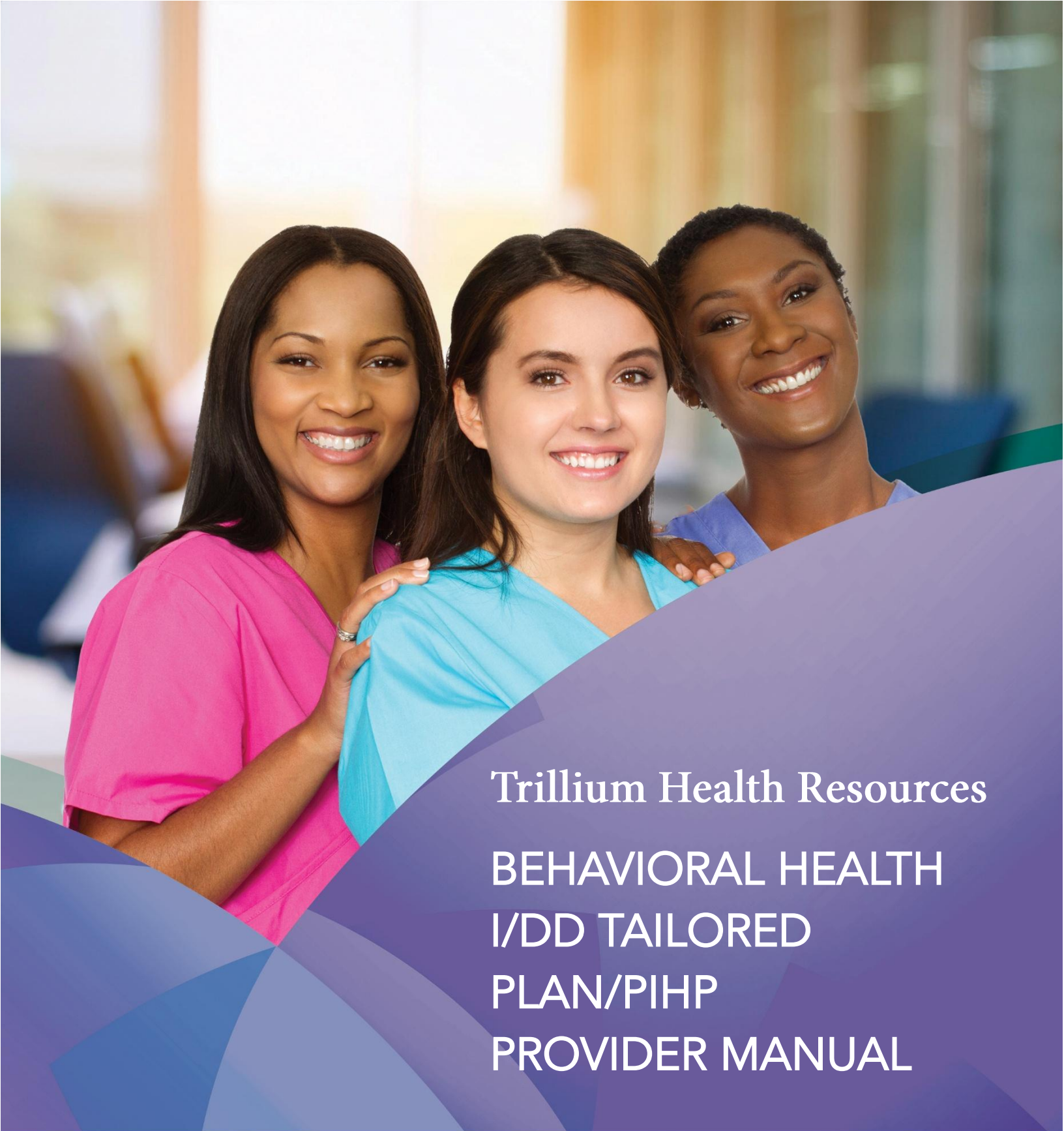




Trillium Health Resources

BEHAVIORAL HEALTH
I/DD TAILORED
PLAN/PIHP
PROVIDER MANUAL

Effective October 1, 2026



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 individuals across our 46-county catchment area with timely access to a comprehensive array of high quality, medically necessary services, including physical health, serious mental health, intellectual and/or developmental disability, substance use and traumatic brain injury services. We work together with our partners and community stakeholders to build and strengthen foundations of well-being and help deepen connections between citizens and their neighbors. Trillium is committed to the principles of recovery and self-determination. We wholeheartedly believe in person-centered services and supports. We fully understand that our success in achieving those goals is dependent upon our provider network. The public behavioral health system is successful because of the dedicated local providers who are deeply rooted in our communities.

This Provider Manual outlines how to do business with Trillium. It describes the processes and procedures we expect from you and tells you what you can expect from us in return. This Provider Manual is intended for Trillium's Provider Network of Tailored Plan, Prepaid Inpatient Health Plan and State-Funded providers. 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.

SENITRIA GOODMAN

Chief Executive Officer

Trillium Health Resources



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



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A. Introduction

Your responsibility as a Trillium Health Resources (Trillium) contracted provider is to review, understand and and comply with the requirements, guidelines, policies and procedures outlined in this Provider Manual. Your adherence to these requirements and applicable standards will assist Trillium in providing you with timely service authorizations and claim reimbursement. We thank you for your participation in our provider network and look forward to a collaborative and productive relationship as we work together to provide responsive, high-quality treatment to the individuals we serve.

The Provider Manual is available on the Trillium Provider Portal and on the Trillium website at TrilliumHealthResources.org under the For Providers tab. Please refer to the [Resources and Web Links section](#) at the end of this Manual for direct links to documents referenced throughout. A printed copy of the information posted on the website is available upon request by contacting Trillium's Provider Support Service Line at 1-855-250-1539.

Trillium communicates new information and procedural changes to the provider network on an ongoing basis to ensure providers remain informed of current requirements and expectations. Providers are responsible for monitoring communications and maintaining awareness of updates. Trillium distributes notifications through our through email distribution system [Constant Contact](#); therefore [at least one staff person in your office must enroll to receive these updates](#). Updates will be incorporated into revised editions of this Provider Manual as. A record of prior revisions to this document is maintained can be found in the concluding section of the Provider Manual.

About Us

Trillium Health Resources is a Tailored Plan and Managed Care Organization (MCO) that manages physical health, serious mental health, substance use, and intellectual/developmental disability and traumatic brain injury services in North Carolina. For individuals receiving Medicaid through the Tailored Plan, we cover pharmacy services as well.

Trillium manages health care plans for eligible individuals in a 46-county region: Anson, Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Guilford, Halifax, Hertford, Hoke, Hyde, Jones, Lee, Lenoir, Martin, Montgomery, Moore, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Randolph, Richmond, Robeson, Sampson, Scotland, Tyrrell, Warren, Washington, Wayne, and Wilson.

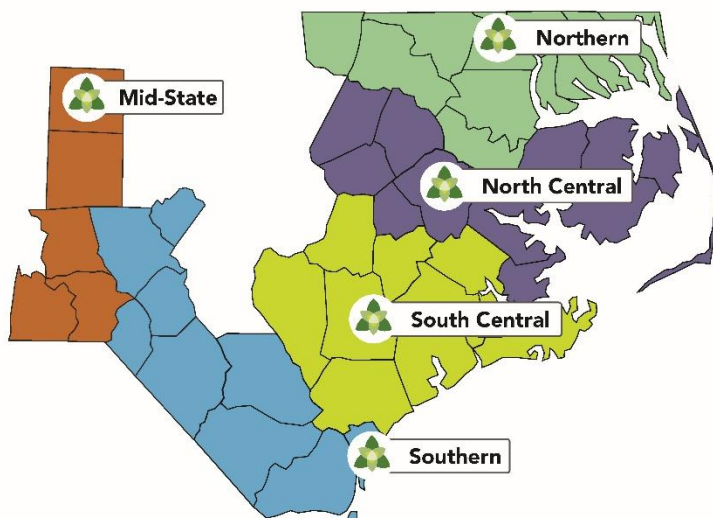
Trillium is nationally accredited by National Committee for Quality Assurance (NCQA) as a Health Plan. Trillium complies with applicable Federal civil rights laws and does not discriminate

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

Navigating Trillium's Provider Portals

To get started, identify your contract type and complete the required System Access Training(s) within thirty (30) calendar days of your contract effective date. Completing these training courses is necessary to access key functions including claims submission, service authorization requests, billing activity management, and provider information maintenance. Please note that some platform credentials may not be issued until required training is completed. Providers can learn more about System Access Training at the [Provider Onboarding](#) information page. Additional optional training modules are also available, including Cultural Competency, Compliance/Fraud, Waste, and Abuse, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

Member & Recipient Services:	1-877-685-2415
Behavioral Health Crisis Line:	1-888-302-0738
Provider Support Service Line:	1-855-250-1539
Pharmacy Line:	1-866-245-4954
Nurse Line:	1-877-685-2415



B. Clinical Practice Standards and Utilization Management Program

The Utilization Management (UM) Department includes Utilization Review (UR) functions. The UM Department determines whether a member meets medical necessity criteria and applicable target population requirements for the requested frequency, intensity and duration of services. Information regarding [UM Program Policies](#) and [Clinical Practice Guidelines](#) is available on the Trillium website to ensure accessibility at the point of care.

The Trillium Health Resources UM program is designed to provide beneficiaries and members with access to the right care, in the right setting and at the right time. The UM Program is comprehensive and applies to all covered services and care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, pharmacy services, ancillary services, and services addressing mental health, substance use disorders, intellectual/developmental disabilities and traumatic brain injury.

The Trillium Health Resources UM Program reviews each service requested to determine whether it meets the applicable benefit coverage requirements, including; medically necessary; appropriate for the member's condition; appropriate setting; and meet professionally recognized standards of care.

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

It is important providers understand the following member rights to support a member's request. A provider agency may not file an appeal of an adverse benefit determination without the written consent of the member or the member's parent or legal guardian authorizing the provider to act on the member's behalf. If the treating physician, practitioner or provider would like to discuss a case with a Trillium UM Care Manager or the physician or psychologist, this discussion is referred to as a peer-to-peer conversation. To request a peer-to-peer consultation please contact the Provider Support Service Line at 1-855-250-1539. There may be times when a member's request for services is denied, or when an existing service is reduced, suspended or terminated by Trillium Utilization Management. These actions constitute adverse benefit determinations and are subject to applicable member due process rights.

Detailed information regarding Due Process and Prior Approval Procedures is available on the website of the Division of Health Benefits. Please refer to the [Resources and Web Links section](#) at the end of this Manual for website links.

Denial

Denials may occur for administrative or clinical reasons. A clinical denial may occur when applicable medical necessity criteria or other clinical requirements are not met to support the request for authorization of a service. An administrative denial may occur when the request is determined to be incomplete or lacks required information.

If a request does not meet the minimum documentation requirements of the applicable Clinical Coverage Policy (CCP) for example, failure to include a Person Centered Plan (PCP), Individual Service Plan (ISP) treatment plan or other required documentation such as Comprehensive Clinical Assessment (CCA), NC SNAP, Psychological Testing, LOCUS®/ CALOCUS®/ASAM Criteria or required service orders the request will be considered incomplete or lacking required information and the will be administratively denied. A new request with the required documentation may be submitted at any time.

The member or the member's legal guardian will receive a written Notice of Adverse Benefit Determination by US Mail explaining the decision and the process for requesting an appeal. If a Notice of Adverse Benefit Determination for Incomplete Request/ Lack of Information is issued, the notice will identify the specific information that was missing from the request.

Reduction, Suspension, or Termination

Services that are currently authorized and being received by a member may be reduced, suspended or terminated at any point during the authorization period based on applicable factors including not following clinical guidelines or failure to continue to meet medical necessity criteria for the frequency, amount, or duration of a service.

The member, the member's parent or legal guardian or authorized representative will receive a written letter by US Mail at least ten (10) calendar days before the change occurs explaining how to request an appeal. If the member, parent, legal guardian or authorized representative requests an appeal within the timeframe specified in the letter, services may continue through the end of the original approved authorization period. Continuation of benefits does not apply to the denial of an initial request for services.

C. Covered Services

A complete table of covered services and applicable Clinical Coverage Policies can be found in the Appendix of this Manual.

OPIOID MISUSE PREVENTION AND TREATMENT PROGRAM

Trillium recognizes the seriousness of the ongoing opioid epidemic and is dedicated to improving the lives of our members with opioid use disorder and other substance use disorders across the

prevention, treatment and recovery continuum throughout covered populations and catchment area. Trillium is committed to increasing prevention awareness, implementing harm reduction strategies, connecting our members to appropriate treatment services for opioid use disorder, and improving access to overdose reversal medications. Trillium also supports the expansion of prevention, treatment, and recovery support services throughout our catchment area.

Trillium abides by the recommendations set by the North Carolina Opioid Action Plan, including the following:

Prevention:

- Cutting the supply of available opioids (both prescribed and illegal)
- Promoting safe prescribing practices consistent with applicable clinical guidelines
- Implementing the Lock In Program, which helps identify members that are at risk for possible overuse or improper use of pain medications
- Educating youth about the risks and harms associated with using opioids
- Regular Screening to identify youth at risk
- Working collaboratively with schools and local youth organizations to provide education and resources
- Providing education and support to parents and caregivers
- Improving treatments for expectant mothers currently using opioids
- Specialized Screening
- Referrals to substance use programs focused on expectant mothers and/or mothers of young children

Reducing Harm:

- Education to members, families, providers and the community regarding opioid dependence, opioid overdose and how to access treatment and support services, the availability and proper use of naloxone (Narcan) kits, and information on where the kits can be obtained.

Connecting to Care:

- Expanding the number of providers offering treatment and recovery services
- Expanding the use of telehealth services to improve access to care
- Addressing the needs of justice-involved populations

- Integrated projects with community partners through local community collaborative meetings

Tobacco Cessation Plan

Trillium contracts with Quit For Life to provide tobacco cessation services for Tailored Plan members. These services promote evidence-based treatments to help individuals quit smoking and using other nicotine products. Trillium collaborates with providers to support tobacco-free sites and facilities, encourage the use of nicotine replacement therapy and other clinically appropriate medications, and educate the public about the health risks associated with continued tobacco use. Members who currently use tobacco products and would like assistance with quitting may contact [Quit For Life](#) at 1-866-QUIT-4-LIFE

D. Eligibility for State-funded Services, Including Federal Eligibility Funding Restrictions and Requirements

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

State-Funded Eligibility Criteria for Behavioral Health (BH) Services:

- Recipient's Income is less than or equal to 300% of the federal poverty level.
- Recipient is uninsured or underinsured (has third-party insurance including Medicaid) that:
 - A. Does not cover the State-funded service and there is no alternative clinically appropriate service available under the third-party or Medicaid coverage; or
 - B. Covers the State-funded substance use disorder (SUD) service, but associated cost-sharing is unaffordable.
- Recipients utilizing State funds will be encouraged to apply for North Carolina Medicaid coverage.

For I/DD and TBI Services:

- No specified income limitation.
- Recipient is uninsured or underinsured (has third-party insurance including Medicaid) that does not cover the State-funded service and there is no alternative clinically appropriate service available under the third-party or Medicaid coverage.

- Recipient has applied for North Carolina Medicaid coverage.
- Eligibility criteria is not applicable to behavioral health crisis services and detoxification as reflected in the Department of Health and Human Services (DHHS) guidelines.

Eligibility for State-Funded Services

Providers requesting State funds must ensure that the recipient(s) also meet the appropriate [State Benefit Plan criteria outlined by DHHS](#) located under the appropriate link for State Fiscal Year documents. State-Funded Services are not an entitlement. Trillium and other Tailored Plans 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

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

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

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.

E. Care Management Delivered Through the BH I/DD Tailored Plans/PIHP

Tailored Care Management is a critical component of the Trillium Behavioral Health I/DD Tailored Plan/PIHP. Tailored Care Management (TCM) incorporates whole person care that is executed with the support of an integrated care team using person-centered practices to achieve better health outcomes for our members. Whole person care incorporates all aspects of a member's needs including behavioral health, physical health, pharmacy, and unmet health related resource needs.

All Trillium Medicaid members are eligible for and automatically enrolled in Tailored Care Management with the following exceptions:

- Members obtaining Assertive Community Treatment (ACT)
- Members participating in Child ACT
- Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs)
- Members participating in Care Management for At-Risk Children
- Members participating in the High-Fidelity Wraparound program
- Members who are currently receiving Critical Time Intervention services
- Members participating in Program of All-Inclusive Care for the Elderly (PACE)
- Members who are currently residing in a Skilled Nursing Facility for 90+ days
- Members who are receiving Community Alternatives Program for Children (CAP/C) waiver services
- Members who are receiving Community Alternatives Program for Disabled Adults (CAP/DA) waiver services
- Members who are receiving primary care case management
- Members who are a part of the Eastern Band of Cherokee Indians (ECBI) Tribal Option

Trillium members may opt out of Tailored Care Management at any time. Members who opt out of Tailored Care Management will continue to receive support as needed through care coordination and care transition activities. Members who opt out of Tailored Care Management may opt back into Tailored Care Management at any time.

Tailored Care Management Entities

Tailored Care Management (TCM) for Medicaid can be provided through three approaches: Care Management Agencies (CMAs), AMH+ (Advanced Medical Home Plus) practices, and Trillium itself. CMAs are provider organizations with experience providing behavioral health, I/DD, and/or TBI (Traumatic Brain Injury) services to Trillium's behavioral health and I/DD population. AMH+ practices are primary care practices whose providers have experience providing primary care services to Trillium's behavioral health and I/DD population. As a Behavioral Health I/DD Tailored Plan/PIHP Trillium can also provide Tailored Care Management to its members.

All the different approaches for TCM will be required to perform the same roles and responsibilities for Trillium's members. All entities have undergone an evaluation of their ability and been certified to execute Tailored Care Management by demonstrating their ability to support Trillium's members and meet associated requirements.

CMAs, AMH+ practices, and the Behavioral Health I/ DD Tailored Plan/PIHP are monitored in the provision of TCM to ensure that all required functions of Tailored Care Management are completed within the requirements set forth by the Department of Health and Human Services (DHHS) and that the support a member receives is effective and efficient in meeting their needs.

Upon enrollment to Tailored Care Management, members receive a choice in the care management approach they would like to receive and can select a provider of that specific TCM approach. Many factors including a member's existing provider relationships, specific behavioral health, I/DD, and/or TBI needs, complexity of medical needs, geographic location, etc. are taken into consideration when options of Tailored Care Management approach and provider are presented to the member.

Elements of Tailored Care Management

Some of the core functions of Tailored Care Management (TCM) include but are not limited to outreach and engagement, comprehensive assessment, care planning, multi-disciplinary care team involvement, ongoing support and follow-up, and support during care transitions, and diversion activities. These functions are consistent for all members receiving TCM.

Although a member may be automatically enrolled in Tailored Care Management, outreach must be conducted by the TCM Entity to engage the member in Tailored Care Management. Initial contact and engagement occur following a member's enrollment with Trillium's BH-I/DD Tailored Plan/PIHP. This engagement is critical to ensure that a member's needs are assessed through completion of a care management comprehensive assessment and addressed as appropriate.

The care management comprehensive assessment considers all aspects of a member's health and related needs. Assessment of a member's needs includes, but is not limited to, immediate care needs, current services and providers across all health needs, functional needs, physical health conditions, current and past mental health, substance status/disorders, medication information, future planning (e.g. advanced directives, power of attorney, legal guardianship, etc.), social supports, unmet health-related resource needs, cultural considerations, employment/ community involvement, education, justice system involvement, caregiver strengths and needs, life transitions, self-management and planning skills, and entitlement benefits. The completion of the assessment is the first step in the development of the Care Plan for members with Behavioral

health needs and an Individual Support Plan (ISP) for members with I/DD and/or TBI needs. The results of the assessment are used to develop the Care Plan or ISP. The Care Plan or ISP is developed using a process that is individualized and puts the member at the center of the planning and their care and outlines a plan of action to best support the member.

The completion of the assessment and Care Plan or ISP is reinforced through the support of a multidisciplinary care team. The care team is centered on the member, their needs and the supports involved in their life. Starting with the member, the care team can also include the member's caregiver/ legal guardian, doctors (e.g. primary care physician, obstetrician/gynecologist, and other specialists), behavioral health providers, I/DD and/or TBI providers, nutritionists, pharmacists, peer supports/ family navigators, and other supports as identified by the member and care manager.

Ongoing Care Management

The information obtained during the assessment and goals developed for the Care Plan or ISP sets the stages for the actions that should be taken to support a member as part of ongoing Care Management. The responsibility of Care Management moving forward is to coordinate, refer, and provide assistance in obtaining and maintaining Medicaid, and/or State-funded services as appropriate, services to address unmet-health related needs, and other care management supports. Care managers also work to conduct medication management and support the member's adherence to medication and other prescribed treatment regimes.

Ongoing communication with the member, legally responsible person, and other members of the Care Team is imperative and occurs regularly. Regular communication based upon the member's needs allows the care manager and other Care Team members to communicate regarding the progress towards goals in the Care Plan. Assessment and care planning become iterative processes in which the Care Team identifies member needs and coordinates to address those needs through the execution of the Care Plan or ISP. Assessment and care planning are conducted annually, when a member's needs change, at the request of the member, and at other triggering events as defined through regulatory requirements.

In-reach

For those members already residing in institutional settings or other higher levels of care that include as Adult Care Homes (ACH), State psychiatric hospitals, State developmental centers, Psychiatric Residential Treatment Facilities (PRTF), and Residential Treatment Levels II/ Program Type III, Care Management will conduct in-reach activities to identify those members who may be able to have their needs safely met in a community setting. AMH+ practices and CMAs can provide in-reach and transition services to children and youth admitted to a state psychiatric

hospital, PRTE, or Residential Treatment Levels II/ Program Type, III, and IV. For adults, AMH+ practices and CMAs can provide in-reach and transition services to those admitted to a state psychiatric hospital or an Adult Care Home (ACH) who are eligible for Tailored Care Management and who are not transitioning to supportive housing. For those members identified as being able to be supported in the community, in-reach services will provide education on peer support/family navigator services and other services/supports available to help support the member in the community, facilitate visits to Community-based services, and identify and address barriers to and concerns with moving to a community-based setting.

If a member decides to transition to a community-based setting, Care managers will work to initiate transition planning with the member's identified Care Team. Transition planning will work to detect a member's needs and link members with supports/ services (i.e. primary care physician, behavioral health providers, I/DD or TBI providers, medical specialists, etc.) among other activities to ensure a safe transition into the community for the member.

Transition Management

Members will move between different clinical settings and services as their needs change and evolve. Care Management will assist members in making these transitions to prevent any adverse consequences such as admissions or readmissions to the hospital, visits to the emergency department, etc. Care managers work closely with the member and the Care Team to proactively plan for these transitions, to support them during the transition, and follow-up afterwards for continuity of care.

Diversion

Care Management works to support the values of community-based services/supports ensuring that members are able to reside in the community and setting of their choosing. To help members accomplish and maintain these values, care managers perform diversion activities as needed for those members who meet certain requirements such as seeking entry to or recently admitted to an institutional setting or ACH or meeting other pre-established criteria for members with I/DD or TBI. Care managers support members by educating them on their eligibility for community-based services, referring and linking the members with those services, assisting with housing as needed, and developing and implementing a Community Integration Plan.

Children and Youth Services

Children and Youth Services support stakeholder collaboration with key community partners such as Department of Juvenile Justice (DJJ), Department of Social Services (DSS), local health departments and others involved in child and family well-being. This unit addresses youth with integrated care needs ranging from ages 0–18 and up to 21 for youth remaining in the 18–21 DSS

Foster Care Programs. This unit is a support mechanism to external stakeholders in navigating Trillium systems and service array in order to promote integrated care for children and youth. Another key focus of Children and Youth Services is to work with internal departments and external entities to uphold a healthy network of providers, ensuring gaps in services are identified through eliciting stakeholders' feedback while seeking resources to fill these gaps. Children and Youth Services is also instrumental in working with stakeholders to ensure appropriate linkage to assessments and evaluations to facilitate access to care.

Primary Care Provider Responsibilities

A primary care provider (PCP) is the participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by or assigned to the member to provide and coordinate all the member's health care needs and to initiate and monitor referrals for specialized services, when required.

Clinical Support

The primary purpose of the Clinical Support Unit is to triage Care Management/Care Coordination matters and send them to the appropriate Care Management/Care Coordination team or appropriate business unit for processing. Items which fall under the purview of the Clinical Support Unit range from processing requests for Care Management and Care Coordination, Care Management related SNOW tickets, TCM Provider requests for assistance, to processing Primary Care Physician requests for Care Management assistance.

Housing

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

Housing staff procure grants to expand community capacity for stable housing options that provide the opportunity for growth, skill building, and increased independent living. They maintain an inventory of housing resources and information on the unmet housing needs of members/ recipients 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 North Carolina Fair Housing Law and How to Be a Good Landlord/Tenant.

Trillium Advantage

Trillium Advantage covers services and settings that may not be covered by typical physical health, behavioral health, or intellectual/developmental disability services.

Trillium offers Value-Added Services specifically targeted to Tailored Plan members who experience challenges related to Health Equity in order to improve their access to resources and improve their overall health outcomes. Members must meet the eligibility requirements for the service and not have any other funding source available to meet the need for the program. Value-Added Service availability is subject to funding.

Trillium's Member Incentive Program helps members become involved in their health. It encourages healthy behaviors and education through gift cards and small rewards. Member Incentives are available to Tailored Plan members and select programs are available to Medicaid Direct recipients. Providers, members, and care managers can apply for incentives on behalf of the member. Members can receive up to \$75 in incentives each fiscal year based on funding availability.

Please visit our [TrilliumAdvantage](#) webpage for the most up to date information on eligibility and applications.

F. Provider Responsibilities

Your responsibility as a Trillium Contracted Provider related to Members' Rights 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 nontreatment 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 the right of all Medicaid members and refer the member to contact the toll-free Trillium's Member and Recipient Services at 1-877-685-2415 if a second opinion is requested.
- Discuss with members any specific requests they may have regarding their care.
- Respect the wishes expressed in Advance Instruction for Mental Health Treatment, or other legal advance directives 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.

Your responsibility as a Trillium Contracted Provider related to Contracts is to:

- Review your contract for accuracy and fully execute the contract and return to Trillium within ten business days of receipt to ensure continued payment for services.
- Sign and have a fully executed Trillium Contract Amendment for any material change to the original contract.
- Have a current disaster plan, including evacuation and fire plan, if providing services in a facility.
- Provide services only at qualified service sites as are approved in the Provider Portal.
- Adhere to all performance guidelines in your contract and work to deliver best practices.

- Comply with the policies and procedures outlined in this manual, any applicable supplements, your provider contract, the general conditions of the procurement contract, and applicable State and federal laws and regulations.
- Understand the obligations and comply with all terms of the contract.
- Notify Trillium of any prospective changes in site(s) and assure all Trillium qualification requirements are met and any contract amendments are in place prior to delivery of contracted services.
- Periodically review your contracted site information in the Provider Portal and make sure that all NPI numbers, address information and taxonomies are current and have correct linkage at NCTracks.
- Monitor your health plan enrollment in NCTracks to ensure it remains active.
- Notify Trillium of any contract terminations, mergers, acquisitions or changes in ownership as soon as possible. The notification should be submitted by the provider in ample time to allow for review and determination of approval.

Your responsibility as a Trillium Contracted Provider related to Training is to:

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

Your responsibility as a Trillium Contracted Provider related to Information Technology and Security is to:

- Have and maintain high speed Internet connectivity.
- Provide complete and accurate data in all submissions to Trillium.
- Comply with HIPAA Security Regulations.
- Subscribe yourself and as many staff from across your company as needed for effective communication (subscribe to Constant Contact).
- Avoid blocking Trillium domain emails.
- Manage your email inbox to avoid “bounce back” or undeliverable messages.
- Must complete the Provider System Administrator training on [Provider MyLearningCampus.org](#) before receiving access to the Provider Portal.

- Notify Trillium within 24 hours of discovery of any known or suspected security incident affecting your organization, including Business Email Compromise (BEC) or unauthorized access to email systems. Provider email accounts are a frequent target of threat actors who may attempt to use compromised accounts to conduct fraudulent activity against Trillium. Failure to report a security incident in a timely manner may result in Trillium temporarily blocking communications from your domain until the issue is confirmed resolved.

Your responsibility as a Trillium Contracted Provider related to Network is to:

- 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 member/ recipient and families.
- 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.
- Ensure that the hours of operation offered to Trillium members are no less than those offered to commercial members.
- Strive to achieve best practice in every area of service.
- Adhere to all performance guidelines in your contract and work to deliver best practices.
- 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/recipient needs by providing services in accordance with Trillium Clinical Practice Guidelines.
- Attempt to first resolve any disputes with other network providers or Trillium through direct contact or mediation.
- Keep apprised of current information through the communication offered and provide services per the most recent State standards or waiver service definitions.

- Comply with the policies and procedures outlined in this manual, any applicable supplements, your provider contract, the general conditions of the 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
- 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 (5) business days of such information being reasonably and reliably known to the provider.
- Notify Trillium of any prospective changes in site(s) and ensure 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 merger or change in ownership because it may have implications for your contract status with Trillium.
- Maintain all licenses, certifications, accreditations, credentialing and registrations required for your facilities and staff providing services to Trillium members and recipients.
- Notify Trillium in writing within five (5) business days of personnel changes or information updates which may include but is not limited to changes in capacity including inability to accept new referrals, addition of capacity or specialty services, address changes as well as changes in other enrollment information.
- Notify Trillium in writing if you wish to take a leave of absence. Notification must occur no later than 60 days prior to the desired effective date.
- Do not request more than six (6) months in an initial leave of absence, with the option of an extension, unless the leave is a result of disabling illness.
- Comply with Clinical Coverage Policy 8-P North Carolina Innovations related to residential services. Private home respite services serving individuals outside their private homes are subject to licensure under North Carolina General Statutes 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month. An Alternative Family Living (AFL) site shall be licensed if serving either (1) one or more minor clients or (2) two or more adult clients.

Minor and adult clients shall not reside in the same location. Unlicensed supervised living homes (AFLs) may only serve one adult as criteria not being met for 10A NCAC 27 G.5601 (b) (1) or (2).

- 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.
- Maintain the required insurance stated in your Contract.

Your responsibility as a Trillium Contracted Provider related to Credentialing is to:

- Provide services for which you are qualified and credentialed by NCDHHS.
- Enroll and maintain active status in NCTracks with an active Medicaid Health Plan.
- Satisfy all application requirements and have a fully executed contract prior to delivery of services to any Trillium member.
- Complete the re-credentialing process as directed by NCDHHS, with all required documentation in a timely manner to avoid expiration.

Your responsibility as a Trillium Contracted Provider related to Crisis Care and Service Enrollment is to:

- Publish and make available the toll-free Trillium Member and Recipient Services line for members, recipients and family members, along with the telephone number for 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.
- Adhere to the appointment wait time standards as outlined in Section I.
- Provide return telephone calls within one hour, 24 hours a day, 7 days a week.
- Be responsive and comply with emergency referrals within one hour, 24-hours a day, 7 days a week.

- Maintain systems and procedures to ensure members with scheduled appointments are 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 seen within the required wait time of two (2) hours after the arrival.
- Develop and implement policies and procedures for receiving and handling complaints and grievances.
- Incorporate results of grievances or complaints into your internal quality assurance/quality improvement 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 Tailored Plan in investigating and resolving complaints within timeframes established by the Tailored Plan.
- Provide Trillium copies of supporting documentation and evidence regarding your agency's investigation (i.e., PCP's, service notes, service orders, etc.) as well as citations of statutes and rules pertinent to each allegation or complaint in order to resolve issues.
- Comply with NC law (N.C.G.S. §122C-18) regarding retaliation against a person for complaining to a member advocate.
- Ensure there are no barriers to treatment, system navigation is friendly, and the screening process is the same no matter where the member presents to be seen.
- Maintain systems and procedures to screen and triage member needs—whether by phone or walkin—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 and Member Service Center to help you in the most efficient and effective way possible.

Your responsibility as a Trillium Contracted Provider related to Utilization Management is to:

- Obtain prior authorizations as required for contracted services.

- Ensure members/recipients meet medical necessity requirements for all services your agency provides
- Provide medically necessary covered services to members as per your contract and authorized by Trillium.
- Comply with Trillium authorization requirements
- Document all services provided per Medicaid requirements, DMH/DD/SUS requirements, NC waiver requirements and North Carolina State rules.
- Submit Treatment Authorization Requests (TARs) with the proper clinical information at least 7 days prior to the end date of the current authorization to allow for Utilization Management activities and authorization prior to beginning services.
- Submit continuing TARs on a timely basis to allow for Utilization Management activities and authorization prior to beginning services.
- Emergency authorizations are available but should only be used when necessary to provide for health, safety and wellbeing.
- Submit an expedited request for emergency/acute care within 48 hours of admission.
- Maintain services at an optimal level to meet member/recipient needs by providing services in accordance with Trillium's Clinical Practice Guidelines.
- Participate actively in a person-centered planning process with others serving the member to develop a comprehensive Person-Centered Plan/ISP/ treatment plan development of treatment and/or habilitative programs that are in accordance with the person-centered plan/ISP/treatment plan.

Your responsibility as a Trillium Contracted Provider related to Care Management is to:

- Comply with Trillium care managers' requirements.
- Work with Trillium to ensure a smooth transfer for any members who desire to change providers, or when you need to discharge a member because you cannot meet their special needs.
- Communicate with the care coordinator about the needs of members that you support.
- Notify the care coordinator of any changes, incidents, other information of significance related to the member supported.
- Ensure that members are appropriately linked to primary health care.

- Assist with referrals to natural and community supports.
- Follow up with a phone call whenever a member who is considered high-risk 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 them.
- Contact Trillium care managers whenever an individual receiving care management misses two appointments.
- Contact Trillium care managers for members on an outpatient commitment order who fail to keep any appointment.
- Educate members on Medicaid transportation.
- Provide accurate and timely responses to TARs.
- 7 calendar days for a routine request.
- 72 hours for an expedited request.
- Ensure members/recipients receive medically necessary services.
- Ensure members/recipients who need a service are listed in the system.
- Inform providers of members/recipients receiving care management.
- Complete telephonic or on-site visits to monitor the health and safety of the member/recipient receiving care management.
- Assess the satisfaction of members/recipients served.
- Monitor implementation of the Individual Support Plan (ISP) or Person-Centered Plan (PCP).
- Communicate with providers on any additional assessments needed.
- Develop and share ISPs. Communicate any recommendations for development or revisions on the PCP/ISP/treatment plan.
- Educate members/recipients receiving care management on Medicaid transportation.
- Share natural and community resources for referrals and linking.

Your responsibility as a Trillium Contracted Provider related to Billing and Claims 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 Medicaid Funded clean claims electronically within 365 calendar days and State Funded 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.
- Ensure all documentation regarding services provided is timely, accurate, and complete.
- 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 by Trillium.

Your responsibility as a Trillium Contracted Provider related to Quality Management is to:

- Cooperate with Trillium's Quality Improvement (QI) activities to improve the quality of care and services and member experience. Cooperation also includes collection and evaluation of data and participation in Trillium's clinical and service measure QI programs such as access to medical records for auditing purposes to measure performance on specific quality indicators.
- Allow Trillium to use performance data for quality improvement activities.
- Support the administration of surveys as requested by Trillium which may include conducting outreach to members.
- Participate in Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the Provider Satisfaction Survey, National Core Indicators (NCI) Survey, Mental Health Statistics Improvement Program

- Consumer Satisfaction Survey, North Carolina Treatment Outcomes and Program Performance System, and other surveys to assess experience in receiving care and quality of life.
- Comply with Trillium's quality management programs, and participate in various quality improvement projects and activities as directed by Trillium.
- Provide data to Trillium in support of quality improvement projects as required by Trillium and/or the Department. This includes participation as required by NCDHHS in N.C. Health Information Exchange Network (NCGS 90-414.7), called NC HealthConnex. For more information and to sign up, please visit [About NC HealthConnex](#).
- Comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations for members/recipients receiving services.
- Complete and report when the provider agency or Employer of Record (EOR) staff member is unable to provide back-up staff (BUS).
- Build or enhance technology infrastructure to collect and analyze data, perform interventions and root cause analysis.
- Actively participate in member/recipient satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements.

G. Network Requirements

Nondiscrimination

Trillium will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, gender identity, color, creed, religion, national origin, ancestry, sex, sexual orientation, age, veteran or marital status, or any unlawful basis not specifically mentioned herein. Additionally, Trillium will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to members to meet their needs and preferences, this information is not required in the contracting process. Decisions are based on issues of professional conduct and competence as reported and verified through the contracting process.

Trillium's procedures and processes will not discriminate against any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification with regards to participation, reimbursement or indemnification.

Cultural Competency and Linguistic Appropriate Services Expectations

- Acknowledge the importance of different cultures and languages in providing effective, quality care and services.
- Provide effective, understandable, respectful care and services to all members.
- Be responsive to the cultural and linguistic needs and preferences of the members served.
- Embrace cultural beliefs, practices, and values within people and communities.
- Earnestly participate in initiatives, such as training and other development opportunities, to educate workforce regularly on culturally competent practices and resources.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services that are culturally competent and linguistically appropriate.
- Develop a cultural competency plan that responds to the cultural and linguistic needs of members served and includes appropriate policies, procedures and accountability measures to comply with cultural competency requirements and practices.
- Offer language assistant to individuals with Limited English Proficiency (LEP) or other communication needs and ensure members understand they have access to language interpretation services by phone and/or in person, including TDD/TTY services with no cost to them.
- Make reasonable attempts to collect and maintain accurate demographic data, including race, ethnicity and language. Provide and explain race and ethnicity categories to a member so they are able to identify and select their race and ethnicity.
- Office locations have posted and printed materials in English and Spanish, and other languages commonly used in the service area.

Trillium's Responsibility to Providers is to:

- Provide training and evaluative feedback relative to proficiency in providing culturally competent and linguistically appropriate services.

On-call Coverage

- Providers must be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care. Refer to Locum Tenens Policy.

Credentialing and Re-credentialing/Network Participation

Trillium has developed as part of its Provider Manual, written policies for the selection and retention of network providers and applies criteria consistent across all providers. This information is published on Trillium's website, including current and previous versions including effective dates.

Trillium follows the NC Department of Health and Human Services' (the Department) Uniform Credentialing and Recredentialing Policy and requires that all providers enroll, credential, and re-credential with the Department as a North Carolina Medicaid or State-funded services provider consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E to be considered for participation in Trillium's network. This requirement applies to all provider types: individual and organizational, including acute, primary, pharmacy, mental health, substance use disorders, intellectual and developmental disability, traumatic brain injury, and long-term services and supports providers. This includes in-state providers, border (i.e., providers who reside within 40 miles of the NC state line), and out-of-state network providers.

Trillium adheres to the Department's requirements for the credentialing and re-credentialing of providers and will confirm a provider's active status on the Provider Enrollment File (PEF) for verification of credentialing/ re-credentialing by the Department. Trillium shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department. Trillium utilizes a standardized process for network provider selection and retention. 42 C.F.R. § 438.12(a)(2).

Trillium shall validate that providers are active utilizing the PEF to ensure providers are eligible for contracting. Trillium receives the PEF via a secure file transfer protocol (FTP) and utilizes the information received to make network contracting decisions in compliance with 42 C.F.R. § 438.206(b)(6).

Trillium shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment 42 C.F.R. § 438.214(c).

Trillium shall not discriminate against a provider for filing a grievance on behalf of and with the written consent of a member or helping a member to file a grievance or for protesting a plan

decision, policy or practice the health care provider believes interferes with its ability to provide medically necessary and appropriate health care.

Trillium shall prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

Providers must complete information requested by Trillium and subcontractors including Carolina Complete Health, and Pharmacy Benefit Manager. This includes demographic data to validate identification on the PEF, additional Provider Directory information as required by the Department, and financial forms required for payment. Trillium has the right to make the final determination about which providers participate within its network. Trillium shall not use, disclose, or share provider credentialing information for any purposes other than use in Medicaid Managed Care without the express written consent of the provider and the Department.

Trillium may execute a network provider contract, pending the outcome of Department screening, enrollment, and revalidation, for up to one hundred twenty (120) days. Trillium must immediately terminate the provider contract upon notification from the State that the network provider cannot be enrolled or upon expiration of the one hundred twenty (120) day period without enrollment of the provider and must notify affected members. See 42 C.F.R. § 438.602(b)(2).

Trillium shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) Calendar Days of suspension, the Department will terminate the provider from Medicaid.

During the Provider Credentialing Transition Period the Department will re-credential providers every five (5) years. After the Provider Credentialing Transition period, the Department will re-credential providers every 3 years (36 months). Trillium suspends claims payment to any provider for dates of services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements. Trillium reinstates payment to the provider upon notice that the Department has received the requested information from the provider.

Trillium is not liable for interests, liquidated damages, or penalties for payment suspension at recredentialing, when directed by the Department. If a provider fails to re-enroll or re-credential with the Department or designated vendor, the provider will be unable to be paid for services

rendered until an updated credentialing file is received from the Department. Providers cannot be reimbursed for services if credentialing has expired.

In addition to the Department's re-credentialing process, Trillium also evaluates provider's continued eligibility based on the above timelines as well as on a daily basis utilizing information on the Provider Enrollment File. This process is consistent with the Department's Uniform Credentialing and Recredentialing Policy.

Contracting Decisions

Trillium shall make network contracting decisions for Medicaid and State Funded providers based upon the credentialing information provided by the Department on the PEF. For behavioral health providers, I/DD, and/or TBI providers this shall include validation of license and accreditation in compliance with relevant Clinical Coverage Policies and/or Service Definitions.

Trillium operates an open network and accepts providers who are enrolled in NC Tracks, meets objective quality standards and accepts Network rates, except for certain services as set forth in N.C. Gen. Stat. § 108D-23(c). For closed network services, Trillium evaluates network adequacy standards including time and distance metrics and appointment wait times to determine if additional network providers are needed.

Trillium will negotiate with any willing provider in good faith regardless of provider or Tailored Plan affiliation. Trillium will include in its network all Essential Providers (as defined by North Carolina Medicaid) for behavioral health, I/ DD, and TBI services located in the region regardless of closed network requirements.

Trillium shall obtain approval from the Department before using, disclosing, or sharing provider credentialing information for any purpose other than use in Medicaid Services.

Network contracting decisions for Non-Emergency Medical Transportation (NEMT) providers will be completed by Modivcare.

Network contracting decisions for pharmacy providers will be completed by the Pharmacy Benefit Manager.

Network contracting decisions for vision services will be completed by Centene Vision.

Modivcare, Trillium's Pharmacy Benefit Manager and Centene Vision will make network contracting decisions for Medicaid providers based solely upon the information provided by the Department on the PEF for any willing provider and acceptance of the contracting terms and rates and shall not contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

State-Funded Providers

Each provider that is credentialed to provide only State-funded services (State-funded only provider) must enroll in Medicaid during its next recredentialing period. The period between BH I/DD Tailored Plan launch and when all State-funded only providers are credentialed with Medicaid will be considered the “State-funded Only Provider Credentialing Transition Period.”

During the State-funded Only Provider Credentialing Transition Period, if a provider is not enrolled and credentialed with the Department, Trillium shall monitor and maintain credentialing records for State funded only providers for continued compliance with credentialing requirements and so that each State-funded only provider transitions to Medicaid enrollment during its recredentialing period. These records shall be made available to DMH/DD/SUS for inspection if requested. During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Department’s Provider Enrollment Process, Trillium will evaluate a contracted provider’s continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. Trillium’s process will occur no less frequently than every five (5) years consistent with the Department’s policy and procedure. After the Provider Credentialing Transition Period, Trillium will evaluate a contracted provider’s continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. This process will occur every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.

Provider Participation Monitoring

Trillium conducts initial and ongoing monitoring activities for network providers to monitor for continued compliance with network participation requirements and to identify occurrences that may indicate substandard professional conduct, performance or competence. Trillium shall not contract with any provider that has been excluded from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act.

Provider Notification

Trillium provides written notice of network contracting decisions to providers within five (5) business days of determination of the provider’s status as an active Medicaid or State-funded services enrolled providers.

Provider Disenrollment and Termination

When a provider fails to submit required documentation to the Department or otherwise fails to meet Department requirements, the Department may impose a payment suspension on the provider.

Within one (1) business day of receipt of receiving notice from the Department of a provider payment suspension, Trillium will suspend claims payment to provider for dates of services on or after the effective date specified by the Department.

Trillium will reinstate payment to the provider upon notice that the Department has received the requested required information from the provider. If the provider does not provide the information within fifty (50) calendar days of payment suspension, the Department may terminate the provider from Medicaid. Trillium is not liable for interest or penalties for late claim payments related to payment suspension.

Trillium may terminate a provider from its Network with or without cause. Any decision to terminate must comply with the requirements of the provider contract.

Termination by the Department

Within one (1) business day of receipt of a notice from the Department of a provider being terminated from the Medicaid program, Trillium will remove the provider from the claims payment system and terminate its contract. This requirement applies to all providers, regardless of the provider's network status. If Trillium suspended the provider payment, then upon notice by the Department that the provider is terminated, Trillium will release applicable claims and deny payment for dates of service after the date of termination. There are no appeal rights against Trillium for a provider terminated or sanctioned, including suspension of provider payment, by the Department.

Trillium will provide written notice to the provider of Trillium's action to terminate the contract. The termination notice will provide the reason for Trillium's decision, the effective date of the termination, the provider's right to appeal, and how to request an appeal, if applicable.

Contracting Information Required

The information, below, is collected from the provider for contracting purposes to support claim payment, directories and data management. Providers shall submit the following information on the corresponding submission form:

Financial

- Tax (W9) Request for Taxpayer Identification Number and Certification
- Electronic Funds Transfer Documents
- Deficit Reduction Act Attestation

Data Exchange

- Trading Partner Agreement
- Provider Portal System Administrator Designee Request Form

Practitioner Information

- PCP or Specialist Status
- New Member Acceptance Status
- Identification of member age restrictions
- Practitioner's hospital affiliations and/or admitting privileges
- Languages spoken by the provider and office staff other than English
- Completion status of cultural competency training

Provider Violations and Sanctions

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 with the Department.
- Failure to maintain, make available or securely retain service records in accordance with federal or state law and NC DHHS policy.
- Suspension by any applicable government authority.
- Failure to maintain the required minimum liability insurance coverage.
- Failure to comply with the Health Insurance Portability and Accountability Act (HIPAA).

- Any instance of fraud, waste or abuse, including altering documents, falsifying records, submitting false claims.
- Evidence of substantial failure to comply with regulatory standards as defined by North Carolina Statutes and Rules for Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SUS).

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/recipients. 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 pending review and/or investigation.

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

- Division of Health Service Regulation (DHSR)
- Department of Social Services (DSS)
- Division of Mental Health, Developmental Disabilities, Substance Use Services (DMH/DD/SUS) - Program Accountability Unit
- Division of Health Benefits (DHB) - Office of Compliance and 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 Suspension
- Recoupment
- Plan of Correction (POC)
- Additional monitoring
- Self-audit review of documentation and/or paid claims

- Monetary Penalty or Liquidated Damages
- Transfer—Offer provider choice and transition of
- Tailored Plan funded members to another provider
- Additional audits, including prepayment claims review
- Denial of network participation of individual practitioners within the agency/provider
- Suspension of referrals
- Termination of contract(s)
- Referral to another regulatory body if the chief medical officer or clinical director is of the opinion that the provider in question poses a significant risk to the health, welfare, or safety of members, and immediate suspension of the provider pending the results of the investigation.

Access Requirements

Trillium network providers are held to Appointment Wait Times for Medicaid, Medicaid Direct, and State funded, see Section I Network Adequacy and Access Standards. Trillium will monitor Network providers regularly to determine compliance with the timely access requirements and take corrective action if it, or its network providers, fail to comply with the timely access requirements.

Notification of Changes in Address

Trillium network providers are required to update their address and make other changes by using the Manage Change Request form in NCTracks. This may include but is not limited to changes in capacity including inability to accept new patients, addition of capacity or specialty services, address changes as well as changes in other provider information.

No-reject Requirements

Trillium's contract with network providers addresses how the providers will have a "no reject" policy for members/recipients who have been determined to meet medical necessity for the covered services provided by a provider or as a licensed practitioner (LP). Providers agree to accept all referrals meeting criteria for services they provide when there is available capacity.

Licensure Requirements

Trillium network providers shall:

- Maintain all licenses, certifications, accreditations, credentialing with the Department and registrations required for your facilities and staff providing services to Trillium members and recipients.
- Notify the Department within thirty (30) calendar days of any change in the status of licenses, accreditations, certifications and the status of such in accordance with applicable licensing boards, administrative code, and clinical coverage policy.

Insurance Requirements

Trillium network providers shall maintain the required insurance coverage stated in their contract.

Required Availability

The access standard for Emergency Services is defined as the following:

Emergency Services for Mental Health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.

Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait time standards.

- The Call Center clinician will determine through clinical screening whether the member/recipient represents an immediate danger to self or others. If member is an imminent danger to self or others, the Call Center Clinician will implement crisis intervention procedures by attempting to keep the member/recipient safe until immediate supports or services are in place.
- When possible, the Call Center Clinician will speak to the caller directly until they can be connected to the appropriate level of care.
- If Member/Recipient is unable to be stabilized the Call Center clinician will, with assistance from another staff when needed, contact the appropriate

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

For detailed information regarding required availability refer to Section I [Network Adequacy and Access Standards](#).

Provider Training

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

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

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

Trillium's responsibility to Providers related to training is to:

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

Provider Communication

Trillium is committed to keeping network providers well-informed of State or federal changes, new information, training, 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 [Provider Communication Bulletin](#). If you do not currently receive these email notifications, please sign up by choosing the [Network Provider List](#).

Provider Representation

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

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

Provider Council

The mission of the 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 network performance against stated goals.
- Review and make recommendations to Trillium regarding performance indicator selection and performance issues, including outliers.
- Review quarterly reports on referrals made/referrals accepted per service per provider; members receiving services per provider; discharges from providers and reasons; and annual review of trend analysis.
- Recommend new service initiatives to address service gaps.
- Assess and provide for staff education and training needs assess community and prevention needs.
- Develop strategies to address funding and financial issues.
- Approve the provider satisfaction survey and review results with recommendations.

- Review and provide input to the Trillium Cultural Competency Action Plan.
- Advise the Chief Executive Officer regarding provider contract reconsiderations, upon the request of the Chief Executive Officer.

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

H. Telehealth

Trillium is dedicated to transforming virtual member and provider communications to increase access to services and care through telehealth, telemedicine, and remote patient monitoring to improve the health and safety as well as the continuity of care for all of our beneficiaries.

Trillium's approach for the use of these services is aligned with the North Carolina Department of Health and Human Services (NCDHHS) goals and contractual requirements.

Telehealth is a covered plan benefit by Trillium subject to limitations, guidelines, and contractual policies/ requirements as set forth by NCDHHS. Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

Virtual Patient Communications

Virtual Patient Communications is a covered plan benefit by Trillium subject to limitations, guidelines, and contractual policies/requirements as set forth by NCDHHS. Virtual communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a beneficiary or a provider and another provider.

Covered virtual communication services include telephone conversations (audio only), virtual portal communications (secure messaging), and store and forward (transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

Remote Patient Monitoring

Remote patient monitoring is a covered plan benefit by Trillium subject to limitations, guidelines, and contractual policies/requirements as set forth by the NCDHHS. Remote patient monitoring is the use Telehealth or digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring

enables providers to collect and analyze information such as vital signs (blood pressure, heart rate, weight, and blood oxygen levels) in order to make treatment recommendations.

There are two types of remote patient monitoring:

1. Self-Measured and Reported Monitoring: When a beneficiary uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation.
2. Remote Physiologic Monitoring: When a beneficiary's physiologic data is wirelessly synced from a beneficiary's digital device where it can be evaluated immediately or at a later time by a provider.

I. Network Adequacy and Access Standards

Trillium will contract with a network of providers that meets the NCDHHS Network Adequacy standards, Trillium will reassess the adequacy of the network to ensure on an ongoing basis to provide Medicaid Members, Medicaid Direct members, and State-funded recipients (Members) with adequate access to care. For Statefunded services, Trillium assesses availability of funds for all services managed in the State-funded benefit plan.

Trillium completes an annual Network Analysis 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.

Trillium's primary goal is to offer 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. In the event that the Trillium network is unable to provide medically necessary services required under the contract, Trillium shall provide timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and coordinate with respect to authorization and payment issues in these circumstances.

Network Gaps

Request for Proposal (RFP), Request for Application (RFA) and Request for Information (RFI) processes used to solicit proposals, applications or information for the development, improvement, support of and/or delivery of services.

These processes are competitive, open and non-discriminatory. Solicitations are based on priorities outlined in the Network Access Plan, North Carolina Service Definitions, and/or identified in the Annual Network Analysis. The process of developing any RFA/RFP/RFI may include some or all of the following: a determination and prioritization of need, funding sources,

and cost/benefit analysis. A transparent and equitable scoring process will be utilized to assess competencies specific to the requirements of the solicitation.

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

Provider Locations and Availability

In order to provide all Tailored Pan members, Medicaid Direct members, and State-funded recipients timely access to all covered health care services in each benefit plan, Trillium's network meets, at a minimum, the following time/distance standards as measured from the member's residence for adult and pediatric providers for Medicaid, Medicaid Direct, and for State-funded services. Certain service types apply to both adult and pediatric provider standards. These service types are marked with a (*) and include hospitals, pharmacies, occupational, physical, or speech therapists, pulmonology specialty, LTSS, and nursing facilities.

For purposes of network adequacy standards for physical health providers/services (except as otherwise noted), adult services are those provided to a member who is age 21 or older, and pediatric (child/children) services are those provided to a member who is younger than age 21.

For purposes of network adequacy standards for substance use disorder and mental health treatment providers, except as otherwise noted, adult services are those provided to a member who is age 18 or older, and pediatric/adolescent (child/children) services are those provided to a member who is younger than age 18. Trillium is required to use the definitions of service categories for behavioral health time/distance standards in the following tables.

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID		
Service Type	Urban Standard	Rural Standard
Primary Care ¹	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Hospitals*	≥ 1 hospital within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospital within 30 minutes or 30 miles for at least 95% of members
Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
Obstetrics ²	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members Research-based BH treatment for autism spectrum disorder (ASD): Not subject to standard	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members Research-based BH treatment for autism spectrum disorder (ASD): Not subject to standard
Location-Based Services	Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members Child and Adolescent Day Treatment Services: Not subject to standard	Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members Child and Adolescent Day Treatment Services: Not subject to standard

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID		
Service Type	Urban Standard	Rural Standard
Crisis Services	Professional treatment services in facility-based crisis program: The greater of: 2+ facilities within each BH I/DD Tailored Plan Region, OR 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). Facility-based crisis services for children and adolescents: ≥ 1 provider within each BH I/DD Tailored Plan Region. Medically monitored inpatient withdrawal services:(non-hospital medical detoxification) ≥ 2 provider within each BH I/DD Tailored Plan Region. Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification), Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal (social setting detoxification), Mobile Crisis Management: ≥ 2 providers of each crisis service within each BH I/DD Tailored Plan Region.	
Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
Community/ Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
All State Plan LTSS (except nursing Facilities and 1915 (i) Services)*	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID		
Service Type	Urban Standard	Rural Standard
Residential Treatment Services	Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region. Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored community residential treatment): Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to 10A NCAC 27G.3400). Clinically managed residential services (Substance abuse non-medical community residential treatment): - Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department: Not subject to standard until ninety (90) Calendar Days after licensure requirements are established - Adolescent: Contract with all designated CASPs statewide - Women and Children: Contract with all designated CASPs statewide Clinically Managed Population-Specific High-Intensity Residential program: contract with all designated CASPs Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house) - Adult: Access to ≥ 1 male and ≥ 1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)³ - Adolescent: Access to ≥ 1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600)3 Psychiatric Residential Treatment Facilities (PRTFs) and Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to Standard. Medically monitored intensive inpatient services (once policy is added)	
1915(c) HCBS Waiver Services: NC Innovations	Community Living and Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. Crisis Intervention and Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard	

BH I/DD TAILORED PLAN TIME/DISTANCE STANDARDS FOR MEDICAID		
Service Type	Urban Standard	Rural Standard
1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment: ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan region. Day Supports, Cognitive Rehabilitation, Crisis Intervention and Stabilization Supports: ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan region. Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification: N/A	
Employment and Housing Services	Individual Placement and Supports (IPS)- Supported Employment (Adult MH): Eligible individuals shall have the choice of at least two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
1915 (i) Services	Community Living and Support, Individual and Transitional Supports, Out-of home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health Condition or SUD): ≥ 2 providers of each 1915 (i) service within each BH I/DD Tailored Plan Region. In-home Respite: ≥ 2 providers within 45 minutes of the member's residence.	

1 Nurse Practitioners and Physician Assistants may be included to satisfy Primary Care access requirements.

2 Measured on members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

3 BH I/DD Tailored Plans must also ensure that gender non-conforming Members have access to Clinically Managed Low-Intensity Residential Treatment Services.

The following provider types are considered “specialty care” providers for purposes of BH I/DD Tailored Plan Time or Distance Standards for Medicaid and Appointment Wait Time Standards for Medicaid.

SPECIALTY CARE PROVIDERS FOR MEDICAID	
Reference Number	Service Type
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology

SPECIALTY CARE PROVIDERS FOR MEDICAID	
Reference Number	Service Type
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery
18.	Pain Management (Board Certified)
19.	Psychiatry
20.	Pulmonology
21.	Radiology
22.	Rheumatology
23.	Urology

BH I/DD TAILORED PLAN TIME OR DISTANCE STANDARDS FOR STATE-FUNDED SERVICES			
Reference Number	Service Type	Urban Standard	Rural Standard
1	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients ¹	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients
2	Location-Based Services	Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Outpatient Program, Outpatient Opioid Treatment (OTP): ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients Child and Adolescent Day Treatment Services: Not subject to standard	Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Outpatient Program, Outpatient Opioid Treatment (OTP): ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients

BH I/DD TAILORED PLAN TIME OR DISTANCE STANDARDS FOR STATE-FUNDED SERVICES			
Reference Number	Service Type	Urban Standard	Rural Standard
			Child and Adolescent Day Treatment Services: Not subject to standard
3	Crisis Services	Facility based crisis for adults: The greater of: ° 2+ facilities within each BH I/DD Tailored Plan Region, OR ° 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available). Ambulatory Withdrawal Management without Extended Onsite Monitoring Services: ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region	
4	Inpatient BH Services	≥ 1 provider within each BH I/DD Tailored Plan Region	
5	Reserved		
6	Community /Mobile Services	Assertive Community Treatment, Support Team, Peer Supports (Individual & Group), Transition Management Service, Intensive In-home, BH Comprehensive Case Management, Multi-Systemic Therapy: Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
		Assertive Engagement: 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients ²	Assertive Engagement: ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients
7	Residential Treatment Services	Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region Substance Abuse Halfway House: Adult: Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)³ Substance Abuse Medically Monitored Community Residential Treatment: Access to ≥1 licensed provider Substance Abuse Non-Medical Community Residential Treatment:	

BH I/DD TAILORED PLAN TIME OR DISTANCE STANDARDS FOR STATE-FUNDED SERVICES			
Reference Number	Service Type	Urban Standard	Rural Standard
		Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department: Not subject to standard until ninety (90) Calendar Days after licensure requirements are established) Substance Use Residential Supports & Mental Health Recovery Residential Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region Clinically Managed High-intensity Residential Services, Clinically Managed High intensity- Pregnant & Parenting, Clinically Managed Medium-intensity Residential Services- Adolescents: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region Medically Monitored Intensive Inpatient Services	
8	Employment and Housing Services	Residential Supports, Supported Living Periodic, Respite Services: Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients. Individual Placement and Support-Supported Employment (Adult MH & Adult SUD): 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients. Day Supports. Community Living & Support, Supported Employment, Adult Day Vocational Programs (ADVP): 100% of eligible recipients must have access to ≥ 1 provider agency within each BH I/DD Tailored Plan Region. Clinically Managed Population-specific High Intensity Residential Programs: To be determined	

1. The Department defines recipients for the purposes of network adequacy as those who received State-funded services during the previous year.
2. The Department defines recipients for the purposes of network adequacy as those who received State-funded services during the previous year.
3. BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

PIHP TIME/DISTANCE STANDARDS		
Service Type	Urban Standard	Rural Standard
Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard
Location-Based Services	Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment Program, Substance Abuse Intensive Outpatient Treatment Program, and Outpatient Opioid Treatment (OTR): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members Child and Adolescent Day Treatment Services: Not subject to standard	Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment Program, Substance Abuse Intensive Outpatient Treatment Program, and Outpatient Opioid Treatment (OTR): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members Child and Adolescent Day Treatment Services: Not subject to standard
Crisis Services	Professional treatment services in facility-based crisis program: The greater of: ○ 2+ facilities within each PIHP Region OR ○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimate) Facility-based crisis services for children and adolescents: ≥ 1 provider within each PIHP Region Medically Monitored Inpatient Withdrawal Services (Non-hospital Medical Detoxification): ≥ 2 providers within each PIHP Region Ambulatory Withdrawal Management without Extended Onsite Monitoring (Ambulatory Detoxification), Ambulatory Withdrawal Management with Extended Onsite Monitoring, Clinically managed residential withdrawal services (social setting detoxification), Mobile Crisis Management: ≥ 2 providers of each crisis service within each PIHP Region Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult): Not subject to standard	

PIHP TIME/DISTANCE STANDARDS		
Service Type	Urban Standard	Rural Standard
Inpatient BH Services	≥ 1 provider of each inpatient BH service within each PIHP Region	
Partial Hospitalization	≥ 1 provider of each Partial Hospitalization within 30 minutes or 30 miles of residence for at least 95% of members	≥ 1 provider of each Partial Hospitalization within 60 minutes or 60 miles of residence for at least 95% of members
Community/Mobile Services	100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
1915 (i) Services	- Community Living and Support, Individual and Transitional Support, Out-of-Home Respite and Supported Employment (for members with IDD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each (i) Option service within each PIHP Region - In-Home Respite: ≥ 2 providers within 45 minutes of the member's residence.	
Residential Treatment Services	- Residential Treatment Facilities Services: access to ≥ 1 licensed provider per PIHP Region - Medically Monitored Intensive Inpatient Services (Substance Abuse Medically Monitored Supervised Residential Treatment): access to ≥ 1 licensed provider per PIHP Region (refer to 10A NCAC 27G.3400) - Clinically Managed Residential Services (Substance Abuse Non-Medical Community Residential Treatment): - Adult: Access to ≥ 1 licensed provider per PIHP Region (refer to licensure requirements to be determined by the Department: Not subject to standard until ninety (90) Calendar Days after licensure requirements are established) - Adolescent: Contract with all designated CASPs statewide ° Women and Children: Contract with all designated CASPs statewide - Clinically Managed Population-Specific High Intensity Residential Program: contract with all designated CASPs - Clinically Managed Low-Intensity Residential Treatment Services (Substance Abuse Halfway House): - Adult: Access to ≥ 1 male and 1 female program per PIHP Region (refer to 10A NCAC 27G. 5600).¹ - Adolescents: Access to ≥ 1 program per PIHP Region (refer to 10A NCAC 27G. 5600) - Psychiatric Residential Treatment Facilities (PRTFs) and Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID): Not subject to standard	

¹ PIHPs must also ensure that gender non-conforming members have access to substance use halfway house services.

PIHP TIME/DISTANCE STANDARDS		
Service Type	Urban Standard	Rural Standard
1915 (c) HCBS Waiver Services: NC Innovations	- Community Living and Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each PIHP Region - Crisis Intervention and Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each PIHP Region - Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard	

DEFINITION OF SERVICE CATEGORY FOR BEHAVIORAL HEALTH TIME/DISTANCE STANDARDS	
Service Type	Definition
Outpatient BH Services	- Outpatient BH services provided by direct-enrolled providers (adults and children) - Diagnostic Assessment Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD)
Location-Based Services (BH I/DD)	- Psychosocial Rehabilitation - Substance Abuse Comprehensive Outpatient Treatment - Substance Abuse Intensive Outpatient Program - Opioid Treatment Program Service (adult) - Child and Adolescent Day Treatment Services
Crisis Services	- Facility-based Crisis Services for Children and Adolescents - Professional Treatment Services in Facility-based Crisis Program (adult) - Ambulatory Withdrawal Management without Extended On-site Monitoring (Ambulatory Detoxification) - Ambulatory Withdrawal Management with Extended On-site Monitoring - Clinically Managed Withdrawal Services (social setting detoxification) - Medically Monitored Withdrawal Management Services (Non-hospital medical detoxification) (adult) - Mobile Crisis Management
Inpatient BH Services	Inpatient Hospital – Adult - Acute Care Hospitals with Adult Inpatient Psychiatric Beds - Medically Managed Intensive Inpatient Withdrawal Management (Acute care hospitals with adult inpatient substance use beds) - Medically Managed Intensive Inpatient Services (Acute care hospitals with adult inpatient substance use beds) Inpatient Hospital – Adolescent/Children - Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds - Medically Managed Intensive Inpatient Services (Acute care hospitals with adolescent inpatient substance use beds) - Acute Care Hospitals with Child Inpatient Psychiatric Beds
Partial Hospitalization	Partial Hospitalization (adults and children)

DEFINITION OF SERVICE CATEGORY FOR BEHAVIORAL HEALTH TIME/DISTANCE STANDARDS	
Service Type	Definition
Residential Treatment Services	- Residential Treatment Facility Services - Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatments) - Clinically Managed Residential Treatments (Substance abuse non-medical community residential treatment) - Clinically Managed Population-Specific High Intensity Residential Program - Clinically Managed Population-Specific Low-Intensity Residential Treatment Services (substance abuse halfway house) - Psychiatric Residential Treatment Facilities (PRTFs) - Intermediate care facilities for Individuals with Intellectual Disabilities (ICF-IID)
Community/Mobile Services	Assertive Community Treatment (ACT) Community Support Team (CST) Intensive In-Home (IIH) Services Multi-systemic Therapy (MST) Services Peer Supports Diagnostic Assessment
1915(c) HCBS Waiver Services: NC Innovations	Assistive Technology Equipment and Supplies Community Living and Support Community Networking Community Transition Crisis Services: Crisis Intervention and Stabilization Supports Day Supports Financial Support Services Home Modifications Individual Directed Goods and Services Natural Supports Education Residential Supports Respite Specialized Consultation Supported Employment Supportive Living Vehicle Modifications
1915(c) HCBS Waiver Services: NC TBI Waiver	Adult Day Health Assistive Technology Cognitive Rehabilitation (CR) Community Networking Community Transition Crisis Supports Services Day Supports Home Modifications In Home Intensive Support Life Skills Training Natural Supports Education

DEFINITION OF SERVICE CATEGORY FOR BEHAVIORAL HEALTH TIME/DISTANCE STANDARDS	
Service Type	Definition
	Occupational Therapy Physical Therapy Remote Supports Residential Supports Resource Facilitation Respite Specialized Consultation Speech and Language Therapy Supported Employment Supportive Living Vehicle Modifications
Employment and Housing Services	Individual Placement and Support-Supported Employment (Adult MH)
1915 (i) Services	• Community Living and Supports • Community Transition • Individual and Transitional Supports • Respite • Supported Employment (for Members with I/DD and TBI) Individual Placement and Support (for Members with a qualifying mental health condition or SUD)

APPOINTMENT WAIT TIME STANDARDS FOR MEDICAID	
Visit Type	Standard
Primary Care	
Preventive Care Service—adult, 21 years of age and older	Within thirty (30) calendar days
Preventive Care Services—child, birth through 20 years of age	Within fourteen (14) calendar days for members less than six (6) months of age Within thirty (30) calendar days for members six (6) months or age and older.
After-Hours Access—Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) calendar days
Prenatal Care	
Initial Appointment—1st or 2nd Trimester	Within fourteen (14) calendar days
Initial Appointment—high risk pregnancy or 3rd Trimester	Within five (5) calendar days
Specialty Care	
After-Hours Access—Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) calendar days
Behavioral Health, I/DD, and TBI Services	
Mobile Crisis Management Services	Within two (2) hours
Facility-Based Crisis Management Services (FBC for Child and Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

APPOINTMENT WAIT TIME STANDARDS FOR MEDICAID	
Visit Type	Standard
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days or ten (10) business days, whichever is less
Routine Services for SUD Services	Within forty-eight (48) hours

APPOINTMENT WAIT TIME STANDARDS FOR STATE-FUNDED BH/IDD SERVICES	
Visit Type	Standard
Mobile Crisis Management Services	Within two (2) hours
Facility-Based Crisis Management Services (FBC for Child and Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days or ten (10) business days, whichever is less
Routine Services for SUD Services	Within forty-eight (48) hours

APPOINTMENT WAIT TIME STANDARDS FOR PIHP	
Visit Type	Standard
Behavioral Health and I/DD Services	
Mobile Crisis Management Services	Within two (2) hours
Facility-Based Crisis Management Services (FBC for Child and Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days or ten (10) business days, whichever is less
Routine Services for SUD Services	Within forty-eight (48) hours

Trillium is also required to meet the appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service. Providers shall notify Trillium if they are unable to meet the appointment wait time standards.

Annual Network Adequacy Analysis

The Annual Network Adequacy Analysis is an annual evaluation of the Trillium catchment area including Medicaid members, Medicaid Direct members, and State-funded recipients that provides the opportunity to reveal where there may be gaps in services and opportunities to enhance access to services supporting diversity and inclusion. The purpose of the assessment is to develop and manage a qualified provider network in accordance with community needs. Trillium reviews all services, including crisis services, and identifies service needs and will prioritize strategies to address any network needs identified.

Upon completion of the annual analysis, Trillium creates a Network Development Plan in order to mitigate any deficiencies. The Network Development Plan includes identification and analyses of gaps and requests for approval of exceptions. Trillium is contractually required to meet the exception process. Trillium may utilize existing approved statewide alternative service definitions or develop and request approval for new alternative service definitions to fill network adequacy and accessibility service needs not met with current service definitions. Services reported under alternative service definitions may be used to support performance measures, while non-UCR services cannot.

J. Billing, Claim Editing, Snip Editing and Clearinghouse Requirements

Finance and Claims Departments

The Finance Department oversees and manages the financial resources, including and not limited to those related to the Tailored Plan. 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 Relations Team. Refer to the [Trillium Billing Guide](#) for additional details. Refer to the Trillium Billing Guide and the Pharmacy Benefit Manager Provider Manual for pharmacy claims.

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

To contact the Claims Relation Team, email ClaimsSupport@TrilliumNC.org or call the Provider Service Line to speak to a member of Trillium's Claims Relations Team.

Important: Requests to change banking or direct deposit information are never processed based on email alone. Trillium will always confirm any banking change through a separate, independent verification step, such as a direct phone call to a known contact at your agency, before any change takes effect.

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. Providers can view member eligibility in the Provider Portals. If you have any questions about a member's eligibility, please contact Trillium.

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

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

This would require that the provider checks the following:

- Determine if the individual has Medicaid or whether the member may be eligible for Medicaid.
- Determine if the individual 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 individual 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 the family to pay for a portion of healthcare services based on the sliding fee schedule established by the provider.
- Determine if the individual has already been enrolled in the Trillium system.

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

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

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

Effective Date of Enrollment

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

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

Member ID

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

Eligibility Determination Process by Provider

Providers should conduct a comprehensive eligibility determination process whenever a member enters the delivery system. Periodically (no less than every 90 days), the provider should update eligibility information to determine if there are any first- or third-party payors for this member by completing a Client Update in the Provider Portal 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, which includes worker's compensation, Medicare, employee assistance programs (EAPs), 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), Explanation of Benefits (EOB) or CARC/RARC from the insurance company should be retained by the provider. 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.

Exceptions for TPL and Coordination of Benefits:

- Medical Support Enforcement: Services provided to members on whose behalf child support enforcement is being carried out if the third-party coverage is through an absent parent
- Preventive Pediatric Services including early and
- Periodic Screening, Diagnosis and Treatment (EPSDT)
- Members entitled to one or more of the following programs or services:

SECTION VI TABLE 1: Program and Service Exceptions for TPL and Coordination of Benefits		
Program of Service	Federal	State
Crime Victims Compensation Fund	X	
Part B and C of Individuals with Disabilities Education Act (IDEA)	X	
Ryan White Program	X	
Indian Health Services	X	
Veteran's Benefits for state nursing home per diem payments	X	
Veteran's Benefits for emergency treatment provider to certain veterans in a non-VA facility	X	
Older American Act Program	X	
World Trade Center Health Program	X	

SECTION V.I TABLE 1: Program and Service Exceptions for TPL and Coordination of Benefits		
Program of Service	Federal	State
Grantees under the Title V of the Social Security Act	X	
Division of Service for the Blind		X
Division of Public Health "Purchase of Care" Program		X
Vocational Rehabilitation Services		X
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X

Process to Modify

If there are known changes to the member's/recipient's income or family status, the provider must update records and adjust the payment amount based on the sliding fee schedule established by the provider. Members who become Medicaid eligible are not subject to sliding fee schedules for Medicaid covered services and payments should be adjusted immediately when this is determined. At least on a quarterly basis (90 days), the member's/ recipient's ability to pay should be verified and adjustments made by completing a Client Update in the Provider Portal system as necessary. The sliding fee schedules are managed by providers, and first party liability must be reported on claims. This compliance issue will be audited.

SLIDING FEE SCHEDULES

Eligibility for Benefit Determination

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

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

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

AUTHORIZATIONS REQUIRED FOR PAYMENT

System Edits

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

Authorization Number and Effective Dates

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

Service Categories or Specific Services

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

Units of Service

Each authorization will indicate the maximum number of units of service that are being authorized. As each claim is being processed, the system will check to make sure that the units being claimed fall within the units of services authorized. The system will deny any claims that exceed the limits. Providers need to establish internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.

Exceptions to Authorization Rule

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

Clean Claims

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

Getting Paid—Clean Claims***Interest provisions for late or underpayments:***

Any claim not paid within Timely Claim Payment limits will be subject to interest at the annual percentage rate of eighteen percent (18%). Interest is calculated for each calendar day after the date the clean claim should have been paid as specified in the contract between Trillium Health Resources and NCDHHS.

Service Codes and Rates—Contract Provisions

All providers are reimbursed for approved services provided at the Trillium published rates unless otherwise stated in their contract. Providers must only use the service codes in their contract or reimbursement will be denied as non-contracted services. Providers can submit claims for more than the published rates, but only the published or contracted rate will be paid. If a provider submits a service claim for less than the published rate, the lower rate will be paid. It is the provider's responsibility to monitor the publishing of rates and to make the necessary changes to their billing systems. For providers who are subject to a rate floor, Trillium will pay the lesser of billed charges or the rate floor only if the provider has mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision.

State-Funded Recipients

State-funded recipients are not required to pay any copayments and providers are prohibited from requiring copayments.

Claims Submission Protocol

Trillium maintains a Tailored Plan and Medicaid Direct Claims Submission Protocol with detailed instructions on claims submission by benefit type on its website. Please reference the [Claims Submission Protocol](#) on Trillium's website.

Electronic Visit Verification (EVV)

Services subject to Electronic Visit Verification (EVV) will need to be submitted through HHAeXchange. Trillium has partnered with an external vendor, HHAeXchange, to provide the EVV tools necessary for designated providers to comply with and meet this requirement. General

EVV information can also be found on the [HHAeXchange North Carolina PHP Provider Information Center](#).

Pharmacy

Pharmacy claims are defined as those claims submitted for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy (point-of-sale claims). Pharmacy Point of Sale claims are processed through Trillium's PBM partner, and may be submitted electronically using the most current NCPDP HIPAA—approved format.

Non-Emergency Medical Transportation and Non-Emergent Ambulance Transportation

Modivcare is Trillium's contractor to facilitate Non Emergency Medical Transportation (NEMT) and Non Emergent Ambulance Transportation (NEAT) services in North Carolina. Modivcare responsibilities include booking of reservations/rides and to process claims for NEMT/NEAT providers.

Providers can bill electronically through Modivcare's web portal, by an Automated Transportation Management System (ATMS), or by submitting paper claims. For any questions on how to bill, Providers should refer to Modivcare's Orientation and Training resources. For claims related questions, please contact Modivcare's Claims Department at 1-800-930-9060. For any other Provider related questions specific to Modivcare rides, please contact: 1-855-397-3604. Additional NC resources may be found in Transportation Provider Manual.

Vision

Vision claims for Medicaid Tailored Plan beneficiaries are processed through Centene Vision (formerly Envolve), a subsidiary of Carolina Complete Health and may be submitted using HIPAA Standard Electronic Transaction set or can be submitted in a [secure web-based Provider Portal](#). Claims may also be submitted through a clearinghouse. Centene Vision utilizes the clearinghouse Change Healthcare. As long as the provider's clearinghouse has a connection to Change Healthcare, then the claim can be passed on to Centene Vision. Centene Vision's Payer ID is 56190.

Provider Portal Claims

The Provider Portals— (Provider Direct for Medicaid/State-funded and iTransact for Tailored Plan) are web-based systems available to Trillium providers upon completion of a Trading Partner Agreement (TPA).

Billing through the provider portals is Direct Data Entry (DDE) where an electronic CMS1500 or UB04 form is accessed and billing information is entered and submitted to for reimbursement. A

direct link to these portals is found on Trillium's website under [For Providers](#). The Provider Portal Webinars are available to assist with completing a CMS1500 and UB04 claim form.

Standard Codes for Claims Submission

- CPT/HCPCS/Revenue Codes
- Modifiers
- ICD-10 Diagnosis Codes

Payment of Claims and Claims Inquiries

Providers must submit claims through the Provider Portal 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.

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 Portal 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 Portal system.

Physical health claims can be submitted on CMS 1500 and CMS 1450 (UB-04). Professional providers and medical suppliers complete the CMS 1500 and institutional providers complete the UB-04 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).

Providers Who Submit Paper Claims

Trillium does accept paper claims. All providers will be required to submit an accurate CMS1500 or UB04 billing form with the correct data elements. 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 Relations Team.

Reimbursement Policy

Trillium's Reimbursement Policy along with the Claims Submission policy serves as a guide to help with accurate claim submissions for proper reimbursement. All providers both participating and non-participating are reimbursed for approved services at the Trillium published rates unless otherwise stated in their contract.

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

With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997, Trillium is prohibited and does not appropriate funds for:

1. Causing or assisting in suicide, euthanasia, or mercy Killing.
2. Compelling any person or entity to provide or fund any item, benefit, program, or service for such purpose.
3. Asserting or advocating a legal right to cause or assist such actions.

Refer to the Trillium Website for the following:

- [Rate Table](#) Trillium follows payment policies and applies edits.

The claims editing software application applies edits based on the following sources:

- Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims
- CMS Claims Processing Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates
- CMS coding resources (HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claim Processing Manual, MLN Matters and Provider Transmittals AMA resources
- State-specific policies and procedures for billing professional and facility claims

- Trillium complies with SNIP editing validation requirements levels 1-5

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 and Authorization Process section of this manual, authorizations are for specific members/recipients, 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.

Billing a covered service does not guarantee reimbursement of a claim. The provider must follow proper billing and submission guides that have been provided in the claims submission policy. The services also have to be supported by medical records and meet medical necessity. If coding and billing guidelines are not followed then a claim could be rejected, denied, or payment recouped/recovered.

RESPONSE TO CLAIMS***Verification and Notification***

Trillium provides the following response to ensure that electronic 837 billing is accepted into the Trillium system for processing 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 Portal. 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.

Remittance Advice

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

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.

Known Systems Issues

Trillium maintains and shares a Known System Issues Tracker that informs providers on known health plan systems issues that may have an impact on providers. The tracker is updated on a weekly basis and shared with providers through [Trillium's website under the For Providers tab](#).

CLAIMS INVESTIGATIONS—QUESTIONABLE BUSINESS PRACTICES***Trends of Use and Potential Fraud***

One of the primary responsibilities of Trillium is to monitor the provider network for fraud, waste and abuse. Both the Medicaid and State contracts require Trillium to monitor and conduct periodic audits for compliance with Federal and State laws and in particular the Medicare/Medicaid Fraud and Abuse laws. Specifically, Trillium shall validate the presence of material information to support billing of services consistent with Medicaid and State regulations. Trillium systematically monitors the paid claims data to look for trends or patterns of abuse.

Audit Process

Trillium conducts audits to determine that funds are being used for the appropriate level and intensity 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 Special Investigations Unit (SIU) conducts the billing audits related to potential fraud, waste and abuse for all contract providers.

Role of Finance Department

The Finance Department assists the SIU with the review of financial reports, financial statements, and accounting procedures. The Finance Department works with the 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. Benefits of and instructions related to the self-audit process for providers, including links to forms, can be found on Trillium's website under [Provider Self-Audits](#). 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 in the [Provider Documents and Forms section](#) under For Providers.

Reporting to State and Federal Authorities

For each case of reasonably substantiated suspected provider fraud, waste and abuse, Trillium is obligated to provide the Division of Health Benefits 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.

Claims Investigation—Repayment Process/Paybacks***Overpayment/Underpayment***

Trillium Health Resources, to the extent required by Contract, promptly reports overpayments, specifying overpayments due to potential fraud in accordance with 42 C.F.R. §438.608(a)(2).

Trillium Health Resources administers recovery of overpayment and underpayment in accordance with N.C. Gen. Stat. §583-225(h).

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 60 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.

Trillium's responsibility to providers is to:

- Certify funding for all contracts in accordance with the North Carolina General Statutes.
- 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.
- Confirm timeframes for scheduling member/recipient appointments are in compliance.
- Confirm provider agencies are in compliance with the "no wrong door" policy.
- Verifies providers do not take adverse actions against real or suspected complainant(s) and to clearly understand this activity will be acted upon by the Tailored Plan accordingly.
- Notify complainant and provider who disagrees with the results of the Tailored Plan action on complaints their appeal rights.

- Reports complaints related to licensed facilities, use, neglect and exploitation, etc., to the appropriate agencies, local Department of Social Services (DSS), Division of Health Service Regulations (DHSR), local police department, etc.
- To report and promptly return overpayments within sixty (60) days of identifying the overpayment.

K. Cultural Competency, Linguistically Appropriate Care and Accessibility Requirements

A primary focus of Trillium is to develop, implement and monitor processes that promote culturally competent and linguistically appropriate responsive, quality care to members.

Trillium recognizes and seeks to understand the unique identities of the members and the communities we serve. Trillium strives to contract with providers who recognize that quality care requires meeting the unique cultural and linguistic needs and preferences of our members and communities.

It is our responsibility to plan for, implement and deliver services that are culturally competent, linguistically appropriate and person-centered to ensure every member we serve obtains high-quality care to improve their health and reach their fullest potential.

Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. A culturally competent approach to services requires the system examine and potentially transform each component of service delivery.

Trillium chose to implement the use of national Culturally and Linguistically Appropriate Services (CLAS) Standards in 2020 to improve quality of care and reduce health disparities. The CLAS Standards, developed by the U.S. Department of Health and Human Services and the Office of Minority Health, can be found at the [Think Cultural Health](#) website.

As a provider, the ability to understand and respect individual's cultural backgrounds, values and beliefs has a profound impact on the quality and effectiveness of the healthcare provided. Cultural competency and linguistically appropriate care results in improved communication, better health outcomes, and reduced health disparities for all.

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

All individuals seeking services from a Trillium Network Provider must have meaningful access to those services. Accessibility involves more than physical access to a building; it includes the

ability to communicate effectively with service providers in a way each recipient can easily understand.

Members and recipients 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.

The General Conditions Contract stipulates that providers ensure compliance with all stated regulations, which includes Title VI of the Civil Rights Act of 1964. Title VI prohibits against exclusion from participation in, denial of benefits of, and discrimination under federally assisted programs on ground of race, color, or national origin. Compliance with Title VI requires recipients of federal funding to provide meaningful access to their programs and services for LEP individuals.

Examples of language access measures include providing free interpretation services, written translation of documents, signage in multiple languages and bilingual staff. The measures ensure that LEP members and recipients can effectively understand and participate in the service, benefit or encounter. For LEP resources, see the Resources and Web Links page at the end of this manual.

L. Care Coordination and Discharge Planning Requirements

CARE COORDINATION AND CARE TRANSITIONS

For all members (regardless of whether or not they choose to opt out of Care Management, does not engage in Tailored Care Management, or is ineligible for Tailored Care Management), Trillium as the Behavioral Health I/DD Tailored Plan will continue to support those members through care coordination and care transitions. Care Coordination addresses all unmet health-related resource needs and link members to appropriate services within the community where they live for those members not participating in Tailored Care Management.

Members who opt out of or never engage in Tailored Care Management will continue to receive oversight from Trillium to manage care transitions such as moving from one clinical setting to another. This is done to prevent readmissions to the hospitals or other higher levels of care, emergency department visits, and other potential adverse outcomes for members. Trillium works with providers in our network to facilitate these transitions for our members not otherwise engaged in Tailored Care Management.

Discharge Review

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

planning process includes use of the member's/recipient's strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the member/recipient with functioning in the community. Involvement of family members and other identified supports, including members of the medical community, require the member's/recipient's written consent. The purpose of this process is to identify the steps to be taken by the Discharge Planning Coordinator in assisting with discharge planning efforts.

Discharge Process

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/recipient understands the status of the discharge plan.
- When the discharge plan is lacking in any respect, the Utilization Management Care Manager addresses the relevant issues with the provider.
- The Utilization Management care manager assists with the development of discharge plans for members/recipients in all levels of care.

Among the functions:

- Identify members/recipients who are remaining hospitalized, or at any other level of care, who do not meet criteria for that level of care and help develop a plan to get the right service at the right level.
- Monitor members/recipients to ensure that they receive clinically indicated services.
- Whenever a member/recipient is discharged from detoxification, inpatient psychiatric or partial hospitalization care, the discharge plan should include a follow-up appointment within seven (7) calendar days.

A Trillium representative will coordinate with the person's Clinical Home to coordinate appropriate services following discharge. If the person does not have a Clinical Home, and the person meets Special Needs Population criteria, the care manager will refer to the Care Management Department for follow-up by a care manager.

M. Department-required Documentation Requirements

MEMBER AND RECIPIENT RECORDS REQUIREMENTS

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

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

Applicable state and federal rules and regulations for complete clinical records are set forth by NCDHHS Records Management and include but may not be limited to:

- NCGS 121 and 132
- 45 CFR 164
- 42 CFR Part 2
- APSM 45-1: Confidentiality Rules
- APSM 45-2: Records Management and
- Documentation Manual for Providers
- APSM 30-1: Rules for MH/DD/SUS Facilities and Services
- APSM 10-5: Records Retention and Disposition Schedule for Providers
- APSM10-6: Records Retention and Disposition Schedule for Health Plans
- NCTracks Provider Claims and Billing Assistance Guide
- NC Clinical Coverage Policies
- NC Innovations Technical Guide

Upon closure of a provider's network operations, non-renewal of contract or termination of the contract regardless of the reason the provider should submit a plan for maintenance and storage of all records for approval by Trillium. When submitting a plan for maintenance, Providers should include a Record Retention Log with: provider name, provider address, and phone number, total number of records involved, agency contact person, procedure for requesting

records, member/recipient name, member/recipient record number, member/recipient date of birth, date of last service, and type of services provided. The Record Retention Log is on the Trillium website under Provider Documents and Forms.

Plan for Maintenance and Log should be sent to:

Trillium Health Resources
Attention: Medical Records
144 Community College Road
Ahoskie, NC 27910
or MedicalRecords@TrilliumNC.org

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

N. Provider Appeals and Grievance Process

Determination and Notification of Actions Taken Against Network Providers

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

The network provider will be notified, in writing, within thirty (30) calendar days of Trillium's invocation of the disciplinary action process.

Written communication will include, as applicable:

- The right to submit additional information.
- The right to request an appeal regarding the decision within established timeframes and the right to request an extension of established timeframes for showings of good cause.

Provider Appeals

In order to respect providers, protect members/ recipients, and satisfy our contractual obligations, Trillium maintains a formal mechanism for the resolution of provider appeals. This Appeals Process is available to any network provider who wishes to appeal an adverse action against them, including suspension of their participation in Trillium provider network.

Appeals to Trillium are available to a network provider for the following reasons:

- Program integrity related findings or activities.
- Finding of fraud, waste, or abuse by Trillium.
- Finding of or recovery of an overpayment by Trillium.

- Withhold or suspension of a payment related to fraud, waste, or abuse concerns.
- Termination of, or determination not to renew, an existing contract for LHD care/care management services.
- Determination to de-certify an AHM+ or CMA.
- Violation of terms between Trillium and the provider.

Out-Of-Network Providers may appeal certain actions taken by Trillium.

Appeals to Trillium are available to an out-of-network provider for the following reasons:

- An out-of-network payment arrangement.
- Finding of waste or abuse by Trillium.
- Finding of or recovery of an overpayment by Trillium.

Providers must submit a formal written request for an appeal within thirty (30) calendar days from when the provider receives written notice informing them of the adverse action. Trillium allows providers to submit written appeal requests through Trillium's online provider portal(s), or by mailing a certified copy of the request to:

Trillium Health Resources
Attn: Appeals Unit
PO Box 12797
Durham, NC 27709

The request should include the date the appeal is being requested, a detailed description of the provider's position with respect to the Trillium action giving rise to the provider's right to appeal, and any supporting documentation. If a provider mails in the certified appeal, it must submit supporting documentation that includes protected health information on a HIPAA-compliant flash drive in PDF format.

Trillium may extend the timeframe by which it accepts a written request for an appeal from a provider by thirty (30) calendar days for good cause determined by Trillium. In order to request a good-cause extension of the timeframe by which a provider would otherwise be required to submit its appeal, a provider must submit a written request to Trillium, either through the provider portal(s) or by mail, that includes the date of the request, the reason the provider is requesting extension, and any supporting documentation that addresses the issue of good cause.

Providers must submit a written request for a good-cause extension within thirty (30) calendar days from when the provider receives written notice from Trillium of the decision giving rise to the right to appeal.

Trillium's decision shall be considered final if a provider's appeal request is not received within thirty (30) calendar days of receiving written notice informing the provider of the action.

Trillium's provider appeals process offers an opportunity for providers to share information that they feel is pertinent to their appeal request. Trillium does not discriminate or retaliate against any provider based on any action taken by that provider in exercising its appeal rights. Trillium allows providers to be represented by an attorney during the appeals process. Trillium requires that providers exhaust Trillium's internal appeals process before seeking a recourse under any other process permitted by contract or law. The network provider who requests an appeal has the burden of proof to establish that the adverse action should be reversed or modified.

Upon receipt of a properly and timely submitted provider appeal request, Trillium's Provider Appeals Coordinator categorizes the appeal request as a claims appeal, an adverse action appeal or a withhold or suspension of payment appeal. Trillium acknowledges receipt of each appeal request within five (5) calendar days of receipt of the request.

CLAIMS APPEALS

In addition to the appeal categories described above, providers have the right to file claims appeals. A claims appeal concerns Trillium's denial, in whole or in part, of a payment for service.

When providers receive a claims denial from Trillium, the provider's Remittance Advice (RA) Form will include instructions on how to file a claims appeal and the deadline to do so. The provider appeal coordinator decides claims appeals based upon written information and documentation contained in the provider's appeal request and upon written information and documentation provided by Trillium's Claims Department.

Trillium provides written notice of its decision of a claims appeal within thirty (30) calendar days of receiving a claims appeals request. This written notice will include information regarding further appeal rights, if and as applicable.

Appeals of Suspension or Withhold of Provider Payment

Trillium limits the issue on appeal in cases of suspension or withholds of provider payment to whether Trillium had good cause to commence the withhold or suspension of provider payment. In such appeals, Trillium does not address whether the provider has or has not committed fraud, waste or abuse.

Trillium notifies the Department within ten (10) business days of a suspension or withhold of provider payment. Trillium offers providers the option for an in-person or telephone hearing when the provider is appealing whether Trillium has good cause to withhold or suspend payment to the provider.

Trillium schedules a hearing and issues a written decision regarding whether Trillium had good cause to suspend or withhold payment within fifteen (15) business days of receiving the provider's appeal. Upon finding that Trillium did not have good cause to suspend or withhold payment, Trillium reinstates any payments that were withheld or suspended within five (5) business days.

ADVERSE ACTION APPEALS

Upon receipt of a written request for an appeal of an adverse action, Trillium's Provider Appeals Coordinator will notify the Trillium department that issued the adverse action giving rise to the appeal. The applicable Trillium department will then designate a departmental representative to compile all available information, including any summaries of his/her own research, if applicable. The designated representative shall be expected to represent Trillium's position throughout the appeal process.

During the appeal process, the network provider and the Trillium departmental representative will have an allotted timeframe to present their evidence.

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

- Trillium's departmental representative presentation
- Network provider presentation
- Rebuttal of network provider's presentation
- Surrebuttal of Trillium's rebuttal

The network provider may submit additional information that it deems relevant to the appeal request no less than five (5) business days prior to the panel meeting. The provider appeals coordinator will submit any information used by the departmental 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 appeal panel, which consists of at least three (3) qualified individuals who were not involved in the original decision, is convened by the Provider Appeals Coordinator. The appeal panel includes an external peer reviewer.

The panel will carefully review the information submitted for the appeal, with particular attention given to the information submitted by the network provider and then, by majority vote, make a decision to uphold, overturn, or modify the adverse action. The provider 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 thirty (30) calendar days from Trillium's receipt of the request for appeal. The appeal resolution letter will include information about the provider's right to further appeal (as appropriate) and the deadline and mechanism to request such an appeal.

MEMBER APPEALS

Medicaid Services Appeal

Any member who does not agree with Trillium's Notice of Adverse Benefit Determination on a request for Medicaid services is entitled to appeal such determination through Trillium's appeal process. To begin the process, an appeal must be requested no later than sixty (60) calendar days from the mailing date of the Notice of Adverse Benefit Determination.

To request an appeal, an appeal request form may be completed and returned by fax, mail or in person, or the member/guardian or authorized representative may request an appeal orally. Trillium will acknowledge receipt of the appeal in writing within five (5) calendar days of receipt of the request. Upon request, Trillium will provide the member/guardian or authorized representative with the case/appeal file, including medical records, and any other documents and records pursuant to Trillium's Member Access to Protected Health Information Procedure free of charge, within two (2) calendar days of Trillium's receipt of the request.

An appeal review is an impartial review of Trillium's decision to reduce, suspend, terminate or deny Medicaid services. A health care professional who has appropriate clinical expertise in treating the member's condition or disorder, and who was not previously involved in the initial decision, determines the appeal decision.

Trillium will issue a decision in response to the request for appeal within thirty (30) calendar days from the receipt of the request for standard appeals and within seventy-two (72) hours from the receipt of the request for expedited appeals. The member/guardian/ authorized representative must complete the internal appeal process with Trillium before requesting a hearing with the Office of Administrative Hearings (OAH), which is known as a State Fair Hearing.

Continuation of Benefits:

- A. Trillium continues and pays for a Member's benefits during the pendency of the plan appeal and/or State Fair Hearing if all of the following occur:

1. The Member, or the Member's authorized representative, files a timely request for an appeal in accordance with federal regulations;
 2. The appeal involves the termination, suspension, or reduction of previously authorized services;
 3. The services were ordered by an authorized Provider;
 4. The period covered by the original authorization has not expired; and
 5. The Member timely files for continuation of benefits within ten (10) calendar days of Trillium sending the adverse benefit determination, or on the intended effective date of Trillium's proposed adverse benefit determination, whichever comes later.
- B. If Trillium continues the Member's benefits while the appeal is pending, the benefits must be continued until one (1) of the following occurs:
1. The Member withdraws the appeal or State Fair Hearing Request, in writing;
 2. The Member does not request a State Fair Hearing and continuation of benefits within ten (10) calendar days from when Trillium mails an adverse Notice of Resolution;
 3. A State Fair Hearing decision adverse to the Member is made.

Trillium does not allow a Provider to request continuation of benefits or request continuation of benefits on behalf of a Member.

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

Expedited Appeal Process

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

For expedited appeal requests filed by providers on behalf of members, Trillium presumes an expedited appeal resolution is necessary and grants the request for an expedited appeal.

Trillium ensures that punitive action is not taken against a provider who requests an expedited appeal or otherwise supports a member's appeal. Expedited appeal requests may be filed orally or in writing with Trillium's Appeals Department. Oral requests for expedited appeal do not require written follow-up.

If an expedited request is received, it is reviewed to determine if there is sufficient evidence to support the need for this type of request. Additional documentation that the member/guardian or

authorized representative wants to be reviewed should be submitted within one (1) calendar day of the date that the appeal request was filed.

If Trillium agrees that the appeal request qualifies for expedited processing, Trillium will complete the appeal within seventy-two (72) hours of Trillium's receipt of the appeal request. If there is not sufficient evidence to require an expedited request, the member/guardian will receive verbal notice of the denial of their request for an expedited appeal and written notice within two (2) calendar days and the appeal will follow the standard appeal timelines. If the member/guardian/authorized representative or provider disagree with the decision, they have the right to file a grievance regarding Trillium's decision to deny the expedited appeal request.

Extension of Timeframes for Expedited and Standard Appeal Process

Trillium may extend the timeframes for appeals resolution up to fourteen (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 appeals timeframes, for any extension not requested by the member, written notice of the reason for the extension will be provided to the member/guardian or authorized representative by Trillium within two (2) calendar days. This notice will also inform the members of their right to file a grievance if they disagree with the extension decision.

Medicaid Services Appeal Mediation

If a member/guardian or authorized representative is dissatisfied with the resolution of the appeal, the member/guardian or authorized representative may file a State Fair Hearing Request with the North Carolina Office of Administrative Hearings (OAH) within one-hundred twenty (120) calendars days from the date of the Decision on your Appeal Letter by submitting the State Fair Hearing Request Form to the addresses specified on that form. The telephone number for OAH is 1-984-236-1860. A copy of the State Fair Hearing Request Form is attached to the Decision on your Appeal Letter. Once a State Fair Hearing Request has been filed with OAH, the Mediation Network of North Carolina will contact the member or the member's authorized representative to offer an opportunity to mediate the disputed issues between the member and Trillium in an effort to resolve the pending petition informally. The mediation process is voluntary.

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

The member or the member's authorized representative will receive notice from OAH of the date and time of the hearing. If the member or the member's authorized representative disagrees with the Final Agency Decision, they may seek judicial review in Superior Court.

NC Medicaid Member Ombudsman Program

The Program serves members across North Carolina, not just members in the Trillium catchment area. The NC Medicaid Ombudsman helps NC Medicaid beneficiaries understand Medicaid and NC Medicaid Managed Care. They can help beneficiaries when they are not able to solve problems with their provider or health plan. The Ombudsman Program does not take the place of Trillium's process for filing an appeal.

Visit: medicaid.ncdhhs.gov/about-nc-medicaid/nc-medicaid-ombudsman or

Call: 1-877-201-3750

For questions concerning the decision Trillium made about the member's request for Medicaid services, please contact Trillium Health Resources Member and Recipient Services 1-877-685-2415. Should you have questions about the State Fair Hearing process, please contact North Carolina Office of Administrative Hearings or Trillium using the contact information listed.

North Carolina Office of Administrative Hearings (OAH)

Attn: Clerk

6714 Mail Service Center Raleigh, NC 27699-6700

Telephone: 1-984-236-1850

Fax: 1-984-236-1871

Trillium Health Resources Appeals Unit

PO Box 12797 Durham, NC 27709

Telephone: 1-866-998-2597

Fax: 1-252-215-6879

Non-Medicaid Service Appeal Process

Non-Medicaid services are not an entitlement. If a recipient/guardian or authorized representative disagrees with the non-Medicaid service decision, they may fill out the Non-Medicaid Service Appeal Form that accompanies the decision and return it to Trillium within fifteen (15) business days of the date of the Notice of Adverse Utilization Decision letter.

Trillium acknowledges receipt of a Non-Medicaid appeal with a letter to the appellant, dated the next working day following Trillium's receipt of the appeal. The non-Medicaid service appeal process maintained by Trillium provides an opportunity for the recipient, 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 appeal.

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

It can take up to seven (7) business days from the date the Non-Medicaid Service Appeal Form is received for a decision to be made by Trillium. The timeframe for processing the appeal begins at the date and time the request was received by Trillium.

If the appeal decision is to uphold the original Adverse Utilization Decision, the written appeal notification will explain that there is an opportunity for the recipient to appeal the decision to the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' Non-Medicaid Appeals Panel ("Non-Medicaid Appeals Panel), as well as the process for doing so.

Non-Medicaid Appeal Request to the Division

If a recipient/guardian/authorized representative disagrees with the non-Medicaid appeal decision, they may submit the Non-Medicaid Appeal Request Form to the Division. The internal Trillium State-Funded Appeal process must be completed prior to filing the appeal request with the Non-Medicaid Appeals Panel.

The non-Medicaid appeal request is reviewed by the Non-Medicaid Appeals Panel. The Non-Medicaid Appeals Panel will issue its findings and decisions within sixty (60) days of receipt of the appeal request form to both the recipient/guardian and Trillium's CEO. Upon receipt of the Non-Medicaid Appeals Panel's findings and decisions, Trillium issues a final decision informed by those findings. Trillium issues the decision in writing within ten (10) calendar days of receipt of the panel's findings and decisions.

Receiving Services during the Non-Medicaid Appeals Process

Trillium has the option of authorizing other non-Medicaid Services that are appropriate. Services may be authorized for the duration of the appeal decision process at the discretion of Trillium. Other community resources may also be referred to the recipient for support. When a recipient/guardian/authorized representative files an appeal for the denial of a new service, Trillium is under no obligation to provide the requested service during the review process.

Grievances and Complaints

A grievance is defined as any expression(s) of dissatisfaction about any matter other than an Adverse Benefit Determination (see definition of action below) filed by a member or by an individual who has been authorized in writing to file on behalf of a member. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of

interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The resolution of a grievance may be appealed.

If a grievant wishes to appeal the resolution of a grievance, the grievant must request an appeal within sixty (60) calendar days of the mailing date of the grievance resolution letter. Trillium does not discriminate or retaliate against an individual for filing a grievance or requesting a grievance appeal.

A complaint is defined as an expression of dissatisfaction about any matter other than utilization review decision by a recipient or a recipient's authorized representative (including legal guardian or provider) who has written consent to act on behalf of the recipient.

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 or recipient's rights. The resolution of a complaint may be appealed. The complaint resolution letter will inform the complainant of the deadline to appeal. Trillium does not discriminate or retaliate against any individual for filing a complaint or requesting a complaint appeal.

Trillium allows providers to submit complaints through Trillium's online Provider Portals, or by mailing a copy of the request to:

**Trillium Health Resources
P.O. Box 12797
Durham, NC 27709**

or by calling the Provider Support and Service Line.

Adverse Benefit Determination means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of a Health Plan or PIHP to act within the timeframes provided in the Federal Regulations.

- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
- The denial of a Medicaid member's request to exercise his or her right, to obtain services outside the network but only if the member lives in a rural area and there is no Trillium network provider who is available to provide the service.

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

The available channels include:

- Member and Recipient Services
- Provider Support Service Line
- Trillium Website
- Trillium Provider Portals
- NCDHHS
- Certified Mail
- Secure Emails

Trillium maintains a formal process to manage complaints and grievances through a centralized, coordinated process. Regardless of how it is submitted, the grievance or complaint submitted is documented and acknowledged by Trillium via letter. If the issue is not something Trillium has oversight of, Trillium will make a referral to the appropriate agency, which could be, but is not limited to, the Department of Social Services, Division of Health Service Regulations, Division of Mental Health/Developmental Disabilities/Substance Use services.

Grievances are resolved within 30 calendar days of receipt. Trillium may extend the timeframe for resolution by up to 14 calendar days if the member/ recipient requests the extension or if the Plan shows there is need for additional information and how the delay is in the member's/recipient's best interest. If the Plan extends the timeframe, it must, for any extension not requested by the member/recipient, give the member/recipient written notice of the reason for the delay.

Once Trillium has completed its investigation of a grievance, Trillium will send a standardized resolution letter to the person who filed the grievance and all other parties involved in the review. Per contractual requirements, providers are required to cooperate fully with all investigative requests, including, but not limited to, immediate access to any of the contractual locations/sites, where services are provided to members/recipients, in addition to any site where financial or clinical records are maintained. Failure to do so may be grounds for contract termination.

Trillium resolves complaints within 15 business days from receipt or within 30 calendar days from receipt, depending on whether Trillium conducts an informal or formal investigation of the complaint. Trillium sends a standardized resolution letter to complainants.

If a provider wishes to issue a complaint about Trillium Health Resources' business operations, they may contact the Provider Ombudsman for support in submitting their complaint via the contact channels below:

Provider Ombudsman

Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Phone: 1-866-304-7062

O. Complaint or Grievance Investigation and Resolution Procedures

GRIEVANCE AND COMPLAINT PROCESS INTERNAL TO CONTRACTED NETWORK PROVIDERS

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

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

Trillium's Member and Recipient Services line 1-877-685-2415 must be published and made available to all members, recipients and family members in the provider's office. Additionally, other agencies available to take grievances/complaints must be posted. These agencies include Division of MH/DD/SUS Member Care Line, 1-919-733-7011, in Raleigh and Disability Rights NC, 1-877-235-4210.

P. Performance Improvement

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

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

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

In a system driven by continuous quality improvement, the QMIP facilitates the objective and systematic measurement, monitoring, and evaluation of internal organizational processes as well as services delivered by network providers. Performance Improvement Projects (PIPs) can be implemented as a result of the findings from these activities and measured periodically for intervention effectiveness. Quality Improvement initiatives are designed to provide support to practitioners/providers to achieve quality goals at the regional and practice level. The QMIP promotes objective and systemic measurement, monitoring, evaluation and improvement of whole person care and services.

The QM Department makes training available to the provider network. Trillium is committed to working in collaboration with providers to aide and assist them with achieving the highest standards of quality in service delivery. The important role of quality management in protecting members/recipients and promoting high-quality treatment is understood and valued.

A strong commitment to continual improvement of programs and services, as well as the services provided directly to members is maintained. Trillium providers are required to maintain a Quality Management Program that is comprehensive and proactive. The areas identified below

provide a description of how the Trillium Health Resources QM Department interfaces with the providers in the network. Trillium communicates activities and outcomes of its QMIP to members and providers/practitioners through Trillium's website. [The Quality Assurance and Performance Improvement \(QAPI\) Work Plan](#) monitors quality related tasks and goals established in the QMIP.

QM INDICATORS AND CONTINUOUS QUALITY IMPROVEMENT

The QM department supports a global continuous quality improvement model that includes all network providers and practitioners. Continuous Quality Improvement (CQI) activities are designed to promote the highest quality care for physical health, behavioral health, intellectual and/or developmental disabilities, traumatic brain injury, and Long-Term Services and Supports needs. Trillium's quality improvement philosophy is based on the continuous quality improvement model which involves a process of design, discovery, remediation, and improvement.

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

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

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

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

The Performance Measures Unit, with the assistance of the Informatics Unit in IT leads the analytic function for support of the continuous quality improvement efforts of the agency and for discerning opportunities for identifying and responding to areas of operational need. Included in

this is the implementation of drill down analytics which provides the opportunity to discover disparities in quality metrics and to understand variation in quality across various venues of performance.

These investigative analytics lead to an understanding of what is driving gaps in services and aid in identifying areas for improvements in order to enhance the overall quality of care for Trillium members/recipients. Trillium uses the information discovered to guide policy decisions and annual improvement goals.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

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

Data is shared with providers on a routine basis. Trillium will utilize dashboards and reports to monitor measures internally and externally with providers to identify areas for improvement and appropriate interventions. For more information on HEDIS, visit [Trillium's HEDIS Resources](#) webpage found on Trillium's website.

SURVEYS

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

Trillium encourages providers and members to participate in any and all surveys, as these are opportunities for providers and members to share feedback with Trillium. There are a number of surveys administered throughout the year. For additional details, a description of each is included below.

Surveys cover the following areas:

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

- Member and Provider Satisfaction

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

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

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

Member Satisfaction Survey

NC Medicaid conducts an annual satisfaction survey for all Medicaid members. NC Medicaid contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess member satisfaction with services the instrument selected for the survey is a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) determined by NCDHHS. This is a member satisfaction survey as well as a major component of Healthcare Effectiveness Data and Information Set (HEDIS).

The CAHPS Health Plan Survey is a standardized survey instrument that asks members to report on their experiences accessing care, experiences with their health plan, and assess the quality of care received by physicians. The Department focuses on evaluating CAHPS survey responses related to members' ability to obtain needed care, their ability to get care quickly, coordination of care, customer service, their rating of the health plan, rating of their personal doctor, and rating of the specialist seen most frequently.

The survey's target population includes individuals of all ages (18 and older for the adult version, and parents or guardians of children ages 0–17 for the child version) who have been continuously enrolled in Medicaid for the six-month measurement period (July 1st through December 31st of previous year) with no more than one 45-day gap in enrollment.

Providers should encourage members to complete these surveys. Once complete, results of the survey are returned to Trillium Health Resources for analysis, review, and any quality improvement interventions if deemed necessary.

National Core Indicator (NCI) Survey

National Core Indicators®—Intellectual and Developmental Disabilities (NCI®-IDD) and National Core Indicators—Aging and Disabilities (NCI-AD™) surveys are administered annually or semi-annually using survey tools as determined by the Department. NCI surveys are administered by the NC Division of MH/DD/SUS with assistance from the Carolina Institute for Developmental Disabilities (CIDD) and the University of NC at Chapel Hill. The NCI survey collects information from people with disabilities and their families and guardians to find out what service areas are working well and what areas may need improvement in North Carolina and nationally.

NC DHHS provides the random sample of members to be interviewed both in person and via mail. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.

Home and Community Based Supports—My Individual Experience Survey

Home and Community Based Supports—My Individual Experience Survey is conducted quarterly. This is a survey from the NC Department of Health and Human Services (NCDHHS) for members receiving specified Medicaid services. The survey was developed to measure members' satisfaction, level of awareness of and access to their rights, privacy requirements and member experience expectations, as outlined in the HCBS requirements. The Member-specific survey responses are reviewed when submitted to the State. When instances appear to be a rights restriction/violation, Trillium will research and attempt to resolve the discrepancy or refer concerns to the Network department to further investigate.

Perceptions of Care Survey

The NC Division of MH/DD/SUS conducts a Perceptions of Care survey on an annual basis to assess members' perception of care of services received from network providers for mental health or substance use services. A designated number of members are required by DMH/DD/SUS to participate in the survey. A team of Quality Management Department staff provide member surveys to providers. Providers assist members with survey administration. Surveys can be completed on paper and returned to the QM Department or completed on the survey website directly for analysis by DMH/DD/ SUS.

Once analysis by DMH/DD/SUS is complete, results of the survey are returned to Trillium for internal analysis, review, and determination of any quality improvement interventions deemed necessary.

Provider Satisfaction Survey

Provider Satisfaction Surveys are administered annually to providers by NC Medicaid to assess the Tailored Plan/PIHP's ability in the following three areas:

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

The instrument selected for the survey is provided by NC Medicaid. Active providers are surveyed for their opinions of satisfaction with Trillium. An active provider is defined as a Medicaid provider that has at least five encounters within the previous six months. The survey is administered over a six-week period using a web survey protocol. Once complete, results of the survey are returned to Trillium for analysis, review, and any quality improvement interventions if deemed necessary.

CLINICAL STUDIES

Providers must actively participate in member/ recipient satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements.

INCIDENT REPORTING

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

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

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.
- Adherence to mandatory reporting requirements.
- Entry of 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/recipients. 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 provider must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated.

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

Regulations regarding Trillium's monitoring and the classification of incidents (Level I, II, or III) as well as requirements related to the submission of incident reports to home and host Tailored Plan and state agencies can be located in North Carolina Administrative Code. Trillium is required to monitor the state IRIS system. Trillium QM staff review all incidents when received 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 QM staff will work with the provider to resolve them. If issues/ concerns are raised related to member care, services, or the provider's response to an incident, QM staff may elect to refer the concerns to the Compliance Department to further investigate. On a daily basis, QM staff track and report specific category types of Level II and III incidents. This information is shared within Trillium to assess if there is any immediate action needed due to health and safety concerns. Providers that fail to report incidents as required by Administrative Rule and the provider contract may be required to complete a Plan of Correction.

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

It is strongly encouraged that each provider read the NC Incident Response Improvement System (IRIS) manual available on the [NCDHHS](#) for further information and clarification. In addition,

Trillium has provided an in-depth training related to IRIS and Incident Reporting that can be located on Trillium's "My Learning Campus". Trillium's QM Department will provide additional training as needed and when there are changes to any guidelines or processes.

Level I Incidents

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

Level II Incidents

These incidents are a threat to a member's/recipient's health or safety or a threat to the health or safety of others due to:

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

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

These reports are to be entered into the IRIS website within seventy-two (72) hours of the learned incident. These incidents must also be reported to the appropriate clinical staff involved in the care of the member/recipient. These reports must not be filed in the member's/ recipient's record but must be able accessible for review during local monitoring.

Level III Incidents

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

- Death due to suicide, violence/homicide, accident, unknown cause, or occurring within 7 days of seclusion or restraint.
- Any action that results in death, permanent physical or psychological impairment, or if the incident is perceived to be a significant danger to or concern of the community.
- Sexual assault/rape, sexual abuse, or permanent physical impairment or psychological impairment to a member/recipient or caused by a member/recipient.
- A substantial risk of death or permanent physical impairment or psychological impairment to a member/recipient or caused by a member/ recipient.
- A threat caused by a member/recipient to a person's safety.
- An allegation of Abuse/Neglect/Exploitation by a provider staff member.
- A report to the media, Amber/Silver Alert.

For Level III incidents, the provider must verbally or electronically notify Trillium within twenty-four (24) hours and must enter a report in IRIS within seventy-two (72) hours of the learned incident. (Exception: allegations of abuse/neglect/exploitation by staff must be reported to HCPR within twenty-four (24) hours via IRIS). Deaths within seven (7) days of a restrictive intervention must be reported verbally and entered into IRIS immediately.

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

enabling them to identify when a Level III incident has occurred and how to conduct a detailed investigation of the event/incident.

The internal review team shall review the member/ recipient record, gather additional information if needed and enter a report in IRIS concerning the incident and notify any other authorities required by law (DSS, law enforcement, DJJ, etc.). The report to the North Carolina Health Care Personnel Registry (for allegations against staff) is completed through IRIS and must be entered within 24 hours of learning of the incident.

The provider must resubmit the IRIS report within 5 working days regarding the results of their investigation. Trillium monitors the provider's progress to ensure that the above process is being adequately implemented. These reports must not be filed in the member/ recipient record but must be filed on site for review during monitoring visits.

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 (i.e., staff is out sick, on extended leave, had an appointment, on vacation, resigned, terminated, did not show to work) or when back up-staffing is offered but declined by the member/guardian. Please note that service breaks do not require back-up staffing reports; service breaks are defined as holidays, family vacations, weather conditions, member illnesses, and scheduling conflicts. The reports must be submitted to Trillium bi-monthly. Hours missed from the first to the 15th of the month are due by the 22nd of that month. Hours missed from the 16th to the end of the month are due by the 7th of the following month. Reports must be submitted to the Quality Management Department at IncidentReporting@TrilliumNC.org or via fax at (252) 215-6880. The form is available on Trillium's webpage, Provider Documents.

Restrictive Interventions

There are two types of restrictive interventions:

Planned Interventions

- If there is a therapeutic need for a member/ recipient to have hands on intervention or other rights' restrictions as ongoing interventions (4 or more incidents within 30 days), it must be included as an addendum to the person-centered plan. This addendum must be signed by a psychologist (PhD) or medical doctor (MD) in addition to the person-centered plan.

- It is also required to have the provider's Human Rights Committee and guardian approval prior to implementation. These restrictive intervention plans may be requested by Trillium staff for submission and review.
- If the member/recipient has a planned intervention as part of their documented treatment plan and 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

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

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

Restrictive Interventions Reporting Requirements in a PRTF Setting

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

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

OUTCOMES REQUIREMENTS

Provider Performance Data

Trillium shares provider-specific performance data at least annually to support ongoing adherence to quality standards. Trillium provides data to practitioners/ providers including interpretation of their QI performance data and feedback regarding QI activities. This offers providers a snapshot into how they are performing in certain areas compared to similar network

practitioners/providers. These reports may include performance data related measures, HEDIS measures, Value Based Purchasing metrics, or other measures.

Trillium utilizes various methods to gather and distribute performance and quality related data to providers. Sharing of this information creates transparency, promotes provider accountability, enhances provider internal processes, and supports continual quality improvement for the network.

This data may be used for comparative purposes, as a way of fostering a high-quality provider network that engages in continuous quality improvement for the purpose of sustaining a high-quality service delivery system. Trillium exercises due care when compiling and releasing provider-specific data to the public.

Trillium has established guidelines and standards for sharing this information that protects the providers and public by ensuring that all applicable confidentiality laws and regulations are followed, and limitations of the information are acknowledged and disclosed.

Provider-specific performance data is obtained utilizing information from various data sources, including but not limited to, claims and authorizations in Trillium's software platform. All reports of provider-specific performance data will include a description of the methodology used to develop the report, as well as the uses and limitations of the information.

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

Provider Performance Improvement Projects

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

Providers should demonstrate a Continuous Quality Improvement (CQI) process by identifying and maintaining PIPs throughout the year. Most often, initiatives or activities are selected based on data that indicates a need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service. Trillium recommends providers complete PIPs that demonstrate evidence of performance improvement related to some aspects of organizational processes/ structure, member outcomes, or other provider improvement activities.

PIPs are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these activities/studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Technical Assistance can be provided upon request. For further information regarding PIPs please reference the training provided on [Trillium's Learning Campus](#) related to PIP's.

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 Use Services measure the quality of substance abuse and mental health services and their impact on members' lives. Please review all details and NC-TOPPS requirements in the manual.

Online interviews conducted at initiation, three months, six months, twelve months, biannually 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 interviews is determined by a hierarchy of services based on age-disability. Priority for the responsible provider agency is noted in hierarchical order so that if a consumer receives two or more of the required services during a given period, the service that is in the highest order on the table is responsible for the NC-TOPPS. [See the hierarchy outlined in the NC-TOPPS Guidelines.](#)

The initial interview must be completed with the member at the beginning of an episode of care during the first or second visit. The Update Interviews (3, 6, and 12 months and biannual or twice a year) are to be submitted within the appropriate time frame as long as the member is receiving treatment. If the member is no longer receiving the qualified treatment, an Episode Completion is submitted. The NC-TOPPS must be administered by a Qualified Professional.

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

NC-SNAP Requirements

All members who receive I/DD services must have an NC-SNAP administered at least annually. An NCSNAP is not required for those members that have an approved Support Intensity Scale (SIS) assessment for Innovation Waiver services or an approved 1915i assessment for 1915i services. Members who receive Innovation Waiver services are required to receive a SIS completed every 2 years for children ages 5–15 years old and every 3 years for adults beginning at the age of 15. Members who are approved and receive 1915i services are required to receive a 1915i assessment annually or sooner if circumstances or needs change.

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

NC-SNAP Examiner Certification Training

NC-SNAP Certification is only available to those staff with the appropriate credentials who are in a position that requires them to complete or review NC-SNAP Assessments as part of their job responsibilities. Typically, this is a Qualified Professional. To request NC-SNAP Training, please complete the NC SNAP Examiner's Training Registration Form and the NC SNAP Eligibility Determination Form and email them to NCSNAP@trilliumnc.org. Please Note: Each of these forms must be completed electronically.

The NC SNAP Examiner's Training Schedule, Training Registration Form, and Eligibility Forms are located on the [NCDHHS NC-SNAP website](#). Trillium is responsible for ensuring that all providers submit the NC-SNAP Assessment annually as part of the Performance Contract with the Department of Health and Human Services which is monitored by the Division of Mental Health, Developmental Disabilities, and Substance Use Services. For Trillium related questions regarding NC SNAP, email NCSNAP@TrilliumNC.org

Government Performance and Results Act Core Client Outcome Measures for Discretionary Services Programs

All providers receiving State Opioid Response (SOR) funding are required to complete the Government Performance and Results Act (GPRA) Core Client Outcome Measures for Discretionary Services Programs tool as required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Any individual receiving new substance use specific treatment service and who is eligible for the Adult Substance Opioid Use Disorder (ASOUD) Benefit Plan is required to be assessed using this tool. Training, webinars, job aids, tools, user guides and other resources can be found on the [NCDHHS website](#).

Root Cause Analysis (RCA) in Transitions to Community Living (TCL) Housing

As part of Trillium's commitment to the Olmstead Settlement Agreement, a top priority is ensuring that members with disabilities are fully integrated into their communities and supported in maintaining permanent housing. To advance this goal, Trillium has established a policy to carefully review housing separations for TCL members when they occur due to significant negative events.

This review takes place through the Root Cause Analysis (RCA) process, which helps identify underlying issues, develop action plans, and implement strategies to prevent future disruptions in housing stability. The RCA process ensures that each separation is fully examined, keeping members' long-term stability at the center of care.

Events That Trigger an RCA

For TCL members, who are in permanent supportive housing, an RCA is conducted when any of the following occurs:

- Housing separation due to member death
- Housing separation due to Level 3 incident
- Loss of housing resulting in homelessness
- Return to or new admission to an Adult Care Home (ACH)

The RCA Process

- **Initiation:** When a significant negative event occurs, Trillium TCL staff complete an internal report and notify Trillium's Quality Management (QM) Department, initiating the RCA process.
- **Review:** For events involving death or Level 3 incidents, QM retrieves and reviews the IRIS report. For homelessness or admission to an ACH, QM will email the provider and request completion of the Provider Event Reporting Form within 3 business days. (These events typically do not require IRIS reports.)
- **Provider Role:** Provider feedback through either the IRIS report or Provider Event Reporting Form is critical. It gives valuable perspective on the circumstances surrounding the housing separation and helps inform Trillium's review. By working together in this structured process, we can reduce the likelihood of housing disruptions and strengthen long-term community integration for TCL members.

Q. Compensation and Claims Processing Requirements

REQUIRED ELECTRONIC FORMATS

Trillium operates a secure web-based module called Provider Direct (Medicaid Direct/State-funded) and iTransact (Tailored Plan) 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 the appropriate Provider Portal. If your agency already has a system administrator for the Provider Portal, please contact that person to be assigned a login. If your agency is new to Trillium and doesn't have a system administrator for the Provider Portal (s), someone at your agency should be designated as the system administrator for the Provider Portal (s) and follow the steps outlined in the [Provider Onboarding Process](#).

Providers may elect to submit their claims using the HIPAA Standard Electronic Transaction Set.

Mandated Timelines

Timeframes for Submission of Claims All claims must be submitted within the timeframes outlined in your provider contract from the date of service, or in the case of a health care provider facility, within 365 days after the date of the members' discharge for Medicaid funded claims.

These timely requirements are pursuant to N.C Gen. Stat 58-3225(f).

Process for Submission of Replacement Paid Claims

Providers may submit replacement claims for originally paid claims. Services submitted outside of contracted timeframes may deny for exceeding billing days. Providers may complete a Claim Request Form (CRF), located on Trillium's website, for consideration of approval of claim denied for exceeding billing days. Refer to Trillium's website for the purpose of the [Claims Request Form \(CRF\) and CRF for completion](#).

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.

R. Interest Provisions for Late or Under-payments

Any claim not paid within Timely Claim Payment limits will be subject to interest at the annual percentage rate of eighteen percent (18%). Interest is calculated for each calendar day after the date the clean claim should have been paid as specified in the contract between Trillium Health Resources and NC DHHS.

S. Member Rights and Responsibilities

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 all providers, to respect these rights at all times and provide members with continual education regarding their rights, as well as support them in exercising their rights. N.C. General Statutes, Administrative code, and federal regulations outline rules and regulations about human rights.

Upon admission, Trillium mails each member a copy of the appropriate [Trillium Member and Family Handbook](#) containing information to help them access services for severe mental health, intellectual/developmental disabilities, traumatic brain injury, and substance use. Electronic copies of the handbooks and other helpful documents are posted on our website.

The handbooks include 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

The following is a list of Member rights:

- The right to request and receive information about Trillium, its services, its providers/practitioners, and member rights and responsibilities presented in a manner they can understand. Trillium notifies members of this right, annually.
- The right to be treated with respect and recognition of dignity and right to privacy.
- The right to participate with providers or practitioners in making decisions regarding health care and the right to refuse treatment.
- The right to a candid discussion with service providers/practitioners on appropriate or medically necessary treatment options regardless of cost or benefit coverage. Members may need to decide among relevant treatment options, the risks, benefits and consequences, including their right to refuse treatment and to express their preferences about future treatment decisions regardless of benefit coverage limitation.
- The right to voice complaints or grievances about the organization or the care it provides.
- The right to appeal decisions with which they disagree.

- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. If they present a danger to themselves or others, and there are no other means available to protect their safety and the safety of others, physical restraint may be used.
- The right to request and receive a copy of their medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. Therapeutic privilege means that if the doctor or therapist determines that this would be detrimental to their physical or mental well-being, they can request that the information be sent to a physician or professional of their choice.
- The right to write a statement to be placed in their file if they disagree with what is written in their medical records. However, the original notes will also stay in the record until the statute of limitations ends according to the State's retention schedule (11 years for adults; 12 years after a minor reaches the age of 18; 15 years for DWI records).
- The right for a treatment plan to be implemented within 30 days after services start. This is known as a Person-Centered Plan.
- The right to a second opinion from a qualified health care professional within or outside the Trillium network, at no cost to the member.
- Upon request, Trillium shall provide one second opinion from a qualified health care professional selected by Trillium, at no cost to the member. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. Trillium shall not be required to provide the member with a third or fourth opinion.
- The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths and preferences.
- The right to take part in the development and periodic review of their treatment plan and to consent to treatment goals in it.
- The right to freedom of speech and freedom of religious expression, including the right to refuse treatment on moral or religious grounds.
- The right to equal employment and educational opportunities.
- The right to ask questions when they do not understand their care or what they are expected to do.

- The right to written notice of any “significant change” to the handbooks and/or contracts at least thirty (30) calendar days before the intended effective date of the change. A “significant change” is a change that requires modifications to the 1115 or 1915 (c) Waiver, a contract between Trillium and the State or Medicaid, or the Medicaid State Plan.
- The right to receive oral interpretation services free of charge.
- The right to request and receive a State Fair Hearing.
- The right to develop an Advance Directive for the mental health treatment they would like in the event of an emergency. They may contact Trillium Health Resources for assistance at 1-877-685-2415. An Advanced Directive explains the treatment they would like and the people they would like to be involved. It also explains the things that they do not want.
- The right to file a grievance with the N.C. Division of Health Service Regulation or with Trillium if they feel the laws governing the advance directives have not been followed correctly.
- The right to be free of mental abuse, physical abuse, neglect and exploitation.
- The right to choose their Provider from the Trillium Provider Network. They have the right to change their choice of Provider at any time by calling the Member and Recipient Services 1-877-685-2415 or speaking to their care manager.
- The right to change their Tailored Plan PCP within 30 days from the date of receipt of their Medicaid ID card. After that they have the right to change their PCP one time each year without cause.

Members can change their PCP more than twice a year with good cause such as:

- PCP does not provide accessible and proper care, services or supplies (for example, does not set up hospital care or consultations with specialists when required for treatment).
- PCP is not able to accommodate special needs.
- Trouble communicating because of a language barrier or another issue.
- They disagree with PCP’s treatment plan.
- PCP moves to a different location that is not convenient.
- PCP changes the hours or days patients are seen.
- Member and PCP agree that a new PCP is what is best for their care.
- Person and PCP agree changing providers is in their best interest.

- Medicaid Direct beneficiaries have the right to choose their PCP and can change their PCP at any time and for any reason.
- Trillium shall hold the Member harmless for any costs associated with the transition between Providers, including copying medical records or treatment plans.

Trillium gives written notice of provider terminations to all Members who have been receiving services. Trillium shall notify each member, at a minimum, who received his or her primary care from, or was seen in the previous 12 months by a terminated provider. Trillium shall give notice within fifteen (15) calendar days after Trillium receives notice that the Provider has terminated the Provider Agreement. When the Division of Health Benefits (DHB) or Trillium terminates a Provider Agreement with a network provider, Trillium shall give written notice of the termination to all members who have been receiving services from the terminated Provider. Trillium shall give notice within fifteen (15) calendar days after Trillium receives notice that DHB has terminated the Provider Agreement or after Trillium provides notice of termination to the Provider (after the appeals deadline expires or all appeals have been exhausted).

- The right to treatment, regardless of age or disability. The treatment received will be age appropriate and in the least restrictive manner possible.
- The right to invite family or friends to help develop their Person-Centered Plan. The purpose of the Person-Centered Plan is to help them make goals to achieve their full potential.
- The right to be notified in advance of all potential risks and benefits of treatments.
- The right to be free from unnecessary or excessive medications. Medications will not be used as punishment or for the convenience of staff or family
- The right to refuse medications. This should always be discussed with their doctor.
- Members CANNOT be treated with Electroshock/ Electroconvulsive Therapy (ECT), experimental drugs or procedures, or be given surgery (unless it is an emergency surgery) without their written permission.
- The right to make recommendations regarding Trillium policies, procedures and services. If they would like to make recommendations regarding changes, they may contact Trillium Health Resources at 1-877-685-2415 or Attention Quality Management Unit PO Box 12797 Durham, NC 27709.

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

Information about them can only be shared when:

- They have given written consent.
- There is a court order.
- They become a danger to themselves or others and it is necessary for someone to submit involuntary commitment papers or find hospital placement for them.
- They are likely to commit a serious crime. Their provider will share the information with the appropriate law enforcement agency.
- Or, as otherwise allowed by law.

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

This includes a right to:

- Dispose of property
- Make purchases
- Enter into contractual relationships
- Vote
- Marry and divorce
- Develop a discharge plan prior to being discharged
- Receive a copy of their treatment plan

Members are free to exercise these rights and exercising these rights shall not adversely affect the way the Tailored Plan or providers treat the member.

Member Rights as a Minor (Under the Age of 18)

Minors have the right to:

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

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

- For treatment of sexually transmitted infection

- For pregnancy
- For abuse of controlled substances or alcohol

Member Rights in a 24-hour Facility/Adult Care Home

In addition to the above, members receiving care in a 24-hour facility or adult care home have the right to:

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

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

Member/Recipient Rights for Residential Providers Only

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

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

- Opportunity for a shower or tub bath daily, or more often as needed.
- Opportunity to shave at least daily.
- Opportunity to obtain the services of a barber or a beautician.
- Provision of linens and towels, toilet paper and soap for each person and other individual personal hygiene articles for each indigent person. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.
- Bathtubs or showers and toilets which ensure individual privacy shall be available.
- Adequate toilets, lavatory and bath facilities equipped for use by a person with a mobility impairment shall be available.
- An atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of people being served.
- Accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team.

- Each shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.

Rights to Informed Consent

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

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

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

Rights of Those with an Intellectual or Developmental Disability

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

Restricted Rights

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

Violated Rights

If member rights have been violated, contact the Member and Recipient Services at 1-877-685-2415. They can file a complaint or grievance in person or by phone. They do not have to give their name. If they feel their protected health information has been violated, they may file a

complaint with Trillium by calling 1-877-685-2415. Trillium Health Resources complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Trillium Health Resources does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. [Trillium's non-discrimination rights can be found online.](#)

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

North Carolina Medicaid Contact Center: 1-888-245-0179

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

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

Phone: Complaint Hotline: 1-800-624-3004 (within N.C.) or 919-855-4500

Complaint Hotline Hours: 8:30 a.m.– 4 p.m. weekdays, except holidays.

Fax: 919-715-7724

Advance Directives

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

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

The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the Advance Directive when the person is deemed to be incapable, unless compliance is not consistent with N.C.G.S. §122C-74(g), i.e., generally accepted practice standards of treatment to benefit the member, availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health, or when the member is involuntarily committed to a 24-hour facility and undergoing treatment as provided by law. If

the doctor is unwilling to comply with part or all of the Advance Directive, he or she must notify the member and record the reason for noncompliance in the patient's medical record.

Under the Health Care Power of Attorney, a member may appoint a person as a health care agent to make treatment decisions on his/her behalf. The powers granted by this document are broad and sweeping and cannot be made by a doctor or a treatment provider under NC law. Providers may decline to inform or counsel members of their right to develop an advance directive if the provider has a religious or moral objection to an item or service, such as an advance directive, that is furnished for the purpose of assisting in the causing of death. Providers may decline to apply or affect any requirement with respect to a portion of an advance directive that directs the purposeful killing, or the purposeful assisting in causing of, or the purposeful assisting in causing, the death of any individual if the provider has a religious or moral objection to applying or affecting such a requirement.

Confidentiality

The network provider is required to ensure and maintain the confidentiality of all medical record information pertaining to all members and recipients 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, or as other authorized by law. 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).

Trillium will support providers by adhering to all confidentiality guidelines as stated in rule, regulation and law, and develop and disseminate educational material relative to accessing services, and member rights. Information can be used without consent to help in treatment, for health care operations, for emergency care, and to law enforcement officers to comply with a court order or subpoena. A disclosure to next of kin can be made when a member is admitted or discharged from a facility, but only if the person has not objected.

Substance use disorder patient records, subject to 42 CFR part 2, cannot be used or shared in civil, criminal, administrative or legislative investigations or proceedings against the member without (1) consent of the member or (2) a court order and a subpoena.

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

This includes the following:

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

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

Human Rights Committee

The Human Rights Committee (HRC) is a provider led committee comprised of board representation, member/recipient family members and practitioners/ providers representing all disability groups. Members are appointed by Trillium's Governing Board, or a designee. Trillium staff serve as liaisons to the committee. HRC plays a vital role by ensuring the protection of member/recipient rights for people receiving mental health, substance use and intellectual and/or developmental disability services. The Committee is responsible for the monitoring and oversight of the use of restrictive interventions, members' and recipients' rights violations, and incidents of abuse, neglect and exploitation, grievances, complaints.

The primary responsibility of the committee is to ensure the protection of members' rights by reviewing:

- Complaints and grievances regarding potential member/recipient rights violations.
- Concerns regarding the use of restrictive interventions by providers.
- Concerns regarding confidentiality.
- Concerns regarding member/recipient incident reports.
- Critical Incidents that involve the use of restrictive interventions, allegations of abuse, neglect, or exploitation against a staff member or facility, and member deaths.

- Concerns related to quality of care, accessibility,
- health and safety, lack of crisis responsiveness.
- Alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation brought by members, advocates, parents or other legally responsible person, staff or community stakeholders.

Providers should adhere to APSM 95-2 regarding clients' rights. If there is interest in participating in the Human Rights Committee, please email QMinfo@TrilliumNC.org.

T. Member Cost Share Requirements

Trillium imposes the same cost-sharing amounts as specified in North Carolina's Medicaid and state plans. Plan members are not required to pay for any covered services other than the co-payment amounts required under the state plans. Trillium tracks cost sharing obligations of each member.

Cost-sharing does not apply to the following:

- Children under age twenty-one (21)
- Pregnant women
- Individuals receiving hospice care
- Federally recognized American Indians/Alaska Natives
- Breast and Cervical Cancer Control Program
- Foster children
- Disabled children under Family Opportunity Act
- 1915(c) waiver beneficiaries
- Traumatic Brain Injury (TBI) beneficiaries
- An individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs

Providers:

- The billing provider is an IHP (Indian Health Provider)/Tribal Provider
- The billing provider is NC Correction Enterprises (Nash Optical)
- A service is rendered at a tribal free-standing facility or tribal provider-based facility
- The billing provider is providing a 1915(C) HCBS Service
- The billing provider is a Comprehensive Outpatient Rehabilitation Facility

- The billing provider is a Health Department billing for tuberculosis or a sexually transmitted disease or infection

Services:

- Emergency Services
- Postoperative, Out of Hospital Care Management associated with a surgical procedure
- Family Planning Services
- A claim is billed with condition code AJ
- Care/case Management Services
- Non-physician patient education
- Mental Health Crisis Intervention
- Pathology or other lab testing procedures
- Radiology, Echocardiography, or other imaging services
- Vaccine administration
- Claims billed with diagnosis codes associated with pregnancy, childbirth, and puerperium, to include prenatal care
- Dialysis procedures or from a dialysis facility
- Medications billed as professional claims [PADP medications]
- DME, Orthotics and Prosthetics
- Home Infusion Therapy
- Annual adult wellness exam
- Claim is billed by a Health Department for tuberculosis or sexually transmitted disease or infection.
- HIV Antiretroviral (ARV) Medications
- Opioid Antagonist Medication
- Nicotine Replacement Therapy Medications
- Opioid Use Disorder Medications
- Approved Adult Vaccines and Administration Recommended by the Advisory Committee on Immunization Practices (ACIP)
- A claim is billed by Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) for core services (T1015)

U. Provider Program Integrity Requirements

Fraud, Waste, and Abuse Reporting

All providers must monitor for possible fraud, waste 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, waste, abuse, ethics and compliance issues. Reports can be made online or by calling the toll-free telephone tip line (1-855-659-7660). EthicsPoint is available 24 hours a day, 7 days a week and 365 days a year. The hotline is confidential and Trillium will honor this anonymity in full compliance with the standards.

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

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

To make a report:

- EthicsPoint or call toll free: 1-855-659-7660

Special Investigations

Trillium Health Resources operates a Special Investigations Unit (SIU) within the Compliance Department with dedicated staff residing in North Carolina. This unit routinely inspects claims submitted to assure Trillium is paying appropriately for covered services. The Special Investigations Unit within the Compliance department is charged with preventing, detecting and correcting fraud, waste, and abuse to ensure the financial and clinical integrity of Trillium's contracted providers are maintained. The team conducts post-payment audits, monitoring and investigations to assure 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, waste 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 allegations and, if warranted, conducts an investigation.

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

Compliance with Other State and Federal Requirements

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

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

Per contractual requirements, contracted providers of Trillium are required to cooperate fully with all investigative requests, including but not limited to immediate access to any of the contractual locations/ sites, where services are provided to members and recipients, in addition to any site where financial or clinical records are maintained. Providers are required to cooperate with requests to view or submit members' and recipients' medical records for review. Medical records should be maintained in compliance with all state and federal laws related to record retention, more information on this can be found in the Compliance section related to Member/Recipients Records Requirements. Failure to do so may be grounds for contract termination.

Fraud, Waste, and Abuse Investigation

Any credible allegation of potential fraud, waste and abuse involving Trillium providers will be referred to Trillium's Special Investigations Unit of the Compliance Department for investigation and action. Investigations may be conducted on-site or by desk review. Findings may be reported to DHB—Office of Compliance and Program Integrity ("DHB—OCPI") North Carolina Medicaid Investigation Division ("MID") appropriate regulatory bodies, and/or law enforcement agencies depending on the nature of the allegation. Any allegations of provider fraud accepted by DHB—OCPI may result in immediate suspension of referral, authorizations and payments pending an investigation by DHB or the MID.

Fraud, Waste, 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, waste, 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.
- Waste is defined as costs that could have been avoided without a negative impact on quality.

Examples of Medicaid fraud, waste, 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

Prepayment Review

Trillium's Prepayment Claims Review program seeks to ensure claims presented by providers for payment meet federal and state laws and regulations and medical necessity criteria in advance of payment. Trillium bases prepayment review process on guidance from NCGS 108 C-7 and HB 696-SL2026-1. Trillium may require a provider to undergo Prepayment Claims Review if Trillium receives allegations of suspected provider fraud, waste, and abuse, identification of aberrant billing practices as result of an investigation or data analysis, or other grounds as defined by Trillium. Trillium notifies the provider in writing of the decision and the process for submitting prepayment claims. A provider may not appeal or otherwise contest a decision of Trillium to place or maintain a provider on Prepayment Claims Review.

Trillium will notify the provider in writing of the decision and the process for submitting prepayment claim supporting documentation. The provider will need to submit their claims electronically; however, the provider will not be entitled to payment prior to claims review by Trillium.

The Prepayment Claims Review Initial Notice letter provides the following:
An explanation of Trillium's decision to place the provider on Prepayment Claims Review.

1. A description of the review process and claims processing times.
2. A description of the claims subject to Prepayment Claims Review.
3. A specific list of all supporting documentation the provider will need to submit with the claims subject to the Prepayment Claims Review.
4. The process for submitting claims and supporting documentation.
5. The standard of evaluation used by Trillium to determine when a provider's claims will no longer be subject to Prepayment Claims Review.

For any claims in which Trillium has given prior authorization, Prepayment Claims Review will not include review of the medical necessity for the approved services. Trillium processes all clean claims submitted for Prepayment Claims Review within 20 calendar days of submission by the provider. If the provider fails to provide any of the specifically requested supporting documentation necessary to process a claim, Trillium sends to the provider written notification of the missing documentation within 15 calendar days of receipt of such claim.

Trillium has an additional 20 calendar days to process a claim upon receipt of the documentation. The provider has 7 calendar days to submit the records. If the provider does not submit requested documentation within 7 calendar days, the claims will be denied for payment as "No Documentation Submitted." Approved claims will resume processing fully through the claims system and the provider's payment will then follow normal check write process.

The provider remains subject to the Prepayment Claims Review process until the provider achieves 3 consecutive months of 80% accuracy provided the number of claims submitted per month is no less than fifty percent (50%) of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review. If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be zero percent (0%) for each month in which no claims were submitted. If the provider does not meet this standard within 6 months of being placed on Prepayment Claims Review, Trillium may impose further sanctions.

If a provider contract is terminated while on Prepayment Claims Review, the provider number is not removed from Prepayment Claims Review if the provider has not met established accuracy goals. Trillium continues to receive reports through the completion of the 6-month review period and compiles a case summary including the provider number, end date and reason. Should the business owner(s) of the end-dated provider open a new business under a new name and

Medicaid number, the prepayment review process will be implemented on that new provider number.

Failure of a provider to meet the eighty percent (80%) clean claims rate minimum requirement may result in a termination action. A termination action taken shall reflect the failure of the provider to meet the eighty percent (80%) clean claims rate minimum requirement and shall result in exclusion of the provider from future participation in the Medicaid program. If a provider fails to meet the eighty percent (80%) clean claims rate minimum requirement and subsequently requests voluntary termination, the termination will reflect the provider's failure to successfully complete prepayment claims review and will result in termination from Trillium's network.

Providers should not withhold claims to avoid the claims review process. Any claims for services provided during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted and regardless of whether the provider has been taken off of prepayment review for any reason, including attaining a minimum of eighty percent (80%) clean claims rate for 3 consecutive months, or the termination of the provider. The decision to place or maintain a provider on prepayment claims review does not constitute a contested case under Chapter 150B of the General Statutes. A provider may not appeal or otherwise contest a decision of Trillium to place or maintain a provider on prepayment review.

If a provider elects to appeal Trillium's decision to impose sanctions on the provider as a result of the prepayment review process to the Office of Administrative Hearings, then the provider has 45 days from the date the appeal is filed to submit any documentation or records addressing or challenging the findings of the prepayment review. Trillium will not review, and the administrative law judge shall not admit into evidence any documentation or records submitted by the provider after the 45-day deadline. In order for a provider to meet its burden of proof under G.S. 108C-12(d) that a prior claim denial should be overturned, the provider must prove all required documentation was provided at the time the claim was submitted and was available for review by the prepayment review vendor and the claim should not have been denied at the time of the vendor's initial review.

When a provider meets the 80% claims accuracy rate, Trillium notifies the provider in writing they have successfully completed the Prepayment Claims Review process. Additional information related to Prepayment Claims Review details for providers can be located in the Provider Manual.

False Claims Act

The False Claims Act was a law 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 \$13,946–\$27,894 for each false claim submitted. The provider may be required to pay back up to three times the amount of damages sustained by the government. If convicted, the provider may be excluded from participation in federal health care programs. In addition, most private insurance programs will also exclude the provider from participation as well.

V. Sections for Medicaid Providers

CLINICAL PRACTICE STANDARDS

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

NCDHHS Community-Based Services Clinical Coverage Policies

NCDHHS offers Community Based Services for members meeting the requirements outlined in NCDHHS' Community Based Services Clinical Coverage Policies (CCPs).

Community Based Services include the following:

- Program for All-Inclusive Care for the Elderly (PACE)
- Hospice Services
- Private Duty Nursing for beneficiaries age 21 and Older
- Private Duty Nursing for beneficiaries under age 21
- Home Infusion Therapy
- Community Alternatives Program for Disabled Adults (CAP/DA-Choice)
- State Plan Personal Care Services (PCS)

Review the Clinical Coverage Policies (CCPs) in detail at [NCDHHS Community Based Services CCP](#). Should you have questions regarding these policies, you may contact Trillium's Provider Support Line to obtain additional information.

NCDHHS Physician Clinical Coverage Policies for Visual and Auditory Services

The NCDHHS offers Visual and Auditory Services and supports for members meeting the requirements outlined in NCDHHS' Physician Clinical Coverage Policies (CCPs).

Visual and Auditory Services include the following:

- Cochlear and Auditory Brainstem Implants
- Blepharoplasty/Blepharoptosis (Eyelid Repair)
- Ocular Photodynamic Therapy
- Transcranial Doppler Studies
- Visual Evoked Potential (VEP)
- Tympanometry and Acoustic Reflex Testing
- Implantable Bone Conduction Hearing Aids (BAHA)

Review the CCPs policies for visual and auditory coverage in detail at [NCDHHS Physician Clinical Coverage Policies](#). Should you have questions regarding these policies, you may contact Trillium's Provider Support Line to obtain additional information.

Long-Term Hospital Services Clinical Coverage Policy

Review the Long-Term Care Hospital Services for members meeting the requirements, outlined in detail at [NCDHHS' Long Term Care Hospital Services CCP](#). Should you have questions regarding this policy, you may contact Trillium's Provider Support Line to obtain additional information.

Child Medical Evaluation and Medical Team

Conference for Child Maltreatment 1A-5 CCP The NCDHHS' Child Medical Evaluation and Medical Team Conference for Child Maltreatment Clinical Coverage Policy (CCP) details the requirements for Medical Evaluations and Medical Team Conferences. Review [NCDHHS' Child Medical Evaluation and Medical Team for CCM, 1A-5](#). Should you have questions regarding this policy, you may contact Trillium's Provider Support Line to obtain additional information.

AUTHORIZATION, UTILIZATION REVIEW, AND CARE MANAGEMENT REQUIREMENTS**Care Management**

The primary Utilization Management function is to make authorization decisions by conducting initial, concurrent and retrospective reviews of services based on meeting medical necessity. UM will determine whether a member/recipient meets medical necessity criteria and target population requirements for the frequency, intensity and duration of requested services. UM

Care managers assist the provider in managing a member's/recipient's care needs and identification of appropriate services.

Treatment Authorization Request Forms

Trillium uses a Treatment Authorization Request (TAR) form to capture demographic and clinical information. The TAR assists the UM 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 the Provider Portal and selecting the Training Materials link from the Client Gateway. Any provider can request technical assistance on TAR submission by contacting Trillium at PDsupport@Trilliumnc.org.

The purpose of this process is to identify the steps required in requesting prior-authorization and continued authorization from the Utilization Management unit. Requesting the Authorization is the responsibility of the provider. Electronic notification of UM decisions may be found in the web portal, so it is the responsibility of the provider to check the portal regularly.

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

Authorization Process

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
- Emergency Services, Family Planning, Children's Screening Services
- 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

To remain consistent with Division of Health Benefits (DHB) guidelines, the Trillium Utilization Management (UM) Department is only able to make formal decisions (approval, denial or extensions when appropriate) when a complete request is received.

Registry of Unmet Needs

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

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. Trillium will also review the appropriateness and accuracy of the service provision in relation to the authorizations. All providers contracted with Trillium who are currently serving Trillium members/recipients are subject to Utilization Reviews to ensure that clinical standards of care and medical necessity are being met.

Incentives

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

Notification of the availability of the Department's provider Ombudsman service

North Carolina Medicaid offers a Provider Ombudsman to assist providers transitioning to Medicaid Managed Care by receiving and responding to inquiries, concerns and complaints regarding health plans. This service is intended to represent the interests of the provider community, provide supportive resources and assist with issues through resolution.

The Ombudsman will also investigate and address complaints of alleged maladministration or violations of rights against the health plans. Health plans are expected to resolve complaints promptly and furnish a summary of final resolution to North Carolina Medicaid. Inquiries may be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov or the Medicaid Managed Care Provider Ombudsman at 1-866-304-7062.

DISASTER AND EMERGENCY RELIEF PLANNING AND RESPONSE***Provider Care to Members***

Trillium's contracted providers and delegated vendors are required to have disaster plans that include evacuation, fire, and emergency response. Trillium and providers will plan and respond in the event of a disaster or emergency that results in a major failure or disruption in care, including but not limited to fire, flood, hurricanes/tornados, terrorist events, earthquake, and/or an epidemic or pandemic disease. Trillium and delegated vendors communicate with the provider

network, to the extent possible, during a crisis such as a natural or human caused emergency or disaster as to their status and ability to provide services. Trillium contacts Residential, Opioid Provider Treatment, and Medication Assistance Treatment providers to ensure emergency plans are being followed prior to any emergency event. Trillium completes outreach efforts to Members to review their emergency plan. Trillium offers our network of providers various resources and educational material that assist our Members during disaster events.

Our resources and education material can be found on our website TrilliumHealthResources.org and Provider My Learning Campus. Trillium's trainings on My Learning Campus provide an introduction on our Regional Community Crisis and Disaster Unit, its purpose, and how they can help during a disaster. Trillium offers monthly preparedness topics included in the Network Communication bulletins.

Provider Support

Prior to a potential disaster event, Trillium utilizes several different avenues to reach our providers such as but not limited to: Network Communications, Urgent Notifications, and social media. These communication efforts provide direction to the provider on how to contact Trillium if they were to be impacted. Trillium created a webpage devoted to Community Crisis and Disaster Response which provides updated information. Trillium has staff devoted to monitoring the Change in Provider Operations Tracking tool which requires prompt action by the staff to ensure the provider's questions are answered. After-hours Trillium's Community Disaster Response Unit is available to answer provider questions and escalate provider concerns as needed. This team is on call afterhours and follows an escalation process to Regional Vice Presidents if additional support is needed. Additionally, they will provide information to the Network team for any information provided or any follow-up needed. Trillium has Provider Support Service Line that currently operates Monday through Saturday, 7 a.m.– 6 p.m. and staffs nine full-time support specialists, one supervisor, and one full-time manager. Employees reside in North Carolina and work within and throughout Trillium's catchment area. During disaster events, Trillium assembles a team of staff whose job is to answer providers' questions and provide resources.

Provider Disaster Plans

Trillium is responsible for providing crisis and emergency services 24 hours a day, 7 days a week. The Trillium Disaster Plan is a comprehensive document designed for use in responding to natural and human-made disasters.

All Trillium contracted providers offering services in a facility must have their own Disaster Plans, including evacuation and fire plans. Depending on the type of disaster, Trillium and certain identified providers could be asked to assist in debriefing of rescue personnel and follow-up crisis

counseling with victims. Our contract with providers and the North Carolina Final Rule, requires that you have an adequate disaster plan and training process in place within your organization. Providers are required to submit annually their Disaster Plans including evacuation plans and fire plans.

W. Provider Obligations

MONITORING AND AUDITING ACTIVITIES

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

Provider Preventable Conditions

Providers must monitor and report on Provider Preventable Conditions (PPC). Trillium will comply with contractual policies/ requirements as set forth by the North Carolina Department of Health and Human Services regarding the reimbursement of provider preventable conditions. Not required for State-funded providers.

There are two categories of Provider Preventable Conditions:

1. Health Care-Acquired Conditions (HCAC)— This term applies to Medicaid inpatient hospital settings and includes at a minimum the full list of Medicare's hospital acquired conditions (except Deep Vein Thrombosis/Pulmonary Embolism following total knee/hip replacement in pediatric and obstetric patients).
2. Other Provider—Preventable Conditions (OPPC) This term applies to Medicaid inpatient and outpatient health care settings where these events may occur and includes at a minimum the subjects of three Medicare National Coverage Determinations (surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery).

Retain Patient Records for the Mandated Period

Providers adhere to the regulations set forth for record retention as addressed in the following:

- NCGS 121 and 132
- 45 CFR 164
- 42 CFR Part 2
- APSM 45-1: Confidentiality Rules

- APSM45-2: Records Management and Documentation Manual for Providers
- APSM 30-1: Rules for MH/DD/SUS Facilities and Services
- APSM 10-5: Records Retention and Disposition Schedule for Providers
- APSM 10-6: Records Retention and Disposition Schedule for Health Plans
- NCTracks Provider Claims and Billing Assistance Guide
- NC Clinical Coverage Policies
- NC Innovations Technical Guide
- DHHS Records Retention and Disposition Schedule for Grants

All Documentation Regarding Services Provided is Timely, Accurate, and Complete

Trillium will review all documentation regarding services provided for timeliness, accuracy, and completeness.

BH I/DD Tailored Plan/PIHP is the Payer of Last Resort

The BH I/DD Tailored Plan should be payer of last resort. All other funding options need to be exhausted first. Recipients with private or group insurance coverage are required to pay the co-pay assigned by their insurance carrier.

Report and Promptly Return Overpayments within 60 Calendar Days of Identification

Trillium will report and promptly return overpayments within sixty (60) days of identifying the overpayment.

Complete Home and Community-Based Services Provider Self-Assessments

Home and Community Based Services (HCBS) Provider Self-Assessments are required for any request to add Residential Supports, Day Supports, and Supported Employment to a behavioral health contract. The Assessment Companion provided by DHHS provides insight on how to successfully complete the assessment. Use of this resource and guidance will offer support to establish full integration status and approval of the assessment. Follow this link to access the Assessment Companion. It is important to ensure that all responses in the assessment are thorough. Fully explain agency policies and procedures related to each question. The responses should support that any member receiving this service is served in the least restrictive and most integrated setting as possible. The HCBS provider self-assessment is a site assessment. Questions should be answered specifically for the site and not individuals. Do not submit any PHI into the assessment.

Assessments must meet criteria for settings under the Innovations Waiver; services to include Residential Supports, Day Supports, and Supported Employment.

Per rule the Care Management team will conduct monthly or quarterly visits and interactions to ensure the HCBS compliance established remains. A tool will be used to facilitate this interaction. The HCBS review tool is designed to document results for items and sections reviewed. They do not contain protected health information (PHI) and may be printed and attached to the review report or given to the provider, as appropriate, as part of the supporting documentation.

Each year the provider will attest that the site remains in compliance with all the HCBS Final Settings Rule. Each assessment question will need to be attested to as still in full compliance and full integration by the provider and information will be reviewed by Trillium (as with the initial provider assessment). Providers will receive a 60-day notification from the State's internal HCBS prior to the attestation due date. The month when the annual attestation is due will be the date the assessment was assigned full integration status. Providers will submit their attestation on the first day of the month in which the attestation is due. For questions regarding annual attestation needs please contact hcbstransplan@dhhs.nc.gov.

The official North Carolina/NCDHHS website provides information about and access to the [Home and Community-Based Services Provider Self-Assessment](#).

X. List of Revisions

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Added Known System Issues Tracker Link	69 Resources and Weblinks	J, b	05/19/23
Removed DHHS reference as a member is not required to send the appeal form to DHHS.	116	Z	05/19/23
Removed statement that a member is not required to file State Fair Hearing with Trillium.	117	Z	05/19/23
Added that members can also file request for State Fair Hearing orally and listed the phone number.	117	Z	05/19/23
Added a red-lined Provider Manual will be available.	NA	c	05/19/23
Updated the link for the State Benefit Plan criteria outlined by DHHS to FY23	28	D	5/19/23
Revised appeal timeframe	74	N	5/19/23
Revised member and provider satisfaction survey	79	P	5/19/23
Deleted ECHO	79	P	5/19/23
Revised and added Core details	80	P	5/19/23
Added incident exception	83	P	5/19/23
Revised to Quality Management and Improvement Program	84 131	P FF	5/19/23
Replaced Quality Improvement Activities to Performance Improvement Project	95 134	S EE	5/19/23

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Added data and methods	133	EE	5/19/23
Revised State-Funded Time and Distance Table	46–48	I	7/7/23
Revised Disenrollment information	111	Z	7/7/23
Revised the frequency of changing a PCP	93	S	7/7/23
Deleted requirement to notify Trillium any change in status	33	F	7/7/23
Edited claims submission	33 90	F Q	7/7/23
Deleted monthly exclusion list monitoring	38–39	G	7/7/23
Deleted termination of credentials	42	G	7/7/23
Revised requirement to notify Trillium of changes	42	G	7/7/23
Deleted requirement to notify Trillium of changes	c	c	7/7/23
Deleted Assertive Engagement and deleted Case Management in table	43–44	G	8/1/23
Removed requirement to complete New Provider Orientation Training for rates to be initialized in the contract	33	F	10/13/23
Added the requirement to complete Provider Direct System Administrator training before receiving access to Provider Direct	34	F	10/13/23
We ended the Seal Program this Jan.	135	FF	1/23/24
Updated the list to 46 counties	113	Z	1/23/24

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Updated claims submission protocol table	58	J	2/1/24
Updated claims submission protocol	58	J	5/28/24
Revised to state the Provider Manual is available on Trillium's website	ii	A	7/1/24
Updated NCQA Designation	ii	A	7/1/24
Added UM Program Policies Link	2	B	7/1/24
Added details for Children and Youth Services	31	E	7/1/24
Revised primary role of the Clinical Support Unit	31	E	7/1/24
Revised days allowed for claims submission	33	F	7/1/24
Updated Time/Distance Standards for Medicaid	45	I	7/1/24
Added Exceptions for TPL	58	J	7/1/24
Revised Claims Submission Protocol	58	J	7/1/24
Revised Provider Appeals Process	74	N	7/1/24
Revised definition of complaint, resolution letter and timeframes	74	N	7/1/24
Revised Performance Improvement	80	P	7/1/24
Revised NC-TOPPS Hierarchy	80	P	7/1/24
Revised NC-SNAP	80	P	7/1/24
Revised Claims Submission Protocol	78	O	7/1/24
Updated Member Cost Sharing Requirements	100	T	7/1/24

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Added details to Prepayment Review Process	101	U	7/1/24
Deleted Provider Council Objective related to the Local Business Plan	130	DD	7/1/24
Deleted and added Committee	135	FF	7/1/24
Revised Board and CFAC Structure	142	HH	7/1/24
Revised Executive Team Functional Areas	143	HH	7/1/24
Revised Claims Submission Protocol	63	J	10/8/24
Revised Claims Submission Protocol	89	Q	10/8/24
Revised Claims Submission Protocol	65	J	12/13/24
Revised Claims Submission Protocol	96	Q	12/13/24
BH MD TP Network Guidance	40	Q	3/14/25
BH MD TP Network Guidance	130	DD	3/14/25
Added Tailored Care Management Exceptions	29	E	7/1/25
Added Opt Back In	29	E	7/1/25
Revised Outreach Sentence	30	E	7/1/25
Deleted Medicare	31	E	7/1/25
Revised Children and Youth Services' Supports	31	E	7/1/25
Deleted Neighborhood Connections	32	E	7/1/25
Added Provider Responsibilities	33–34	F	7/1/25
Dept: Updated Time/Distance Standards	48	I	7/1/25

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Revised Cultural Competency and Linguistically Appropriate Services	38	G	7/1/25
Changed Contact for Claims Support	59	J	7/1/25
Deleted Penalty	63	J	7/1/25
Updated Clearinghouse	63	J	7/1/25
Revised Program Integrity Unit Terminology	71	J	7/1/25
Added Provider Self Audit Resources	71	J	7/1/25
Revised Culturally Competent and Linguistically Appropriate Services	73	K	7/1/25
Deleted Housing and Added Linkage	74	L	7/1/25
Updated Member Satisfaction Survey	81	P	7/1/25
Updated Perceptions of Care Survey	82	P	7/1/25
Updated Provider Satisfaction Survey	82	P	7/1/25
Updated QM Staff and Department	83	P	7/1/25
Updated NC-TOPPS Guidelines Link	88	P	7/1/25
Revised NC-SNAP Age	89	P	7/1/25
Root Cause Analysis (RCA) in Transitions to Community Living (TCL) Housing	90	P	7/1/25
Revised GPRA Resource Link	90	P	7/1/25
Updated Clearinghouse	91	Q	7/1/25
Deleted Penalty	95	R	7/1/25
Added Mailing the Handbook and Traumatic Brain Injury	96	S	7/1/25

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Revised Program Integrity Unit Terminology	104	U	7/1/25
Updated Prepayment Claims Review Process	106	U	7/1/25
Revised Penalty Range	107	U	7/1/25
Revised Learning Campus	110	V	7/1/25
Updated to Monthly Preparedness Topics	110	V	7/1/25
Revised Director to Vice President	110	V	7/1/25
Revised Support Service Line Staffing	110	V	7/1/25
Updated Record Retention Regulations	111	W	7/1/25
Revised Quit Now to Quit4Life	119	Y	7/1/25
Added Virtual or Onsite Reviews	131	CC	7/1/25
Deleted Licensed Independent Practitioner Tool	131	CC	7/1/25
Deleted CMA Certification Completed by the Tailored Plan	131	CC	7/1/25
Added Appeal Process for Plans of Correction	139	DD	7/1/25
Changed Plan of Correction due date from 15 to 30 days	139	DD	7/1/25
Added HEDIS Resource Link	142	EE	7/1/25
Revised Health Equity Council to Council on Health Disparities	143	FF	7/1/25
Added LTSS and I/DD-Innovations Waiver Member Advisory Council	143	FF	7/1/25
Added Reference to APSM 95-2	144	FF	7/1/25

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Revised Trillium Functional Areas	151	HH	7/1/25
Changed Email Address for Provider Change Form	a	Correspondence Timelines and Address Reference	7/1/25
Updated Provider Learning Campus User Agreement Link	b	Resources and Web Links	7/1/25
Added Provider Self-Audits Link	b	Resources and Web Links	7/1/25
Updated routine authorization timeframe from 14 to 7 days	15	Provider Responsibilities	1/1/26
Revised emergency services definition	23	Network Requirements	1/1/26
Inserted hyperlink to Trillium Billing Guide & Claims Submission Protocol	41	Billing, Claim Editing, Snip Editing And Clearinghouse Requirements	1/1/26
Added Home and Community-Based Services Provider Self-Assessments Details	88	Provider Obligations	1/1/26
Added Definition of Service Category For Behavioral Health Time/Distance Standards Chart	36	Network Adequacy and Access Standards	1/1/26
Updated State Funded Table	115	Appendix-Covered Services	1/1/26
Added DMH/DD/SUS to 5th bullet	14	Provider Responsibilities	1/1/26
Revised licensure requirements to add the Department and revised from 10 to 30 days	22	Network Requirements	1/1/26
Revised Prepayment requirements related to House Bill 696	101-103	Provider Program Integrity Requirements	5/14/26

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Revised Trillium's office address	78,64,86	Provider Appeals and Grievance Process	7/20/26
Revised Trillium's office address	108	Member Rights and Responsibilities	7/20/26
Revised Trillium's office address	139	Correspondence Timelines and Address Reference	7/20/26
Added Navigating Trillium's Provider Portals information	5	Introduction	10/1/26
Added Trillium Advantage Incentive Program	19	Care Management Delivered Through the BH I/DD Tailored Plans/PIHP	10/1/26
Revised Provider Direct to Provider Portals	18	Provider Responsibilities	10/1/26
Added requirement to notify Trillium within 24 hours of any known or suspected security incident	19	Provider Responsibilities	10/1/26
Added quality management requirements related to NC Health Information Exchange Network, critical incident and death reporting, and back up staff reporting.	26	Provider Responsibilities	10/1/26
Deleted that sanctions imposed by Trillium may be progressive or cumulative.	34	Network Requirements	10/1/26
Added that Trillium will confirm any banking change through a separate, independent verification step.	57	Billing, Claim Editing, Snip Editing and Clearinghouse Requirements	10/1/26
Revised Provider Direct to Provider Portals	64	Provider Portal Claims	10/1/26
Removed Provider Direct Claims Section	65	Provider Direct Claims	10/1/26
Removed rate floor information	66	Reimbursement Policy	10/1/26
Removed reference to the weekly claims status report in Provider Direct.	68	Accounts Receivable Management	10/1/26
Revised Trillium's address	76	Provider Appeals	10/1/26

SUMMARY OF REVISIONS	PAGE	SECTION	DATE REVISIONS COMPLETED
Revised Provider Direct to Provider Portals	76	Provider Appeals	10/1/26
Revised Trillium's address	82	Medicaid Member Ombudsman Program	10/1/26
Revised Trillium's address	84	Grievances and Complaints	10/1/26
Revised CAHPS Health Plan Survey information	90	Member Satisfaction Survey	10/1/26
Added Community Based Supports- My Individual Experience Survey Section	91	Surveys	10/1/26
Revised Provider Direct to Provider Portals	102	Required Electronic Formats	10/1/26
Added substance use disorder patient record disclosure requirement	113	Confidentiality	10/1/26
Updated member cost share requirements	114-116	Member Cost Share Requirements	10/1/26
Revised Provider Direct to Provider Portals	123	Treatment Authorization Request Forms	10/1/26
Updated Value-Added Services & Member Incentive Programs	163-165	Value-Added Services & Member Incentive Programs	10/1/26
Added Update on Delegation Authorization of Physical Health Services information	165-166	Update on Delegation Authorization of Physical Health Services	10/1/26

Correspondence Timelines and Address Reference

ITEM TO BE SUBMITTED IN WRITING TO TAILORED PLAN	TIMEFRAME FOR SUBMISSION	ADDRESS TO SUBMIT
Review/fully executed contract	Within 30 business days of receipt of contract	Trillium Health Resources Attn: Contracts Unit PO Box 12797 Durham, NC 27709
Provider Appeals	Within 30 days from date of receipt of the letter	Trillium Health Resources Attn: Appeals Unit PO Box 12797 Durham, NC 27709
Changes in Current Practice Information—Provider Change Form	Within one (1) business day of any changes in status within five (5) business days of personnel changes or information updates	Follow the instructions at the bottom of the Provider Change Form and email NetworkServicesSupport@TrilliumNC.org
Plan of Correction (POC) Revised POC Resubmission	Within 30 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 Respite Site Application	As needed	NetworkMonitoring@TrilliumNC.org
Medicaid Services Appeal-Level I (on behalf of member with written permission from member/parent/guardian)	Within 60 days of the date of the Notice of Adverse Benefit Determination	Attn: Appeals Unit PO Box 12797 Durham, NC 27709 Fax: (252) 215-6879 Upon receipt of fax confirmation page, please contact Trillium Appeals Unit to confirm receipt of said fax at 1-877-685-2415.

Resources and Web Links

Trillium Resources

[Benefit Plans and Service Definitions](#)
[Billing Codes and Rates and Checkwrite Schedule](#)
[Claims Request Form](#)
[Cultural and Linguistic Competency Action Plan Recommendations](#)
[Provider Self-Audits](#)
[Provider Direct](#)
[iTransact](#)
[Provider Learning Campus User Agreement](#)
[Provider Documents and Forms](#)
[Records Retention Log](#)
[Electronic Visit Verification](#)

Trillium Provider Communications

[Provider Communication Bulletins](#)
[Sign up for Email Lists](#)

NC DHHS Resources

[NC-TOPPS Guidelines](#)
[Clinical Coverage Policies, Division of Medical Assistance](#)
[NC-SNAP Guidelines](#)
[Prior Approval and Due Process Procedures](#)
[Incident Response Improvement System](#)
[Plan of Correction Template](#)
[Service Definitions](#)
[Behavioral Health Services](#)
[NC Innovations Waiver](#)

Fraud, Waste, and Abuse/Program Integrity List

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

Limited English Proficiency (LEP)

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

Important Email Addresses

ClaimsSupport@trilliumnc.org

Used to submit questions related to Claims.

NetworkMonitoring@TrilliumNC.org

Used for provider monitoring reviews, provider change forms.

TrilliumProviderDirectory@TrilliumNC.org

Used to submit questions related to Trillium's Provider Directory.

NetworkManagement@TrilliumNC.org

Used for questions regarding Network Communication Bulletins.

NetworkServicesSupport@TrilliumNC.org

Used for any other questions providers may have enrollment/credentialing, and statements around voluntarily withdrawing from the network.

UM@TrilliumNC.org

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

Note: Trillium submits this Provider Manual to Department for approval thirty (30) days after Contract Award. Trillium will not use or distribute prior to approval by Department. Trillium regularly reviews and updates this Provider Manual annually, or upon request by the Department to reflect changes to applicable federal and state laws, rules and regulations, Department or Trillium policies, procedures, bulletins, guidelines or manuals, or Trillium business processes as necessary. Within the provider manual, Trillium shall track and maintain a list of revisions made in the manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed. Trillium may update this Provider Manual once per quarter in the event of substantive updates or revisions that impact providers or BH I/DD Tailored Plan/PIHP business. Unless directed by the Department, Trillium shall not update the provider manual more than once per quarter during the Contract Year. Submissions of the provider manual to the Department by Trillium during the Contract Year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section. Trillium will submit this Provider Manual to Department for approval within fifteen (15) calendar days of making substantive updates or revisions. Trillium will make the redline Provider Manual available, within five (5) calendar days of approval from the Department, in an electronic version accessible via website or the provider web portal, and in writing upon request of a contracted provider. Trillium will not post, print or enforce the updates until Trillium has received approval from the Department. Trillium will correct errors in the electronic version of this Provider Manual or make revisions as requested by the Department within fifteen (15) calendar days of notification or request by Department. Corrections or revisions to the printed version will be included in the next printing.

Appendix: Covered Services

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Allergies	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy	YES
Ambulance Services	42 C.F.R. § 410.40 NC State Plan Att. 3.1- A.1, Page 18 NC Clinical Coverage Policy 15	YES
Anesthesia	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy 1L-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)	YES
Auditory Implant External Parts	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement	YES
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes	YES
Cardiac Procedures	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound	YES
Cell and Gene Therapies	NC Clinical Coverage Policy 1S-13: Cell and Gene Therapies	Yes
Certified pediatric and family nurse practitioner services	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a	YES
Chiropractic Services	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Clinic Services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments	YES
Dietary Evaluation and Counseling and Medical Lactation Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services	YES
Durable Medical Equipment (DME)	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics and Prosthetics	YES
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members	YES
Family Planning Services	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services	YES
Federally Qualified Health Center (FQHC) Services	SSA, Title XIX, Section 1905(a)(2) (C) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Freestanding birth center services (when licensed or otherwise recognized by the State)	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11	YES
Gynecology	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions	YES
Hearing Aids	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services	YES
HIV Case Management Services	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management	YES
Home Health Services	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. §440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.I, Pages 13, 13a-13a.4 NC Clinical Coverage Policy 3A	YES
Home Infusion Therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy	YES
Hospice Services	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services	YES
ICF-IID Services	42 C.F.R. 440.150 8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Innovations Waiver Services	8P: North Carolina Innovations (*Innovations waiver enrollees only)	YES
Inpatient Hospital Services	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. §440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services	YES
Inpatient Psychiatric Services for Individuals under age 21	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Clinical Coverage Policy 8B, Inpatient BH Services	YES
Inpatient substance use services	NC Clinical Coverage Policy 8B, Inpatient BH Services: Medically Managed Intensive Inpatient Withdrawal Services Medically Managed Intensive Inpatient Services	Yes

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Inpatient and Outpatient BH services	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: - Mobile Crisis Management - Intensive-In-Home Services - Multisystemic Therapy Psychosocial Rehabilitation - Child and Adolescent Day Treatment - Partial Hospitalization Professional Treatment Services in a Facility Based Crisis System Substance Use Comprehensive Outpatient Program - Medically Monitored Intensive Inpatient Services (substance abuse medically monitored community residential treatment) - Clinically Managed Residential Services (substance abuse non-medical community residential treatment) - NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program - NC Clinical Coverage Policy 8A-2: Facility-Based Crisis Management for Children and Adolescents - NC Clinical Coverage Policy 8A-6: Community Support Team (CST) - NC Clinical Coverage Policy 8A-7: Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification) - NC Clinical Coverage Policy 8A-8: Ambulatory Withdrawal Management with Extended On-Site Monitoring - NC Clinical Coverage Policy 8A-10: Clinically Managed	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Inpatient and Outpatient BH services	North Carolina Clinical Coverage Policy 8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 North Carolina Clinical Coverage Policy 8D-2: Residential Treatment Services NC Clinical Coverage Policy 8D-4: Clinically Managed Population Specific High Intensity Residential Program NC Clinical Coverage Policy 8D-5: Clinically Managed Residential Services (Substance abuse non-medical community residential treatment) £ NC Clinical Coverage Policy 8D-6: Medically Monitored Intensive Inpatient Services £ NC Clinical Coverage Policy 8B: Inpatient BH Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F – Researched Based BH Treatment for Autism Spectrum Disorders NC Clinical Coverage Policy 8G – Peer Supports NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH) NC Clinical Coverage Policy 8A-5: Diagnostic Assessment NC Clinical Coverage Policy 8A-9 Opioid Treatment Program (OTP) NC Clinical Coverage Policy 8A-12: Substance Abuse Intensive Outpatient Program (SAIOP) NC Clinical Coverage Policy 8A-13: Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Laboratory and X-ray services	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services	YES
Maternal Support Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow- up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit	YES
Non-Emergent Transportation to Medical Care	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Page 18 Non-Emergency Medical Transportation Managed Care Policy	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Nursing Facility Services	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. §440.40 42 C.F.R. §440.140 42 C.F.R. §440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities	YES
Obstetrics	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home	YES
Occupational Therapy	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15, 13e NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES
Office Based Opioid Treatment (OBOT)	NC Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone	YES
Ophthalmological Services	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Optometry Services	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 441.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21	YES
Other diagnostic, screening, preventive and rehabilitative services	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5	YES
Outpatient Hospital Services	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. §440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1	YES
Personal Care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Pharmacy—including Prescription drugs and Medication Management	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 12(c); Att. 3.1-A.1, Pages 14-14h; NC Prior Approval Drugs and Criteria NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The- Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters	YES
Physical Therapy	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15, 13e ID775NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Physician Services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. §440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.I, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy NC Clinical Coverage Policy 1A-12, Breast Surgeries NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Physician services	NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty	YES

SUMMARY OF MEDICAID COVERED SERVICES and CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Podiatry Services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care	YES
Private Duty Nursing (PDN) Services	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age	YES
Prosthetics, Orthotics and Supplies	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics	YES
Reconstructive Surgery	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision	YES

SUMMARY OF MEDICAID COVERED SERVICES and CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Respiratory Care Services	SSA, Title XIX, Section 1905(a)(20) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services	YES
Rural Health Clinic Services (RHC)	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics	YES
Services for individuals age 65 or older in an Institution for Mental Disease (IMD)	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient BH Services	YES
Speech, Hearing and Language Disorder Services	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring	YES
Tobacco Cessation Counseling for Pregnant Women	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2	YES

SUMMARY OF MEDICAID COVERED SERVICES AND CLINICAL COVERAGE POLICIES		
SERVICE	KEY REFERENCES	COVERED BY MEDICAID
Transplants and Related Services	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non-Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood	YES

	NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy	
Transplants and Related Services	NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/ Liver and Multivisceral Transplants	YES
Ventricular Assist Device	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device	YES
Vision Services	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older	YES
1915(i) Option Services	NC Clinical Coverage Policy 8H-1: Supported Employment for IDD and TBI NC Clinical Coverage Policy 8H-2: Individual Placement and Support (IPS) NC Clinical Coverage Policy 8H-3: Individual and Transitional Support (ITS) NC Clinical Coverage Policy 8H-4: Respite NC Clinical Coverage Policy 8H-5: Community Living and Supports (CLS) NC Clinical Coverage Policy 8H-6: Community Transition	YES

£ [North Carolina's Medicaid State Plan](#) is available online.

£ The Department reserves the right to update the clinical coverage policies for covered benefits.

STATE-FUNDED BH, I/DD, AND TBI SERVICES		
Disability Group	Core Services	Non-Core Services
All-Disability	1. Diagnostic Assessment ^{22 21} 2. Facility Based Crisis for Adults* ²³ 3. Inpatient BH Services* 4. Mobile Crisis Management* 5. Outpatient Services²⁴	1. BH Urgent Care* 2. Facility Based Crisis for Children and Adolescents*
Adult Mental Health	1. Assertive Community Treatment (ACT) 2. Assertive Engagement ²⁵ 3. Reserved ²⁶ 4. Community Support Team (CST) 5. Peer Support Services²⁷ 6. Psychosocial Rehabilitation 7. Mental Health Recovery Residential Services ²⁸ 8. Individual Placement and Support (IPS)-Supported Employment ²⁹ 9. Transition Management Service 10. Critical Time Intervention 11. BH Comprehensive Case Management	1. Partial Hospitalization
Child Mental Health	1. Reserved³⁰ 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement	1. Mental Health Day Treatment
I/DD and TBI	1. Residential Supports 2. Day Supports Group 3. Community Living and Support 4. Supported Living Periodic 5. Supported Employment³¹ 6. Respite 7. Adult Day Vocational Programs (ADVP) 8. I/DD and TBI Care Management ³²	1. TBI Long Term Residential Rehabilitation Services
Substance Use Disorder-Child	1. Multi-systemic therapy (MST) 2. SAIOP 3. Substance Use Residential Services and Supports 4. Reserved. 5. Assertive Engagement 9. Clinically Managed Medium-intensity Residential Services-Adolescent ³⁵	1. Intensive in-home 2. Day Treatment Child and Adolescent 3. Respite

STATE-FUNDED BH, I/DD, AND TBI SERVICES		
Disability Group	Core Services	Non-Core Services
Substance Use Disorder–Adult	1. Ambulatory Withdrawal Management without Extended Onsite Monitoring and Ambulatory Withdrawal Management with Extended Onsite Monitoring * 2. Assertive Engagement 3. Reserved. 4. Clinically Managed Population Specific High Intensity Residential Services³³ 5. Opioid Treatment Program Services 6. Medically Monitored Inpatient Withdrawal Management Services* 7. Peer Supports ³⁴ 8. Substance Use Residential Services and Supports ³⁵ 9. Substance Abuse Halfway House 10. Substance Abuse Comprehensive Outpatient Treatment 11. Substance Abuse Intensive Outpatient Program 12. Substance Abuse Medically Monitored Community Residential Treatment 13. Substance Abuse Non-Medical Community Residential Treatment 14. Individual Placement and Support (IPS) Supported Employment 15. Community Support Team 16. BH Comprehensive Case Management 17. Medically Monitored Intensive Inpatient Services ³⁵ 18. Clinically Managed High-Intensity Residential Service–Pregnant and Parenting ³⁵ 19. Clinically Managed High-Intensity Residential Services ³⁵	1. Clinically Managed Residential Withdrawal Management Services*

* Crisis Services as defined as Section V.C.4.iv.a.

22 Diagnostic assessments may be provided through Telehealth.

23 This service is referred to as Professional Treatment Services in a Facility-Based Crisis Program in the North Carolina Medicaid program.

24 The BH I/DD Tailored Plan may authorize, and fund medically necessary office based opioid treatment (OBOT) service

5 The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients

26 Reserved.

27 Peer supports include individual and group services.

28 This category of services may include group living and supervised living among other services.

- 29 The SAMHSA Supported Employment Evidence-Based Practices Kit can be found online.
- 30 Reserved.
- 31 I/DD and TBI care management will only be provided by the BH I/DD Tailored Plan.
- 32 This service may include critical time intervention, case management, and RICCM.
- 33 The Department is working to add this service to its array by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan will be required to cover this service upon notification from the Department.
- 34 Peer supports include individual and group services.
- 35 This category of services will be covered on an interim basis until the Department completes its implementation of the 1115 SUD waiver and updates to the service definitions for SUD services to completely align with the ASAM criteria.

BEHAVIORAL HEALTH, I/DD, AND TBI SERVICES COVERED BY PIHP

Inpatient BH Services

Medically Managed Intensive Inpatient Services (Inpatient BH Services)

Medically Managed Intensive Inpatient Withdrawal Services (Inpatient BH Services)

Outpatient BH Emergency Room Services

Outpatient BH Services Provided by Direct-Enrolled Providers

Psychological Services In Health Departments and School-Based Health Centers

Sponsored By

Health Departments

Peer Supports

Partial Hospitalization

Mobile Crisis Management

Facility-Based Crisis Services for Children and Adolescents

Professional Treatment Services In Facility-Based Crisis Program

Outpatient Opioid Treatment

Ambulatory Withdrawal Management, Without Extended On-Site Monitoring (Ambulatory Detoxification)

Ambulatory Withdrawal Management, With Extended On-Site Monitoring

Clinically Managed Residential Withdrawal Services (Social Setting Detoxification)

Research-Based BH Treatment for Autism Spectrum Disorder (ASD)

Diagnostic Assessment

Medically Monitored Inpatient Withdrawal Management (Non-Hospital Medical Detoxification)

Residential Treatment Facility Services

Child And Adolescent Day Treatment Services

Intensive In-Home Services

Multi-Systemic Therapy Services

Psychiatric Residential Treatment Facilities (PRTF)

Assertive Community Treatment (ACT)

Community Support Team (CST)²

Psychosocial Rehabilitation

Clinically Managed Low-Intensity Residential Treatment Services (Substance Abuse Halfway House)

BEHAVIORAL HEALTH, I/DD, AND TBI SERVICES COVERED BY PIHP

Clinically Managed Population-Specific High-Intensity Residential Services
 Clinically Managed Residential Services (Substance Abuse Non-Medical Community Residential Treatment)
 Medically Monitored Intensive Inpatient Services (Substance Abuse Medically Monitored Residential Treatment)
 Substance Use Intensive Outpatient Program (SAIOP)
 Substance Use Comprehensive Outpatient Treatment Program (SACOT)
 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
 Early And Periodic Screening, Diagnostic and Treatment (EPSDT) Services
 1915(I) SPA Services
 Supported Employment
 Individual Transition and Support
 Respite
 Community Living and Supports
 Community Transition
 1915(B)(3) Long Term Residential and Day Support Services

* Tribal Members who are Innovations Waiver beneficiaries are included in the population that may obtain listed services from the PIHP.

² CST includes tenancy supports.

CROSSWALK OF COVERED AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) SUD SERVICES TO NORTH CAROLINA MEDICAID COVERED SUD SERVICES

ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
1	Outpatient Services	
2.1	Intensive Outpatient Services	Substance Use Intensive Outpatient Program
2.5	Partial Hospitalization Services	Substance Use Comprehensive Outpatient Treatment
3.1	Clinically Managed Low-Intensity Residential Treatment Services	Clinically Managed Low-Intensity Residential Treatment Services (Substance Abuse Halfway House)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	Clinically Managed Population-Specific High-Intensity Residential Services
3.5	Clinically Managed High-Intensity Residential Services	Clinically Managed Residential Services (Substance Abuse Non-Medical Community Residential Treatment)
3.7	Medically Monitored Intensive Inpatient Services	Medically Monitored Intensive Inpatient Services (Substance Abuse Medically Monitored Community Residential Treatment)

CROSSWALK OF COVERED AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) SUD SERVICES TO NORTH CAROLINA MEDICAID COVERED SUD SERVICES		
ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
4	Medically Managed Intensive Inpatient Services	Medically Managed Intensive Inpatient Services (Inpatient BH Services)
Office-based opioid treatment	Office-Based Opioid Treatment	Office-Based Opioid Treatment
Opioid treatment services	Opioid Treatment Services	Outpatient Opioid Treatment
1-WM	Ambulatory Withdrawal Management Without Extended On-Site Monitoring	Ambulatory Withdrawal Management, Without Extended On-Site Monitoring (Ambulatory Detoxification)
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	Ambulatory Withdrawal Management, With Extended On-Site Monitoring
3.2-WM	Clinically Managed Residential Withdrawal Management	Clinically Managed Residential Withdrawal Services (Social Setting Detoxification)
3.7-WM	Medically Monitored Inpatient Withdrawal Management	Medically Monitored Inpatient Withdrawal Management (Non-Hospital Medical Detoxification)
4-WM	Medically Managed Intensive Inpatient Withdrawal	Medically Managed Intensive Inpatient Withdrawal Management (Inpatient BH Services)

Covered Services, Benefits and Carved-out Services

MEDICAID SERVICES	
BH, I/DD, and TBI Services Covered by BOTH Standard Plans and Tailored Plans	BH, I/DD, and TBI Services Covered EXCLUSIVELY by Tailored Plans
Professional Treatment Services In Facility-Based Crisis Program	Residential Treatment Facility Services
Outpatient Opioid Treatment	Child And Adolescent Day Treatment Services
Ambulatory Detoxification	Intensive In-Home Services
Research-Based BH Treatment for Autism Spectrum Disorder (ASD)	Multi-Systemic Therapy Services
Diagnostic Assessment	Psychiatric Residential Treatment Facilities (PRTF)

MEDICAID SERVICES	
<i>BH, I/DD, and TBI Services Covered by BOTH Standard Plans and Tailored Plans</i>	<i>BH, I/DD, and TBI Services Covered EXCLUSIVELY by Tailored Plans</i>
Non-Hospital Medical Detoxification	Assertive Community Treatment (ACT)
Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization	Community Support Team (CST)
Early And Periodic Screening, Diagnostic, And Treatment (EPSDT) Services	Psychosocial Rehabilitation
Inpatient BH Services	Substance Abuse Non-Medical Community Residential Treatment
Outpatient BH Services Provided By Direct-Enrolled Providers	Substance Abuse Medically Monitored Residential Treatment
Psychological Services In Health Departments And School-Based Health Centers Sponsored By Health Departments	Substance Abuse Intensive Outpatient Program (SAIOP)
Peer Supports	Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)
Partial Hospitalization	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
Mobile Crisis Management	Waiver Services
Facility-Based Crisis Services for Children and Adolescents	Innovations Waiver Services
	TBI Waiver Services

Basic Benefit Services include Outpatient Treatment:	
Mobile Crisis Management	Medication Management
Individual, Family And Group Therapy	Behavioral Health Counseling
Assessment And Psychological Testing	

I/DD Services Array Includes:	
Respite Services	Community Navigator
Developmental Day	Supported Employment
Community Living and Support	Day Supports
Alternative Family Living (AFL)	Supported Living
Residential Supports/Group Homes	

Value-Added Services & Member Incentive Programs

Members must meet the eligibility requirements for the service or incentive and must not have any other available funding source to meet the need for the program. Individual program eligibility can be found on the [Trillium Advantage page](#). All programs are subject to funding availability.

Value-Added Services Tailored Plan Only	
HOMES Funds	Assistance with maintaining housing.
One Time Move-In Assistance Funds	Assistance with obtaining new permanent housing.
GED Test Voucher	Assistance once per lifetime with GED testing costs.
Gym Membership	Assistance with gym membership or home exercise equipment for qualifying members.

Value-Added Services Tailored Plan Only	
TCM Engagement	Earn a reward for completing your Care Management Comprehensive Assessment (CMCA) with your care manager within 60 days of the beginning of a Tailored Care Management (TCM) assignment.
Substance Use Recovery App	Mobile App/website to help build social support networks for peers and caregivers.
Stay Connected Cell Phones	Assistance with a cell phone for qualifying members
Transportation	Assistance with accessing your community with a Transportation voucher.
Child Education Support	Assistance with back-to-school supplies for pre-k to grade 12 once annually. Members can apply in July and August.

Medicaid Direct Population

Medicaid Direct Population	
Member Incentive Program	Rewards
Create a My Learning Campus Account - My Learning Campus is our free, online training website.	Up to \$10 in rewards
Complete the Trillium New Member Orientation on My Learning Campus	Member Tool-Kit
Complete the Healthy Eating course on the Trillium My Learning Campus	Up to \$25 Healthy Foods rewards

Tailored Plan Population

Medicaid Direct Population	
Member Incentive Program	Rewards
Create a My Learning Campus Account - My Learning Campus is our free, online training website.	Up to \$10 in rewards
Complete the Trillium New Member Orientation on My Learning Campus	Member Tool-Kit
Complete the Healthy Eating course on the Trillium My Learning Campus	Up to \$25 Healthy Foods rewards
Complete Pregnancy Intendedness Course on My Learning Campus	Up to \$25 in rewards
Complete a Well Visit with your Doctor	Up to \$25 in rewards
Don't Let the Flu Catch You!	Up to \$10 in rewards

Quit Now-Tobacco Cessation Program	Up to \$50 in rewards
Asthma Medication Refill	Vacuum Cleaner
Well-Child Visits	Up to \$25 in rewards
Prenatal Visit	Baby Care Kit
Postpartum Visit	Up to \$25 in rewards
HbA1c Lab Test	Up to \$25 in rewards
Cervical Cancer Screening	Up to \$25 in rewards
Mammogram	Up to \$25 in rewards
Colorectal Screening	Up to \$25 in rewards
Follow-Up Visit After Discharge	Up to \$25 in rewards

Update on Delegation Authorization of Physical Health Services

On October 1, 2026, 2026, Trillium Health Resources will no longer delegate certain physical health services for Tailored Plan members. The following listed services will be reviewed by Trillium Health Resource Utilization Management staff: Anesthesia Services, Certain Surgeries, Ambulance Services, Inpatient Hospital, Chiropractic if applicable, Out of State Services, Emergency Department (ED) visits for health-related conditions oncology, hematology, Ophthalmology, Home Infusions, Cell/Gene Therapy, Post-Acute Care, Obstetrics and Gynecology (OBGYN) lab and specialized outpatient services. Trillium Health Resources will continue to contract with delegates to deliver selected physical health services including Non-Emergency Medical Transportation (NEMT), Durable Medical Equipment (DME), Long Term Services and Supports (LTSS), Personal Care Services, PCS), Home Health, Genetic Testing, HIV Therapeutic lab, Radiation Oncology, Transplant, Vision, Outpatient cardiology procedures, MSK surgeries include spine, Spinal Cord Stimulators, and Outpatient imaging.

Medicaid Direct and State Funded services will continue to be managed with current protocols.

Our delegates will be our Standard Plan Partner and their assigned vendors and our PBM. Please see table below;

<i>Authorization Service Type</i>	<i>Action for the Provider</i>
Durable Medical Equipment (DME), including Orthotics and Prosthetics and Hearing Aid Services	Submit authorizations to Carolina Complete Health
Genetic Testing	Submit authorizations to EviCore
HIV Therapeutic Lab Testing	Submit authorizations to Carolina Complete Health
Outpatient Cardiology Procedures	Submit authorizations to Turning Point
Outpatient Imaging	Submit authorizations to Evolent
Outpatient Musculoskeletal Surgery and Interventional Pain Management	Submit authorizations to Evolent
LTSS, PCS, Private Duty Nursing, Home Health, Hospice	Submit authorizations to Carolina Complete Health
Radiation Oncology	Submit authorizations to Evolent
Transplants and CAR-T-Cell therapy	Submit authorizations to Carolina Complete Health
Vision	Submit authorizations to Centene Vision