254B.06 REIMBURSEMENT; PAYMENT; DENIAL.

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for substance use disorder services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. The remaining receipts must be deposited in the behavioral health fund.

Subd. 2. **Allocation of collections.** The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

Subd. 3. **Payment; denial.** The commissioner shall pay eligible vendors for placements made by local agencies under section 254B.03, subdivision 1, and placements by tribal designated agencies according to section 254B.09. The commissioner may reduce or deny payment of the state share when services are not provided according to the placement criteria established by the commissioner. The commissioner may pay for all or a portion of improper county substance use disorder placements and bill the county for the entire payment made when the placement did not comply with criteria established by the commissioner. The commissioner may make payments to vendors and charge the county 100 percent of the payments if documentation of a county approved placement is received more than 30 working days, exclusive of weekends and holidays, after the date services began. The commissioner shall not pay vendors until private insurance company claims have been settled.

Subd. 4. **Reimbursement for institutions for mental diseases.** The commissioner shall not deny reimbursement to a program designated as an institution for mental diseases under United States Code, title 42, section 1396d, due to a reduction in federal financial participation and the addition of new residential beds.

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.

History: *1986 c 394 s 13; 1987 c 299 s 15; 1989 c 282 art 2 s 107; 1992 c 513 art 7 s 13; 1Sp1993 c 1 art 3 s 21; 2007 c 147 art 11 s 16; 1Sp2010 c 1 art 19 s 14; 1Sp2011 c 9 art 8 s 5; 2016 c 189 art 16 s 8,9; 1Sp2019 c 9 art 6 s 50,51; 2021 c 30 art 13 s 83; 2022 c 98 art 4 s 51; 2025 c 38 art 4 s 33*