POLICY AND PROCEDURE

POLICY NAME: Family Centered Treatment In Lieu of Services	**POLICY ID:** ARTC.UM.21
BUSINESS UNIT: Arkansas Total Care	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 01/01/2026	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 10/6/2025	
REGULATOR MOST RECENT APPROVAL DATE(S): Refer to system of record – Archer	

POLICY STATEMENT:
All Areas and Departments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

PURPOSE:
The purpose of this policy and procedure is to outline the procedure for authorization of Family Centered Treatment In Lieu of Services (FCT) for the Plan's members.

SCOPE:
This policy applies to employees of the Utilization Management (UM) Department of Arkansas Total Care (ARTC). This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

DEFINITIONS:

Family Centered Treatment® (FCT) is a comprehensive, evidence-based trauma treatment model of intensive in-home services for at-risk children, adolescents and their families. FCT is a preventative, stabilization and reunification service designed to end cycles of maladaptive family functioning and break the multi-generational transmission of trauma. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. Services included in FCT are:

- Family-based trauma services
- Youth and family skills training
- Behavioral interventions
- Analysis of maladaptive behaviors that lead to home disruption
- Implementation of behavior plans
- Relationship/attachment building between youth and family members
- Active coaching with family members to identify and replace maladaptive behaviors with new positive behaviors
- Empowering families to develop goals for themselves toward improving family functions
- Crisis interventions twenty-four (24) hours per day, seven (7) days per week

In Lieu Of Services: In general, these services are not covered by Medicaid and therefore are not a PASSE-covered benefit. However, the PASSE may determine it is more cost effective to provide a non-covered service in lieu of more expensive care which is covered under the PASSE program. The cost of the non-covered service may be reported in the numerator of the plan's MLR, and the capitation rate development will include the cost of the covered service that was replaced by the non-covered "in lieu of' service.

Medical Necessity: Medically necessary services are those that:

- Are appropriate and consistent with the diagnosis of the treating practitioner and the omission of which could adversely affect the member's medical or behavioral health (BH) condition.

- Are compatible with the standards of acceptable medical practice in the community.
- Are provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.
- Are not provided solely for the convenience of the member, the practitioner, or the facility providing care.
- Are not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage and appropriate; and
- There must be no other effective and more conservative or substantially less costly treatment, service and setting available.
- Treat the prevention, diagnosis, and treatment of the member's disease, condition, and/or disorder that results in health impairments and/or disability.
- Allow for the ability for the member to achieve age-appropriate growth and development.
- Allow for the ability for the member to attain, maintain, or regain functional capacity; and
- Allow the opportunity for the member receiving LTSS to have access to the benefits of community living, achieve person-centered goals, and live and work in the setting of their choice.

POLICY:

The Plan authorizes FCT as In Lieu of services for members between the age of 4 and 18 who meet the eligibility requirements and medical necessity requirements of the service. To meet the requirements for eligibility and medical necessity for FCT, the plan requires all of the following

1. The member meets all eligibility requirements listed under procedures below.
2. The FCT provider has submitted the required request form, medical records, treatment plan, assessments, and/or monthly updates in their entirety.
3. The FCT provider must be in-network for the plan, and meet all of the Arkansas Department of Human Services requirements, including, but not limited to:
    a. Training and certification
    b. Appropriate supervision of staff.
    c. Staffing and Program Requirements.
4. FCT services requested must include:
    a. At least two direct multiple hour sessions per week, adjusted as indicated by the youth and family's involving needs.
    b. Family involvement in services must include 85% of the time direct clinical work with the family, and documentation is submitted to support this evidence.
5. No other Home and Community Based Service (HCBS) can be provided to a member while they are receiving FCT. Counseling level service may continue **including individual or family psychotherapy which is required.**
    a. If a member has an open HCBS authorization, the UM team will follow our procedure to end that authorization prior to authorization of FCT.
    b. It is **a requirement** for participation in FCT that the member continue individual or family psychotherapy on **<u>at least a monthly basis</u>** while receiving FCT.
        i. If there are barriers for monthly therapy, the FCT provider should document those barriers and how those barriers are being overcome and include the documentation with all requests
        ii. The FCT provider, if not the provider providing Psychotherapy, should collaborate with the therapy provider (and other providers) on the member during treatment.
        iii. The request is for the appropriate billing codes
    a. H0037 U4 , V1 Monthly
    b. H0037 U4, , V2 Daily
6. The request for services **<u>must be approved prior to the start of services if ARTC will be billed for the service.</u>**
7. The FCT treatment plan is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs.

8. FCT can be safely furnished, and no other service/treatment is available statewide that will be as equally effective and more conservative, or less costly.
9. FCT is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.
10. The member meets and continues to meet the eligibility requirements for this service, and treatment goals have not yet been achieved. Services and interventions must be reviewed for effectiveness, and interventions should be modified, if necessary, so that the individual makes greater progress.

PROCEDURE:

Authorization Protocols (Initial and Reauthorization)

The plan determines medical necessity for FCT as per established UM processes when a request is received. The plan requires that all FCT requests meet the requirements below, and that appropriate assessments, request forms, treatment plans, and/or monthly updates are included as part of the medical records provided with the request.

1. Eligibility requirements: For FCT medical necessity determination, the member must meet all of the following criteria:
    a. Member **meets ALL** of the following:
        i. Children aged 4 through 18 with a confirmed diagnosis of mental health or a co-occurring disorder
        ii. A mental health evaluation/FCT assessment determines FCT is appropriate
        iii. Guardian/Caregiver must be available to participate actively in the treatment process, as FCT is designed to promote family stability and prevent out-of-home placements
    b. Member has **at least ONE** of the following:
        i. At significant risk of losing current placement or undergoing potential out-of-home placement related to a mental health diagnosis or behavioral challenges
        ii. Presence of serious behavioral problems at home, in school, or amongst peers
        iii. Symptoms (such as) of physical aggression or severe emotional distress that is unmanageable in current setting
        iv. Current need for crisis intervention services to mitigate multiple episodes of high-risk behaviors.
    c. Member meets **at least ONE** of the following:
        i. Difficulties in coordinating appropriate care in the community
        ii. Individual will not benefit from, or have not benefited from, lower levels of care (multiple outpatient treatment episodes without long term success)
        iii. Unsuccessful with previous level of care (residential, sub-acute, and Counseling Level services, etc.)
        iv. History of involvement with multiple systems such as child welfare or juvenile justice and documented difficulties in engaging with previous treatments

2. **ARTC will utilize InterQual criteria to determine medical necessity**. Requests can be submitted 14 days prior to the start date.

    a. The initial request will be reviewed for 90 calendar days.
        i. The Provider must submit the assessment and the treatment plan.
    b. Concurrent (additional) reviews will be reviewed for 30 calendar days.
        i. **For concurrent reviews, the monthly update/request form(s) are required medical records for FCT and must be filled out completely.** For the first concurrent review after the initial request, the provider must submit 2 months of completed monthly updates as part of the records required to meet medical necessity.

3. The request may include Per Diem (Daily Units) and/or Monthly units.

a. Per diem (daily unit) and Monthly units (rolling 30 days) cannot overlap.
    i. If there were per diem units authorized prior to the monthly code/modifier, those dates will have to be ended prior to monthly start date.
    ii. A provider must not bill for the monthly FCT rate until the monthly minimum service delivery has occurred.
    iii. If a provider has a monthly FCT authorization and the member discharges prior to meeting the requirements of that month, the FCT provider needs to contact UM to end the monthly authorization and review for per diem units prior to discharge.
    iv. Per diem (daily rate) billing may only occur if a face-to-face service has been provided.

b. Per Diem billing should only be requested in the following circumstances:
    i. Up to a 45-day transition period as member is being discharged from a residential treatment center (RTC) setting.
    ii. The member's discharge will occur prior to meeting the monthly minimum requirements.
c. If Per diem units are requested while a member is in RTC, the provider **must submit** the assessment and the treatment plan with the request.

4. Continuation of services
    a. FCT will continue to meet medical necessity, with appropriate documentation, if the member does not meet discharge criteria, and appropriate progress for the member/family is made as evidenced by at least one of the following:
        i. The member/family is making satisfactory progress toward meeting goals and there is documentation that supports the fact that continuation of this service will be effective in addressing the goals outlined in the Treatment Plan and Person-Centered Service Plan, OR
        ii. The member/family is making some progress, but the specific interventions in the Treatment Plan need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible; OR,
        iii. The member/family has yet to make progress, or demonstrate regression, in meeting goals through the interventions outlined in the Treatment Plan.
            1. The member's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services.
    b. Discharge from FCT is indicated if one of the following criteria is met:
        i. The member has achieved goals and is no longer in need of FCT services; OR,
        ii. The member's level of functioning has improved with respect to the goals outlined in the Treatment Plan, inclusive of a transition plan to step down to a lower level of care; OR,
        iii. The member is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; OR,
        iv. The member or legally responsible person no longer wishes to receive FCT services; OR,
        v. The member, based on presentation and lack of improvement despite modifications in the Treatment Plan, requires a more appropriate best practice treatment modality. or
        vi. Failure of the member's parent/guardian or legally responsible person to participate in FCT at the level required.

REFERENCES:

ATTACHMENTS:
Family Centered Therapy In Lieu of Service: Program Requirements for providers.
Family Centered Therapy Initial Prior Authorization Request Form.

ROLES & RESPONSIBILITIES: NA

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	N/A	10/2025

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.