

Chapter 15

Chemical Dependency

Overview

Publicly paid chemical dependency (CD) treatment services are delivered two different ways in Minnesota:

1. Managed care
2. Fee-for-service (FFS)

The Consolidated Chemical Dependency Treatment Fund (CCDTF) is the only FFS payment mechanism for CD treatment services in Minnesota. Medical Assistance (Medicaid) and MinnesotaCare members not receiving their services through a managed care organization (MCO) must receive funding for their services through the CCDTF. Individuals not on public health care can also receive services through the CCDTF if they meet CCDTF income and household size guidelines.

Definitions

Assessor: A person qualified to perform a chemical use assessment who has a relationship with a placing authority for conducting chemical use assessments.

Chemical Abuse: A pattern of inappropriate and harmful chemical use that could be linked to specific situations in a member's life, such as loss of a job, death of a loved one, or sudden change in life. Chemical abuse does not involve a pattern of pathological use, but it may progress toward it.

Chemical Dependency (CD): A pattern of pathological use, accompanied by the physical manifestations of increased tolerance to the chemical or chemicals being used or withdrawal syndrome following cessation of chemical use.

Chemical Dependency (CD) Services: A planned program of care for the treatment of CD or chemical abuse to minimize or prevent further chemical abuse. Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services not included in the licensed rehabilitative program are not IMCare-covered services.

Chemical Use Assessment/Rule 25 Assessment: An assessment interview and written listing of the member's specific problems related to chemical use and risk description that will enable the assessor to determine an appropriate treatment planning decision according to the [Minnesota Matrix \(DHS-5204B\)](#).

Guest Dosing: Guest dosing is the practice of administering a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication. The client must be enrolled in an opioid treatment program (OTP) elsewhere in the state or country and receiving the medication on a temporary basis because the client is not able to receive the medication at the program where the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and are not for the convenience or benefit of either program. Guest dosing may also occur when the client's primary clinic is not open and the client is not receiving take-out doses.

Because guest dosing only occurs when the person receiving the medication is not enrolled at the OTP providing the medication and receives no other services, guest dosing is not considered "treatment" by the Alcohol and Drug Abuse Division (ADAD). A "guest doser" is, by definition, not admitted under Rule 31, and as such, IMCare cannot pay for guest dosing, nor may provider bill IMCare-entitled individuals for guest doses.

Managed Care Organization (MCO)/Prepaid Health Plan: An organization that contracts with Minnesota Health Care Programs (MHCP) to provide medical services, including CD treatment services, to members in exchange for a prepaid capitation rate and uses authorized funds.

Placing Authority: An authorized county ([MN Rules parts 9530.6600 – 9530.6655](#)), prepaid health plan, or tribal governing board.

Referral: If the assessor determines the member meets the criteria for chemical abuse, placement should be made in an appropriate program.

Rule 24: This CCDTF rule regulates county and provider responsibilities, as well as member eligibility.

Rule 25: This rule establishes criteria for the appropriate level of CD care for IMCare members.

Rule 31: This rule regulates CD treatment provider licensing.

Rule 32: This rule regulates detoxification provider licensing.

Rules and Licensing for Chemical Dependency (CD) Treatment and Residential Programs

1. Rule 25: [MN Rules parts 9530.6600 – 9530.6655](#), which establish criteria for the appropriate level of CD care for IMCare members
2. Rule 31: [MN Rules parts 9530.6405 – 9530.6505](#) (CD Licensed Treatment Facilities)
3. License to provide residential services for members under age 19: [MN Rules parts 2960.0010 – 2960.0220](#).
4. License to provide residential substance use services for members older than 15 years of age and under 21 years of age: [MN Rules parts 2960.0010 – 2960.0220](#) and [MN Rules parts 2960.0430 – 960.0490](#), or be licensed under [MN Rules parts 9530.6405 – 9530.6505](#)
5. Licensed Residential Treatment for adults: [MN Rules part 9530.6505](#)

Eligible Providers

To be eligible for referrals and reimbursement through the IMCare, CD treatment programs must meet all of the following criteria:

1. Possess an acceptable license to provide CD treatment services and/or room and board services
2. Enroll with MHCP as an MHCP provider
3. Participate in the Drug and Alcohol Abuse Normative Evaluation System (DAANES)

Acceptable Licenses

Several different types of licenses are acceptable for reimbursement. They include the following:

1. Rule 31 CD treatment program
2. Children's Residential Facility with CD certification
3. Appropriate tribal license, for programs located on tribally owned reservation property
4. Appropriate room and board license*
5. For out-of-state providers, an appropriate CD treatment license for their state

*Room and board providers are eligible for reimbursement if all of the following are met:

1. The program is certified by the county or tribal governing body as having rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and providing consequences for infractions of those rules
2. The program has a current contract with a county or tribal governing body
3. The program is determined to meet applicable health and safety requirements
4. The program is not housed in a jail or prison
5. The program is not concurrently receiving Group Residential Housing (GRH) funding for the member

Providers with more than one service delivery location must obtain a separate license for each service delivery location.

Contact the [Alcohol and Drug Abuse Division \(ADAD\) of the Minnesota Department of Human Services \(DHS\)](#) if you have questions about the appropriateness of a license.

Initial and Ongoing Provider Enrollment with Minnesota Health Care Programs (MHCP)

IMCare recognizes MHCP providers as eligible CD treatment providers. For information on becoming an MHCP provider, refer to the [DHS Provider Manual](#).

Drug and Alcohol Abuse Normative Evaluation System (DAANES)

CD treatment programs will not receive reimbursement unless they have complied with the DAANES requirements for each IMCare-authorized member. Contact the DAANES office at **1-651-431-2631** to obtain the necessary training and documents required for participation in DAANES.

Eligible Members

Access

Refer members to the [social service agency](#) in their county or tribe of residence. The county or tribal agency will determine the member's need for treatment by conducting a Rule 25 chemical use assessment and will also determine whether the member is eligible to have his/her treatment paid for using public funds.

The county or tribe may choose to contract with a qualified individual/entity to perform Rule 25 assessments within the member's county or tribe of residence. This agreement is between the county and the Rule 25 assessor and will include specific duties/responsibilities that are required when performing the Rule 25 assessment. Duties may include, but are not limited to, the assessment and case management for the member needing treatment.

Eligibility for CD treatment is based on two criteria: clinical and financial eligibility. If a member is determined to have both a clinical need for treatment and is financially eligible for IMCare, then IMCare may pay for his/her CD treatment services.

Effective August 1, 2014, members enrolled in the Minnesota Restricted Recipient Program are required to have a referral form from their assigned primary care provider in addition to meeting clinical and financial eligibility when in need of Medication Assisted Therapy (MAT) services.

The *Minnesota Restricted Recipient Program (RRP) Referral Form* on the IMCare website. This form must be completed by the primary care provider must be faxed to IMCare at 218-327-5545 within 90 days of the MAT start date.

Use the Minnesota Information Transfer System (MN-ITS) to verify a member's Minnesota Restricted Recipient Program status and contact the primary care provider listed on the members eligibility response page.

Clinical Eligibility

Clinical eligibility is based on an interview referred to as a Rule 25 chemical use assessment. This is a face-to-face interview conducted by a qualified county assessor from the member's county of residence. The assessor gathers information using the [Rule 25 Assessment tool \(DHS-5204\)](#) and the [Minnesota Matrix \(DHS-5204B\)](#) to determine whether the member has a clinical need for treatment. Members who score a severity rating of 2, 3, or 4 in Dimensions IV, V, or VI meet clinical eligibility for treatment.

Rule 25 assessments must be conducted, using the [Rule 25 Assessment tool \(DHS-5204\)](#) and [Minnesota Matrix \(DHS-5204B\)](#), for all members—whether the individual is assessed by his/her county or tribe of residence. The Rule 25 assessor must screen for co-occurring mental health diagnoses using an appropriate screening tool. The current Rule 25 Assessment satisfies this requirement with the completion of the GAIN-SS embedded in the existing Rule 25 Assessment. If a different screener is selected, it must meet the following criteria:

1. Reads at a grade level no more than 9th grade
2. Is easily administered and scored by a non-clinician
3. Is tested in a general population at the national level
4. Has demonstrated reliability and validity
5. Has a documented sensitivity of at least 70 percent
6. Has an overall accuracy of at least 70 percent
7. Predicts a range of diagnosable major mental illnesses such as: affective disorders, anxiety disorders, personality disorders, and psychosis

Financial Eligibility

Financial eligibility is determined by the county human services agency located in the county of the member's residence. Potential members need to go to their county to be assessed for MHCP, IMCare, or CCDTF eligibility.

Service Authorization-Out of Network

IMCare requires a service authorization for all out-of-network chemical dependency treatments (All Suboxone/Methadone Treatment requires a service authorization).

After a member has completed the Rule 25 assessment with the county assessor, the assessor will fax the [Client Placement Authorization \(CPA\) – CCDTF \(DHS-2780\)](#) and the [Rule 25 Assessment and Placement Summary \(DHS-2794\)](#) to IMCare at **1-218-327-5545**. Once all the necessary information is received by the Utilization Management (CD) department staff, a service authorization letter will be sent to the assessor and the out of network treatment provider.

When a service authorization letter is received, it is advisable that the provider reviews and agrees with the services recommended by the Rule 25 assessor. Please verify that the start date of services, number of units, end date of services, procedure codes, and appropriate modifiers are correct. If errors are found, this would be the best time for the provider to contact the county Rule 25 assessor to adjust the [Client Placement Authorization](#)

[\(CPA\) – CCDTF \(DHS-2780\)](#) and re-fax the form to IMCare.

IMCare recommends that the CD provider obtain a copy of the completed and signed CPA for each recipient before admission. Doing this provides additional documentation of the service agreement.

Programs cannot bill IMCare for services until the program receives a service notification letter. If a program has not received a service notification letter, the program must contact the authorizing county or tribe.

Mid-Treatment Authorization

A member may be approved and referred for treatment by one placing authority and then experience a change in his/her eligibility/enrollment status while in treatment. When this occurs, providers and placing authorities have specific responsibilities.

Month-by-Month Structure

Responsibility for assessments, authorizations, continued authorizations, and payments may change on a month-to-month basis, depending on the member's status with regard to public health care eligibility and whether he/she is enrolled in IMCare.

When the placing authority changes, the new placing authority must honor the existing placement, at least until a Rule 25 assessment update is completed by the new placing authority. Only after a Rule 25 assessment update is completed can the new placing authority choose to transfer the member to a different program. The new placing authority can choose to change providers due to clinical reasons (e.g., member's clinical needs changed) or program preferences (e.g., the current provider is not in the placing authority's network).

Since the placing authority can change at any time during the assessment, referral, and treatment process, the CD program must take several steps to ensure proper authorization for the member's treatment services, as well as to ensure payment from the correct placing authority.

Follow these guidelines to determine who is responsible for what when the placing authority changes at different steps in the assessment, placement, and treatment process.

When the placing authority changes between the request for an assessment and the assessment interview:

1. The existing placing authority refers the individual to the new placing authority
2. The new placing authority is responsible for the assessment

When the placing authority changes between the assessment interview and the determination:

1. The existing placing authority completes the determination and referral process
2. The new placing authority honors the plan the existing placing authority is initiating
3. The new placing authority is responsible for payment for the referred services
4. The new placing authority cannot transfer the member to a different provider without first conducting an assessment update

When the placing authority changes between determination and referral to treatment:

1. The existing placing authority completes the referral process
2. The new placing authority honors the plan that the existing placing authority initiated
3. The new placing authority is responsible for payment for the referred services
4. The new placing authority cannot transfer the member to a different provider without first conducting an assessment update

When the placing authority changes between referral to treatment and admission to treatment:

1. The new placing authority honors the plan that the existing placing authority initiated
2. The new placing authority is responsible for payment for the referred services
3. The new placing authority cannot transfer the member to a different provider without first conducting an assessment update

When the placing authority changes after admission to treatment:

1. The new placing authority honors the placement
2. The new placing authority is responsible for payment for the referred services
3. The new placing authority cannot transfer the member to a different provider without first conducting an assessment update

Enrollment/Disenrollment

Members who apply for and receive public health care may be enrolled in IMCare. IMCare becomes responsible for managing the member's health care as of the first of the month the member is enrolled with IMCare. When a member is referred to CD treatment by a county or tribe and subsequently becomes enrolled in IMCare, IMCare is responsible for the member's CD treatment as of the first of the month the member is enrolled in IMCare.

A member enrolled in IMCare may become disenrolled from IMCare, but keep his/her public health care. The patient's health care is now FFS, and the patient is entitled to have his/her CD treatment services paid with public funds. Since the member is disenrolled, IMCare is no longer responsible for the member's health care. The county or tribe of residence is responsible for the member and the payments, through the CCDTF, as of the first of the month following the member's IMCare disenrollment.

If a member loses his/her public health care, he/she needs to be immediately referred to the [social service agency](#) in his/her county or tribe of residence to determine if he/she eligible for funding through the CCDTF.

Eligibility of Members**Providers should check each member's eligibility for IMCare or CCDTF at each of the following times:**

1. Admission
2. The first of each month

American Indians enrolled in pre-paid health plans that are placed at CCDTF-enrolled tribal 638 facilities are paid through the CCDTF.

Providers must check to see if:

1. The member has any public health care (e.g., Medical Assistance [Medicaid] or MinnesotaCare)
2. Whether the member is enrolled in IMCare

Eligibility Verification

To verify member eligibility, please see Chapter 4, Billing Policy, of the IMCare *Provider Manual*.

Placing Authority Responsibility

When checking eligibility, refer to the following table:

Member on Medical Assistance (Medicaid) or MinnesotaCare	Member Receiving Services through a Managed Care Organization (MCO)	Responsible Placing Authority
No	No	County or tribe of residence
Yes	No	County or tribe of residence
Yes	Yes, at nontribal 638 facilities	IMCare or county/tribe of residence
Yes	Yes at tribal 638 facilities	County or tribe of residence

Institutions of Mental Disease (IMDs)

CD programs identified as an IMD experience a few exceptions to the above procedures.

IMCare, as a placing authority, is responsible for IMD placements that are authorized. Assessments may be provided by the county or tribe of residence; however, all IMD placements for members must be coordinated and authorized by IMCare. IMCare is then responsible for the member and associated payments through discharge, or until the member disenrolls from IMCare, whichever comes first.

Members who are initially placed in an IMD through the CCDTF and are then enrolled in IMCare remain the responsibility of the CCDTF until discharge.

Hospital-Based Inpatient Placements

When a placing authority (IMCare, tribe, or CCDTF) initiates a placement at a hospital-based inpatient program, the placing authority remains responsible for the placement through discharge, regardless of whether the member’s eligibility status changes.

Placing Authority Notification

If, when checking eligibility, the program learns the placing authority currently responsible for the member is different than the previous placing authority, the program must immediately take the following steps:

1. Obtain a signed IMCare Mental Health and Chemical Dependency Release of Information form from the member to allow the program to share clinical information with the new placing authority and county or tribe of residence.
2. Forward the signed IMCare Mental Health and Chemical Dependency Release of Information form to the IMCare Compliance Officer.
3. Forward the signed [Client Placement Authorization \(CPA\) – CCDTF \(DHS-2780\)](#), and the most recent [Rule 25 Assessment & Placement Summary \(DHS-2794\)](#) received from the Rule 25 assessor to the new placing authority. Also fax them to IMCare at **1-218-327-5545**.
4. Forward any additional documents as requested by the new placing authority

When checking eligibility, refer to the following table:

Is member on MA and MinnesotaCare?	Is member receiving services through IMCare?	Responsible Placing Authority:
No	No	County or tribe of residence
Yes	No	County or tribe of residence
Yes	Yes, at nontribal 638 facilities	IMCare

Yes	Yes, at tribal 638 facilities	County or tribe of residence
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Covered Services

Chemical Dependency (CD) Treatment

All services that are provided under a licensed program of care and maintain a provider agreement with MHCP are covered by CCDTF and IMCare. This includes the following:

1. Non-residential treatment
2. Residential treatment
3. Hospital-based inpatient treatment
4. Free standing room and board (when CD treatment is currently authorized and used)
 - a. Effective July 1, 2014, free standing room and board claims must be submitted to MHCP using MN-ITS
5. Service coordination, a form of treatment included in the bundled rate
6. Laboratory services such as serology and toxicology (UDS) can be billed by an independent laboratory if the provider meets the requirements to enroll in the Minnesota Health Care Programs (MCHP) as a provider type 80 (independent laboratory) and meets all the requirements for that provider type.

Service Coordination

Service coordination must be included in the bundled services unit rate. This means Rule 31 licensed providers must offer service coordination to members unless it is “clinically inappropriate and the justifying clinical rationale is documented.”

Refer to the CCDTF Rate Grid found in MN-ITS for possible enrolled service combinations and rates. If you are a residentially licensed provider, the services you provide must be contracted for, authorized, and billed using daily units.

If you are a non-residentially licensed provider, the services you provide must be contracted for, authorized, and billed using hourly units.

Medication-assisted therapies must be contracted for, authorized, and billed using daily units.

Service coordination can be contracted for as a stand-alone service. It can only be provided as a stand-alone service when it is delivered to a member not concurrently receiving services for the same date span with the program delivering the service coordination.

Two different providers may be authorized to deliver treatment and service coordination to the same member, for the same date span. In this situation, the two providers must coordinate their service delivery to ensure provision of their respective services on different days. Failure to do so will result in only one provider receiving payment for days they both provided services.

Detoxification

Detoxification is only covered by IMCare if the service is deemed medically necessary.

Telemedicine

[Per MN Stat. sec. 254B.05, subd. 5, as amended by chapter 78, article 2, sec. 3 of the 2015 Minnesota Session Laws](#), telemedicine/telehealth CD services are covered and paid at the same rate as direct face-to-face services.

The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Services provided via telemedicine have the same service thresholds and authorization requirements as services delivered face-to-face. The originating site should bill using modifier GT (services delivered via interactive audio and video telecommunication systems) for mental health services delivered via telemedicine. IMCare will reimburse the receiving site a facility charge. Please note the receiving site is the site where the member is located. Bill Q3014 for the facility charge.

Please refer to Chapter 16, Mental Health Services, for further information.

Managed Care Members

Members who get Medical Assistance (Medicaid) or MinnesotaCare services through IMCare must work with their county Rule 25 assessor to obtain prior authorization for out of network services (except for Methadone). Programs serving members who get Medical Assistance (Medicaid) or MinnesotaCare services through IMCare must work with IMCare and the county Rule 25 assessor on authorization and payment issues.

[Rule 25 Assessment and Placement Summary \(DHS-2794\)](#)

[Client Placement Authorization \(CPA\) – CCDTF \(DHS-2780\)](#)

CCDTF does not pay for services when the member is enrolled in IMCare. There are only five exceptions to this:

1. The member is placed by a county or tribe into a CD treatment provider classified as an IMD. The county/tribe remains responsible for the member through discharge and CCDTF pays for these services.
2. The member is placed by a county or tribe into an inpatient hospital-based residential program. The county/tribe remains responsible for the member through discharge and CCDTF pays for these services.
3. The member has MinnesotaCare. The provider must immediately refer the member to the [social service agency](#) in his/her county or tribe of residence. The county or tribe will authorize CCDTF to pay for treatment if the individual is CCDTF-eligible. The member receives services at a freestanding room-and-board program or a residential room-and-board program.
5. The member is an American Indian who is enrolled in a prepaid health plan and is placed at a CCDTF-enrolled tribal 638 facility.

Billing Freestanding and Residential Program Room-and-Board Charges for IMCare members

On and after July 1, 2014, bill freestanding or residential program room-and-board charges (revenue codes 1002 and 1003) that are authorized by IMCare to MHCP using [MN-ITS](#) Direct Data Entry ([DDE](#)) or [Batch](#). Report the following information in the “Value Code” field:

1. Value code 80 and the number of inpatient covered days
2. Value code 24 and the appropriate amount from the CCDTF Rate Grid found in in MN-ITS if the facility qualifies for a rate enhancement

A service agreement is not required. Do not report a service agreement number on the claim.

IMCare continues to be the placing authority for enrolled members. Therefore, IMCare will continue to authorize all out of network services, including room and board, for IMCare members. Do not bill for services that require IMCare authorization or services that are in an Appeal process until the services are authorized.

Non-Covered Services

IMCare will not reimburse for the following services/situations:

1. Services provided by a program that does not have a host county/tribal purchase of service contract
2. Services provided by a non-licensed program
3. Services not included in the program's assurance statement filed with MHCP.
4. Services provided by a non-MHCP-enrolled program
5. Services provided by individuals (IMCare only reimburses licensed programs)
6. Room and board services when not clinically/medically necessary
7. Room and board services without a concurrent treatment span
8. Rule 25 chemical use assessments by non-authorized assessors
9. Services delivered to individuals who are not clinically eligible for CCDTF
10. Services delivered prior to the completion of a Rule 25 assessment
11. Services not pre-authorized by a county or tribe with no notification to IMCare
12. Detoxification except for acute medically necessary treatment
13. More than one treatment service for the same member, for the same date span, provided by the same program, except for nonresidential groups and individuals.
14. Services delivered at one location and being billed to another location
15. Guest dosing

Billing

IMCare Authorized Services

The service authorization letter generated when IMCare receives the [Client Placement Authorization \(CPA\) – CCDTF \(DHS-2780\)](#) and [Rule 25 Assessment and Placement Summary \(DHS-2794\)](#) is required to bill for authorized out of network services. Providers must review service authorization letters for accuracy and must not bill from an inaccurate service notification letter. If problems exist on the service notification letter (e.g., incorrect dates, rates, number of units), the provider must contact the authorizing county assessor or tribe and request the necessary changes. Once the changes are made, another service notification letter will be generated. Providers must only bill IMCare when they have received an accurate service notification letter.

Modifiers: Effective April 15, 2016, all modifiers associated with the approved services must be included on the claim in order to be considered for reimbursement. Do not include modifiers on claims with dates of service prior to April 15, 2016. Please refer to the service notification letter when billing.

Programs cannot bill IMCare for services until the program receives a service notification letter. If a program has not received a service notification letter, the program must contact the authorizing county or tribe.

Discharge Date: The [Client Placement Authorization \(CPA\) – CCDTF \(DHS-2780\)](#) and IMCare notification letter will **not** include the discharge date; however, it must be included on the claim as the service end date to follow standard billing practices. Enter the service end date as the date of discharge.

Treatment Services

Treatment services can be delivered as either individual or group services.

Any service that is billed for at a group rate, including all treatment services identified in MN Rules part 9530.6430, subps. 1 – 2, must not exceed the counseling group staffing requirements in MN Rules part 9530.6445, subp. 4 (adults) or MN Rules 9530.6485, subp. 3 (adolescents).

Treatment services, billed by hour of service delivered and specific to the procedure code used.

Providers billing for treatment services must use the appropriate Healthcare Common Procedure Coding System (HCPCS) code based on the American Medical Association's Current Procedural Terminology (CPT).

Treatment services billed in nonresidential programs.

HCPCS code H2035 is used for individual counseling and H2035 HQ is used for group counseling provided in these settings. The code is defined as “alcohol and/or drug counseling per hour.” Because this code is defined by a unit of time, both the Administrative Uniformity Committee (AUC) and CPT language support the concept that the unit of time is attained when the mid-point is passed, and that more than half of the time must be spent performing the service in order to report that code, excluding any breaks. Accordingly, treatment services must last 31 continuous minutes to qualify as an hour of service. Breaks may not be included in these continuous minutes.

Examples:

1. 30 minutes or less of treatment services provided = 0 billable hours
2. 31 minutes of treatment services provided = 1 billable hour
3. 1 hour and 30 minutes of treatment service provided = 1 billable hour
4. 1 hour and 31 minutes of treatment service provided = 2 billable hours

The following are allowed numbers of units for treatment services billed in nonresidential programs:

1. H2035 (individual) – 1 hour per day
2. H2035 HQ (group) – no limit on the amount of hours billed in one day

Treatment services billed in residential programs.

HCPCS code H2036 is used for treatment program services in these settings. H2036 is a per diem code. Accordingly, the five, 15, and 30 hours of clinical services required for the respective intensity level must be provided based upon an actual count of continuous minutes of treatment service provided. Breaks may not be included in these continuous minutes.

Examples:

1. 45 minutes of continuous treatment services provided = .75 hours
2. 1 hour and 45 minutes of continuous treatment services provided = 1.75 hours
3. 2 hours of treatment service with a scheduled 15-minute break during treatment service = 1.75 hours

Type of Bill (TOB)

Enter the appropriate code in the TOB field:

1. 011x is for hospital-based residential treatment
2. 013x is for acute care hospital outpatient services
3. 086x is for the treatment and room and board components of non-hospital-based residential treatment.
4. 089x is for non-hospital-based outpatient treatment

Numeric values for frequency (fourth digit) are as follows:

1. –xxx1: Admit to discharge. This frequency code cannot be used if the patient status is “still a patient” (30) or “expected to return for outpatient services.” It is valid to use with patient status codes 01 – 02, 07, and 20.
2. –xxx2: First claim in a series of continuous claims or interim billing. When submitting the first claim, the admission date field must be the same as the statement date.
3. –xxx3: Continuous claim or interim billing

4. –xxx4: Discharge claim. This frequency code cannot be used if the patient status is “still a patient” (30).
5. –xxx7: A replacement claim
6. –xxx8: A void claim

Discharge Status

Inpatient: Assign the appropriate status for the member that reflects the TOB submitted for the claim.

Outpatient: Always use status 01.

Please refer to Chapter 4, Billing Policy, for further information.

Providers are responsible for checking eligibility for members to determine the existence of a copay and for collecting it from the member. Refer to the [Benefit Charts for Chemical Dependency Treatment Services \(DHS-5161\)](#) for guidance.

Members who have a Medical Assistance (Medicaid) basis of eligibility cannot have services withheld due to an inability to meet their copay responsibility. Providers must follow the IMCare copay policy found in Chapter 4, Billing Policy, under *Copay Guidelines*.

Medicare

Billing procedures do not change for Medicare members who receive CCDTF authorization for CD treatment, unless the provider is an enrolled Medicare facility. Medicare facilities must follow the IMCare Medicare policy found in Chapter 4, Billing Policy.

Third Party Liability (TPL)

For dates of service on or after July 1, 2008, IMCare TPL policy applies to all CD treatment programs. When a member has private commercial insurance, the CD treatment program must first bill the private commercial insurance prior to billing IMCare.

Check eligibility of the member prior to submitting bills to IMCare. If eligibility information indicate there is TPL for the date(s) the provider would like to bill for, then the provider must first bill the TPL displayed in the IMCare HealthX provider portal for those date(s). If a program bills IMCare for dates of service when TPL exists, IMCare will deny the claim.

Once a provider bills TPL, the provider must submit appropriate coordination of benefits (COB) documentation on their electronic claim submission to IMCare. Providers must follow the TPL policy (Billing Policy) found in Chapter 4, Billing Policy.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a program developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services (HHS) to provide screening, intervention, and referrals intended to stop alcohol and substance abuse before they become serious problems. In effect since 2010, [the SBIRT approach](#) has demonstrated that it is an effective way to reduce alcohol and substance abuse.

The approved SBIRT screening tools are short, simple to administer, and include instructions for conducting the screening and intervention strategies. If, following the screening, a member needs a referral for a more thorough

chemical dependency assessment (also known as a Rule 25 assessment), the member is referred to the Social/Family/Human Services department of his/her county of residence or to his/her tribe.

IMCare reimburses providers for conducting SBIRT screenings if billed with the following codes:

1. G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention, 15 – 30 minutes
2. G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention, greater than 30 minutes
3. 99408: Alcohol and/or substance (other than tobacco) abuse structured screening services (e.g., Alcohol Use Disorders Identification Test [AUDIT], Drug Abuse Screen Test [DAST-10]) and screening brief intervention (SBI) services
4. 99409: Alcohol and/or substance (other than tobacco) abuse structured screening services (e.g., AUDIT, DAST-10) and SBI services

IMCare has created the below grid with the proper coding for SBIRT. Please note that Medicare created G0396 and G0397 as a replacement for the CPT codes. IMCare reimburses providers for conducting SBIRT screenings if billed with the following codes:

Code	Description
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15-30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
**G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (AUDIT, DAST, CAGE, etc.) and brief intervention, 15 – 30 minutes
**G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (AUDIT, DAST, CAGE, etc.) and intervention, greater than 30 minutes

**When billing this service for Medicare members, “G” codes must be used.

The following screens/structured assessments are accepted for use in the SBIRT process:

1. [Alcohol Use Disorders Identification Test \(AUDIT or AUDIT-C\)](#)
2. [National Institute on Drug Abuse Medical Screening \(NIDAMED\)](#)
3. [Drug Abuse Screen Test \(DAST-10\)](#)
4. [CAGE Adapted to Include Drugs \(CAGE-AID\)](#)
5. [Alcohol, Smoking and Substance Involvement Screening Test \(ASSIST\)](#)
6. [CRAFT](#)

Legal References

[MN Stat. sec. 254A.03](#) – State Authority on Alcohol and Drug Abuse

[MN Stat. Chap. 254B](#) – Chemical Dependency Treatment

[MN Stat. sec. 256L](#) – MinnesotaCare

[MN Rules parts 2960.0010 – 2960.0220](#) – Licensure and Certification of Programs for Children; Additional Standards for Group Residential Settings

[MN Rules parts 2960.0430 – 2960.0490](#) – Chemical Dependency Treatment Program Certification Standards

[MN Rules parts 9530.6405 – 9530.6505](#) – Chemical Dependency Licensed Treatment Facilities

[MN Rules part 9530.6505](#) – Requirements for Licensed Residential Treatment

[MN Rules parts 9530.6600 – 9530.6655](#) – Chemical Dependency Care for Public Assistance Recipients

[MN Rules parts 9530.7000 – 9530.7030](#) – Consolidated Chemical Dependency Treatment Fund

[MN Rules parts 9530.6800 – 9530.6810](#) – Need for Chemical Dependency Treatment Programs

[Title 42 Code of Federal Regulations \(CFR\) Part 440.130\(d\)](#) – Diagnostic, screening, preventive, and rehabilitative services

[Title 42 Code of Federal Regulations \(CFR\) Part 2](#) – Confidentiality of Alcohol and Drug Abuse Patient Records