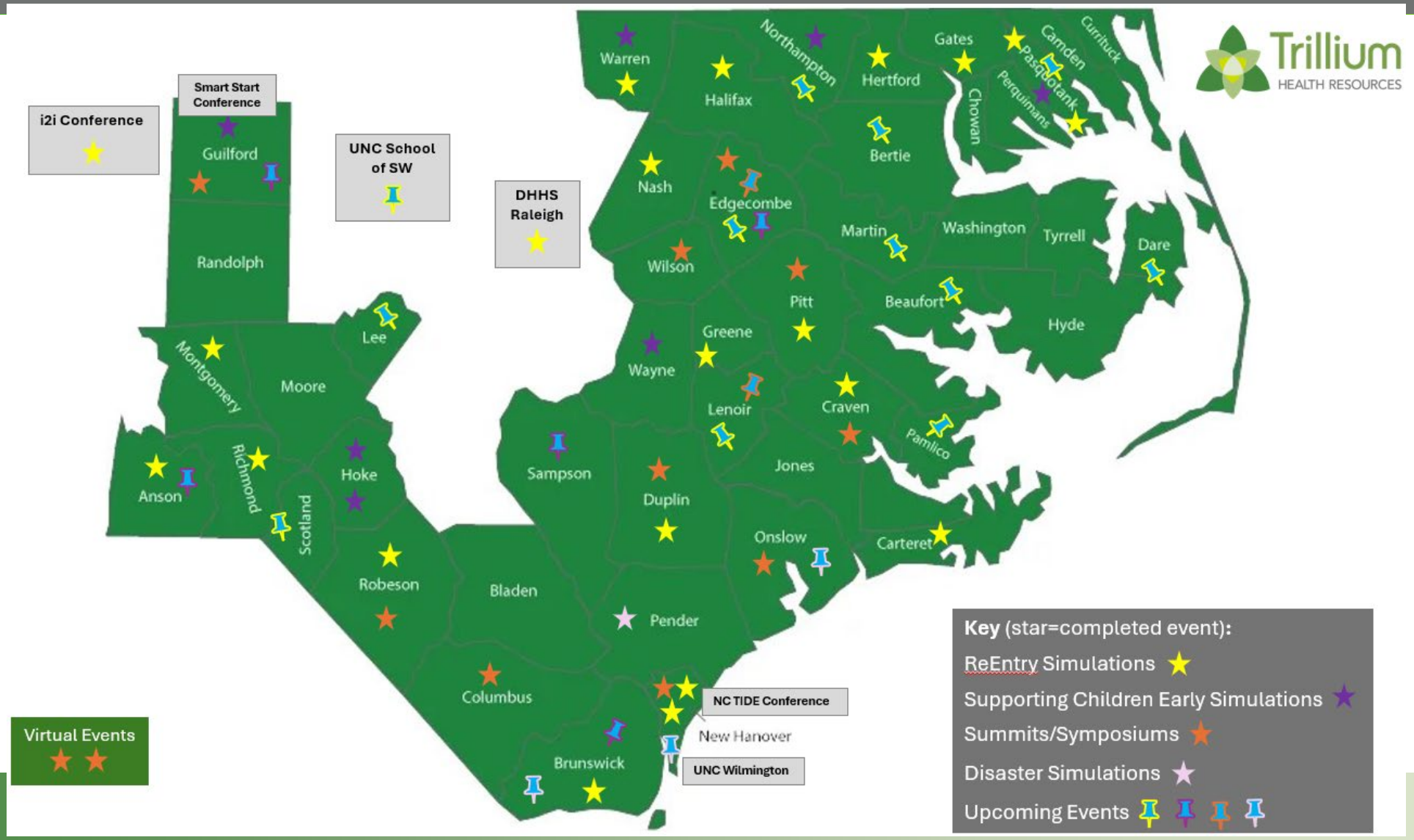

7

Claim Denials | Known Issues | Claim Processes

Jacqueline Thomas
Claims Processing Supervisor • Claims - Processing

Claim Denials

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Top Denial Reasons and How to Resolve Them

- **62 - Service not authorized** – Steps to resolve this would be to check to make sure you have a current authorization for the member for the service and if there is a discrepancy, please send an email to UM@TrilliumNC.org
  - Additional resources for claims denied 62-Service not authorized
    Prior Authorization Services | Trillium Health Resources
    Benefit Plans | Service Definitions | Trillium Health Resources
- **330 – Patient not enrolled on the date of service** – Claims that fall outside of the member's eligibility effective dates will deny. Providers can check Provider Direct or NC MMIS (NC Tracks) to check members' eligibility.
  - Home of NCTracks - Home of NCTracks
  - Sign up or sign in Provider Direct (Training Tab – Client search, Insurance, and Target Pops)
  - Questions regarding enrollment/eligibility contact the Enrollment and Eligibility Team @ EnrollmentandEligibility@TrilliumNC.org.
  - Providers may also experience this denial if they are billing a service code that is not included for the member's eligibility type.

Claim Denials cont.

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- **1018 – Claim received after billing period** – Claims received after the required timeframe will deny as specified in the provider's contract. Timely filing guidelines could vary between lines of business and funding sources.
  - A CRF-Billing Window form could be used to request a time limit override under appropriate circumstances. The CRF form and instructions can be found on:
    - Provider Documents & Forms | Trillium Health Resources 'Claims Request Form'
  - Additional information can be found regarding timely filing:
    - Claims Billing Guide
    - Prompt Payment Tip Sheet
- **1271 – Billing Provider NPI and billing 9-digit zip** – Billing Provider NPI and billing 9-digit zip code combination not found in our system. Steps to resolve this is to first check NC MMIS (NC Tracks) to ensure that the NPI and address in NC MMIS matches to what you submitted on the claim. If the address in your contract does not match what is in NC MMIS, then you will need to send an email to Contracts@TrilliumNC.org to update. After confirmation of update is received, the provider will need to rebill the claim.
  - Home of NCTracks - Home of NCTracks
- **1377 – Please submit to Carolina Complete Health for processing** – The Physical Health claim has been submitted to the wrong processing system. Please see the Tailored Plan & Medicaid Direct Claims Submission Protocol for assistance with routing claims to the appropriate processing system.

Claim Denials cont.

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- **1027 – Invalid service or service discontinued** – Review the service code you are billing and check to see if it is active in the Benefit Plan (link below). Information concerning covered procedure codes is also available via the NCDHHS Online Covered Procedure Codes site for North Carolina Medicaid (link below).
  - Benefit Plans | Service Definitions | Trillium Health Resources
  - https://ncdhhs.servicenowservices.com/fee_schedules?id=ccm

- **1073 - Client has other covered insurance COB** – As payer of last resort, member's primary insurance (Medicare or other private health insurance) should be billed before Medicaid. Check with the member to identify Third-Party Insurers, then verify if in Provider Direct (PD) and if the primary insurance is incorrect or missing from our system, submit a ticket to claimssupport@trilliumnc.org for further assistance with updating the member's insurance if end dated, etc . Following all validations and billing to third-party claims can be submitted to Trillium with the COB information on the claim.
  - Home of NCTracks - Home of NCTracks
  - Provider Direct Portal Access https://www.ncinno.org/

KIT / Claims Processes

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- **Known Issues Tracker (KIT)**
  - To locate the KIT please visit our website and go to Provider Documents & Forms | Trillium Health Resources go to Claims/Finance Information & Forms select the Trillium-Known-Issues-Tracker.pdf

- **Claims Submission Protocol**
  - Tailored Plan & Medicaid Direct Claims Submission Protocol

How To Contact Claims Support

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- For information and questions, regarding claim inquiries and/or denials providers may contact via the email or contact number below:

ClaimsSupport@TrilliumNC.org

Provider Support Services: 1-855-250-1539

8

Housing

Amy Modlin
Head of Housing

Trillium Housing Department

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- Administers federal housing grants.
- Seeks new funding to support an increase in affordable housing.
- Builds and maintains relationships with Public Housing Authorities and other organizations that offer affordable housing resources.
- Connects community agencies/organizations to Fair Housing and Requests for Reasonable Accommodations/Modifications Training.
- Promotes positive relationships with landlords and acts as a mediator, when needed, between landlord and tenant.
- Participates in Continuums of Care throughout catchment area.

Continuum of Care

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Continuum of Care (CoC):

- Coordinates activities to meet the needs of individuals and families who are experiencing homelessness.
- A mechanism for agencies to apply for federal funds.
- Promotes communitywide commitment to the goal of ending homelessness by providing funding for efforts by nonprofit providers and State and local governments
- Promotes access to and effect utilization of mainstream programs by homeless individuals and families.

Trillium and Continuums of Care

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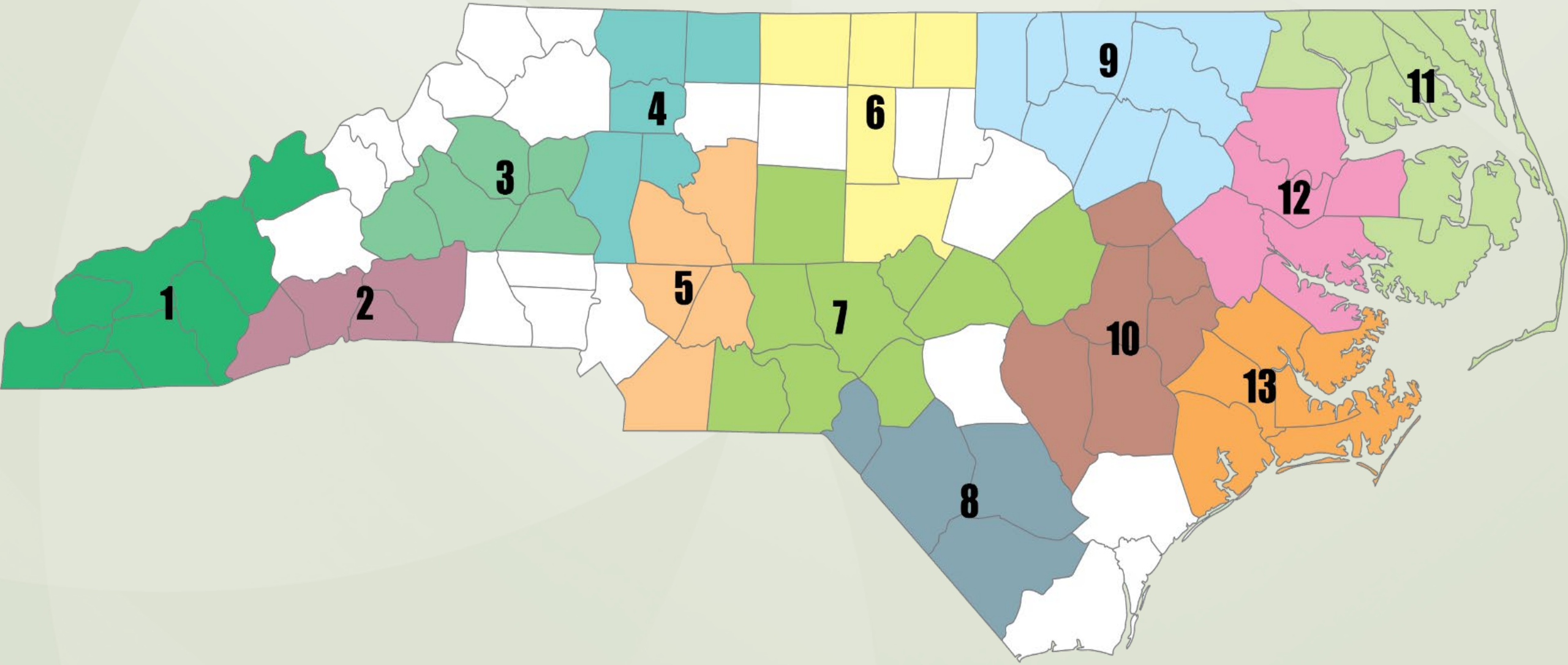
- The majority of Trillium's catchment area (42 counties) falls under the Balance of State CoC (BoS)
  - All of Trillium's current housing programs are under the BoS.
- The other 2 CoCs in Trillium's catchment area:
  - Guilford County CoC
  - Cape Fear Homeless CoC (New Hanover, Brunswick, and Pender)

Balance of State CoC
Regional Committees



Trillium Housing Programs

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- All programs in the housing department are federal grants funded from the Department of Housing and Urban Development (HUD).
- One of Trillium's grants has been in continuous operation for 25 years!
- All Trillium housing programs follow the Housing First Model and are only accessible through the Coordinated Entry Process
- The programs that Trillium administers are:
  - Permanent Supportive Housing (PSH), formerly Shelter Plus Care
  - Back@Home-Balance of State (B@H-BoS)
  - Coordinated Entry (CE)

Homeless Definition

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Criteria for ALL HUD Continuum of Care Housing Programs are, the person must meet the HUD definition of homelessness which is:

- Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
  1. Has a primary nighttime residence that is a public or private place not meant for human habitation; or
  2. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
  3. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

  Note: An individual or family only needs to meet one of the above three subcategories to qualify as Homeless Category 1: Literally Homeless.

OR

- Any individual or family who meets the DV definition:
  1. Is fleeing, or is attempting to flee, domestic violence;
  2. Has no other residence; and
  3. Lacks the resources or support networks to obtain other permanent housing

Chronically Homeless

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- Unhoused individuals are considered chronically homeless if:
  - They have a long-standing disability that significantly impedes their ability to live independently.
  - They have been unhoused continuously for a year or on at least four occasions within a three-year period.
- Trillium's Permanent Supportive Housing Programs prioritize Chronically Homeless individuals and families.

Who Does Not Meet the Definition

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- Staying with friends or family
- Staying in a hotel paid for by anyone other than a charitable organization or government agency
- Received an eviction notice but still living in the unit

Housing First

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- Housing First Ends Homelessness
- A national best practice model, not a program
- Quickly and successfully connects individuals and families to permanent housing
- No preconditions such as sobriety, treatment compliance and service and/or income requirement
- **Offers** supportive services to maximize health stability to prevent returns to homelessness rather than meeting arbitrary benchmarks to permanent housing entry
- Housing First is cost effective

Permanent Supportive Housing

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- Permanent Supportive Housing (PSH) is a voucher program similar to Section 8/Housing Choice Vouchers funded by the Department of Housing and Urban Development.
- Participants must be chronically homeless, have a disability, low to no income.
- It provides rent and utility assistance based on income.
- Scattered site housing in the unit and community of their choice
- Services are encouraged but are not required to participate in the program.
- Housing Case Management through the housing department
- Permanent with no time limit.
- Currently in program: 175 Households, 300 Individuals (224 Adults and 76 Children)
- Available in most of Trillium's catchment but not administered by Trillium in:
  - Guildford, Pender, Brunswick, New Hanover, Anson, Montgomery, Moore, Lee, Richmond or Hoke Counties

Back@Home-BoS

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- Combines Permanent Supportive Housing and Rapid Re-Housing
- Adds Street Outreach
- Three-year grant, 10/2023-09/2026 – sub-grantee of the NC Office of Resiliency and Recovery
- Includes all counties in the BoS CoC, rural-specific grant
- Currently in Program: 124 Households, 246 Individuals (148 Adults and 98 Children)
- Trillium's program covers:
  - Beaufort, Bertie, Bladen, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Nash, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Warren, Washington

Coordinated Entry

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- Coordinated Entry (CE) increases the efficiency in homeless services by standardizing how people access programs and coordinating referrals
- HUD requires all CoCs to implement coordinated entry
- The Balance of State uses a decentralized coordinated entry system, with each regional committee selecting the model that best fits its resources and community needs
  - NC BoS Homeless Assessment and Referral Tool (HART)
    - Assesses the vulnerability of the individual or family if they continue to be unhoused
- Guilford County and Cape Fear Homeless CoCs use a centralized model
  - These CoCs use the Vulnerability Index - Service Prioritization Decision Assistant Tool (VI-SPDAT)
    - Essentially does the same thing as the HART

Trillium and Coordinated Entry

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- Trillium acts as the Coordinated Entry Lead in the following regions/counties
  - Region 9: Granville, Vance, Franklin, Warren, Nash, Halifax, Edgecombe, Northampton
  - Region 10: Wilson, Wayne, Greene, Lenoir, Lenoir, Duplin, Samson
  - Region 11: Hertford, Gates, Camden, Currituck, Pasquotank, Perquimans, Chowan, Tyrrell, Dare, Hyde
  - Region 12: Martin, Washington, Pitt, Beaufort, Bertie
  - Region 13: Onslow, Carteret, Jones, Pamlico, Craven

- Coordinated Entry Lead:
  - Serves as primary CE system contact for the NC BoS staff for the regional committee
  - Attends monthly CE Council meetings to represent the regional committee
  - Facilitates regular case conferencing meetings where the community selects individuals and families experiencing homelessness for permanent housing resources
  - Maintains the regional committee's by-name list in the Homeless Management Information System (HMIS) and provide information to regional partners during case conferencing
  - Maintain regular contact with participating agencies to troubleshoot ongoing challenges

How to Access Housing Programs

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Email: HousingServices@TrilliumNC.org

Please include the following information:

- Name of head of household
- Current living situation
- City and county they are located
- Contact information of person submitting the referral

Someone from the Housing Department will follow up with you regarding next steps. This will depend on where the individual/family is located.

More Information

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- Trillium's Housing Department is separate from the Transitions to Community Living (TCL) Department
- We do not have any emergency funding or housing
- We do not provide hotel stays
- We only work with independent community-based housing and not group homes, adult care homes, etc.
- Questions?

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Current Service Needs

Richard Uranga
Network Development Coordinator

Current Service Needs

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- **Adult Partial Hospitalization** – Dare, Hyde
- **Child/Adolescent Partial Hospitalization** – Dare County
- **Opioid Treatment Program** – Anson, Beaufort, Bertie, Dare, Hyde, Lee, Richmond, and Washington
- **Psychosocial Rehabilitation** – Brunswick, Currituck, Dare, Hyde, New Hanover, and Onslow Counties
- **Substance Abuse Comprehensive Outpatient Treatment (SACOT)** – Dare and Hyde Counties
- **Substance Abuse Intensive Outpatient (SAIOP) –** Dare and Hyde Counties.

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CCH UPDATES

Gaines Carey, CHES
Education and Training Coordinator

Trillium
HEALTH RESOURCES

Reminders for Physical Health Providers

Gaines Carey, Education and Training Coordinator CCHN

ACCREDITED NCQA HEALTH PLAN ACCREDITED

Trillium Physical Health Portal Overview

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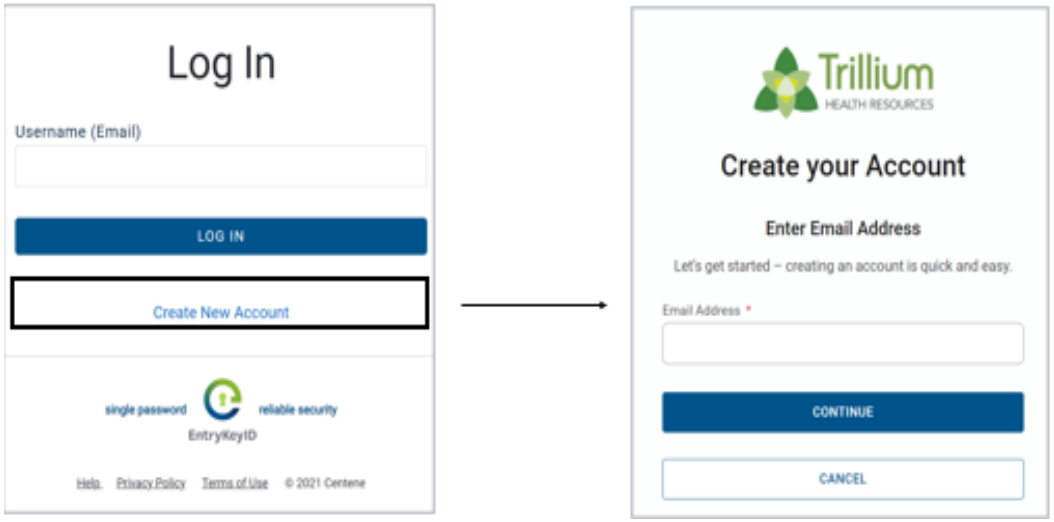
Key Functions: Member Eligibility, Prior Authorizations, Claims Submissions, Claims Disputes, View Payments, View Health Records, and more.

- Create New Account: https://provider.trilliumhealthresources.org/
- For more information with images view: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/Trillium-PH-Orientation.pdf.
- Need additional support? Connect directly with your assigned Provider Engagement Administrator or email ProviderEngagement@cch-network.com to schedule a meeting!



Portal Access for Third-party Billers

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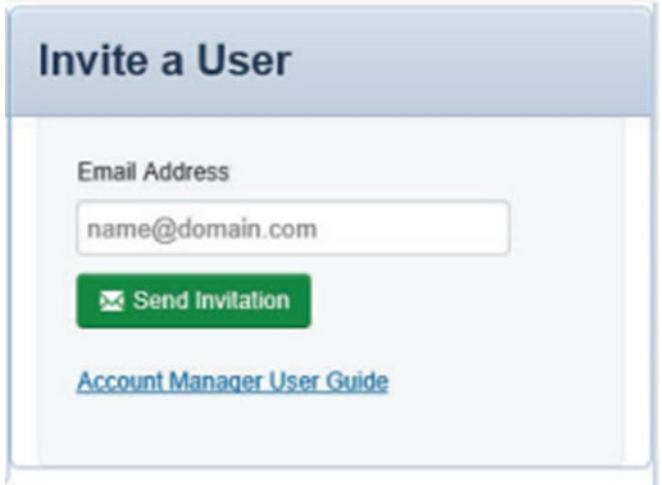
- Third-party billing entities supporting Trillium providers third-party have accounts to the Secure Provider Portal when validated by the practice's **Portal Account Manager.**
- The Account Manager should Invite a User by sending an invitation to the email address for the third-party biller.
- This 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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Claim Denial Trend- September 2025

Claim Denial	Provider Guidance
Non-eligible/non-reimbursable service per plan or regulatory guidelines	The service billed is not covered and non-reimbursable based on NC Medicaid fee schedule. Please check the NC Medicaid fee schedule, Download Fee Schedules - DHB Fee Schedule & Covered Codes Portal. Additionally, review the clinical coverage policy and make sure the procedure is billable by your provider type. Clinical Coverage Policy Index | NC Medicaid
Billing Provider Taxonomy Required	Please ensure your provider data has active credentialing status with NC Tracks and the data on the claim matches what is in NC Tracks. Missing rendering and/or missing billing taxonomy is a common cause of claim processing delays and denials. Taxonomy numbers must also align with your provider data in NCTracks. Please also advise your Clearinghouse to make sure the changes made to taxonomy placement are permanent on your account going forward. Provider Guide: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Prvr-Taxonomy-Guide.pdf
Deny-Bill NPI+ taxonomy not on medicaid file or not active on SVC dates	Please ensure your provider data has active credentialing status with NC Tracks and the data on the claim matches what is in NC Tracks. Provider Guide: Provider Enrollment and Data (PDF)
Referring provider NPI not in Medicaid file/not active on SVC	Please ensure your provider data has active credentialing status with NC Tracks and the data on the claim matches what is in NC Tracks. Provider Guide: Provider Enrollment and Data (PDF)
Deny: Revenue codes not billed on the UB92, please resubmit.	This denial occurs when the required revenue code(s) are missing from a claim submitted on the UB92 institutional claim form. Verify that each billed service line includes the correct revenue code that matches the service and corresponding CPT/HCPCS code. Revenue Codes and NDC Codes can be found on page 25: https://medicaid.ncdhhs.gov/health-plan-billing-guide-version-29-jan-10-2025/download?attachment

*Always check our Known Issues Tracker for related issues that impact providers https://network.carolinacompletehealth.com/

Trainings Available

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- Personal Care Services Provider Training (PDF)
  - Recording
  - Q&A (PDF)
- Trillium Physical Health Provider Orientation Register in Advance
- Trillium New Provider Onboarding Checklist (PDF)
- EVV Hard Launch is official! **Managed Care Electronic Visit Verification Home Health Implementation Hard Launch Effective Oct. 1, 2025 | NC Medicaid**
- **Join us for our next Home Health Office Hours to review what this all means and how to prepare on September 18, 2025, at 11:00 a.m. Register here.**

Additional Resources

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- Covered services view the Clinical Coverage Policies: https://network.carolinacompletehealth.com/resources/clinical-policies.html
- 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
- Trillium Durable Medical Equipment (DME) Provider Guide (PDF)
- Trillium Tailored Plan Provider Resources
- Connect with the Provider Experience Team: Provider Engagement and Provider Relations

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Provider Forum Schedule

Chauncey Dameron, MBA
Provider Relations and Engagement Manager

Provider Forum Meeting Dates

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📆 Upcoming Meeting Schedule

✅ Scheduled Meetings:

- **October 8, 2025** – 10:00 a.m.

🚫 No Meetings:

- **November 2025**
- **December 2025**

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Resources, Questions and Answers

Chauncey Dameron, MBA
Provider Relations and Engagement Manager

Previous Forum Information

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https://www.trilliumhealthresources.org/

For Providers

Overview

CLINICAL

- Behavioral Health Screening Programs
- Benefit Plans | Service Definitions
- Billing Codes & Rates | Check Write Schedule
- Clinical Practice Guidelines
- Developmental Centers
- EPSDT
- Evidence-Based Practices
- HEDIS Resources
- NC-TOPPS
- Prior Authorization Services Instructions
- Tailored Care Management for Providers
- Tailored Plan Medicaid Providers Pharmacy Benefits
- Value-Based Care

RESOURCES

- Communications
- Contracting with Trillium
- Electronic Health Records - Health Information Exchange
- Electronic Visit Verification (EVV)
- Network Participation Opportunities
- Provider Council
- Provider Directory
- Provider Documents & Forms
- Provider Self-Audits
- Trillium Funding Opportunities

PROVIDER INFORMATION

- Contact Information and Provider Portals
- How do I...?
- My Learning Campus Providers
- Provider Forum

TAILORED PLANS - INFORMATION FOR PROVIDERS

- Tailored Plans - Information for Providers
- Provider Tailored Plan Contracting Reminders
- Tailored Plan Trillium Training
- NCDHHS Information

Select Provider Forum

April 9, 2025

Provider Forum Questions & Answers Coming Soon

Provider Forum Presentation

Provider Forum Recording

Thank you for your participation.

Connect With Us

- Trillium Health Resources
- Trillium Direct Connect for Enrichment
- Trillium Direct Connect for Recovery
- Trillium Health Resources
- Trillium Health Resources

Trillium HEALTH RESOURCES

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Member & Recipient Service Line
1-877-685-2415

Provider Support Service Line
1-855-250-1539

Administrative & Business Matters
1-866-998-2597