Department of Mental Health
Adult Community Clinical Services (ACCS)
Billing Guidelines

Activity Code 3055

Revised: June 2025

I. OVERVIEW

DMH's ACCS programs deliver evidence-based interventions, including rehabilitative interventions, within the context of a standardized, clinically focused model to promote:

1) Active engagement and assertive outreach to prevent homelessness;
2) Clinical coverage 24/7/365 days a year;
3) Consistent assessment and treatment planning;
4) Risk assessment, crisis planning and prevention;
5) Skill building and symptom management;
6) Behavioral and physical health monitoring and support;
7) Addiction treatment support;
8) Family engagement;
9) Peer support and recovery coaching; and
10) Reduced reliance on emergency departments, hospitals and other institutional levels of care.

II. DEFINITIONS RELATED TO BILLING PROCEDURES

277 Transaction – Standardized electronic exchange used to acknowledge the receipt of a HIPAA 837 Claims submission and indicate if one or more claims is rejected.

Accommodation Rate (AR) Invoice - The mechanism used to bill for the total amount due for a month of services (not dependent on the number of clients receiving the services).

Activity/Sub Activity Code – The Activity Code is a 4-digit number used in MMARS (Commonwealth accounting system) and EIM that identifies the service. ACCS activity code is 3055. The sub activity code is a 2 – 3 numeric suffix to the Activity Code and further defines the service type.

Attendance Codes – Codes entered on the Unit Rate SDR to identify the type of client encounter that occurred each enrolled day. Below are the codes used for ACCS.

1. **Enrolled no contact (E) -** Client enrolled in Integrated Team only or Supported Independent Environment setting but no client encounter occurred.
2. **Enrolled Contact (C)** - Client enrolled in Integrated Team only or Supported Independent Environment setting and a client encounter occurred.
3. **Enrolled with Telephonic or Collateral Rehabilitative contact (O)** – Client enrolled in Integrated Team only or Supported Independent Environment setting and a Telephonic or Collateral Rehabilitative contact occurred. This code is not used if a client is admitted to setting in which Rehab cannot be claimed (see definition for Rehabilitative Encounter and Section XI. Rehabilitative Services).

4. **Enrolled with Rehab (R) -** Client enrolled in Integrated Team only or Supported Independent Environment setting and a Rehabilitative encounter occurred (see definition for Rehabilitative Encounter).
5. **Enrolled in bed (B) -** Client enrolled and present within a Group Living Environment within the 24 period and not enrolled or admitted to another service (e.g. inpatient facility, Respite).
6. **Enrolled in bed with Rehab (BR) -** Client enrolled and present in a Group Living Environment or Intensive Group Living Environment within the 24-hour period and a Rehabilitative encounter occurred (see definition for Rehabilitative Encounter).
7. **Enrolled in bed with Telephonic or Collateral Rehabilitative contact (BO) –** Client enrolled and present in a Group Living Environment or Intensive Group Living Environment within the 24-hour period and a Telephonic or Collateral Rehabilitative contact occurred.
8. **Enrolled not in bed no contact (A) -** Client enrolled in a Group Living Environment or Intensive Group Living Environment but is not present within the 24 hour period and there was no contact with the client.
9. **Enrolled not in bed with contact (AC) -** Client enrolled in a Group Living Environment or Intensive Group Living Environment but is not present during the 24-hour period. A client encounter occurred outside of the GLE setting.
10. **Enrolled not in bed with Telephonic or Collateral Rehabilitative contact (AO) –** Client enrolled in a Group Living Environment or Intensive Group Living Environment but is not present during the 24-hour period. A Telephonic or Collateral Rehabilitative contact occurred. This code is not used if a client is admitted to setting in which Rehab cannot be claimed (see definition for Rehabilitative Encounter and Section XI. Rehabilitative Services).
11. **Enrolled not in bed with Rehab (AR) -** Client enrolled in a Group Living Environment or Intensive Group Living Environment but is not present during the 24-hour period. A Rehabilitative encounter occurred outside of the GLE setting. This code is not used if a client is admitted to setting in which Rehab cannot be claimed (see definition for Rehabilitative Encounter and Section XI. Rehabilitative Services).

Contact (Encounter) – A face-to-face encounter with a client; may be brief in nature.

Cost Reimbursement (CR) Invoice - The mechanism used to bill for budgeted costs incurred during the delivery of services in the previous month.

Enterprise Invoice Management System (EIM) – The web-based invoice system that automates the transmission of client information and service data that Commonwealth purchase-of-service contractors transmit to agencies from which they seek reimbursement for the provision of services.

HIPAA Billing – The mechanism used by Health Care Providers, Clearinghouses and Billing Services to submit electronic claims directly to the Virtual Gateway through a file transfer application.

Lease Management Add-On – A monthly rate payment a Contractor receives for providing a qualifying lease activity(s) to clients who are receiving rental assistance. Qualifying Lease

Activity(s) includes housing searches, lease up activities, re-certification paperwork, tenancy support and tenancy preservation.

Mental Health Information System (MHIS) – DMH's electronic medical record system.

MHIS Account Number – The number MHIS generates when a client is enrolled into a Contractor's ACCS Service. The number is unique to the enrollment. In EIM, *the MHIS Account Number appears as the Agency Enrollment ID*.

Occupancy - The payment rate contractors receive for all Supervised GLEs, SIEs; IGLEs and certain Provider-Based Independent Settings. The payment of the rate is based on bed capacity and is independent of bed utilization. The Occupancy Rate will be offset by other payments attributable to occupancy costs.

Occupancy Offsets – Other payments that are applied to defray total occupancy costs (e.g. SNAP Benefits, housing subsidies, charges for residential services and support pursuant to 104 CMR 30.06).

Provider Portal (DMHPP) **–** The Virtual Gateway's secure website used by providers to upload ACCS data in XML format to the Department of Mental Health.

Rehabilitative Encounter – A clinical intervention that is delivered in accordance with Federal claiming requirements for Medicaid Rehabilitation Option (Rehab Option) and as outlined in DMH Rehab Option guidance documentation. Telephonic contacts and collateral activities, including work completed to develop, update and/or revise and assessment and or treatment plan are rehabilitative encounters when provided as outlined in DMH Rehab Option guidance documented.

Service Delivery Report (SDR) – An electronic document accessed through the Enterprise Invoice Management System (EIM) that Contractors use to report to DMH each day a client is enrolled in ACCS. The SDR is populated using enrollment information maintained with MHIS. The SDR will be used to generate a payment or reconcile ready payments made to the contractor.

Service Type – ACCS is comprised of 4 Service Types with an associated set of rates and Service and Attendance Codes. Each client can only be enrolled in one Service Type at a time. The ACCS Service Types are:

1. **Integrated Team (IT) -** A multi-disciplinary team of clinical, direct care, and peer staff providing clinical interventions, housing services, and peer and family support to facilitate engagement, support functioning and community living skill development, and maximize self-management consistent with the treatment plan.

2. **Group Living Environments (GLE) -** A temporary setting providing a clinically oriented environment and structure in which staff is present on a planned staffing schedule. The setting provides increased treatment and engagement interventions to enable the client to develop the skills necessary to live in a more independent setting. Clients residing in GLEs also receive interventions from the Integrated Team. GLE staff members are part of the Integrated Team and

perform the duties and responsibilities of the direct care staff members of the Team for clients residing in the GLEs. There are three different GLE rates, which are based on the capacity of the living environment: 4-6; 7-9 and 10-12.

3. **Supported Independent Environment (SIE) –** A temporary setting providing clinical outreach and treatment in an environment with individual or shared units and staff present on a planned schedule within the setting, generally within an office or separate unit. Clients residing in SIEs also receive interventions from the Integrated Team. SIE staff members are part of the Integrated Team and perform the duties and responsibilities of the direct care staff members of the Team for clients residing in the SIEs. There are three different SIE rates, which are based on bed capacity: 13-16; 17-25 and 26-35.

4. **Intensive Group Living Environment (IGLE) –** A temporary group living setting providing clients with the service components and specific clinical interventions particular to a defined service model for which they are referred. There are separate rates for the different types of IGLEs and each IGLE type has different approved rates based on bed capacity.

   A. Intensive Behavioral GLE (IBGLE) - Provides increased therapeutic interventions and supervision that focus on identifying triggers and precipitant behaviors, coping skills, improving communication skills, addressing issues around substance use, and identifying and resolving barriers to more independent community living and employment. Other rehabilitative, support, and supervision services are provided to clients as their needs indicate.
   B. Intensive Behavioral Assessment GLE (IBAGLE) - Provides an intensive level of supervision, including one-to-one (line of sight) coaching on a consistent basis throughout the day. Coaching interventions focus on identifying and practicing pro-social communication and community engagement. Rehabilitation and other support services are provided to clients, as their needs indicate.
   C. Intensive Clinical GLE (ICGLE) - Delivers rapid response to a client's emerging clinical needs including, but not limited to, symptom management, de-escalation strategies, or one to one assistance. Clients enrolled in this program require either an experience of a length of stay in a Department of Mental Health (DMH) Continuing Care Hospital for two years or more or prior histories of multiple failed efforts in standard DMH community services. The program is designed to develop, implement, and monitor person centered clinically intensive care. Other rehabilitative, support, and supervision services are provided to clients as their needs indicate.
   D. Intensive Medical GLE (IMGLE) - Provides daily medical management that may be complicated by symptoms and/or behaviors related to the client's mental health. In addition to medical management and other rehabilitative services, clients receive support and supervision services as their needs indicate.
   E. Enhanced Medical GLE (EMGLE) – Provides a variety of skilled healthcare and supportive services including around the clock nursing and personal care assistance. Services are designed to meet and support the daily needs of Persons with chronic medical conditions, terminal illnesses and/or disabilities which are impacted by their significant mental illness. Components allow Persons who have needs that exceed an IMGLE model to receive services that will assist with safely transitioning into an IMGLE or another community setting.

III. REFERRAL AND ENROLLMENT

ACCS operates on a closed referral basis with all referrals generated from the applicable DMH Area and/or Site Office.

In making a referral for ACCS, DMH will specify which Service Type the client is to receive.

A referral will include the reason(s) for referral, demographics, the client's other service provider(s), the Care Coordination Entity, if known at time of referral, and relevant clinical information with any known risk issues identified consistent with the DMH Risk Mitigation Policy. If the client is being referred for a Supervised GLE, SIE or an Intensive GLE, the environment location will be specified in the referral and the date the client l is expected to move into the Environment.

A Contractor may not move a client in or out of a Supervised GLE, SIE or an Intensive GLE, including a change in location, without authorization from DMH.

A Contractor must accept all referrals that are within their negotiated contract capacities.

A client can only be enrolled in one Service Type at any given time.

The enrollment date is the day of the first **Face to Face** encounter, unless otherwise determined by DMH.

IV. TRANSITION AND DISCHARGE

When DMH determines, through a level of care review with the ACCS Contractor, that a new level of care is needed, that the client needs to transition to a new GLE, SIE or IGLE, or that the client will transition from ACCS to other behavioral health services, the account for the current Service Type is closed.

The end date will be the date agreed upon by DMH and the Contractor. The end date is entered in DMH's MHIS system and will flow to EIM the following day. The EIM application will not allow the provider to bill for dates of service that occur after the end date.

If, for any reason, there is a delay in the end date propagating to EIM, and services are reported by a Contractor on dates that occur after the end date, the discrepancy will be sent to the DMH site office to resolve the issue with the Contractor. Resolution may result in a change the end date in the MHIS system and EIM and/or in the client's SDR or HIPAA claims being denied or canceled, depending on the status of the SDR or HIPAA Claims. If the SDR or HIPAA Claims are Denied or Canceled, a supplemental billing may be submitted with the correct dates of service (see section VII.E (HIPAA) and VIII.E (SDREIM) below).

At no time will two ACCS accounts overlap. If a client is transitioning to a different Service Type within the same contract, or will be served under a different ACCS contract, the start date for the new account must be a date that occurs after the end date of the account that is being closed.

V. CONTRACT STRUCTURE

Each ACCS award consists of two contracts. Example is given below.

- **Contract Doc ID = SCDMH23100192XXXCM3A – ending in A for Unit Rate**
- **Contract Doc ID = SCDMH23100192XXXCM3B – ending in B for Occupancy, Lease Management Add-On and Contingency Funds.**

SCDMH23100192XXXCM3A	Type	Billing in EIM
Services	Unit Rate	SDR
SCDMH23100192XXXCM3B	Type	Billing in EIM
Occupancy	Accommodation Rate	Accommodation Rate Invoice
Lease Management Add-on	Accommodation Rate	Accommodation Rate Invoice
Contingency	Cost Reimbursement	Cost Reimbursement Invoice

HIPAA Billing applies to "A" Contracts only. "B" Contracts will continue to bill via the EIM Accommodation Rate Invoice and Cost Reimbursement Invoice.

VI. UNIT RATE BILLING (UR)

A. Unit of Service

Integrated Team Only: The unit of service is a day a Person is Enrolled.
Integrated Team with GLE/SIE: The unit of service is a day a Person is Enrolled in the Integrated Team ACCS Service Type.
Supervised Group Living Environment: The unit of service for these rates is a day a Person is Enrolled in the applicable GLE with Integrated Team services.
Supported Independent Environment: The unit of service for these rates is a day a Person is Enrolled in the applicable SIE with Integrated Team services.
Intensive Group Living Environment Rates: The unit of service for Intensive Group Living Environment is a day of Enrollment in the applicable IGLE.
All services will be billed as a Unit Rate in EIM.

B. Rates

There are multiple unit rates for this service. ACCS Services reimbursement rates are regulated by the Executive Office of Health and Human Services as required by Chapter 257 of the Acts of 2008. The regulation for ACCS Services is included in the 101 CMR 426.00: RATES FOR

CERTAIN ADULT COMMUNITY MENTAL HEALTH SERVICES:
https://www.mass.gov/regulations/101-CMR-42600-rates-for-certain-adult-community-mental-health-services

See Sections VI.B and VII.B for additional information.

VII. HIPAA BILLING

The following sections apply to Contractors billing "A" contracts via HIPAA Billing.

A. USE Of EIM

All Contractors are required to use the Enterprise Invoice Management System (EIM) for billing DMH monthly for all ACCS Services. EIM is accessed through the Executive Office of Health and Human Services (EOHHS) Virtual Gateway. To utilize the EIM system, Contractors must contact EOHHS Virtual Gateway Business Operations (VGBO) Services to become an authorized user and to be trained on how to use its billing functionality required when billing DMH. Contractors who are currently not authorized users and/or trained in the EIM billing functionalities should contact the VGBO. Please use the following link:
http://www.mass.gov/eohhs/gov/commissions-and-initiatives/vg/

The following link is also available on the Virtual Gateway to access Job Aids for EIM:
https://www.mass.gov/service-details/eimesm-training-and-user-materials

Following Virtual Gateway access, Contractors will launch the File Transfer Service (FTS) application (also referred to as the "HIPAA Mailbox"), allowing Contractors to upload a HIPAA claims file, view files previously uploaded, and view downloadable files which have been sent back to the provider from EIM or the HIPAA translator.

Semi-Monthly Billing (in lieu of Ready Payments)
Contractors who have successfully completed the DMH HIPAA Billing onboarding and testing process are required to complete and submit their billing information on a semi-monthly billing cycle in lieu of receiving ready payments:

BILLING CYCLE	APPLICABLE TIME PERIOD	FILE SUBMISSION DEADLINE*
First Billing Cycle	1st through the 15th	20th of the month
Second Billing Cycle	16th through the end of the month	5th of the following month

*In cases where the file submission deadline falls on a weekend or holiday, Contractors shall submit on the next business day.

Following submission in EIM, a Contractor must send a separate email to the DMH Accounts Payable Office at **BBhsposinvoices@MassMail.State.MA.US** containing the HIPAA Claim Batch Number.

B. HIPAA BILLING CODES AND RATES

HIPAA Claiming utilizes a single code combining EIM Service and Attendance codes:

DMH ACCS Service Settings						EIM Service Codes for HIPAA Billing						
Service Settings	Serv Mnemonic	Sub Activity	Desc	Rate	Service Code	E	C	O	R			
Integrated Team (IT)	ACCSIT	3055199	ACCS INTEGRATED TEAM	**$56.32**	IT	ITE	ITC	ITO	ITR			
Group Living Environments (GLE)						B	BR	BO	A	AC	AO	AR
GLE	ACCSGLE6	305526	ACCS GLE 4-6 BED	**$400.43**	GLE6	GLE6B	GLE6BR	GLE6BO	GLE6A	GLE6AC	GLE6AO	GLE6AR
GLE	ACCSGLE9	305529	ACCS GLE 7-9 BED	**$295.59**	GLE9	GLE9B	GLE9BR	GLE9BO	GLE9A	GLE9AC	GLE9AO	GLE9AR
GLE	ACCSGLE12	3055212	ACCS GLE 10-12 BED	**$247.94**	GLE12	GLE12B	GLE12BR	GLE12BO	GLE12A	GLE12AC	GLE12AO	GLE12AR
Intensive Behavioral GLE (IBGLE)						B	BR	BO	A	AC	AO	AR
IBGLE	ACCSIB6	305536	ACCS INTENSIVE GL IB 4-6 BED	**$569.68**	IB6	IB6B	IB6BR	IB6BO	IB6A	IB6AC	IB6AO	IB6AR
IBGLE	ACCSIB9	305539	ACCS INTENSIVE GL IB 7-9 BED	**$431.37**	IB9	IB9B	IB9BR	IB9BO	IB9A	IB9AC	IB9AO	IB9AR
IBGLE	ACCSIB12	3055312	ACCS INTENSIVE GL IB 10-12 BED	**$370.77**	IB12	IB12B	IB12BR	IB12BO	IB12A	IB12AC	IB12AO	IB12AR
Intensive Behavioral Assessment GLE (IBAGLE)						B	BR	BO	A	AC	AO	AR
IBAGLE	ACCSIBA6	305546	ACCS INTENSIVE GL IBA 4-6 BED	**$462.33**	IBA6	IBA6B	IBA6BR	IBA6BO	IBA6A	IBA6AC	IBA6AO	IBA6AR

IBAGLE	ACCSIBA12	3055412	ACCS INTENSIVE GL IBA 10 -12 BED	**$319.89**	IBA12	IBA12B	IBA12BR	IBA12BO	IBA12A	IBA12AC	IBA12AO	IBA12AR
Intensive Clinical GLE (ICGLE)						B	BR	BO	A	AC	AO	AR
ICGLE	ACCSIC6	305556	ACCS INTENSIVE GL IC 4-6 BED	**$614.30**	IC6	IC6B	IC6BR	IC6BO	IC6A	IC6AC	IC6AO	IC6AR
ICGLE	ACCSIC9	305559	ACCS INTENSIVE GL IC 7-9 BED	**$524.67**	IC9	IC9B	IC9BR	IC9BO	IC9A	IC9AC	IC9AO	IC9AR
ICGLE	ACCSIC12	3055512	ACCS INTENSIVE GL IC 10-12 BED	**$496.93**	IC12	IC12B	IC12BR	IC12BO	IC12A	IC12AC	IC12AO	IC12AR
Intensive Medical GLE (IMGLE)						B	BR	BO	A	AC	AO	AR
IMGLE	ACCSIM6	305566	ACCS INTENSIVE GL IM 4-6 BED	**$529.22**	IM6	IM6B	IM6BR	IM6BO	IM6A	IM6AC	IM6AO	IM6AR
IMGLE	ACCSIM9	305569	ACCS INTENSIVE GL IM 7-9 BED	**$440.27**	IM9	IM9B	IM9BR	IM9BO	IM9A	IM9AC	IM9AO	IM9AR
IMGLE	ACCSIM12	3055612	ACCS INTENSIVE GL IM 10-12 BED	**$395.87**	IM12	IM12B	IM12BR	IM12BO	IM12A	IM12AC	IM12AO	IM12AR
Supported Independent Environment (SIE)						E	C	O	R			
SIE	ACCSSIE16	3055716	ACCS SIE 13-16 BED	**$127.74**	SIE16	SIE16E	SIE16C	SIE16O	SIE16R			
SIE	ACCSSIE25	3055725	ACCS SIE 17-25 BED	**$108.90**	SIE25	SIE25E	SIE25C	SIE25O	SIE25R			
SIE	ACCSSIE35	3055735	ACCS SIE 26-35 BED	**$90.07**	SIE35	SIE35E	SIE35C	SIE35O	SIE35R			
Enhanced Medical GLE (EMGLE)						A	AC	AO	AR	B	BO	BR

EMGLE	ACCSEM6	305586	ACCS EM 4-6 BED	**$600.76**	EM6	EM6A	EM6AC	EM6AO	EM6AR	EM6B	EM6BO	EM6BR
EMGLE	ACCSEM9	305589	ACCS EM 7-9 BED	**$485.10**	EM9	EM9A	EM9AC	EM9AO	EM9AR	EM9B	EM9BO	EM9BR
EMGLE	ACCSEM12	3055812	ACCS EM 10-12 BED	**$456.52**	EM12	EM12A	EM12AC	EM12AO	EM12AR	EM12B	EM12BO	EM12BR

C. MHIS Linked to EIM and EIM Linked to HIPAA Claim Reports

DMH will provide an electronic data feed of client enrollments from MHIS to EIM to pre-populate the semi-monthly compliant HIPAA billing claim report for each Contract.

NOTE: ACCS Contractors must submit the date of the first face to face encounter with an ACCS referral to DMH. This triggers the enrollment of the client into an ACCS service and the first billable day. Billing is not permitted before a DMH client's Enrollment date or after the client's Disenrollment date.

For each client included on the HIPAA billing claims file, the submitted file contains a claim for each day of service. The billing code is the combined Service Code and Attendance Code. Only one billing code is allowed per day/per client.

1. Integrated Team Only:

HIPAA Billing Code =

ITE – Integrated Team, Enrolled by NO Encounter
ITC – Integrated Team, Enrolled with Encounter
ITO – Integrated Team, Enrolled with Telephonic or Collateral REHAB Contact
ITR – Integrated Team, Enrolled with REHAB Encounter

2. Group Living Environment:

a) HIPAA Billing Code =

GLE6B - 4-6 Bed capacity, Enrolled in Bed
GLE6BR - 4-6 Bed capacity, Enrolled in Bed with REHAB
GLE6BO – 4-6 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB Contact
GLE6A - 4-6 Bed capacity, Enrolled NOT in Bed NO Contact
GLE6AC - 4-6 Bed capacity, Enrolled NOT in Bed Contact
GLE6AO – 4-6 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB Contact
GLE6AR - 4-6 Bed capacity, Enrolled NOT in Bed with REHAB

GLE9B - 7-9 Bed capacity, Enrolled in Bed
GLE9BR - 7-9 Bed capacity, Enrolled in Bed with REHAB
GLE9BO – 7-9 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB Contact
GLE9A - 7-9 Bed capacity, Enrolled NOT in Bed NO

Contact
GLE9AC - 7-9 Bed capacity, Enrolled NOT in Bed Contact
GLE9AO – 7-9 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB Contact
GLE9AR - 7-9 Bed capacity, Enrolled NOT in Bed with REHAB

GLE12B - 10-12 Bed capacity, Enrolled in Bed
GLE12BR - 10-12 Bed capacity, Enrolled in Bed with REHAB
GLE12BO – 10-12 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB Contact
GLE12A - 10-12 Bed capacity, Enrolled NOT in Bed NO Contact
GLE12AC - 10-12 Bed capacity, Enrolled NOT in Bed Contact
GLE12AO – 10-12 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB Contact
GLE12AR - 10-12 Bed capacity, Enrolled NOT in Bed with REHAB

3. **Intensive Behavioral GLE:**

a) HIPAA Billing Code =

IB6B - 4-6 Bed capacity, Enrolled in Bed
IB6BR - 4-6 Bed capacity, Enrolled in Bed with REHAB
IB6BO – 4-6 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IB6A - 4-6 Bed capacity, Enrolled NOT in Bed NO Contact
IB6AC - 4-6 Bed capacity, Enrolled NOT in Bed Contact
IB6AO – 4-6 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IB6AR - 4-6 Bed capacity, Enrolled NOT in Bed with REHAB
IB9B - 7-9 Bed capacity, Enrolled in Bed
IB9BR - 7-9 Bed capacity, Enrolled in Bed with REHAB
IB9BO – 7-9 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IB9A - 7-9 Bed capacity, Enrolled NOT in Bed NO Contact
IB9AC - 7-9 Bed capacity, Enrolled NOT in Bed Contact
IB9AO – 7-9 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IB9AR - 7-9 Bed capacity, Enrolled NOT in Bed with REHAB

IB12B - 10-12 Bed capacity, Enrolled in Bed
IB12BR - 10-12 Bed capacity, Enrolled in Bed with REHAB
IB12BO – 10-12 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IB12A - 10-12 Bed capacity, Enrolled NOT in Bed NO Contact
IB12AC - 10-12 Bed capacity, Enrolled NOT in Bed Contact
IB12AO – 10-12 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IB12AR - 10-12 Bed capacity, Enrolled NOT in Bed with REHAB

4. **Intensive Behavioral Assessment GLE:**

HIPAA Billing Code =

IBA6B - 4-6 Bed capacity, Enrolled in Bed
IBA6BR - 4-6 Bed capacity, Enrolled in Bed with REHAB
IBA6BO – 4-6 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IBA6A - 4-6 Bed capacity, Enrolled NOT in Bed NO Contact
IBA6AC - 4-6 Bed capacity, Enrolled NOT in Bed Contact
IBA6AO – 4-6 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IBA6AR - 4-6 Bed capacity, Enrolled NOT in Bed with REHAB
IBA12B - 10 -12 Bed capacity, Enrolled in Bed
IBA12BR - 10 -12 Bed capacity, Enrolled in Bed with REHAB
IBA12BO – 10 -12 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IBA12A - 10 -12 Bed capacity, Enrolled NOT in Bed NO Contact
IBA12AC - 10 -12 Bed capacity, Enrolled NOT in Bed Contact
IBA12AO – 10 -12 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact

5. **Intensive Clinical GLE:**

HIPAA Billing Code =

IC6B - 4-6 Bed capacity, Enrolled in Bed
IC6BR - 4-6 Bed capacity, Enrolled in Bed with REHAB
IC6BO – 4-6 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact

IC6A - 4-6 Bed capacity, Enrolled NOT in Bed NO Contact
IC6AC - 4-6 Bed capacity, Enrolled NOT in Bed Contact
IC6AO – 4-6 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IC6AR - 4-6 Bed capacity, Enrolled NOT in Bed with REHAB
IC9B - 7-9 Bed capacity, Enrolled in Bed
IC9BR - 7-9 Bed capacity, Enrolled in Bed with REHAB
IC9BO – 7-9 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IC9A - 7-9 Bed capacity, Enrolled NOT in Bed NO Contact
IC9AC - 7-9 Bed capacity, Enrolled NOT in Bed Contact
IC9AO – 7-9 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IC9AR - 7-9 Bed capacity, Enrolled NOT in Bed with REHAB
IC12B - 10-12 Bed capacity, Enrolled in Bed
IC12BR - 10-12 Bed capacity, Enrolled in Bed with REHAB
IC12BO – 10-12 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IC12A - 10-12 Bed capacity, Enrolled NOT in Bed NO Contact
IC12AC - 10-12 Bed capacity, Enrolled NOT in Bed Contact
IC12AO – 10-12 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IC12AR - 10-12 Bed capacity, Enrolled NOT in Bed w/ REHAB

6. **Intensive Medical GLE:**

HIPAA Billing Code =

IM6B - 4-6 Bed capacity, Enrolled in Bed
IM6BR - 4-6 Bed capacity, Enrolled in Bed with REHAB
IM6BO – 4-6 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IM6A - 4-6 Bed capacity, Enrolled NOT in Bed NO Contact
IM6AC - 4-6 Bed capacity, Enrolled NOT in Bed Contact
IM6AO – 4-6 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IM6AR - 4-6 Bed capacity, Enrolled NOT in Bed with REHAB

IM9B - 7-9 Bed capacity, Enrolled in Bed
IM9BR - 7-9 Bed capacity, Enrolled in Bed with REHAB
IM9BO – 7-9 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IM9A - 7-9 Bed capacity, Enrolled NOT in Bed NO Contact
IM9AC - 7-9 Bed capacity, Enrolled NOT in Bed Contact
IM9AO – 7-9 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IM9AR - 7-9 Bed capacity, Enrolled NOT in Bed with REHAB
IM12B - 10-12 Bed capacity, Enrolled in Bed
IM12BR - 10-12 Bed capacity, Enrolled in Bed with REHAB
IM12BO – 10-12 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
IM12A - 10-12 Bed capacity, Enrolled NOT in Bed NO Contact
IM12AC - 10-12 Bed capacity, Enrolled NOT in Bed Contact
IM12AO – 10-12 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
IM12AR - 10-12 Bed capacity, Enrolled NOT in Bed with REHAB

7. <u>Enhanced Medical GLE:</u>

HIPAA Billing Code =

EM6B - 4-6 Bed capacity, Enrolled in Bed
EM6BR - 4-6 Bed capacity, Enrolled in Bed with REHAB
EM6BO – 4-6 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
EM6A - 4-6 Bed capacity, Enrolled NOT in Bed NO Contact
EM6AC - 4-6 Bed capacity, Enrolled NOT in Bed Contact
EM6AO – 4-6 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
EM6AR - 4-6 Bed capacity, Enrolled NOT in Bed with REHAB
EM9B - 7-9 Bed capacity, Enrolled in Bed
EM9BR - 7-9 Bed capacity, Enrolled in Bed with REHAB
EM9BO – 7-9 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
EM9A - 7-9 Bed capacity, Enrolled NOT in Bed NO Contact
EM9AC - 7-9 Bed capacity, Enrolled NOT in Bed Contact
EM9AO – 7-9 Bed capacity, Enrolled NOT in Bed with

Telephonic or Collateral REHAB contact
EM9AR - 7-9 Bed capacity, Enrolled NOT in Bed with REHAB
EM12B - 10-12 Bed capacity, Enrolled in Bed
EM12BR - 10-12 Bed capacity, Enrolled in Bed with REHAB
EM12BO – 10-12 Bed capacity, Enrolled in Bed with Telephonic or Collateral REHAB contact
EM12A - 10-12 Bed capacity, Enrolled NOT in Bed NO Contact
EM12AC - 10-12 Bed capacity, Enrolled NOT in Bed Contact
EM12AO – 10-12 Bed capacity, Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
EM12AR - 10-12 Bed capacity, Enrolled NOT in Bed with REHAB

8. **Supported Independent Environment:**

HIPAA Billing Code =
SIE16E - 13-16 Bed capacity, Enrolled but NO Encounter
SIE16C - 13-16 Bed capacity, Enrolled with Encounter
SIE16O - 13-16 Bed capacity, Enrolled with Telephonic or Collateral REHAB contact
SIE16R - 13-16 Bed capacity, Enrolled with REHAB Encounter
SIE25E - 17-25 Bed capacity, Enrolled but NO Encounter
SIE25C - 17-25 Bed capacity, Enrolled with Encounter
SIE25O - 17-25 Bed capacity, Enrolled with Telephonic or Collateral REHAB contact
SIE25R - 17-25 Bed capacity, Enrolled with REHAB Encounter
SIE35E - 26-35 Bed capacity, Enrolled but NO Encounter
SIE35C - 26-35 Bed capacity, Enrolled with Encounter
SIE35O - 26-35 Bed capacity, Enrolled with Telephonic or Collateral REHAB contact
SIE35R - 26-35 Bed capacity, Enrolled with REHAB Encounter

D. Approval Process (HIPAA)

a. Once the HIPAA claims file(s) is accepted by EIM, the Contractor sends an email containing the HIPAA Batch Number to the AP mailbox bbhsposinvoices@mass.gov. The claim

files(s) are submitted twice a month in batches: the first covering days 1-15, and the second covering days 16 to the end of month.

b. Within five (5) business days of receipt of the Batch number and with an EIM status of PRC/CEC Ready, DMH Accounts Payable (AP) staff will run the HIPAA Claim Status Report in EIM and save the report to the designated payment file. DMH AP staff will then notify the respective Program Approver by email and attach the HIPAA Claim Status Report for review. Any rejected claims appearing on a 277 file will have an Adjudication Outcome of **"None"** [i.e. are unpaid]**,** and are listed on the HIPAA Claim Status Report with the specific rejection reason and corresponding code. These rejections will need to be corrected and re-sent in a Supplemental File (see Section VII.E.).

c. The Program Approver will apply the first level of approval of the PRC/CEC document in EIM: PM PRC/CEC Approved

d. The DMH AP staff will review the PRC and ensure it references the correct contract lines and that the payment amount is apportioned to the correct funding sources. They then apply the second level of approval of the PRC/CEC document in EIM: ACT PRC/CEC Approved.

e. Once a PRC/CEC document has obtained both levels of approval it will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will generate payments for PRCs and recoups CECs.

f. If the Program Approver determines the HIPAA Claim(s) is not accurate, the Program Approver will contact the Contractor and explain the reason(s). If appropriate, the Contractor can submit a void and or corrected HIPAA claim submission for the client(s) with the inaccurate claim(s) as a Supplemental as described in Section VII.E below.

g. A PRC will not be processed as Approved unless the total of Units of Service reported are less than the maximum number of Units of Service that can be billed for the applicable Contract for that fiscal year.

E. Supplemental Billing (HIPAA)

Supplemental Billing is any billing that is done for a month that is submitted subsequent to the initial bill for that month. Supplemental billing can be either for a positive or negative adjustment. **Positive and negative adjustments cannot be combined – they must be submitted separately.** Any negative adjustments must be processed prior to any positive adjustments. Adjustments must be made in the format in which the original billing was submitted, i.e., supplemental billing applicable to a month in which billing was via EIM/SDR must be submitted via EIM/SDR; supplemental billing applicable to a month in which billing was via HIPAA must be submitted via HIPAA.

a) Contractors receiving notification of "277" errors must timely correct and resubmit all affected claims.

b) If there was an omission of a client(s) or day(s) of service from the original HIPAA claims, the Contractor must complete the required information as described above in this Section VII.

c) If a Contractor submits an updated claim for a date which was previously approved under a different service code, the Contractor must void the original claim.

d) The Program Approval of the CEC document in EIM must be done prior to Accounting Approval and must also be done prior to approval of any PRCs for the same contract. **All CECs must be approved prior to PRCs for any given contract**.

e) Once Program Approval is completed for the CEC, the DMH AP staff will review the CEC and apply the Accounting Approval for the CEC document.

f) When a CEC document has obtained both levels of approval, it will appear in the PRC/CEC Batch Report for the next business day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS and will process overnight and activate the credit memo process that will offset future payments until the full amount of the CEC has been recouped.

VIII. EIM/SDR BILLING

The following sections apply to Contractors billing "A" and "B" contracts via Service Delivery Reports (SDRs).

A. EIM BILLING

All Contractors are required to use the Enterprise Invoice Management System (EIM) for billing DMH monthly for all ACCS Services unless a Contractor has converted to HIPAA Billing as described above in Section VII. Contractors are required to complete the EIM Service Delivery Report (SDR) for the Unit Rate portion of the ACCS Contract (Contract A). To utilize the EIM system, Contractors must contact EOHHS Virtual Gateway Business Operations (VGBO) Services to become an authorized user and to be trained on how to use its billing functionality required when billing DMH. Contractors who are currently not authorized users and/or trained in the EIM billing functionalities should contact the VGBO. Please use the following link: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/vg/

The following link is also available on the Virtual Gateway to access Job Aids for EIM: https://www.mass.gov/service-details/eimesm-training-and-user-materials

When invoicing via EIM/SDR, Contractors are required to complete and submit their billing information for each month in EIM by the 10th day of the subsequent month.

B. SERVICE DELIVERY REPORT (SDR) BILLING CODES AND RATES

SDRs require separate codes for service and attendance.

DMH ACCS Service Settings	**101 CMR 426.00**				EIM	EIM
	Serv Mnemonic	EIM Subactivity	Desc	**Effective 7/1/24**	SDR Service Codes	Attendance Codes
Integrated Team (IT)	ACCSIT	3055199	ACCS INTEGRATED TEAM	**$56.32**	IT	E, C, O, or R
Group Living Environments (GLE)						Service Settings
GLE *	ACCSGLE6	305526	ACCS GLE 4-6 BED	**$400.43**	GLE6	B, BR, BO, A, AC, AO, or AR
GLE *	ACCSGLE9	305529	ACCS GLE 7-9 BED	**$295.59**	GLE9	B, BR, BO, A, AC, AO, or AR
GLE *	ACCSGLE12	3055212	ACCS GLE 10-12 BED	**$247.94**	GLE12	B, BR, BO, A, AC, AO, or AR
Intensive Behavioral GLE (IBGLE)						
IBGLE	ACCSIB6	305536	ACCS INTENSIVE GL IB 4-6 BED	**$569.68**	IB6	B, BR, BO, A, AC, AO, or AR
IBGLE	ACCSIB9	305539	ACCS INTENSIVE GL IB 7-9 BED	**$431.37**	IB9	B, BR, BO, A, AC, AO, or AR
IBGLE	ACCSIB12	3055312	ACCS INTENSIVE GL IB 10-12 BED	**$370.77**	IB12	B, BR, BO, A, AC, AO, or AR
Intensive Behavioral Assessment GLE (IBAGLE)						
IBAGLE	ACCSIBA6	305546	ACCS INTENSIVE GL IBA 4-6 BED	**$462.33**	IBA6	B, BR, BO, A, AC, AO, or AR

IBAGLE	ACCSIBA12	3055412	ACCS INTENSIVE GL IBA 10 -12 BED	**$319.89**	IBA12	B, BR, BO, A, AC, AO, or AR
Intensive Clinical GLE (ICGLE)						
ICGLE	ACCSIC6	305556	ACCS INTENSIVE GL IC 4-6 BED	**$614.30**	IC6	B, BR, BO, A, AC, AO, or AR
ICGLE	ACCSIC9	305559	ACCS INTENSIVE GL IC 7-9 BED	**$524.67**	IC9	B, BR, BO, A, AC, AO, or AR
ICGLE	ACCSIC12	3055512	ACCS INTENSIVE GL IC 10-12 BED	**$496.93**	IC12	B, BR, BO, A, AC, AO, or AR
Intensive Medical GLE (IMGLE)						
IMGLE	ACCSIM6	305566	ACCS INTENSIVE GL IM 4-6 BED	**$529.22**	IM6	B, BR, BO, A, AC, AO, or AR
IMGLE	ACCSIM9	305569	ACCS INTENSIVE GL IM 7-9 BED	**$440.27**	IM9	B, BR, BO, A, AC, AO, or AR
IMGLE	ACCSIM12	3055612	ACCS INTENSIVE GL IM 10-12 BED	**$395.87**	IM12	B, BR, BO, A, AC, AO, or AR
Supported Independent Environment (SIE)						
SIE *	ACCSSIE16	3055716	ACCS SIE 13-16 BED	**$127.74**	SIE16	E, C, O, or R
SIE *	ACCSSIE25	3055725	ACCS SIE 17-25 BED	**$108.90**	SIE25	E, C, O, or R
SIE *	ACCSSIE35	3055735	ACCS SIE 26-35 BED	**$90.07**	SIE35	E, C, O, or R
Enhanced Medical GLE (EMGLE)						
EMGLE	**ACCSEM6**	305586	ACCS ENHANCED MEDICAL 4-6	**$600.76**	EM6	A, AC, AO, AR, B, BO, or BR
EMGLE	**ACCSEM9**	305589	ACCS ENHANCED MEDICAL 7-9	**$485.10**	EM9	A, AC, AO, AR, B, BO, or BR

EMGLE	**ACCSEM12**	3055812	ACCS ENHANCED MEDICAL 10-12	**456.52**	EM12	A, AC, AO, AR, B, BO, or BR

*** Note: For billing purposes GLE & SIE combined rate included in the Integrated Team with GLE/SIE rate.**

SERVICE DELIVERY AND ATTENDANCE (SDR) CODES

C. EIM /SDR– Unit Rate billing

DMH will provide an electronic data feed of client enrollments from MHIS to EIM to pre-populate the monthly SDR for each Contract. The SDR will include a monthly calendar for each client enrolled by DMH during the reporting month. The calendar will contain the names and Enrollment IDs (MHIS Account Numbers) of clients served.

NOTE: The ACCS provider submits the date of the first face to face encounter to DMH. This triggers the enrollment in an ACCS service and the first billable day.

For each client included on a SDR, the Contractor will select the Service Code from the drop-down menu. Selection will be limited to the appropriate codes predetermined by client enrollment at the sub activity level. The Contractor **must** indicate the day(s) the DMH client was enrolled by entering the unit of service (always "1') for each day and the applicable attendance code. Only one Attendance Code may be reported on any given date.

(Note: EIM does not permit the reporting of service delivery before a client's Enrollment date or after the client's Disenrollment date.)

1. **Integrated Team Only:** A calendar indicating the type of Encounter the client received each day (Rehab Encounter, Other Face to Face Encounter, Enrolled but No Encounter).

a) SDR Service Code = **IT** - Integrated Team Only / Sub Activity 3055199

b) SDR Attendance Code =
E - Enrolled but NO Encounter
C - Enrolled with Encounter
O – Enrolled with Telephonic or Collateral REHAB Contact
R - Enrolled with REHAB Encounter

2. **Group Living Environment:** A calendar indicating if the client was Enrolled and Present or Enrolled and Absent and indicating the type of Encounter the client received each day (Rehab Encounter, Other Face to Face Encounter, Enrolled but No Encounter).

a) SDR Service Code =
GLE6 - 4-6 Bed capacity / Sub Activity 305526
GLE9 - 7-9 Bed capacity / Sub Activity 305529
GLE12-10-12 Bed capacity / Sub Activity 3055212

b) SDR Attendance Code =
B - Enrolled in Bed
BR - Enrolled in Bed with REHAB
BO – Enrolled in Bed with Telephonic or Collateral REHAB Contact
A - Enrolled NOT in Bed NO Contact

AC - Enrolled NOT in Bed Contact
AO – Enrolled NOT in Bed with Telephonic or Collateral REHAB Contact
AR - Enrolled NOT in Bed with REHAB

3. Intensive Behavioral GLE: A calendar indicating if the client was Present with Rehab Encounter, Present with No Rehab Encounter, Enrolled and Absent.

   a) SDR Service Code = **IB6** - 4-6 Bed capacity / Sub Activity 305536
   IB9 - 7-9 Bed capacity / Sub Activity 305539
   IB12 - 10-12 Bed capacity / Sub Activity 3055312

   b) SDR Attendance Code = **B** - Enrolled in Bed
   BR - Enrolled in Bed with REHAB
   BO – Enrolled in Bed with Telephonic or Collateral REHAB contact
   A - Enrolled NOT in Bed NO Contact
   AC - Enrolled NOT in Bed Contact
   AO – Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
   AR - Enrolled NOT in Bed with REHAB

4. **Intensive Behavioral Assessment GLE:** A calendar indicating if the client was Present with Rehab Encounter, Present with No Rehab Encounter, Enrolled and Absent.

   a) SDR Service Code = **IBA6** - 4-6 Bed capacity / Sub Activity 305546
   IBA12 - 10 -12 Bed capacity / Sub Activity 3055412

   b) SDR Attendance Code = **B** - Enrolled in Bed
   BR - Enrolled in Bed with REHAB
   BO – Enrolled in Bed with Telephonic or Collateral REHAB contact
   A - Enrolled NOT in Bed NO Contact
   AC - Enrolled NOT in Bed Contact
   AO – Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
   AR - Enrolled NOT in Bed with REHAB

5. **Intensive Clinical GLE:** A calendar indicating if the client was Present with Rehab Encounter, Present with No Rehab Encounter, Enrolled and Absent.

   a) SDR Service Code = **IC6** - 4-6 Bed capacity / Sub Activity 305556
   IC9 - 7-9 Bed capacity / Sub Activity 305559
   IC12 – 10-12 Bed capacity / Sub Activity 3055512
   b) SDR Attendance Code = **B** - Enrolled in Bed
   BR - Enrolled in Bed with REHAB

BO – Enrolled in Bed with Telephonic or Collateral REHAB contact
A - Enrolled NOT in Bed NO Contact
AC - Enrolled NOT in Bed Contact
AO - Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
AR - Enrolled NOT in Bed with REHAB

6. **Intensive Medical GLE:** A calendar indicating if the client was Present with Rehab Encounter, Present with No Rehab Encounter, Enrolled and Absent.

   a) SDR Service Code = **IM6** - 4-6 Bed capacity / Sub Activity 305566
   IM9 - 7-9 Bed capacity / Sub Activity 305569
   IM12 – 10-12 Bed capacity / Sub Activity 3055612

   b) SDR Attendance Code = **B** - Enrolled in Bed
   BR - Enrolled in Bed with REHAB
   BO – Enrolled in Bed with Telephonic or Collateral REHAB contact
   A - Enrolled NOT in Bed NO Contact
   AC - Enrolled NOT in Bed Contact
   AO – Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
   AR - Enrolled NOT in Bed with REHAB

7. **Supported Independent Environment:** A calendar indicating if the client was Enrolled and Present or Enrolled and Absent and indicating the type of Encounter the client received each day (Rehab Encounter, Other Face to Face Encounter, Enrolled but No Encounter).

   c) SDR Service Code = **SIE16** - 13-16 Bed capacity / Sub Activity 3055716
   SIE25 - 17-25 Bed capacity / Sub Activity 3055725
   SIE35 - 26-35 Bed capacity / Sub Activity 3055735

   d) SDR Attendance Code = **E** - Enrolled but NO Encounter
   C - Enrolled with Encounter
   O - Enrolled with Telephonic or Collateral REHAB contact
   R - Enrolled with REHAB Encounter

8. **Enhanced Medical GLE:** A calendar indicating if the client was Present with Rehab Encounter, Present with No Rehab Encounter, Enrolled and Absent.

   a) SDR Service Code = **EM6** - 4-6 Bed capacity / Sub Activity 305566
   EM9 - 7-9 Bed capacity / Sub Activity 305569
   EM12 – 10-12 Bed capacity / Sub Activity 3055612

b) SDR Attendance Code = **B** - Enrolled in Bed
BR - Enrolled in Bed with REHAB
BO – Enrolled in Bed with Telephonic or Collateral REHAB contact
A - Enrolled NOT in Bed NO Contact
AC - Enrolled NOT in Bed Contact
AO – Enrolled NOT in Bed with Telephonic or Collateral REHAB contact
AR - Enrolled NOT in Bed with REHAB

D. Approval Process (SDR)

1. After completing the SDR for each client that was enrolled during the month, the Contractor must release and authorize the SDR in EIM.
2. Within five (5) business days of receipt of the SDR in EIM and with an EIM status of Authorized, DMH Accounts Payable (AP) staff will save the original SDR to the designated file. DMH AP staff will then notify the respective Program Approver to conduct their review and approve/deny all or part of the SDR (see Attachment C).
3. If the Program Approver determines the SDR to be accurate he/she will Approve the SDR in EIM. The approved SDR will run overnight in EIM and create a PRC (Payment Request document) on the next business day. ***Note: This includes CECs (Encumbrance Correction documents).***
4. If the Program Approver determines the SDR not to be accurate, they may deny one or more client record(s). If this is done, they will contact the Contractor and explain the reason(s) for the denial. If appropriate, the Contractor can submit a corrected SDR for that client(s) on a Supplemental SDR as described in Section VIII E below. If necessary, the Program Approver will then approve the remaining records.
5. An SDR will not be processed as Approved unless the total of Units of Service reported, including those reported in the SDR, are less than the maximum number of Units of Service that can be billed for the applicable Contract for that fiscal year.
6. The DMH AP staff will next complete the "Program Approval" of the PRC in EIM. This must be done prior to the “Accounting Approval.”
7. The DMH AP staff will review the PRC and ensure that it references the correct contract lines and that the payment amount is apportioned to the correct funding sources. They then apply the Accounting Approval for the PRC.
8. When a PRC document has obtained both levels of approval it will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will generate payments for PRCs and recoups CECs.

E. Supplemental Billing (EIM/SDR)

Supplemental Billing is any billing from a Contractor for a month that is submitted subsequent to the initial bill for that month. Supplemental billing can be either for a positive or negative adjustment. **Positive and negative adjustments cannot be combined – they**

must be submitted separately. Any negative adjustments must be processed prior to any positive adjustments. Adjustments must be made in the format in which the original billing was submitted, i.e., supplemental billing applicable to a month in which billing was via EIM/SDR must be submitted via EIM/SDR; supplemental billing applicable to a month in which billing was via HIPAA must be submitted via HIPAA.

1. If there was an omission of a client(s) or day(s) of service from the original SDR, EIM functionality allows for the Contractor to enter services by accessing the enrollment link for a client. The Contractor completes the required information as described above in Unit Rate Contracts. The DMH Program Approver and the DMH AP staff process the documents as outlined above.
2. If a Contractor over-reported units of service in any previously submitted monthly SDR, the Contractor will access the client's enrollment link and void the applicable units.
3. If a Contractor submits an updated SDR using revised service codes for dates which were previously approved under different service codes, the Contractor must void the original claims.
4. Upon receipt of the negative Supplemental SDR in EIM, the SDR will be processed in accordance with Section VII.D, except that the approved Supplemental SDR will create an Encumbrance Correction (CEC) document the following business day. If the Supplemental SDR is not accurate, it will be denied and another corrected SDR must be submitted by the Contractor.
5. DMH AP staff will complete the Program Approval of the CEC document in EIM. This must be done prior to Accounting Approval and must also be done prior to approval of any PRCs for the same contract. **All CECs must be approved prior to PRCs for any given contract**.
6. Once Program Approval is completed for the CEC, the DMH AP staff will review the CEC and apply the Accounting Approval for the CEC document.
7. When a CEC document has both levels of approval completed, it will appear in the PRC/CEC Batch Report the next business day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS and will process overnight and activate the credit memo process that will offset future payments until the full amount of the CEC has been recouped.

IX. ACCOMMODATION RATE (AR) BILLING - OCCUPANCY & LEASE MANAGEMENT

A. Unit of Service

Occupancy - A unit of service is a month of bed availability for ACCS. The payment of the rate is based on bed capacity and is independent of bed utilization.

Lease Management Add-on - A unit of service is per client per month. Covered lease management activities where the contractor is directly involved in providing a qualifying leasing activity for clients receiving rental assistance.

B. Reporting Offsets- Occupancy Rate Adjustment

The Occupancy Rate will be offset by other payments attributable to occupancy costs (e.g. SNAP Benefits, rental subsidies, charges for Residential Services and Supports) received.

DMH will utilize previous fiscal year offset data submitted by providers to calculate a 1/12 monthly accommodation rate payment using the current $13,015 per bed plus modifier for the current fiscal year.
Once this rate has been established for the fiscal year, it would only be amended if agreed upon by the Area. For example, a program has closed, opened or there is some other significant change that would warrant an adjustment to the occupancy payment.

All Contractors must submit an itemized list of the offsets received to the designated DMH site office in a standard format as determined by DMH. The documentation is due to DMH by the twentieth (20th) day of the month. Payment will not be approved until documentation is received and approved. (see Attachment E).

C. Lease Management Add-On Reporting

The contractor must submit a client list monthly to the designated DMH site office in a standard format as determined by DMH. The documentation will include a current list of clients receiving rental assistance, type of subsidy and of that list who received a qualifying leasing activity for that month. This documentation is due to DMH by the twentieth (20th) day of the month. Payment will not be approved until documentation is received and approved. (see Attachment H).

D. Staff Vacancy Report

All Contractors must submit a Staff Vacancy Report to the designated DMH site office in a standard format as determined by DMH. The documentation is due to the DMH site office no later than the twentieth (20th) day of the month. Payment will not be approved until the documentation is received and reviewed (see Attachment D).

E. EIM Accommodation Rate Invoicing – Occupancy & Lease Management

1. Occupancy & Lease Management
    a. Occupancy - The Contractor will invoice DMH monthly. DMH will populate the EIM monthly rate equal to 1/12th of the agreed upon total.
    b. Lease Management – The Contractor will invoice DMH monthly by entering the number of clients that received a qualifying leasing activity in the reporting month.
2. The Provider creates an Accommodation Rate Invoice and enters a Unit of "1" each month on the AR line labeled "OCCUP". On a separate AR line labeled "LEASE" the provider will enter the total number clients that received a qualifying lease management activity in the reporting month. The Provider then does a "Release and Authorize" of the invoice.
3. Once the AR Invoice is in 'Authorized Status', the EIM system will automatically create a PRC (Payment Request Document) overnight. Within five (5) business days of receipt of the AR Invoice in EIM and with an EIM status of Authorized, The DMH Accounts

Payable (AP) staff will then notify the respective DMH Program Approver for that contract.

4. The Program Approver will then review the AR Invoice, **check that the Staff Vacancy, Occupancy and Lease Management monthly reports were received and complete**, **confirm that the amounts invoiced are correct,** and approve/deny the associated PRC.
5. Once Program Approval is completed for the PRC, DMH AP staff will review the PRC and ensure that it references the correct contract lines and that the payment amount is apportioned to the correct funding sources. They then apply the Accounting Approval of the PRC.
6. All PRC documents that have both levels of approval completed will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will generate payments for PRCs and recoups CECs.
7. If the Program Approver denies the PRC, s/he will contact the provider to explain the reason for the denial and have the provider submit a Supplemental AR Invoice with the corrected information. The Supplemental AR invoice will then be processed as outlined in steps #2 - #5 above.

X. COST REIMBURSEMENT (CR) BILLING – CONTINGENCY

A. Contingency Funds - A Contractor will be reimbursed for DMH approved Contingency Fund expenditures on a cost reimbursement basis up to the applicable Contract's Contingency Fund Annual Maximum Obligation Amount. These funds cannot be used to support GLEs, SIEs or Provider-Based Independent Settings.

All Contractors must submit an itemization of contingency payments **to the designated DMH site office in a standard format** as determined by DMH to support the contingency expenses. The itemization must include the following information: the Person on whose behalf the payment was made; type of payment (item purchased, rent, etc.), amount expended, recipient of the funds (store, landlord, etc.). Contractors must maintain records of expenditures along with receipts and have these available for DMH review if requested. The documentation is due to DMH by the twentieth (20^{th}) day of the month. Payment will not be approved until documentation is received and approved (see Attachment F).

B. EIM Cost Reimbursement Invoicing

1. The provider enters an invoice in EIM based on the line-item component(s) contained in the approved budget.
2. Once the invoice is complete, the provider then performs a "Release and Authorize" of the invoice**. DMH will require additional documentation to be submitted to the designated DMH site office for the cost reimbursement invoice to support the contingency expenses.**
3. The authorized invoice will run overnight in EIM and create a PRC on the next business day.

4. The Program Approver will review the invoice and additional documentation then approve/deny the associated PRC.
5. Once Program Approval is completed for the PRC, the DMH AP staff will review the PRC and ensure that it is referencing the correct contract lines and that the payment amount is apportioned to the correct funding sources. They will then apply the Accounting Approval for the PRC.
6. All PRC documents that have both levels of approval completed will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will generate payments for PRCs and recoups CECs. If the Program Approver denies the PRC, s/he will contact the provider to explain the reason for the denial and have the provider submit a Supplemental Invoice with the corrected information. The Supplemental invoice will then be processed as outlined in this section.

C. Billing Communication

All billing issues or problems should be addressed to the DMH POS Accounts Payable division at the following address: **BBhsposinvoices@MassMail.State.MA.US**

XI. REHABILITATIVE SERVICES

DMH will submit claims to Medicaid for rehabilitative services provided by ACCS. Rehabilitative Services being claimed under the Rehabilitative Option must comply with guidance provided by DMH. The rehabilitative services indicated in SDRs and HIPAA Claim files will be used to import and post charges into MHIS in order to claim for reimbursement according to established MHIS monthly billing schedules. DMH will determine a client's Medicaid eligibility.

DMH's claiming processes include a review of a client's eligibility for Medicaid prior to claiming. DMH cannot bill Medicaid when (1) a DMH client has been hospitalized, (2) enrolled into another third party program that receives Medicaid (e.g., Skilled Nursing Facility, PACE), (3) the client is not Medicaid eligible, or (4) there is no documentation in support of the rehabilitative service.

Contractors may not bill Medicaid, Medicare, or any insurer for ACCS services provided to a client under an ACCS contract. Contractors must maintain documentation to support the delivery of the rehabilitative service and timely update DMH of any changes impacting DMH's ability to seek reimbursement through Rehabilitative Option.

Contractors HIPAA Billing must have systems or processes to identify and void previously approved claims in cases where such claims are altered and resubmitted to reflect a change in rehabilitative status.

XII. DOCUMENTATION

All billing (SDRs, HIPAA Claims, Accommodation Rate Invoices and Cost Reimbursement Invoices) must be retained by both the contractor and DMH for a minimum period of 7 years

beginning on the first day after the final period of a contract, or such longer period as is necessary for the resolution of any mitigation, claim, negotiation, audit, or other inquiry involving a contract (Paragraph 7 of the Commonwealth Terms and Conditions for Human and Social Services). Records may be retained electronically in PDF Format or by hard copy.

For state operated providers, the applicable date is 7 years after the last date of service provision to any client listed in the SDR or a HIPAA Claim file. Records may be retained electronically in PDF Format or by hard copy.

XIII. ATTACHMENTS

Attachment A - HIPAA Onboarding Guidelines

Attachment B - EIM SDR Procedures for Providers

Attachment C - EIM Procedures for DMH Program Approvers

Attachment D - Staff Vacancy Report Template

Attachment E - Offsets Monthly Report Template

Attachment F - Contingency Funds Report Template

Attachment G – ACCS SDR and HIPAA Billing Codes

Attachment H – Lease Management Report Template

Attachment I – EIM Procedures for DMH Program Approvers (HIPAA)