

Trillium Provider Manual

DOING BUSINESS WITH TRILLIUM HEALTH RESOURCES

AS A CONTRACTED NETWORK PROVIDER



Transforming Lives



PROVIDER MANUAL

This document is available on the Trillium web site at www.TrilliumHealthResources.org, on the For Providers Tab, 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 Web site is available upon request by calling Trillium at one of the local business numbers listed 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 will incorporate those changes and publish revised editions of this Provider Manual periodically.

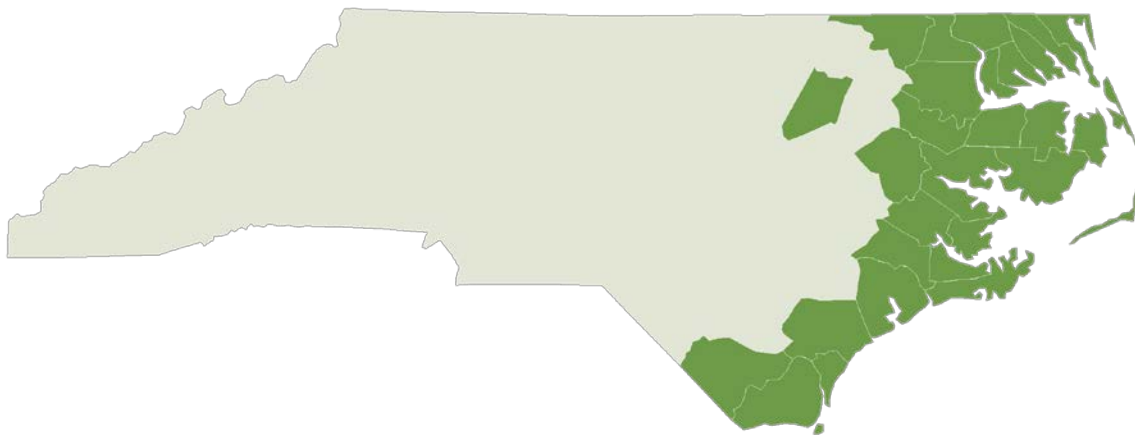
Trillium Regional Offices

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 Crisis Care & Service Enrollment 1.877.685.2415 | Administrative/Business Calls: 1-866-998-2597



Please use the Administrative & Business toll free number for all Network Provider matters.

Please note the toll free Trillium Crisis Care & Service Enrollment number, 1-877-685-2415, is intended for and limited to members and issues around member care.



A MESSAGE FROM THE CEO

Trillium Health Resources

*Transforming the lives of people in need
by providing them with ready access to quality care.*

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 26-county catchment area with timely access to a full array of high quality, medically necessary mental health, intellectual and developmental disability and substance use services.

Trillium is committed to the principles of recovery and self-determination. We whole-heartedly believe in person-centered services and supports. And, we fully understand that our success in achieving those goals is dependent upon our Provider Network.

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.

Leza Wainwright
Chief Executive Officer

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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.

We are the second largest LME/MCO in terms of geography covered and numbers of counties served. Our counties have a total population of approximately 1.26 million with about 210,000 being Medicaid-eligible.

Trillium is nationally accredited by URAC in the areas of Call Center, Provider Network Management and Utilization Management. Trillium, its contractors and employees do not discriminate based on race, color, national origin, sex, religion, age or disability in the provision of services.

Trillium's mission is *"Transforming the lives of people in need by providing them with ready access to quality care."*

ABOUT THE MEDICAID WAIVER

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

The NC MH/DD/SAS Health Plan is a pre-paid inpatient health plan (PIHP) funded by Medicaid. All Medicaid MH/DD/SA services are authorized by and provided through the Trillium Provider Network in accordance with the risk-based contract between the NC Division of Medical Assistance and Trillium. As a prepaid inpatient health plan, Trillium is at financial risk for a discrete 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.




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 A 1915(B) (C) WAIVER SYSTEM PRESENTS

- 🌱 **Coordination** - The waiver allows us to better coordinate a system of care for members, families and providers.
- 🌱 **Efficient Management of limited public 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 MH/DD/SAS HEALTH PLAN

- 🌱 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 in the Trillium Network contracted with Trillium to provide the service they need.

ABOUT THE NC INNOVATIONS WAIVER

The NC Innovations Waiver is a 1915(c) Home and Community Based Waiver. 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 may participate in the Individual-/Family-Directed Services Agency with Choice model.

GOVERNANCE & ADMINISTRATION

GOVERNANCE

Trillium is a political sub-division of the State created under the authority of NC GS §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 Trillium Executive Director reports to the Board, and all other staff of Trillium report to the Executive Director.

2 TIERED GOVERNANCE STRUCTURE

-  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 = 17; Southern = 13
- 🌱 Regional CFACs
- 🌱 All duties outlined in statute for CFAC, including advice Regional Advisory Board. Chair sits on Regional Board and Governing Board

GOVERNING BOARD

- 🌱 13 Member Board
- 🌱 CFAC chair, one commissioner or designee, and 2 other members who meet criteria outlined in G. S. 122C-118.1 from each Region
- 🌱 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 Office of the Executive Director 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 Vice President leads each of the major functional areas of Trillium:

BUSINESS OPERATIONS

- 🌱 Finance
- 🌱 Claims
- 🌱 Contracts & Training
- 🌱 Human Resources
- 🌱 Information Technology
- 🌱 Regional Operations
- 🌱 Geriatric Adult Specialty Team (GAST)
- 🌱 Quality Management

CLINICAL OPERATIONS

- 🌱 Call Center/Customer Service
- 🌱 Care Coordination
- 🌱 Utilization Management
- 🌱 Transitions to Community Living
- 🌱 Network
- 🌱 Housing Services
- 🌱 Connections

GENERAL COUNSEL

- 🌱 Program Integrity
- 🌱 Internal Compliance

COMMUNICATIONS & MARKETING

- 🌱 Communications
- 🌱 Marketing

TRILLIUM'S CHIEF MEDICAL OFFICER

- 🌱 Medical Affairs

The Chief Medical Officer is responsible for the overall 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.

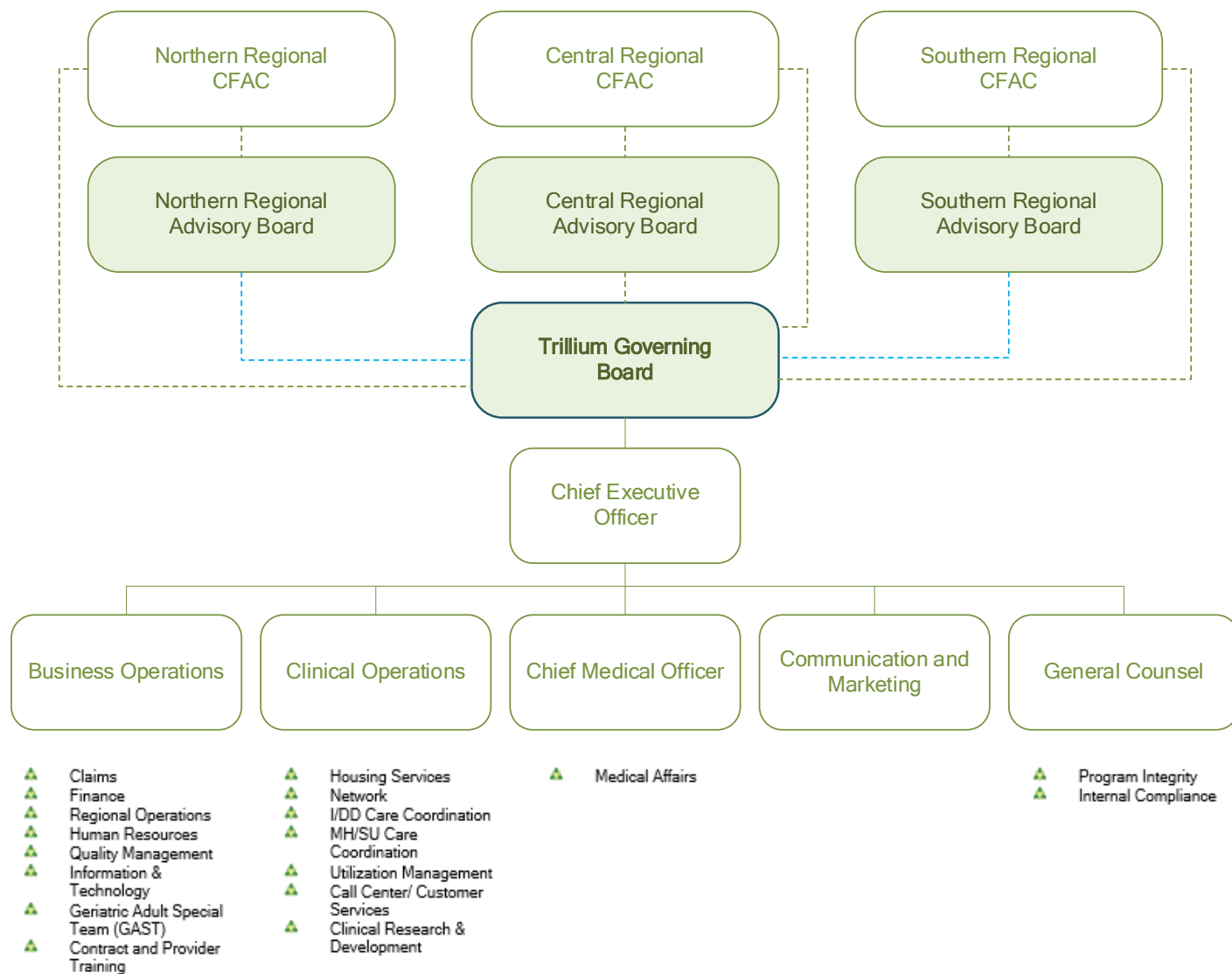
MEDICAID CONTRACT MANAGER

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.)

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 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.

FUNCTIONAL ORGANIZATIONAL CHART



STAKEHOLDERS & 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 family members, providers and stakeholders together to address issues and concerns, to provide important feedback to Trillium around its performance, and to assist in pro-active 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 for collaborative planning 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. It is expected these groups will continue to grow in their collective ability to impact Trillium operations and management in a positive manner.

ATTACHMENT L: COMMUNICATION FLOW BETWEEN COMMITTEES








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 to the fullest extent.

Upon admission, Trillium notifies each member of the availability of the [Trillium Member & Family Handbook](http://www.trilliumhealthresources.org/sites/default/files/docs/Individuals-Families/Manual/Trillium-Member_Handbook.pdf) (http://www.trilliumhealthresources.org/sites/default/files/docs/Individuals-Families/Manual/Trillium-Member_Handbook.pdf) containing information to help them access services for mental health, intellectual/ developmental disabilities and substance use. Electronic copies of the handbook and other helpful documents are posted on our Web site. 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

Trillium maintains a Human Rights Committee whose members are appointed by the Governing Board of Trillium Health Resources. The primary role of the Human Rights Committee is to protect the rights of its members. The Committee is responsible for the monitoring and oversight of the use of restrictive interventions, client rights violations, and incidents of abuse, neglect and exploitation, deaths, grievances, complaints, and appeals.

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 *NC GS §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 NC GS §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, an 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.

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 an 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 venereal diseases
-  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

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.

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 responsibility to Providers is to:

- 🌱 adhere to all confidentiality guidelines as stated in rule, regulation and law
- 🌱 develop and disseminate educational material relative to accessing services; member rights and protection; appeals and grievances; and advanced directives
- 🌱 ensure providers maintain a Client Rights Committee as outlined in General Statute and Administrative Code

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, e-mail and Web site.

TRILLIUM WEB SITE

Our Web site is a source of information for available services, network providers, provider performance, LME/MCO events and operations, and links to other Web sites. The Trillium Web site 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. To get started, providers can go to the Trillium Web site and download a System Administrator Designee Request Form to complete and return to Trillium. (Please see the [Resources & Web Links](#) section at the end of this Manual for the web link to the form.)








Providers may elect to submit their claims using the HIPAA Standard Electronic Transaction Set. This can be accomplished in three ways: first through the web portal in Provider Direct (PD), secondly via security FTP, and finally 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 EMDEON and The SSI Group. Any Trillium provider can enter an agreement with 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 PDsupport@TrilliumNC.org


E-MAIL 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 listservs for information, education and marketing.

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
-  follow technical support procedures as identified by Trillium (IT Tickets submitted via email to PDsupport@TrilliumNC.org or feedback button within Provider Direct)
-  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

Trillium responsibility to Providers is to:

-  provide Help Desk technical assistance to support provider interface Monday through Friday, 8:30 am to 5:00 pm (excluding holidays)

CONTRACTS AND TRAINING

The Contracts Department manages all contracts, procurement activities and external training for Trillium.

PROCUREMENT CONTRACTS & GENERAL CONDITIONS

Trillium must enter into Procurement Contracts with Network Providers before any services can be authorized or paid. Network Providers are required to have a fully executed Trillium Contract, prior to delivery of services to a Trillium member. To view and verify all the services that Trillium Health Resources has approved, sign in to Provider Direct at <https://www.ciecbh.org/ProviderDirect/Provider/SiteSearch>; select "Admin"; and then select "Provider Management" in the top right side of the screen. Once Provider Management is selected, the Master Site will be listed along with the subsites. The Master Site will be on the top of the list. If you select the Master Site, then all of the services that are in the contract will display.

If you select one of the subsites, then only the services that are contracted for that subsite will display. Network Providers can print all the services that are in their contract from Provider Direct (Master Site) for their files. This document serves as the Attachment A that is referenced in the Contracts.

The Trillium contract is divided into two sections: a Procurement Contract, and a set of General Conditions. Each contract outlines the specifics for the provider type, including disabilities to be served and related provisions. Trillium Medicaid UCR contracts are multi-year contracts. State UCR contracts are only for the current Fiscal Year.

There is a designated version of the General Conditions contract to accompany each Procurement Contract. The General Conditions describe the compliances according to federal and state regulations, as well as our waiver participation.

The Trillium Provider Manual and the Trillium NC Innovations Operations Manuals are incorporated into the contract by reference.

All the Trillium Contract Templates have been approved by the Secretary of the Department of Health and Human Services as required by *NC GS §122C 142(a)*









PROVIDER TRAINING

The Provider Training Unit 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, Member & Family Advisory Committee (CFAC), Provider Network Council (PNC) and Clinical Advisory Group (CAG.) The Provider Training Unit also partners with staff, providers, stakeholders and community partners to develop training around special Trillium initiatives on categories of topics.

Trillium is committed to offering on-going training opportunities to Network Providers as a mechanism to maintain professional competence and remain up-to-date with changes that occur in the behavioral healthcare industry. The Trillium Training Unit implements a training plan that is reviewed and updated annually.

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 5 to 10 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 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

TRAINING

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

Trillium responsibility to Providers is to:**CONTRACTS**

- 🌱 send written correspondence via USPS 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
- 🌱 support the development and support of best practices or emerging best practices

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 Web site
- 🌱 update Provider Manual to reflect changes in requirements

PROVIDER NETWORK**NETWORK DEPARTMENT**

The Network Department is responsible for the development and maintenance of the Provider Network to meet the needs of members while ensuring choice and best practices in services. The Department includes two units: Network Auditing and Network Services.

NETWORK AUDITING

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

Clinical Practice Guidelines can be found on our website at <http://www.trilliumhealthresources.org/for-providers/clinical-practice-guidelines>

NETWORK SERVICES

The Network Service Team handles the credentialing of Agencies, LIP/LIP Groups, and Supplemental Clinicians providing services to members. The Network Services Team also manages the Network Services Ticket System.

PROVIDER NETWORK CULTURAL COMPETENCE

The past two decades have seen unprecedented demographic shifts nationally and in North Carolina. Increased cultural and linguistic diversity have 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 competence 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 mental health, intellectual and developmental disability, and substance use services.

Trillium's Cultural Competency Plan was created in collaboration with the Provider Network Council. The plan can be found on the Trillium website under Provider Documents at under <https://www.trilliumhealthresources.org/sites/default/files/docs/Provider-documents/Trillium-Competency-Plan.pdf>.

TYPES OF NETWORK PROVIDERS

AGENCY-BASED PROVIDERS

An agency-based Provider is an entity organized as a corporation, limited liability company, partnership 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 Enrollee, 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 is met.

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 Access 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 member 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 areas, and 45 miles or 45 minutes in rural areas. Longer distances as approved by DMA are allowed for facility-based or Specialty Providers.

There may be only one provider of facility-based services, such as Psychosocial Rehabilitation, in a county 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 Capacity Study (Gaps & Needs Analysis 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.

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 (DMHDDSAS) and the Division of Medical Assistance (DMA) 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 Network Department utilizes the 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 provider monitoring process is used to monitor both Medicaid and State-funded behavioral health services. Provider monitoring consists of a 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 and post payment clinical reviews.

All Agency Providers will participate in a Provider Monitoring a minimum of every two (2) years. All Licensed Independent Practitioners and Group Practices will participate in a Provider Monitoring a minimum of every three (3) years. The Network Auditing Department will coordinate all Provider Monitoring and maintain a master schedule.

All Provider Monitoring will be conducted using tools developed by NC DHHS, which are made available to providers and practitioners on the NC DHHS Web site. (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

All reviews include an exit conference to provide the LIP or agency with general and immediate feedback. Discussion will include at least the following:

- 🌱 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.

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.

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 | 🌱 Global QI Committee |
| 🌱 Credentialing Committee | 🌱 Ad hoc work group |
| 🌱 Clinical Advisory Committee | |

PROVIDER SATISFACTION SURVEYS

Provider Satisfaction Surveys are completed by an outside vendor for Trillium. The results of the surveys are reported back to Trillium once a year. We truly appreciate the time our providers take to complete 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 network providers

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 Executive Director regarding provider contract reconsiderations, upon Executive Director'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 Web site.

PROVIDER CREDENTIALING AND ENROLLMENT

The credentialing process at Trillium is based on URAC accreditation credentialing standards and incorporates contractual and policy requirements set forth by the Department of Health and Human Services (DHHS).

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 an agency/facility enrolled in the Trillium network.

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

- 🌱 Medical Doctors (MD)
- 🌱 Practicing Psychologists (PhD and PsyD)
- 🌱 Psychologist Associates (Master's Level Psychologist (LPA)
- 🌱 Licensed Clinical Social Workers (LCSW) and Associates
- 🌱 Licensed Marriage and Family Therapists (LMFT) and Associates
- 🌱 Licensed Professional Counselors (LPC) and Associates
- 🌱 Licensed Addiction Specialists (LCAS) and Associates
- 🌱 Certified Clinical Supervisor (CCS)
- 🌱 Advanced Practice Psychiatric Clinical Nurse Specialists
- 🌱 Psychiatric Nurse Practitioners
- 🌱 Licensed Physician Assistants
- 🌱 Family Nurse Practitioners
- 🌱 Behavioral health group practices and agencies that employ individuals with various degree types and other credentials to deliver MH/SA/IDD services to members
- 🌱 Facilities, such as residential treatment facilities

Practitioners who provide care exclusively within the inpatient setting do not need to undergo the Trillium credentialing process and are not listed in the Trillium Provider Directory.

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 URAC 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
- 🌱 Maintain the Credentialing Committee
- 🌱 Establishment of criteria for provider network participation
- 🌱 Assurance of confidentiality of all credentialing information
- 🌱 Assurance that Trillium credentialing personnel do 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 credentialed providers and licensed practitioners enrolled in the Trillium Network are required to have their credentials reviewed and verified every 3 years—at minimum—from the date of the last credentialing review for each agency/practitioner. Any network provider or licensed practitioner not returning the completed re-credentialing packet within the designated time period of the original notification of re-credentialing may be sanctioned, suspended from the network, or required to cease providing and billing for Medicaid-reimbursable services.

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 the Provider Monitoring Program.

As with the initial credentialing process, Trillium works with providers to obtain the complete re-credentialing application and supporting documentation. Once all necessary items are marked complete on the Checklist and both primary and secondary source verification has been completed on those items that are subject to change, the re-credentialing file is thoroughly reviewed by the Credentialing Specialist. Final approval is made by the Credentialing Committee, and notification of the decision is sent within ten (10) business days of the determination.

As part of the Re-credentialing process, each licensed practitioner operating as an LIP or through a group practice, agency, or facility has the right to:

- 🌱 Upon request, review information collected during the re-credentialing process except references and National Practitioner Database (NPDB) findings
- 🌱 Be informed of the status of their re-credentialing application, within 14 calendar days
- 🌱 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 two (2) weeks of notification on any discrepancies in the application
- 🌱 Be notified about the Credentialing Committee's decision within 10 business days of the Credentialing Committee's decision

ALTERATION OF CREDENTIALLED 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 enrollment 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 investigation, 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 Rule for Division of Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services (MH/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, Intellectual/Developmental Disabilities, Substance Abuse Services (DMH/IDD/SAS) – Program Accountability Unit
- 🌱 Division of Medical Assistance (DMA) – 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 Medical 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

All 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 calendar days** from the letter informing of the action.

Formal Written Requests must be sent to:

Trillium Health Resources
 Attn: Appeals Coordinator
 3809 Shipyard Boulevard
 Wilmington, NC 28403

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 reconsideration request is not received within **30 calendar days**, from the letter informing 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 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.

The Director of the department that took the adverse action shall designate a department representative to compile all available information, including any summaries of his/her own research, if applicable. The designated representative shall be expected to represent the department that took the adverse action throughout 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. 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 provider shall have one hour in which to make its presentation.

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.

Reconsiderations of professional conduct or competence 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.

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 peer provider 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.

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 Director, 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.

When reporting all changes to the Network Department, providers should use the **Trillium Provider Change Form** found on the Trillium Website under Provider Documents.

Providers are to notify the LME/MCO in writing **within one (1) business day** of any changes in their **status**, including, but not limited to:

-  licensure status;
-  changes in privileged status with other accrediting organizations;
-  pending citations;
-  pending malpractice claims, etc.

Providers shall notify the Network Department in writing **within (3) three business days** of changes in **ownership/management**. Providers are also required to notify the Network Department in writing **within (5) 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 "good standing" as defined by DHHS; 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 Development.

HEALTH & SAFETY SITE REVIEW

If a Health and Safety Site visit is required for the new service, Network Auditing will schedule the site visit within 30 calendar days of the approval of the written application. Any site requested to be added to the contract for the new service will be reviewed on all applicable areas. During the site visit, Trillium will evaluate the provider applicant's readiness to provide services according to the requirements outlined in state regulations, the service definition(s), and the Trillium contract.

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 agencies 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 Medical Assistance, 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 Certified US 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 Web site. (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 **10 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 10 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/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 7 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 the Trillium Provider Learning Portal 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 Capacity Study (Gaps & Needs Analysis Report). The Plan is used to delineate priorities for Service and Program Development as identified in our Local Business Plan and the Annual Capacity Study. 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 agency 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
- 🌱 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 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 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
- 🌱 notify the LME/MCO **within one (1) business day** of any change in the status of licenses, accreditations, certifications and the status of such

- 🌱 notify LME/MCO 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 LME/MCO 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 Medical Assistance (DMA).
 - Automobile Liability Insurance- If you and/or the agency 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
- 🌱 comply with Trillium credentialing outlined in the Enrollment Process to become a Network Provider
- 🌱 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 form and disclosure, complete with all required materials
- 🌱 provide current documentation as requested in the re-credentialing packet
- 🌱 return the completed re-credentialing packet **within 10 business days** of receipt
- 🌱 be prepared for a New Unlicensed Site Review, if indicated for new service

RECONSIDERATION

- 🌱 submit 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 21 business days** of the date you are advised of the action

CULTURAL COMPETENCE

- 🌱 be responsive to the cultural and linguistic needs of the members served
- 🌱 earnestly participate in initiatives to achieve cultural competence
- 🌱 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

TRILLIUM 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
- 🌱 perform a New Unlicensed Site Review within 30 calendar days of application approval, when indicated for new service
- 🌱 send written correspondence via USPS 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 including, but not limited to URAC
- 🌱 make available to providers upon request, the results of Capacity Study (Gaps & Needs Analysis Report) which identifies 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 (Gaps & Needs Analysis Report)
- 🌱 conduct on-site 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 revise 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 DMA upon request.

CREDENTIALING

- 🌱 qualify, credential, and re-credential providers
- 🌱 mail a re-credentialing packet to each agency/licensed practitioner 120 days prior to the 36 month appointment period
- 🌱 review the returned application materials for completeness and compliance with credentialing standards
- 🌱 notify the re-credentialing agency/licensed practitioner of the Credentialing Committee's decisions regarding ongoing network participation via USPS 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
- 🌱 determine Network need for specific service upon request of application for change in contract to become private practitioner
- 🌱 perform a completeness review of the application within 10 business days of receipt; incomplete applications will be returned to the provider with a letter noting the missing or incomplete items; provider will have 10 days to return the completed application
- 🌱 perform a Primary Source Verification (PSV) review; if application is deemed "clean," it will be forwarded to the Medical Director for review; subsequent to the Medical Director's review, the application will be forwarded to the Credentialing Committee

RECONSIDERATION

- 🌱 offer an opportunity to meet face-to-face at Trillium to discuss reconsideration
- 🌱 review the written request for local reconsideration along with any supporting documentation and make a decision to uphold or overturn the action
- 🌱 schedule the face-to-face meeting for an hour 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 right to appeal to the next level (as applicable) and the mechanism to request such reconsideration
- 🌱 notify the LIP within three (3) business days of his/her appeal rights in writing of the time the Medical Director takes a disciplinary action against the practitioner
- 🌱 ensure the notification letter includes the rights as detailed above
- 🌱 provide the LIP with 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 Gaps & Needs Analysis 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 by using the SIPS (Service Information and Prioritization Spreadsheet). 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.

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 “close” or limit the 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 Capacity Study (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.

PROGRAM INTEGRITY

The Program Integrity department is charged with preventing, detecting and correcting fraud and abuse to ensure the financial and clinical integrity of Trillium. 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 Medical Assistance-Program Integrity and other appropriate regulatory bodies.

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 NC Division of Medical Assistance-Program Integrity, NC Medicaid Investigation Division, appropriate regulatory bodies, and/or law enforcement agencies depending on the nature of the allegation. Any credible allegations of provider fraud that are accepted by DMA Program Integrity may result in immediate suspension of referral, authorizations and payments pending an investigation by DMA 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 (<http://www.trilliumhealthresources.ethicspoint.com>) 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 DMA Fraud and Abuse Report line at 1-877-362-8471
- 🌱 NC DMA Online Confidential Complaint Form on the DMA Web site (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: www.trilliumhealthresources.ethicspoint.com
- 🌱 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 3 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.

COMPLIANCE

MEMBER RECORDS REQUIREMENTS

Each provider must adhere to the regulations set forth for Medical Records Compliance.

Network Providers will be required to maintain clinical records that meet the requirements in the *Records Management and Documentation Manual for Providers* (APSM 45-2) and *Rules for MH/DD/SAS Facilities and Services* (APSM 30-1) and the *NCTracks Provider Claims and Billing Assistance Guide*. Each entity, including Trillium and service providers, owns the records they generate and bear responsibility for these records. Information in member records must adhere to the following regulations:

🌱 Clinical Service Record

○ Record Retention and Disposition

- Trillium will follow these four schedules and outlined regulations which address the retention and disposition for publicly funded MH/DD/SA services:
 - ▲ G.S. §121 and §132
 - ▲ NC DHHS Records Retention and Disposition Schedule
 - ▲ APSM 10-5, Records Retention and Disposition Schedule for LME/MCO Providers
 - ▲ APSM10-6, Records Retention and Disposition Schedule for LME/MCO

○ Records Management

- Trillium requires service records to be maintained in a manner consistent with the principles of privacy and security outlined by the following:
 - ▲ Clinical Coverage Policy 8A – Enhanced Mental Health and Substance Abuse Services
 - Person Centered Plans
 - Documentation Requirements
 - Attachment C: Documentation – Best Practice Guidelines
 - Documentation Requirements listed under each service definition
 - ▲ Clinical Coverage Policy 8C – Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
 - Additional Requirements
 - ▲ Clinical Coverage Policy 8D-1 – Psychiatric Residential Treatment Facilities for Children Under the Age of 21
 - EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age
 - When the Service is Covered
 - Continued Stay Criteria
 - ▲ Clinical Coverage Policy 8D-2 - Residential Treatment Services
 - Documentation Requirements listed under each service
 - ▲ North Carolina Innovations Technical Guide
 - General Documentation Requirements
 - ▲ APSM 45-2 – Records Management and Documentation Manual for Providers of Publicly-Funded MH/DD/SA Services, CAP-MR/DD Services, and Local Management Entities
 - ▲ NC GS §132 – Maintenance of public records
 - Confidential Information
 - Sensitive Public Security Information
 - Social Security Numbers and Other Personal Identifying Information

- o Limited access to identifying information of minors participating in local government programs and programs funded by the North Carolina Partnership for Children, Inc., or a local partnership in certain localities.
 - o Limited access to identifying information of minors participating in local government parks and recreation programs and programs funded by the North Carolina Partnership for Children, Inc., or a local partnership in other localities.
 - o Provisions for copies of public records; fees.
 - o Keeping records in safe places; copying or repairing; certified copies.
 - ▲ NC GS §122C – Confidentiality of members
 - o Privacy of personnel records.
 - o Review and protection of information.
 - ▲ 42 CFR, Chapter 1, Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records
- Each entity, including the LME/MCO and service providers, owns the records generated and bears a responsibility for the maintenance and retention of those records per prescribed guidelines.
 - ▲ Trillium may review personnel and member records to ensure all rules and regulations are being followed
- Privacy and Security of Service Records
- Trillium requires service providers to ensure all individuals providing services maintain the confidentiality of all members and other information received in the course of providing services outlined by the following:
 - ▲ APSM 45-1, Confidentiality Rules
 - ▲ NC GS §122C, Article 3
 - o Addresses confidentiality of all information acquired in attending or treating an member
 - ▲ 42 CFR, Chapter 1, Subchapter A, Part 2
 - o Addresses confidentiality of records of drug and alcohol use service recipients

Upon closure of providers network operations, non-renewal of contract or termination of the contract regardless of the reason, the following shall apply:

1. The provider must provide a copy of all records for Members served under the contract to Trillium Health Resources within sixty (60) days.

OR

2. The provider may submit a plan for maintenance and storage of all records for approval by Trillium Health Resources. Trillium has the sole discretion to approve or disapprove of this record retention plan.

Providers must submit 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 name, member record number, member 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](#).

Records and log should be sent to:

Trillium Health Resources
 Attention: Medical Records
 3809 Shipyard Blvd.
 Wilmington, NC 28403-6150

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. A manual that details all the NC-TOPPS requirements can be found at: <https://nctopps.ncdmh.net/dev/GettingStartedWithNCTOPPS.asp>

Online interviews conducted at initiation, (3 months, 6 months, 12 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 1st or 2nd visit. The Update Interviews (3, 6, and 12 months and Bi-Annual) 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, and 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 Internal Compliance Department. 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

- 🌱 All active members, with an Intellectual or other Developmental Disability (I/DD) who receive I/DD services or are placed on the waiting list to receive I/DD supports, must have an NC-SNAP administered annually.
- 🌱 NC-SNAP Assessments will be completed in accordance with protocols specified in the *NC-SNAP Examiner's Guide*. (<http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-support-needs-assessment-profile>)
- 🌱 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 members 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 Internal Compliance 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 Form section Operational Information & Forms (<https://www.trilliumhealthresources.org/for-providers/provider-documents-forms>) with date and location of each training.

Trillium Health Resources 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 about the NC-SNAP, visit the state's NC-SNAP website at:

<http://www.ncdhhs.gov/mhddsas/providers/NCSNAP/index.htm>

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:

- | | | | |
|---------------------------------|---------------------------------|-----------------------------------|----------------------------------|
| <input type="radio"/> Beaufort | <input type="radio"/> Craven | <input type="radio"/> Martin | <input type="radio"/> Pender |
| <input type="radio"/> Bertie | <input type="radio"/> Currituck | <input type="radio"/> Nash | <input type="radio"/> Perquimans |
| <input type="radio"/> Brunswick | <input type="radio"/> Dare | <input type="radio"/> New Hanover | <input type="radio"/> Pitt |
| <input type="radio"/> Camden | <input type="radio"/> Gates | <input type="radio"/> Northampton | <input type="radio"/> Tyrrell |
| <input type="radio"/> Carteret | <input type="radio"/> Hertford | <input type="radio"/> Onslow | <input type="radio"/> Washington |
| <input type="radio"/> Chowan | <input type="radio"/> Hyde | <input type="radio"/> Pamlico | |
| <input type="radio"/> Columbus | <input type="radio"/> Jones | <input type="radio"/> Pasquotank | |

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 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:

<input type="radio"/> Beaufort	<input type="radio"/> Craven	<input type="radio"/> Martin	<input type="radio"/> Pender
<input type="radio"/> Bertie	<input type="radio"/> Currituck	<input type="radio"/> Nash	<input type="radio"/> Perquimans
<input type="radio"/> Brunswick	<input type="radio"/> Dare	<input type="radio"/> New Hanover	<input type="radio"/> Pitt
<input type="radio"/> Camden	<input type="radio"/> Gates	<input type="radio"/> Northampton	<input type="radio"/> Tyrrell
<input type="radio"/> Carteret	<input type="radio"/> Hertford	<input type="radio"/> Onslow	<input type="radio"/> Washington
<input type="radio"/> Chowan	<input type="radio"/> Hyde	<input type="radio"/> Pamlico	
<input type="radio"/> Columbus	<input type="radio"/> Jones	<input type="radio"/> Pasquotank	
- 🌱 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 with private families 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."

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 MHDDAS Web site. (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
-  no longer qualifies for Medicaid or becomes a beneficiary ineligible for enrollment

- 🌱 If a member is dis-enrolled due to loss of Medicaid eligibility as indicated on the 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
- 🌱 Request by member
- 🌱 Member's uncooperative or disruptive behavior resulting from their special needs with the exception of when their continued enrollment would seriously impair Trillium Health Resources' ability to furnish services to the member or other members

ELIGIBILITY FOR STATE-FUNDED SERVICES

Members 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 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.

Members 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 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/Customer Service; Care Coordination; 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 Director oversees all clinical activities performed in Clinical Operations and supports the Clinical Advisory Group.

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 Web site. (See the [Resources & Web Links](#) section at the end of this Manual for the link to this document.)

CALL CENTER/CUSTOMER SERVICE

Trillium is responsible for timely response to the needs of members and for efficient linkages to Network Providers. Call Center/Customer Service 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 an member or family member calls the toll free Trillium Crisis Care & Service Enrollment Number, staff is 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 14 calendar days of contact at 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.

ROUTINE REFERRAL PROCESS

1. The Call Center Staff will collect demographic information on the caller and search for the member in the CIE System.
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.
3. The Call Center staff will evaluate the member's clinical need as follows:
 - 🌿 Complete the state mandated Screening, Triage and Referral tool and document the information obtained following the current CIE System;
 - 🌿 Retrieve and review the member's historical information, as needed;
 - 🌿 Use the information provided, determine the type of clinical services needed.
4. The Call Center Staff will offer the member a choice of two (2) providers (when available) and document the selection in the CIE System. Choice is determined by weighting providers in the following areas:
 - 🌿 Availability of service
 - 🌿 Proximity to member
 - 🌿 Member's desired attribute in provider or provider specialty
5. The Call Center staff will call the chosen provider for immediate scheduling with the member on the line. If an appointment is not available within availability guidelines, the member may choose another provider.
 - 🌿 Call Center staff will provide the agency with a brief overview of the member'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 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. An member's clinical need may be considered URGENT if, but not limited to the following:
 - 🌿 An member reporting a potential substance-related problem

- 🌿 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
- 3. The Call Center Clinician will determine through clinical screening whether the member 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 safe until immediate supports or services are in place.
- 4. 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 IS UNABLE TO BE STABILIZED

1. 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.
2. Trillium Call Center Clinicians will continue to follow-up with any Emergency contact until it is ascertained that the member 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, Web site 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




1. 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.
2. After reviewing the request, if the member's situation meets Trillium's established clinical criteria for the requested service, the Clinician will complete the following steps:
3. Authorize the service based on the Authorization Guidelines.
4. 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'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 with functioning in the community.



The Call Center staff may assist with the discharge planning for members in acute levels of care. Among the functions:

-  Identify members 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 Coordination
-  Make follow-up appointments with appropriate community providers

FOLLOW UP AFTER DISCHARGE

Call Center staff recognizes the importance of follow up care after an member is discharged from an acute level of care. Every effort is made to ensure the member 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 is still not able to engage in treatment, the Provider with the assistance of Call Center Staff will attempt to re-engage the member into services.

GRIEVANCES & COMPLAINTS

A ***grievance*** is defined as any expression(s) of dissatisfaction about any matter other than a Adverse Benefit Determination (see definition of action below) **filed by an member or by an individual who has been authorized in writing to file on behalf of an 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 cannot be appealed, unless it is a state-funded service.

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.

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;
- 🌱 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 § 438.408(b)
- 🌱 The denial of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
- 🌱 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.

Grievances and Complaints can be received and entered by anyone at Trillium. Trillium staff is available to assist members in filing their complaint or grievance. If an individual requests to have a complaint or grievance filed anonymously, all reasonable efforts will be made to protect their identity. Trillium provides safeguards for protecting the complainant/grievant from harassment or retaliation; Call Center/Customer Services is responsible for entering grievances and complaints received via telephone call through the Crisis Care and Service Enrollment number or through the Trillium toll free business line, 1-866-998-2597. Grievances and complaints that come through the Trillium website (www.TrilliumHealthResources.org) or by US mail to Trillium are entered by the Call Center/Customer Services. Trillium maintains a formal process to manage complaints and grievances through a centralized, coordinated process overseen by the Customer Service Team.

If the issue is not something that Trillium agency has oversight of, the Customer Services Manager or designee will make a referral to the appropriate agency, which could include but is not limited to the Department of Social Services, Division of Health Service Regulation, Division of Mental Health/Developmental Disabilities/Substance Abuse Services.

All Provider related complaints or grievances will be referred by the Customer Services Team to the Network Department. Once resolution is determined, The Network Department Team member will send a standardized resolution letter to the person who filed the complaint or grievance.

Written acknowledgement of the receipt of complaints and grievances will be provided to person who initiated the complaint or grievance. Most grievances and complaints are resolved within 30 calendar days of receipt. Per Federal Regulation 438.408 the MCO may extend the timeframe by up to 14 calendar days if the member requests the extension, or if the MCO shows that 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. Trillium Health Resources will investigate all complaints and grievances within 30 calendar days of receipt, and will issue written resolution to all parties involved. Per contractual requirements, contracted Providers of Trillium Health Resources are required to cooperate fully with all investigative requests, including but not limited to, immediate access to any of the contracted 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 Health Resources Call Center/Customer Services.

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

Trillium Health Resources' toll free business line, 1-866-998-2597, must be published and made available to all members 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 in Raleigh and Disability Rights NC.

TRILLIUM CARE COORDINATION DEPARTMENTS

Care Coordination 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 coordinator.

Care Coordination admission is determined by the entrance criteria set by the DMA and DMH contracts.

Care Coordination at Trillium consists of a Mental Health/Substance Use and Transitions to Community Living (TCLI) Department and an Intellectual and Developmental Disability Department. These departments assist members through:

- 🌱 Education regarding MH/SU, IDD, and TCLI services available; including recovery oriented supports and natural/community supports
- 🌱 Ensuring members served have received a quality comprehensive assessment identifying symptoms/diagnosis, how the symptoms affect daily life, and identifies strengths and treatment needs
- 🌱 Developing and monitoring the Person Centered Plan(s) and Individual Support Plan(s)
- 🌱 Requesting and monitoring Crisis Plans
- 🌱 Linkage to needed psychological, behavioral, educational, and integrated health care services
- 🌱 Assisting with coordination of all Medicaid benefits including primary care engagement
- 🌱 Monitoring the treatment and health/safety of the person served, satisfaction with care and services, and to ensure services are delivered as specified in the plan.

Care Coordination 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.

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 IPRS functions. IPRS

stands for integrated payment and reporting system, which processes state-funded claims submitted by providers.

HOUSING

The Housing Department works to ensure members 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 residential 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*.

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 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'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.

For a full listing of all NC Medicaid Plan Service Definitions and Criteria, visit the Division of Medical Assistance Web site. (See the [Resource 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.

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 and/or 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 / 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 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 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 NC DMA Clinical Coverage 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 Medical Assistance (DMA) 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:
 - 🌱 Recipient 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.

A Person-Centered Plan/Individual Support Plan (PCP/ISP) by itself does not initiate a request for service.

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

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

AUTHORIZATION

Timeframes for completion of the clinical review are as follows:

- 🌱 Urgent – 72 hours
- 🌱 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 an 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 an Member's life or health or ability to attain, maintain, or regain maximum functioning.

If the review of the TAR indicates the member'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 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 applicable clinical criteria and guidelines, a Peer Review ***can be requested by the provider agency*** with a Peer Reviewer.
 - 🌱 Peer Reviewer Definition – The Medical Director 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'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 with functioning in the community.

Involvement of family members and other identified supports, including members 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;
 -  The Member understands the status of the discharge plan;
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 in all levels of care. Among the functions:
 -  Identify Members 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 to assure that they receive clinically indicated services.
- 🌱 Whenever an Member 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 the member 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 Coordination Department (CCD) for follow-up by a Care Coordinator.

HOSPITAL ADMISSIONS

For members 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 involuntary) until such member is discharged from the hospital.

REGISTRY OF UNMET NEEDS

Trillium maintains a Registry of Unmet Needs to track requests for non-emergency services that have not been met through neither state-funded nor non-entitled Medicaid categories. The purpose of the Registry is to allow Trillium and providers to coordinate services for members. The Registry is available to providers through the Client Gateway of Provider Direct.

SECOND OPINION

A Medicaid member has the right to a second opinion (at no cost to them if it is obtained from a network provider) if the person does not agree with the diagnosis, treatment, or the medication prescribed. The Trillium Clinical Operations Department will arrange for a second opinion in collaboration with the Call Center/Customer Services Department upon request by an member or recipient.

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 one of the local Trillium Business Numbers listed on page two of this Manual.

There are times when an 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 Medical Assistance (DMA) Web site. (See the [Resources & Web Links](#) section at the end of this Manual for Web site 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 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 Notice of Denial for Incomplete Request/ Lack of Information is issued, the notice will identify what information was missing from the request.

REDUCTION, SUSPENSION, OR TERMINATION

Services an 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. 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 member/guardian or authorized representative requests reconsideration by the deadline stated in the letter, the services may continue through the end of the original authorization.

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

MEDICAID SERVICES APPEAL - LEVEL I

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 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 reconsideration review, the request must be completed and returned by fax, mail or in person.

Upon request, Trillium will provide the appellant/ authorized representative the case/reconsideration file, including medical records, and any other documents and records. Once appellant/authorized representative has requested the case file, Trillium will also provide and any new or additional evidence considered, relied upon, or generated by LME/MCO Trillium in connections with the appeal of the adverse benefit determination. The information must will 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 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 initial decision, determines the Reconsideration Decision.

Trillium is allowed to take 30 calendar days from the date the Request for Reconsideration is received for a decision to be made by the LME/MCO.

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

STEPS TO FILE A RECONSIDERATION REQUEST

To request an Trillium Reconsideration, the member/guardian/authorized representative and/or the provider (in making the request on the member's/guardian's behalf or supporting the member's/guardian's request with *written* consent) must complete and return the Trillium Reconsideration Review Form by one of the following methods:

- 🌱 Fax to 252.215.6879
- 🌱 Mail to address listed on [Correspondence Timeline & Addresses](#) page at end of this manual
- 🌱 Or hand-deliver form to Trillium administrative/ corporate office location(s).

A request made orally must be followed with a signed, written request within 30 calendar days, unless it is a request for an expedited appeal. The date of an oral filing request is made constitutes the filing date. If requested, Trillium will provide another copy of the Reconsideration Request Form to facilitate the process.

Trillium ensures that punitive action is not taken against the network provider who either requests an expedited request or supports an 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. However, unless the member or the network provider requests an expedited appeal, an oral filing must be followed by a written, signed appeal. 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 or health or ability to attain, maintain, or regain maximum function.

Expedited Reconsideration requests may be filed orally or in writing. Oral requests for Expedited Reconsideration that are accepted do not require written follow-up requests.

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 reconsideration review and written notice within 2 calendar days and the process will follow the standard reconsideration timelines.

An 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 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 AND 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 by Trillium.

MEDICAID SERVICES APPEAL MEDIATION - LEVEL II

Once the Appeal is processed, The Mediation Network of North Carolina will contact the member/guardian to offer an opportunity to mediate the disputed issues in an effort to resolve the pending appeal informally. If the member/guardian accepts mediation, it must be completed within 25 days of the request.

If the issues are resolved at mediation, the appeal will be dismissed and services will be provided pursuant the Mediation Agreement. If member/guardian does not accept the offer of mediation or the results of mediation, the case will proceed to a hearing and will be heard by an Administrative Law Judge with the Office of Administrative Hearings. This is referred to as the state Fair Hearings process.

MEDICAID SERVICES APPEAL /HEARING - LEVEL III

Member/guardian must file an appeal with the NC Office of Administrative Hearings (OAH), Department of Health and Human Services and Trillium within 120 calendar days from the mailing date of the Reconsideration Review Decision to the addresses listed on the form.

This state level hearing is conducted by an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH.) The hearing is scheduled to occur by telephone unless member/guardian requests to attend in person.

Member/guardian will receive notice of the date, time and location of the hearing. The hearing will be scheduled at the member's/guardian's convenience in a location close to the member/guardian.

For questions concerning the decision Trillium made about your request for Medicaid services, please contact Trillium at 1-877-685-2415. Should you have questions about the State Fair Hearing, please contact OAH using the contact information below, or visit

<http://www.oah.state.nc.us/hearings/medicaid.html>.

Agency	Mailing Address	Telephone Number	Fax Number
North Carolina Office of Administrative Hearings (OAH)	Attn: Clerk 6714 Mail Service Center Raleigh, NC 27699-6700	919-431-3000	919-431-3100
Trillium Health Resources	Appeals Department 201 W. First Street Greenville, NC 27858	1-877-685-2415	252-215-6879

MEDICAID SERVICES APPEAL FINAL AGENCY DECISION - LEVEL IV

If the member/guardian disagrees with the Final Agency Decision, they may retain an attorney and ask for a judicial review in Superior Court.

If the final resolution of the Appeal is not decided in the member's/guardian's favor, (meaning 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, s/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 URAC--the external accrediting body--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.

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 *Division's Non-Medicaid Appeals Panel*, as well as the process for doing so.

NON-MEDICAID APPEAL REQUEST TO DHHS

If member/guardian/authorized representative disagrees with the Non-Medicaid Service Decision, s/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 member'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 (DMH/DD/SAS.) The panel will issue their findings and decisions within 60 days of receipt of the Appeal Request form to both the member/guardian and Trillium Executive Director.

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 member for support.

When a member/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 Crisis Care & Service Enrollment Number 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 14 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**
- 🌱 maintain systems and procedures to ensure, for emergencies, provider staff must provide emergency face-to-face care within the required **wait time of two hours after the request** for care is initiated by the member; life threatening emergencies shall be managed **immediately**
- 🌱 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 (*NC GS §122C-18*) regarding retaliation against a person for complaining to an 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/Customer Service Center to help you in the most efficient and effective way possible

Utilization Management

- 🌱 obtain authorizations as required for contracted services
- 🌱 ensure members 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 member 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 needs by providing services in accordance with Trillium Practice Guidelines
- 🌱 participate actively in a person-centered planning process with others serving the member to develop a comprehensive Person-Centered Plan
- 🌱 development of treatment and/or habilitative programs that are in accordance with the Person-Centered Plan

Care Coordination

- 🌱 comply with Trillium care coordination requirements
- 🌱 work with Trillium to ensure a smooth transfer for any members who desire to change providers, or when you need to discharge an member because you cannot meet his/her special needs
- 🌱 communicate with the Care Coordinators 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 coordinators whenever an individual receiving Care Coordination misses two appointments
- 🌱 contact Trillium care coordinators for members on an outpatient commitment order who fail to keep any appointment
- 🌱 educate members on Medicaid transportation

Trillium responsibility to Providers is to:

- 🌱 provide accurate and timely response to TARs
 - 14 days for a routine request
 - 72 hours for an expedited request
- 🌱 ensure members receive medically necessary services
- 🌱 ensure members who need a service are listed in the system
- 🌱 inform providers of members receiving Care Coordination
- 🌱 complete telephonic or on-site visits to monitor the health and safety of the member receiving Care Coordination
- 🌱 assess the satisfaction of members 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
- 🌱 educate members receiving Care Coordination 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.

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.

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 an 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 an 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 member has Medicaid or has already been enrolled in the Trillium system, s/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.

The Medicaid information must be provided when requesting an enrollment. If the member has any other third party insurance, including Medicare, this information must also be included in the enrollment request. Members whose services are 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.

COORDINATION OF BENEFITS

Trillium is the payor of last resort. Providers are required to collect all first and third party funds **prior** to submitting claims to Trillium for reimbursement.

First party payors are the members or their guarantors. Services paid for with Local or State funds are subject to the sliding fee schedule established by the provider.

Third party payors are any other funding sources that can be billed to pay for the services provided to the member. Third party payors can include worker's compensation, disability insurance or other health insurance coverage.

All claims must identify the amounts collected from both first and third parties and only request payment for any remaining amount.

In accordance with the contract between the Division of Medical Assistance (DMA) and Trillium, no co-payments, deductibles, or other forms of cost sharing from Medicaid Members can be charged for Medicaid services.

ELIGIBILITY DETERMINATION PROCESS BY PROVIDER

Providers should conduct a comprehensive eligibility determination process whenever an 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 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 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 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 an 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, s/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 an member, not to a provider. Once the annual limit has been reached for an 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

Provider contracts include a listing of services which they are eligible to provide. All providers are reimbursed at the Trillium published rates for the service being provided 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.

STANDARD CODES FOR CLAIMS SUBMISSION

Refer to the Trillium Web site for the following

-  CPT/HCPCS/Revenue Codes
-  Modifiers
-  Diagnosis Codes
-  Place of Service Codes

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:

-  Claim Inquiry
-  Adjustment request
-  Void a claim
-  Open billing window
-  Resubmission of denied claims

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 bundled 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 Web site.

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 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 on Trillium's website at www.trilliumhealthresources.org in the Provider Document Library under For Providers.8

REPORTING TO STATE AND FEDERAL AUTHORITIES

For each case of reasonably substantiated suspected provider fraud and abuse, Trillium is obligated to provide DMA 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

Trillium's responsibility to Providers is to:

- 🌱 certify funding for all contracts in accordance with GS 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
- 🌱 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 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.

QUALITY MANAGEMENT

The Quality Management Department has oversight for quality assurance and improvement activities throughout the Trillium Health Resources system. The department supports a Global Continuous Quality Improvement system that includes all network providers.

Within the organization, quality assurance is used as the foundation for quality improvement and provides information in guiding the improvement process. Information from quality assurance 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 Quality Management 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 Quality Management Department provides training to the Provider Network on standards, requirements, quality improvement, indicators and targets and other critical areas of performance as needed. The department provides necessary information to the Global Quality Improvement Committee and Human Rights Committee and tracks, evaluates, and investigates incidents. The Quality Management Department also implements a system of review and investigation and will make referrals for monitoring to the Network Department if deemed necessary.

Trillium Health Resources 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 Quality Management Department interfaces with the providers in the network. The Trillium Health Resources Quality Management Plan describes an in-depth overview of the Quality Management Program and agency quality management activities and can be found on the website at www.trilliumhealthresources.org.

TRILLIUM QUALITY MANAGEMENT DEPARTMENT

An important part of Trillium Health Resources' role as an LME/MCO is to monitor the performance of providers in its network therefore the Quality Management Department is responsible for the following functions related to network provider performance:

-  Incident Report monitoring
-  Quality Improvement Projects
-  Surveys
-  CQI
-  Global Quality Improvement Committee
-  Provider Performance Data

The Data Unit within the Quality Management Department is responsible for Data Analysis and Data Management within Trillium Health Resources. The Data Unit consists of a Data Manager and Data Analysts. The Data Unit is responsible for measuring outlined Performance Indicators in the core functional areas in order to assure compliance with DMH and DMA contract requirements, as well as accreditation standards.

The Data Unit generates reports, analyzes data, and identifies notable trends and patterns for various quality measures. Decisions and recommendations are made based on this data.

The Data Unit 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 Health Resources members. Trillium Health Resources uses the information discovered to guide policy decisions and annual improvement goals.

The Performance Improvement Unit within the Quality Management Department consists of a Performance Improvement Manager and Quality Management Coordinators.






This Unit is responsible for monitoring provider incident reports, reviewing provider quality improvement projects, administering satisfaction surveys, policy and procedure management and tracking, conducting root cause analyses, internal monitoring of accreditation standards and various other projects and tasks.

INCIDENT REPORT MONITORING

Providers of publicly funded services licensed under NC General Statutes 122C, AND providers of publicly funded non-licensed, periodic mental health, developmental disabilities and substance abuse services are required to complete and report incidents for members receiving mental health, developmental disabilities and substance abuse services. Private independent practitioners, clinicians, and hospitals are not required to report. These reports should not be filed in the member record, but should be filed on site for review during local monitoring.

Providers are required to develop and maintain a system to collect documentation on any incidents that occur in relation to an member. This includes all state reporting regulations in relation to the documentation and reporting of critical incidents. In addition, providers must submit all Level II and Level III incident reports to Trillium Health Resources through the IRIS system.

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 are protected from involvement with that staff person until the allegation is substantiated or unsubstantiated. The agency must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated.

Trillium Health Resources is required, under North Carolina Administrative Code, to monitor certain types of incidents that occur with providers in its network, as well as, providers who while not in Trillium Health Resources network, operate services in one of the counties Trillium Health Resources area covers.

Regulations regarding 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 Health Resources is required to monitor the state IRIS system. Performance Improvement unit staff review all incidents when received by Trillium Health Resources 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.

If concerns are raised related to member's care or services or the provider's response to an incident, the Quality Management Department may collaborate with the Program Integrity Department to conduct a review as needed. A Plan of Correction may be required for failure to report incidents as required by Administrative Rule and the Provider Contract.

An incident is an event at a facility or in a service that is likely to lead to adverse effects upon an 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 for further information and clarification. Trillium Health Resources will provide training as needed and when changes are made by the Division of MH/DD/SAS.




The Incident and Death Response Systems Manual and IRIS Manual can be found at NC MH/DD/SAS: Manuals and Forms. IRIS website locations:

<http://www.ncdhs.gov/mhddsas/providers/NCincidentresponse/index.htm>

LEVEL I INCIDENTS - These incidents are those that do not threaten the health and safety of the member or others, and require routine care. Level I incidents should be reported to the appropriate clinical staff involved in the care of the member. It is required that they be documented and filed on site, these reports will be reviewed during local monitoring visit. These reports should not be filed in the member record, but should be filed on site for review during local monitoring.

LEVEL II INCIDENTS - These incidents are those that are "any happening, which is not consistent with the routine operation of a facility or service or the routine care of an member that is likely to lead to adverse effects upon the member." These reports are to be entered into the IRIS website within seventy two (72) hours of the incident. These incidents should also be reported to the appropriate clinical staff involved in the care of the member. These reports should not be filed in the member's record, but should be filed on site for review during local monitoring.

LEVEL III INCIDENTS - These incidents are those that are "any happening, which is not consistent with the routine operation of a facility or service or the routine care of a member, that is likely to lead to adverse effects upon the member, and result in:

-  Death, permanent physical impairment or psychological impairment to a member
-  A death, permanent physical impairment or psychological impairment caused by a member or
-  A threat to public safety caused by a member

For Level III incidents the provider will verbally notify Trillium Health Resources within twenty five (25) hours and will file a report in IRIS within seventy two (72) hours of the incident. Deaths within seven (7) days of a restrictive intervention must be reported verbally and filed into IRIS immediately.

For Level III incidents the provider shall conduct a peer review meeting within 24 hours of the incident.

The peer review shall review the member record, gather additional information if needed, and file a report in IRIS concerning the incident and notify any other authorities required by law (DSS, North Carolina HealthCare Personnel Registry, DJJ, etc). The report needs to be submitted within 24 hours of the incident.

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

Additional Reporting to the MCO and DMH/DD/SA - If an incident is likely to be reported in a newspaper, on television or in other media, or if the member is perceived to be a significant danger to or concern to the community, the provider in addition to submitting the report in IRIS, is to verbally report the incident to the Performance Improvement Unit at IncidentReporting@TrilliumNC.org within 24 hours of learning of the incident.

RESTRICTIVE INTERVENTIONS - Restrictive interventions must be documented in the state IRIS system at <https://iris.dhhs.state.nc.us/>. There are two types of restrictive interventions:

PLANNED INTERVENTIONS - If there is a therapeutic need for an member to have hands on intervention or other rights' restrictions as on-going interventions it needs to be included as an addendum to the member's 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 Health Resources staff for submission and review.

If the member has a planned intervention as part of their documented treatment and the member is 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 members person centered plan and have not been approved for use by a Human Rights Committee. These incidents 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

Effective 3/16/2016, all restrictive interventions that occur in a Psychiatric Residential Treatment Facility (PRTF) are no longer considered Planned Interventions even with an approved behavior plan or standing order. Therefore, all restrictive interventions are considered Emergency Interventions and are required to be entered into the Incident Response Improvement System (IRIS). Presentation with reporting requirements can be viewed on the Trillium website.

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. The reports must be submitted to Trillium bi-monthly. Hours missed from the 1st to the 15th 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 should be submitted to the Performance Improvement Unit at IncidentReporting@TrilliumNC.org, or via fax at 252-215-6880.

CONTINUOUS QUALITY IMPROVEMENT

Trillium Health Resources quality improvement philosophy is based on the continuous quality improvement model which involves a process of design, discovery, remediation, and improvement. This model includes:

- 🌱 A process for implementing appropriate remedial action for continuous quality improvement;
- 🌱 A structured and systematic approach to identify quality improvement opportunities;
- 🌱 A common language for problem solving techniques;
- 🌱 Facilitation of communication among groups;
- 🌱 Provides supports for the basis quality value of managing by data;
- 🌱 An increase in the credibility of data and reproducibility

The design, discovery, remediation and improvement model is a process to identify and implement strategies and improvement activities.

DESIGN

The designing and incorporation of quality and improvement strategies into the structures and processes of the organization.

DISCOVERY

Evaluate data, identify opportunities to prevent/improve behavioral health problems or occurrences, and identify appropriate intervention strategies based on best practices and known barriers.

REMEDiate

Implement program(s) to address identified needs and barriers.

IMPROVEMENT

Measure the effects of the improvement program and assess its effectiveness. Continue intervention if effective. Adjust as necessary to achieve goal targets. Repeat cycle if intervention does not achieve desired result.

Trillium Health Resources values and expects Network 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, 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 Health Resources.

PROVIDER QUALITY IMPROVEMENT PROJECTS

A Quality Improvement Project is an initiative to measure and improve the service and/or care provided by the 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 a minimum of three (3) quality improvement projects per fiscal year (July-June.)

Trillium Health Resources requires all state contracted providers to complete three (3) annual quality improvement projects that demonstrate evidence of performance improvement related to some aspect of organizational processes/structure, member outcomes, or other Provider Improvement activities. These projects are due annually by July 31st.

The Quality Management Team reviews the annual QI projects using a standardized check sheet tool and provides feedback to each of the submitting providers.

The tool can be found on the Trillium Health Resources website at <http://www.trilliumhealthresources.org/for-providers/provider-documents-forms>. Technical assistance is provided upon request. A Plan of Correction may be requested from those state-funded providers that fail to submit QI projects.

For further information please reference the training provided on the Learning Portal as well as other documents on the Trillium Health Resources website.

SURVEYS

PROVIDER SATISFACTION SURVEY

An annual Provider Satisfaction Survey is conducted by the Division of Medical Assistance (DMA). DMA contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess provider satisfaction. Once complete, results of the survey are returned to Trillium Health Resources for analysis, review, and any corrective action if deemed necessary.

MEMBER SATISFACTION SURVEY

The NC Division of Medical Assistance (DMA) conducts an annual satisfaction survey for all Medicaid members. DMA contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess member satisfaction with services. Once complete, results of the survey are returned to Trillium Health Resources for analysis, review, and any corrective action if deemed necessary.

PERCEPTION OF CARE SURVEY

The NC Division of MH/DD/SAS conducts a Perception of Care survey on an annual basis to assess members perception of care of services received from network providers. 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 complete, results of the survey are returned to Trillium Health Resources for analysis, review, and any corrective action if deemed necessary. The Perception of Care survey is administered to a random selection of members each year. Providers are expected to participate in the survey process upon receiving notification from Trillium Health Resources.

GLOBAL QUALITY IMPROVEMENT COMMITTEE

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

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

The objectives of this Committee include:

- 🌱 Review quality concerns developing in the Network
- 🌱 Assess training needs of the Network related to quality
- 🌱 Collaborate with Trillium Health Resources QM staff regarding quality issues
- 🌱 Review current standards and set minimum standards for providers QA/QI systems
- 🌱 Allow for avenues in which providers can learn from each other

GQIC members are offering a 'Confidential Peer Review' process for providers interested in receiving feedback from the committee on how they can improve the development, tracking, and reporting of their annual QIPs.

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

When receiving the results of your QIP, the process for requesting this review will be included in your correspondence from Trillium. Email QMinfo@TrilliumNC.org if interested in engaging in the 'Confidential Peer Review' process.

Information from this committee is announced in Network Communication Bulletins. If there is interest in participating in the Global Quality Improvement Committee, please email at QMinfo@TrilliumNC.org.

PROVIDER PERFORMANCE DATA

Provider Performance Data Reports are created by the QM Data Unit. Trillium Health Resources shares performance data with network providers on, at minimum, an annual basis for the purpose of offering a snapshot into how they are doing in certain areas and allowing them to see how they are performing compared to similar providers. Performance data is shared with providers that have a full contract with Trillium Health Resources. Providers are grouped into "agencies" and "LIPs". Within these groups, like providers are determined by the number of people the provider serves. Each provider meeting these criteria will receive a report on their data and how their numbers compare to those other similar providers on an annual basis.

These reports may include performance data related to Claim Denials and Claim Denial Reasons, Authorization Denials and Authorization Denial Reasons, Accessibility, Quality Improvement Projects or other data elements of interest. This data is for informational purposes and can assist the providers in making internal improvements such as validating data or possible Quality Improvement Projects.

Trillium shares provider-specific performance data that 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.

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. The LME will offer training for providers around how to empower the people they serve to be prepared for a crisis such as disaster.

CORRESPONDENCE TIMELINES & ADDRESSES REFERENCE

ITEM TO BE SUBMITTED IN WRITING TO LME/MCO	TIMEFRAME FOR SUBMISSION	ADDRESS TO SUBMIT
Review/fully execute 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: Credentialing Specialist 112 Health Drive Greenville, NC 27834-7704
Re-credentialing – LIPs and Agencies	within 60 days of the original notification of re-credentialing	Trillium Health Resources Attn: Credentialing Specialist 112 Health Drive Greenville, NC 27834-7704
Provider Appeals/ Reconsideration	within 30 calendar days of the date of the letter	Trillium Health Resources Attn: Appeals Coordinator 3809 Shipyard Boulevard Wilmington, NC 28403-6150
Changes in Current Practice Information	within one (1) business day of any changes in status within five (5) business days of personnel changes or information updates	Trillium Health Resources Attn: Provider Operations Manager 112 Health Drive Greenville, NC 27834-7704
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	Trillium Health Resources Attn: Credentialing Specialist 112 Health Drive Greenville, NC 27834-7704
Medicaid Services Appeal-Level I (<i>on behalf of member with written permission from member/parent/guardian</i>)	within 60 days of the date of the Notice of Adverse Benefit Determination	Trillium LME/MCO Attn: Appeals Coordinator 3809 Shipyard Boulevard Wilmington, NC 28403-6150 Fax: (252) 215-6879

RESOURCES & WEB LINKS

Claims Request Form - For provider -> Provider Documents & Forms -> Claims
<https://www.trilliumhealthresources.org/for-providers/provider-documents-forms>

Clinical Coverage Policies, Division of Medical Assistance
<http://www.ncdhhs.gov/dma/mp/index.htm>

Constant Contact Subscription
[Constant Contact](#)

Record Retention Log - (Former Member Records Storage Log) For provider -> Provider Documents & Forms -> Operational Information & Forms
<https://www.trilliumhealthresources.org/for-providers/provider-documents-forms>

Cultural and Linguistic Competency Action Plan Recommendations - For provider -> Provider Documents & Forms -> Operational Information & Forms
<http://www.trilliumhealthresources.org/for-providers/provider-documents-forms>

Due Process and Prior Approval Procedures
<https://dma.ncdhhs.gov/providers/programs-services/prior-approval-and-due-process>

Trillium Help Desk
PDsupport@TrilliumNC.org

Fraud and Abuse List

- <https://dma.ncdhhs.gov/meetings-and-notice/report-fraud-waste-or-abuse>
- <http://www.trilliumhealthresources.ethicspoint.com/>

Classification of Incidents (Level I, II, or III)
<http://www.ncdhhs.gov/mhddsas/providers/NCincidentresponse/index.htm>

Limited English Proficiency (LEP)
<http://www.lep.gov/index.htm> Federal agency: Limited English Proficiency
www.ncitlb.org/ NC Interpreters and Transliteration Board
<http://www.ncdhhs.gov/dsdhh/directories.htm> Sign Language Interpreters/Transliteration Directory
<http://www.catiweb.org/> Carolina Association of Translators and Interpreters

Trillium Provider Communications

- Clinical Communications
<http://www.trilliumhealthresources.org/for-providers/provider-communications/clinical-communication-bulletins>
- The Network Communication Bulletins
<http://www.trilliumhealthresources.org/for-providers/provider-communications/network-communication-bulletins>

Learning Portal User Agreement For provider -> Provider Documents & Forms -> IT Information & Forms
<https://www.trilliumhealthresources.org/for-providers/provider-documents-forms>

NC-TOPPS Guidelines
<http://www.ncdhhs.gov/mhddsas/providers/NCTOPPS/index.htm>

Provider Direct
<https://www.ciecbh.org/ProviderDirect/Account/Login>

RESOURCES & WEB LINKS

NC-SNAP Guidelines

<http://www.ncdhhs.gov/mhddsas/providers/NCSNAP/index.htm>

Plan of Correction Template

<http://www.ncdhhs.gov/providers/provider-info/health-care/plan-of-correction>

Plans of Correction; Policy and Procedure for the Review, Approval and Follow-Up of

<https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/poc-policy.pdf>

Psychiatric Advanced Directive (PAD) and Health Care Power of Attorney legal forms

<http://pad.duhs.duke.edu/>

Service Definitions

<http://www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm>

Service Rates

<http://www.ncdhhs.gov/dma/fee/>

Target Population Criteria

<http://www.ncdhhs.gov/mhddsas/providers/IPRS/Targetpopulations/index.htm>

Waiver, NC MH/DD/SAS Health Plan and the NC Innovations

https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/0212_SPECIAL_BULLETIN_1915bc_Waiver.pdf





NC Innovations Waiver

<https://www2.ncdhhs.gov/ncinnovations/>




APPENDIX A

SUMMARY OF THE PROVISIONS OF THIS AGREEMENT TO BE PROVIDED TO MEMBERS AND PROVIDERS






The following statements, which are directed to members and providers, supersede any information contained in this handbook which may be inconsistent with these statements:

-  During the planning process, your Care Coordinator will explain the different services to you and work with you to develop your Plan of Care based on the services you wish to request. Your Care Coordinator will also explain the requirements in the Innovations Waiver around those services.
-  Your Care Coordinator will assure that your Plan of Care will include the services that you want to request, for the length of time that you want to request them. Your Plan of Care should be used to plan for the entire year, and services that you expect to need at any point during that year. If you expect to need services for the entire year, your Care Coordinator will assure that the plan requests those services for the entire year.
-  You must have a signed Plan of Care in order to receive services through the Innovations Waiver. That means that you need to sign a Plan containing the level of services that you want to request, which may be different than the level of services that will be approved. Your Care Coordinator will draft the Plan of Care based on your wishes, will review the plan with you before you sign it, will answer any questions you have, and will make any changes to the plan that you request before you are asked to sign it.
-  If you wish to change or add services during the plan year, you may ask your Care Coordinator to help you request the change by writing an update to your Plan of Care at any time.

(Include next two paragraphs for Members and their Providers for whom Trillium Health Resources has implemented or is about to implement the SNM.):

-  The Support Needs Matrix (SNM) and Support Intensities Scale ® (SIS ®) are tools that may be used in the planning process. You may have an assigned SNM Base Budget, which is not a limit on the amount of services you 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 your assigned SNM Budget if Trillium Health Resources determines that services are medically necessary. If any of the services that you requested are denied, you will receive written notice with information about how you can appeal that decision.
-  During the planning process, your Care Coordinator will review your Base Budget with you. As mentioned above, your Care Coordinator will assure that your Plan of Care includes the level of services you want to request, for the length of time you want to request them. Your Care Coordinator will discuss service options with you, but will not ask you to submit or update a Plan of Care to request services to fit within your SNM Base Budget if you do not wish to do so
-  You (or your legally responsible representative) will need to sign the Plan of Care once it is complete.

You will not be asked to sign a plan that does not contain the level of services that you want to request. If you expect to need those services all year, you 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 you request are medically necessary, not your Care Coordinator. A decision on your request for services in your Plan of Care will be made within 15 days unless more information is needed.
-  If any service requested in your 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 you requested), you will receive a written explanation of that decision and information about how you can appeal.
-  Trillium Health Resources will not retaliate against you in any way if you appeal. Your Care Coordinator can assist you with the forms needed to file an appeal.
-  If some services are approved and some are denied, you can receive the services that were approved while you appeal the services that were denied. You may also make a new request for different services while your appeal is pending, if you wish to do so.
-  Your Plan of Care will include information on the period of time for which services are requested. If services that have been requested in your Plan have been approved and then are later reduced, suspended, or terminated before the approval period has ended, and you appeal that decision, you may be able to continue to receive services during an appeal. You will receive written notice about that process before any services are reduced, suspended, or terminated.