MEDICAL POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Intensive In-Home Services: Family Centered Treatment-AR PASSE-MM-1543	01/01/2026
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Intensive In-Home Services: Family Centered Treatment

B. Background

Family Centered Treatment® (FCT) is a comprehensive, evidence-based, trauma treatment model of intensive in-home services (IIHS) for children, adolescents and families at risk for out-of-home placement. This preventative, stabilization and reunification service is designed to address family functioning and multi-generational trauma. It is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services.

FCT is time-limited and intensive with multiple goals, including the prevention of out-of-home placement for the member, the reduction of psychiatric or comorbid disorder symptoms and the improvement of family functioning. Interventions attempt to ensure the successful transition of care from residential services to home settings and linkage to community services and resources while providing initial and on-going crisis response interventions. The member's home or a community setting is the place of service, and parents/caregivers are active participants in treatment, applying individualized services developed in full partnership with the family.

This multi-faceted approach may be used as a step-down program for youth leaving residential placements or when the member is best served by receipt of services in the home. FCT can be used to minimize lengths of stay or reduce the risk of readmission. Emphasis is placed on support systems, during and after services, by developing a system of community resources and natural supports that enhance treatment. Building a network of support also promotes sustainable outcomes by providing resources to be utilized after discharge.

FCT is authorized and approved as an In Lieu of Service (ILOS) by the Arkansas Dept of Human Services (DHS) in accordance with federal guidelines. CareSource follows state and federal regulations in the provision of care to members. Any guidance provided by the State supersedes information in this policy.

C. Definitions

- **Crisis Response** – Immediate access and availability, as clinically indicated, to the member and family (eg, crisis stabilization services, safety planning, alleviation of the presenting crisis).
- **Family or Significant Other** – Any individual or caregiver related by blood or affinity whose close association with the member is the equivalent of a family relationship as identified by the member, including kindship and foster care.
- **Home** – Any family living arrangement including, but not limited to, biological, kinship, adoptive, foster home, and non-custodial families who have made a commitment to the member.

- **In Lieu of Service (ILOS)** – Services/settings that are substitutes for services/ settings covered under state plans in accordance with 42 CFR §§ 438.3(e)(2) and 438.16.
- **Intensive Case Management Services** – Required service to facilitate integrated, systemic work inherent to the FCT model, including
  - psychoeducation regarding diagnosis, condition, and services to the member, family, caregivers, or other individuals involved with care
  - initial and ongoing assessment, including data collection and progress reporting
  - initial and ongoing service planning
  - linkage and referral to paid and natural supports
  - case consultation and coordination across multiple agencies, when applicable
  - collaboration with the PASSE Care Coordinator

D. Policy

I. General Guidelines and Program Requirements

A. FCT providers must follow staffing and program requirements, including any training and certification requirements, supervision requirements and ratios for caseloads outlined in the DHS FCT ILOS definition and the PASSE Provider Agreement with DHS.

B. A review of service benefit determination is required prior to service provision.

1. The FCT provider accepting the referral is responsible for completing the medical necessity review submission process.
2. A referral may be completed by the current outpatient mental health provider, the inpatient provider, the CareSource care coordinator, child welfare worker, juvenile justice worker or other involved community agency representative.
3. A Mental Health Diagnosis/Evaluation completed by a licensed BH professional employed by a licensed FCT provider guides the referral.
4. Clinical responsibility and oversight, including crisis response, of the client referred for FCT services only transitions to the FCT provider after the initiation of FCT services begin.

C. Members ages 4-18 are eligible for FCT.

D. Services must

1. be directly related to the member's diagnostic and clinical needs
2. are expected to achieve specific rehabilitative goals detailed in the treatment plan (TP) and Person-Centered Service Plan (PCSP)
3. be evaluated to determine if medical necessity supports more or less intensive services
4. are authorized in the most cost-effective mode, as long as the treatment that is made available is similarly efficacious as services requested by the member's physician, therapist, or other licensed practitioner
5. must be generally recognized as an accepted method of medical practice or treatment

E. All requests must meet **ALL** the following criteria:

1. individualized, specific and consistent with symptoms or confirmed diagnosis under treatment and not in excess of the member's needs

2. can be safely furnished with no equally effective and more conservative or less costly treatment available statewide
3. not primarily intended for the convenience of the member, the member's caretaker or the provider
4. met eligibility requirements for this service with treatment goals not yet achieved (ie, interventions regularly reviewed for efficacy and modified, if necessary, for the achievement of greater progress)

F. The practitioner must develop an individualized FCT service plan using established psychotherapeutic techniques and intensive family systems interventions to target the intersection of trauma symptomology and the Areas of Family Functioning. Families must participate in pre-mid-post trauma/family functioning assessments for service planning and progress reporting.
G. Communication between involved agencies and the licensed FCT provider is required at least monthly or more often if needed throughout services.
   1. At a minimum, communication includes participation in the Child and Family monthly meeting.
   2. Involved agency participation is encouraged for care coordinators, Division of Child and Family Services (DCFS)/Division of Youth Services (DYS) case workers, probation officers, Court-Appointed Special Advocates and outpatient BH providers.
   3. Discharge planning is critical for transitioning. All agencies will collaborate and include the family in the development of aftercare planning.
H. During the provision of FCT services, no other home and community-based services will be provided. Only services from the *Counseling and Crisis Services Provider Manual* may continue, if medically necessary.
I. Generally, a minimum of 2 direct multiple-hour sessions per week are provided and adjusted by evolving needs. Service duration is approximately 6 months. However, duration may be extended due to clinical complexity. Services must include 85% of direct, clinical work with the family.
J. The member has a person-centered treatment plan.

II. Initial Authorization

With the submission of adequate documentation and a PA request, CareSource will authorize an initial request up to 90 calendar days (CDs). If a member is preparing to discharge to a caregiver's home directly from a residential setting, and if FCT services are prior-approved by CareSource, the FCT practitioner may begin services during the time the member is on therapeutic home visits up to 45 days prior to discharge. The encounter billing rate may be used for each day an FCT- specific service is provided in the home setting**.** Services will be considered medically necessary when **ALL** the following criteria are met:

A. A licensed professional has documented a BH diagnosis as defined in the most recent edition of the *Diagnostic and Statistical Manual (DSM),* excluding solely intellectual or developmental disabilities. Documentation will be reviewed on a case-by-case basis and accepted from a BH agency, another provider (eg, primary care physician), possible self-report or other documentation.

B. A mental health evaluation determines FCT is appropriate, and a guardian/caregiver is available to actively participate in treatment.
C. Member must display **at least 1** of the following:
    1. significant risk of losing current placement or potential out-of-home placement related to a mental health diagnosis or behavioral challenges
    2. presence of serious behavioral problems at home, in school or with peers
    3. unmanageable symptoms (eg, physical aggression, severe emotional distress) in current setting
    4. current need for crisis intervention services that mitigate multiple episodes of high risk behaviors
D. Member must also have **at least 1** of the following:
    1. difficulties in coordinating appropriate care in the community
    2. will not or has not benefit(-ed) from lower levels of care (ie, multiple outpatient treatment episodes without long term success)
    3. unsuccessful previous level of care (eg, residential, sub-acute, counseling level)
    4. history of involvement with multiple systems (eg, child welfare, juvenile justice) and documented difficulties engaging with previous treatments

III. Continuation of Benefits

Continuation will be available for up to 30 CDs, if accompanied by documentation supporting the need for continuing services, including the desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the member's TP and PCSP or if the member continues to be at risk for out-of-home placement based on current clinical assessment, history and the functional gains. Providers must also submit the *FCT Monthly Update Form* via the Provider Portal with any requests. Continuation will be considered medically necessary when the above criteria in D.II. are met, and measurable progress based on symptom and behavioral improvement associated with diagnosis(-es) is documented not less than every 4 weeks with **1** the following:

A. Member/family are cooperative with treatment and meeting TP or PSCP goals.
B. The member/family is making some progress, but the specific interventions in the TP need to be modified so that greater gains consistent with the member's premorbid level of functioning are possible.
C. Progress is not occurring, or regression is occurring. Both the member diagnosis and TP is being re-evaluated to identify any unrecognized co-occurring disorder(s), more appropriate interventions or need for alternative or additional services by the appropriately licensed professional.

IV. Discharge Criteria

Discharge may occur after an adequate discharge plan has been established outlining the provision of additional services, providers to be involved in care and at least **1 or more** of the following:

A. achieved goals and no longer in need of FCT services
B. level of functioning improved with respect to TP goals, inclusive of a transition plan to step down to a lower level of care

C. no progress or regression and exhausted all reasonable strategies and interventions, indicating a need for more intensive services
D. no longer wishes to receive FCT services (ie, member, legal responsible person)
E. based on presentation and lack of improvement despite modifications in the TP, requires more appropriate, best practice treatment modality
F. no engagement in treatment by family and/or no successful contact to reengage the family in more than 30 days

V. Evidenced-based practices may have exclusionary criteria based on program models allowed by DHS. Exclusionary criteria will be assessed by providers, not CareSource (eg, gang involvement with an inability to sever affiliations, violent behavior due to gang involvement, problematic sexual behavior in members 13 and older without completion of a sexual behavior treatment program, current homicidal ideation or behaviors with intent and plan).

VI. Telehealth
FCT is an in-person service. Telehealth is only allowable under the direction and written approval of the FCT Foundation and CareSource. Any approved telehealth services will be minimal and time-limited.

E. Conditions of Coverage

I. CareSource reserves the right to request additional documentation prior to service provision. All FCT practitioners must understand and abide by best practice standards for IIHS, including, but not limited to, safety of client, family, others and self, coordination of services (eg, medical, on-call, crisis), quick and timely responses to intake and interventions that are timely, accessible and not experimental in nature. FCT licensed organizations will follow the best practices outlined in *A Core Elements Approach to Child Welfare In-Home Services* by the National Resource Center for In-Home Services.

II. Members should continue to receive medically necessary outpatient BH services (eg, individual therapy, medication management). This is not a requirement of the FCT model, though CareSource may require members to receive therapy during an FCT course of treatment. If outpatient services are necessary, the services may be billed separately from the monthly FCT rate, as some providers might be billing daily. The outpatient BH service provider must have an up-to-date treatment plan clearly reflecting FCT services are occurring.

F. Related Policies/Rules

Nonmedical Community Supports and Services
Person-Centered Service Plans
Behavioral Health Service Record Documentation

G. Review/Revision History

	DATE	ACTION
Date Issued	08/16/2023	Approved at Committee.
Date Revised	07/31/2024 07/16/2025 10/08/2025	Annual review. Updated references. Approved at Committee. Annual review. Updated references. Approved at Committee. Review. Updated policy (AR change to FCT model of IIHS). Updated references. Approved at Committee.
Date Effective	01/01/2026	
Date Archived		

H. References

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