Sentara Health Plans

Medicaid

# Functional Family Therapy

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| Effective Date | 12/2021 |
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| Coverage Policy | BH 36 |
| Version | 5 |

**All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual *.**

## Purpose:

This policy addresses Functional Family Therapy.

## Description & Definitions:

Mental Health Services (formerly CMHRS) – App. D - Intensive Community Based Support – Youth p. 17 (11/30/2021) & Functional Family Therapy (FFT) - effective 12/1/2021

**Functional Family Therapy (FFT)** is a short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including cooccurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT addresses both symptoms of serious emotional disturbance in the identified youth as well as parenting/caregiving practices and/or caregiver challenges that affect the youth and caregiver's ability to function as a family. The FFT model serves as a step-down or diversion from higher levels of care and seeks to understand and intervene with the youth within their network of systems including, family, peers, school and neighborhood/community. FFT is targeted towards youth between the ages of 11 - 18, however, the service is available to any youth under the age of 21 who meets medical necessity criteria.

FFT is a phase-based service that addresses youth behavior problems by systematically targeting risk and protective factors at multiple levels in the youth's environment. In order to accomplish these changes in the most effective manner, FFT includes five major phases that build upon each other through treatment. These phases include engagement, motivation, relational assessment, behavior change and generalization. Specific fidelity standards guide the delivery of FFT services and providers are required to follow these standards.

The critical features of the FFT model include:

- A philosophy about people that includes an attitude of respectfulness, of individual difference, culture, ethnicity, and family composition.

- A focus on family that involves alliance building and involvement with all family members with FFT professionals who do not “take sides” and who avoid being judgmental.
- A change model of care focused on risk and protective factors.
- An inclusive list of interventions that are specific and individualized for the unique challenges, diverse qualities, and strengths of all families and family members.
- An inter-relational focus versus individual problem focus.

Covered services include:

- Assessment,
- Therapeutic interventions,
- Crisis intervention,
- Care Coordination

FFT is primarily a home-based service, but providers may conduct the service in clinic settings, as well as in schools, child welfare facilities, probation and parole offices/aftercare systems and mental health and Substance Use Disorder treatment facilities. The FFT professional meets with the whole family and does not organize service delivery around an individual participant. FFT delivery includes both the clinical interventions as well as the care coordination activities that are necessary for the participants in the service.

FFT professionals work with families to assess family behaviors that maintain problem behaviors, modify dysfunctional family communication, train family members to negotiate effectively, set clear rules about privileges and responsibilities, and generalize changes to community contexts and relationships. Each of the FFT phases has its own goals, focus and intervention strategies/techniques, and these are summarized below:

**Engagement**

- Goals: Enhancing the youth’s perceptions of FFT professional responsiveness and credibility;
- FFT Professional’s Focus: Immediate responsiveness to family needs and maintaining a strength-based relational perspective;
- Activities: High availability, therapeutic interventions with as many family members as possible.

**Motivation**

- Goals: Creating a positive motivational context by decreasing family hostility, conflict and blame, increasing hope and building balanced alliances with family members;
- FFT Professional’s Focus: Changing the meaning of family relationships by emphasizing possible hopeful alternatives, maintaining a non-judgmental approach and conveying acceptance and sensitivity to diversity;
- Activities: Interruption of negative interaction patterns, sequencing and reframing of themes presented by family interactions, changing meaning through a strength-based relational focus.

**Relational assessment**

- Goals: Identifying patterns of interaction within the family to understand the positive interpersonal benefits for individual family members’ behaviors;
- FFT Professional’s Focus: Gathering and analyzing information pertaining to relational processes, and assess each dyad in the family using perception and understanding of relational processes;
- Activities: Observations, questionings, inferences regarding the functions of negative behaviors, and switching from an individual problem focus to a relational perspective.

**Behavior Change**

- Goals: Reducing or eliminating referral problem(s) by improving family functioning and individual skill development;
- FFT Professional’s Focus: Focused on improving family communication and teaching new skills to achieve more positive interaction through domain-specific interventions (e.g., problemsolving, anger management, depression, anxiety, substance use, etc.) that are tied to the relational assessment;

- Activities: Introduction of tasks or skills to the family by providing the rationale for the exercise; coaching, modeling, and rehearsing techniques; and giving feedback along with homework for the family to practice outside of the session.

**Generalization**

- Goals: Extending the improvements made during the Behavior Change phase into new situations or systems, relapse planning, and incorporating community systems into the treatment process;
- FFT professional's focus: Maximizing a multisystemic/systems understanding and ability to establish links, maintain energy, and provider outreach into community systems;
- Activities: Accessing and maintaining connection to community supports, initiating clinical linkages, creating relapse planning, and helping the family to develop independence.

It is not a requirement of the FFT model to offer 24/7 access to the FFT professional. Based on referral information and assessment of family risk and protective factors, the FFT provider may increase the frequency and length of sessions. If there is a crisis, the FFT provider may adjust the frequency and length to address the need. The FFT program intentionally includes development skills and interventions to reduce negativity and blame, factors that underlie crisis behavior.

Booster sessions are a short term resumption of services initiated by the youth and/or family after successful discharge. Booster sessions may also be planned in advance as part of the discharge planning when the FFT professional is aware of transitional events.

In addition to the required activities for all mental health services providers located in Chapter IV of the DMAS manual, the following required activities apply to FFT:

- At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the youth's diagnosis/es and describing how service needs match the level of care criteria.
- ISPs shall be required during the entire duration of services and must be current (see Chapter IV of the DMAS manual for requirements). The FFT Behavior Change Session Plan (as defined by FFT, LLC.) can be used as the ISP as long as it includes all of the requirements of an ISP. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. In cases where the FFT Professional is a QMHP-E, QMHP-C, CSAC or CSAC-supervisee, the FFT Supervisor directs and authorizes the treatment planning process as part of the FFT model.
- The ISP must be reviewed and updated as necessary at a minimum of every 30-calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30-calendar day review as well as additional quarterly review requirements. These 30 day reviews are consistent and comply with the routine activities required for fidelity in the FFT model and include treatment team meetings, consultations with FFT supervisors and consultants, meetings with youth and natural supports and administration of fidelity measures.
- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV of the DMAS manual).

## Criteria:

Mental Health Services (formerly CMHRS) – App. D - Intensive Community Based Support – Youth p. 17 (11/30/2021) & Functional Family Therapy (FFT) - effective 12/1/2021

**Functional Family Therapy (FFT)** is considered medically necessary for **All** of the following:

- Treatment is for **1 or more** of the following:
    - **Initial care** with **all of the** following:
        - The youth must be under the age of 21
        - The initial assessment completed by a LMHP, LMHP-R, LMHP-RP, LMHP-S provides evidence of symptoms and functional impairment that the youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual that falls within the categories of disruptive behavior, mood, substance use or trauma and stressor-related disorders. There may be additional primary behavioral health diagnoses that may benefit from the interventions of FFT that may be considered on a case-by-case basis under EPSDT

- Within the past 30 calendar days the youth has demonstrated at least **1 or more** of the following that puts the youth at risk of out of home placement:
    - Persistent and deliberate attempts to intentionally inflict serious injury on another person
    - Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of behaviors that are endangering to self or others are difficult to control, cause distress, or negatively affect the youth's health
    - Increasing and persistent symptoms associated with depression (e.g. chronic irritability, anhedonia, significant changes in sleep/eating, disrupted emotion regulation, …) or anxiety (e.g. rumination, panic attacks, hypervigilance, dissociation, …), in combination with externalizing problems (e.g. physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the community
    - Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community
    - The youth is returning home from out-of-home placement and FFT is needed as step down service from an out-of-home placement
- The youth's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the FFT model. Participation in an alternative community-based service would not provide the same opportunities for effective intervention for the youth's problem behaviors.
- There is a family member or other committed caregiver available to participate in this intensive program
- Arrangements for supervision at home/community are adequate to ensure a reasonable degree of safety and a safety plan has been established or will be quickly established by the FFT program as clinically indicated.

- **Continuation of services** are considered medically necessary with **all of the** following:
    - Within the past thirty (30) calendar days, FFT continues to be the appropriate level of care for the youth as evidenced by at least **1 or more** of the following
        - The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria
        - The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP
        - Progress toward ISP goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved
    - To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through **all of the** following:
        - An ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention. The treatment must support community integrative objectives including the development of the youth's network of personal, family, and community support. Treatment objectives are related to readiness for discharge and FFT specific expected outcomes
        - Progress toward objectives is being monitored weekly within fidelity to the model
        - The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement
        - The type, frequency and intensity of interventions are consistent with the ISP and fidelity to the model
        - The provider is making vigorous efforts to affect a timely transition to an appropriate lower level of care. These efforts require documentation of discharge planning beginning at the time of admission to include communication with service

practitioners, community partners, and natural supports that will meet the needs of the client
        - The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care
    - If youth **does not meet criteria for continued treatment**, FFT may still be authorized for up to an additional 10 calendar days under any **1 or more** of the following circumstances:
        - There is no less intensive level of care in which the objectives can be safely accomplished
        - The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting
        - The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.
    - Service authorizations shall meet the components related to Procedures Regarding Service Authorization of Mental Health Services.

In addition to the "Prohibited Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

- The provision of FFT is limited to youth under the age of 21
- Youth can participate in FFT services with only one FFT team at a time.
- FFT may not be authorized concurrently for a youth (note: other family members may be receiving one of the above services and still participate in FFT as appropriate for the benefit of the individual receiving FFT services) with **1 or more** of the following:
    - ARTS ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7 and 4.0
    - Assertive Community Treatment
    - Community Stabilization
    - Group or Family Therapy
    - Intensive In-Home Services
    - Mental Health Intensive Outpatient
    - Mental Health Partial Hospitalization Program
    - Mental Health Skill Building
    - Multisystemic Therapy
- If the youth continues to meet with an existing outpatient therapy provider, the FFT provider must coordinate the treatment plan with the provider.
- Other Mental Health and ARTS services, Inpatient Services, and Residential Treatment Services may be authorized and billed concurrently for no more than 14 consecutive calendar days, as the youth are being admitted or discharged from FFT to other behavioral health services.
- Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with FFT, as are E/M outpatient services for the purposes of psychiatric medication evaluation and management.
- Activities not authorized or reimbursed under FFT:
    - Inactive time or time spent waiting to respond to a behavioral situation
    - Therapeutic interventions or collateral contacts that are not medically necessary.
    - Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor
    - Childcare services or services provided as a substitute for the parent or others responsible for providing care and supervision
    - Respite care
    - Transportation for the youth or family. Additional medical transportation for service needs which are not considered part of FFT program services may be covered by the transportation service through the FFS Non-Emergency Medical Transportation Broker or MCO. Medical transportation to Medicaid providers may be billed to the transportation broker
    - Services not in compliance with the FFT service manual and not in compliance with fidelity standards
    - Supervision hours of the staff

- Any art, movement, dance, or drama therapies outside the scope of the FFT model fidelity. Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers, which are not part of the ISP
- Anything not included in the approved FFT service description
- Time spent doing, attending, or participating in recreational activities
- Changes made to FFT that do not follow the requirements outlined in the provider contract, this appendix, or FFT fidelity standards
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services

**Exclusions:**

Youth are not eligible to receive FFT who meet **1 or more** of the following:

- The youth is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is NOT available through the provision of FFT.
- The youth is living independently, or the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
- The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors.
- The youth's functional impairment is solely a result of Developmental Disability, as defined in the Code of Virginia § 37.2-100.

## Discharge Criteria:

The youth meets discharge criteria if **1 or more** of the following are met:

- The youth's documented ISP goals and objectives have been substantially met and all FFT phases have been completed
- The youth's needs can be met at a lower level of care
- The youth's current level of function requires a higher level of care
- The youth or the youth's family have not benefited from FFT despite documented efforts to engage the youth or family and there is no reasonable expectation of progress at this level of care despite ISP changes or the youth or the youth's family has achieved maximal benefit from this level of care
- The youth is placed in a hospital, skilled nursing facility, residential treatment facility, or other residential treatment setting and is not ready for discharge within 14 consecutive calendar days to a family home environment or a community setting with community-based support
- Required consent for treatment is withdrawn
- If there is a lapse in service greater than 31 consecutive calendar days

## Coding:

Medically necessary with criteria:

| Coding | Description |
|---|---|
| 90791 | Psychiatric diagnostic evaluation |
| 90792 | Psychiatric diagnostic evaluation with medical services |
| H0036 | Community psychiatric supportive treatment, face-to-face, per 15 minutes |

Considered Not Medically Necessary:

| Coding | Description |
|---|---|
| | None |

U.S. Food and Drug Administration (FDA) - approved only products only.

## Document History:

Revised Dates:

- 2023: July
- 2022: April, June

Reviewed Dates:

- 2023: March
- 2022: August

Effective Date:

- December 2021

## References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Mental Health Services Revision Date: 11/30/2021 Appendix D: Intensive Community Based Support – Youth. Retrieved 4.4.2024. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-07/MHS%20-%20Appendix%20D%20%28updated%2011.30.21%29_Final.pdf

Commonwealth of Virginia. Department of Medical Assistance Services. Project BRAVO: Behavioral Health Redesign for Access, Value & Outcomes, New Enhanced Behavioral Health Services, Effective December 1, 2021 and Applied Behavior Analysis. Retrieved 4.5.2024 https://vamedicaid.dmas.virginia.gov/bulletin/project-bravo-behavioral-health-redesign-access-value-outcomes-new-enhanced-behavioral

## Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

## Keywords:

Functional Family Therapy, FFT, Behavioral Health 36, BH, Mental Health Services, Intensive Community Based Support, youth, behavior