Clinical Policy: Functional Family Therapy – Child Welfare

Reference Number: LA.CP.MP.501c
Date of Last Revision: 42/23

Coding Implications
Revision Log

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

Description

Functional Family Therapy-Child Welfare (FFT-CW) is deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 0 and 18 and are exhibiting significant externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the member's/enrollees interpersonal experiences to include cognitive, emotional, and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and his or her family system. FFT-CW restrengths-based models of intervention, which emphasize the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

Policy/Criteria

It is the policy of Louisiana Healthcare Connections that **Functional Family Therapy – Child Welfare (FFT-CW)** is medically necessary when the following is met:

I. Admission Criteria: Must meet ALL
   A. Suspected or indicated child abuse or neglect; Problems include at least one of the following:
      i. Youth truancy
      ii. Educational neglect
      iii. Parental neglect or abuse
      iv. History of domestic violence
      v. Adult caregiver substance abuse
      vi. Adult caregiver anxiety, depression, and other mental health issues
   B. Youth, ages 0-18, displays externalizing behavior, which adversely affects family functioning; behaviors include but not limited to the following:
      i. Antisocial behavior or acts
      ii. Violent behaviors
      iii. Disruptive behavior disorder, i.e., (attention deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and/or conduct disorder
   C. DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder or internalizing psychiatric conditions and substance use. Diagnosis can be for youth or caregiver.
   D. Functional impairment not solely a result of an autism spectrum disorder or intellectual disability
   E. At least one adult caregiver is available to provide support and is willing to be involved in treatment
   F. Documented medical necessity for an intensive in-home service

II. Continued Services Criteria: Must meet ALL

A. Member/enrollee continues to meet admission criteria.
B. Member/enrollee demonstrates documented progress or maintenance of community skills relative to goals based on the four domains of assessment.
C. There is adequate documentation from the provider that the member/enrollee is receiving the scope and intensity of services required to meet the program goals.

III. Discharge Criteria: Must meet ALL
A. An adequate continuing care plan has been established.
B. The goals of Individualized Treatment Plan have been substantially met.
C. The member/enrollee requests discharge, and the member/enrollee is not imminently in danger of harm to self or others.
D. Transfer to another service is warranted by change in the member's/enrollees condition.

IV. Exclusions: Criterion A or B must be met to preclude eligibility for the service
A. FFT shall not be billed in conjunction with PRTF services:
B. FFT may also be billed in conjunction with another behavioral health service (such as individual therapy, Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), or Independent Living Skill Building (ILSB)) if:
   i. The youth has a high level of need such that a combination of both family-focused and individually-focused services is needed to meet the youth's required level of treatment intensity;
   ii. There is a clear treatment plan or Plan of Care indicating distinct goals or objectives being addressed by both the FFT/FFT-CW service and by the concurrent service; and
   iii. The services are delivered in coordination of each other to ensure no overlap or contradiction in treatment.

Background

FFT-CW is deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 0 to 18 and are exhibiting significant externalizing behaviors.

It is a systems-based model of intervention/prevention, which incorporates various levels of the member's/enrollees interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and his or her family system.

FFT-CW is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

On average, a youth receives FFT-CW for approximately 3 to 5 months. The therapist works with the family in twelve to fifteen one- to two-hour sessions for less severe cases and up to 30 - one- to two-hour sessions for youth with more complex needs. The frequency of the sessions varies on a case-by-case basis and over the course of the treatment; sessions could occur daily to weekly, as needed. Services occur in the office, family's home and/or community at times that are convenient for the family. FFT-CW therapists provide regular telephonic follow-up and support to families between sessions.

FFT-CW is carried out in the context of five distinct phases (Pretreatment, Engagement, Motivation, Relational Assessment, Behavior Change, and Generalization). Each phase consists of an assessment, goal-setting and an intervention component; all services rendered are carried-out based upon the theoretical framework of the three core principles.

- *Core Principle One: Understanding members/enrollees*
  This is a process whereby the therapist comes to understand the youth and family in terms of their strengths on the individual, family system and multi-systemic level.
- *Core Principle Two: Understanding the member/enrollee systemically*
  This is a process whereby the therapist conceptualizes the youth's behaviors in terms of their biological, relational, family, socio-economic and environmental etiology. Subsequently, the therapist assesses the youth's relationships with family, parents, peers, their school and their environment and how these roles/relationships contribute to the maintenance and change of problematic behaviors.
- *Core Principle Three: Understanding therapy and the role of the therapist as a fundamentally relational process*
  This is a process where the therapist achieves a collaborative alliance with the youth and family. Subsequently, the therapist ensures that the therapy is systematic and purposeful, while maintaining clinical integrity. More specifically, the therapist follows the model but also responds to the emotional processes (needs/feelings/behaviors) that occur in the immediacy during clinical practice.

There are four domains of assessment used to monitor progress towards goals in FFT-CW:

- *Member/enrollee assessment* (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):
  - Helps understand individual, family and behavior in a context functioning.
  - Adds to clinical judgment, helps target behavior change targets, tool in treatment.
- *Adherence assessment* (through the use of the Family Self Report and Therapist Self Report, and Clinical Services System (CSS) tracking/adherence reports, global therapist ratings):
  - Identify adherence to FFT/FFT-CW to enhance learning and supervision.
  - Judge clinical progress, monitor clinical decisions.
- *Outcome assessment* (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):
  - To understand the outcome of your work – accountability.
  - Changes in member/enrollee functioning (pre-post).

  NOTE: The term "counseling" throughout the FFT section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by LMHPs under their respective scope of practice license.
- *Case monitoring and tracking* (member/enrollee service system reports)
  - Every member/enrollee contact/planned contact, outcome of that contact (helps monitor practice)

Coding Implications

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date.	09/24/19	
Under Admission Criteria removed the following: Youth displays externalizing behavior which adversely affects family functioning. Youth's behaviors may also affect functioning in other systems.	11/22/19	
Added minor language from LDH Provider Manual Grammatical changes Updated Exclusion criteria to follow LDH Provider Manual Added LBHP Service Authorization Criteria Reference Removed LDH website from reference	08/2020	
Annual Revision – no changes	04/2021	
Annual review. Format changes only, no changes to criteria.	042/2023	

References

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. LHCC 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.

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