DEPARTMENT OF HUMAN SERVICES

Side-by-Side Legislative Changes 2025: Substance Use Disorder Billing

Includes: Changes to substance use disorder (SUD) treatment services billing procedures and rates.

Please note that there are legislative changes in section 254B.05, subdivision 5 in both HF 3 and HF 2115. To help distinguish these changes, HF 3 changes are shown in red text and the HF 2115changes are shown in purple text.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained for sections which require approval.

Chapter Section Subd	Previous Statute Language	Updated Statute Language	Effective Date	Chapter/ Article/ Section
254B.05, subd. 5	Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter. (b) Eligible substance use disorder treatment services include: (1) those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to the following ASAM levels of care: (i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1); (ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2); (iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);	Subd. 5. **Rate requirements.** (a) Subject to the requirements of subdivision 6, the commissioner shall establish rates for the following substance use disorder treatment services ~~and service enhancements~~ funded under this chapter~~.~~: ~~(b) Eligible substance use disorder treatment services include:~~ (1) those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to the following ASAM levels of care: (i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1); (ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2); (iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);	July 1, 2025, except for the change to the new paragraph (a), clause (4), which is effective July 1, 2026, or upon federal approval, whichever is later August 1, 2025	HF 3 Chapter 9, Article 4, Section 33 HF 2115 Chapter 38, Article 4, Section 32

	(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4); (v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5). The commissioner shall use the base payment rate of $79.84 per day for services provided under this item; (vi) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled treatment services each week. The commissioner shall use the base payment rate of $166.13 per day for services provided under this item; (vii) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item; and (viii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item; (2) comprehensive assessments provided according to section 254A.19, subdivision 3; (3) treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5); (4) peer recovery support services provided according to section 245G.07, subdivision 2;	(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4); (v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5)~~. The commissioner shall use the base payment rate of $79.84 per day for services provided under this item~~; (vi) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled treatment services each week~~. The commissioner shall use the base payment rate of $166.13 per day for services provided under this item~~; (vii) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6)~~. The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item~~; and (viii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7)~~. The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item~~; (2) comprehensive assessments provided according to section 254A.19, subdivision 3; (3) treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5); (4) peer recovery support services provided according to section 245G.07, subdivision ~~2~~ 2a, paragraph (b), clause (8) (2);		

	(5) withdrawal management services provided according to chapter 245F; (6) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to 144.56; (7) substance use disorder treatment services with medications for opioid use disorder provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or under an applicable Tribal license; (8) medium-intensity residential treatment services that provide 15 hours of skilled treatment services each week and are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license; (9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable Tribal license; (10) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and (11) room and board facilities that meet the requirements of subdivision 1a. (c) The commissioner shall establish higher rates for programs that meet the requirements of	(5) withdrawal management services provided according to chapter 245F; (6) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to 144.56; (7) substance use disorder treatment services with medications for opioid use disorder provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or under an applicable Tribal license; (8) medium-intensity residential treatment services that provide 15 hours of skilled treatment services each week and are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license; (9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable Tribal license; (10) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and (11) room and board facilities that meet the requirements of subdivision 1a. ~~(c)~~ (b) The commissioner shall establish higher rates for programs that meet the requirements of		

	paragraph (b) and one of the following additional requirements: (1) Programs that serve parents with their children if the program: (i) provides on-site child care during the hours of treatment activity that: (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or (B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or (ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as: (A) a child care center under Minnesota Rules, chapter 9503; or (B) a family child care home under Minnesota Rules, chapter 9502; (2) Culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a; (3) Disability responsive programs as defined in section 254B.01, subdivision 4b; (4) Programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week if the medical needs of the client and the nature	paragraph ~~(b)~~ (a) and ~~one of the following additional requirements: the requirements of one clause in this paragraph.~~ (1) Programs that serve parents with their children ~~are eligible for an enhanced payment rate~~ if the program: (i) provides on-site child care during the hours of treatment activity that: (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or (B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or (ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as: (A) a child care center under Minnesota Rules, chapter 9503; or (B) a family child care home under Minnesota Rules, chapter 9502~~;~~. In order to be eligible for a higher rate under this clause, a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services. (2) Culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a~~;~~, are eligible for an enhanced payment rate. (3) Disability responsive programs as defined in section 254B.01, subdivision 4b~~;~~, are eligible for an enhanced payment rate. (4) Programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week are eligible for an enhanced payment rate if the medical needs of the client and the nature and		

	and provision of any medical services provided are documented in the client file; or (5) Programs that offer services to individuals with co-occurring mental health and substance use disorder problems if: (i) the program meets the co-occurring requirements in section 245G.20; (ii) the program employs a mental health professional as defined in section 245I.04, subdivision 2; (iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission; (iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented; (v) family education is offered that addresses mental health and substance use disorder and the interaction between the two; and (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually. (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services. (e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to	provision of any medical services provided are documented in the client file~~; or.~~ (5) Programs that offer services to individuals with co-occurring mental health and substance use disorder problems are eligible for an enhanced payment rate if: (i) the program meets the co-occurring requirements in section 245G.20; (ii) the program employs a mental health professional as defined in section 245I.04, subdivision 2; (iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission, excluding weekends and holidays; (iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented; (v) family education is offered that addresses mental health and substance use disorder and the interaction between the two; and (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually. ~~(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services.~~ ~~(e)~~ Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to		

	2960.0690, are exempt from the requirements in paragraph (c), clause (5), items (i) to (iv). (f) Substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. (g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio. (h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner. (i) Payment for substance use disorder services under this section must start from the day of service initiation, when the comprehensive assessment is completed within the required timelines. (j) A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this	2960.0690, are exempt from the requirements in ~~paragraph (c), clause (5),~~ items (i) to (iv). ~~(f)~~ (c) Substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. ~~(g)~~ (d) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio. ~~(h)~~ ~~(e)~~ Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner. ~~(i)~~ (f) Payment for substance use disorder services under this section must start from the day of service initiation, when the comprehensive assessment is completed within the required timelines. ~~(j)~~ (g) A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this		

	paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence. (k) Hours in a treatment week may be reduced in observance of federally recognized holidays. (l) Eligible vendors of peer recovery support services must: (1) submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity of peer recovery support services for entities billing for peer recovery support services individually and not receiving a daily rate; and (2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services. (m) Peer recovery support services not provided in accordance with section 254B.052 are subject to monetary recovery under section 256B.064 as money improperly paid.	paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence. ~~(k)~~ (h) Hours in a treatment week may be reduced in observance of federally recognized holidays. ~~(l)~~ (i) Eligible vendors of peer recovery support services must: (1) submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity of peer recovery support services for entities billing for peer recovery support services individually and not receiving a daily rate; and (2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services. ~~(m)~~ (j) Peer recovery support services not provided in accordance with section 254B.052 are subject to monetary recovery under section 256B.064 as money improperly paid.		
254B.05, Subd. 6		Subd. 6. **Rate adjustments.** (a) Effective for services provided on or after January 1, 2026, the commissioner must implement the following base payment rates for substance use disorder treatment services under subdivision 5, paragraph (a): (1) for low-intensity residential services, 100 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18; (2) for high-intensity residential services, 83 percent of the modeled rate included in the final	July 1, 2026, or upon federal approval, whichever is later	HF 3 Chapter 9, Article 4, Section 34

		report required by Laws 2021, First Special Session chapter 7, article 17, section 18; and (3) for treatment coordination services, 100 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18. (b) Effective January 1, 2027, and annually thereafter, the commissioner of human services must adjust the payment rates under paragraph (a) according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.		
254B.06, Subd. 5	N/A	Subd. 5. **Prohibition of duplicative claim submission.** (a) For time-based claims, submissions must follow the guidelines in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System and the American Medical Association's Current Procedural Terminology to determine the appropriate units of time to report. (b) More than half the duration of a time-based code must be spent performing the service to be eligible under this section. Any other claim submission for service provided during the remaining balance of the unit of time is duplicative and ineligible. (c) A provider may only round up to the next whole number of service units on a submitted claim when more than one and one-half times the defined value of the code has occurred and no additional time increment code exists.	July 1, 2025	HF 2115 Chapter 38, Article 4, Section 33

62Q.75, Subd. 3	Subd. 3. **Claims filing.** Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six-month submission requirement may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Any request by a health care provider or facility specified in subdivision 2 for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline. This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.	Subd. 3. **Claims filing.** (a) Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. (b) A health care provider or facility that does not make an initial submission of charges within the six-month period in paragraph (a), the 12-month period in paragraph (c), or the additional six-month period in paragraph (d) shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. (c) The six-month submission requirement in paragraph (a) may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. (d) The six-month submission requirement in paragraph (a) must be extended an additional six months if a health plan company or third-party administrator makes any adjustment or recoupment of payment. The additional six months begins on the date the health plan company or third-party administrator adjusts or recoups the payment. (e) Any request by a health care provider or facility under paragraph (c) or (d)	August 1, 2025	HF 2115 Chapter 38, Article 9, Section 1

		must reference that the submission is pursuant to this subdivision. (e) Any request by a health care provider or facility under paragraph (c) or (d) must reference that the submission is pursuant to this subdivision. (f) Any request by a health care provider or facility specified in subdivision 2 for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline. (g) This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.		
		DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT BILLING UNITS. The commissioner of human services must establish six new billing codes for nonresidential substance use disorder individual and group counseling, individual and group psychoeducation, and individual and group recovery support services. The commissioner must identify reimbursement rates for the newly defined codes and update the substance use disorder fee schedule. The new billing codes must correspond to a 15-minute unit and become effective for services provided on or after July 1, 2026, or upon federal approval, whichever is later.	July 1, 2026, or upon federal approval, whichever is later	HF 3 Chapter 9, Article 4, Section 53