Family Centered Treatment In Lieu of Service

Reference Number: AR.CP. BH.504
Last Review Date: 02/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

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.

This is a time-limited, intensive intervention that is intended to accomplish the following as applicable:

- Prevent out-of-home placement for the member.
- Ensure successful transitions of care from residential services to home settings.
- Reduce presenting psychiatric or co-morbid disorder symptoms.
- Provide initial and on-going crisis response interventions.
- Ensure linkage to community services and resources.
- Improve youth and family functioning.

Children and adolescents eligible for FCT may be involved in the juvenile justice system, child welfare system, residing in out-of-home placements and in need for reunification and may display severe emotional and behavioral challenges due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse, etc.), and/or serious mental health disorders. By improving youth and family functioning, FCT may be used:

- as a step-down program for youth leaving residential placements; or,
- to provide an alternative to out-of-home placement; or,
- when it is in the youth's best interest to receive services out of the home; or,
- to minimize the length of stay and reduce the risk of readmission.

FCT is one of few multifaceted home-based service models with extensive experience with youth with severe emotional and behavioral challenges, child welfare needs and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. FCT providers are expected to adopt a "no reject, no eject" admission approach and provide 24/7 crisis services as needed.

Note: 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.*** *If a member has an open HCBS authorization, the UM team will follow our procedure to end that authorization prior to authorization of FCT.*

Family Centered Treatment Providers should meet all program requirements as outlined in the ARTC FCT Program requirements for providers found on the ARTC website at this link: https://www.arkansastotalcare.com/providers/resources.html

Policy/Criteria

I. It is the policy of Arkansas Total Care that Family Centered Therapy (FCT) is **medically necessary, upon initial review,** for the following indications:
   A. Eligibility requirements: For FCT medical necessity determination, the member must meet all of the following criteria:
      1. Member **meets ALL** of the following:
         a) Children aged 4 through 18 with a confirmed diagnosis of mental health or a co-occurring disorder
         b) A mental health evaluation/FCT assessment determines FCT is appropriate
         c) 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
      2. Member has **at least ONE** of the following:
         a) At significant risk of losing current placement or undergoing potential out-of-home placement related to a mental health diagnosis or behavioral challenges
         b) Presence of serious behavioral problems at home, in school, or amongst peers
         c) Symptoms (such as) of physical aggression or severe emotional distress that is unmanageable in current setting
         d) Current need for crisis intervention services to mitigate multiple episodes of high-risk behaviors.
      3. Member meets **at least ONE** of the following:
         a) Difficulties in coordinating appropriate care in the community
         b) Individual will not benefit from, or have not benefited from, lower levels of care (multiple outpatient treatment episodes without long term success)
         c) Unsuccessful with previous level of care (residential, sub-acute, and Counseling Level services, etc.)
         d) History of involvement with multiple systems such as child welfare or juvenile justice and documented difficulties in engaging with previous treatments
      4. It is **a requirement** for participation in FCT that the member continue individual or family psychotherapy on **at least a monthly basis** while receiving FCT.
         a) 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
         b) The FCT provider, if not the provider providing Psychotherapy, should collaborate with the therapy provider (and other providers) on the member during treatment.

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

The initial request will be reviewed for 90 calendar days.

II. It is the policy of Arkansas Total Care that FCT is **medically necessary, for continuation of services review,** for the following indications:

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:
   1. 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
   2. 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,
   3. The member/family has yet to make progress, or demonstrate regression, in meeting goals through the interventions outlined in the Treatment Plan.

      a) 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. It is **a requirement** for participation in FCT that the member continue individual or family psychotherapy on **at least a monthly basis** while receiving FCT.
   b) 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
   c) The FCT provider, if not the provider providing Psychotherapy, should collaborate with the therapy provider (and other providers) on the member during treatment.

C. **ARTC will utilize InterQual criteria to determine medical necessity**.

Concurrent (additional) reviews will be reviewed for 30 calendar days.

III. It is the policy of Arkansas Total Care for FCT that discharge from FCT is indicated for the following indications:
A. Member **meets at least one** of the following indications:
   1. The member has achieved goals and is no longer in need of FCT services.
   2. 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.

3. 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.
4. The member or legally responsible person no longer wishes to receive FCT services.
5. The member, based on presentation and lack of improvement despite modifications in the Treatment Plan, requires a more appropriate best practice treatment modality.
6. Failure of the member's parent/guardian or legally responsible person to participate in FCT at the level required.
7. Member is not receiving required individual or family psychotherapy on a monthly basis despite documentation of removal of barriers.

IV. It is the policy of Arkansas Total Care for FCT that the following documentation requirements must be met:

A. The FCT provider has submitted the required request form, medical records, treatment plan, assessments, and/or monthly updates in their entirety.

B. FCT services requested must include:
   1. At least two direct multiple hour sessions per week, adjusted as indicated by the youth and family's involving needs.
   2. Family involvement in services must include 85% of the time direct clinical work with the family, and documentation is submitted to support this evidence.

C. The request may include Per Diem (Daily Units) and/or Monthly units.
   1. Per diem (daily unit) and Monthly units (rolling 30 days) cannot overlap.
      a) 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.
      b) A provider must not bill for the monthly FCT rate until the monthly minimum service delivery has occurred.
      c) 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.
      d) Per diem (daily rate) billing may only occur if a face-to-face service has been provided.
      e) Monthly unit must consist of at least 10 direct documented service hours every 30 day time period.

   2. Per Diem billing should only be requested in the following circumstances:
      a) Up to a 45-day transition period as member is being discharged from a residential treatment center (RTC) setting.
      b) The member's discharge will occur prior to meeting the monthly minimum requirements.
   3. 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.

D. For concurrent reviews, the monthly update/request form(s) are required medical records for FCT and must be filled out completely.

1. 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.

Background

A guiding principle of FCT is that it is family centered. While the referred client is integral to the process, FCT is a family system model and includes with family members when their behaviors or roles are critical to the progress of the referred family member (client). FCT highlights the importance of family voice and caregiver empowerment. By engaging the family system into services, FCT strengthens the family's problem-solving skills and operant family functioning systems, including how they communicate, handle conflict, meet the needs for closeness and manage the tasks of daily living that are known to be related to poor outcomes for children/youth. The caregiver must be an active participant in the development of goals and delivery of interventions throughout services.

FCT places emphasis on support systems—both during and after services. FCT develops a system of community resources and natural supports based on the youth and family's needs and preferences to enhance the individualized treatment plan. Building a network of support will also promote sustainable outcomes by providing the youth and family with resources to utilize after discharge. Other individuals/supports that may have key roles in the youth's wellbeing (e.g., caregivers, immediate and extended family, community members, stakeholders, psychiatrists, referral sources, other providers, community programming, etc.) are also viewed as critical to the success of FCT and are, at minimum, informed of progress. They can be more integrally involved based on the family's needs and preferences.

Family Centered Treatment Goals and Objectives:

1. Enable family stability via preservation of or development of family placement or reunification by fostering necessary shifts in family functioning that underly the causes of family dissolution.

2. Address maladaptive behaviors affecting family functioning by experientially practicing new interactions and learning the underlying function of the behaviors while developing an emotional and functional balance so the family can cope effectively with present and future challenges.

3. Support discovery and effective use of the intrinsic strengths necessary for sustaining change and upholding stability by incorporating generational, cultural and systemic influences of trauma while harnessing the power of giving and instilling hope.

FCT Four Phases of Treatment

FCT is comprised of four phases, and the entire family system and support networks are intentionally engaged across all phases.

- Phase 1-Joining and Assessment: Rapport building, especially with the caregiver(s), identify family strengths, gain acceptance and trust, assess for systematic changes and adjustments. (Family Centered Evaluation©)
- Phase 2-Restructuring: Enactments (experiential practice) target repetitive emotional and behavioral patterns (i.e., family structure) to shift and develop healthier, more functional patterns. The family progressively takes ownership of the problems, a necessary pre-requisite for progressing to Phase 3.
- Phase 3-Valuing Change: The family is challenged to question and define the reasons for the change. Sustainable change in a family system occurs when the emotional-behavioral changes made during restructuring are valued, seen as necessary by the family and thereby internalized.
- Phase 4-Generalization: Skill adoption and family success. Family becomes able to use strategies independently and plan how they will use their new competencies and confidence to navigate future predictable and unpredictable challenges.

Trauma in Families

Family Centered Treatment is an identified SAMHSA National Child Traumatic Stress Network (NCTSN) trauma intervention. Trauma, particularly in vulnerable families, often affects both individuals and the entire family system leading to issues such as anxiety, depression, behavioral problems, and interpersonal conflict. FCT addresses the impact of trauma on the whole family, not just the individual. By focusing on healing the family dynamic, FCT helps strengthen relationships, improve communication, and promote long-term recovery.

How FCT Addresses Trauma

Family Centered Treatment recognizes that trauma does not just affect one person in isolation, but ripples through the family structure, affecting communication patterns, parenting styles, and conflict resolution strategies. Trauma-informed approaches in FCT help families:

1. **Understand the impact of trauma:** Family members learn how trauma influences their behavior, emotional responses, and relationships. This includes exploring how past traumatic events influence current family dynamics, particularly in areas like communication and problem-solving.
2. **Address trauma in the context of family roles:** FCT works with the family system to highlight how roles and behaviors within the family may be shaped or even reinforced by

past trauma. This could include understanding why certain members may withdraw, react aggressively, or engage in maladaptive behaviors.

3. **Build resilience and coping strategies:** By helping families process their trauma in a safe, supportive setting, FCT fosters resilience and develops coping mechanisms that are both individual and systemic. The goal is to help the family function better despite the challenges posed by trauma.
4. **Integrate trauma-based interventions:** Trauma-informed interventions are woven into the process, such as trauma processing, cognitive-behavioral techniques, and strategies to reduce re-traumatization. These interventions are tailored to the specific needs of the family and its members.

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.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are

included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
H0037 U4 V1	Community psychiatric supportive treatment program, Monthly
H0037 U4 V2	Community psychiatric supportive treatment program, Daily

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	10/6/2025	10/10/2025
Clarified at least 10 direct documented service hours per each 30 day period must be used for monthly unit	02/20/2026	02/20/2026

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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