STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Family Functional Therapy
THR-003

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	10/20/2023
Revision Number:	1	**Last Rev Date:**	10/20/2023
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	10/18/2024
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	10/20/2023

Descriptive Narrative

Family Functional Therapy (FFT) is an evidenced based family therapy targeted at members who are appropriate candidates for this treatment . FFT provides clinical assessment and treatment for the member and their family to improve communication, problem-solving, and conflict management to reduce problematic behavior of the member. It is a short-term treatment strategy that is built on a foundation of respect for members, families, and cultures.

The model includes an emphasis on assessment in understanding the purpose that behavior problems serve within the family relationship system, followed by treatment strategies that pave the way for motivating the member and their families to become more adaptive and successful in their lives.

FFT is designed to improve family communication and supports, while decreasing intense negativity and dysfunctional patterns of behavior. Therapy also includes training parents how to assist their child based on their diagnosis.

Iowa Medicaid was directed by the legislature to submit a State Plan and establish coverage in 2022 (HF 2578, Section 13, Item 21, Page 29).

Service Expectations

Expectations of FFT include **ALL** the following:

- An initial diagnostic interview/assessment will be completed prior to the beginning of treatment and will serve as the initial treatment plan until a comprehensive treatment plan is completed; **AND**
- Assessments and treatment shall address mental health/substance abuse needs, and mental health and/or emotional issues related to medical concerns; **AND**
- The treatment plan will be individualized and will include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the member's progress; and the responsible professional. The treatment plan will be developed with the member and the identified

appropriate family members as part of the outpatient family therapy treatment planning process; **AND**

- Treatment plans will be reviewed every 90 days or more often if clinically indicated.

Admission Criteria

Prior authorization is required.

FFT is considered medically necessary when **ALL** the following are met:

1. The member is 21 years of age or younger; **AND**
2. Acting out behaviors shall be present to the degree that functioning level is impaired; **AND**
3. Members are referred by other service providers and agencies on behalf of the member and/or family; **AND**
4. At least one adult caregiver is available to provide support and is willing to be involved in treatment; **AND**
5. Current DSM diagnosis is primary focus of treatment symptoms and impairments are the result of a primary disruptive/externalizing behavior disorder although internalizing psychiatric conditions and substance use disorders may be secondary; **AND**
6. Members displays externalizing behavior which adversely affects functioning across domains (i.e., home, school, work, social, etc.).

Continued Stay Criteria

Continuation of FFT is considered when **ALL** the following are met:

1. Admission criteria continues to be met; **AND**
2. There is a reasonable likelihood of benefit as a result of active continuation in the therapy as demonstrated by behavioral improvement, but the member is not yet ready for discharge; **AND**
3. Documented evidence that continuation of FFT services is necessary to regain family functioning; **AND**
4. The member and family are actively participating in treatment.

Discharge Criteria

FFT is considered completed when **ANY** of the following have been met:

1. Member's documented treatment plan goals have been substantially met, including discharge planning; **OR**
2. Member/family no longer meet admission criteria or meets criteria for a less or more intensive level of care; **OR**
3. Member and/or family have not benefited from FFT despite documented efforts to engage and there is no reasonable expectation of progress at this level of care despite treatment.

Exclusion Criteria

ANY of the following criteria are sufficient for exclusion from MST services:

1. The member is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is **not** available through the provision of this therapy; **OR**
2. Members living independently, or members for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers; **OR**
3. Referral problem is limited to serious sexual misbehavior.

Coding

The following lists of codes are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

HCPCS	Description (modifier required)
90846	Family psychotherapy (without patient present), 50 minutes.
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes.

Modifier	Description
HK	Specialized mental health programs for high-risk populations.
AF	Specialty physician.
HO	Master's degree level.
HP	Doctoral level.
SA	Nurse practitioner rendering service in collaboration with a physician.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature

review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

EncoderPro

HHS Behavioral Health Provider Manual. https://hhs.iowa.gov/sites/daefault/files/BehaviorHealth.pdf.

Blueprints for Healthy Youth Development. https://www.blueprintsprograms.org/

FFT Services. Evidence-Based Interventions and Family Counseling (fftllc.com).

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version

Signature

Change Date	Changed By	Description of Change	Version
10/20/2023	CAC	Criteria implementation.	1

Signature
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