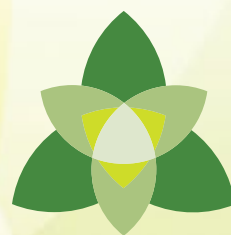
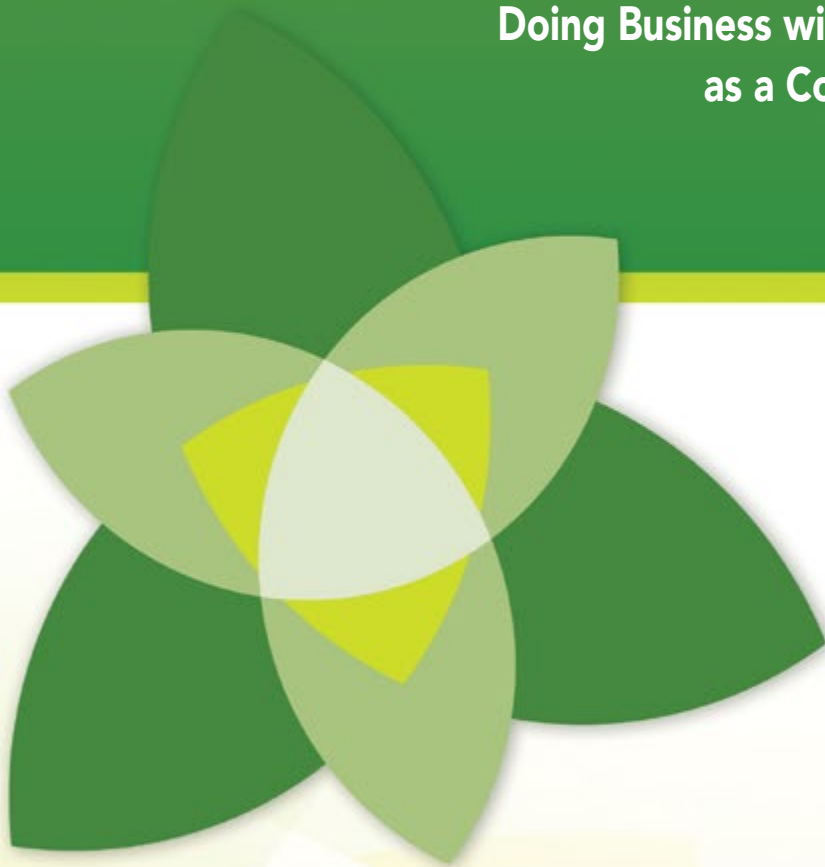


TRILLIUM HEALTH RESOURCES PROVIDER MANUAL

Doing Business with Trillium Health Resources
as a Contracted Network Provider



Trillium
HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

March 2022

PROVIDER MANUAL

This document is available on the Trillium Health Resources (Trillium) website at TrilliumHealthResources.org on the *For Providers* tab, and under the [Provider Documents & Forms page](#). Please see the [Resources & Web Links section](#) at the end of this Manual for more specific webpage links for documents referenced throughout. A printed copy of the information posted on the website is available upon request by calling Trillium at the Provider Support Service Line below.

Trillium keeps the provider network apprised of new information and procedural changes on an ongoing basis to ensure providers are up-to-date and understand revised expectations as they happen. We send timely messages through our email distribution via Constant Contact; [please be sure at least one staff person in your office signs up to receive these updates](#). We will incorporate those changes as necessary and publish revised editions of this Provider Manual periodically.

TRILLIUM REGIONAL OFFICES

Trillium Northern Regional Office
144 Community College Rd.
Ahoskie,
NC 27910-9320

Trillium Central Regional Office
201 West First St.
Greenville,
NC 27858-1132

Trillium Southern Regional Office
3809 Shipyard Blvd.
Wilmington,
NC 28403-6150

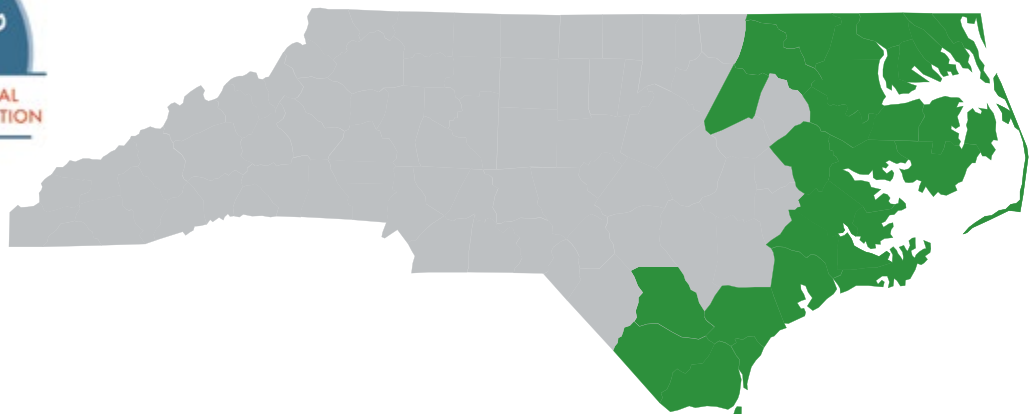
24-Hour Behavioral Health Crisis Line:
1-877-685-2415

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

Please note the toll-free Member & Recipient Service Line number, 1-877-685-2415 is intended for and limited to members and recipient issues around member care.

Provider Support Service Line:
1-855-250-1539

Please use the Provider Service Line toll free number for all Network Provider Matters.



A MESSAGE FROM THE CEO

WELCOME TO THE TRILLIUM HEALTH RESOURCES PROVIDER NETWORK!

We are pleased to have you as a partner. Thank you for helping us fulfill our responsibility to provide people in our 28-county catchment area with timely access to a full array of high quality, medically necessary physical health, serious mental health, intellectual and/or developmental disability, substance use services and traumatic brain injury services. We work together with our partners and community stakeholders to build and strengthen foundations of well-being and help deepen connections between citizens and their neighbors.

Trillium is committed to the principles of recovery and self-determination. We whole-heartedly believe in person-centered services and supports. We fully understand that our success in achieving those goals is dependent upon our provider network. The public behavioral health system is successful, because of the dedicated, local providers who are deeply rooted in our communities.

This Provider Manual outlines how to do business with Trillium. It includes the processes and procedures we expect from you and tells you what you can expect from us in return. It is our intent for this Manual to be a living document that serves as a resource for Trillium staff and our provider network. To that end, we welcome your suggestions for improvement



JOY FUTRELL

Chief Executive Officer



Trillium Health Resources

*Transforming lives and building community
well-being through partnership and proven
solutions.*

TABLE OF CONTENTS

A MESSAGE FROM THE CEO	III
WELCOME TO TRILLIUM!	1
TRILLIUM—WHO WE ARE	1
ABOUT THE MEDICAID WAIVER	1
WHAT IS THE NC MH/DD/SAS HEALTH PLAN?	1
OPPORTUNITIES THE 1915(B)(C) WAIVERS PRESENT	2
ABOUT THE NC 1915(B) WAIVER	2
ABOUT THE NC INNOVATIONS WAIVER	2
Recovery and Resilience	3
GOVERNANCE & ADMINISTRATION	3
GOVERNANCE	3
Two Tiered Governance Structure	4
OFFICE OF THE CHIEF EXECUTIVE OFFICER	4
Business Operations	4
Clinical Operations	4
Trillium's Chief Medical Officer	4
Communications & Marketing	4
Technology and Informatics	4
General Counsel	4
Medicaid Contract Manager	5
STAKEHOLDER & COMMUNITY PARTNERS	5
Stakeholder Involvement	5
Operational Committees	5
MEMBER RIGHTS & EMPOWERMENT	5
RIGHTS OF MEMBERS	5
MEMBER RIGHTS AS A MINOR (UNDER THE AGE OF 18)	7
MEMBER RIGHTS IN A 24-HOUR FACILITY/ADULT CARE HOME	8
MEMBER RIGHTS FOR RESIDENTIAL PROVIDERS ONLY	9
RIGHTS TO INFORMED CONSENT	9
RIGHTS OF THOSE WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY	9
RESTRICTED RIGHTS	10
VIOLATED RIGHTS	10
EXECUTIVE MANAGEMENT TEAM	11
ADVANCE DIRECTIVES	11

CONFIDENTIALITY	12
LIMITED ENGLISH PROFICIENCY, LIMITED READING ABILITY, IMPAIRED VISION, AND HEALTH LITERACY	12
CULTURAL AND LINGUISTIC COMPETENCY	13
INFORMATION TECHNOLOGY	15
TRILLIUM WEBSITE	15
PROVIDER DIRECT	15
EMAIL COMMUNICATIONS	15
CONTRACTS	16
PROCUREMENT CONTRACTS & GENERAL CONDITIONS	16
TRAINING	16
PROVIDER TRAINING	16
PROVIDER NETWORK	18
NETWORK MANAGEMENT DEPARTMENT	18
Network Accountability	18
Network Auditing	18
QUALITY MONITORING	18
NC DHHS Provider Monitoring	18
Home and Community Based Services (HCBS)	19
PROGRAM INTEGRITY	20
FRAUD AND ABUSE INVESTIGATION	20
FRAUD AND ABUSE MONITORING AND AUDITING	20
Fraud and Abuse Reporting	21
FALSE CLAIMS ACT	21
Practice Management	21
Provider Service Support	22
TYPES OF PROVIDERS	22
Agency-Based Providers	22
State-Operated Health Care Facilities	22
Licensed Independent Practitioners and Professional Practice Groups	22
Hospital Facilities	22
PROVIDER LOCATIONS	22
PROVIDER COMMUNICATION	23
Provider Representation	23
SURVEYS	23
PROVIDER COUNCIL	23

PROVIDER CREDENTIALING	24
Credentialing Objectives.....	25
Re-Credentialing	25
Alteration of Credentialed Status	26
PROVIDER VIOLATIONS AND SANCTIONS	26
Violations	26
Technical Guidance, Disciplinary Actions and Sanctions	27
Determination and Notification of Actions Taken	
Against Network Providers	28
Reconsideration of Actions Against Providers	28
REPORTING OF DISCIPLINARY ACTIONS	29
CHANGES IN CURRENT PRACTICE INFORMATION.....	30
APPLYING FOR ADDITIONAL SERVICES.....	30
Consideration Criteria	30
PLAN OF CORRECTION PROCESS	31
Follow-Up Review	31
NETWORK DEVELOPMENT PLAN.....	32
Credentialing.....	34
Reconsideration of Administrative Matters or in Relation to Professional	
Conduct or Competence.....	34
Cultural Competence	34
Credentialing.....	35
Reconsideration of Administrative Matters or in Relation to Professional	
Conduct or Competence.....	36
Cultural Competence	36
NETWORK DEVELOPMENT	36
Provider Network Size and Scope.....	37
Notice of Rights Under Federal Conscience and Anti-Discrimination Laws ..	37
COMPLIANCE.....	38
MEMBER RECORDS REQUIREMENTS.....	38
HIPAA INCIDENT REPORTING	38
NORTH CAROLINA TREATMENT AND OUTCOMES PROGRAM PERFORMANCE	
SYSTEM (NC-TOPPS)	39
NC-SNAP REQUIREMENTS.....	39
NC-SNAP EXAMINER CERTIFICATION TRAINING	39
GPRA CORE CLIENT OUTCOME MEASURES FOR DISCRETIONARY SERVICES	
PROGRAMS	40

TRILLIUM BENEFIT PLAN	41
MEDICAID WAIVER ELIGIBILITY	41
The NC MH/DD/SAS Health Plan (1915(b) waiver)	41
The NC Innovations Waiver (1915(c) waiver)	41
ENROLLMENT	42
Service Eligibility	42
DISENROLLMENT	43
ELIGIBILITY FOR STATE-FUNDED SERVICES	43
ELIGIBILITY FOR REIMBURSEMENT BY TRILLIUM	43
CLINICAL OPERATIONS	44
TRILLIUM CLINICAL DESIGN PLAN	44
CALL CENTER & MEMBER SERVICES	44
Accessing Routine Services	44
Routine Referral Process	44
Accessing Urgent Services	45
Urgent Referral Process	45
Accessing Emergent Services	46
Emergent Referral Process	46
If Member/Recipient Is Unable To Be Stabilized	46
Process for Service Authorization	47
Discharge	47
Follow Up After Discharge	47
Grievances & Complaints	47
GRIEVANCE & COMPLAINT PROCESS INTERNAL TO CONTRACTED NETWORK PROVIDERS	49
TRILLIUM'S CARE MANAGEMENT DEPARTMENTS	49
Innovations Waiver Care Management	49
Transitions to Community Living (TCL)	51
CLINICAL SUPPORT	51
HOUSING	52
NEIGHBORHOOD CONNECTIONS	52
TRILLIUM ADVANTAGE	52
UTILIZATION MANAGEMENT	52
Care Management	52
Treatment Authorization Request Forms	52
Utilization Review	53
Incentives	53
Focused Utilization Review	53
Routine Utilization Review	53
Authorization Process	54

Authorization	54
Discharge Review.	55
Discharge Process	56
Hospital Admissions	57
Registry of Unmet Needs	57
Second Opinion.	57
Decisions to Deny/Reduce/Suspend/Terminate a Medicaid Service.	57
Denial.	57
Reduction, Suspension, or Termination	58
Medicaid Services Appeal—Level 1	58
Steps to File a Reconsideration Request	59
Expedited Reconsideration Review Process.	59
Extension of Timeframes for Expedited & Standard Reconsideration Requests.	60
Medicaid Services Appeal Mediation—Level 2	60
Medicaid Services Appeal—Level 3—Judicial Review.	61
Non-Medicaid Service Reconsideration Process	61
Non-Medicaid Appeal Request to DHHS	62
Receiving Services during the Non-Medicaid Grievance Process	62
Utilization Management	63
Care Management.	64
GETTING PAID	65
FINANCE & CLAIMS DEPARTMENTS	65
ENROLLMENT AND ELIGIBILITY PROCESS	65
Eligibility Determination	65
Key Data to Capture during Enrollment	65
Effective Date of Enrollment.	66
Member ID.	66
Eligibility Determination Process by Provider.	66
Obligation to Collect.	66
Reporting of Third Party Payments	66
Process to Modify	66
Sliding Fee Schedules	66
AUTHORIZATIONS REQUIRED FOR PAYMENT	67
System Edits.	67
Authorization Number and Effective Dates	67
Service Categories or Specific Services	67
Units of Service	67
Exceptions to Authorization Rule	67

CLEAN CLAIMS	67
Service Codes and Rates–Contract Provisions	67
Payment of Claims and Claims Inquiries	68
Timeframes for Submission of Claims	68
Provider Direct Claims Submission	69
837 Claims Submission	69
Process for Submission of Replacement Paid Claims	69
Process for Submission of Voided Paid Claims	69
Process for Submission of Replacement for Denied Claims	69
Providers Who Submit Paper Claims	70
RESPONSE TO CLAIMS	70
Remittance Advice	70
Electronic Remittance Advice (835)—for 837 Providers	70
Accounts Receivable Management	70
CLAIMS INVESTIGATIONS–QUESTIONABLE BUSINESS PRACTICES	71
Trends of Use and Potential Fraud	71
Audit Process	71
Role of Finance Department	71
Voluntary Repayment of Claims	71
Reporting to State and Federal Authorities	71
REPAYMENT PROCESS/PAYBACKS	71
QUALITY MANAGEMENT	73
QM INDICATORS	73
HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)	74
INCIDENT REPORTING, MEMBER HEALTH AND SAFETY, QUALITY OF CARE	74
Level I Incidents	76
Level II Incidents	76
Level III Incidents	76
Restrictive Interventions	77
Restrictive Interventions Reporting Requirements in a PRTF Setting	77
CONTINUOUS QUALITY IMPROVEMENT	78
PROVIDER QUALITY IMPROVEMENT ACTIVITIES	79
SURVEYS/MEMBER EXPERIENCE	79
Provider Satisfaction Survey	79
Member Satisfaction Survey (ECHO- Experience of Care and Health Outcomes)	80
National Core Indicator (NCI) Survey	80
Network Adequacy and Accessibility Assessment	80
Perceptions of Care Survey	81

COMMITTEE STRUCTURE	82
QUALITY IMPROVMENT COMMITTEE	82
GLOBAL QUALITY IMPROVEMENT COMMITTEE	82
HUMAN RIGHTS COMMITTEE	83
PROVIDER PERFORMANCE DATA	83
VALUED PROVIDER SEAL PROGRAM	84
PROVIDER DISASTER PLANS	85
PROVIDER DISASTER PLANS	85
CORRESPONDENCE TIMELINES & ADDRESS REFERENCE	A
RESOURCES & WEB LINKS	B
IMPORTANT EMAIL ADDRESSES	C

WELCOME TO TRILLIUM!

Your responsibility as a Trillium contracted provider is to be familiar with and adhere to guidelines outlined in this manual. Your adherence to these guidelines will assist Trillium in providing you with timely service authorizations and claims reimbursement. We thank you for your participation in our provider network and look forward to a long and rewarding relationship as we work together to provide responsive treatment to the people we both serve.

TRILLIUM—WHO WE ARE

Trillium is a Local Management Entity (LME) and Managed Care Organization (MCO) responsible for publicly funded behavioral health (mental health and substance use) and intellectual/developmental disability services and supports for people living in—or whose Medicaid eligibility was established in—the counties we serve.

Our mission is to transform lives and build community well-being through partnership and proven solutions.

Trillium prioritizes finding the right individualized care for the people we serve. A person's overall well-being is dependent upon so much more than just health care. Where a person physically and socially lives, learns, works, and plays all have a tremendous impact. We take a person-centered, community-based approach to health and well-being.

Trillium is nationally accredited by NCQA as a Managed Behavioral Healthcare Organization

Trillium Health Resources complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, sexual orientation or gender identity.

Trillium Health Resources does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, sexual orientation or gender identity.

ABOUT THE MEDICAID WAIVER

WHAT IS THE NC MH/DD/SAS HEALTH PLAN?

Trillium is a pre-paid inpatient health plan (PIHP) funded primarily by Medicaid. All Medicaid MH/DD/SA services are authorized by Trillium and provided through the Trillium provider network in accordance with the risk-based contract between the NC Division of Health Benefits and Trillium. As a prepaid inpatient health plan, Trillium is at financial risk for a specific set of MH/DD/SA services, including both NC Medicaid State Plan services and services included in the NC Innovations Waiver.

The NC MH/DD/SAS Health Plan is a combination of two types of waivers authorized by the federal Social Security Act, the federal legislation creating and governing the Medicaid program. They are identified by the specific sections of Social Security Act, which authorizes them.

A Section 1915(b) Waiver, commonly referred to as a "freedom of choice waiver," allows States to waive the provisions of the Medicaid program that require "any willing and qualified provider," statewide requirements (meaning Medicaid has to operate the same way in every part of the state), and certain fiscal requirements regarding rate-setting and payment methodologies.

A Section 1915(c) Waiver, generally known as a Home and Community Based Waiver, allows the State to offer home and community based services not normally covered by the State's Medicaid program if they can be proven to be no more expensive than an institutional level of care covered by Medicaid. In North Carolina this is referred to as the Innovations Waiver.

Both waivers are approved under different federal Medicaid regulations and require different reporting and oversight. This type of waiver system is not intended to limit care but to create an opportunity to work closely with members and providers on better coordination and management of services, resulting in better outcomes for members and more efficient use of resources.

OPPORTUNITIES THE 1915(B)(C) WAIVERS PRESENT

- Coordination—The waiver allows us to better coordinate a system of care for members, families and providers.
- Efficient management of fiscal resources—We are able to manage all system resources so money can be directed to services most appropriate for identified member needs.
- Flexibility in services offered—We have developed a more complete range of services and supports in the community, including new services, in order to reduce and redirect reliance on high cost institutional and hospital care.

ABOUT THE NC 1915(B) WAIVER

- This waiver applies to members with Medicaid from any of the counties in our service area. All Medicaid members in specified eligibility groups will be eligible and automatically enrolled into this plan for their mental health, intellectual/developmental disability, and substance use service needs.
- Available services include all current NC Medicaid State Plan services for mental health, intellectual/developmental disabilities and substance use services, including inpatient hospitalization,

outpatient therapy, enhanced services, residential services, crisis services, Psychiatric Residential Treatment Facilities (PRTF) and Intermediate Care Facilities for Individuals with Intellectual and/or Developmental Disabilities (ICF/IDD) and Division of State Operated Healthcare Facilities (DSOHF).

- Trillium is partnering with the state to create additional services identified as best practices in care.
- Members are able to choose from any provider that is fully contracted and approved to be in the Trillium Provider Network and offers a service that is clinically appropriate.

ABOUT THE NC INNOVATIONS WAIVER

The NC Innovations Waiver is a 1915(c) Home and Community Based Waiver. Participation in the Innovations Waiver is limited to the number of individuals approved by the federal Centers for Medicare & Medicaid Services (CMS) each year of the Waiver and the funding approved by the N.C. General Assembly. Under this waiver, members who would otherwise meet the criteria for services in an ICF/IDD setting may receive services in their home and community, as long as the aggregate cost of those services does not exceed the cost of ICF/IDD care.



This waiver incorporates the essential elements of self-direction, Person-Centered Planning, individual budgets, member protections, and quality assurance. The waiver supports the development of a stronger continuum of services enabling members to move to more integrated settings. People served and their families have the information and opportunity to make informed decisions about their health care and services, and exercise more control over the decisions they make regarding services and supports.

The NC Innovations Waiver has a Provider-Directed and Individual/Family-Directed track. In the Provider-Directed track, the services are delivered in a traditional manner with staff in the employment of an agency. Members and their families have the option to participate in the Individual-Family Directed Services or Agency with Choice Model.

Recovery and Resilience

Trillium believes that everyone is resilient and that people can recover from trauma. Everyone deserves to experience a fulfilling and productive life. Through the recovery process, people who experience psychiatric or substance use disorders are empowered to understand that who they are as a whole person—not their diagnosis—is central to their lives. Providers can help their members identify their strengths and reach their goals to achieve recovery through that resilience.

Trillium strives to support members on their path to recovery by engaging in community collaboration and promoting services that improve the health and wellbeing of those we serve. Our hope is that these programs will help individuals achieve their recovery goals and empower them to live in a healthy, safe and meaningful way. This would not be possible without the support and hard work of our providers.

For more information on Trillium's recovery and resilience mission, please read the [Member Handbook on our website](#).

GOVERNANCE & ADMINISTRATION

GOVERNANCE

Trillium is a local political subdivision of the State created under the authority of N.C.G.S. §122C. It is a public authority governed by a 13-member board. The Trillium Board of Directors is a policy-making body, which focuses on establishing and monitoring goals as well as the development of public policy. The Chief Executive Officer reports to the Board, and all other staff of Trillium report to the Chief Executive Officer.

N.C.G.S. §122C-170 requires that area authorities and county programs establish a Consumer and Family Advisory Committee (CFAC). CFAC consists of individuals who receive mental health, intellectual/developmental disability and substance use services and family members of those individuals. It is a self-governing committee that serves as an advisor to Trillium administration and the Board of Directors. Trillium has established three CFACs, one for each region in its catchment area. One CFAC member from each region also serves on the Governing Board.

The duties of the CFAC, as outlined in statute, include:

- Reviewing, commenting on, and monitoring the implementation of the local business plan; identifying service gaps and underserved populations;
- Making recommendations regarding the service array and monitoring the development of additional services;
- Reviewing and commenting on the area authority or county program budget; participate in all quality improvement measures and performance indicators;
- Submitting to the State Consumer and Family Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.

Two Tiered Governance Structure

Trillium has a two-tiered governance structure that is made up of Regional Advisory Boards and the Governing Board. Descriptions of both boards are as follows:

Regional Advisory Boards

- One county commissioner or designee from each county, one other member appointed by the county who fits one of the criteria of G. S. 122C-118.1
- Chair of the Regional CFAC
- Duties: Monitor performance at regional level, identify gaps and needs, maintain connection to counties and communities, participate in evaluation of regional directors, appoint members to Governing Board
- Northern–21 members; Central–19; Southern–15

Governing Board

- 13 Member Board
- 1 County Commissioner from each Regional Advisory Board
- The Chair from each Regional Consumer & Family Advisory Committee
- 2 more representatives from each Regional Advisory Board that meet membership requirements
- Provider Network Council Chair or designee (non-voting member)
- Duties: all outlined in Statutes including selection and evaluation of CEO, fiduciary responsibility, strategic planning, etc

OFFICE OF THE CHIEF EXECUTIVE OFFICER

The CEO is responsible for the overall management of the LME/MCO, including both short and long term planning. Planning includes the management of resources, direction of the network toward best practices, alignment of incentives with agency planning, how to invest new dollars and how to reinvest savings which occur as service utilization changes.

A member of Trillium's executive team leads each of the major functional areas of Trillium:

Business Operations

- Finance
- Claims
- Contracts
- Training
- Human Resources
- Regional Operations
- Network Management

Clinical Operations

- Call Center & Member Services
- Innovative Development
- Housing Services
- Neighborhood Connections

Trillium's Chief Medical Officer

- Medical Affairs
- Quality Management
- Utilization Management
- Care Management
- Transitions to Community Living

Communications & Marketing

- Communications
- Marketing

Technology and Informatics

- Informatics
- Business Systems
- Information Technology Operations
- Cybersecurity
- Facilities

General Counsel

- I Compliance
- Program Integrity
- Appeals
- Medicaid Contract Manager

The Chief Medical Officer is responsible for the oversight of all clinical management of services to members, including authorization of services, and utilization management. Other activities include collaboration with Trillium network providers, medical providers in the community, and State and community hospitals as well as development of preventive health projects for Trillium members and recipients.

Medicaid Contract Manager

Trillium's Medicaid Contract Manager is the point person for coordination of the Trillium 1915(b)(c) Medicaid Waiver. The Manager is responsible for monitoring the overall performance and compliance of Trillium with all areas of the Medicaid contract and acts as the primary contact with the NC Department of Health and Human Services (DHHS.)

STAKEHOLDER & COMMUNITY PARTNERS

Stakeholder Involvement

Trillium has a comprehensive system of operational forums in order to ensure engagement of members, family members, advocates, providers and community agencies. This involves a number of operational committees that bring Trillium staff, members, and guardians, providers and stakeholders together to address issues and concerns, to provide important feedback to Trillium around its performance, and to assist in proactive planning.

Operational Committees

The chart below depicts the interactions among the Trillium Operational Committees. The use of these forums, where staff, members, family members, providers and the community come together to exchange ideas, address issues, and plan collaboratively has been a resounding success.

For Trillium, this has been a way for us to "keep our feet on the ground" and understand the impact of our activities. For the members of these teams, it has been an opportunity to understand and assist with the requirements and challenges Trillium has faced in its role as regional systems manager.

MEMBER RIGHTS & EMPOWERMENT

RIGHTS OF MEMBERS

The protection and promotion of member rights is a crucial component of the service delivery system. All members are assured rights by law. We expect providers to respect these rights at all times and provide members continual education regarding their rights, as well as support them in exercising their rights. N.C. General Statutes, Administrative code, and federal regulations outline rules and regulations about human rights. The following is a list of the rights of our members:

Members have the following rights:

- The right to request and receive information about Trillium, its services, its providers/practitioners, and member rights and responsibilities presented in a manner they can understand. Trillium notifies members of this right, annually.
- The right to be treated with respect and recognition of dignity and right to privacy.
- The right to participate with providers or practitioners in making decisions regarding health care and the right to refuse treatment.
- The right to a candid discussion with service providers/practitioners on appropriate or medically necessary treatment options regardless of cost or benefit coverage. Members may need to decide among relevant treatment options, the risks, benefits and consequences, including their right to refuse treatment and to express their preferences about future treatment decisions regardless of benefit coverage limitation.
- The right to voice complaints or grievances about the organization or the care it provides.
- The right to appeal decisions with which they disagree.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. If they present a danger to themselves or others, and there are no other means available to protect their safety and the safety of others, physical restraint may be used.

- The right to request and receive a copy of their medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. Therapeutic privilege means that if the doctor or therapist determines that this would be detrimental to their physical or mental well-being, they can request that the information be sent to a physician or professional of their choice.
- The right to write a statement to be placed in their file if they disagree with what is written in their medical records. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SA retention schedule (11 years for adults; 12 years after a minor reaches the age of 18; 15 years for DWI records).
- The right for a treatment plan to be implemented within 30 days after services start. This is known as a Person-Centered Plan.
- The right to a second opinion from a qualified health care professional within or outside the Trillium network, at no cost to the member. Upon request, Trillium shall provide one second opinion from a qualified health care professional selected by Trillium, at no cost to the member. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. Trillium shall not be required to provide the member with a third or fourth opinion.
- The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths and preferences.
- The right to take part in the development and periodic review of their treatment plan and to consent to treatment goals in it.
- The right to freedom of speech and freedom of religious expression, including the right to refuse treatment on moral or religious grounds.
- The right to equal employment and educational opportunities.
- The right to ask questions when they do not understand their care or what they are expected to do.
- The right to written notice of any "significant change" to the handbook and/or contracts at least thirty (30) calendar days before the intended effective date of the change. A "significant change" is a change that requires modifications to the 1915 b/c Waiver, a contract between Trillium and the State or Medicaid, or the Medicaid State Plan.
- The right to receive oral interpretation services free of charge.
- The right to request and receive a State Fair Hearing.
- The right to develop an Advance Directive for the mental health treatment they would like in the event of an emergency. They may contact Trillium Health Resources for assistance at 1-877-685-2415. An Advanced Directive explains the treatment they would like and the people they would like to be involved. It also explains the things that they do not want. The right to file a grievance with the N.C. Division of Health Service Regulation or with Trillium if they feel the laws governing the advance directives have not been followed correctly.
- The right to be free of mental abuse, physical abuse, neglect and exploitation.
- The right to choose their Provider from the Trillium Provider Network. They have the right to change their choice of Provider at any time by calling 1-877-685-2415 or speaking to their care coordinator.
- When a Provider leaves the Network (either by choice or otherwise), Trillium will contact all members currently in treatment with the Providers. Trillium will make every effort to notify each member in writing thirty (30) calendar days prior to Provider leaving the Network. If Trillium learns of a Provider's departure less than thirty (30) calendar days before termination date, Trillium will make every effort to notify each member in writing fifteen (15) calendar days after Trillium receives notice of termination or within fifteen (15) calendar days after Trillium terminates the Provider.

- The right to treatment, regardless of age or disability. The treatment received will be age appropriate and in the least restrictive manner possible.
- The right to receive Medicaid services at no cost to them (no required co-payments, deductibles, or other forms of cost sharing); they also will not be charged for missed appointments.
- The right to invite family or friends to help develop their Person-Centered Plan. The purpose of the Person Centered Plan is to help them make goals to achieve their full potential.
- The right to be notified in advance of all potential risks and benefits of treatments.
- The right to be free from unnecessary or excessive medications. Medications will not be used as punishment or for the convenience of staff or family
- The right to refuse medications. This should always be discussed with their doctor.
- Members CANNOT be treated with electroshock/ electroconvulsive therapy, experimental drugs or procedures, or be given surgery (unless it is an emergency surgery) without their written permission.
- The right to make recommendations regarding Trillium policies, procedures and services. If they would like to make recommendations regarding changes, they may contact Trillium Health Resources at 1-877-685-2415.

They may also write us at:

**Trillium Health Resources,
201 West First Street,
Greenville, NC 27858-1132.**

- The right to keep their care and medical records confidential. Even the fact that they are receiving services is confidential.

Information about them can only be shared when:

- They have given written consent.
- There is a court order.
- They become a danger to themselves or others and it is necessary for someone to submit involuntary commitment papers or find hospital placement for them.

- They are likely to commit a serious crime. Their provider will share the information with the appropriate law enforcement agency.

Unless they have been declared incompetent by a court of law, and have a legal guardian appointed to them, they have the same basic rights as everyone else.

This includes a right to:

- Dispose of property
- Make purchases
- Enter into contractual relationships
- Vote
- Marry and divorce
- Develop a discharge plan prior to being discharged
- Receive a copy of their treatment plan. Members are free to exercise these rights and exercising these rights shall not adversely affect the way the LME/MCO or providers treat the member.

Members are free to exercise these rights and the exercise of these rights shall not adversely affect the way the Trillium or its providers treat the member.

MEMBER RIGHTS AS A MINOR (UNDER THE AGE OF 18)

Minors have the right to:

- Proper adult supervision and guidance
- Age appropriate activities, special education and vocational training if needed
- Appropriate structure and treatment separate from adults.

Minors can also agree to some treatments without the consent of a parent or guardian.

These include:

- For treatment of sexually transmitted infection
- For pregnancy
- For abuse of controlled substances or alcohol

MEMBER RIGHTS IN A 24-HOUR FACILITY/ADULT CARE HOME

If members receive care in a 24-hour facility or adult care home, they have the rights listed above.

They also have the right to:

- Receive necessary medical care if they are sick. If their insurance does not cover the cost, then they will be responsible for payment.
- Receive a reasonable response to requests made to facility administrator or staff.
- Receive upon admission and during the stay a written statement of the services provided by the facility and the charges for these services.
- Be notified when the facility is issued a provisional (temporary) license or notice of revocation (reversal) of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. Their responsible family member or guardian shall also be notified.
- Send and receive unopened mail. Have access to writing material, postage, and staff assistance if requested.
- Contact and consult with a member advocate.
- Contact and see a lawyer, their own doctor, or other private professionals. This will be at their own expense, not at the expense of the facility.
- Contact and consult with their parent or legal guardian at any time, if they are under 18 years of age.
- Make and receive confidential telephone calls. All long distance calls will be at their expense, not at the expense of the facility.
- Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. Visiting hours must be available six hours each day. Two of those hours must be after 6 p.m. If they are under the age of 18, visitors cannot interfere with school or treatment.
- Communicate and meet with individuals that want to communicate and meet with them. This may be under supervision if their treatment team feels this is necessary.
- Make visits outside the facility, unless it has been included in your Person Centered Plan that this is not recommended.
- Be outside daily. Access to facilities and/or equipment for physical exercise several times per week.



- Have individual storage space for their private belongings that can be locked and only accessible by them, the administrator, or supervisor-in-charge.
- Keep personal possessions and clothing, except those items that are prohibited by law.
- Keep and spend a responsible sum of their own money; if the facility is holding money for them, they can examine the account at any time.
- Participate in religious worship if they choose.
- Retain a driver's license, unless they are not of age or have been prohibited to do so by a court of law.
- Not be transferred or discharged from a facility except for medical reasons, theirs or another's welfare, nonpayment, or if mandated by State or federal law. They must be given 30 days' of notice except in cases of safety to themselves or others. They can appeal a transfer or discharge (according to rules by the Medical Care Commission), and they can stay in the facility until resolution of the appeal.

MEMBER RIGHTS FOR RESIDENTIAL PROVIDERS ONLY

Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care.

Such rights shall include, but need not be limited to the:

- Opportunity for a shower or tub bath daily, or more often as needed;
- Opportunity to shave at least daily;
- Opportunity to obtain the services of a barber or a beautician; and
- Provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.
- Bathtubs or showers and toilets which ensure individual privacy shall be available.
- Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.

- An atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team.
- Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.

RIGHTS TO INFORMED CONSENT

Members have the right to be informed in advance of the potential risks and benefits of treatment options, including the right to refuse to take part in research studies.

Members have the right to consent to or refuse any treatment unless one of the following applies:

- It is an emergency situation
- They are not a voluntary patient
- Treatment is ordered by a court of law
- They are under 18 years of age, have not been emancipated and the guardian or conservator gives permission.

RIGHTS OF THOSE WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

If their primary disability is an intellectual/developmental disability, they have the right to continuity of care. If they are discharged from a residential facility and still need residential care, the provider MUST provide them with a 60-day written notice as written into law General Statute 122C-63, "Assurance for Continuity of Care." This gives them time to find a new residence. This right exists as long as they have not committed any illegal acts or are not a safety threat to others.

RESTRICTED RIGHTS

Member rights can only be restricted for reasons related to their care or treatment by their treatment team. They must be part of their treatment team and the decision making process. They have the right to have an advocate or someone they trust involved. A restriction of their rights must go through a Human Rights Committee for approval. Any restriction will be documented and kept in their medical record. Any implementation of restrictions requires a fading plan for the member to restore those rights.

VIOLATED RIGHTS

If member rights have been violated, contact the Behavioral Health Crisis Line or Member and Recipient Service Line at 1-877-685-2415. They can file a complaint or grievance in person or by phone. They do not have to give their name. If they feel their protected health information has been violated, they may file a complaint with Trillium by calling 1-877-685-2415. Trillium Health Resources complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Trillium Health Resources does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. [Trillium's non-discrimination rights can be found here.](#)

Members who feel that their rights have been violated may also contact:

**NC Medicaid Contact Center
1-888-245-0179**

Individuals living in Adult Care Homes have the right to report to the NC Division of Health Service Regulation (DHSR) any suspected violation of their member rights:

DHSR

**Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711**

By Phone

**Complaint Hotline: 1-800-624-3004
(within N.C.) or 919-855-4500
Complaint Hotline Hours:
8:30 a.m.–4:00 p.m. weekdays,
except holidays.**

By Fax

**Please fax your information to
919-715-7724**

Upon admission, Trillium notifies each member of the availability of the [Trillium Member & Family Handbook](#) containing information to help them access services for severe mental health, intellectual/developmental disabilities and substance use. Electronic copies of the handbook and other helpful documents are posted on our website.

The handbook includes information and instructions for members regarding:

- Where to call when they are in need of assistance
- A list of rights and responsibilities
- How to obtain services
- How to make a complaint or grievance
- Contact information for Trillium



EXECUTIVE MANAGEMENT TEAM

This Executive Management Team strives to maintain strong working relationships with local and state partners including local public agencies, provider agencies, public officials, elected officials, advocacy organizations as well as state and regional staff. Trillium's Executive Management includes management of operations, performance outcomes and achievement of goals, as well as direction of financial resources to achieve desired outcomes. The Executive Management Team directs and supports other Trillium management and staff in achieving agency goals and objectives.

ADVANCE DIRECTIVES

Members have the right to develop a plan for mental health treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. A plan may be referred to as an Advance Directive for Mental Health Treatment or a Psychiatric Advance Directive, which are interchangeable terms.

A statutory form for Advance Instruction for Mental Health Treatment is provided by N.C.G.S. §122C- 77 of the North Carolina General Statutes. The member must sign the form in the presence of two (2) qualified witnesses and be acknowledged before a notary public. The witnesses may not be the attending physician, the mental health treatment provider, an employee of the physician or mental health treatment provider, the owner or employee of a health care facility in which the member is a resident, or a person related to the member or the member's spouse. The document becomes effective upon its proper execution and remains valid unless revoked.

Upon being presented with an Advance Directive, the physician or other provider must make it a part of the person's medical record.

The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the Advance Directive when the person is deemed to be incapable, unless compliance is not consistent with N.C.G.S. §122C-74(g), i.e., generally accepted practice

standards of treatment to benefit the member, availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the member is involuntarily committed to a 24-hour facility and undergoing treatment as provided by law. If the doctor is unwilling to comply with part or all of the Advance Directive, he or she must notify the member and record the reason for noncompliance in the patient's medical record.

Under the Health Care Power of Attorney, a member may appoint a person as a health care agent to make treatment decisions on his/her behalf. The powers granted by this document are broad and sweeping and cannot be made by a doctor or a treatment provider under NC law.

Providers may decline to inform or counsel members of their right to develop an advance directive if the provider has a religious or moral objection to an item or service, such as an advance directive, that is furnished for the purpose of assisting in the causing of death. Providers may decline to apply or affect any requirement with respect to a portion of an advance directive that directs the purposeful killing, or the purposeful assisting in causing of, or the purposeful assisting in causing, the death of any individual if the provider has a religious or moral objection to applying or affecting such a requirement.



CONFIDENTIALITY

The network provider is required to ensure and maintain the confidentiality of all medical record information pertaining to all members served by them in the course of business. All confidential paper and medical record information must be safeguarded and secured according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all applicable federal and state confidentiality laws, rules, and regulations. This is to include 45 CFR Part 160 and 164-The Privacy Rule, and 42 CFR, Part 2-the confidentiality of substance abuse information in the medical record. Confidential information should not be discussed, transmitted or narrated in any form, except as authorized by the documented signature of a competent adult or and member's legally responsible person. Secondary records which contain information about a specific member or members that can be personally identified shall be protected with the same safeguards and security as the original service record. Providers shall be monitored and reviewed to ensure that they demonstrate thorough and specific evidence of their compliance with HIPAA and other federal and state confidentiality laws in regard to the security and safeguarding with policy and procedure in regard to member's Protected Health Information (PHI).

Information can be used without consent to help in treatment, for health care operations, for emergency care, and to law enforcement officers to comply with a court order or subpoena.

A disclosure to next of kin can be made when a member is admitted or discharged from a facility, but only if the person has not objected.

A minor may authorize consent for release of confidential information under specific circumstances as outlined in APM45-1, Confidentiality Rules for Mental Health, Developmental Disabilities, and Substance Abuse Services.

This includes the following:

- Treatment of sexually transmitted infection
- Pregnancy
- Use of controlled substances or alcohol
- Emotional disturbance

If the member disagrees with what a physician, treating provider, clinician, or case manager has written in their records, the member can write a statement from their point of view to go in the record, but the original notes will also stay in the record in accordance with state requirements.

LIMITED ENGLISH PROFICIENCY, LIMITED READING ABILITY, IMPAIRED VISION, AND HEALTH LITERACY

It is important for anyone seeking services from a Trillium network provider to have meaningful access to those services. Accessibility involves more than getting into a building. It means being able to communicate effectively with the service provider in a way each recipient can easily understand.

Members who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can have Limited English Proficiency (LEP). This includes people who are deaf, hard of hearing, as well as those who speak a language other than English.

These members may be entitled to language assistance with respect to a particular type of service, benefit, or encounter.

The General Conditions Contract stipulates that providers ensure compliance with all stated regulations, which includes Title VI of the Civil Rights Act of 1964. Compliance with Title VI involves the provision of linguistically and culturally appropriate services. Further, Title VI requires federally-funded practitioners to make services linguistically accessible by providing free language assistance through translated materials, interpreters or bilingual staff.

For LEP resources, see the [Resources and Web Links page](#) at the end of this Manual.

CULTURAL AND LINGUISTIC COMPETENCY

A primary focus of Trillium is to develop, implement and monitor processes that promote culturally competent and responsive care to members. Trillium recognizes the cultural diversities woven through the communities we serve and strives to contract with providers who recognize that efficacious services requires meeting the unique cultural needs of our communities and the individuals who reside within them.

The past two decades have seen unprecedented demographic shifts nationally and in North Carolina. Increased diversity, both cultural and linguistic, has produced significant challenges for health care delivery systems. It is our responsibility to plan for, implement and deliver services that are culturally competent, member- focused and person-centered to an increasingly diverse community.

The fundamental precepts of cultural competency include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of one's self and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse members and communities.

A culturally competent approach to services requires the system examine and potentially transform each component of service delivery.

Trillium is committed to the development, strengthening and sustaining of relationships. Trillium maintains a Cultural Competency Plan that includes objectives for serving a culturally and linguistically diverse membership as mechanisms for meeting the needs of those served. In addition to the plan, Trillium ensures its providers/practitioners and delegated vendors participate in trainings to increase understanding of the populations we support.



Trillium practitioners/providers have access to cultural competency and health literacy training via our on-line learning portal. The credentialing and re-credentialing application asks a practitioner/ provider to indicate if they have completed the available cultural competency training. Cultural Competency training is offered to network providers that includes cultural awareness when working with Native American Indian populations. The Cultural Competency training is available on Trillium's "My Learning Campus", as well as additional resources to help providers support the needs of diverse members. Annually, as a component of the Network Adequacy and Accessibility Analysis, Trillium evaluates the language needs of members in comparison to the network and makes adjustments to the network accordingly.

[Trillium's Cultural Competency Plan](#) was created in collaboration with the Provider Council. The plan can be found on the Trillium website under [Provider Documents & Forms](#).

As a provider, the ability to understand, appreciate and interact effectively with members has a profound impact on the effectiveness of the healthcare provided. Members must be able to communicate symptoms clearly and understand the recommended treatment.

Your responsibility as a Trillium Contracted Provider is to:

- Respect members' rights at all times
- Provide continual education to members regarding their rights, as well as support them in exercising their rights to the fullest extent
- Be knowledgeable of, and develop operational procedures to ensure compliance with, all outlined statutes and regulations regarding member rights and the use of restrictive interventions and protective devices
- Maintain an ongoing knowledge of changes to the statutes and regulations and immediately alter operations to meet changes
- Maintain a Client Rights Committee consistent with regulations outlined in North Carolina General Statute and Administrative Code
- Advocate for medical care or treatment options

- Provide information the member needs in order to decide among all relevant treatment options
- Provide information to the member about the risks, benefits, and consequences of treatment or non-treatment options
- Provide information to the member about his/her right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions
- Be aware that requesting a second opinion is a right of all Medicaid members and refer the member to contact the toll free Trillium Crisis Care & Service Enrollment if a second opinion is requested
- Discuss with members any specific requests they may have regarding their care
- Respect the wishes expressed in an Advance Instruction for Mental Health Treatment, or other legal advance directive and make it part of the person's medical record
- Maintain the confidentiality of all members and other information received in the course of providing services
- Avoid discussing, transmitting, or narrating any member information in any form—personal, medical or otherwise—unless authorized in writing by the member or his legally responsible person, or as otherwise permitted by federal and state confidentiality laws and regulations
- Comply with Title VI of the Civil Rights Act of 1964 by making services linguistically accessible by providing free language assistance through translated materials, interpreters or bilingual staff

Trillium will support providers by adhering to all confidentiality guidelines as stated in rule, regulation and law, and develop and disseminate educational material relative to accessing services; and member rights.

INFORMATION TECHNOLOGY

The Trillium information system must support both members and providers while ensuring confidentiality and privacy. We do this by maintaining a secure software system, email and website.

TRILLIUM WEBSITE

Our website is a source of information for available services, network providers, provider performance, LME/MCO events and operations, and links to other websites. The Trillium website is also an essential element in how Trillium and the provider network communicate and conduct business with each other.

PROVIDER DIRECT

Trillium operates a secure Web-based module called Provider Direct, which is the exclusive Web portal for contracted network providers to enroll new individuals, search for members, update member information, submit treatment authorization requests (TARs), view authorization letters, and submit claims for processing.

Providers must have a login and password to use Provider Direct. If your agency already has a System Administrator for Provider Direct, please contact that person to be assigned a login. If your agency is new to Trillium and doesn't have a System Administrator for Provider Direct, someone at your agency should be designated as the System Administrator for Provider Direct and follow the instructions for [Accessing Provider Direct for New Contractors](#).

Providers may elect to submit their claims using the HIPAA Standard Electronic Transaction Set, This can be accomplished in three ways:

1. Through the web portal in Provider Direct (PD),
2. via secure FTP, and
3. a provider can submit their claims through a clearinghouse.

If a provider elects to submit their claims through a clearinghouse, Trillium has an agreement to utilize Change Healthcare formerly known as EMDEON and The SSI Group. Any Trillium provider can enter into an

agreement with Change Healthcare formerly known as EMDEON or The SSI Group to submit their billing for them. Trillium will respond electronically to all HIPAA EDI transactions.

Please refer to the Network Communication Bulletins and Urgent Notifications to providers for up-to-date information on system enhancements to Provider Direct. If you have any questions regarding Provider Direct, please email IT.Support@TrilliumNC.org.

EMAIL COMMUNICATIONS

E-mail has become the standard method of communication between Trillium and network providers. To make that communication most effective, Trillium uses Constant Contact, a web-based system for maintaining large listserves for information, education and marketing. If you have not received these communications, please [subscribe using this form](#). Visit our [Provider Communications page](#) to review the archives of Clinical, Network, and Urgent Notifications.

We ask our providers to send an email to the help desk at NetworkServicesSupport@TrilliumNC.org for any questions regarding paperwork, processes, and other information. The email will be assigned to an agent who will respond in the order your correspondence was received. If you have a question about claims, go to the [Provider Documents section of our webpage](#) to identify your claims representative through the [Provider Claims Split document](#).

Your responsibility as a Trillium Contracted Provider is to:

- Have and maintain high speed Internet connectivity
- Provide complete and accurate data in all submissions to Trillium
- Comply with HIPAA Security Regulations
- Subscribe yourself and as many staff from across your company as needed for effective communication (subscribe to Constant Contact)
- Avoid blocking Trillium domain emails
- Manage your email inbox to avoid "bounce back" or undeliverable messages

CONTRACTS

The Contracts Unit manages all contracts and procurement activities for Trillium.

PROCUREMENT CONTRACTS & GENERAL CONDITIONS

Providers must enter into a Procurement Contract with Trillium before any services can be authorized, provided, and billed. The Trillium Combined Contract template is divided into two sections: a Procurement Contract and a set of General Terms and Conditions. This multi-year agreement outlines the requirements needed to remain in compliance according to federal and state regulations and Trillium's waiver participation. Providers that contract with Trillium must adhere to each section of the contract and appendices if they wish to remain a contracted provider in the Trillium Network.

The Trillium Provider Manual and the Trillium N.C. Home and Community Based Services Innovations Waiver manual are incorporated into the contract by reference.

Unsure about what sites and services are approved by your contract? Log into your Provider Direct (PD):

Need to view your sites?

- Log into [PD](#)
- Select "Admin"
- Select "Provider Management"
- This screen will display the Master Site at the top of the list, followed by each sub-site approved by the contract.

Need to view your services?

- Log into [PD](#)
- Select "Admin"
- Select "Provider Management"
- All services: Select the Master Site from the top of the list
- Only services at a sub-site:
Select the desired sub-site

For contract questions and concerns, please contact Network Services Support at NetworkServicesSupport@TrilliumNC.org or call Trillium's Provider Support Service Line at 1-855-250-1539.

TRAINING

PROVIDER TRAINING

The Training Department identifies training needs and coordinates all training for the provider network. The team collaborates with various groups for input and feedback, including Trillium staff, Provider Network, Consumer & Family Advisory Committee (CFAC), Provider Council (PC) and Clinical Advisory Committee (CAC.) The Provider Training Department also partners with staff, providers, stakeholders and community partners to develop training around special Trillium initiatives or categories of topics.

Trillium is committed to offering ongoing training opportunities to network providers as a mechanism to maintain professional competence and remain up-to-date with changes that occur in the behavioral health-care industry. The Trillium Training Department implements a training plan that is reviewed and updated annually.

Providers are required to participate in and assist with all surveys conducted by DHHS and Trillium in accordance with DDHS guidelines, upon receiving notification from Trillium.

Trillium's Training Unit manages an online learning platform, where multiple trainings are available on demand. Any active provider in our network is eligible to sign up for our online learning platform. Vital trainings such as our New Trillium Provider Orientation and all of our Provider Direct trainings can be found there and accessed 24 hours a day, 7 days a week, 365 days a year. We regularly update and add to the list of trainings available on the online learning platform. To sign up for our online learning platform, please complete the [Trillium Learning Campus Agreement form](#).

Your responsibility as a Trillium Contracted Provider is to:

CONTRACTS

- Review your contract for accuracy and fully execute the contract and return to Trillium within ten business days of receipt to assure continued payment for services
- Sign and have a fully executed Trillium Contract Amendment for any material change to the original contract
- Have a current Disaster Plan, including evacuation and fire plan, if providing services in a facility provide services only at qualified service sites as are approved in Provider Direct
- Adhere to all performance guidelines in your contract and work to deliver best practices
- Comply with the policies and procedures outlined in this manual; any applicable supplements; your Provider Contract; the General Conditions of the Procurement Contract; and applicable state and federal laws and regulations
- Understand the obligations and comply with all terms of the contract
- Notify Trillium of any prospective changes in site(s) and assure all Trillium qualification requirements are met and any contract amendments are in place prior to delivery of contracted services
- Periodically review your contracted site information in Provider Direct and make sure that all NPI numbers, address information and Taxonomies are current and have correct linkage at NCTracks
- Monitor your health plan enrollment in NCTracks to ensure it remains active
- The New Provider Orientation training must be completed prior to rates getting initialized in the contract.

TRAINING

- Participate in ongoing training opportunities as applicable
- Review the Trillium website for updates on a regular basis
- review the State websites for most up-to-date information on a regular basis (see [Resources & Web Links section](#) of this Manual)
- offer provider training on empowering people served to be prepared for disaster and crisis

Trillium's responsibility to Providers is to:

CONTRACTS

- Send written correspondence via USPS mail or email as needed
- Provide technical assistance as needed related to Trillium's contract requirements and Provider Manual requirements
- Respond to provider inquiries and provide feedback in a timely manner

TRAINING

- Identify training needs and provide training and technical assistance to the provider/practitioner network
- Keep network providers informed through provider meetings, electronic updates, notifications and the trillium website



PROVIDER NETWORK

NETWORK MANAGEMENT DEPARTMENT

The Network Management Department is responsible for the development and maintenance of the provider network to meet the needs of members and recipients while ensuring choice and best practices in services. The Department includes: Provider Service Support, Network Accountability (Network Auditing/ Contracts Monitoring, Practice Management, Development, Credentialing and Contracts

Network Accountability

The Network Accountability Team is comprised of 2 separate units: Network Auditing and Program Integrity.

Network Auditing

The Network Auditing Team handles provider monitoring and auditing activities. Common review activities include but are not limited to provider monitoring reviews, post payment reviews, and initial/ annual site visits.

QUALITY MONITORING

Our responsibility is to assure the quality of services provided by the Trillium provider network. Trillium is accountable to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Health Benefits (DHB) in the management of both state and Medicaid services.

In addition to state requirements, Medicaid Waiver quality requirements are extensive and include:

- Health and safety of members
- Rights protection
- Provider qualifications
- Member satisfaction
- Assessment of outcomes to determine efficacy of care management of care for Special Needs Populations
- Preventive health initiatives
- Clinical best practice

NC DHHS Provider Monitoring

Trillium utilizes a standard NC DHHS Provider Monitoring Process to ensure high quality services for individuals.

It is the vehicle used for entry into the provider network and the evaluation of service providers against quantitative and qualitative measures using monitoring tools developed by NC DHHS. The standard Provider Monitoring process is used to monitor both Medicaid and State-funded behavioral health services.

Standard Provider Monitoring consists of a regularly scheduled provider monitoring review and/or a post-payment review.

This section does not discuss other types of audits and investigations Trillium may conduct, such as Program Integrity investigations, complaint and grievance investigations and post-payment clinical reviews.

All provider agencies will participate in Standard Provider Monitoring a minimum of every two (2) years. All Licensed Independent Practitioners and Group Practices will participate in Provider Monitoring as needed.

All Standard Provider Monitoring will be conducted using tools based on those developed by NC DHHS, which are made available to providers and practitioners on the NC DHHS website. (See the [Resources & Web Links section](#) at the end of this manual for the link.)

The selection of tools is determined by both the type of provider and the array of services they render to Trillium members.

For LIPs, Provider Monitoring includes the DHHS Review Tool for LIPs and the LIP Post-Payment Review Tool.

For provider agencies, the selection of tools is determined by the type of services provided:

- The DHHS Monitoring Tool for Providers is used except when the agency provides Unlicensed AFL services, in which case only the DHHS Unlicensed AFL Review Tool for Providers is used.
- The specific post-payment review tool(s) to be used is based on services identified for
- Provider Monitoring.
- For those services that DHSR-MHL surveys on an annual basis (i.e., residential services and opioid treatment services), only a post-payment review is done.
- General impressions on preparedness
- Verification of contact(s) for receipt of report: Name, Mailing Address, and Email Address.

Trillium will share comprehensive findings with the provider within 15 calendar days after completion of the review. Documentation will outline areas reviewed, scores achieved, and required follow up. Any monitoring or post-payment tools can be used at any time for targeted monitoring or investigations.

Home and Community Based Services (HCBS)

Home and Community Based Service Assessments must be submitted when requesting the following services: Supported Employment Services (H2025), Initial Supported Employment (H2023), Residential Supports (H2016), Residential Supports (T2016), Day Supports (T2021), and Day Supports Developmental Day (T2027).

The [HCBS Provider Self-Assessment](#) can provide additional guidance to all Home and Community Based Services final rules.

For questions concerning Home and Community Based Services assessments email HCBSTransplan@dhhs.nc.gov or HCBS@TrilliumNC.org.



PROGRAM INTEGRITY

Trillium Health Resources operates a Special Investigations Unit (SIU) within Program Integrity with dedicated staff residing in North Carolina. This unit routinely inspects claims submitted to assure Trillium is paying appropriately for covered services. The Program Integrity department is charged with preventing, detecting and correcting fraud and abuse to ensure the financial and clinical integrity of Trillium's contracted providers are maintained. The team conducts post-payment audits, monitoring and investigations to assure that payments made to providers for services are rendered in accordance with rules, regulations, policies, and the terms of the provider contract. The team receives allegations of fraud and abuse from various sources to include: a tip-line, complaints, incident reports, issues identified by staff, data mining, detection tools, and statistical sampling. The team conducts reviews of all allegations and if warranted conducts an investigation.

The team makes referrals of suspected fraud to Division of Health Benefits (DHB)-Program Integrity and other appropriate regulatory bodies.

Trillium Health Resources instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Per contractual requirements, contracted Providers of Trillium are required to cooperate fully with all investigative requests, including but not limited to immediate access to any of the contractual locations/sites, where services are provided to members, in addition to any site where financial or clinical records are maintained. Providers are required to

cooperate with request to view or submit member medical records for review. Medical records should be maintained in compliance with all state and federal laws related to record retention, more information on this can be found in Compliance section related to Member Records Requirements. Failure to do so may be grounds for contract termination.

FRAUD AND ABUSE INVESTIGATION

Any credible allegation of potential fraud and abuse involving Trillium providers will be referred to Trillium's Program Integrity Department for investigation and action. Investigations may be conducted on-site or by desk review. Findings will be reported to DHB-Program Integrity, NC Medicaid Investigation Division, appropriate regulatory bodies, and/or law enforcement agencies depending on the nature of the allegation. Any allegations of provider fraud that are accepted by DHB Program Integrity may result in immediate suspension of referral, authorizations and payments pending an investigation by DHB or the Medicaid Investigation Division.

FRAUD AND ABUSE MONITORING AND AUDITING

Trillium has adopted a fully operational set of processes that proactively protects the agency and detects fraud and abuse, which contains both internal and external components. Trillium has taken reasonable steps to monitor, audit, and document questionable business practices, also known as fraud and abuse.

- **Abuse** is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.
- **Fraud** is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person.

Examples of Medicaid fraud and abuse include, but are not limited to:

- A member does not report all income when applying for Medicaid.
- A member does not report other insurance when applying for Medicaid.
- A non-member uses a member's card with or without the recipient's knowledge.
- A provider's credentials are not accurate.
- A provider bills for services which were not rendered.
- A provider performs and bills for services not medically necessary

Fraud and Abuse Reporting

All providers must monitor for possible fraud and abuse and take immediate action to address reports or suspicion. Trillium has initiated [EthicsPoint](#), a secure and confidential tool to report suspected violations of fraud, abuse, ethics and compliance issues. [Reports can be made online](#) or by calling the toll free telephone tip line (1-855-659-7660). EthicsPoint is available 24 hours a day, 7 days a week and 365 days a year. The hotline is confidential and Trillium will honor this anonymity in full compliance with the standards.

Providers may report fraud and abuse concerns by utilizing one of the following mechanisms:

- Trillium toll-free, anonymous, EthicsPoint Hotline
- Anonymous online submission through the EthicsPoint web address listed above
- NC DHB Fraud and Abuse Report line at 1-877-362-8471
- NC DHB Online Confidential Complaint Form on the DHB website (For a link to this form and additional information of Medicaid Fraud and Abuse, please see [Resources & Web Links section](#) at the end of the Manual)

To make a report:

- From any computer: [EthicsPoint](#)
- Call toll free: 1-855-659-7660

FALSE CLAIMS ACT

The False Claims Act was a law that was established to punish persons or entities that file false or fraudulent claims for payments by government agencies.

The False Claims Act makes it unlawful for any Medicaid provider to knowingly make or cause to be made, a false claim for payment, "Knowingly" is defined as:

- Has actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsifies the information.

The penalty can range from \$11,000–\$22,000 for each false claim submitted. The provider may be required to pay back up to three times the amount of damages sustained by the government.

If convicted, the provider may be excluded from participation in federal health care programs. In addition, most private insurance programs will also exclude the provider from participation as well.

Practice Management

The Practice Management team is responsible for leading Trillium's development of performance and value based payment strategies. Our Practice Management team develops and leads innovative strategies to increase the use of value based purchasing arrangements that will assist the organization in providing quality, effective, personalized, whole-person care to the members we serve. Our Practice Management Consultants work directly with our network of providers to lead performance improvement projects, identify performance measures, track member outcomes and enhance service delivery. The Practice Management team assists in the development and growth of our provider network, recruitment and retention of high-performing providers, training, and education. We work with providers to identify priority areas and domains needed by providers to participate in alternative payment arrangements in the delivery of care, across all populations that Trillium serves.

[Clinical Practice Guidelines](#) can be found on our website.

Provider Service Support

The Provider Support Service Line (PSSL) is a direct phone line specifically available for provider agencies, hospitals and Licensed Independent Practitioners (LIP) to call Trillium with questions, inquiries and issues and receive a “one touch” resolution. The PSSL team, comprised of knowledgeable customer service professionals, is prepared to interact with providers directly to assist with their needs or initiate a warm transfer to the staff member identified in the appropriate department to assist with answering provider question(s). The PSSL’s hours of operation is Monday through Friday (8:30AM to 5:00PM) and will follow Trillium’s Holiday schedule. The PSSL will be fully operational and in compliance with BH I/DD Tailored Plan requirements and metrics by July 2022.

If preferred, providers can continue to utilize the web-based self-service help desk to submit their concerns and questions into our Network Service Ticket System NetworkServicesSupport@TrilliumNC.org.

TYPES OF PROVIDERS

Agency-Based Providers

An agency-based provider is an entity organized as a corporation, limited liability company, or other designation overseen by the NC Secretary of State, either for-profit or not-for-profit, engaged in the provision of services covered by Trillium. Employees of the agency provide the services to the member, and agency management assures that the employees meet the qualifications to provide services and that all other requirements of the contract between PIHP and the agency-based provider are met.

State-Operated Health Care Facilities

The state of North Carolina oversees and manages 14 state-operated healthcare facilities that treat adults and children with mental illness, IDD, substance use disorders and neuro-medical needs.

Licensed Independent Practitioners and Professional Practice Groups

Licensed Practitioners in the areas of Psychiatry, Psychology, and Social Work are enrolled in Trillium’s provider Network. Licensed Practitioners provide Outpatient services such as psychiatric care, assessment and outpatient therapy.

Practitioners may work for an Agency-based Provider (LP) or may directly contract with Trillium (LIP). Members are offered a choice of LIPs or agency-based providers when calling the 24-Hour Behavioral Health Crisis line and requesting evaluation or outpatient treatment services.

Hospital Facilities

Hospitals with inpatient psychiatric facilities and/or outpatient psychiatric programs are also enrolled in the network.

Hospitals that provide Emergency Services to members with a behavioral health discharge diagnosis are paid for these services under an out of network agreement.

PROVIDER LOCATIONS

Most services are available within 30 miles distance or 30-minute drive time in the most densely populated urban areas, and 45 miles or 45 minutes in rural areas. Longer distances as approved by DHB are allowed for facility-based or Specialty Providers.

There may be only one provider of facility-based services, such as Psychosocial Rehabilitation, in a 30-45 mile region due to insufficient demand to support two providers and economy of scale factors. Trillium will annually evaluate the location of providers and types of services in its Network Adequacy and Accessibility Report to determine the need for additional providers. Trillium also maintains mapping software which allows us to associate location of providers relative to where members live within the catchment area.

PROVIDER COMMUNICATION

Trillium is committed to keeping network providers well-informed of state or federal changes, new information, trainings, requests for proposals, and opportunities for collaboration. Trillium's website offers links to a variety of web-based resources. Trillium disseminates critical and/or time-sensitive information through [The Network Communication Bulletins](#) and/or [Clinical Communication Bulletins](#). If you do not currently receive these email notifications, please sign up by choosing the [Network Provider List](#).

Provider Representation

Trillium has also incorporated provider representation into numerous aspects of our operations to offer the opportunity for input and feedback regarding things that affect network providers, including:

- Provider Council (see more information below)
- Credentialing Committee
- Clinical Advisory Committee
- Global Quality Improvement Committee
- Ad hoc work group (i.e., groups that are designated for a specific assignment)

SURVEYS

Trillium encourages providers to participate in any and all voluntary surveys, as this is one of the provider's opportunities to give input and participate in quality improvement activities within the MCO. There are a number of voluntary surveys administered throughout the year. For additional details, a description of each is included in the Quality Management Section of this manual. Trillium requests that all providers designate one main contact in your company that would be the contact person for all surveys.

PROVIDER COUNCIL

The mission of Trillium Provider Council is to serve as a fair and impartial representative of all service providers within the Network. The Provider Council facilitates an open exchange of ideas; shares vision, values and goals; and promotes collaboration and mutual accountability among providers. The Provider Council strives to achieve best practices to empower members within our community to achieve their personal goals.



The Provider Council's objectives are to:

- Review and advise Trillium regarding the Local Business Plan, goals, and objectives of the Network
- Review network performance against stated goals
- Review and make recommendations to Trillium regarding performance indicator selection and performance issues, including outliers
- Review quarterly reports on referrals made/referrals accepted per service per provider; members receiving services per provider; discharges from providers and reasons; and annual review of trend analysis
- Recommend new service initiatives to address service gaps
- Assess and provide for staff education and training needs assess community and prevention needs
- Develop strategies to address funding and financial issues
- Approve the provider satisfaction survey and review results with recommendations
- Review and provide input to the Trillium Cultural Competency Action Plan
- Advise the Chief Executive Officer regarding provider contract reconsiderations, upon Chief Executive Officer's request

The [Provider Council](#) is a key Trillium committee. The Provider Council membership is designed to reflect the diversity of the network. The Council represents the interests and challenges of the network providers. This committee also reviews and makes recommendations regarding network management policies, accreditation standards, key performance indicators, service initiatives and requirements. Minutes from Provider Council meetings are posted on the Trillium website.

PROVIDER CREDENTIALING

The credentialing process at Trillium is based on the accrediting bodies' credentialing standards and incorporates contractual and policy requirements set forth by the N.C. Department of Health and Human Services (DHHS).

The credentialing process begins when a prospective provider or independent practitioner has been approved by the Network Development Department to be credentialed and/or contracted. All applications should be submitted via email to Credentialing@TrilliumNC.org. The omission of any required application information will deem the application to be incomplete and it will be returned. Trillium can only process and approve COMPLETE applications.

Trillium credentials all licensed independent practitioners that provide services pursuant to a contract between Trillium and an individual or group practice. Trillium also credentials licensed practitioners who are employed by a provider contracted in the Trillium Network.

The following are common examples of providers and licensed practitioners who must go through Trillium's credentialing process:

- Medical Doctors (MD)
- Licensed Marriage and Family Therapists (LMFT) and Associates
- Licensed Addiction Specialists (LCAS) and Associates
- Advanced Practice Psychiatric Clinical Nurse Specialists
- Licensed Physician Assistants
- Behavioral health group practices and agencies that employ individuals with various degree types and other credentials to deliver MH/SU/IDD services to members
- Psychologist Associates (Master's Level Psychologist [LPA] and Associates)
- Practicing Psychologists (PhD and PsyD)
- Licensed Clinical Social Workers (LCSW) and Associates
- Licensed Clinical Mental Health Counselor (LCMHC) and Associates
- Certified Clinical Supervisor (CCS)
- Psychiatric Nurse Practitioners
- Family Nurse Practitioners

- Facilities, such as residential treatment facilities

[Credentialing applications](#) can be found on our website.

Prior to submitting a Credentialing Application to Trillium Health Resources, all providers need to enroll in NCTRAKS and must be active in the Medicaid Health Plan. If a provider is not enrolled and active in the NC Medicaid Health Plan, a credentialing application will not be accepted.

Practitioners who provide care exclusively within inpatient settings and hospitals do not need to be credentialed.

Credentialing documents and credentialing questions or status updates should be sent to Credentialing@TrilliumNC.org

Credentialing Objectives

The Trillium Credentialing Program's overall goal is to verify the professional qualifications of participating providers.

To that end, Trillium has established the following objectives for their credentialing program:

- Compliance with accreditation standards for credentialing providers
- Assurance that the criteria for network participation is applied uniformly
- Documentation of all credentialing activity
- Determination of how credentialing files are stored and maintained
- Maintenance of the Credentialing Committee
- Establishment of criteria for provider network participation

Assurance of confidentiality of all credentialing information

- Assurance that Trillium does not discriminate against any provider seeking network participation
- Assurance that Trillium does not place economic factors above quality of care factors when considering the participating provider's performance

Re-Credentialing

All providers and Licensed Clinicians/Behavioral Healthcare Professionals credentialed with Trillium are required to have their credentials reviewed and verified within three years of the date of the last credentialing review. Network providers who do not return the completed Re-Credentialing Packet prior to their expired date **MUST** cease billing upon credentialing expiration. In order to participate in Trillium's provider network, providers and practitioners are required to maintain their credentials for their organization and/or staff. Failure to comply with this contractual requirement can result in loss of revenue, recoupment, contract termination, as well as disruption in services for our members. Network providers should utilize an internal auditing process that tracks all of its applicable credentialing such as credentialing expiration dates.

Trillium re-verifies, through primary and/or secondary source verification, information that is subject to change, such as conduct checks. Trillium does not re-verify credentials that do not expire or change over time, such as education. In addition, Trillium considers any collected information regarding the participating provider's performance, including any information collected through provider monitoring.

As with the initial credentialing process, Trillium works with providers to obtain the complete re-credentialing application and supporting documentation. Once the application has been reviewed, final approval is made for providers/practitioners by either the Chief Medical Officer or Credentialing Committee. Chief Medical Officer has delegated authority to approve "clean" applications. All "red flagged" applications must be reviewed by the Credentialing Committee.

As part of the Re-credentialing process, each credentialed practitioner or provider has the right to:

- Review information collected during the re-credentialing process except references
- Be informed of the status of their re-credentialing application.

- Be notified of information significantly different than reported by the applicant and have the opportunity to correct erroneous information in writing.; Correction of the erroneous information should be provided by the practitioner/entity within 10 business days of notification on any discrepancies in the application
- Be notified about the credentialing decision within 10 business days.

Alteration of Credentialed Status

Trillium maintains standards for all participating providers to ensure competent, effective, and quality care. Trillium retains the right to suspend or terminate a network provider's credentials and enrollment in the Trillium Network for actions and/or omissions which are contrary to Trillium standards of practice, contractual agreements, or regulatory requirements.

The following conditions can affect a network provider's or licensed practitioner's credentialing and network contract status:

- Failure to maintain compliance with the credentialing and re-credentialing criteria;
- Election to terminate, or failure to execute, a Trillium contract;
- The chosen area of practice, in the opinion of the Credentialing Committee, involves experimental or unproven modalities of treatment, or therapy not widely accepted in the local behavioral health community;
- Breach of any material term of the Trillium contract, including failure to comply with Medical Management or Quality Improvement requirements;
- Failure to adhere to the controlling authority identified in the Trillium Contract or this Provider Manual;
- Substantiated contact with a member of a sexual or amorous nature, or violation of other practitioner/member boundaries.

The Credentialing Committee may, after review of information, terminate or suspend a provider's or licensed practitioner's credentials for, among other things:

- Any of the reasons set forth above
- Termination of the provider contract
- Failure to attain re-credentialing
- Failure to maintain licensure

Furthermore, termination or suspension of credentialing may result in sanctions against a network provider, up to and including termination of its contract to participate in the Trillium Network.

PROVIDER VIOLATIONS AND SANCTIONS

Violations

Violations are categorized broadly as those pertaining to issues of professional competence or conduct and those pertaining to administrative matters.

Violations include, but are not limited to:

- Poor quality of care;
- Inappropriate use of clinical interventions;
- Inappropriate or incomplete adherence to a service definition or best practice;
- Inappropriate relationships/professional boundaries;
- Failure to comply with standards of practice;
- Actions jeopardizing professional ethics;
- Lack of verification of experience as required;
- Failure to deliver/document the service as required by the service definition;
- Failure to submit, revise, or implement a plan of correction within the specified timeframes;
- Failure to comply with the explicit requirements of the contract and the controlling authority identified in the contract;
- Failure to maintain required license(s), accreditation or credentialing;
- Failure to maintain, make available or securely retain service records in accordance with federal or state law and NC DHHS policy;

- Suspension by any applicable government authority;
- Failure to maintain the required minimum liability insurance coverage;
- Failure to comply with the Health Insurance Portability and Accountability Act (HIPAA);
- Any instance of fraud, waste or abuse, including altering documents, falsifying records, submitting false claims;
- Evidence of substantial failure to comply with regulatory standards as defined by North Carolina Statutes and Rules for Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/IDD/SAS).

Trillium may impose sanctions on a network provider for a variety of reasons, including but not limited to violations related to contractual obligations, state and federal laws, rules, regulations and policies set to protect the health and safety of members. Sanctions imposed by Trillium may be progressive or cumulative in order to address the specific area(s) of violation and/or Contract that are not being fulfilled by the network provider.

Trillium makes every effort to expedite the investigation of these cases, especially if the provider has been suspended. However, Trillium does not compromise the outcomes to complete the case quickly; therefore, Trillium follows the same deadlines in all cases. A suspended network provider may not receive authorizations or receive new referrals from Trillium for up to 15 business days pending review and/or investigation.

In addition, Trillium may provide written notification, as appropriate, to the following external authorities:

- Division of Health Service Regulation (DHSR);
- Department of Social Services (DSS);
- Division of Mental Health, Developmental Disabilities, Substance Abuse Services (DMH/DD/SAS) – Program Accountability Unit
- Division of Health Benefits (DHB) – Program Integrity Unit

Technical Guidance, Disciplinary Actions and Sanctions

Technical Guidance, disciplinary actions or sanctions that can be taken against a network provider include, but are not limited to, any one or a combination of the following:

- Education and/or technical assistance given to the provider
- Referral Freeze
- Recoupment
- Plan of Correction (POC)
- Additional monitoring
- Self-audit review of documentation and/or paid claims
- Monetary Penalty
- Transfer - Offer provider choice and transition of LME/MCO funded members to another provider
- Additional audits, including prepayment claims review
- De-credentialing of individual practitioners within the agency/provider
- Suspension of referrals
- Termination of credentials
- Termination of contract(s)
- Referral to another regulatory body

If the Chief Medical Officer or Clinical Director is of the opinion that the provider in question poses a significant risk to the health, welfare, or safety of members, the provider may be immediately suspended pending the results of the investigation.

Sanctions imposed by Trillium may be progressive or cumulative in order to address the specific area(s) of the contract that are not being fulfilled by the network provider.

Determination and Notification of Actions Taken Against Network Providers

Generally, sanction recommendations are reviewed by the Trillium Sanctions Committee. The Committee may determine to impose a sanction or to use a corrective action based on the evidence, and/or significance and nature of the violation.

The network provider will be notified by "Certified-Return Receipt Requested" letter within thirty (30) calendar days of invocation of the disciplinary action and the due process afforded for requesting reconsideration of the action.

Written communication will include, as applicable:

- The right to submit additional information; and,
- The right to request a reconsideration of the decision within established timeframes.

Reconsideration of Actions Against Providers

In order to respect providers, protect members, and satisfy our contractual obligations, Trillium maintains a formal mechanism for the resolution of participating provider (network provider) disputes. This Reconsideration Process is available to any participating provider (network provider) who wishes to initiate it when Trillium takes an adverse action against them and/or suspends their participation in the provider network.

If Trillium takes an action against a network provider that does not affect the provider's network status or does not relate to the provider professional competency or conduct, the formal Reconsideration Process is not available.

Nor is the Reconsideration Process available when the action taken by Trillium is mandated by state or federal authority or if the contract is terminated without cause.

Providers must submit a formal written request via certified mail within 30 days from date of the letter informing them of the action.

Unless otherwise indicated by Trillium, formal written requests must be sent to:

**Trillium Health Resources
Attn: Appeals Department
201 West First Street
Greenville, NC 27858**

The request should include the date and a detailed description of the disputed action, a request for reconsideration, and supporting documentation for the request for reconsideration.

Trillium's decision shall be considered final if a provider's reconsideration request is not received within 30 calendar days of the date of the letter informing the provider of the action.

The provider must provide any additional information at the time the Request for Reconsideration is filed on a flash drive in a PDF format via USPS certified mail. The flash drive must be in compliance with HIPAA requirements.

The provider is given the option to submit paper copies if the submission in an electronic format on a flash drive is not an option for the provider. The reconsideration process is designed to be informal and offer an opportunity for the provider agency to share information they feel is pertinent to the reconsideration request. In an effort to keep the process informal, attorneys and legal representation are not permitted.

The network provider who requests reconsideration has the burden of proof to establish that the adverse action should be reversed or modified.

Upon receipt of a properly submitted request for reconsideration, Trillium will determine if the dispute concerns an administrative matter (non-clinical) or a matter of professional competence or conduct.

An administrative matter concerns a provider's reconsideration of the denial, in whole or in part, of payment for service. Reconsiderations of administrative matters are decided by the Appeals Coordinator, or designee.

Reconsiderations of professional competence or conduct matters are determined by an ad hoc committee convened by the Appeals Coordinator. The ad hoc committee is referred to as the first/second-level panel.

Upon receipt of a reconsideration request related to professional competence or conduct matters, Trillium will designate a representative to compile all available information, including any summaries of his/her own research, if applicable. The designated representative shall be expected to represent Trillium's position throughout the reconsideration process.

During the reconsideration process, the network provider and Trillium department representative will have an allotted timeframe to present their evidence and they will not address each other during this review.

Except as otherwise approved by the Appeals Coordinator, the network provider shall have up to one hour to make its presentation, and the presentation of information will proceed as follows:

1. Trillium's department representative presentation,
2. Network provider presentation
3. Rebuttal of network provider's presentation,
4. Surrebuttal of Trillium's rebuttal.

The network provider may submit additional information that it deems relevant to the reconsideration request no less than five (5) business days prior to the first-level panel meeting. The Appeals Coordinator will submit any information used by the department representative to the network provider, upon request. The network provider is not permitted to submit additional information after the meeting has occurred.

In all cases, minutes of the proceedings are kept and are made available to the network provider upon written request.

The panel shall carefully review the information submitted for the reconsideration, with particular attention given to the information submitted by the network provider and then, by majority vote, make a decision to uphold, overturn, or modify the adverse action.

The first-level panel will include three qualified individuals not involved at any level, with one being a clinical peer of the provider being reviewed. The first-level panel conducts a face-to-face meeting with the provider.

A second-level is requested and formed when a provider is not satisfied with the outcome of the first-level panel. The same panel criterion applies as with the first level panel, except the provider peer must be different from the first-level. The second-level panel conducts a desk review.

All requests for first and/or second-level panels must be received within 30 calendar days from the communication from Trillium informing providers of their rights to request a first or second-level appeal.

The Appeals Coordinator will draft the written notification of the panel's decision and send it to the network provider via certified mail, return receipt requested within 60 calendar days from receipt of the request for reconsideration. The notification will include information about the network provider's right to further appeal (as appropriate) and the mechanism to request such reconsiderations.

REPORTING OF DISCIPLINARY ACTIONS

All Disciplinary Actions based on professional competency or conduct which would adversely affect clinical privileges for a period longer than 30 calendar days or would require voluntary surrender or restriction of clinical privileges, while under, or to avoid, investigation is required to be reported to the appropriate entity (i.e., State Medical Board, National Practitioner Data Bank, Federation of State Medical Boards, etc.)

Upon the direction of the Trillium Medical Officer, the Network Department will be responsible for notifying all appropriate entities including State Medical Board, National Practitioner Data Bank, Federation of State Medical Boards, and the appropriate licensing bodies within 15 business days of the final determination.

CHANGES IN CURRENT PRACTICE INFORMATION

Trillium strives to maintain an up-to-date provider database with the current practice information submitted by our agencies and practitioners. We also utilize this information to populate the provider directory that is available to all members on the Trillium website.

When reporting all changes to the Network Department, providers should use the Trillium Provider Change Form found on the Trillium website under Provider Documents. It is important for providers to regularly verify their information that populates in the Trillium Provider Directory on the website to ensure the information remains accurate and as current as possible. Any changes/updates to information that is received by a provider will populate in the Trillium Provider Directory within 30 calendar days of Trillium receiving the information.

Providers must maintain all licenses, certifications, accreditations, credentialing and registrations required for its facilities and staff providing services to Trillium members. Providers are to notify Trillium in writing within five (5) business days of notification of exclusion by the U.S. Office of Inspector General, CMS or any other State Medicaid program and the plan for compliance.

Providers may not bill Trillium for any services provided during any period of revocation or suspension of required licensure or accreditation of the Provider's facility, or for any services provided by a staff member of the Provider during any period of revocation or suspension of the staff member's required certification, licensure, or credentialing.

Providers must notify Trillium within the following timeframes:

- Forty-eight (48) hours of knowledge or notice of claim, suit, criminal or administrative proceeding against Provider or staff regarding the quality of service delivery.
- Forty-eight (48) hours of any cancellation, material change, or carrier change of insurance coverage, provide evidence of continual coverage.

- Three (3) business days of changes in ownership/management.
- Ten (10) days of receiving notice of sanction by any applicable licensing board, certification or registration agency, or accrediting body or other authority which affect the Provider or staff's ability to bill for services.
- Five (5) business days of all other changes including, but not limited to, the following:
 - Changes in contact information
 - Proposed changes in facility location
 - Changes in capacity
 - Inability to accept new referrals
 - Any proposed acquisitions
 - Any proposed mergers
 - Any pending investigations for Medicaid fraud

For contact information and where to submit documents, please see the Correspondence Timeline & Addresses Reference page at the end of this manual.

APPLYING FOR ADDITIONAL SERVICES

Consideration Criteria

There are three main criteria that need to be met before a provider is eligible to add additional services:

1. Provider must be in compliance with applicable licensing boards, accrediting bodies, regulatory authorities, etc.; and
2. Trillium has established there is sufficient need for the service(s); and
3. Any sanctions and/or the submission of a Plan of Correction (POC), follow-up review and/or established wait period following satisfactory implementation of a Plan of Correction--must be completed and verified by Trillium.

Please see RFPs/RFAs posted on our website for needs/gaps in our network. To make contract requests outside of the RFPs/RFAs, please email NetworkServicesSupport@TrilliumNC.org for further consideration.

PLAN OF CORRECTION PROCESS

A Plan of Correction (POC) is a tool used to describe a plan of how issues that have been found to be out of compliance will be corrected. It is a method for describing how the provider will immediately correct identified problems. It is also a method for identifying the systemic root cause of the problem and what system changes are needed to prevent the problem from reoccurring in the future.

A POC may result from any review or monitoring that finds systemic or programmatic issues that are in violation or contrary to Federal, State, or Local law, Provider Contract, Provider Manual, or the agency's own policies/procedures. A POC may also be the result of an investigation of a complaint or allegation which also results in out of compliance findings. In cases where the issue is outside the scope of Trillium, Trillium will determine the appropriate point of referral for the issue or circumstance observed. Such referrals may be made to the Division of Health Service Regulation, the Division of Social Services, the Division of Health Benefits, the Department of Labor, the appropriate DMH/DD/SAS team or other appropriate agency.

POCs are requested in writing via a letter on Trillium letterhead sent via secure e-mail with a return receipt. The POC request letter will inform the provider of where and how to submit the POC. The POC template can be found on the Trillium website. (See the [Resources & Web Links section](#) at the end of this Manual for the link to this document.)

All Trillium POCs are submitted via e-mail to the Department requesting the POC. The POC will be due to Trillium within 15 calendar days of delivery or attempted delivery of the request letter. If the POC is accepted, it is considered to be appropriate and contains all of the required criteria. The provider will be notified in writing of the POC acceptance within 15 calendar days and a follow-up monitoring will be scheduled no more than 60 days from the acceptance date.

If the POC is not accepted, the provider will be notified in writing of its non-acceptance within 15 calendar days.

The letter will specify what corrections are needed for the second—and final—POC to be accepted.

The provider has ten calendar days to revise the POC and resubmit it in full to the LME/MCO. Once received, the final POC is reviewed by the designated Trillium department.

If the final POC is accepted, the provider will be notified in writing of the POC acceptance within 15 calendar days and a follow-up monitoring will be scheduled no more than 60 days from the acceptance date. If the final POC is not accepted, the matter will be submitted to the appropriate personnel for further review and potential imposed sanction(s). Criteria used to review the POC can be found in NC DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plans of Correction (POC.) See the [Resources & Web Links section](#) at the end of this Manual for the link to this document.

If a provider does not submit a POC within the required time frames, a reminder letter will be sent, including the consequences of failure to submit a POC. If there is still no response within ten days of attempted delivery of the final request letter, it will be treated as a non-accepted POC. Failure to respond and submit a POC will result in termination of contract for service(s).

Follow-Up Review

No later than 60 calendar days following the date the POC is approved or accepted a Monitoring Review Team will follow-up to ensure the POC has been implemented and the identified out-of-compliance findings have been corrected. The provider will be notified in writing and by fax of the follow-up review at least seven calendar days in advance.

At the first follow-up, if the reviewers determine that the POC is being followed and the issues have been corrected, the team will designate the action closed. If the department determines that the POC is not being followed and/or the issues have not been corrected, a second and final follow-up review will be required.

The provider will be notified in writing of the need for the second follow-up. In approximately 20 calendar days following receipt or attempted delivery of the “additional follow-up required” letter, a Monitoring Review Team will follow-up to ensure the POC has been implemented and the identified out-of-compliance findings have been corrected. If the reviewers determine that the POC is being followed and the issues have been corrected, the team will designate the action closed. If the issues are still not resolved, the matter will be submitted to the appropriate personnel for further review and potential imposed sanction(s). For additional information related to POCs, please go to Provider.MyLearningCampus.org to view a training on Plans of Correction. (See the [Resources & Web Links section](#) at the end of this manual for the link.)

NETWORK DEVELOPMENT PLAN

The Network Development Plan is informed by and part of the Network Adequacy and Accessibility Report. The Plan is used to delineate priorities for Service and Program Development as identified in our Local Business Plan and the Network Adequacy and Accessibility Report. Responsible Trillium Departments and/or Committees are incorporated into the plan, as well as accountability at the Executive Management level. Progress is monitored through regular reports at the Executive and Board levels of the LME/MCO.

Your Responsibility as a Trillium Contracted Provider is to: Network

- Work in collaboration with other providers, members and families
- Work on a solution-focused and collaborative basis within the network
- Demonstrate member-friendly services and attitude to ensure good communication with members and families
- Have a “no reject” policy for members who have been determined to meet medical necessity for the covered services provided by your provider or as a Licensed Practitioner

- Have a clinical backup system in place to respond to emergencies on weekends and evenings for people you serve, or serve as a first responder as outlined in the service definition and your contract
- Provide services only at qualified service sites as outlined in your contract
- Strive to achieve best practice in every area of service
- Adhere to all performance guidelines in your contract and work to deliver best practices
- Actively participate in member satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements
- Conduct self-monitoring activities for compliance and develop and implement plans of correction for any non-compliance identified
- Maintain services at an optimal level to meet member needs by providing services in accordance with Trillium Clinical Practice Guidelines
- Attempt to first resolve any disputes with other network providers or Trillium through direct contact or mediation
- Keep apprised of current information through the communication offered and provide services per the most recent State standards or Waiver service definitions
- Comply with the policies and procedures outlined in this manual; any applicable supplements; your Provider Contract; the General Conditions of the the General Conditions of the Procurement Contract; and applicable state and federal laws and regulations
- Understand the obligations and comply with all terms of the contract and all requirements in the Trillium Provider Manual and the Trillium NC Innovations Operations Manual
- Use best efforts to report to the County DSS any known change in the household composition affecting the member's eligibility for Medicaid, including changes to family size, marital status or residence, within five working days of such information being reasonably and reliably known to the provider

- Notify Trillium of any prospective changes in site(s) and assure all Trillium qualification requirements are met and any contract amendments are in place prior to delivery of contracted services
- Notify Trillium in advance of any mergers or change in ownership since it may have implications for your contract status with Trillium
- Maintain all licenses, certifications, accreditations, credentialing and registrations required for your facilities and staff providing services to Trillium members
- Notify Trillium within ten (10) business days of any change in the status of licenses, accreditations, certifications and the status of such
- Notify Trillium in writing within five (5) business days of personnel changes or information updates which may include, but is not limited to changes in capacity including inability to accept new referrals, addition of capacity or specialty services, address changes as well as changes in other enrollment information
- Notify Trillium in writing if you wish to take a Leave of Absence; notification must occur no later than 60 days prior to the desired effective date
- Do not request more than six (6) months in an initial Leave of Absence, with the option for an extension, unless the leave is a result of disabling illness;
- Submit request for an extension no later than 60 days prior to the expiration of the original Leave of Absence; extension to the original leave may not exceed an additional six (6) months
- Adhere to the regulations set forth for record retention as addressed in the following: DHHS Records Retention and Disposition Schedule for Grants; the Records Retention and Disposition Schedule for State; APSM 10-3 Records Retention and Disposition Schedule; and APSM 10-5, Records Retention and Disposition Schedule
- Transfer all member records to Trillium upon termination of the Trillium provider contract
- Maintain the required insurance stated in your contract in the amounts that equal or exceed the limits established by Division of Health Benefits (DHB)



- **Automobile Liability Insurance**—If you and/or the provider do not provide transportation to recipients, then you would need to type a brief statement on your company letterhead that states that you do not transport recipients.
- **Worker's Compensation Insurance**—The provider **ONLY** needs to carry this insurance if there are 3 or more employees; must include owners and employees.
- **Commercial/General Liability Insurance**—The provider **ONLY** needs to carry this insurance if they own the building where the services are rendered. If the provider does not own the building the provider would need to type a brief statement on their company letterhead that states they do not own the office space.
- **Professional Liability Insurance**
- **Tail Coverage**—Tail Coverage would **ONLY** need to be purchased if your policy is on a claims-made basis and you ever change insurance carriers.

Credentialing

- Provide services for which you are qualified and credentialed by Trillium
- Enroll and maintain active status in NCTRAKS with an active Medicaid Health Plan
- Comply with Trillium re-credentialing, which is outlined in the Trillium Provider Manual
- Request an application from Trillium to establish your own practice if previously credentialed while under the employment of another contracted provider
- Satisfy all application requirements, be qualified and credentialed, and have a fully executed contract prior to delivery of services to any Trillium member
- Complete, sign, and return the Trillium re-credentialing packet, complete with all required documentation, by the first day of the month preceding your credentialing expiration (Example—credentialing expiration: 2/13/2021 re-credentialing packet due: 01/01/2021)

Reconsideration of Administrative Matters or in Relation to Professional Conduct or Competence

- Submit a dated and signed request for reconsideration in writing with a brief statement of the basis upon which the decision is being challenged and any corresponding documentation to support the request
- Submit the reconsideration request to be received within 30 calendar days of the date of the letter informing the provider of the action

Cultural Competence

- Be responsive to the cultural and linguistic needs of the members served
- Interact effectively with members of different cultures
- Acknowledge the importance of different cultures and languages
- Embrace cultural strengths with people and communities and understand cultural and linguistic differences
- Earnestly participate in initiatives to achieve cultural competence, such as trainings and other development opportunities
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner
- Provide culturally competent services and ensure the cultural sensitivity of staff members
- Develop a cultural competency plan and comply with cultural competency requirements
- Ensure members understand they have access to medical interpreters, signers and TDD/TTY services without cost to them
- Ensure care is provided with consideration of member's race/ethnicity and language
- Make reasonable attempts to collect race and language specific information. Assist in explaining race/ethnicity categories to a member so they are able to identify with appropriate race/ethnicity
- Office locations have posted and printed materials in English and Spanish, and other non-English languages, if requested.

Trillium's Responsibility to Providers is to:

- Review the provider's performance record for any quality citations, actions that resulted in suspension of referrals, Division of Health and Safety Regulation (DHSR) findings, as well as demonstrations of quality and best practice
- Send written correspondence via secure e-mail as needed
- Provide technical assistance as needed related to: Trillium contract requirements; Trillium Provider Manual requirements; the development of appropriate clinical services; quality improvement initiatives; or to assist the provider in locating sources for technical assistance
- Respond to provider inquiries and provide feedback in a timely manner
- Assist providers in understanding and complying with Trillium policies and procedures, applicable policies and procedures of the Department of Health and Human Services and federal agencies including the Centers for Medicare and Medicaid, as well as the requirements of our accreditation agencies
- Make available to providers upon request, the results of Network Adequacy and Accessibility Report which identifies service gaps and needs in Trillium's catchment area, provider under/over-capacity, as well as priorities for Network Development
- Actively recruit network providers with a mission and vision consistent with Trillium
- Support the development and support of best practices or emerging best practices
- Identify gaps in network services and develop a strategy to develop those services through existing providers or by recruiting new providers for the network
- Respond to requests for applications for network enrollment according to the needs identified in the Capacity Study (Network Adequacy and Accessibility Report)
- Conduct monitoring of providers to ensure appropriate implementation of services, member health and safety, member satisfaction, positive outcomes for members and compliance with provisions of the provider's contract

- Conduct provider monitoring of provider documentation in relation to appropriateness and accuracy of information submitted for authorizations and payment
- Promote awareness of provider monitoring information/tools available on the NC DHHS website
- Review insurance limits and request revisions to them as needed
- Require all network providers to obtain coverage that cannot be suspended, voided, canceled or reduced unless the carrier gives 30 calendar days prior written notice to Trillium Health Resources
- Require network providers to submit certificates of coverage to Trillium Health Resources
- Submit copies of these certificates to DHB upon request

Credentialing

- Qualify, credential, and re-credential providers
- E-mail a reminder of re-credentialing prior to the 36 month period
- Review the returned application materials for completeness and compliance with credentialing standards
- Notify the re-credentialing provider/licensed practitioner of the Credentialing Committee's decisions regarding ongoing network participation via secure e-mail
- Maintain up-to-date Network database and Credentialing information
- Notify providers in writing if the change of information impacts their referral status
- Notify providers in writing of the Credentialing Committee decision regarding requested Leaves of Absence
- Perform a completeness review of the application; incomplete applications will be returned to the provider with a letter noting the missing or incomplete items;
- Perform a Primary Source Verification (PSV) review; if application is deemed "clean," it will be forwarded to the Medical Officer for review; subsequent to the Medical Officer's review, the application will be forwarded to the Credentialing Committee

Reconsideration of Administrative Matters or in Relation to Professional Conduct or Competence

- Offer an opportunity to meet face-to-face at Trillium when appropriate, to discuss reconsideration
- Review the written request for reconsideration along with any supporting documentation and make a decision to uphold or overturn the action
- Schedule the face-to-face meeting and notify the provider, in writing, of the date and place in which the appeal will be reviewed
- Send written notification to the provider regarding the outcome of the review
- Include in the written notification information about the participating provider's (network provider's) right to appeal to the next level (as applicable) and the mechanism to request such reconsideration
- Ensure the notification letter includes the rights as detailed above
- Provide a written notification of the appeal decision that contains the specific reasons for the decision

Cultural Competence

- Provide evaluative feedback relative to proficiency in providing culturally competent services

NETWORK DEVELOPMENT

Network Development utilizes all the mechanisms necessary to recruit and select providers to meet the standards related to access, availability, quality of care and quality of service.

The purpose of the Request for Proposal (RFP), Request for Application (RFA) and Request for Information (RFI) process is to solicit proposals, applications or information for the development, improvement, support of and/or delivery of mental health, developmental disability, and substance use services. This is a competitive, open and non-discriminatory process.

Solicitations are based on priorities outlined in the Strategic Plan, North Carolina Service Definitions, and/or identified in the Network Adequacy and Accessibility Report consistent with the organization's mission and values. The process of developing any RFA/RFP/RFI may include some or all of the following: a determination and prioritization of need, funding sources and cost/benefit analysis. A transparent and equitable scoring process will be utilized to assess competencies specific to the requirements of the solicitation.



Related contracts will include all regulatory and legal requirements.

The goal of this process is to determine the most cost effective, comprehensive, and highest quality services and/or materials for the organization and those we serve.

[Please see RFPs/RFAs](#) posted on our website for needs/gaps in our network. To make contract requests outside of the RFPs/RFAs, please email NetworkServicesSupport@TrilliumNC.org for further consideration.

Provider Network Size and Scope

The NC MH/DD/SAS Health Plan, as a managed care waiver, allows Trillium to waive a member's total "freedom of choice" of provider. This means Trillium can determine the size and scope of the provider network and can require providers to meet higher quality of care standards than the minimum requirements.

This ability to waive freedom of choice is not unlimited. Under the waiver, Trillium must ensure members have choice and services are readily accessible.

The ability to manage our provider network promotes efficiency by eliminating the cost of excess capacity while at the same time helping to ensure economic viability of providers in the Network. Our primary goal is to ensure choice and to develop provider expertise in evidence-based practices of care so the system can be shaped to better meet the needs of individuals we serve.

Trillium completes an annual Network Adequacy and Accessibility Report (also referred to as the Gaps & Needs Analysis Report)—informed by utilization initiatives—as well as an annual access study using geo-mapping. The purpose of these activities is to evaluate the capacity of the contracted provider network to meet the needs of the people served, and to measure geographic access to provider locations.

Notice of Rights Under Federal Conscience and Anti-Discrimination Laws

Trillium complies with applicable Federal conscience and anti-discrimination laws prohibiting exclusion, adverse treatment, coercion, or other discrimination against individuals or entities on the basis of their religious beliefs or moral convictions. You may have the right under Federal law to decline to perform, assist in the performance of, refer for, undergo, or pay for certain health care-related treatments, research, or services (such as abortion or assisted suicide, among others) that violate your conscience, religious beliefs, or moral convictions.

If you believe that Trillium has failed to accommodate your conscientious, religious, or moral objection, or has discriminated against you on those grounds, you can file a conscience and religious freedom complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the [Office for Civil Rights Complaint Portal](#).

By mail at:

**U.S. Department of Health and Human
Services 200 Independence Avenue SW,
Room 509F, HHH Building Washington, DC
20201**

or by phone at:

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms and more information is available about [Federal conscience and anti-discrimination laws](#).

COMPLIANCE

MEMBER RECORDS REQUIREMENTS

Each provider must adhere to the regulations set forth for records compliance, including medical records. In efforts for the provider to render the highest quality healthcare service to members, providers must keep accurate and complete medical records. This will also enable Trillium Health Resources to review the quality and appropriateness of the services rendered. Each entity, including Trillium and service providers, owns the records they generate and bear responsibility for these records and they should be stored in a secure location.

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the beneficiaries participating primary care physician or provider, documenting all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Applicable state rules and regulations for complete clinical records are set forth by [NCDHHS Records Management](#) and include:

- NCGS 121 and 132
- 45 CFR
- 42 CFR Part 2
- APSM 45-1: Confidentiality Rules
- APSM 45-2: Records Management and Documentation Manual for Providers
- APSM 30-1: Rules for MH/DD/SAS Facilities and Services
- APSM 10-5: Records Retention and Disposition Schedule for Providers
- APSM10-6: Records Retention and Disposition Schedule for LME/MCO
- NCTracks Provider Claims and Billing Assistance Guide
- NC Clinical Coverage Policies
- NC Innovations Technical Guide

Upon closure of a provider's network operations, non-renewal of contract or termination of the contract regardless of the reason the provider may submit a plan for maintenance and storage of all records for approval by Trillium. When submitting a plan for maintenance, Providers should include a Record Retention Log that includes: provider name, provider address, and phone number, total number of records involved, agency contact person, procedure for requesting records, member/recipient name, member/recipient record number, member/recipient date of birth, date of last service, and type of services provided. The Record Retention Log is on the Trillium website under Provider Documents & Forms.

Plan for maintenance and log should be sent to:

**Trillium Health Resources Attention:
Medical Records 144 Community College Road
Ahoskie, NC 27910**

or MedicalRecords@TrilliumNC.org

Trillium has the sole discretion to approve or disapprove of this record retention plan. If disapproved, Trillium may ask the provider for copies of all member/recipient records served under the contract to be delivered to Trillium within sixty (60) days.

HIPAA INCIDENT REPORTING

Providers should adhere to regulations regarding HIPAA standards. In the instance of a HIPAA breach/violation, Trillium should be notified within 72 hours of the occurrence. All potential HIPAA violations/breaches should be reported in the EthicsPoint system. EthicsPoint can be accessed through the Trillium website. Providers must comply with the Breach Notification Rule requirements following a breach of unsecured protected health information.

NORTH CAROLINA TREATMENT AND OUTCOMES PROGRAM PERFORMANCE SYSTEM (NC-TOPPS)

The program by which the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services measure the quality of substance abuse and mental health services and their impact on members' lives. NC-TOPPS requirements and details in their entirety can be found in the [Resources Guide](#).

Online interviews conducted at initiation, three months, six months, twelve months and at the end of an episode of care provide information on each member's service needs and outcomes. The responsibility for completing the NC-TOPPS lies with the member's primary provider agency/clinical home. The initial interview must be completed with the member at the beginning of an episode of care during the first or second visit. The Update Interviews (3, 6, and 12 months and biannual or twice a year) are to be submitted within the appropriate time frame as long as the member is receiving treatment.

If the member is no longer receiving the qualified treatment, an Episode Completion is submitted. The NC-TOPPS must be administered by a Qualified Professional.

For more information on submitting the NC-TOPPS or for training, you may contact the Network Management Department at NCTOPPS@TrilliumNC.org. The agency will monitor the compliance of providers in its network. Providers who fail to meet the benchmark established by the agency will be issued Plans of Correction.

NC-SNAP REQUIREMENTS

The North Carolina Support Needs Assessment Profile (NC-SNAP) measures an individual's level of intensity of need for developmental disabilities (DD) supports and services. All active members, with an Intellectual/Developmental Disability (I/DD) who receive I/DD services (with the exception of members who receive Innovation Waiver services), or are placed on the waiting list to receive I/DD supports must have an NC-SNAP administered annually. Members who receive

Innovation Waiver services are required to receive a Supports Intensity Scale (SIS) completed every 2 years for children ages 5-15 ½ years old and every 3 years for adults beginning at the age of 15 ½.

- NC-SNAP Assessments will be completed in accordance with protocols specified in the [NC-SNAP Examiner's Guide](#).
- All NC-SNAP Assessments are required to be completed by a Certified NC-SNAP Examiner.

NC-SNAP EXAMINER CERTIFICATION TRAINING

NC-SNAP Certification is only available to those staff with the appropriate credentials who are in a position that requires them to complete or review NC-SNAP Assessments as part of their job responsibilities. Typically, this is a Qualified Professional. To request NC-SNAP training, contact the Network Department or complete the Examiner Training Request and Eligibility Determination Forms on the Trillium website. The Training Calendar is also located on our website under "Provider Documents and Forms" in the "Operational Information and Forms" section (www.TrilliumHealthResources.org/for-providers/provider-documents-forms) with date and location of each training.

Trillium is responsible for ensuring that all providers submit the NC-SNAP Assessment annually as part of the Performance Contract with the Department of Health and Human Services which is monitored by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

For additional information, visit the [state's NC-SNAP website](#).

For Trillium-related questions regarding NC SNAP, email NCSNAP@TrilliumNC.org.

GPRA CORE CLIENT OUTCOME MEASURES FOR DISCRETIONARY SERVICES PROGRAMS

All providers receiving State Opioid Response (SOR) funding are required to complete the Government Performance and Results Act (GPRA) Core Client Outcome Measures for Discretionary Services Programs tool as required by Substance Abuse and Mental Health Services Administration (SAMHSA).

Any individual receiving new substance use specific treatment service and who is eligible for the Adult Substance Opioid Use Disorder (ASOUD) Benefit Plan is required to be assessed using the [GPRA Assessment Tool](#). Please read the [Instruction Guide](#), [FAQ](#), and details for [additional requirements](#).



TRILLIUM BENEFIT PLAN

MEDICAID WAIVER ELIGIBILITY

The NC MH/DD/SAS Health Plan (1915(b) waiver)

Eligibility for members meeting the criteria listed below is required. Children are eligible beginning the first day of the month following their third birthday for 1915(b) services.

A member who currently receives Social Security Insurance (SSI), Special Assistance to the Blind, Work First Family Assistance, or Special Assistance for the Aged or Disabled is automatically eligible for Medicaid.

The following criteria must be met for a member to be eligible for inclusion in the waiver:

- Be a U.S. citizen or provide proof of eligible immigration status
- Be a resident of North Carolina
- Have a Social Security number or have applied for one
- Apply and be approved for Medicaid at the local Department of Social Services (DSS) Office
- Be in one of the Medicaid aid categories that qualifies individuals for the NC MH/DD/SAS Health Plan

The member's Medicaid County of Eligibility is:

- | | |
|-------------|---------------|
| • Beaufort | • Hyde |
| • Bertie | • Jones |
| • Bladen | • Martin |
| • Brunswick | • Nash |
| • Camden | • New Hanover |
| • Carteret | • Northampton |
| • Chowan | • Onslow |
| • Columbus | • Pamlico |
| • Craven | • Pasquotank |
| • Currituck | • Pender |
| • Dare | • Perquimans |
| • Gates | • Pitt |
| • Halifax | • Tyrrell |
| • Hertford | • Washington |

The NC Innovations Waiver (1915(c) waiver)

A person with intellectual disability and/or a related developmental disability may be considered for NC Innovations Waiver funding is based on an allotment from the North Carolina General Assembly, and not determined by Trillium, if all of the following criteria are met:

- Be a U.S. citizen or provide proof of eligible immigration status
- Be a resident of North Carolina
- Have a Social Security number or have applied for one
- Apply and be approved for Medicaid at the local Department of Social Services (DSS) Office
- Be in one of the Medicaid aid categories that qualifies members for the NC MH/DD/SAS Health Plan

The member's Medicaid County of Eligibility is:

- | | |
|-------------|---------------|
| • Beaufort | • Hyde |
| • Bertie | • Jones |
| • Bladen | • Martin |
| • Brunswick | • Nash |
| • Camden | • New Hanover |
| • Carteret | • Northampton |
| • Chowan | • Onslow |
| • Columbus | • Pamlico |
| • Craven | • Pasquotank |
| • Currituck | • Pender |
| • Dare | • Perquimans |
| • Gates | • Pitt |
| • Halifax | • Tyrrell |
| • Hertford | • Washington |

- The member is eligible for Medicaid coverage, based on assets and income of the applicant whether he/she is a child or an adult.
- The member meets the requirements for ICF-IDD level of care. Refer to the Trillium NC Innovations Operations Manual for the ICF-IDD Criteria.
- Lives in an ICF-IDD facility or is at high risk for placement in an ICF-IDD facility.
- High risk for ICF-IDD institutional placement is defined as a reasonable indication that member may need such services in the near future

- The member's health, safety, and well-being can be maintained in the community with waiver support.
- The member, his/her family, or guardian desires participation in the NC Innovations Waiver program rather than institutional services.
- The member will use one waiver service per month for eligibility to be maintained.
- NC Innovations members must live in a private home (either independently or with family/ roommate) or in living arrangements with six (6) or fewer persons unrelated to the owner of the facility.
- Qualifies for the NC Innovations Waiver and has been assigned a waiver "slot."
- Trillium maintains a registry of unmet needs for members who would like to be reviewed for eligibility for the Innovations Waiver. To be placed on the registry of unmet needs please contact the Member & Recipient Service Line at 1-877-685-2415 or by email RUN@TrilliumNC.org.
- Please refer to the applicable [Benefit Plan](#) on our website for further information and details.

ENROLLMENT

Providers must ensure member enrollment data is up-to-date based on the most current Trillium Enrollment procedures and training. If enrollment data is not complete prior to service provision, authorizations and claims may be affected. This could result in denial of authorizations requested and/or claims submitted for reimbursement.



Service Eligibility

Services are divided into multiple service categories as follows.

Basic Services

The Basic Benefit package includes those services that will be made available to Medicaid-entitled members and, to the extent resources are available, to non-Medicaid members. These services are intended to provide brief interventions for members with acute needs. The Basic Benefit package is accessed through a simple referral from Trillium to an enrolled Trillium provider. Once the referral is made, there are certain specified unmanaged visits for adults and children that require no prior authorization for these services.

Enhanced Services

The Enhanced Benefit package includes those services available to Medicaid-entitled members and to non-Medicaid members meeting State Benefit Plan criteria.

Enhanced Benefit services are accessed through a person-centered planning process and provide a range of services and supports more appropriate for members requiring higher levels of care. The person-centered plan also includes both a proactive and reactive crisis contingency plan. The goal is to ensure these members' services are highly coordinated, reflect best practice, and are connected to the person-centered plan authorized by Trillium.

State Benefit Plans

State Benefit Plan designation is for State-funded services. It does not apply to members who are only receiving Medicaid services. The provider, through review of screening, triage and referral information, must determine the specific State Benefit Plan for the member according to the Division of MH/DD/SA Criteria.

Each State Benefit Plan is based on diagnostic and other indicators of the member's level of need. The most current version of State Benefit Plan Criteria can be found on the NC Division of MHDDSAS website. (See the [Resources & Web Links section](#) at the end of this Manual for the link to this information.)

DISENROLLMENT

When a member becomes eligible for Medicaid outside of Trillium's catchment area, we continue to be responsible for their care until their Medicaid eligibility is transferred to their new county of eligibility and the disenrollment is processed by the Eligibility Information System at the State.

Disenrollment due to a change of Medicaid County of eligibility is effective at midnight on the last day of the month.

Automatic disenrollment occurs if a member:

- Changes county of Medicaid eligibility to a county outside the catchment area of Trillium Health Resources.
- Is deceased.
- Is admitted to a correctional facility for more than thirty days.
- Is admitted to a facility that meets the definition of an IMD (Institute for Mental Disease) and is between the ages of 22 and 64, with the exception of "short term" admissions defined as no more than fifteen (15) calendar days in any month.
- No longer qualifies for Medicaid or becomes a beneficiary ineligible for enrollment.
- If a member is disenrolled due to loss of Medicaid eligibility as indicated on the Global Eligibility File (GEF), the member will automatically be reenrolled at the point in which the eligibility is reflected as active on the GEF daily update.
- Is enrolled in an eligibility group not included in the NC Medicaid 1915(b)(c) MH/DD/SAS Health Plan or NC Innovations waivers.

Disenrollment will not occur due to the following:

- An adverse change in the member's health status
- Member's utilization of medical services
- Member's diminished mental capacity
- Member's uncooperative or disruptive behavior resulting from their special needs with the exception of when their continued enrollment would seriously impair Trillium's ability to furnish services to the member or other members

ELIGIBILITY FOR STATE-FUNDED SERVICES

Individuals who do not have Medicaid may be eligible for state-funded services based on their income and level of need. No one that meets eligibility requirements can be denied services based on inability to pay. The provider's sliding fee schedule is designed to assess a person's ability to pay.

State-Funded Services are not an entitlement. Trillium and other LME/MCOs are not required to fund services beyond the resources that are available to them.

There are also some services, including most residential services for adults, which are not reimbursed by Medicaid. Therefore members who receive Medicaid may also receive state-funded services based on their individual needs and availability of funding.

ELIGIBILITY FOR REIMBURSEMENT BY TRILLIUM

Members or recipients who have their services paid for in whole or in part by Trillium must be enrolled in the Trillium system. If you have any questions about a member's eligibility, please contact Trillium.

Those who are at 100% ability to pay according to the provider agency's sliding fee schedule, or who have insurance coverage that pays 100% of their services, must not be enrolled into the Trillium system. However, the person may still receive and pay for services from a provider independent of Trillium involvement.

Medicaid and State Funds should be payment of last resort. All other funding options need to be exhausted first. Members or recipients with private or group insurance coverage are required to pay the co-pay assigned by their insurance carrier.

Members eligible for Medicaid from counties in the Trillium catchment area are fully enrolled in the Trillium system and are eligible to receive Basic Benefit Services or Enhanced Services which have been authorized by Trillium.

CLINICAL OPERATIONS

Clinical Operations manages the Trillium Crisis Care & Service Enrollment system, through its Departments of Call Center & Member Services; Care Management; Housing; and Utilization Management. The Clinical Operations Team defines authorization guidelines, conducts authorization, performs utilization management, operates a 24/7 call center for service access, and oversees the crisis response system. Additionally, it researches utilization trends to use for planning; identifies areas for further study and review; and develops Clinical Guidelines and written protocols.

The Medical Officer oversees all clinical activities performed in Clinical Operations and supports the Clinical Advisory Committee.

TRILLIUM CLINICAL DESIGN PLAN

The Trillium Health Resources 1915(b) Waiver and the Innovations (c) Waiver are designed to create a system that will more effectively and efficiently address the needs of members with mental illness, intellectual/developmental disabilities, and substance use disorders.

The successful implementation of this system depends on integration of primary care and behavioral health, as well as coordination and management of all public resources. Federal, State and County funds will be strategically managed for optimal outcomes for people. Trillium has started and continues a thoughtful and transparent process of change and improvement through this implementation.

The complete Trillium Clinical Design Plan is available on the Trillium website. (See the [Resources & Web Links section](#) at the end of this Manual for the link to this document).

CALL CENTER & MEMBER SERVICES

Trillium is responsible for timely response to the needs of members and recipients and for efficient linkages to network providers. Call Center & Member Services staff provides critical monitoring and management of referral follow-up to care, as well as entry and management of grievances, complaints and concerns.

Trillium maintains a telecommunications system with 24 hours per day, 7 days per week access to services at any given time. We answer all calls personally and offer an option of leaving a message for a clinician. When a member or family member calls the 24-Hour Behavioral Health Crisis Line, staff are able to assess the member's needs and offer options based on the member's preferences and the service needed. Unless members prefer to make their own arrangements, staff will contact the provider while the member is on the line and assist in scheduling an appointment, or they will refer the member to an Open Access provider depending on the member's urgency of need and geographic location.

Accessing Routine Services

The Access Standard for Routine Services is to arrange for services within ten (10) calendar days of contact at the 24-Hour Behavioral Health Crisis Line. The geographic access standard for services is 30 miles or 30 minutes driving time in urban areas, and 45 miles or 45 minutes driving time in rural areas.

Routine Referral Process

1. The Call Center Staff will collect demographic information on the caller and search for the member or recipient in the online billing platform.
2. If the member is not located in the eligibility file, the Access Staff will advise the caller of this, and proceed with collection of enrollment data on the most current Trillium Enrollment Form.

The Call Center staff will evaluate the member or recipient's clinical need as follows:

- Complete the state mandated Screening, Triage and Referral tool and document the information obtained following the current online billing platform;
- Retrieve and review the member or recipient's historical information, as needed;
- Use the information provided, determine the type of clinical services needed.

3. The Call Center Staff will offer the member or recipient a choice of two (2) providers (when available) and document the selection in the online billing platform.

Choice is determined by weighting providers in the following areas:

- Availability of service
 - Proximity to member/recipient
 - Member/recipient's desired attribute in provider or provider specialty
4. The Call Center staff will call the chosen provider for immediate scheduling with the member/recipient on the line. If an appointment is not available within availability guidelines, the member/recipient may choose another provider.
 - Call Center staff will provide the agency with a brief overview of the member/recipient's need for service as well as indicating the service to be provided. Either Call Center staff remain on the line with the provider and member to obtain the date of the initial appointment, or request the provider call back to provide this information.
 - This is to ensure appointments are being set within the state required timeframe for the determined level of care and is documented in the computer system.
 - In the event the member/recipient chooses to contact the selected agency on his/her own, Call Center staff will indicate this in their documentation.

Trillium network providers are held to the following standard regarding Appointment Wait Time for ROUTINE Referrals:
Scheduled—one hour; Walk-in—within two hours.

Accessing Urgent Services

The Access Standard for Urgent Care is to arrange for services within 48 hours of contacting the Crisis Care & Service Enrollment Number. The geographic access standard for services is 30 miles or 30 minutes driving time in urban areas, and 45 miles or 45 minutes driving time in rural areas.

Urgent Referral Process

1. A person's clinical need may be considered URGENT if, but not limited to the following:
 - A member/recipient reporting a potential substance-related problem
 - The member/recipient seems at risk for continued deterioration in functioning if not seen within 48 hours
2. The Call Center staff will collect the enrollment data and proceed with a state screening form to identify treatment needs.
3. After completing the screening, the Call Center staff will offer the member/recipient a choice of two providers (when available) and document the provider selected in the software platform.
4. The Call Center staff will call the chosen provider and schedule an appointment, which must be available within 48 hours, or they will refer the member/recipient to an Open Access provider depending on the member's geographic location. If this does not occur, an explanation is documented.
5. If there are no scheduled appointments available within the required timeframe, or there are no Open Access providers within a reasonable distance of the member/recipient's geographic location, the member will be referred to a Walk-In Clinic (hours of availability differ by geographic location and are based on the annual Network Adequacy & Accessibility Report).

6. The Call Center Clinician will remind the member that the Trillium Access Call Center is available 24 hours a day and instruct the member to contact the 24-Hour Behavioral Health Crisis Line again by telephone at any time should the situation escalate and require immediate attention. The Call Center will also provide the member with the number for mobile crisis team servicing their county.
7. Trillium Call Center Staff will continue to follow-up with any Urgent contact until it is determined that the member has been able to receive the care that is most appropriate to meet the member/recipient's clinical needs
8. If member/recipient requires urgent care, they are referred to a provider regardless of funding status (Medicaid, Medicare, Insurance, etc.)

Trillium network providers are held to the following standard regarding Appointment Wait Time for URGENT Referrals: Scheduled Appointment—one hour; Walk-in—within two hours.

Accessing Emergent Services

The access standard for Emergency Services is two (2) hours or immediately, for life-threatening emergencies. The geographic access standard for services is 30 miles or 30 minutes driving time.

In potentially life-threatening situations, the safety and well-being of the member has priority over administrative requirements. Eligibility verification will be deferred until the caller receives appropriate care.

Emergent Referral Process

Any calls that are deemed to be EMERGENT are immediately transferred to a Call Center Clinician via a "warm" transfer (Member/recipient remains on the line without being put on hold.) Emergent needs can be life threatening conditions; timeframe for response to emergent needs will be provided by immediate access to care which includes dispatching emergency services by calling 911.

An EMERGENT situation is indicated if the member demonstrates one or more of the following, including, but not limited to:

- Real and present or potential danger to self or others as indicated by behavior, plan or ideation
- Labile or unstable and demonstrates significant impairment in judgment, impulse control, and/or functioning due to psychotic symptoms, chemical intoxication, or both
- Immediate and severe medical complications concurrent with or as a consequence of psychiatric or substance use illness and its treatment.
- Caller indicates (either by request or through assessed need) a need to be seen immediately
- The Call Center Clinician will determine through clinical screening whether the member/recipient represents an immediate danger to self or others. If member is an imminent danger to self or others, the Call Center Clinician will implement crisis intervention procedures by attempting to keep the member/recipient safe until immediate supports or services are in place.
- When possible, the Call Center Clinician will speak to the caller directly until they can be connected to the appropriate level of care.

If Member/Recipient Is Unable To Be Stabilized

- The Call Center Clinician will, with assistance from another staff when needed, contact the appropriate emergency agency (i.e. law enforcement, emergency medical services, etc.) to respond and attempt to keep the caller on the phone until they arrive. A Call Center Agent or Coordinator will collect the remaining enrollment data from the crisis worker when it becomes available.
- Trillium Call Center Clinicians will continue to follow-up with any Emergency contact until it is determined that the member/recipient has been able to receive the care that is most appropriate to meet the member's clinical needs.

Members are informed of the availability and types of Crisis Services in the Trillium area through the Trillium Member & Family Handbook, various print materials, Community Collaborative meetings, System of Care coordination efforts, website postings, billboards and local media community bulletin boards.

Trillium network providers are held to the following standard regarding Appointment Wait Time for EMERGENT Referrals:

- Provider will see all Emergencies within two (2) hours. If situation is life threatening, Provider should seek assistance from the appropriate law enforcement, emergency medical services (EMS) or fire and rescue service.

Process for Service Authorization

- Clinicians have the ability to authorize initial and concurrent inpatient treatment requests and services such as, but not limited to, Detoxification Services, Facility-Based Crisis Services, Crisis respite and mobile crisis.
- After reviewing the request, if the member/recipient's situation meets Trillium's established clinical criteria for the requested service, the Clinician will complete the following steps:
- Authorize the service based on the Authorization Guidelines.
- If the member's condition does not meet the criteria for the requested service, after the Physician Advisors have made such a determination, the Clinician may explore treatment alternatives with the provider and member.

Discharge

Discharge planning begins at the time of the initial assessment and is an integral part of every member's treatment plan regardless of the level of care being delivered.

The discharge planning process includes use of the member/recipient's strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of

community services and support when appropriate to assist the member/recipient with functioning in the community.

The Call Center staff may assist with the discharge planning for members/recipients in acute levels of care.

Among the functions:

- Identify members/recipients who have multiple admissions to acute care facilities and make recommendations, when appropriate, that enhanced services start prior to member discharge.
- Refer the member for Care Management.
- Make follow-up appointments with appropriate community providers.

Follow Up After Discharge

Call Center staff recognize the importance of follow up care after a member/recipient is discharged from an acute level of care. Every effort is made to ensure the member/recipient is engaged in treatment. All discharge appointments are followed up on to make sure the member was seen. This is done by contacting the provider to verify that the appointment was kept.

If an appointment is not kept, Call Center staff:

- Document the reason, i.e., No Show, member canceled, provider canceled, etc. and whether the appointment was rescheduled.
- If the member/recipient is still not able to engage in treatment, the provider with the assistance of Call Center Staff will attempt to re-engage them into services.

Grievances & Complaints

A **grievance** is defined as any expression(s) of dissatisfaction about any matter other than an Adverse Benefit Determination (see definition of action below) filed by a member or by an individual who has been authorized in writing to file on behalf of a member. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The resolution of a grievance may be appealed.

If a grievant wishes to appeal the resolution of a grievance, the grievant must request an appeal within sixty calendar days of the mailing date of the grievance resolution letter by contacting the Appeals Coordinator.

Complaint means an expression of dissatisfaction communicated verbally or in writing by an external provider, stakeholder/organization, or family member who does not have written consent to file a grievance on a member's behalf about any matter other than an adverse benefit determination, as is defined below. Possible subjects for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The resolution of a complaint may be appealed.

If a complainant wishes to appeal the resolution of a complaint, the complainant must request an appeal within twenty-one (21) calendar days from the receipt of the complaint resolution letter by contacting the Appeals Coordinator.

Adverse Benefit Determination means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination.
- The failure to provide services in a timely manner, as defined by the State;
- The failure of an MCO or PIHP to act within the timeframes provided in the Federal Guidelines.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

- The denial of a Medicaid member's request to exercise his or her right, to obtain services outside the network but only if the member lives in a rural area and there is no Trillium network provider who is available to provide the service.

Trillium takes an Omni-channel approach to submitting complaints or grievances so providers, members, stakeholders or anyone else may choose their preferred method of engagement. We accept complaints or grievances verbally, electronically or in writing. If an individual requests to have a complaints or grievances filed anonymously, all reasonable efforts will be made to protect their identity and Trillium will provide safeguards for protecting the individual from harassment or retaliation. Our "no wrong door" policy allows any Trillium staff to accept and file a complaint or grievance on behalf of anyone.

The available channels include:

- Trillium Member & Recipient Service Line or the Administrative/Business Line
- Provider Support Service Line
- [Trillium's Website](#)
- NCDHHS
- Certified Mail
- Secure Emails

Trillium maintains a formal process to manage complaints and grievances through a centralized, coordinated process. Regardless of how it is submitted, the complaint or grievance submitted is documented and acknowledged by Trillium via letter within five (5) calendar days of receipt of the complaint or grievance.

If the issue is not something Trillium has oversight of, Trillium will make a referral to the appropriate agency, which could be but is not limited to the Department of Social Services, Division of Health Service Regulations, Division of Mental Health/Developmental Disabilities/ Substance Abuse services.

Complaints are resolved within thirty (30) calendar days of receipt. For all Medicaid grievances, this will occur within thirty (30) calendar days, per NCGS 108D-12 and no more than ninety (90) calendar days, per 42 CFR § 438.408. According to Federal Regulation 438.308, the MCO may extend the timeframe by up to 14 calendar days if the member requests the extension or if the MCO shows there is need for additional information and how the delay is in the member's best interest. If the MCO extends the timeframe, it must, for any extension not requested by the member give the member written notice of the reason for the delay. Once a resolution is determined, Trillium will send a standardized resolution letter to the person who filed the complaint or grievance and all other parties involved in the review within fifteen (15) calendar days of the resolution of complaint or grievance. Per contractual requirements, contracted Providers of Trillium are required to cooperate fully with all investigative requests, including but not limited to immediate access to any of the contractual locations/sites, where services are provided to members, in addition to any site where financial or clinical records are maintained. Failure to do so may be grounds for contract termination.

GRIEVANCE & COMPLAINT PROCESS INTERNAL TO CONTRACTED NETWORK PROVIDERS

All contracted network providers must have a grievance/complaint process to address any concerns of the member and the member's family related to the services provided. The provider must keep documentation on all grievances received, including date received, points of grievances, and resolution information. Any unresolved concerns or grievances should be referred to Trillium's Call Center & Member Services Department.

Upon enrollment and upon request, the grievance/complaint Process must be shared with all members/recipients and families of members. The provider must advise them that they may contact Trillium directly about any concerns or grievances.

Trillium's Administrative/Business Line, 1-866-998-2597, must be published and made available to all members/recipients and family members in the provider's office. Additionally, other agencies available to take grievances/complaints must be posted. These agencies include Division of MH/DD/SAS Member Care Line, 1-919-733-7011, in Raleigh and Disability Rights NC, 1-877-235-4210.

TRILLIUM'S CARE MANAGEMENT DEPARTMENTS

Care Management is: A person-centered, assessment based interdisciplinary approach to integrating behavioral health services, primary health care and natural and community social support services. This function is completed in a cost-effective manner in which a member's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by a care manager.

Care Management is designed to proactively intervene and ensure optimal care for Special Needs Populations. The goal is to identify these members and intervene in order to ensure members receive both an appropriate assessment and medically necessary services. Special Needs Populations are defined by specific diagnostic, functional and/or service utilization patterns that are indicators of risk. The goal is to ensure the member is referred to, and appropriately engaged with MH/DD/SA provider(s) and primary care physicians who can meet the member's needs. Trillium primarily delivers Care Coordination telephonically.

Care Management admission is determined by the entrance criteria set by the DHB and DMH contracts.

Innovations Waiver Care Management

The following statements are directed to members and providers regarding innovations waiver care management processes:

- During the planning process, the assigned Care Manager (CM) will explain the different services to their assigned members and work with the provider to develop the member's Plan of Care based on the services they wish to request. The Care Manager will also explain the requirements in the Innovations Waiver around those services.

- The member's assigned Care Manager will assure that the Plan of Care will include the services that the member wants to request, for the length of time that they want to request them. Their Plan of Care should be used to plan for the entire year, and services that they expect to need at any point during that year. If they expect to need services for the entire year, the Care Manager will assure that the plan requests those services for the entire year.
- Members must have a signed Plan of Care in order to receive services through the Innovations Waiver. That means that the provider needs to sign a plan containing the level of services that they want to request, which may be different than the level of services that will be approved. Their assigned Care Manager will draft the Plan of Care based on their wishes, will review the plan with them before they sign it, will answer any questions they have, and will make any changes to the plan that they request before they are asked to sign it.
- If the member wishes to change or add services during the plan year, they may ask their Care Manager to help them request the change by writing an update to their Plan of Care at any time.
- The Support Needs Matrix (SNM) and Support Intensities Scale ® (SIS ®) are tools that may be used in the planning process. Members may have an assigned SNM Base Budget, which is not a limit on the amount of services they can request or have approved, but along with the SIS ® is used as information and as a guideline for base budget services. Services will be approved above their assigned SNM Budget if Trillium Health Resources determines that services are medically necessary. If any of the services that the member requests are denied, they will receive written notice with information about how they can appeal that decision.
- During the planning process, their assigned Care Manager will review their Base Budget with them. As mentioned above, their Care Manager will assure that their Plan of Care includes the level of services they want to request, for the length of time they want to request them. Their Care Manager will discuss service options with them, but will not ask them to submit or update a Plan of Care to request services to fit within their SNM Base Budget if the member does not wish to do so.
- The member (or their legally responsible representative) will need to sign the Plan of Care once it is complete.
- The member will not be asked to sign a plan that does not contain the level of services that they want to request. If they expect to need those services all year, they will not be asked to sign a plan that does not request those services for the entire plan year.
- The Utilization Management Department of Trillium Health Resources will determine whether or not the services the member requested are medically necessary, not their assigned Care Manager. A decision on their request for services in their Plan of Care will be made within 14 calendar days unless more information is needed.
- If any service requested in their Plan of Care is not fully approved (for example, a service is denied, or is approved for fewer hours or for a length of time that is less than what they requested), they will receive a written explanation of that decision and information about how they can appeal.
- Trillium Health Resources will not retaliate against members in any way if they appeal. Their assigned Care Manager can assist them with the forms needed to file an appeal.
- If some services are approved and some are denied, the member can receive the services that were approved while they appeal the services that were denied. They may also make a new request for different services while their appeal is pending, if they wish to do so.
- A member's Plan of Care will include information on the period of time for which services are requested. If services that have been requested in their Plan have been approved and then are later reduced, suspended, or terminated before the approval period has ended, and they appeal that decision, they may be able to continue to receive services during an appeal. The member will receive written notice about that process before any services are reduced, suspended, or terminated.

Transitions to Community Living (TCL)

The State of North Carolina entered into a settlement agreement with the United States Department of Justice (DOJ) in 2012. The purpose of this agreement was to make sure that persons with mental illness are able to live in their communities in the least restrictive settings of their choice.

The NC Department of Health and Human Services (DHHS) has implemented the agreement through the Transitions to Community Living (TCL). Trillium operates the TCL program through the Care Management department.

Components of TCL:

- **In-reach:** Certified Peer Specialists will go into facilities and build relationships with members to discuss community-based mental health services and potential housing resources.
- **Diversion:** Referral Screening Verification Process (RSVP) is a screening tool used prior to any admission into an Adult Care Home to determine if the individual has a mental illness.
- **Transition planning:** Once a member is identified by In-reach as interested in community-based mental health or housing services, then they are assigned to a Transition Coordinator. The Transition Coordinator helps develop a plan to transition a member into the community.

Available services:

- Housing slots with financial rental assistance
- Tenancy Support to assist with transitioning to independent living, setting up household supplies and furniture, explaining what to do in an emergency, budgeting, and providing ongoing tenancy support
- Individual Placement and Support-Supported Employment service (for individuals with mental health and substance use disorders) to obtain competitive employment in an integrated work setting
- Work Incentives Planning and Assistance (WIPA) (for individuals with disabilities who receive Social Security benefits) to help acquire, retain, and increase meaningful employment with the goal of improving financial independence

- Special Assistance-In Home provides cash supplement to help low-income adults who are at risk of placement in a licensed residential care setting to reside in a private living setting

As part of the DOJ settlement, NC DHHS has determined that the following members are potentially eligible for inclusion in TCL. Approval for inclusion in the TCL program comes from screening a member who has been referred via the Referral Screening and Verification Process (RSVP) to determine if they meet the criteria for TCL.

- Individuals with severe and persistent mental illness (SPMI) who reside in adult care homes that are determined to be Institutes of Mental Disease (IMD)
- Individuals with SPMI who reside in adult care homes licensed for at least 50 beds, and in which 25% or more of the population has a mental illness
- Individuals with SPMI who reside in adult care homes licensed for 20-49 beds, and in which 40% or more of the population has a mental illness
- Individuals with SPMI who are or will be discharged from a State psychiatric hospital, and who are homeless or have unstable housing
- Individuals diverted from entry into adult care homes pursuant to the pre-admission screening and diversion

Please visit [Transitions to Community Living](#) for more information, or call Trillium at 1-866-998-2597.

CLINICAL SUPPORT

The Primary Purpose of the Clinical Support unit is to manage all service-related member/recipient notices, Continuous Quality Improvement (CQI) for Clinical Operations and integrated payment and reporting system (IPRS), which processes state-funded claims submitted by providers.

HOUSING

The Housing Department works to ensure members/recipients have options for safe, decent and affordable housing. Housing staff members serve on, facilitate and support community groups, boards, councils and organizations that share the Trillium goal of welcoming people with disabilities into the community.

Housing staff procure grants to expand community capacity for stable housing options that provide the opportunity for growth, skill building, and increased independent living. They maintain an inventory of housing resources and information on the unmet housing needs of members and families served.

Providers may seek assistance from Housing staff for members who are seeking safe and affordable housing. Staff can also provide or arrange for education to providers on a variety of housing topics such as NC Fair Housing Law and How to Be a Good Landlord/Tenant.

NEIGHBORHOOD CONNECTIONS

The Neighborhood Connections Department works to enhance and increase the accessibility and availability of resources that influence a person's overall health and wellness. The department includes teams that coordinate: the Registry of Unmet Needs; specialty care needs such as assistive technologies, home and vehicle modifications, and community networking classes; residential searches; and assisting members with non-medical drivers of health such as food access, transportation, housing, education/ employment, inclusion and interpersonal safety. Neighborhood Connections Specialists offer wellness education in partnership with providers and community based organizations

TRILLIUM ADVANTAGE

Trillium Advantage covers services and settings not currently available to members in NC Medicaid. These options are better suited to meet the individual needs of our members that may not be covered by typical behavioral health or I/DD services. We will offer value-added services to help address unmet health-related resource needs.

UTILIZATION MANAGEMENT

The Utilization Management (UM) Department includes Care Management (CM) and Utilization Review (UR) functions. Care Management will determine whether a member meets medical necessity criteria and target population requirements for the frequency, intensity and duration of requested services.

Care Management

The primary Care Management function is to make authorization decisions by conducting initial, concurrent and retrospective reviews of services based on meeting medical necessity. Care Management will determine whether a member/recipient meets medical necessity criteria and target population requirements for the frequency, intensity and duration of requested services. UM Care Managers assist the provider in managing a member/recipient's care needs and identification of appropriate services.

Treatment Authorization Request Forms

Trillium uses a Treatment Authorization Request (TAR) form to capture demographic and clinical information. The TAR assists the Care Manager in making the clinical determination. The TAR must include accurate and complete clinical information to avoid a delay or denial of authorization request.

An instruction manual is available for review by logging into Provider Direct and selecting the Training Materials link from the Client Gateway. Any provider can request technical assistance on TAR submission by contacting Trillium.

The purpose of this process is to identify the steps required in requesting prior-authorization and continued authorization from the Utilization Management unit. Requesting the Authorization is the responsibility of the provider.

Electronic notification of UM decisions may be found in the web portal so it is the responsibility of the provider to check the portal regularly.

For a full listing of all NC Medicaid Plan Service Definitions and Criteria, visit the Division of Health Benefits (DHB) website. (See the [Resources & Web Links section](#) at the end of this Manual for the link to this website.)

Utilization Review

The primary Utilization Review function is to monitor the utilization of mental health, substance use and intellectual/developmental disability services and review utilization data to evaluate and ensure that services are being provided appropriately within established benchmarks and clinical guidelines; that services are consistent with the authorization and approved Person-Centered Plan (PCP)/Individual Support Plan (ISP)/Treatment Plan.

Utilization review is an audit process that involves a review of a sample of services that have been provided. Information from the member's record (assessment information, treatment plan and progress notes) is evaluated against Medical Necessity Criteria. Indicators will be identified to select cases for review, such as high utilization of service, frequent hospital admissions, etc. as well as random sampling of other events. Trillium uses both Focused Utilization Review and a sampling process across network providers in its Utilization Review methodologies.

Incentives

Trillium does not offer incentives that would discourage requests or approval of service requests. Decision making is based solely on appropriateness of care and existence of coverage. We do not offer incentives for utilization management staff or contractors to deny, reduce, terminate, suspend, limit or discontinue medically necessary services to any member. We also do not offer physician incentive plans.

Focused Utilization Review

A Focused Review will be based on the results of Monitoring Reports that identify outliers as compared to expected / established service levels or through specific cases identified in the Trillium clinical staffing process to be outside the norm.

Focused samples may include:

- High-risk members—Examples may include, but are not limited to, members who have been hospitalized more than one time in a 30-day period; members with intellectual/developmental disabilities as identified in the Risk/Support Needs Assessment; children and youth with multiple agency involvement; or active substance use by a pregnant female.
- Under-utilization of services—Examples may include, but are not limited to, members who utilize less than 70% of an authorized service or members who have multiple failed appointments.
- Over-utilization of services—Example: members who continue to access crisis services with no engagement in other services.
- Services infrequently utilized—Example: an available practice not being used.
- High-Cost Treatment—Members in the top 10% of claims for a particular service.

Routine Utilization Review

Routine Utilization Review will focus on the efficacy of the clinical processes in cases as they relate to reaching the goals in the member's PCP/ISP/treatment plan. Trillium will also review the appropriateness and accuracy of the service provision in relation to the authorizations. All providers contracted with Trillium who are currently serving Trillium members/recipients are subject to Utilization Reviews to ensure that clinical standards of care and medical necessity are being met. A routine UR will be inclusive of, but not limited to: evaluations of services across the delivery spectrum; evaluations of members/recipients by diagnostic category or complexity level; evaluations of providers by capacity, service delivery, and best-practice guidelines and evaluations of utilization trends.

The criteria used in the Utilization Review processes will be based on the most current approved guidelines and service manuals utilized under the NC MH/DD/SAS 1915(b)(c) waivers and processes for NC State services.

These documents include, but are not limited to, the current NC State Plan service definitions with Admission, Continuation, and Discharge criteria; the Trillium approved Clinical Guidelines; the current approved DHB policies; and any Trillium approved clinical guidelines developed and/or recommended by the Clinical Advisory Committee.

In cases where the care that is needed is emergent or acute, an expedited request for authorization, if necessary, is available up to 48 hours after admission. Medical necessity criteria must be established by the provider along with other clinical information. Trillium has created an environment that supports rapid access for many crisis services to divert from unnecessary inpatient hospitalization.

Authorization Process

1. Prior-authorization is required for all Trillium covered services, with the following exceptions:
 - Basic Services, within prescribed levels, see current benefit plan for details
 - Emergency/Crisis services for Behavioral Healthcare
 - Codes specifically agreed upon by Trillium and provider to be listed as "No Auth Required" under a contract; (see your contract for applicability)
 - Services that have a "pass through" as outlined in Clinical Coverage Policy, see current benefit plan for details
2. To remain consistent with Division of Health Benefits (DHB) guidelines, the Trillium Utilization Management (UM) Department is only able to make formal decisions (approval, denial or extensions when appropriate) when a complete request is received. For a request to be considered "complete" it must contain the following elements.
 - Member Name
 - Medicaid ID
 - Date of Birth
 - Provider contact information and signatures

- Date of request
- Service(s) requested
- Service Order
- Completed Check boxes (Signature Page/ Service Order Yes or No Check Boxes related to medical necessity, direct contact with the member, and review of the member's Clinical Assessment)
- Person-Centered Plan (PCP)/Individual Support Plan (ISP) (if applicable)
- A copy of the Comprehensive Clinical Assessment (CCA), Psychoeducational Testing, or other assessments or documentation to support medical necessity.

Level of care tool scores will also help determine medical necessity and these may include LOCUS®, CALOCUS®, ASAM, and The Early Childhood Services Intensity Instrument (ECSI) for Infants, Toddlers and Pre-Schoolers.

A Person-Centered Plan/Individual Support Plan/treatment plan by itself does not initiate a request for service.

If Trillium receives a TAR requesting a service or frequency different from the PCP/ISP/treatment plan, it can be administratively denied due to lack of information.

If Trillium receives a TAR without the required corresponding PCP/ISP/treatment plan, it will be administratively denied due to lack of information and provider notified via TAR comments in Provider Direct.

Electronic notification of UM decisions may be found in the web portal so it is the responsibility of the provider to check the portal regularly.

Authorization

Timeframes for completion of the clinical review are as follows:

- Urgent—72 hours from the receipt of the request
- Non-Urgent—14 calendar days

For urgent and non-urgent cases this period may be extended one time by the organization for up to 14 calendar days and may be requested by a member or a provider:

- Provided that Trillium determines that an extension is necessary because of matters beyond its control; and notifies the member prior to the expiration of the initial 14 calendar-day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and
- If a provider agency fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the provider agency must be given at least 14 calendar days from receipt of notice to respond to the plan request for more information.

Prior-authorization for all services may be requested through submission of the Treatment Authorization Request (TAR) form. Enhanced Services require prior authorization; backdating is prohibited.

An expedited prior-authorization can be requested telephonically for any service, if immediate access is clinically indicated. If the caller established clinical necessity, the clinician verbally authorizes and reminds the provider to complete enrollment and submit the TAR.

An expedited request can be made in cases where adherence to the standard timeframe of 14 days for UM decisions could seriously jeopardize a members/recipient's life or health or ability to attain, maintain, or regain maximum functioning.

If the review of the TAR indicates the member's/recipient's situation meets Trillium established clinical criteria for the requested service, the UM Care Manager authorizes the service based on the Authorization Guidelines. The UM Care Manager generates an authorization letter which can be viewed by the provider in Provider Direct on the Print Authorizations link.

If the member's/recipient's condition does not meet the criteria for the requested service, the UM Care Manager may explore treatment alternatives with the provider and member.

1. If agreement is reached regarding treatment at a different level of care or with a different service, the UM Care Manager will document the treatment plan agreed upon, and complete the authorization and notification procedures for that level of care or service.
2. If the provider continues to request authorization for services that do not appear to meet Trillium's applicable clinical criteria and guidelines, a Peer Review can be requested by the provider agency with a Peer Reviewer.
 - Peer Reviewer Definition—The Medical Officer or a senior clinical staff person within UM or a Contractor with expertise in the area requested.
3. UM Care Manager decision outcomes are communicated and documented in the CI system. Providers are responsible to check the CI system on a regular basis to check on the status of the TAR and review any communications from the UM Department.
4. Any denial of service will follow the Medicaid Clinical Reconsideration Process procedure for Medicaid services and/or the Clinical Reconsideration Process procedure for Non-Medicaid services.
5. At the time of need for a continued authorization (no earlier than 30 calendar days prior to the expiration of the current authorization), the provider shall complete a TAR online and submit it electronically to Utilization Management via Provider Direct. The information required establishing the need for continued medical necessity and service continuation criteria must be included. The PCP/ISP review and/or update and other supporting documentation must be uploaded as part of the TAR submission.

Discharge Review

Discharge planning begins at the time of the initial assessment and is an integral part of every member/recipient's treatment plan regardless of the level of care being delivered.

The discharge planning process includes use of the member's strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the member/recipient with functioning in the community.

Involvement of family members and other identified supports, including member or recipient's of the medical community, require the member's written consent. The purpose of this process is to identify the steps to be taken by the Utilization Management Care Manager in assisting with discharge planning efforts.

Discharge Process

1. The Utilization Management Care Manager reviews the status of the discharge plan at each review to assure that:
 - A discharge plan exists;
 - The plan is realistic, comprehensive, timely and concrete;
 - Transition from one level of care to another is coordinated;
 - The discharge plan incorporates actions to assure continuity of existing therapeutic relationships;
2. When the discharge plan is lacking in any respect, the Utilization Management Care Manager addresses the relevant issues with the provider.
3. The Utilization Management Care Manager assists with the development of discharge plans for members/recipients in all levels of care. Among the functions:
 - Identify members/recipients who are remaining hospitalized, or at any other level of care, who do not meet criteria for that level of care and help develop a plan to get the right service at the right level.
 - Monitor members/recipients to assure that they receive clinically indicated services.
 - Whenever a member/recipient is discharged from detoxification, inpatient psychiatric or partial hospitalization care, the discharge plan should include a follow-up appointment within seven (7) calendar days. A Trillium representative will work with the discharging facility to ensure that an appointment is made and monitor whether they kept the appointment.



- ° A Trillium representative will coordinate with the person's Clinical Home to ensure there are appropriate services in place following discharge. If the person does not have a Clinical Home, and the person meets Special Needs Population criteria, the Care Manager will refer to the Care Management Department (CMD) for follow-up by a Care Manager.

Hospital Admissions

For members/recipients hospitalized on or after the effective date of enrollment in the waiver operated by Trillium. Trillium will provide authorization for all covered services, including inpatient and related inpatient services, according to medical necessity requirements. Trillium shall provide authorization for all inpatient hospital services to members who are hospitalized on the effective date of disenrollment (whether voluntary or in-voluntary) until they are discharged from the hospital. Hospitals not fully contracted for inpatient or related inpatient services are required to complete a Provider Payment Agreement before authorization and reimbursement can occur.

Registry of Unmet Needs

Trillium maintains a Registry of Unmet Needs to track requests for non-emergency services that have not been met through either state-funded or non-entitled Medicaid categories. The purpose of the Registry is to allow Trillium and providers to coordinate services for members/recipients. Inquiries about the registry of unmet needs can be sent to RUN@TrilliumNC.org.

Second Opinion

The right to a second opinion from a qualified health care professional within or outside the Trillium network, at no cost to the member. Upon request, Trillium shall provide one second opinion from a qualified health care professional selected by Trillium. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. Trillium shall not be required to provide the member with a third or fourth opinion.

Members are informed of the right to a second opinion in the Trillium Member and Family Handbook, which is made available to them at the time of enrollment.

Decisions to Deny/Reduce/Suspend/Terminate a Medicaid Service

It is very important that providers understand the following rights so they may support the member's request. A provider agency cannot appeal an action without the written consent of the member/parent/legal guardian to make the appeal on the member's behalf.

If the treating physician/practitioner/provider would like to discuss the case with the Trillium UM care manager or the physician/psychologist, referred to as a peer-to-peer conversation, please call the Administrative/Business Line at 1-866-998-2597.

There are times when a member's request for services is denied, and there are times when a current service is changed (i.e. terminated, reduced or suspended) by Trillium Utilization Management.

Detailed information about Due Process and Prior Approval Procedures can be accessed via the Division of Health Benefits (DHB) website. (See the [Resources & Web Links](#) section at the end of this Manual for website links.)

Denial

Denials could occur for administrative or clinical reasons. A clinical denial could occur if the criteria are not met to support a new authorization request for a service. An administrative denial could occur if a request is determined to be an incomplete request or due to lack of information.

If the request does not meet the minimum requirements of the applicable clinical coverage policy (i.e., fails to include a PCP/ISP/treatment plan or other specific documents required by policy, including CCA, NC SNAP, Psychological Testing, LOCUS®/CALOCUS®/ASAM, service orders) it is incomplete or lacks information and the request will be denied. A new request with the needed documentation may be submitted at any time.

The member/guardian will receive a letter by US Mail explaining the decision and how to request a Reconsideration Review. If a Notice of Adverse Benefit Determination for Incomplete Request/ Lack of Information is issued, the notice will identify what information was missing from the request.

Reduction, Suspension, or Termination

Services a member is currently authorized for and receiving may be reduced, suspended or terminated at any point during the authorization period based on several different factors including: not following clinical guidelines or not continuing to meet medical necessity for the frequency, amount, or duration of a service. A member/guardian or authorized representative will receive a letter by US Mail at least ten (10) days before the change occurs explaining how to request a reconsideration. If the member/guardian or authorized representative requests reconsideration by the deadline stated in the letter, the services may continue through the end of the original approved authorization.

This does not apply for the denial of an initial service request.

Medicaid Services Appeal—Level 1

Under The North Carolina MH/DD/SAS Health Plan 1915(b) and NC Innovations Waiver 1915(c), all persons who do not agree with Trillium's Notice of Adverse Benefit Determination on a request for Medicaid services are entitled to appeal through the Trillium appeal process. This process is referred to as Reconsideration in North Carolina. To begin the process, a request for reconsideration must be filed no later than 60 calendar days after the mailing date of the notice of adverse benefit determination.

To request an appeal, the the member/guardian/ authorized representative and/or the provider (acting with written consent) may file a request for an appeal orally or in writing. Trillium will acknowledge receipt of the appeal in writing via a letter to the appellant and will also notify the provider requesting the service.

Upon request, Trillium will provide the appellant/ authorized representative the case/reconsideration file, including medical records, and any other documents and records pursuant to Trillium's Member Access to Protected Health Information Procedure. Once an appellant/authorized representative has requested the case file, Trillium will also provide any new or additional evidence considered, relied upon, or generated by Trillium in connection with the appeal of the adverse benefit determination.

The information must be provided free of charge and sufficiently in advance of the resolution timeframe for the appeal.

A reconsideration review is a local impartial review of Trillium's decision to reduce, suspend, terminate or deny Medicaid services.

A health care professional who has appropriate clinical expertise in treating the member's condition or disorder, and who was not previously involved in the initial decision, determines the Reconsideration Decision.

Trillium will issue a decision in response to the Request for Reconsideration within thirty (30) calendar days from the receipt of the request.

The member/guardian/authorized representative must complete the local reconsideration process with the LME/MCO before requesting a hearing with the Department of Health and Human Services (DHHS) and Office of Administrative Hearings (OAH.)

Provision of Medicaid services during the appeal process:

- There is no maintenance of services as we know it under fee for service.
- If the initial request for service is denied, there are no services to be provided during the pendency of the appeal.
- If the concurrent request is terminated, the only services that the member/recipient can receive are those approved under the current authorization.
- If the authorization expires or all units are exhausted during the appeal process, no further services may be provided during the pendency of the appeal.

If the concurrent request is approved but the amount, duration, intensity is reduced (i.e., the service is approved but not at the level requested), the member/recipient can receive services at the rate previously authorized until the authorization expires or all the units are exhausted. Once that occurs and for the pendency of the appeal, the member can only receive the amount authorized by the MCO (the amount the service was reduced to by the MCO).

Trillium shall continue the service during the Reconsideration process and during the State Fair Hearing if all of the following are met:

- The Member files the request for an appeal timely in accordance with 42 C.F.R § 438.402 (c)(1)(ii) and (c)(2)(ii) Reconsideration is requested within 10 calendar days or the intended effective date of Trillium's proposed adverse benefit determination.
- The Reconsideration involves the termination, suspension, or reduction of a currently and previously authorized service.
- The service was ordered by an authorized provider.
- The period covered by the original authorization has not yet expired current service authorization has not expired. AND
- The member timely files for requests a continuation of benefits.

Timely files shall mean the member files for continuation of benefits on or before the later of the following:

- Within 10 calendar days of date of adverse benefit determination, or
- The intended effective date of the proposed adverse benefit determination

If requested, and services are reinstated during an appeal or State Fair Hearing, the service must continue until one of the following occurs:

- The member withdraws from the Reconsideration process or request for State Fair Hearing; or
- Ten calendar days after the Reconsideration decision is made, unless the member requests a State Fair Hearing within those 10 calendar days or the intended effective date of Trillium's proposed adverse benefit determination; or

- The State Fair Hearing decision is not in favor of the member; or
- The service authorization expires.

Steps to File a Reconsideration Request

To request an appeal, the member/guardian/authorized representative and/or the provider (acting with written consent) may file requests for appeals orally or in writing. When requested orally, the date of the oral filing establishes the filing date.

The date an oral filing request is made constitutes the filing date. Upon receipt of the reconsideration request, an acknowledgment letter will be sent to the member/guardian/authorized representative and provider agency.

Trillium ensures that punitive action is not taken against the network provider who either requests an expedited request or supports a member appeal.

Upon completion of the reconsideration decision, if the member/guardian disagrees with the Trillium decision, the member/guardian/authorized representative can then appeal the decision to both DHHS and OAH by filing a Request for Hearing, also known as the State Fair Hearing process.

A member, or a network provider that has been authorized in writing to act on the member's behalf, may file requests for appeals orally or in writing. When requested orally, the date of the oral filing establishes the filing date.

Expedited Reconsideration Review Process

An Expedited Reconsideration may be requested by the member/recipient/legally responsible person, an authorized representative, or a provider requesting on the recipient's behalf if it is documented that taking the time for a standard resolution could seriously jeopardize the recipient's life, health, or ability to attain, maintain, or regain maximum function.

Expedited Reconsideration requests may be filed orally or in writing with Trillium's Appeals Department. Oral requests for Expedited Reconsideration do not require written follow-up.

If an expedited request is received, it is reviewed to determine if there is sufficient evidence to support the need for this type of request. If so, a Reconsideration Review will be completed within 72 hours and the member will be notified of the decision.

If there is not sufficient evidence to require an expedited request, the member/guardian will receive verbal notice of the denial of their request for an expedited appeal and written notice within two (2) calendar days and the process will follow the standard appeal timelines. If the member/authorized representative or provider disagree with the decision, they have the right to file a grievance.

A member and/or their legal guardian or a provider may request an expedited reconsideration if failure to do so will jeopardize the member's health and safety. Trillium will inform the member and/or their legal guardian by phone if Trillium is in agreement that it is necessary for the request to be expedited.

Trillium will complete the expedited review within 72 hours of the request and inform the member and/or their legal guardian of the decision by phone. A written decision will be mailed to the member no more than 72 hours after that. This timeframe can be extended by up to fourteen (14) days at the member's request, or if Trillium determines that we need additional information and the extension would be in the member's best interest. If Trillium does not agree that the request should be expedited, the member will be notified in writing and can file a grievance if they disagree.

Extension of Timeframes for Expedited & Standard Reconsideration Requests

Trillium may extend the timeframes up to 14 calendar days if the member requests the extension; or Trillium shows that there is need for additional information and how the delay is in the member's best interest.

If Trillium extends the timeframes, for any extension not requested by the member, written notice of the reason for the delay will be provided to the member/ or authorized representative by Trillium within two (2) calendar days and inform the member the right to file a grievance if he or she disagrees with that decision.

Medicaid Services Appeal Mediation—Level 2

Once the appeal is processed, The Mediation Network of North Carolina will contact the member/guardian. If a member or the member's authorized representative is dissatisfied with the Resolution of the Reconsideration Request, the member or the member's authorized representative may file a petition for a case contested with the North Carolina Office of Administrative Hearings (OAH) and Trillium within 120 calendar days from the date of the Resolution of the Reconsideration Request by submitting the Petition for a Contested Case Form to the addresses specified on that form. A copy of the Petition for a Contested Case Form is attached to Resolution of the Reconsideration Request.

Once a petition for a contested case has been filed with OAH, the Mediation Network of North Carolina will contact the member or the member's authorized representative to offer an opportunity to mediate the disputed issues between the member and Trillium in an effort to resolve the pending petition informally. If the member or the member's authorized representative accepts mediation, it must be completed within 25 days of the petition's filing with OAH.

If all issues are resolved at mediation, the petition will be dismissed and services will be provided pursuant to the Mediation Agreement. If the member or the member's authorized representative does not accept the offer of mediation or the results of mediation, then the petition will proceed to a hearing and will be heard by an Administrative Law Judge (ALJ) with OAH. This is referred to as the State Fair Hearing Process.

This State-level hearing will be held by telephone, unless the member or the member's authorized representative specifically requests an in-person or videoconference hearing. The member or the member's authorized representative will receive notice of the date and time of the hearing.

For questions concerning the decision Trillium made about the member's request for Medicaid services, please contact Trillium at 1-866-998-2597. Should you have questions about the State Fair Hearing process, please contact [OAH](#) or Trillium.

North Carolina Office of Administrative Hearings (OAH)

Attn: Clerk
6714 Mail Service Center
Raleigh, NC 27699-6700
Telephone: 1-919-431-3000
Fax: 1-919-431-3100

Trillium Health Resources

Appeals Department
201 W. First Street
Greenville, NC 27858
Telephone: 1-866-998-2597
Fax: 1-252-215-6879

Medicaid Services Appeal—Level 3—Judicial Review

If the member or the member's authorized representative disagrees with the Final Agency Decision, they may seek judicial review in Superior Court.

If the final resolution of the Appeal is not decided in the member's/guardian's favor, (meaning the Trillium or DHHS action was upheld), Trillium may recover the cost of the services furnished to the member/guardian while the Appeal is pending.

Non-Medicaid Service Reconsideration Process

Non-Medicaid services are not an entitlement. If member/guardian disagrees with the Non-Medicaid Service Decision, she/he or authorized representative may fill out the Non-Medicaid Service Reconsideration Form that accompanies the decision and return it to the Trillium within 15 business days of the date of the non-certified notification letter.

Trillium acknowledges receipt of the appeal in writing via a letter to the appellant dated the next working day following receipt.

The Non-Medicaid Service Reconsideration process maintained by Trillium provides an opportunity for the member, guardian, and authorized representative, ordering/treating provider and/or facility rendering service to submit information related to the case, including any documents, records, written comments, or other information that may be helpful in processing the reconsideration.

Peer Reviewers who process the reconsideration consider all the information received from the member, guardian, and authorized representative, ordering/treating provider and/or facility rendering service, regardless of whether the information was presented during the initial clinical review.

Member/guardian/authorized representative will receive a Clinical Review Decision conducted by a health care professional that has appropriate clinical expertise in treating the member's condition or disorder within appropriate timeframes.

Timeframes for the reconsideration process, which are in accordance with the requirements of the NC Division of Mental Health/Developmental Disabilities/Substance Use Services (DMH/DD/SAS) and Trillium's external accrediting bodies are documented in Trillium policies and procedures and are available upon request to any member/guardian, provider or facility rendering service.

It can take up to (7) business days from the date the Non-Medicaid Service Reconsideration Form is received for a decision to be made by the LME/MCO. An expedited reconsideration may be requested by the member or legally responsible person if it is documented that taking the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain function. Expedited reconsideration requests may be filed orally or in writing. Oral requests for expedited reconsideration do not require written follow up. If an expedited request is received, it is reviewed to determine if there is sufficient evidence to support the need for this type of request. If so, a reconsideration review will be completed within 72 hours and the member will be notified of the decision.

The timeframe for processing the reconsideration begins at the date and time the request was received by Trillium.

If the reconsideration decision is to uphold the original non-certification, the written notification will explain that there is an opportunity to appeal the decision to the DMH/DD/SAS Hearing Office, Customer Service and Community Rights, as well as the process for doing so.

Non-Medicaid Appeal Request to DHHS

If recipient/guardian/authorized representative disagrees with the Non-Medicaid Service Decision, she/he may submit the Non-Medicaid Appeal Request Form to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

The internal Trillium State Funded Clinical Reconsideration process must be completed prior to filing the Appeal Request form with the Division. The DMH/DD/SAS hearing office must receive the recipient's appeal within 11 calendar days from the date on the Trillium Notice of Decision Request for Non Medicaid Services Denial.

The Non-Medicaid Appeal Request is reviewed by a panel of individuals designated by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (by DMH/DD/SAS.) The panel will issue their findings and decisions within 60 days of receipt of the Appeal Request form to both the recipient/guardian and Trillium's CEO.

Upon receipt of the panel's findings and decisions, Trillium will issue a final decision based on those recommendations in writing within ten (10) days. This decision is final and there are no further appeal rights.

Receiving Services during the Non-Medicaid Grievance Process

Trillium has the option of authorizing other Non-Medicaid Services that are appropriate. Services may be authorized for the duration of the Reconsideration Decision process at the discretion of Trillium.

Other community resources may also be referred to the recipient for support.

When a recipient/guardian/authorized representative files Reconsideration for the denial of a new service, Trillium is under no obligation to provide the requested service during the review process.

Your responsibility as a Trillium Contracted Provider is to:

Crisis Care & Service Enrollment

- Publish and make available the toll free Trillium Member Service Line for members and family members, along with the telephone number for the Disability Rights of North Carolina
- Cooperate fully with all investigative requests; refusal to comply with any grievance follow-up or investigation is a breach of contract
- Provide and comply with face-to-face emergency care within two (2) hours (Emergent Request) after a request for care is received by provider staff initiated by member; the provider must provide face-to-face emergency care immediately for life threatening emergencies
- Provide and comply with initial face-to-face assessments and/or treatment within 48 hours (Urgent Request) after the day and time a request for care is received by provider
- Provide and comply with initial face-to-face assessments and/or treatment within 10 calendar days (Routine Request) of the date a request for care is received by provider
- Provide return telephone calls within one hour, 24 hours a day, seven days a week
- Be responsive and comply with emergency referrals within one hour, 24-hours a day, seven days a week
- Maintain systems and procedures to ensure members with scheduled appointments are being seen within the required wait time of 60 minutes after the appointed meeting time
- Maintain systems and procedures to ensure members who walk in are being seen within the required wait time of two (2) hours after the arrival
- Submit Treatment Authorization Requests (TAR) with the proper clinical information at least 14 days prior to the end date of the current authorization to allow for Utilization Management activities and authorization prior to beginning services

- Submit Continuing TARs on a timely basis to allow for Utilization Management activities and authorization prior to beginning services. Emergency Authorizations are available, but should only be used when necessary to provide for member health, safety and wellbeing
- Submit an expedited request for emergency/acute care within 48 hours of admission
- Develop and implement policies and procedures for receiving and handling complaints and grievances
- Incorporate results of grievances or complaints into your internal QA/QI committee to assure systemic issues related to the complaint are being addressed
- Develop and implement a process to inform members/families of your policy and procedures on complaints
- Be responsive to complaints and cooperate fully with the LME/MCO in investigating and resolving complaints within timeframes established by the LME/MCO
- Provide to Trillium copies of supporting documentation and evidence regarding your agency's investigation (i.e., PCP's, service notes, service orders, etc.) as well as citations of statutes and rules pertinent to each allegation or complaint in order to resolve issues
- Comply with NC law (N.C.G.S. §122C-18) regarding retaliation against a person for complaining to a member advocate
- Ensure there are no barriers to treatment, system navigation is friendly, and the screening process is the same no matter where the member presents to be seen
- Maintain systems and procedures to screen and triage member needs—whether by phone or walk-in—and schedule that person for an appointment within required timeline
- Be as clear as possible in requests for information or services to enable our Call Center & Member Service Center to help you in the most efficient and effective way possible

Utilization Management

- Obtain authorizations as required for contracted services
- Ensure members/recipients meet medical necessity requirements for all services your agency provides
- Provide medically necessary covered services to members as per your contract and authorized by Trillium
- Comply with Trillium authorization requirements
- Document all services provided per Medicaid requirements, NC Waiver requirements and North Carolina State Rules
- Add service openings in the Registry of Unmet Needs available in Provider Direct; search for, review and place members who are appropriate for the vacancy based on the criteria entered
- Submit Treatment Authorization Requests (TAR) with the proper clinical information at least 14 days prior to the end date of the current authorization to allow for Utilization Management activities and authorization prior to beginning services
- Submit Continuing TARs on a timely basis to allow for Utilization Management activities and authorization prior to beginning services; Emergency Authorizations are available, but should only be used when necessary to provide for health, safety and wellbeing
- Submit an expedited request for emergency/acute care within 48 hours of admission
- Maintain services at an optimal level to meet member/recipient needs by providing services in accordance with Trillium's Clinical Practice Guidelines
- Participate actively in a person-centered planning process with others serving the member to develop a comprehensive Person-Centered Plan/ISP/treatment plan
- Development of treatment and/or rehabilitative programs that are in accordance with the Person-Centered Plan/ISP/treatment plan.

Care Management

- Comply with Trillium Care Managers requirements
- Work with Trillium to ensure a smooth transfer for any members who desire to change providers, or when you need to discharge a member because you cannot meet his/her special needs
- Communicate with the care coordinator about the needs of members that you support
- Notify the care coordinator of any changes, incidents, other information of significance related to the member supported
- Ensure that members are appropriately linked to primary health care
- Assist with referrals to natural and community supports
- Follow-up with a phone call whenever a member who is considered a high risk member misses an urgent or emergent appointment; send a letter if unable to contact the member by phone and document within the member's chart all attempts to reach member
- Contact Trillium Care Managers whenever an individual receiving Care Management misses two appointments
- Contact Trillium Care Managers for members on an outpatient commitment order who fail to keep any appointment
- Educate members on Medicaid transportation

Trillium's responsibility to providers is to:

- Provide accurate and timely response to TARs
 - 14 calendar days for a routine request
 - 72 hours for an expedited request
- Ensure members/recipients receive medically necessary services
- Ensure members/recipients who need a service are listed in the system
- Inform providers of members/recipients receiving care management
- Complete telephonic or on-site visits to monitor the health and safety of the members/recipients receiving care management
- Assess the satisfaction of members/recipients served
- Monitor implementation of the Individual Support Plan (ISP) or Person-Centered Plan (PCP)
- Communicate with providers on any additional assessments needed
- Develop and share ISPs; communicate any recommendations for development or revisions on the PCP/ISP/treatment plan
- Educate members/recipients receiving care management on Medicaid transportation
- Share natural and community resources for referrals and linking



GETTING PAID

FINANCE & CLAIMS DEPARTMENTS

The Finance Department manages the financial resources of the LME/MCO. This includes management of fund sources and provider payment, ensuring compliance with General Statute 159 (The Local Government Fiscal Control Act) and other general accounting requirements. All providers are required to participate in Direct Deposit. The Claims Department supports providers with claims submission training and questions through its Claims Specialists.

If you do not know who your Claims Specialist is, you can refer to the [Trillium Claims Caseload Provider Split](#) found on our website under [Provider Documents](#).

All Trillium claims are submitted electronically. Providers can send standard HIPAA compliant transaction sets, or use the Trillium web-based billing system and enter their claims directly or submit through one of Trillium's contracted clearinghouses.

ENROLLMENT AND ELIGIBILITY PROCESS

Eligibility Determination

Members who have their services paid for in whole or in part by Trillium must be enrolled in the Trillium system. Assistance is available in Provider Direct (PD) using Trillium Enrollment documentation. If you have any questions about a member's eligibility, please contact Trillium.

Members who are at 100% ability to pay according to the sliding fee schedule established by the provider or who have insurance coverage that pays 100% of their services, must not be enrolled in the Trillium system. However, the person may still receive and pay for services from a provider independent of Trillium involvement.

It is the responsibility of each provider to make a complete and thorough investigation of a member's ability to pay prior to requesting to enroll that person into the Trillium system.

This would require that the provider check for the following:

- Determine if the member has Medicaid or whether the member may be eligible for Medicaid.
- Determine if the member has Medicare or any other third party insurance coverage.
- Determine if there is any other payer involved—worker's compensation, EAP program, court ordered services paid for by the court, etc.
- Determine if the member meets Trillium criteria for use of Local or State Funds to pay for services. The criteria will be the lack of Medicaid or other third party insurance and the inability of the member or family to pay for a portion of healthcare services based on the sliding fee schedule established by the provider.
- Determine if the member has already been enrolled in the Trillium system.

If the individual has Medicaid or has already been enrolled in the Trillium system, she/he is financially eligible for Medicaid reimbursable services from Trillium. If they are not yet enrolled, then the provider must provide the data necessary to enroll the member. Enrollment can be performed electronically through the Provider Direct system or by contacting Trillium.

Providers should assist members who may be eligible for Medicaid funding in applying for Medicaid through their county Department of Social Services.

Key Data to Capture during Enrollment

All providers are required to ensure enrollment data is up-to-date based on the most current Trillium Enrollment Procedures and training.

Training documentation is found by logging into Provider Direct and clicking on the Training Materials link.

Submission of authorizations and claims prior to completing enrollment data will result in denials of authorizations and claims.

Third party insurance, including Medicare, must be included in the enrollment request. Medicaid members whose services will be paid in part by third party insurance can be enrolled if Trillium is to be a secondary payor.

Effective Date of Enrollment

Enrollment in the Trillium system must be done prior to providing services except in emergency situations. It is the Provider's responsibility to complete the eligibility determination process, including verification of previous enrollment in the Trillium system and to complete the enrollment process prior to providing services. Events with service dates prior to an enrollment date will be denied.

Crisis services provided in an emergency situation are an exception to this rule. In these cases, the provider must enroll the member within seven (7) days and indicate the date of enrollment as the date that the emergency services were provided.

Member ID

The Member ID Number identifies the specific member receiving the service and is assigned by the Trillium information system. The member must be enrolled in the Trillium system to obtain this number. All claims submitted with incorrect Member ID numbers or for members whose enrollment is no longer active will be denied.

Eligibility Determination Process by Provider

Providers should conduct a comprehensive eligibility determination process whenever a member enters the delivery system. Periodically (no less than every 90 days), the provider should update eligibility information to determine if there are any first or third party payors for this member by completing a Client Update in the Provider Direct system. It is the provider's responsibility to monitor this information and to adjust billing accordingly.

Obligation to Collect

Providers must make good faith efforts to collect all first and third party funds prior to billing Trillium. First party charges must be shown on the claim whether they were collected or not. The Trillium Claims Processing System has the ability to validate third party payors and can deny or adjust the claim.

Reporting of Third Party Payments

Providers must bill any third party insurance coverage. This includes worker's compensation, Medicare, EAP programs, etc.

Providers are required to record on the claim either the payment or denial information from a third party payor. Copies of the Electronic Remittance Advice (ERA) or Explanation of Benefits (EOB) from the insurance company should be retained by the provider if they submit electronic billing. If paper claims are submitted to Trillium, the provider is required to submit copies of the ERA or EOB with the claim form to Trillium.

If an insurance company pays after a claim has been submitted to Trillium, the provider must notify and reimburse Trillium by submitting a replacement claim to reflect payment made by the third party insurance.

Process to Modify

If there are known changes to the member's income or family status, the provider is required to update records and adjust the payment amount based on the sliding fee schedule established by the provider. Members who become Medicaid eligible are not subject to sliding fee schedules for Medicaid covered services and payments should be adjusted immediately when this is determined.

At least on a quarterly basis (90 days), the member's/recipient's ability to pay should be verified and adjustments made by completing a Client Update in the Provider Direct system as necessary.

The sliding fee schedules are managed by providers and first party liability must be reported on claims. This compliance issue will be audited.

Sliding Fee Schedules

Eligibility for Benefit Determination

All members/recipients must be evaluated at the time of enrollment on their ability to pay. This determination should be updated at least every 90 days to ensure compliance with the sliding fee schedule established by the provider.

Process to Establish the Sliding Fee

Prior to being entered in the Trillium system, each member/recipient must have completed the financial eligibility process to establish any third party coverage and to establish the ability to pay for services. The combination of a member's adjusted gross monthly income and the number of dependents determines the payment amount based on the sliding fee schedule established by the provider.

Medicaid members are not subject to sliding fee schedules for services paid for by Medicaid.

If a person does not qualify for the sliding fee schedule established by the provider, she/he should pay 100% of the services being provided. In this case, the person should not be enrolled in the Trillium system and claims should not be submitted to Trillium for reimbursement.

AUTHORIZATIONS REQUIRED FOR PAYMENT

System Edits

The Trillium information system is specifically designed to look for authorization data prior to paying claims. It has edits that are verified; therefore, the provider must be very attentive to what has been authorized to ensure maximum reimbursement.

Authorization Number and Effective Dates

Each authorization will have a unique number, a start date, and an end date. Only services with dates of service within these specific time frames will be paid. Dates and/or units outside these parameters will be denied.

Service Categories or Specific Services

Each authorization will indicate specific categories of services or in some cases very specific services that have been authorized. Each service will be validated against the authorization to make sure that the service matches the authorization. Services that are outside of these parameters will be denied.

Units of Service

Each authorization will indicate the maximum number of units of service that are being authorized. As each claim is being processed, the system will check to make sure that the units being claimed fall within the units of services authorized. The system will deny any claims that exceed the limits.

Providers need to establish internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.

Exceptions to Authorization Rule

There are certain services that will be paid without an authorization. These services are limited in scope and are limited in total number to a member, not to a provider. Once the annual limit has been reached for a member, then all services without an authorization, regardless of the provider of the service, will be denied. Providers must be constantly aware of this issue in order to avoid denied claims.

CLEAN CLAIMS

A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. The term includes a claim with errors originating in the LME/MCO's claims system. The term does not include a claim from a provider who is under investigation by a governmental agency for fraud or abuse, or a claim under review for medical necessity. A clean claim must meet timely filing guidelines.

Service Codes and Rates–Contract Provisions

All providers are reimbursed for approved services provided at the Trillium published rates unless otherwise stated in their contract. Providers must only use the service codes in their contract or reimbursement will be denied as non-contracted services. Providers can submit claims for more than the published rates, but only the published or contracted rate will be paid. If a provider submits a service claim for less than the published rate, the lower rate will be paid. It is the provider's responsibility to monitor the publishing of rates and to make the necessary changes to their billing systems.

Providers will need to comply with their contract for billable CPT/HCPCS/Revenue Codes, Modifiers, Diagnosis codes and Place of Service codes.

Refer to the Trillium Website for the following:

- [Rate Table](#)

Trillium follows payment policies and applies edits based on guidelines from sources that may include, but not limited to:

- Center for Medicare & Medical Services' (CMS)
- National Correct Coding Initiative (NCCI) for professional and facility claims
- CMS Claims Processing Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates
- CMS coding resources (National Physician Fee Schedule, Provider Benefit Manual, Claim Processing Manual, MLN Matters and Provider Transmittals)
- AMA resources
- State-specific policies and procedures for billing professional and facility claims
- National Uniform Billing Code (NUBC)
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Disease (ICD)

Payment of Claims and Claims Inquiries

Providers must submit claims through Provider Direct or submit an electronic 837 file unless their contract specifically states an alternative method. Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule. The [Claims Request Form](#) may be submitted for the following:

Timeframes for Submission of Claims

All claims must be submitted within 90 days of the date of service to ensure payment, unless otherwise specified in provider's contract. Claims submitted outside of the allowable billing days will be denied. Providers must notify the Trillium Claims Department in writing if they anticipate not being able to meet this guideline.

Other general rules to follow include:

Formats

NC Innovations Services, Outpatient Therapy, Residential (state-funded) and other daily and periodic services must be submitted using the ANSI 837P (Professional) format or the electronic CMS 1500 form if billing through the Provider Direct system.

Inpatient, Therapeutic Leave, Residential Services (Medicaid-funded), Outpatient Revenue Codes and ICF Services must be submitted using the ANSI 837I (Institutional) format or the electronic UB04 form if billing through the Provider Direct system.

Multiple Occurrences of Same Service in a Day

When a specific service is rendered multiple times in a single day, the service must be combined and billed using multiple units rather than separate line items. This will prevent a duplicate billing denial.

Authorization

As described in the authorization section of this Manual, authorizations are for specific members, providers, types of services, date ranges, and for a set number of units. Providers are responsible for maintaining internal controls within their information systems to avoid a denial due to inconsistency with the authorization

NPI (National Provider Identifier)

Providers are required to obtain an NPI number to submit billing on the CMS1500 and UB04 forms. The NPI number and taxonomy code are required for claims to be accepted and processed. Failure to comply with these guidelines will result in denied billing.

Verification and Notification

Trillium provides the following responses to ensure that electronic 837 billing is accepted into the Trillium system for processing and payment:

- 999 X12 File—This file acknowledges receipt of the 837 billing file.
- 824 X12 File—This file provides feedback regarding whether line items in the 837 file have been accepted or rejected. If the line item has been rejected a detailed explanation will be provided.

These files are available in the File Repository option of the Provider Direct system. It is the provider's responsibility to review these responses to verify billing has been accepted for processing so reimbursement is not interrupted due to file formatting issues.

Provider Direct Claims Submission

Providers are contractually required to submit billing electronically. Provider Direct is a web-based system available to Trillium providers upon completion of a Trading Partner Agreement (TPA.)

Billing through the Provider Direct system is Direct Data Entry (DDE) where an electronic CMS1500 or UB04 form is accessed and billing information is entered and submitted to Trillium for reimbursement. Provider Direct Webinars are available in the Provider Direct Module to assist with completing a CMS1500 and UB04 claim form.

837 Claims Submission

Detailed instructions are provided in the Companion Guide, a user manual for electronic 837 submissions. The Companion Guide gives very specific instructions on what is required to submit claims electronically to Trillium. The entire testing and approval process is covered in this document.

The HIPAA compliant ANSI transactions are standardized; however each payer has the ability to exercise certain options and to insist on use of specific loops or segments. The purpose of the Companion Guide is to clarify those choices and requirements so providers can submit accurate HIPAA transactions.

Trillium will accept only HIPAA compliant transactions as required by law. Trillium provides the following HIPAA transaction files back to providers: 999 (an acknowledgment receipt) 824 (a line by line acceptance/rejection response), and 835 (an electronic version of the remittance advice).

Process for Submission of Replacement Paid Claims

Providers may submit replacement claims for originally paid claims. Billing days for a replacement claim is 180 calendar days from the date of service. Claims submitted past 180 calendar days from the service date will be denied for exceeding billing days and cannot be resubmitted.

Once a replacement claim has been received, your original claim will deny and the replacement claim will be processed according to all Trillium billing guidelines.

Process for Submission of Voided Paid Claims

Providers may submit voided claims for originally paid claims. Voided claims will be reverted from our system and the original claim payment will be recouped.

Process for Submission of Replacement for Denied Claims

Providers may resubmit replacement claims for originally denied claims. Billing days for a replacement claim is 180 days from the service date, providing the original claim was submitted within 90 days from the service date. Claims submitted past 180 calendar days from the service date will be denied for exceeding billing days and cannot be resubmitted.

The process for submitting replacement, voided and denied claims can be found on the Trillium website.

Providers Who Submit Paper Claims

Trillium will accept paper claims from non-network providers only. Non-network providers will be required to submit an accurate CMS1500 or UB04 billing form with the correct data elements.

A remittance advice will be provided by Trillium explaining payments and/or denials. Inquiries regarding the status of claims should be directed to the Trillium Claims Specialists.

RESPONSE TO CLAIMS

Remittance Advice

The Remittance Advice is Trillium's way of communicating back to the provider network exactly how each and every service has been adjudicated. Trillium provides the Remittance Advice in the form of Adobe Acrobat (*.PDF) files. The Remittance Advice can be accessed through Provider Direct under the File Repository.

Electronic Remittance Advice (835)—for 837 Providers

HIPAA regulations require payors to supply providers with an electronic Remittance Advice known as the 835. The 835 will report electronically the claims status and payment information. This file is used by the provider's information system staff or vendor to automatically post payments and adjustment activity to their member accounts. This allows providers the ability to manage and monitor their accounts receivables.

Accounts Receivable Management

Providers must take full responsibility for the management of their member accounts receivables. Trillium produces Remittance Advices based on the current [check write schedule](#). Trillium produces a weekly claims status report in an Excel document format of cumulative processed claims for the current fiscal year.

Providers may select, sort and manage their billings, payments and denials. This file can be accessed through the provider's download file folder in Provider Direct.



CLAIMS INVESTIGATIONS– QUESTIONABLE BUSINESS PRACTICES

Trends of Use and Potential Fraud

One of the primary responsibilities of Trillium will be to monitor the provider network for fraud and abuse. Both the Medicaid and State contracts make Trillium responsible for monitoring and conducting periodic audits to ensure compliance with all Federal and State laws and in particular the Medicare/Medicaid Fraud and Abuse laws. Specifically, Trillium will need to validate the presence of material information to support billing of services consistent with Medicaid and State regulations.

Trillium will systematically monitor the paid claims data to look for trends or patterns of abuse.

Audit Process

Trillium has the responsibility to ensure that funds are being used for the appropriate level and intensity of services as well as in compliance with Federal, State, and general accounting rules. The Trillium Provider Integrity (PI) Unit is responsible for billing audits for all contract providers.

Role of Finance Department

The Finance Department will assist the PI Unit with the review of financial reports, financial statements, and accounting procedures. The Finance Department will work with the Monitoring audit team and provider in the collection of any determined paybacks.

Voluntary Repayment of Claims

It is the provider's responsibility to notify Trillium in writing of any claims billed in error that will require repayment. To refund a claim to Trillium, the provider should complete either a replacement claim or void the claim. The adjustment will process and will appear on the next Remittance Advice. [Instructions](#) on how to complete an adjustment/void can be found in the Provider Documents and Forms section under For Providers on Trillium's website.

Reporting to State and Federal Authorities

For each case of reasonably substantiated suspected provider fraud and abuse, Trillium is obligated to provide DHB with the provider's name and number, the source of the complaint, the type of provider, the nature of the complaint, the approximate range of dollars involved and the legal and administrative disposition of the case.

REPAYMENT PROCESS/PAYBACKS

The Finance Department is responsible for the recovery of funds based on any audit findings.

If Trillium determines a provider has:

- Failed to comply with State, Federal, Medicaid or any other revenue source requirements; or
- Been paid for a service or a portion of a service that should have been disallowed; or
- Been paid for a claim that was fraudulently billed, then

Trillium will recoup the amount owed from current and/or future claims. If payback amount exceeds outstanding provider claims, Trillium will invoice the provider the amount owed. The provider shall have 30 calendar days from the invoice date to pay back the total amount owed. Fraudulent billing may include, but is not limited to, unbundling services, billing for services by non-credentialed or non-licensed staff, or billing for a service the provider never rendered or for which documentation is absent or inadequate.

Your responsibility as a Trillium contracted provider is to:

- Verify member insurance coverage at the time of referral/admission or each appointment; and on a quarterly basis
- Determine the member's ability to pay using your agency's sliding fee schedule for all designated non-Medicaid services based on your agency's contract requirements
- Bill all first and third party payers prior to submitting claims to Trillium
- Report all first party required fees and third party payments and denials on the claim

- Submit clean claims electronically within 90 calendar days of the service date, unless otherwise stated in your contract
- Ensure all billing submitted for payment is supported by documentation meeting all requirements for billing a service
- Identify all billing errors to the Trillium Claims Department
- Self-initiate paybacks for services billed in error or without supporting documentation
- Manage your agency's Accounts Receivable
- Submit all documentation which is required for federal, state, or grant reporting requirements; this includes, but is not limited to, required enrollment demographics that must be reported to the State of North Carolina by Trillium
- Issue payments and Remittance Advices (RAs) on paid and denied claims
- Recover funds based on audit findings
- Audit providers for coordination of benefits
- Investigate and respond to member grievances and complaints related to provider services
- Review provider's documentation of complaints, grievances and their resolutions and to ensure providers incorporate these complaints into their QA/QI process
- Determine when complaints should be forwarded to provider network for an investigation
- Determine if complaints are substantiated, partially substantiated, unsubstantiated, resolved or unresolved
- Ensure timeframes for scheduling member/recipient appointments are in compliance
- Ensure provider agencies are in compliance with the "no wrong door" policy
- Ensure providers do not take adverse actions against real or suspected complainant(s) and to clearly understand this activity will be acted upon by the LME/MCO accordingly
- Notify complainant and provider who disagrees with the results of the LME/MCO action on complaints their appeal rights
- Ensure complaints related to licensed facilities, use, neglect and exploitation, etc., are reported to the appropriate agencies, local Department of Social Services (DSS), Division of Health Service Regulations (DHSR), local police department, etc.

Trillium's responsibility to providers is to:

- Certify funding for all contracts in accordance with N.C.G.S. 159
- Review and approve all financial commitments made by Trillium
- Assign and monitor maximum funding for contracts
- Notify providers, at least 30 calendar days in advance, of any changes in fee schedules or contract provisions
- Monitor grant funds
- Monitor retroactive Medicaid eligibility and recovery of funds
- Manage claims processing and pay clean claims within prompt pay guidelines



QUALITY MANAGEMENT

Trillium's Quality Assessment and Performance Improvement (QAPI) Program is the foundation of Quality Management throughout Trillium. The QAPI was developed to align with the critical needs of our population and meet the requirements as set forth by NCDHHS. Trillium seeks to improve health outcomes for Medicaid members/State-funded Recipients (members) by focusing on rigorous and well-defined outcomes measurements, promoting health outcomes for all diverse populations we serve through reduction or elimination of health disparities, and rewarding providers for advancing quality goals. Our QAPI Program addresses the integrated health needs of our members with the goal of improving access to care and meeting the needs of all members, regardless of age or health condition.

In alignment with NC's quality strategies, the overarching purpose of Trillium's QAPI Program is focused on whole person-centered care that supports:

- Better care delivery and improved Member experience
- Healthier people, healthier communities
- Improved provider experience
- Smarter spending

Within the organization, quality assurance is used as the foundation for quality improvement and provides information in guiding the improvement process.

Information from quality improvement activities is utilized as a platform for data reporting and analysis and provides the opportunity for organizational planning and informed decision-making. Quality improvement within the organization not only focuses on adhering to standards and statutory requirements, but also serves as the mechanism for emphasizing the agency's commitment to excellence.

In a system driven by continuous quality improvement, the QAPI Program facilitates the objective and systematic measurement, monitoring, and evaluation of internal organizational processes as well as services delivered by network providers. Quality improvement activities are implemented as a result of the findings from these activities and measured periodically for intervention effectiveness.

The QM Department makes training available to the provider network. Trillium is committed to working in collaboration with providers to aide and assist them with achieving the highest standards of quality in service delivery. The important role of quality management in protecting members and promoting high-quality treatment is understood and valued. A strong commitment to continual improvement of programs and services, as well as the services provided directly to members is maintained. Trillium providers are required to maintain a Quality Management Program that is comprehensive and proactive. The areas identified below provide a description of how the Trillium Health Resources QM Department interfaces with the providers in the network. Trillium communicates activities and outcomes of its QAPI Program to members and providers/practitioners through Trillium's website. The QAPI Plan describes an in-depth overview of the [QAPI Program and agency quality management activities](#).

QM INDICATORS

Trillium is required to comply with numerous quality, satisfaction, performance indicator and financial reporting requirements under our DHB and DMH/DD/SAS contracts, including requirements to measure and report indicators. Trillium provides ongoing monitoring of Healthcare Effectiveness Data and Information Set (HEDIS) measures and key performance indicators (KPIs) to assure practitioners and providers are meeting and maintaining identified performance benchmarks.

In addition, Trillium's role as an LME/MCO is to monitor the performance of providers in its network. QM is responsible for monitoring provider incident reports, reviewing provider quality improvement activities, administering surveys, policy and procedure management and tracking, facilitating root cause analyses, collaborating internally on accreditation standards and various other projects and tasks.

It is expected that network providers perform continual self-assessment of services and operations, as well as develop and implement plans to improve member outcomes. The continual self-assessment of services and operations, as well as the development and implementation of plans to improve outcomes to members, is a value and requirement for all network providers. The assessment of need as well as the determination of areas for improvement should be based on valid and reliable data.

Providers are required to follow all Quality Assurance and Improvement standards outlined in North Carolina Administrative Code as well as the provider contract and provider manual.

The Informatics Team within the IT Department leads the analytic function for support of the continuous quality improvement efforts of the agency and for discerning opportunities for identifying and responding to areas of operational need. Included in this is the implementation of drill down analytics which provides the opportunity to discover disparities in quality metrics and to understand variation in quality across various venues of performance. These investigative analytics lead to an understanding of what is driving gaps in services and aid in identifying areas for improvements in order to enhance the overall quality of care for Trillium members/recipients.

Trillium uses the information discovered to guide policy decisions and annual improvement goals.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used set of performance measures in managed care. HEDIS measures related to behavioral health, physical health and pharmacy data are monitored on a routine basis to ensure the identified benchmarks are being met. Trillium uses the information discovered to guide policy decisions and annual improvement goals.

Data is shared with providers on a routine basis. Trillium will utilize dashboards and reports to monitor measures internally and externally with providers to identify areas for improvement and appropriate interventions.

INCIDENT REPORTING, MEMBER HEALTH AND SAFETY, QUALITY OF CARE

Member health and safety along with Quality of Care are priorities for Trillium. Monitoring and promoting member health and safety is integrated throughout many activities, including incident reporting. Incidents and potential quality of care concerns are tracked and monitored for trends, areas needing immediate attention or opportunities for improvement.

Providers of publicly funded services licensed under NC General Statutes 122C, AND providers of publicly funded non-licensed, periodic mental health, developmental disabilities and/or substance abuse services are required to complete and report incidents for members receiving mental health, developmental disabilities and/or substance abuse services. Private independent practitioners, clinicians, and hospitals are not required to report through the Incident Response Improvement System (IRIS) system, as they follow their own reporting guidelines. These reports must not be filed in the member record, but must be filed on site for review during any type of local monitoring by the LME/MCO.

As part of its quality management process, it is important for the provider to implement procedures that ensure the review, investigation and follow up for each incident that occurs through its own internal Quality Management process.

This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns
- Strategies aimed at the reduction/elimination of trends and patterns
- Documentation of the efforts of improvement as well as an evaluation of ongoing progress
- Mandatory reporting requirements are followed
- Enter Level II and III incidents into the state's Incident Response Improvement System (IRIS)

There are specific state laws governing the reporting of abuse, neglect or exploitation of members. It is important that the provider's procedures include all of these requirements. If a report alleges the involvement of a provider's staff in an incident of abuse, neglect or exploitation, the provider must ensure that members/recipients are protected from involvement with that staff person until the allegation is substantiated or unsubstantiated. The provider must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated.

Trillium is required to monitor certain types of incidents that occur with providers in its network, as well as providers who, while not in Trillium's network, operate services in one of the counties Trillium covers.

Regulations regarding LME/MCO monitoring and the classification of incidents (Level I, II, or III) as well as requirements related to the submission of incident reports to home and host LME/MCOs and state agencies can be located in North Carolina Administrative Code. Trillium is required to monitor the state IRIS system. QM staff review all incidents when received by Trillium for completeness, appropriateness of interventions, achievement of short and long term follow up both for the individual member, as well as the provider's service system. If questions/concerns are noted when reviewing the incident report, the Quality Management Coordinator will work with the provider to resolve them. If issues/concerns are raised related to member care, services, or the provider's response to an incident, QM staff may elect to refer the concerns to the Network Department to further investigate. On a daily basis, QM staff track and report specific category types of Level II and III incidents. This information is shared within Trillium to assess if there is any immediate action needed due to health and safety concerns.

Providers that fail to report incidents as required by Administrative Rule and the provider contract may be required to complete a Plan of Correction.

An incident is any happening which is not consistent with the routine operation of a facility or service or the routine care of a member and that is likely to lead to adverse effects upon a member. There are three levels of response to incidents (Level I, Level II, Level III) based on the potential or actual severity of the event.

It is strongly encouraged that each provider read the instructions manual available on NC DHHS, [NC Incident Response Improvement System \(IRIS\)](#) for further information and clarification. In addition, Trillium has provided an in-depth training related to IRIS and Incident Reporting that can be located on Trillium's "My Learning Campus". Trillium's QM Department will provide additional training as needed and when there are changes to any guidelines or processes.



Level I Incidents

These incidents are events that, in isolated numbers, do not significantly threaten the health or safety of an individual, but could indicate systematic problems if they occur frequently, Level I Incidents require routine care. Level I incidents should be reported to the appropriate clinical staff involved in the care of the individual. These reports must not be filed in the record, but must be filed on site for review during local monitoring.

Level II Incidents

These incidents are a threat to health or safety or a threat to the health or safety of others due to:

- **Death:** Terminal illness or other natural cause (must be listed as such on a Death Certificate or member is receiving hospice).
- **Restrictive Intervention:** Any emergency, unplanned use or planned use of restrictive intervention that exceeds authorized limits, is administered by an unauthorized person or results in discomfort, complaint or requires medical treatment Consumer Injury: Any injury that requires treatment by a medical professional beyond First Aid. Car Accidents that occur while member is receiving services from the provider.
- **Abuse/Neglect/Exploitation:** Any allegation of abuse by family, peers, or strangers that requires a report to law enforcement and/or DSS.
- **Medication Error:** Error that threatens an individual's health or safety, as determined by a physician and/or pharmacist.
- **Consumer Behavior:** Suicidal behavior not resulting in death or permanent damage; Inappropriate sexual behavior, Aggressive behavior, Destructive behavior and/or Illegal behavior involving a report to law enforcement or complaint to an oversight agency; and Consumer Absence greater than 3 hours or requiring police contact.
- **Suspension:** Any provider withdrawal of services for one day or more due to the member's/recipient's misconduct.

- **Expulsion:** Any permanent provider withdrawal of services due to the member's misconduct.
- **Fire:** Threatens health or safety of the member/recipient or others.

These reports are to be entered into the IRIS website within seventy two (72) hours of the learned incident. These incidents must also be reported to the appropriate clinical staff involved in the care of the member.

These reports must not be filed in the member's record, but must be able to access for review during local monitoring.

Level III Incidents

These incidents are defined as any happening, which is not consistent with the routine operation of a facility or service or the routine care, that is likely to lead to adverse effect and result in:

- Death, sexual assault or permanent physical impairment or psychological impairment to a member/recipient, or caused by a member/recipient;
- A substantial risk of death or permanent physical impairment or psychological impairment to a member/recipient or caused by a member/recipient, or
- A threat caused by a member to a person's safety
- An allegation of Abuse/Neglect/Exploitation by a provider staff member,
- A report to the media.

For Level III incidents, the provider must verbally notify Trillium within twenty four (24) hours and must enter a report in IRIS within seventy two (72) hours of the learned incident. Deaths within seven (7) days of a restrictive intervention must be reported verbally and entered into IRIS immediately.

For Level III incidents that occur while the member/recipient is receiving a service or that occurred on the provider's premises, the provider must convene an Internal Review Team within 24 hours of the incident. Trillium requires all Network Providers to have a process in place enabling them to identify when a Level III incident has occurred and how to conduct a detailed investigation of the event/incident.

The internal review team shall review the member/recipient record, gather additional information if needed, and enter a report in IRIS concerning the incident and notify any other authorities required by law (DSS, law enforcement, DJJ, etc.). The report North Carolina Health Care Personnel Registry (for allegations against staff) is completed through IRIS and must be entered within 24 hours of learning of the incident. The provider must resubmit the IRIS report within 5 working days regarding the results of their investigation. Trillium monitors the provider's progress to ensure that the above process is being adequately implemented.

These reports must not be filed in the member/recipient record, but must be filed on site for review during monitoring visits.

Restrictive Interventions

There are two types of restrictive interventions:

Planned Interventions

- If there is a therapeutic need for a member/recipient to have hands on intervention or other rights' restrictions as ongoing interventions (4 or more incidents within 30 days), it must be included as an addendum to the person centered plan. This addendum must be signed by a PhD psychologist or MD in addition to the person centered plan.
- It is also required to have the provider's Human Rights Committee and guardian approval prior to implementation. These restrictive intervention plans may be requested by Trillium staff for submission and review.
- If the member/recipient has a planned intervention as part of their documented treatment plan and they are not injured during the intervention then this is considered a Level I incident. It is the expectation that these Level I incidents be reported to the appropriate clinical staff.

Emergency Interventions—Emergency interventions are those interventions that are:

- Not planned, are not part of the person-centered plan and have not been approved for use by a Human Rights Committee;
- Planned, but administered improperly or without proper authorization, by staff without proper training, or for longer than the authorized time;
- Planned, but resulting in discomfort, complaint, death or injury requiring treatment by a licensed health professional.

Emergency Interventions are considered level II incidents and must be reported within seventy-two (72) hours of the incident via IRIS.

Restrictive Interventions Reporting Requirements in a PRTF Setting

All restrictive interventions that occur in a Psychiatric Residential Treatment Facility (PRTF) are not considered planned interventions even with an approved behavior plan. PRTFs are prohibited from using any standing, "as-needed" or "PRN" order for restraint or seclusion. Therefore, all restrictive interventions in a PRTF setting are considered emergency interventions and are required to be entered into the IRIS system.

Back-Up Staffing Reports—Providers are required to submit back-up staffing reports for all Innovations members when there is a deviation in the member's staff coverage schedule. "Failure to Provide Back-Up Staffing" forms must be completed when back-up staffing is not available or when back up-staffing is offered but declined by the member/guardian. Please note that service breaks do not require back-up staffing reports; service breaks are defined as holidays, family vacations, weather conditions, illnesses, and scheduling conflicts. The reports must be submitted to Trillium bi-monthly. Hours missed from the first to the 16th of the month are due by the 22nd of that month. Hours missed from the 15th to the end of the month are due by the 7th of the following month. Reports must be submitted to the Quality Management Department at IncidentReporting@TrilliumNC.org, or via fax at 252-215-6880.

QM 11—In Subsection (e) of Rule 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers, Category A (licensed) and Category B (non-licensed) providers are required to report a summary of Level I, II and III incidents to the LME-MCO each quarter on the QM-11 Form. Trillium requested a waiver of this requirement. Therefore, Providers do not have to complete the QM11 reports. The QM11 report requirement has been waived until 12/31/21.

CONTINUOUS QUALITY IMPROVEMENT

The QM department supports a global continuous quality improvement model that includes all network providers and practitioners. Continuous Quality Improvement (CQI) activities are designed to promote the highest quality care for physical health, behavioral health, intellectual and/or developmental disabilities, traumatic brain injury, and Long Term Services and Supports needs. Trillium's QAPI Program takes a data driven, outcomes based approach to quality. Quality Improvement initiatives are designed to provide support to practitioners/providers to achieve quality goals at the regional and practice level.

The QAPI Program promotes objective and systemic measurement, monitoring, evaluation and improvement of whole person care and services.

At its core, QI is a team process. It is the responsibility of each individual to be an active and contributing member of the team. Each member participating on a workgroup, committee, or as part of a team, brings a unique perspective to the process; i.e., how things work; what happens when changes are made, and how to sustain improvements during daily work. Focus is on the team component of the principles because as an organization we are all interdependent.

Data is an important cornerstone of quality improvement. Data is used to describe how well current systems are working; what happens when changes are applied, and to document successful performance.

PDSA, which stands for plan, do, study, act, is a continuous quality improvement process used as a framework for problem solving and performance improvement. PDSA is a four-step process for carrying out change that is utilized by Trillium. Just as a circle has no end, the PDSA cycle should be repeated again and again for continuous improvement.

The Plan-Do-Study-Act Process:

1. **Plan:** Recognize an opportunity, identify a project and plan a change.
2. **Do:** Gather data to test the change. Carry out a small-scale study.
3. **Study:** Review the test, analyze and study the data, and identify what you've learned. Determine if performance goals were met or not. If they were met, move to the final phase.
4. **Act:** Take action based on what you learned in the study step. If the change did not work, go through the cycle again with a different plan. If you were successful, incorporate what you learned from the test into wider changes. Use what you learned to plan new improvements, beginning the cycle again.

Trillium values and expects providers to perform continual self-assessment of services and operations, as well as develop and implement plans to improve member outcomes.

Network providers are required to be in compliance with all Quality Assurance and Improvement standards outlined in North Carolina Administrative Code as well as the provider contract. The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, and valid data. The provider's improvement system, as well as systems used to assess services, plans for improvement and their effectiveness will be evaluated by Trillium.

PROVIDER QUALITY IMPROVEMENT ACTIVITIES

A Quality Improvement Activity (QIA) is an initiative to measure and improve the service and/or care provided by an organization. Quality measures are used to improve services by monitoring and analyzing data and modifying practices in response to this data.

Providers should demonstrate a Continuous Quality Improvement (CQI) process by identifying and maintaining quality improvement activities throughout the year. Most often, initiatives or activities are selected based on data that indicates a need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Trillium recommends providers complete quality improvement activities that demonstrate evidence of performance improvement related to some aspect of organizational processes/structure, member outcomes, or other provider improvement activities.

Quality Improvement Activities are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these activities/studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service.

Technical Assistance can be provided upon request.

For further information regarding QIA's please reference the training provided on the [Provider MyLearningCampus.org](#) as well as other documents on the Trillium website related to QIA's.

SURVEYS/MEMBER EXPERIENCE

An important aspect of our quality program and the services provided to members is surveys and member experience. Feedback through surveys is obtained from members, practitioners/providers, community stakeholders, family members, etc. at least annually.

Surveys cover the following areas:

- Services provided and our network of behavioral health care practitioners and providers
- Ease of accessibility to our staff and our network providers
- Availability of appropriate types of behavioral health practitioners, providers and services
- Acceptability (about cultural competence to meet member needs)
- Claims processing
- Utilization management process
- Coordination of care

Trillium also collects data from all sources of member complaints/grievances and appeals and aggregates them into the following categories:

- Quality of Care
- Access
- Attitude and Service
- Billing and Financial Issues
- Quality of Practitioner Office Site

Trillium assesses complaints/grievances, appeals, member experience, out-of-network request and utilization to determine opportunities for improvement. When opportunities are identified and interventions implemented.

Trillium requires a contact person for all surveys be identified. Please submit your point of contact for all surveys and their contact information to QMInfo@TrilliumNC.org.

Provider Satisfaction Survey

Provider Satisfaction Surveys are administered annually to providers to allow DHB to assess the LME/MCO's ability in the following three areas:

1. Interacting with their network providers
2. Providing training and support to their providers
3. Providing Medicaid Waiver materials to help their providers strengthen their practice

The instrument selected for the survey is provided by DHB. Active providers are surveyed for their opinions of satisfaction with Trillium. An active provider is defined as a Medicaid provider that has at least five 1915(b)/(c) waiver encounters within the previous six months. The survey is administered over a six-week period using a web survey protocol.

Once complete, results of the survey are returned to Trillium for analysis, review, and any corrective action if deemed necessary.

Member Satisfaction Survey (ECHO-Experience of Care and Health Outcomes)

The Division of Health Benefits (DHB) conducts an annual satisfaction survey for all Medicaid members. DHB contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess member satisfaction with services. The instrument selected for the survey is the Adult and Child Experience of Care and Health Outcomes (ECHO®) Survey 3.0 (which is the CAHPS® behavioral health survey) for use in assessing the performance of the health plans. CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a member satisfaction survey as well as a major component of HEDIS. The CAHPS survey is a measurement tool, used for all products, which ask members to report and evaluate their experiences with health care in areas of customer service, access to care, claims processing and provider interactions.

The survey sample includes adult Medicaid recipients over the age 18 and parents or guardians of child Medicaid recipients between the ages of 12 to 17 who received mental health, substance abuse, or intellectual and developmental disability services through the LME/MCO within the last year. The survey is administered over a 12-week period using a mixed-mode (mail and telephone) protocol.

The three-wave protocol consists of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing to non-respondents, and finally a phone follow-up to non-respondents for whom a valid telephone number is available.

Providers should encourage members to complete these surveys. Once complete, results of the survey

are returned to Trillium Health Resources for analysis, review, and any corrective action if deemed necessary.

National Core Indicator (NCI) Survey

NCI surveys are administered annually by the NC Division of MH/DD/SAS with assistance from the Carolina Institute for Developmental Disabilities (CIDD) and the University of NC at Chapel Hill. The NCI survey collects information from people with disabilities and their families and guardians to find out what service areas are working well and what areas may need improvement in North Carolina and nationally.

Each MCO is responsible for drawing a random sample of members to be interviewed both in person and via mail. Results of the survey are returned to Trillium Health Resources for analysis, review, and any corrective action if deemed necessary.

Network Adequacy and Accessibility Assessment

The Network Adequacy and Accessibility Assessment (formally called the Gaps and Needs Assessment) is an annual analysis of the Trillium catchment area including Medicaid members and state funded recipients that provides the opportunity to reveal where there may be gaps in services and opportunities to enhance access to services supporting diversity and inclusion. The purpose of the assessment is to develop and manage a qualified provider network in accordance with community needs. The process incorporates data analysis of practitioners/providers for language, access to and choice of providers as well as input from members, family members, practitioners/providers and other stakeholders.

Trillium reviews all services, including crisis services, and identifies service needs and will prioritize strategies to address any network needs identified. The assessment takes into consideration the characteristics of the population in the entire catchment area and includes input from individuals receiving services and their family members, the practitioner/provider community, local public agencies, and other local system stakeholders. The state requirements include quantifiable and measurable standards for the number of each type of behavioral healthcare practitioner and provider.

Annually, surveys with questions from the state and from the Consumer and Family Advisory Committee(s) (CFAC) are completed by members, families and stakeholders to gather information for the assessment. Ultimately, the assessment serves as a roadmap for determining future growth based on current capacity and identified needs. Trillium will contract with a network that complies with the standards and will reassess the adequacy of the network annually to ensure members have appropriate access to care. Trillium will ensure its network meets time and distance standards through annual assessment and geo access mapping reports.

Upon completion of the assessment, Trillium creates a Network Development Plan to meet identified community needs. The Network Development Plan includes identification and analyses of gaps and requests for approval of exceptions Trillium is contractually required to meet the exception process as identified in the annual requirements document, which provides instructions for conducting each year's "LME/MCO Network Adequacy and Accessibility Analysis". Trillium may utilize existing approved statewide alternative service definitions or develop and request approval for new alternative service definitions to fill network adequacy and accessibility service needs not met with current service definitions. Services reported under alternative service definitions may be used to support performance measures, while non-UCR services cannot.

Perceptions of Care Survey

The NC Division of MH/DD/SAS conducts a Perceptions of Care survey on an annual basis to assess members' perception of care of services received from network providers for mental health or substance use services. A designated number of members are selected to participate in the survey. A team of Quality Management Department staff deliver member surveys and, if needed, assist with administering the surveys to members at provider agency sites. Once the designated number of surveys is completed, the surveys are returned to NC DMH/DD/SA for analysis.

Once analysis by NC DMH/DD/SAS is complete, results of the survey are returned to Trillium for internal analysis, review, and determination of any corrective action if deemed necessary. The Perceptions of Care survey is administered to a random selection of members each year.

Providers are required to participate in the survey process upon receiving notification from Trillium. We truly appreciate the time our providers take to assist with administration of these surveys. The feedback we receive from providers is invaluable. Responses received have shaped our current roles/responsibilities in developing a collaborative partnership between Trillium and providers.

Trillium's Quality Management department is committed to sharing information with our members, families and network about our quality activities and initiatives. Trillium shares results of Member Experience Surveys with members, families, and the network by posting results on our website and sharing with various committees including the Global Quality Improvement, Consumer Family Advisory Committee (CFAC), and the Provider Council.



COMMITTEE STRUCTURE

Trillium's Governing Board has ultimate authority for the oversight of the QAPI Program and has established various committees and sub-committees to monitor and support the QAPI Program. The consortium of committees report up to one main committee, the Quality Improvement Committee (QIC). Trillium recognizes the role providers and practitioners involvement plans in the success of the QAPI. Involvement in various levels of the process is highly encouraged through provider/practitioner representation on key quality related committees such as, but not limited to, Global Quality Improvement, Provider Council, Clinical Advisory Committee and Human Rights Committee.

Trillium supports the following committees that report up to the QIC on a scheduled basis—refer to page 4 for communication flow between various committees:

- Global Quality Improvement Committee
- Human Rights Committee
- Sentinel Events Review Group
- Compliance Committee
- Sanctions Committee
- Clinical Advisory Committee
- Provider Council
- Credentialing Committee

QUALITY IMPROVEMENT COMMITTEE

The Quality Improvement Committee (QIC) is a cross functional senior management committee that includes members from various departments across the organization, in addition to the Trillium Health Resources Chief Medical Officer. The purpose of the QIC is to provide oversight and direction for the QAPI Program. The QIC has been established as the method by which the annual QAPI is brought to life. The QIC is designed to support Trillium Health Resources' goal of providing care of the highest caliber possible within the constraints of available resources. The Committee is charged with working cross-functionally to accomplish the Quality Improvement Activities of the organization

The objectives of this committee include:

- Provide guidance to staff on quality management priorities and projects
- Consult on quality improvement activities to undertake
- Monitor progress in meeting quality improvement goals
- Monitor adherence to HEDIS measures and key performance indicators (KPI) internally and externally
- Establish processes and structure to ensure National Committee for Quality Assurance (NCQA) compliance
- Review and approve the Quality Management Plan and QM Work Plan
- Evaluate the effectiveness of the QAPI Plan annually
- Approve and maintain policies and procedures
- Evaluate member experience survey results and determine opportunities for improvement

GLOBAL QUALITY IMPROVEMENT COMMITTEE

The Global Quality Improvement Committee (GQIC) serves as a fair and impartial committee representing the practitioners/providers network to discuss and explore ideas related to Quality Improvement issues.

Participants of this Committee consist of an array of practitioner/provider representatives in addition to Trillium Health Resources staff.

In addition to practitioner/provider representatives, the committee membership also includes representatives from the Regional Consumer and Family Advisory Committees (CFAC). The goal of the GQIC is to represent collaboration and strengthen the relationship between practitioners/providers and Trillium Health Resources. The GQIC discusses and monitors the quality needs of the network and identifies recommendations from the committee members to the QIC as appropriate and necessary. The QIC has ultimate decision making authority regarding recommendations and initiatives. Trillium staff serve as liaisons to the committee and act as administrative support to the committee. The GQIC liaison regularly makes reports to the QIC.

The objectives of this committee include:

- Review quality concerns developing in the Network
- Assess practitioner/provider training needs related to quality
- Assess training needs of the Network related to quality
- Collaborate with Trillium QM staff regarding quality issues, which includes providing feedback on the LME/MCO's QI activities
- Review current standards and set recommend minimum standards for providers' QA/QI systems
- Allow for avenues in which practitioners/providers can learn from each other.

GQIC members offer a 'Confidential Peer Review' process for providers interested in receiving feed-back from the committee on how they can improve the development, tracking, and reporting of their annual QIAPs.

'Confidential Peer Review' means that the GQIC members will be reviewing the QIAPs of a provider that requested the committee's feedback without knowing the identity of such provider as this information would be removed by Trillium.

Email QMinfo@TrilliumNC.org if interested in engaging in the 'Confidential Peer Review' process.

Information from this committee shared is announced in Network Communication Bulletins and posted on the Trillium website. If there is interest in participating in the Global Quality Improvement Committee, please email QMinfo@TrilliumNC.org.

HUMAN RIGHTS COMMITTEE

The Human Rights Committee is a provider led committee comprised of board representation, member/family members and practitioners/providers representing all disability groups. Members are appointed by Trillium's Governing board, or a designee. Trillium staff serve as liaisons to the committee. HRC plays a vital role by ensuring the protection of member rights for people receiving mental health, substance use and intellectual and/or developmental disability services. The Committee

is responsible for the monitoring and oversight of the use of restrictive interventions, members' rights violations, and incidents of abuse, neglect and exploitation, grievances, complaints, and appeals.

The primary responsibility of the committee is to ensure the protection of member's right by:

- Reviewing complaints and grievances regarding potential member rights violations
- Reviewing member appeals (monthly and quarterly data)
- Reviewing concerns regarding the use of restrictive interventions by providers
- Reviewing concerns regarding confidentiality
- Reviewing concerns regarding member incident reports

Information related to this committee is shared in Network Communication Bulletins and posted on the Trillium website. Providers should adhere to APSM 95-2 regarding clients' rights. If there is interest in participating in the Human Rights Committee, please email QMinfo@TrilliumNC.org.

PROVIDER PERFORMANCE DATA

Trillium shares provider-specific performance data at least annually to support ongoing adherence to quality standards. Trillium provides a report to practitioners/ providers including interpretation of their QI performance data and feedback regarding QI activities. The purpose of the Provider Performance Report is to offer providers a snapshot into how they are performing in certain areas compared to similar network practitioners/providers. These reports may include performance data related to 1-7 day follow-up percentages, Claim Denials and Claim Denial Reasons, Authorization Denials and Authorization Denial Reasons, Accessibility, and Quality Improvement Activities, among other measures. This data may be used for comparative purposes, as a way of fostering a high quality provider network that engages in continuous quality improvement for the purpose of sustaining a high quality service delivery system. Trillium exercises due care when compiling and releasing provider-specific data to the public.

Trillium has established guidelines and standards for sharing this information that protects the providers and public by ensuring that all applicable confidentiality laws and regulations are followed, and limitations of the information are acknowledged and disclosed. Provider-specific performance data is obtained utilizing information from various data sources, including but not limited to, claims and authorizations in Trillium's software platform. All reports of provider-specific performance data will include a description of the methodology used to develop the report, as well as the uses and limitations of the information.

Trillium may engage in focused clinical and operational improvements with practitioner/provider practices related to performance metrics as a part of alternative payment arrangements in the delivery of care across populations served. This activity could also include training, remediation and technical assistance on value-based purchasing and performance metrics. Trillium's goal is to decrease gaps in treatment and develop improvement opportunities which result in the recruitment and retention of high performing practitioners/providers.

VALUED PROVIDER SEAL PROGRAM

Trillium Health Resources deeply values its provider community and seeks to recognize outstanding agencies. Our Valued Provider Seals Program offers agency seals which highlight provider commitment to maintaining certain operational and clinical criteria. Each seal is available in electronic and hard copy format for the provider agency to proudly display on its website, email signatures, and/or within its office locations. For detailed information about the [Seal program criteria and its participation application](#) please visit our website.

Providers may use and display these Valued Provider Seals only with the express written permission of, and in accordance with the rules and restrictions established by, Trillium Health Resources. Any unauthorized use, disclosure or distribution of these Trillium seals is prohibited by Trillium and may result in the imposition of sanctions related to such unauthorized use, disclosure or distribution, up to and including termination of the provider's contract with Trillium.



PROVIDER DISASTER PLANS

PROVIDER DISASTER PLANS

Trillium is responsible for providing crisis and emergency services 24 hours a day, 7 days a week. The Trillium MCO Disaster Plan is a comprehensive document designed for use in responding to natural and human-made disasters. Disaster preparedness greatly enhances the ability to respond during a crisis situation.

All Trillium contract providers offering services in a facility must have their own Disaster Plans, including evacuation and fire plans. Depending on the type of

disaster, Trillium and certain identified providers could be asked to assist in debriefing of rescue personnel and follow-up crisis counseling with victims. Our contract with providers requires that you have an adequate disaster planning and training process in place within your organization. Providers are required to submit annually their Disaster Plans including evacuation plans and fire plans to NetworkMonitoring@TrilliumNC.org.

Failure to submit your Disaster Plan annually may result in an audit and/or plan of correction.



CORRESPONDENCE TIMELINES & ADDRESS REFERENCE

ITEM TO BE SUBMITTED IN WRITING TO LME/MCO	TIMEFRAME FOR SUBMISSION	ADDRESS TO SUBMIT
Review/fully executed contract	within 30 business days of receipt of contract	Trillium Health Resources Attn: Contracts Administrator 201 West First St. Greenville, NC 27858-1132
Changes in Credentialed Status	within one (1) business day of any change in the status of licenses, accreditations, certifications/status of such	Trillium Health Resources Attn: Network Development Staff 201 West First Street Greenville, NC 27858-1132 Credentialing@TrilliumNC.org
Re-credentialing —LIPs and Agencies	within 60 days of the original notification of re-credentialing	Trillium Health Resources Attn: Network Development Staff 201 West First Street Greenville, NC 27858-1132 Credentialing@TrilliumNC.org
Provider Appeals	within 30 days of the date of the letter	Address to Submit: Trillium Health Resources Attn: Appeals Department 201 West First Street Greenville, NC 27858-1132
Changes in Current Practice Information —Provider Change Form	within one (1) business day of any changes in status within five (5) business days of personnel changes or information updates	Follow the instructions on the bottom of the Provider Change Form or NetworkMonitoring@TrilliumNC.org
Plan of Correction (POC) Revised POC Resubmission	within 15 calendar days of delivery or attempted delivery of the POC request letter 10 calendar days to revise the POC	E-mail to the Trillium staff member who requested the POC
Additional Services Application	within 60 days of the application mailing date to the provider	NetworkMonitoring@TrilliumNC.org
Medicaid Services Appeal-Level I (on behalf of member with written permission from member/parent/guardian)	within 60 days of the date of the Notice of Adverse Benefit Determination	201 West 1st Street Greenville, NC 27858-1132 Upon receipt of fax confirmation page, please contact Trillium Appeals Department to confirm receipt of said fax at 1-877-685-2415.

RESOURCES & WEB LINKS

Claims Request Form: For Provider —> *Provider Documents & Forms* —> *Claims*
[Provider Documents & Forms](#)

Clinical Coverage Policies, Division of Medical Assistance
[Documents](#)

[Constant Contact](#)

Record Retention Log—(Former Member Records Storage Log) For Provider —> *Provider Documents & Forms* —> *Operational Information & Forms*
www.TrilliumHealthResources.org/for-providers/provider-documents-forms

Cultural and Linguistic Competency Action Plan Recommendations—For Provider —>
[Provider Documents & Forms](#) —> *Operational Information & Forms*

[Prior Approval and Due Process Procedures](#)

Fraud and Abuse/Program Integrity List

- [OCPI/Fraud Waste and Abuse](#)
- [EthicsPoint](#)

[Classification of Incidents \(Level I, II, or III\)](#)

Limited English Proficiency (LEP)

- [Federal agency: Limited English Proficiency](#)
- [NC Interpreters and Translators Board](#)
- [Sign Language Interpreters/Translators Directory](#)
- [Carolina Association of Translators and Interpreters](#)

Trillium Provider Communications

- [Clinical Communications](#)
- [The Network Communication Bulletins](#)

[Provider.MyLearningCampus.org User Agreement](#)

[NC-TOPPS Guidelines](#)

[Provider Direct](#)

[NC-SNAP Guidelines](#)

[Plan of Correction Template](#)

[Psychiatric Advanced Directive \(PAD\) and Health Care Power of Attorney Legal Forms](#)

[Service Definitions](#)

[Waiver, NC MH/DD/SAS Health Plan and the NC Innovations](#)

[NC Innovations Waiver](#)



IMPORTANT EMAIL ADDRESSES

NetworkMonitoring@TrilliumNC.org

Is used for provider monitoring reviews, provider change forms.

TrilliumProviderDirectory@TrilliumNC.org

Is used to submit all Provider Directory Forms for updating Trillium's Provider Directory.

NetworkManagement@TrilliumNC.org

Is used for questions regarding Network Communication bulletins and submission of reports for Non UCR contracts (CURES reports, etc.).

Credentialing@TrilliumNC.org

Is used for any credentialing documentation providers need to submit due to licensure updates, re-credentialing or initial credentialing.

NetworkServicesSupport@TrilliumNC.org

Is used for any other questions providers may have, statements around voluntarily withdrawing from the network.

UM@TrilliumNC.org

Is used to request UM criteria decision-making guidelines, or call the Provider Support Service Line at 1-855-250-1539 to request a hard copy.