Substance Use Disorder Services (SUD)

Overview

Publicly paid substance use disorder (SUD) treatment services may be delivered through either managed care or fee-for–service.

- Funding for substance use disorder (SUD) services are covered by the Consolidated Chemical Dependency Treatment Fund (CCDTF) for Medical Assistance (MA) and MinnesotaCare fee-for-service payment.

Minnesota Substance Use Disorder Reform

In 2017, SUD reform added services to the state's Medicaid benefit set and provided a more streamlined process for accessing SUD services.

- Reimbursement of three new services (Comprehensive Assessment, Treatment Coordination, and Peer Recovery services)
- How to add newly eligible vendors of SUD services, including individuals in private practice, counties and tribes, and recovery community organizations.

Eligible Providers

To provide, bill and receive payment for SUD services a provider must:

- Be enrolled as a Minnesota Health Care Program (MHCP) provider for alcohol and drug abuse
- Meet all provider qualifications as stated on the assurance statement for the provider type.
- Enroll and participate in the Drug and Alcohol Abuse Normative Evaluation System (DAANES). As a SUD treatment provider, you will not receive reimbursement unless you have complied with the DAANES requirements for each CCDTF recipient. All SUD clients regardless of funding need to be entered into DAANES for each admission episode. Contact the DAANES office by email or call 651-431-2631 to obtain the necessary training and documents required to participate in DAANES.

Eligible providers include the following:

- Residential SUD treatment programs
- Nonresidential (outpatient) SUD treatment programs
- Counties and tribes
- Recovery Community Organizations (RCO)
- Hospitals
- Qualified Substance-use disorder professional
- Medication-assisted treatment program

• Eligible Recipients

SUD services are available to IMCare members. Clinical eligibility is determined via the Rule 25 assessment or Direct Access- or all MHCP funded SUD services.

For a person to be eligible to get substance use disorder treatment they must meet MHCP income guidelines (DHS-3461A) (PDF) and CCDTF financial eligibility guidelines.

Individuals having private or publicly funded medical insurance may qualify for CCDTF payment if their insurance does not fully cover SUD treatment services. This may include copays, coinsurance, or a deductible.

Individuals enrolled with an MHCP contracted managed care organization (MCO) must contact their MCO for details on coverage and accessing SUD services.

Covered Services

Covered services must be delivered as outlined in the Minnesota Statutes. Each facility must be enrolled as an eligible provider of specific services, specialties, or complexity add-ons to receive reimbursement from IMCare. Providers are responsible to know and understand the rules and regulations pertaining to any services they submit for reimbursement. See the CCDTF Service Rate Grid for service and complexity add-on rates.

SUD services that can be reimbursed include the following:

- Hospital-based inpatient treatment
- Room and Board only
- Comprehensive assessment
- Treatment Coordination
- Recovery peer support
- Medication assisted therapies (MAT). MAT services may also be included as an add-on to the per diem of residential treatment services. MAT services are reimbursed on a per diem basis and may include:
- MAT-Methadone
- MAT-all other
- MAT-Methadone-PLUS
- MAT-all other-PLUS
- When providers are paid an encounter rate, encounter payments are not available for self-administered medication.

Noncovered Services

The following are not covered:

- Rule 25 chemical use assessments
- Services delivered before the completion of a Rule 25 or Comprehensive Assessment
- Room-and-board services not clinically or medically necessary
- Services delivered to people with MHCP managed by an MCO, with the exception of room and board services.
- Detoxification services
- More than one treatment service for the same person, for the same date span, provided by the same provider, except for nonresidential group and individual guest dosing

A county may choose to pay 100 percent of any service that MHCP does not cover.

Billing

Refer to the Rate Reform Grid with Dollar Amounts (DHS-7612) (PDF) document for possible enrolled service combinations and rates.

CCDTF-Authorized Services

The service agreement (SA) letter generated when a county or tribe makes a CCDTF authorization contains most of the information you will need to bill IMCare for CCDTF-authorized services. You must:

- Review the information in the SA letter for accuracy (procedure codes and modifiers, dates, rates, number of units, etc.).
- Contact the authorizing county or tribe if you believe that you received an incorrect SA letter and obtain a corrected SA letter before billing.
- Report the approved SA rate for the service provided on the claim service line (reporting other rates may result in an inaccurate unit decremented from the SA).

Use the following electronic claim formats for the program types when billing IMCare for CCDTF-authorized services.

Claim formats for program types

Program Type	Electronic Claim Format
Inpatient hospital based	837I (institutional)
Residentially licensed (daily units)	837I (Institutional)
Room and board only (daily units)	837I (Institutional)
Nonresidential (hourly units)	837I (Institutional) or 837P (Professional)
Medication-assisted therapy (daily units)	837P (Professional)

Revenue and Procedure Codes

The following tables describe the codes to use when billing IMCare for CCDTF-authorized services.

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Claim Format	Type of Bill	Service Limitations
Inpatient hospital – bundled room and board and treatment	Day	0101	None	837I	11X	Per diem
Inpatient hospital – room-and-board component only	Day	0118 0128 0138 0148 0158	None	837I	11X	Per diem
Inpatient hospital – treatment component only	Day	0944 0945	None	837I	11X	Per diem
Residential program – room-and-board component only	Day	1002	None	837I	86X	Per diem
*Residential program – treatment component only	Day	0944 0945 0953	None	837I	86X	Per diem
Freestanding room and board	Day	1003	None	837I	86X	Per diem
Outpatient individual (nonresidential) treatment	Hour	0944 0945 0953	H2035	837I or 837P	89X or 13X	3 units per day
Outpatient group (nonresidential) treatment	Hour	0944 0945 0953	H2035 with modifier HQ	837I or 837P	89X or 13X	10 units per day
**Nonresidential treatment – medication-assisted therapy (all other)	Day		H0047	837P		Per diem
**Nonresidential treatment – medication-assisted therapy plus (all other)	Day		H0047 with modifier UB	837P		Per diem
**Nonresidential treatment – medication-assisted therapy (methadone)	Day		H0020	837P		Per diem

**Nonresidential treatment – medication-assisted therapy plus (methadone)	Day		H0020 with modifier UA	837P		Per diem
Treatment Coordination	15 minutes	0944 0945 0953	T1016 with modifier U8 HN	837I or 837P	89X or 13X	8 units per day
Peer Support Specialist	15 minutes	0944 0945 0953	H0038 with modifier U8	837I or 837P	89X or 13X	8 units per day
Comprehensive Assessment		0944 0945 0953	H0001	837I or 837P	89X or 13X	2 allowable every rolling 6 months. *Note: Assessments may be billed as Outpatient individual (nonresidential) treatment if limitation is exceeded.

Interim Billing

Effective for date of service on or after Jan. 1, 2019, bill residential and inpatient hospital claims that span multiple months using interim billing method. Include the date of discharge on the final treatment claim along with appropriate patient status code.

Nonresidential clinic billing

Bill nonresidential medication-assisted therapy (MAT) and MAT Plus using the professional (837P) claim format. Report the appropriate place of service to distinguish on-site dosage(s) from take-home dosage(s). Itemize dosages by listing each date of service on a separate service line.

Additional Billing Information

Medicare

Certified Medicare facilities serving Medicare-eligible clients must follow the IMCare Medicare policy found in the IMCare Provider Manual under Billing Policy.

Third-Party Liability (TPL)

• IMCare TPL policy applies to all SUD treatment providers. When a recipient has private, commercial insurance for an authorized treatment placement, you must first bill the private, commercial insurance before billing IMCare.
• Check MN–ITS before submitting bills to IMCare. If MN–ITS indicates that TPL exists for the date(s) that you would like to bill for, then you must first bill the third party displayed in MN–ITS for the date(s). If you bill IMCare for dates of service when TPL exists, IMCare will deny the claim.
• After billing the third party, submit appropriate documentation to IMCare. You must follow the IMCare TPL policy found in the IMCare Provider Manual under Billing Policy.

Legal References

Minnesota Statutes, section 254A.03 (Alcohol and Drug Abuse)
Minnesota Statutes, Chapter 254B (Consolidated Chemical Dependency Treatment Fund)
Minnesota Statutes, section 256B.031 (Prepaid Health Plans)
Minnesota Statutes, section 256L (MinnesotaCare)
Minnesota Rules, parts 9530.6600 to 9530.6655 (Rule 25)
Minnesota Rules, parts 9530.6800 to 9530.7030 (Rule 24)
Minnesota Rules, parts 9530.6405 to 9530.6505 (Rule 31)
Minnesota Rules, parts 9530.6510 to 9530.6590 (Rule 32)
Minnesota Rules, part 9530.6615, subp. 2 (Rule 25, Staff Performing Assessment)
Minnesota Rules, part 9530.6605, subp. 21a (Rule 25, Definitions, Placing Authority)
42 Code of Federal Regulations, section 440.130(d)

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