Trillium
HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Trillium Claims Billing Guide 2024

Table of Contents

Introduction **3**

Billing Information **3**

Trading Partner Agreement (TPA)/ Provider Direct (PD) Access: 3
Eligibility: 4
General Billing Overview: 5
Claim Forms 5
CMS 1500 Claim Form *6*
UB-04 Claim Form *16*
Paper Claims Submission: 27
Common causes of delays, denials and up front rejections: 28
Paper Claims – CMS 1500 ..... *28*
Paper Claims – UB04 ..... *29*
Tailored Care Management Claims (TCM) *31*
62 - Service not authorized *31*
330 – Patient not enrolled on the date of service *31*
765 – Duplicate Claim *31*
1018 – Claim received after billing period *31*
1140 – Reference Claim has already been submitted *32*
1271 – Billing Provider NPI and billing 9-digit zip code combination not found in CI *32*
1377 – Please submit to Carolina Complete Health for processing. *32*
Common 837 Rejection issues *32*
Third Party Liability / Coordination of Benefits: 33
Cost sharing: 33
Populations: *33*
Providers: *34*
Services: *34*
Prompt Payment Guidelines: 35
Interest and Penalties *36*
Overpayment/ Underpayment *36*
Claims Request Form/ Timely filing: *37*
835/ Remittance Advice: 38
Remittance Advices (RAs) *38*

835 - Electronic Remittance Advice/ Health Care Claim Payment/Advice: 39
Electronic Funds Transfer (EFT): 39
Code Auditing and Editing....40
Auditing principles/ Coding Structure: 40
National Correct Coding Initiative (NCCI): 41
NCCI For Medicare | CMS....41
Taxonomy: 41
Diagnoses: 42
Tailored Care Management (TCM): 43
Other Relevant Billing Information 43
State funded: 43
Tribal Claims: 43
Out of Network Providers: 45
Reconsideration: 46
Appeals: 46
Appeals and Complaints 46
Prepaid Health Plan (PHP) Billing Guidance:....47
Additional Information Sources 47
Frequently Asked Questions (FAQ's): 47
Partner Information: 49
For Tailored Plan Services: 50
For All Trillium Lines of Business: 50
Reimbursement Policy: 50
Training: 51
Resources/ Website:....51
Common Acronyms:....52

INTRODUCTION

Trillium is a local political subdivision of the State created under the authority of N.C.G.S. §122C. Trillium is nationally accredited by the National Committee for Quality Assurance (NCQA) as a Managed Behavioral Healthcare Organization and complies with applicable Federal laws. Trillium will apply claim edits based on guidelines from sources that may include, but not limited to, the Center for Medicare & Medical Services' (CMS), American Medical Association (AMA), State-specific policy and procedures, and as set forth in the Provider Manual.

Trillium Health Resources (Trillium) Billing Guide will provide information to support your claim processes. This guide should be used together with Trillium's Provider Manuals, Communication Bulletins, and guidance from the Department of Health Benefits, the Division of Mental Health and NC Medicaid Management Information System (MMIS). This document will be available on *Trillium's website*.

For Tailored Plan services, additional guidance can be found through our partners' websites and links located in the Additional Information/Resources section of this guide.

In addition, any billing questions may be answered by contacting **Trillium's Provider Support Service Line at 1-855-250-1539** or by emailing ClaimsSupport@TrilliumNC.org.

BILLING INFORMATION

TRADING PARTNER AGREEMENT (TPA)/ PROVIDER DIRECT (PD) ACCESS:

- **Trading Partner Agreement**
  - A Trading Partner Agreement is required by our IT Department and is needed when exchanging Electronic Data Interchange (EDI) for Tailored Plan, Medicaid Direct, and State funded claims.
  - The agreement is available on the Trillium's website, in the
    - For Providers
    - Provider Documents and Forms
    - IT Information & Forms section
  - The Trading Partner Agreement is a part of the onboarding process for Behavioral Health I/DD contracted providers and must be signed by an executive member of the provider agency or the provider's system administrator.

Additional information on system administrators can be found in the Provider Direct Access section of the Billing Guide.

- **Provider Direct Access**
  - During provider onboarding for Behavioral Health, I/DD contracted providers, each provider will be given access to Trillium's Secure Provider Portal, Provider Direct. The portal can be used to submit billing via SFTP and Direct Data Entry, Treatment Authorization Requests, providers can review member/recipient eligibility information, claims status reports, Remittance Advices (RA), etc.
  - Trillium requires each agency to have a designated system administrator, who is responsible for creating all users for the organization. In order to become a system administrator for Provider Direct, the agency's designated individual will have to complete the system administrator training and then submit their certificate of completion as well as the system administrator request form. The Provider Direct System Administrator Designee Request Form is required for IT to set up a new provider's access to the Trillium Business System.
    - System Administrator Training – Once a System Administrator Designee receives the login info, the designee must complete the Single Sign-on (SSO) for System Administrators training. This training is intended for System Administrators who are signing into Provider Direct (PD) using SSO for the first time; adding new users or editing an existing user.
    - Links to Trillium's Secured Behavioral Health I/DD portal, Provider Direct, will be accessible on the Trillium website on the "For Provider".
    - The System Administrator Designee Request Form is available on the Trillium website, in the
      - For Providers
      - Provider Documents and Forms
      - IT Information & Forms section

For any issues with accessing the platform providers can contact PDSupport@TrilliumNC.org

ELIGIBILITY:

Medicaid program eligibility is determined by the County Departments of Social Services. Trillium receives a daily eligibility file from NC DHHS which is loaded into Trillium's claims processing systems. Member demographics, Medicaid eligibility, treatment authorization requests and third-party insurance policies are visible to

providers within the provider portals. State Funded eligibility is a limited resource available for recipients who are uninsured or underinsured. State Funding can be requested by providers through a New Enrollment in Provider Direct. Providers are responsible for ensuring and documenting all State Funded eligibility and State Benefit Plan criteria are met.

General Billing Overview:

Trillium has the responsibility under both the Medicaid Direct Contract and the Tailored Plan Contract, to process and reimburse claims in accordance with guidelines for both in-network and out-of-network providers. The provider is responsible for submitting accurate claims data. The submission of a claim does not guarantee payment. The provider must follow proper billing and submission of claims guidelines. Trillium processes behavioral health and I/DD claims in accordance with N.C Gen Stat 58-3-225 prompt payment guidelines.

As a Tailored Plan, physical health claims for Trillium members are processed by Trillium's partner, Carolina Complete Health (CCH). Pharmacy point of sale claims for Trillium members are processed by Trillium's pharmacy benefit manager (PBM), PerformRx. Trillium's standard plan partner and pharmacy benefit manager are held to the same federal and state laws, requirements, and regulations that Trillium is held.

Providers should submit clean claims to ensure timely claim processing. Not having the correct information on the claim form could cause delays in claim processing, claim status, and provider payment. Providers should ensure that claim forms contain accurate information and all required fields are completed.

Providers can visit our website, under the "For Providers" section for additional information.

Claim Forms

Please refer to the Clinical Coverage Policy to determine what type of claim form should be used for the service provided.

- **CMS 1500**
  - Claim form used by physicians and other health care providers to bill for professional health care services.
  - Equivalent of 837P electronic claim submission file

- **UB-04**
  - Claim form used by institutional facilities such as hospitals or outpatient facilities to bill for services.
  - Equivalent of 837I electronic claim submission file

CMS 1500 Claim Form

The information in the table below is an overview of the Form Locator Fields for the CMS 1500 form. Please ensure the most current CMS1500 claim form and instruction manual by the National Uniform Claim Committee (NUCC) is being used.

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
1	Type of Insurance	Indicate the type of health insurance coverage that is applicable to this claim by placing an X in the appropriate box.	Required
1a	Insured's ID Number	Enter the insured's ID number as shown on the insured's ID card. This field should reflect the member/recipient's Medicaid CNDS number.	Required
2	Patient's Name	Enter the patient's full legal last name, first name, and middle initial. If the patient uses a last name suffix (Jr, Sr), enter it after the last name and before the first name. Do not include titles and professional suffixes.	Required
3	Patient's Birth Date/Sex	Enter the patient's 8 digit birth date (MM/DD/YYYY). Enter an X in the correct box to indicate sex (gender) of the patient.	Conditional
4	Insured's Name	Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (Jr, Sr), enter it after the last name and before the first name. Do not include titles and professional suffixes.	Required
5	Patient's Address	Enter the patient's address. The first line is the street address, the second line is the city and	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		state, the third line is the ZIP code. Do not use punctuation in this field.	
6	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to the insured. For NC Medicaid members/recipients this field should always indicate self.	Conditional
7	Insured's Address	Enter the insured's address. The first line is the street address, the second line is the city and state, the third line is the ZIP code. Do not use punctuation in this field.	Not Required
8	Reserved for NUCC Use	Designated by NUCC, please review the 1500 Claim Form instruction manual for additional information	Conditional
9	Other Insured's Name	If field 11d is marked, complete fields 9, 9a and 9d, otherwise leave blank. Required for members/recipients who have a third-party insurance. If other insured, enter insured's full last name, first name, and middle initial. If the insured uses a last name suffix (Jr, Sr), enter it after the last name and before the first name. Do not include titles and professional suffixes.	Conditional
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.	Not Required
9b	Reserved for NUCC Use	Designated by NUCC, please review the 1500 Claim Form instruction manual for additional information	Not Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
9c	Reserved for NUCC Use	Designated by NUCC, please review the 1500 Claim Form instruction manual for additional information	Conditional
9d	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name.	Conditional
10a-c	Is Patient's Condition Related To:	If applicable, enter an X in the correct box to indicate if any of the services described in Field 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked.	Conditional
10d	Claim Codes (Designated by NUCC)	Designated by NUCC, please review the 1500 Claim Form instruction manual for additional information	Conditional
11	Insured Policy, Group or FECA Number	Enter the insured's policy or group number as it appears on the health care card. Required if Field 4 is completed.	Conditional
11a	Insured's Date of Birth, Sex	Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured.	Conditional
11b	Other Claim ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use by the NUCC: ❍ Y4: Property Casualty Claim number For Workers Compensation or Property & Casualty, Required if known, enter claim number assigned by the payer	Conditional
11c	Insurance Plan Name or Program Name	Enter the name of the insurance plan or program of the insured.	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
11d	Is there another Health Benefit Plan	If applicable, mark Yes. If marked 'Yes', fields 9, 9a, and 9d are required.	Required
12	Patient's or Authorized Person's Signature	Enter "Signature on File", "SOF", or legal signature. If no signature on file, enter "No Signature on File" and enter 6-digit date format (MM/DD/YY) or 8-digit date format (MM/DD/YYYY).	Required
13	Insured's or Authorized Person's Signature	❍ Enter "Signature on File", "SOF", or legal signature. If no signature on file, enter "No Signature on File".	Conditional
14	Date of Current Illness, Injury or Pregnancy (LMP)	Enter date of the first date of the present illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period as the first date. Enter date using 6-digit date format (MM/DD/YY) or 8-digit date format (MM/DD/YYYY). Enter the applicable qualifier set by the NUCC to identify which date is being reported: ❍ 431 Onset of Current Symptoms or Illness ▸ 484 Last Menstrual Period	Conditional
15	Other Date	Enter another date related to the patient's condition or treatment. Enter date using 6-digit date format (MM/DD/YY) or 8-digit date format (MM/DD/YYYY). Enter the applicable qualifier set by the NUCC to identify which date is being reported: ❍ 454 Initial Treatment ❍ 304 Latest Visit or Consultation ❍ 453 Acute Manifestation of a Chronic Condition	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		❍ 439 Accident ❍ 455 Last X-ray ❍ 471 Prescription ❍ 090 Report Start (Assumed Care Date) ❍ 091 Report End (Relinquished Care Date) ❍ 444 First Visit or Consultation	
16	Dates Patient Unable to Work in Current Occupation	❍ If patient is employed and unable to work in current occupation, enter date unable to work. Enter date using 6-digit date format (MM/DD/YY) or 8-digit date format (MM/DD/YYYY).	Conditional
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service or supplies. Enter the applicable qualifier set by the NUCC to identify which provider is being reported: ❍ DN Referring Provider ❍ DK Ordering Provider ▸ DQ Supervising Provider	Conditional
17a	Other ID#	The other ID number of the referring, ordering or supervising provider. Enter the applicable qualifier set by the NUCC to identify the number that is being reported: ❍ 0B State License Number ❍ 1G Provider UPIN Number ❍ G2 Provider Commercial Number ❍ LU Location Number (This qualifier is used for Supervising Provider only.)	Conditional
17b	NPI #	Enter the NPI number of the referring, ordering, supervising provider.	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
18	Hospitalization Dates Related to Current Services	Enter the inpatient hospital admission date followed by the discharge date, if not discharged, leave the discharge date blank. Enter date using 6-digit date format (MM/DD/YY) or 8-digit date format (MM/DD/YYYY).	Conditional
19	Additional Claim Information (Designated by NUCC)	Designated by NUCC, please review the 1500 Claim Form instruction manual for additional information	Required
20	Outside Lab? $ Charges	Complete this field when billing for purchased services by entering an X in "Yes". Service must be provided by an entity other than the billing provider. A "No" mark or blank indicates that no purchased services are included on the claim. If Yes is marked, enter the purchase price under Charges.	Required
21	Diagnosis or Nature of Illness or Injury	Enter the applicable ICD indicator. ❍ 9 ICD-9-CM ❍ 0 ICD-10-CM In fields A-L, identify the patient's diagnosis or condition to the greatest level of specificity and do not include the decimal point.	Conditional
22	Resubmission Code and Original Reference Number	Enter the appropriate bill frequency code: ❍ 7 Replacement of prior claim ❍ 8 Void/cancel of prior claim List the original reference number for resubmitted claims.	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
23	Prior Authorization Number	Enter any of the following prior authorization number, referral number or Clinical Laboratory Improvement Amendments (CLIA) number.	Required
24A	Date(s) of Service (Lines 1-6)	Enter the date of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From". Leave "To" blank or re-enter "From" date	Conditional
24A	Additional Narrative Description	NDC Code	Required
24B	Place of Service (Lines 1-6)	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. Place of Service codes are available at CMS, this does not indicate the Place of Service will be covered, providers should ensure they are following NC Medicaid billing guidelines and clinical coverage policies	Not Required
24C	EMG (lines 1-6)	Emergency indicator identifies if the service was an emergency. If applicable, enter Y for Yes or N for No.	Required
24D	Procedure, Services, or Supplies (lines 1-6)	Enter the CPT or HCPCS code(s) and modifier (s) (if applicable) from the appropriate code set in effect on the date of service.	Required
24E	Diagnosis Pointer (lines 1-6)	Enter the diagnosis code reference letter (pointer) as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnoses. If multiple services are performed, the primary reference letter for each service should be listed first.	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
24F	$Charges (lines 1-6)	Enter the charge amount for each listed service.	Required
24G	Days or Units (lines 1-6)	Enter the number of days or units.	Conditional
24H	EPSDT/Family Plan (lines 1-6)	For reporting of Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services using the below codes in the unshaded area: ❍ AV Available – Not Used (Patient refused referral.) ❍ S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) ❍ ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) ❍ NU Not Used (Used when no EPSDT patient referral was given.) For reporting of Family Planning services enter Y for Yes in the unshaded area.	Required
24I	ID Qualifier (lines 1-6)	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. ❍ 0B State License Number ❍ 1G Provider UPIN Number ❍ G2 Provider Commercial Number ❍ LU Location Number ❍ ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		ZZ will remain the qualifier for the 1500 Claim Form.) The Other ID# of the rendering provider should be reported in 24J in the shaded area.	
24J	Rendering Provider ID # (lines 1-6)	The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded are of the field. Enter the NPI number in the unshaded area of the field.	Required
25	Federal Tax ID Number	Enter the Federal Tax ID Number of the Billing Provider listed in Field 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate whether the SSN or EIN number is being reported.	Not required
26	Patient's Account No.	Enter the patient's account number assigned by the provider of service.	Required
27	Accept Assignment?	Enter an X in the correct box indicating Yes or No. Only one box can be marked. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	Required
28	Total Charge	Enter total charges for the services (total of all charges in Field 24F).	Conditional
29	Amount Paid	Enter total amount the patient and/or payers paid on the covered services only.	Not required
30	Reserved for NUCC Use	Designated by NUCC, please review the 1500 Claim Form instruction manual for additional information	Required
31	Signature of Physician or Supplier Including	Signature of Physician or Supplier including Degrees or Credential. Enter "Signature on File", "SOF", or legal signature. Enter the date the form was signed.	Conditional for Medicaid Funded Claims, Required for

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
	Degrees or Credentials		State Funded Claims
32	Service Facility Location Information	Enter the name, address, city, state and Zip code of the location where services were rendered. The first line is the street address, the second line is the city and state, the third line is the ZIP code. Do not use punctuation in this field.	Conditional
32a	NPI#	❍ Enter the NPI number of the service facility location.	Conditional
32b	Other ID#	Enter the qualifier identifying the non-NPI number followed by the ID number. ❍ 0B State License Number ❍ G2 Provider Commercial Number ❍ LU Location Number ❍ ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)	Required
33	Billing Provider Info & Ph #	Enter the provider's billing name, address, Zip code and phone number. The first line is the street address, the second line is the city and state, the third line is the ZIP code. Do not use punctuation in this field.	Required
33a	NPI #	❍ Enter the NPI of the billing provider.	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
33b	Other ID#	Enter the qualifier identifying the non-NPI number followed by ID number. ○ 0B State License Number ○ G2 Provider Commercial Number ▸ ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)	

UB-04 Claim Form

The information in the below table is an overview of the Form Locator Fields for the UB-04 form. Please ensure the most current UB-04 claim form and instruction manual by the National Uniform Billing Committee (NUBC) is being used.

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
1	Billing Provider Name, Address, and Telephone Number	Enter the provider name and address information. The first line is the provider name, the second line is the street address, the third line is city and state and ZIP code and the fourth line is the phone number.	Required
2	Billing Provider's Designated Pay to Address	Required when the pay to name and address is different than the billing provider in FL1. The first line is the pay to provider name, the second line is the street address, the third line is city and	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		state and ZIP code, and the fourth line is the phone number.	
3a	Patient Control Number	Patient control number assigned by the provider.	Required
3b	Medical Record Number	The number assigned to the patient's medical record by the provider. Different than FL 3a.	Conditional
4	Type of Bill	4-digit code indicating specific type of bill. ❍ First digit: 0 ❍ Second Digit: Type of Facility ❍ Third Digit: Bill Classification ❍ Fourth Digit: Frequency Type of Bill codes can be found on the NUBC UB-04 Uniform Billing Manual.	Required
5	Federal Tax Number	Enter the Provider's Tax Id (TIN) or Employer ID (EIN)	Required
6	Statement Covers Period (From-Through)	Enter the beginning and end dates of the period included on the bill. For services received in a single day, use the same date for 'From' and 'Through'. Enter date using 6-digit date format (MMDDYY)	Required
7	Reserved for Assignment by the NUBC	Please review the UB-04 billing manual for additional information	Not Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
8a	Patient's Name	Enter the patient's last name, first name and middle initial if applicable.	Required
8b	Patient Identifier	❍ Enter the patient's insurance ID number, for NC Medicaid this should be the CNDS number.	Required
9	Patient Address	Enter the patient's full mailing address. ❍ Line a: Street Address ❍ Line b: City ❍ Line c: State ❍ Line d: Zip code ❍ Line e: Country Code	Required
10	Patient Birth Date	❍ Enter the patient's birthdate using 8-digit date format (MMDDYYYY)	Required
11	Patient Sex	Enter the gender of the patient ❍ M: Male ❍ F: Female ❍ U: Unknown	Required
12	Admission/Start of Care Date	Enter date of admission to hospital or facility. Enter the date using 6-digit date format (MMDDYY)	Required
13	Admission Hour	❍ Enter hour patient admitted for care. Admission hour codes can be found on the NUBC UB-04 Uniform Billing Manual.	Required for all inpatient claims except TOB 021x
14	Priority (Type) of Admission or Visit	Enter the code indicating priority of admission.	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		❍ 1: Emergency ❍ 2: Urgent ❍ 3: Elective ❍ 4: Newborn ❍ 5: Trauma ❍ 6-8: Reserved, please review the UB-04 billing manual for additional information.	
15	Point of Origin for Admission or Visit	Enter the code for the source of referral for the admission or visit. Source of admission codes can be found on the NUBC UB-04 Uniform Billing Manual.	Required
16	Discharge Hour	Enter hour of discharge. Discharge hour codes can be found on the NUBC UB-04 Uniform Billing Manual.	Conditional
17	Patient Discharge Status	Enter the patient's status as of the Through Date of the billing period. Discharge status codes can be found on the NUBC UB-04 Uniform Billing Manual.	Required
18-28	Condition Codes	Enter the corresponding code to describe any applicable conditions or events for this billing period. Condition codes can be found on the NUBC UB-04 Uniform Billing Manual.	Conditional
29	Accident State	Two-digit state abbreviation where accident occurred.	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
30	Reserved for Assignment by the NUBC	Please review the UB-04 billing manual for additional information	Not Required
31-34	Occurrence Codes	Enter the code and associated date defining a specific event relating to this billing period. Enter the date using 6-digit date format (MMDDYY). Occurrence codes can be found on the NUBC UB-04 Uniform Billing Manual.	Conditional
35-36	Occurrence Span Code and Dates	Enter codes and associated beginning and ending dates defining a specific event related to this billing period. Enter the dates using 6-digit date format (MMDDYY). Occurrence Span codes can be found on the NUBC UB-04 Uniform Billing Manual.	Conditional
37	Reserved for Assignment by the NUBC	Please review the UB-04 billing manual for additional information	Not required
38	Responsible Party Name and Address	Enter name and address of party responsible for bill.	Not required
39-41	Value Codes and Amounts	Enter the code and related dollar or unit amount. Value codes can be found on the NUBC UB-04 Uniform Billing Manual.	Conditional
42	Revenue Codes	Enter the revenue code that identifies the specific accommodation, ancillary service, or arrangement. Revenue codes can be found on the NUBC UB-04 Uniform Billing Manual. This does	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		not indicate the Place of Service will be covered, providers should ensure they are following NC Medicaid billing guidelines and clinical coverage policies.	
43	Revenue Description	Enter a narrative description or standard abbreviation for each revenue code in FL 42. Field can be used for corresponding National Drug Code (NDC)	Required
44	HCPCS/Rates/HIPPS Rate Codes	Enter the HCPCS code describing the procedure. Use the appropriate code set that was effective during date of service.	Conditional
45	Service/Assessment Date	Enter service dates using 6-digit date format (MMDDYY).	Conditional
46	Service Units	Enter the quantity of services.	Required
47	Total Charges	Enter total charges for claim	Required
48	Noncovered Charges	Enter total non-covered charges	Conditional
49	Reserved for Assignment by the NUBC	❍ Please review the UB-04 billing manual for additional information	Not Required
50	Payer Name	Enter name of payer in order of liability ❍ Line A: Primary Payer ❍ Line B: Secondary Payer ❍ Line C: Tertiary Payer	Required
51	Health Plan ID	Enter the health plan ID number	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
52	Release of Information Certification Indicator	Enter Y if provider has on file a signed statement permitting it to release date to other organizations for adjudication of claim.	Required
53	Assignment of Benefits Certification Indicator	Enter Y or N to indicate if provider has signed authorized the third-party payer to remit payment directly to the provider.	Required
54	Prior Payments-Payor	Enter the amount the provider has received by the health plan toward payment of the bill on the appropriate line.	Conditional
55	Estimated Amount Due-Payer	Enter estimated amount due from the indicated payer.	Required
56	National Provider Identifier-Billing Provider	Enter Provider Billing NPI	Required
57	Other Provider ID	Enter any other unique identification numbers assigned to the provider	Conditional
58	Insured's Name	❍ Enter the name of the individual whose name the insurance benefit is carried for the appropriate line. Enter by last name, first name, and middle initial if applicable.	Required
59	Patient's Relation to the Insured	If the provider is claiming payment under FL58, enter the code indicating the relationship of patient to the insured. ❍ 01: Spouse	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		❍ 18: Self ❍ 19: Child ❍ 20: Employee ❍ 21: Unknown ❍ 39: Organ Donor ❍ 40: Cadaver Donor ❍ 53: Life Partner ❍ G8: Other Relationship	
60	Insured's Unique ID	Enter the Health Insurance ID number as listed on health insurance card. List in order of liability.	Required
61	Insured Group Name	Enter Group or plan name in order of liability	Conditional
62	Insurance Group Number	Enter Group Number in order of liability	Conditional
63	Authorization Code/Referral Number	Enter when an authorization or referral number is assigned by the payer.	Conditional
64	Document Control Number	Enter number assigned to the original bill by the health plan. Required when type of bill frequency indicates replacement or void claim.	Conditional
65	Employer Name	❍ Enter name of employer that provides health care coverage	Conditional
66	Diagnosis and Procedure Code Qualifier	Enter ICD code qualifier to indicate version of ICD used. ❍ 9: Ninth Revision	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		❍ 0: Tenth Revision	
67	Principal Diagnosis Code and Present on Admission Indicator (POA)	Enter the ICD code for the principal diagnosis.	Required
67A-67Q	Other Diagnosis Code and Present on Admission Indicator (POA)	Enter any additional diagnosis codes appropriate to revision indicated in FL66	Conditional
68	Reserved for Assignment by the NUBC	Please review the UB-04 billing manual for additional information	Not required
69	Admitting Diagnosis Code	Enter the diagnosis for admission code appropriate to revision indicated in FL66	Required
70	Patient's Reason for Visit	Enter Reason for visit code appropriate to revision indicated in FL66	Conditional
71	Prospective Payment System Code	Enter code assigned to identify the DRG	Conditional
72a-c	External Cause of Injury Code and Present on Admission (POA) Indicator	Enter ICD code appropriate to revision indicated in FL66 pertaining to environmental events, circumstances, and conditions	Conditional
73	Reserved for Assignment by the NUBC	Please review the UB-04 billing manual for additional information	Not Required
74	Principal Procedure Code and Date	Required on inpatient claims when additional procedures must be reported, enter ICD code	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		appropriate to revision indicated in FL66 that identifies the principal diagnosis. Enter date using 6 digit date format (MMDDYY).	
74	Other Procedure Codes and Dates	Enter ICD code appropriate to revision indicated in FL66 that identifies all significant procedures other than the principal procedure. Enter date using 6-digit date format (MMDDYY).	
75	Reserved for Assignment by the NUBC	❍ Please review the UB-04 billing manual for additional information	Not Required
76	Attending Provider Name and Identifiers	Enter attending provider's information. ❍ Line 1: NPI, Secondary Identifier Qualifier and identifier, see qualifiers below: ▸ 0B: State License Number ▸ 1G: Provider UPIN Number ▸ G2: Provider Commercial Number ▸ B3: Taxonomy Code ❍ Line 2: Last Name, First Name	Required
77	Operating Physician Name and Identifiers	Enter provider information when a surgical procedure is listed. ❍ Line 1: NPI, Secondary Identifier Qualifier and	Conditional

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		identifier, see qualifiers below: ▸ 0B: State License Number ▸ 1G: Provider UPIN Number ▸ G2: Provider Commercial Number ▸ B3: Taxonomy Code ❍ Line 2: Last Name, First Name	
78-79	Other Provider Name and Identifiers	Enter any other provider's information. ❍ Line 1: NPI, Secondary Identifier Qualifier and identifier, see qualifiers below: ▸ 0B: State License Number ▸ 1G: Provider UPIN Number ▸ G2: Provider Commercial Number ▸ B3: Taxonomy Code ❍ Line 2: Last Name, First Name	Conditional
80	Remarks	❍ Enter any remarks needed to show information that is not elsewhere on the bill.	Conditional
81cc a	Code-Code Field	Enter Billing Provider Taxonomy Code, qualifier: ❍ B3: Taxonomy Code	Required
81cc b	Code-Code Field	Enter Attending Provider Taxonomy Code, if not placed in FL 76, qualifier:	Required

Form Locator Fields	Form Locator Description	Instructions/Comments	Required/Not Required/ Conditional
		○ B3: Taxonomy Code	
81cc c-d	Code-Code Field	Use field to report additional codes, additional codes can be found on the NUBC UB-04 Uniform Billing Manual.	Conditional

PAPER CLAIMS SUBMISSION:

- Contracted providers are contractually required to submit their claims electronically via 837 HIPAA Transaction Files or can be entered via direct data entry into the appropriate provider portal.

- Behavioral Health I/DD paper claims for non-contracted providers can be submitted to:

Trillium Health Resources
PO Box 240909
Apple Valley, MN 55124

- Paper claims will be sent to our mail room vendor where the claims will be scanned for processing and data capture systems and translated to electronic format.
- Paper claims that do not pass reviews for completion and business rule compliance validation will be rejected and returned to the provider.
- Physical Health paper claims for Tailored Plan, should be submitted to:

Carolina Complete Health
Attn: Claims
PO Box 8040
Farmington, MO 63640-8040

COMMON CAUSES OF DELAYS, DENIALS AND UP FRONT REJECTIONS:

Incorrect and missing data on paper claims can cause an increase in delays, denials and rejections. Please use the below information as a guide to commonly missed fields and suggestions to ensure paper claims are submitted correctly.

Paper Claims – CMS 1500

- FL 10a-c Patients Conditions Related To
  - Ensure information is populated in these fields as they are often missed
- FL 11d Is there another Health Benefit Plan
  - Complete if member has a third-party insurance
  - Missing information will cause the claim to deny if the member has other insurance that is not included on the claim.
- FL 9a Other Insured's Policy or Group Number, 9d Insurance Plan Name or Program Name
  - If FL 11d, Is there another Health Benefit Plan, is answered yes, other insurance information including policy name and policy number should be entered in this field.
  - Missing information will cause the claim to deny if the member has other insurance that is not included on the claim.
- FL 12 Patient signed/date
  - Required Field
  - Indicate Y if signature is on file and date
  - This field is often missed by providers.
- FL 20 Outside lab
  - This field is often missed by providers.
- FL 21a-l Diagnosis or Nature of Illness
  - Required Field
  - Diagnosis codes should be placed in these boxes,
  - Missing or invalid entry will cause claim to deny for invalid diagnosis
  - Providers should reference the Claims Submission Protocol available in the Tailored Plan Provider Manual to ensure correct routing of claims.
- FL 24j Non-NPI Provider ID

- Required Field
- Rendering provider taxonomy code should be entered
- A missing/invalid field entry will cause claim to deny for missing/invalid taxonomy code
- Please reference the 'Taxonomy Claim Submission Fact Sheet' on our website for proper placement of taxonomy codes on claims.

- FL 24i ID qualifier
  - Required Field
  - Providers should ensure they are using the correct qualifier to reflect the taxonomy code
  - Please reference the claim forms section of this billing guide for the proper qualifier as well as the 'Taxonomy Claim Submission Fact Sheet' on our website.
- FL 33b Other ID #
  - Required Field
  - Should be used to enter Billing provider taxonomy code using the appropriate qualifier
  - A missing/invalid field entry will cause claim to deny for taxonomy information missing, please reference the claim forms section of this billing guide for the proper qualifier as well as the 'Taxonomy Claim Submission Fact Sheet' on our website
- FL 31 Physician/Supplier,
  - Required Field
  - Should be signed, checked, and dated
  - This field is often missed by providers
- FL 32 Service Facility Location Information and 32a Service Facility NPI;
  - When data is submitted for Service Facility Location Information a Service Facility NPI will be required
  - A missing/invalid field entry will cause claim to deny for missing NPI information

Please reference 1500 Claim Form Reference Instruction Manual by the National Uniform Claim Committee.

Paper Claims – UB04

- FL 3A Patient Control Number

- Required field.
- Patient Control Number is assigned by the provider and should be populated on the UB04 form.
- If not populated, a denial of "missing patient identification information" will be received

- FL 4 Type of Bill
  - Required Field
  - Missing information or incorrect bill type will cause claims to deny
- FL 6 Date(s) of service
  - Required Field
  - Usual denials are for timely filing, providers should make sure claims are submitted timely as per the timeframes in the Prompt Payment Guidelines section of this billing guide and your Procurement Contract.
- FL 14 Admission type, 15 Point of Origin for Admission/Visit, and 17 Discharge Status
  - Required Fields
  - Usual denial is for missing information

- FL 66 a-q. Diagnosis codes
  - Required Field
  - Missing or invalid entry will cause claim to deny for invalid diagnosis
  - Providers should reference the Claims Submission Protocol available in the Tailored Plan Provider Manual.
- FL 76 Attending provider Name and Identifiers
  - Required Field
  - A missing/invalid field entry will cause claim to deny for missing/invalid taxonomy code
  - Please reference the Taxonomy Claim Submission Fact sheet for proper placement of taxonomy codes on claims.
- FL 81cc Code-Code Field,
  - Required Field
  - Field should be used for any additional external codes including Billing and Attending Taxonomy Codes

- A missing/invalid field entry will cause claim to deny for missing/invalid taxonomy code
- Please reference the claim forms section of this billing guide for the proper qualifier as well as the Taxonomy Claim Submission Fact Sheet on our website Usual denial is for either missing or invalid taxonomy code

Please reference UB04 Data Specifications Manual by the American Hospital Association and National Uniform Billing Committee.

Tailored Care Management Claims (TCM)

- Providers may only submit claims for members who are assigned to them during a given month
- Only one TCM claim will be paid during a given month for a member
- TCM services should not be billed for members receiving duplicative services. Please see the NCDHHS Fact Sheet which identifies services considered duplicative of TCM.

62 - Service not authorized

- 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.

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 to check members' eligibility.

765 – Duplicate Claim

- Duplicate claim means the member already has a paid claim for the same service and date of service.
- Please check your RA/Claims status report/Provider Direct portal to verify paid claim status for the member's date of service.

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 or funding sources.

- A Claims Request Form (CRF) could be used under appropriate circumstances. The CRF form and instructions can be found on for Providers Documents & Forms, 'Claims Request Form.'

1140 – Reference Claim has already been submitted

- Multiple resubmissions are not allowed. The claim number being replaced has already been replaced or the claim number attempting to be replaced is not a valid claim number.
- Please check our website for the Replacement/Voided/Denied Claims Process.

1271 – Billing Provider NPI and billing 9-digit zip code combination not found in CI

- Billing Provider NPI and billing 9-digit zip code combination not found in CI – Steps to resolve this is to first check NC MMIS to make sure that the NPI and address in NC MMIS matches what is in your Trillium – Provider Direct contract. If the address in your contract does not match what is NC MMIS then you will need to send an email to Contracts@TrilliumNC.org to update.

1377 – Please submit to Carolina Complete Health for processing.

- The claim has been submitted to the wrong processing system. Please see the Medicaid Direct & Tailored Plan Claims Submission Protocol for the appropriate claims processing system.

Common 837 Rejection issues

- File names will need to be unique
- Payer/Receiver ID for Behavioral Health claims: 43071
- Sender/Submitter ID for Behavioral Health claims will be your Trillium issued Provider ID
- Zip code submitted will need to be 9 digits
- Third Party Billers submitting claims for multiple providers will require a separate SFTP set up

Referenced Documents

- 1500 Claim Form Reference Instruction Manual by the National Uniform Claim Committee
- UB04 Data Specifications Manual by the American Hospital Association and National Uniform Billing Committee

- Claims Request Form (CRF) and Taxonomy Claim Submission Fact Sheet, the fact sheet are available on Trillium's website, in the
  - For Providers
  - Provider Documents and Forms
  - Claims/Finance Information & Forms section

THIRD PARTY LIABILITY / COORDINATION OF BENEFITS:

Medicaid is the payer of last resort. Other health insurance including Medicare or other insurance carrier that may be liable to pay healthcare expenses of the member is defined as Third Party Liability (TPL) and is always primary to Medicaid coverage.

Third Party resource information is maintained within Trillium's software programs for provider visibility and cost avoidance when coordination of benefits has not been performed before billing occurs. In addition, providers may also access NCDHHS website to complete form This form is 2057, and is designed to give the Medicaid program information that can be used to verify or reverify private health insurance coverage for Medicaid recipients. The form can be accessed via the following link:

- Health Insurance Referral Form

Providers are required to include third party insurance payment or denial information on claims submitted where the member has other commercial insurance, Medicare, or any other source liable to pay healthcare expenses with the exception of members/services that meet the qualifications of pay and chase for coordination of benefits.

COST SHARING:

Cost Sharing (Copay) amounts should be imposed as specified in North Carolina's Medicaid State Plans. Providers may not refuse to provide services if a beneficiary cannot pay a copay at the time of service. Exceptions to cost share requirements:

Populations:

- Children under age twenty-one (21)
- Pregnant women,
- Individuals receiving hospice care
- Federally-recognized American Indians/Alaska Natives
- Breast and Cervical Cancer Control Program (BCCCP) beneficiaries

- Foster children
- Disabled children under Family Opportunity Act
- 1915(c) waiver beneficiaries
- Traumatic Brain Injury (TBI) beneficiaries
- An individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

Providers:

- the billing provider is an IHP (Indian Health Provider)/Tribal Provider
- the billing provider is a Federally Qualified Health Center
- the billing provider is a Rural Health Center
- the billing provider is NC Correction Enterprises (Nash Optical)
- a service is rendered at a tribal free-standing facility or tribal provider-based facility
- The billing provider is providing a 1915(C) HCBS Service
- The billing provider is a Comprehensive Outpatient Rehabilitation Facility
- The billing provider is a Health Department billing for tuberculosis or a sexually transmitted disease or infection

Services:

- Emergency services
- Postoperative, out of hospital care management associated with a surgical procedure
- Family planning services
- HCPCS lines representing: COVID 19 Vaccine, Testing, Treatment
- A claim is billed with condition code AJ
- Care/case management services
- Non-physician patient education
- Mental health crisis intervention
- Pathology or other lab testing procedures
- Radiology, echocardiography, or other imaging services
- Vaccine administration
- Claims billed with diagnosis codes associated with pregnancy, childbirth, and puerperium, to include prenatal care.

- Dialysis procedures or from a dialysis facility
- Medications billed as professional claims [PADP medications]
- DME, orthotics and prosthetics
- Home Infusion Therapy
- Annual adult wellness exam
- Pandemic-related services
- Claim is billed by a Health Department for tuberculosis or sexually transmitted disease or infection
- HIV Antiretroviral (ARV) Medications
- Opioid Antagonist Medication
- Nicotine Replacement Therapy Medications
- Opioid Use Disorder Medications
- Approved Adult Vaccines and Administration Recommended by the Advisory Committee on Immunization Practices (ACIP)

State funded BH, I/DD, and TBI services are not subject to cost sharing (copays).

PROMPT PAYMENT GUIDELINES:

- Under Medicaid Direct and Tailored Plan all claims will be paid in accordance with GS 58-3-225 Prompt payment Standards:
- Trillium shall reimburse providers in a timely and accurate manner when a clean medical claim is received.
    - Medical Claims
        - The BH I/DD Tailored Plan shall, within eighteen (18) Calendar Days of receiving a medical claim, notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to timely process the claim.
        - The BH I/DD Tailored Plan shall pay or deny a medical Clean Claim at lesser of thirty (30) Calendar Days of receipt of the Clean Claim or the first scheduled provider reimbursement cycle following adjudication.
        - A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
        - If the requested additional information on a medical pended Claim is not submitted within ninety (90) Calendar Days of the notice requesting the required additional information, the BH I/DD Tailored Plan may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).

- Tailored Plan may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the member by the health care provider and, in the case of health care provider facility claims, within three hundred sixty-five (365) Calendar Days after the date of the member's discharge from the facility. However, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the BH I/DD Tailored Plan and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required. As an additional resource, please click the link below to access prompt payment tips: please see prompt payment tips.

- State Funded claims are required to be submitted within ninety (90) Calendar Days.

Interest and Penalties

Interest will be paid to the provider at the annual percentage rate of eighteen percent (18%) of the approved claim amount for each calendar day after the date the clean claim should have been paid as specified in the contract between Trillium and NC DHHS. A penalty will also be paid of one percent (1%) of the approved claim amount for each calendar day following the date that the clean claim should have been paid as specified in the contract between Trillium and NC DHHS. Interest and penalties apply only to Medicaid Funded claims, State Funded claims are not subject to interest and penalty payments.

Overpayment/ Underpayment

- Trillium will promptly report overpayments identified or recovered, specifying overpayments due to potential fraud to the state in accordance with 42 C.F.R. §438.608(a)(2). Trillium administers recovery of overpayment and underpayment in accordance with N.C. Gen. Stat. §58-3-225(h).

- In meeting the requirement of 42 C.F.R. § 438.608(a)(2), Trillium may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments. Not less than sixty (60) Calendar Days before Trillium seeks overpayment recovery or offsets future payments, Trillium will give

written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless Trillium has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents. The health care provider or health care facility may recover underpayments or non-payments by Trillium by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by Trillium may include applicable interest. The recovery of underpayments or non-payments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

- Trillium cannot accept a partial refund via a paper check. All partial refunds or adjustments to original claims must be done by submitting a replacement claim. A full refund of a claim may be done by sending a paper check with proper documentation attached referencing original claim information and reason for refund or by submitting a voided claim.

Claims Request Form/ Timely filing:

- Claims Request Form
  - Trillium's Claims Request Form (CRF) can be used for the following:
    - Claim Adjustment Requests
      - Full Recoupments
      - Overpayment/Underpayment
    - Time Limit Override Requests
  - Find the CRF-Billing Window form here
- Additional details on the use of the CRF, instructions on how to fill out the CRF, and a copy of the CRF can be found on Trillium's website, in the
  - For Providers
  - Provider Documents and Forms
  - Claims/Finance Information & Forms section
- Claims Inquiry Form
  - Trillium's Claims Inquiry Form can be used to submit questions/inquiries regarding claim status and denial reasons.

- Additional details on the use of the Claims Inquiry Form, instructions on how to complete the form and the link to the form can be found on Trillium's website, in the
  - For Providers
  - Provider Documents and Forms
  - Claims/Finance Information & Forms section:
- Timely Filing
  - Providers should reference their contract with Trillium for the days to file a claim timely. Non-contracted providers have 365 days to submit a Medicaid Funded medical claim.
  - Providers have 90 calendar days to submit a State Funded medical claim
  - Any exceptions to timely filing guidance will follow the prompt payment guidelines stated above, all other Time Limit Override requests will need to be submitted for review.
  - Microsoft Word - Trillium Prompt Payment Tip Sheet

835/ REMITTANCE ADVICE:

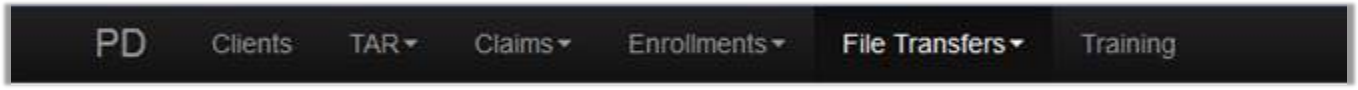
Remittance Advices (RAs)

All providers will have access to RAs the day after the checkwrite. The RA is the documentation of adjudicated claims status. The RA is used to post claim status your system. When a claim is submitted to Trillium, a RA will be posted in the Provider Direct Portal to explain any payment, adjustment or denial to the claim. The RA will provide reason codes to assist in identifying if any additional action is needed on the claim.

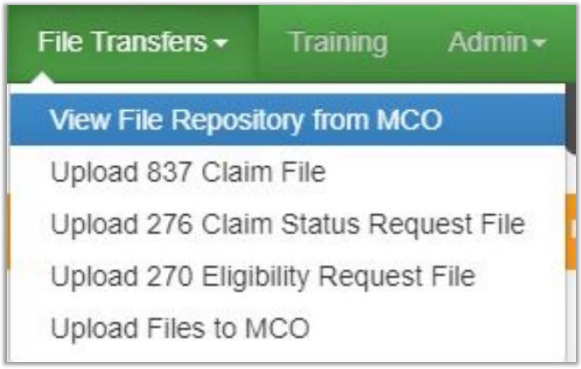
Trillium offers a Remittance Advice (RA) Companion Guide to providers on our website to assist with reading their RA.

- For Providers
- Provider Documents and Forms
- Claims/Finance Information & Forms section

Provider agencies will access payment reporting in the File Transfers section of Provider Direct.



Select File Transfers and a drop down menu will appear



The RA is located under the View File Repository from MCO, along with the following files:

- Remittance Advice
- Claims Status Report
- Current Authorization Dump
- Current Client Dump
- TAR Update Status
- 824 files
- 835 files
- 999 files
- Splitter report

835 - Electronic Remittance Advice/ Health Care Claim Payment/Advice:

Providers submitting 837 - Health Care Claim files will be able to retrieve their 835 - Electronic Remittance Advice the day after checkwrite. The 835 will electronically report the claim status and payment information. This file may be used to automatically post claim payments or adjustments to member accounts. Providers may access these files by their secure FTP folder or through the Provider Direct Portal following the same instructions as above.

ELECTRONIC FUNDS TRANSFER (EFT):

- **How to set up EFT?**

  As providers are contracted and on boarded the EFT set up for payment will be a part of the providers Welcome Packet, existing providers can make changes or enroll by contacting our Finance Department at FinanceForms@TrilliumNC.org.

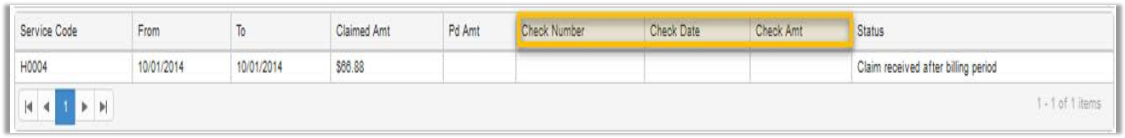
Checkwrite Schedule

The checkwrite Schedule for BH/IDD Tailored Plan services is posted on the Trillium's website and will occur weekly with the exception of a few holidays. Exceptions will be captured on the checkwrite schedule.

For all other Tailored Plan services, please see the appropriate vendor's checkwrite information.

How to identify EFT number in the Secured Behavioral Health I/DD Portal, Provider Direct (PD)?

- Using the Claims Search function in Provider Direct



Service Code	From	To	Claimed Amt	Pd Amt	Check Number	Check Date	Check Amt	Status
H0004	10/01/2014	10/01/2014	$66.88					Claim received after billing period

1 - 1 of 1 items

- The Check Number will be the EFT number from the check write that paid the claim
- The Check Date will be the date the EFT was issued
- The Check Amount will be the total amount of the EFT – not the amount of the claim being searched

How to identify EFT number in the Remittance Advice (RA) document?

At the top of the RA the Check Number/EFT Number will be displayed as shown below:

Trillium HEALTH RESOURCES

Remittance Advice

Check Write Date 12/5/2017

3 Of 4

Provider Name: ABC Provider Services

Provider ID: 012345

Process Dates Selected: 11/22/2017 to 11/28/2017

Questions - Contact your Claims Specialist

Type Key:
1: Payment
4: Denial
10: Partial Payment
22: Reversal of Payment

Check Number EFT000000 Check Dt 12/5/2017 Check Amt $15,960.40

CODE AUDITING AND EDITING

AUDITING PRINCIPLES/ CODING STRUCTURE:

Trillium will apply claim edits based on guidelines from sources that may include but not limited to the Center for Medicare & Medical Services' (CMS), American Medical Association (AMA), and State-specific policy and procedures (CCP). In making payment determinations, Trillium shall utilize nationally recognized coding structures including the National Uniform Billing Code (NUBC), Current Procedural Terminology (CPT),

Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases (ICD). Failure to follow appropriate coding guidelines may result in claim denial.

The list below is not an all-inclusive list of Trillium's audit principles. Providers must comply with all appropriate guidelines

National Correct Coding Initiative (NCCI):

The National Correct Coding Initiative (NCCI) helps to control improper coding leading to inappropriate and duplicate payment. The Affordable Care Act (ACA) requires all state Medicaid programs to incorporate NCCI methodologies in their claims processing. These edits include Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE).

PTP edits define pairs of HCPCS or CPT codes that should not be reported or billed together for various reasons. These edits also prevent improper payment when incorrect code combinations are reported.

MUE edits define for each HCPCS or CPT code, the maximum units of service that a provider should bill under most circumstances for a member on a single date of service.

Any claims billed in violation of the NCCI methodologies will be denied.

Additional information on NCCI edits can be found at National Correct Coding Initiative Medicaid webpage.

Or

NCCI For Medicare | CMS

NCCI Factsheet is also available on Trillium's website under:

- For Providers
- Provider Documents and Forms
- Claims/Finance Information & Forms section or
- National Correct Coding (NCCI) Fact Sheet

Taxonomy:

Taxonomy Codes

- The Health Care Provider Taxonomy code is a unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Grouping, Classification, and Area of Specialization. The

taxonomy submitted on a claim for billing, rendering, and attending providers must be a taxonomy for which the provider is enrolled with NCTracks.

- Taxonomy codes are required on claim forms for accurate claims processing. For the correct placement of taxonomy codes on claims please refer to the 'Taxonomy Claim Submission Fact Sheet'. The fact sheet is available on Trillium's website, in the:
  - For Providers
  - Provider Documents and Forms
  - Claims/Finance Information & Forms section:
    - The fact sheet will include:
      - Field location and qualifiers for taxonomy codes for both the CMS1500 & UB-04 claim forms.
      - Loop/Segment and qualifier information for taxonomy codes for electronic 837P & 837I claim submissions.

Diagnoses:

Providers should report the ICD-10-CM to the highest level of specificity that supports medical necessity on all claim types. Providers should use the most current ICD-10 edition at the time of service.

The primary diagnosis should be listed first, it should identify the condition being treated, and it should match member benefit plan/service billed.

Please refer to the Claims Submission Protocol for additional information.

- For Providers
- Provider Documents and Forms
- Claims/Finance Information & Forms section
  - Medicaid Direct & Tailored Plan Claims Submission Protocol

For State Funded Services:

Providers should reference the State Fiscal Year Diagnosis Code Array documentation at the time of service. This information is located on NCHHS's website.

Tailored Care Management (TCM):

Auditing Tailored Care Management (TCM) Claims

Providers submitting claims for payment of TCM services should submit Professional Claims to Trillium Health Resources. All required components of a claim should be completed. For additional details on specific requirements for TCM claims, please see our TCM Billing Guide on Trillium's website:

- For Providers
- Provider Documents and Forms
- Claims/Finance Information & Forms section
  - Tailored Care Management Billing Guide

OTHER RELEVANT BILLING INFORMATION

STATE FUNDED:

State funded claims must be billed to Trillium by direct entry of CMS-1500 or UB-04 claim form available in Provider Direct or by electronic 837P or 837I. All claims should be billed in accordance with general CMS 1500 and/or UB04 billing guidelines.

Providers should follow state service definitions and/or clinical coverage policies applicable to the service(s) provided to the member. All state funded claims will adjudicate nightly and receive a status of approved, denied or pended.

State Funded Service Definitions can be found at:

- NC DHHS: Service Definitions

Clinical Coverage Policies can be found at:

- Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov)

TRIBAL CLAIMS:

- Indian Health Care Providers (IHCP)
  - In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), Trillium will reimburse IHCPs as follows:
    - Those IHCPs that are not enrolled as an FQHC, regardless of whether they participate in Trillium's Network.
    - The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or

- The Medicaid Fee for Service rate for services that do not have an applicable encounter rate.
- Those IHCPs that are enrolled as FQHCs, but do not participate in Trillium's network, an amount equal to the amount the Trillium would pay a network FQHC that is not an IHCP.

- Trillium will not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.

  - **Claims**

    - Trillium will process claims from an Indian Health Care Provider (IHCP) in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.
    - Trillium allows any Tribal member eligible that receives services from an IHCP to choose the IHCP as the Tribal member's primary care provider (PCP), if the IHCP has the capacity to provide PCP service at all times. Trillium considers a referral from any IHCP acting as the member's PCP to a network Provider as satisfying any coordination of care or referral requirement of Trillium. Section 1932(h)(1) of the Social Security Act, 42 C.F.R § 438.14(b)(3) and 457.1209.
    - Consistent with section 1916(j) of the Social Security Act and 42 C.F.R. § 447.53 and §457.535, Trillium does not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost-sharing, or similar charge will be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization or through referral under contract health services.

  - **Reimbursement**

    - In accordance with 42 C.F.R. §438.14(c) and consistent with 42 C.F.R. §438.14(b), Trillium reimburses IHCPs as follows:

      - Those IHCPs that are not enrolled as a Federally Qualified Health Center (FQHC), regardless of whether they participate in Trillium's network, are reimbursed at the applicable encounter rate published annually in the Federal Register by the Indian Health Service, or for services that do not have an applicable encounter rate, at the Medicaid Fee-for-Services rate.

- IHCPs enrolled as FQHCs, but not participating in Trillium's network, are reimbursed at an amount equal to the amount Trillium would pay a network FQHC that is not an IHCP.
- Trillium will not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges used on the Tribal Member.
- Tribal Payment Policy states eligible Tribal providers will receive the All-Inclusive Rate (AIR), also referred to as the OMB rate, for services rendered at Cherokee Indian Hospital (CIHA) and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. Trillium will honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with Trillium will continue to follow those arrangements. To promote same day access and reduce barriers or burdens to a member such as transportation or taking time off from work, providers receiving the AIR rate may receive up to four (4) AIR encounters per day (single day of service) such as but not limited to follows:
    - Medical
    - Dental
    - Behavioral
    - One other such as optical or pharmacy depending on the nature of the member's schedule.
- The Tribal Payment Policy also states Tribal entity claims will not add up to the AIR rate since the AIR rate is established for all federally recognized Tribes. NC Medicaid adopted the AIR (also known as the OMB rate) as the rate to be used for the reimbursement of services provided by CIHA.
- Trillium complies with DHHS Tribal Payment Policy and the IHCP payment requirements. Trillium provides and maintains a point of contact for IHCP billing issues to the Department and with the Tribe.

Out of Network Providers:

During the Transition of Care Period (TOC), Trillium will reimburse an out-of-network provider at one hundred percent (100%) of the Medicaid Fee for Service rate. After the initial period, with the exception of out-of-network emergency services, post-stabilization services and services provided during the transition of coverage, out-of-network

providers will be reimbursed at a maximum of ninety percent (90%) of the Medicaid Fee for Service rate.

Please refer to the Contracting with Trillium page on the Trillium Health Resources website for additional details on out of network Single Case Agreements (SCA) and Provider Payment Agreement (PPA).

RECONSIDERATION:

Reconsideration Requests for Tailored Plan, Medicaid Direct or State Funded Behavioral Health/IDD Claims

- Providers can send requests for claims to be reconsidered using the Claims Inquiry Form via the Smartsheet located on Trilliums website by following the steps above under Claims Request Form.
- Additional details on the use of the Claim Inquiry Form, instructions on how to fill out the form, and a copy of the form can be found on Trillium's website:
  - For Providers
  - Provider Documents and Forms
  - Claims/Finance Information & Forms section
- Providers will need to include all the information on the request including:
  - Provider name
  - Provider number
  - Member name and information
    - A secure excel attachment is acceptable for multiple members in a request
  - Detailed claim information including the claim number
    - A secure excel attachment is acceptable for multiple members in a request
  - Specific details outlining the reason for the Claim Inquiry
  - Supporting documentation can be uploaded for submission.
  - Provider will "Submit" the Claims Inquiry Form

APPEALS:

Appeals and Complaints

- Details including timeframes on filing a claims appeal is available on your provider Remittance Advice (RA). To appeal a claims action (denial, underpayment, etc.), providers must submit a detailed, written appeal request, including the

corresponding claim number(s), the claim action(s) being appealed, and information that permits member or recipient identification. Additionally, providers may submit any documentation that they feel would assist in the appeal resolution.

- To submit a claims appeals request, provider may:
  - Utilize Trillium's on-line Provider Portal, Provider Direct;
  - Fax the appeal request to (252) 215-6879;
  - Email the appeal, via secure e-mail, to Appeals@TrilliumNC.org; or
  - Mail the appeal, hardcopy, to:

    Attn: Appeals Department
    201 W. 1st St.
    Greenville, NC 27858

Prepaid Health Plan (PHP) Billing Guidance:

NC DHHS Division of Health Benefits has published a Health Plan Billing Guidance to assist providers.

ADDITIONAL INFORMATION SOURCES

FREQUENTLY ASKED QUESTIONS (FAQ'S):

1. **What is the status of my claim? Where can I find my claim status?**
   The claim status for Behavioral Health/IDD claims can be found on your Remittance Advice/835, Claims Status Report, and can also be found using the claims search tab in Provider Direct. For more information please reference the Remittance Advice/835 section of this Billing Guide. For more information on Physical Health Claims Status please reference the Carolina Complete Health Secure Provider Portal Guide at: Carolina Complete Health Secure Provider Portal Guide

2. **How do I know if a member is eligible with Trillium for Date of Service?**
   Member/Recipient eligibility can be verified using NCTracks and the Behavioral Health/IDD secured portal Provider Direct using the client search tab. For more information please reference the Eligibility section of this Billing Guide.

3. **Where can I find my EFT number and check amount?**
   Your EFT number and check amount can be found on your Remittance Advice/835 and can also be found using the claims search tab in the Behavioral Health/IDD secured portal Provider Direct. For additional information please

reference the Remittance Advice/835 and the Electronic Funds Transfer sections of this Billing Guide. For more information on EFT numbers and check amounts for Physical Health Claims please reference the Carolina Complete Health Payspan information sheet at: Carolina Complete Health Payspan information sheet.

4. **How can I access my Remittance Advice (RA)?**
   Providers submitting Behavioral Health/IDD claims electronically can access their RA in the Behavioral Health/IDD secured portal Provider Direct. For more information please reference the Remittance Advice/835 section of this Billing Guide. For more information on accessing your Remittance Advice for Physical Health claims please reference the Carolina Complete Health Payspan information sheet at: Carolina Complete Health Payspan information sheet.

5. **I have a credit memo on my Remittance Advice (RA), what does that mean?**
   For Behavioral Health/IDD claims a credit memo is the result of a replaced, voided, and/or recouped claim, meaning the remaining balance will be offset from future claims. This will be shown on your RA as either a positive or negative credit memo. For more information please reference the Remittance Advice/835 section of this Billing Guide and the Remittance Advice (RA) Companion Guide available on our website, on the For Providers tab, Documents and Forms subtab, in the Claims/Finance Information & Forms section.

6. **How can I correct/replace, and/or void my claims?**
   Behavioral Health/IDD claims requiring corrections can be replaced and/or voided using the Replacement-Voided-Denied Claims Process available on the For Providers, Provider Documents and Forms subtab, in the Claims/Finance Information & Forms section.

7. **My rates have changed, how can I correct my claims to reflect the updated amount?**
   In order to correct Behavioral Health/IDD claims that have not already been corrected due to rate changes or incorrect rates submitted on claims, a replacement claim can be submitted using the Replacement-Voided-Denied Claims Process on the For Providers, Provider Documents and Forms subtab, in the Claims/Finance Information & Forms section.

8. **What should I do if my NPI/Taxonomy has been end dated at NCTracks and Trillium?**

The North Carolina Department of Health and Human Services (the Department), through NCTracks, will continue to collect information and verify credentials for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid and/or Health Choice programs or as a State-funded service provider. This information will be sent to Trillium through what is called the Provider Enrollment File (PEF). Trillium will use the information provided by the Department as the source of truth, NPI and taxonomy updates/re-enrollments should be sent to NCTracks by providers. For additional information regarding the PEF please refer to the Network Communication Bulletin #279, 'Tips for Reducing Provider Abrasion'.

9. **How can I access the Behavioral Health/IDD secured portal Provider Direct?**
   Access to the Behavioral Health/IDD secured portal Provider Direct is completed by our IT department for new provider set ups, once a provider is set up, access to the portal is authorized by the providers designated System Administrator. For additional information please refer to the Trading Partner Agreement and Provider Direct Access section of this Billing Guide.

10. **How can I add or remove a site location in my provider profile?**
    The North Carolina Department of Health and Human Services (the Department), through NCTracks, will continue to collect information and verify credentials for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid and/or Health Choice programs or as a State-funded service provider. This information will be sent to Trillium through what is called the Provider Enrollment File (PEF). Trillium will use the information provided by the Department as the source of truth, site location additions and removals should be sent to NCTracks by providers. For additional information regarding the PEF please refer to the Network Communication Bulletin #279, 'Tips for Reducing Provider Abrasion'.

11. **If I have a question regarding a claim who do I contact?**
    Questions regarding claims can be sent to ClaimsSupport@TrilliumNC.org.

PARTNER INFORMATION:

Trillium has chosen to partner with several subcontractors/vendors. Below is a list of some of the subcontractors/vendors and their role:

For Tailored Plan Services:

- **Carolina Complete Health (CCH)** – CCH is our Standard Plan (SP) partner. As a Tailored Plan, Trillium will be responsible for whole person care including both Behavioral, Physical and Pharmacy claims. The Physical Health (PH) claims will processed by CCH.
- **PerformRx** – Our Pharmacy Benefit Manager (PBM). Responsible for processing pharmacy claims for Tailored Plan members.
- **Modivcare** – Facilitates Non-Emergency Medical Transportation (NEMT) and Non-Emergent Ambulance Transportation (NEAT) services in North Carolina. Modivcare is a subcontractor of CCH.
- **Centene/Envolve Vision** –.Centene/Envolve is a subsidiary of CCH. Centene/Envolve vision will process vision claims for our TP members.
- **Availity**- This is a clearinghouse that is utilized by CCH. As long as the provider's clearinghouse has a connection to Availity, then a PH claim can be passed on to CCH using the payer ID 68069.

For All Trillium Lines of Business:

- **Gainwell Technologies (formerly known as HMS) –** This is our Third Party Liability (TPL) vendor. Gainwell is responsible for TPL processes for Trillium members.
- **Homecare Software Solutions, HHAeXchange (HHA) -** Electronic Visit Verification (EVV) vendor that is used by Trillium and CCH, to capture the six elements mandated by the State for EVV service codes.
- **Change Healthcare formerly known as Emdeon -** This is a clearinghouse that Trillium has an agreement with that providers may submit 837s. Trillium's payer ID is 56089 when using Change Healthcare.
- **The SSI Group -** This is a clearinghouse that Trillium has an agreement with that providers may submit 837s. Trillium's payer ID is 43071 when using The SSI Group.
- **WebbMason -** Trillium's Mailroom vendor responsible for mailings, reporting related to member mailings, and paper claim processing.

REIMBURSEMENT POLICY:

Trillium has the responsibility to process and reimburse claims in accordance with guidelines for both in-network and out-of-network providers. Providers are responsible for submitting accurate claims data. The submission of a claim does not guarantee payment. Providers must follow proper billing and submission of claims guidelines.

TRAINING:

Trillium offers many useful trainings to assist you in submitting a claim and working denials. Some available training resources include MyLearningCampus, NC MSSI and more.

The links will be provided below:

- MyLearningCampus
- NC Tracks
- Provider Direct

RESOURCES/ WEBSITE:

- Link to For Providers
- Trillium's Electronic Visit Verification (EVV)
- Trillium's Tailored Care Management Billing Guide
- Carolina Complete Health Claims and Billing (CCH)
- PHP Billing Guide
- Medicaid Direct & Tailored Plan Claims Submission Protocol

COMMON ACRONYMS:

Acronyms	Description
ABD	Adverse Benefit Determination
ACA	Affordable Care Act
ACTT	Assertive Community Treatment Team
ADATC	Alcohol and Drug Abuse Treatment Center
ADVP	Adult Developmental Vocational Program
AMH	Advanced Medical Home - State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.
AMH+	Advanced Medical Home Plus - Primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population, or can otherwise demonstrate strong competency to serve that population and have certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch) as such.
AUBP	Additional Utilization Based Payments
AVRS	Automated Voice Response System
BAA	Business Associate Agreement
CAGC	Claim Adjustment Group Code
CAQH	Council for Affordable Quality Healthcare
CARC	Claim Adjustment Reason Code
CASP	Cross Area Service Program
CCH	Carolina Complete Health, our Standard Plan partner who processes all Tailored Plan physical health claims.
CCNC	Community Care of NC
CFS	Child and Family Services
CFAC	Consumer and Family Advisory Committee
CHAT	Comprehensive Health Assessment for Teens

Acronyms	Description
CIN	Clinically Integrated Network - Entities with which provider practices choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH+ practice or CMA.
CIT	Crisis Intervention Team
CMA	Care Management Agency - Provider organization with experience delivering BH, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management to BH I/DD Tailored Plan members assigned to it, under the Tailored Care Management model as certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch).
CNDS	Common Name Data Service
CPP	Child Parent Psychotherapy
CRD	Community Resource Development
DME	Durable Medical Equipment
EB	Enrollment Broker
EBCI	Eastern Band of Cherokee Indian
EPS	Encounter Processing System
EVV	Electronic Visit Verification
HFW	High Fidelity Wraparound
HIPAA	Health Insurance Portability and Accountability Act
HMS	Health Management Systems--Vendor for Third Party Liability Processes
HOP	Healthy Opportunities Pilot
HSO	Human Services Organization
ICF	Intermediate Care Facility
IDD	Intellectual and Developmental Disabilities
IEP	Individualized Education Program
IHCP	Indian Health Care Provider
ILOS	In Lieu of Services

Acronyms	Description
IMD	Institution for Mental Diseases
IPS-NC CORE	Individual Placement and Support - NC Collaborative for Ongoing Recovery through Employment
IPV	Interpersonal Violence
ISP	Individualized Service Plan
IW	Innovations Waiver
LHD	Local Health Departments
LME	Local Management Entity
LOB	Line(s) of Business
LOC	Level of Care
LTC	Long Term Care
LTSS	Long-Term Services and Supports
Medicaid Direct	Refers to the Medicaid Fee-For-Service program serving enrollees who are not enrolled in a prepaid health plan (PHP) or the EBCI Tribal Option
MCO	Managed Care Organization
MOA	Memorandum of Agreement
MOE	Maintenance of Effort
MCT/MCM	Mobile Crisis Team, Mobile Crisis Management
Member	Term for Medicaid Beneficiaries
MN	Medical Necessity
NABD	Notice of Adverse Benefit Determination
NCCARE360	An electronic platform providing: (a) a robust statewide resource repository of community-based organizations and social service agencies and the services they provide, and (b) a referral platform for payers, care managers, clinicians, community health workers, social service agencies, and others to refer and connect members directly to community resources and track the connections and outcomes through "closed loop referral" capacity. The platform is being deployed as part of a public-private partnership with the Foundation for Health Leadership and Innovation.

Acronyms	Description
NC FAST	NC Families Accessing Services through Technology - The Department's integrated case management system that provides eligibility and enrollment for Medicaid, NC Health Choice, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.
NC MMIS	North Carolina Medicaid Management Information System (Currently NCTracks)
NEMT	Non-Emergency Medical Transportation Services
NIA	National Imaging Associates
NL	Network Lead
NCQA	National Committee for Quality Assurance
OON	Out of Network
PBM	Pharmacy Benefit Manager
PCP	Primary Care Provider
PESA	Pilot Eligibility and Service Assessment
PHI	Protected Health Information
PHP	Prepaid Health Plan
PMP	Pregnancy Management Program The PMP provides comprehensive, coordinated maternity care with a special focus on preterm birth prevention for all pregnant women enrolled in Medicaid health plans. This program is administered as a partnership between managed care plans and local maternity care service providers (defined as any provider of perinatal services). A key feature of the program is the use of a standardized screening tool to identify and refer women at risk for an adverse birth outcome to the Care Management for High-Risk Pregnant Women (CMHRP) program.
PMPM	Per Member Per Month This is the term used in reference to a payment that is made either to a provider or to Trillium on a Per Member Per Month basis
PSSL	Provider Support Specialist Line
QSO	Qualified Service Organization

Acronyms	Description
RA	Remittance Advice
RARC	Remittance Advice Remark Codes
Recipient	Term for State Funded Beneficiaries
TA	Technical Assistance
TBI	Traumatic Brain Injury
Tailored Care Management (TCM)	Whole-person care management. Care managers work with members and providers to ensure member's physical health, behavioral health, I/DD, pharmacy needs are all being met.
Tailored Plan (TP)	Integrated health plan for individuals with significant behavioral health and I/DD needs.
VAS	Value-Added Service
VBP	Value-Based Payment
VR	Vocational Rehabilitation