EFFECTIVE 10/1/16 ADDITIONAL CHANGES TO:
CASE CONSULTATIONS, FAMILY
CONSULTATIONS, AND COLLATERAL CONTACT
AUTHORIZATION PROCEDURES AND
PARAMETERS

The following information should be noted immediately by your chief executive officer, chief medical
officer, chief operating officer, chief financial officer, program director, quality management director,
compliance officer, billing director, and staff.

The Massachusetts Behavioral Health Partnership (MBHP)/Health New England Be Healthy (HNE BH) has long recognized the importance of active and effective coordination of care between behavioral health, medical, and other treating providers for our Members. To that end, Members (adult and child) have the benefit of case consultations and family consultations. In recognition of the special needs that children and adolescents under the age of 21 require, providers may also access collateral contacts for this segment of the Member population.

In an effort to better meet the needs of our Members and to facilitate coordinating services and communicating appropriately with those involved in the Member’s care, the MassHealth Managed Care Entities (MCEs) have worked together to align the program specifications of these codes.

Outpatient Services providers are to utilize case consultation, family consultation, and collateral contacts to involve parents/guardians/caregivers in the planning, assessment, and treatment for Members, as clinically indicated, and to educate them on mental health and substance use disorder treatment and relevant recovery issues. Additionally, with Member consent and as applicable, Outpatient Services providers are to utilize case consultation and collateral contacts in order to involve the collaterals identified within the Care Coordination section of the General performance specifications in the planning, assessment, and treatment for Members. All such activities are to be documented in the Member’s health record and releases of information obtained, as required.

Please read this information carefully and be sure that it is communicated to all clinicians and billing staff in your agency. This information can also be found in the Outpatient Services Performance Specifications on the MBHP/HNE BH website at https://www.masspartnership.com/HNE/default.aspx. Questions should be directed to our
Community Relations Department at 1-800-495-0086.

**Case Consultation**, Service Code 90882
(Please see your outpatient fee schedules for use of modifiers and descriptions.)

**Definition:** a documented meeting of at least 15 minutes’ duration, either in person or by telephone, between the treating provider and other behavioral health/medical clinicians or physician, concerning a Member who is a client of the BH provider.

Goals of case consultation are to identify and plan for additional services, coordinate a treatment plan, review the individual’s progress, and revise the treatment plan, as required.

The scope of required service components provided includes, but is not limited to the following:

- Treatment coordination
- Treatment planning
- Assessment of the appropriateness of additional or alternative treatment
- Clinical consultation (which does not include supervision)
- Second clinical opinion
- Aftercare planning
- Termination planning

**Requirements:**

- The provider who submits the claim must obtain appropriate documentation, including the date and time of the consultation, names of all parties involved, purpose of consultation, and whether the consultation was in-person or telephonic. Documentation should also include what actions will occur as a result of the consultation.
- The meeting is either between two outpatient providers who do not share the same provider number or between the outpatient provider and any behavioral health provider offering services at a different level of care, or between the treating outpatient provider and a representative from a school, state, medical office, or residential provider.
- Multiple providers with different provider numbers may bill for the same case consultation if more than one provider is present or on a phone conference.

**Limitations:**

- One unit equals 15 minutes. There is no maximum unit restriction/day.
- Consultations are authorization free.
- The provider must be contracted with MBHP/HNE BH in order to be reimbursed for these services.

**Family Consultation**, Service Code 90887
(Please see your outpatient fee schedules for the use of modifiers and descriptions.)

**Definition:** a documented meeting of at least 15 minutes’ duration, either in person or by telephone, between the treating provider and with family members or others who are significant to the Member.
and clinically relevant to a Member’s treatment
Goals of family consultation are to educate, identify, and plan for additional services or resources, coordinate a treatment plan, review the individual’s progress, or revise the treatment plan, as required.

The scope of required service components provided includes, but is not limited to, the following

- Treatment coordination
- Treatment planning with the Member’s family or identified supports
- Assessment of the appropriateness of additional or alternative treatment
- Aftercare planning
- Termination planning
- Supporting or reinforcing treatment objectives for the Member’s care

Requirements:
- The provider who submits the claim must maintain appropriate documentation, including the date and time of the consultation, names of all parties involved, purpose of consultation, and whether it was in-person or telephonic. Documentation should also include what actions will occur as a result of the consultation.
- Multiple providers with different provider numbers may bill for the same family consultation if more than one provider is present or on a phone conference.

Limitations:
- One unit equals 15 minutes. There is no maximum unit restriction/day.
- Consultations are authorization free.
- The provider must be contracted with MBHP/HNE BH in order to be reimbursed for these services.

Collateral Contact, Service Code H0046
(please see your outpatient fee schedules for the use of modifiers and descriptions)

Definition: a documented communication of at least 15 minutes’ duration, either in-person, by telephone (including voice mails), or by email. These contacts are between a provider and individuals who are involved in the care or treatment of a Member under the age of 21. This would include, but is not limited to: school and day care personnel, state agency staff, human services agency staff, court-appointed personnel, religious or spiritual advisers, and/or other community resources.

The scope of required service components provided includes, but is not limited to, the following

- Treatment coordination
- Treatment planning with the Member’s family or identified supports
- Implementation of additional or alternative treatment
- Aftercare planning
- Termination planning
- Supporting or reinforcing treatment objectives for the Member’s care
**Requirements:**

- The provider who submits the claim must obtain appropriate documentation, including the date and time of the contact, names of all parties involved, purpose of contact, and whether the contact was in-person, telephonic, or by email.
- Multiple providers with different provider numbers may bill for the same collateral contact if more than one provider is present or is part of a phone conference.

**Limitations:**

- One unit equals 15 minutes. There is no maximum unit restriction/day.
- Consultations are authorization free.
- The provider must be contracted with MBHP/HNE BH in order to be reimbursed for these services.

**Periodic Record Audits**

To ensure quality of the consultations and per state requirements, MBHP/HNE BH will schedule periodic record audits with providers who receive reimbursement for any of the services contained in this *Alert*. Reimbursement for these services is contingent upon appropriate documentation within the medical record. During the audit, records corresponding to a list of paid claims and dates of service will be reviewed to verify that all required documentation is present.

Payment will be subject to recoupment if any of the required medical necessity criteria, documentation, parameter or exclusion requirements, as noted above, have not been met.