Subject: Family Centered Treatment (FCT) ILOS **Current Effective Date:** 02/10/2026
Status: Active **Last Review Date:** 02/10/2026

Description

Family Centered Treatment ® (FCT) is an evidence-based, intensive in-home treatment model specifically designed for children and adolescents who are at risk ages 3-20. This strategy treats the youth and their families with tailored therapeutic interventions. FCT is primarily aimed at maintaining their permanency goals. It serves children and adolescents who might be part of the juvenile justice system, face the risk of out-of-home placements, or be up for reunification. They may have severe emotional and behavioral issues originating from neglect, abuse, trauma from domestic violence, sexual abuse, substance use disorder, or serious mental health disorders. FCT works by enhancing the functioning of the youth and their families, providing them with an alternative to out-of-home placements, minimizing their duration if unavoidable and reducing the risk of recurrence. The professional delivering FCT maintains an average caseload of 4-6 individuals or families and is supervised by a trained FCT supervisor, or an FCT supervisor undergoing FCT Supervisor Certification.

The evidence-based model FCT is founded in the belief that families seemingly stuck in a downward spiral can make positive, lasting changes. Resilience theory holds that children and families have the capacity to function well in the face of significant life challenges. Because of this belief, all aspects of treatment value the youth and family's voice in the process and employ strength-based approaches that focus on hope rather than on deficits, challenges, and barriers. The intention is to promote permanency goals while preserving the dignity of youth and families within their culture and community.

FCT's origins derive from Qualified Professionals' efforts to find practical, commonsense solutions for families faced with forced removal of their children from the home or dissolution of the family, due to both external and internal stressors and circumstances. FCT is an alternative model grounded in the use of sound and research-based treatment. Personalized techniques are integrated from empirically supported behavioral and family therapies and services are provided frequently, with FCT Qualified Professionals available 24/7 to support the youth and family when needed. Addressing needs while observing strengths and patterns of interaction as they are happening allows skilled Qualified Professionals to help families create change in the core components of family functioning.

Anticipated Outcomes: The overarching objective of providing FCT to families is to keep children

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safe and thriving in their home environment. Specifically, the objective of FCT is to

provide an alternative to out-of-home placements, minimize the length of stay in out-of-home placements and reduce the risk of additional out-of-home placements by improving child/youth and family functioning. To achieve this, targeted goals for FCT include:

- Decrease in crisis episodes and inpatient stays
- Decrease in the length of stay in inpatient and crisis facilities
- Decrease in emergency room visits
- Successfully engage families in treatment (target = 85% of families)
- Maintain low recidivism rate (target = less than 10% of clients will require future FCT services minimally six months post discharge because of an increase in sustainability and stability due to focus on family functioning)
- Reduce or eliminate symptoms, including antisocial, aggressive, violent behaviors, or those symptoms related to trauma or abuse/neglect
- Achieve permanency goals (target = 80% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge)
- Improve and sustain developmentally appropriate functioning in specified life domains
- Enable family stability via preservation of or development of a family placement
- Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution
- Reduce hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the Qualified Professionals
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

Characteristics of a family that may be an appropriate referral to FCT include but are not limited to the following:

- Significant family functioning issues
- A step down from a higher level of care
- DSS involvement in the last year

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- Juvenile Justice involvement in the last 6 months
- A behavioral health emergency department (ED) visit and/or hospitalization in the last 6 months
- Multiple school suspensions within the past year
- Crisis intervention in the last 6 months to include (but not exclusive of) law enforcement involvement, crisis line calls, mobile crisis service, emergency crisis bed stay
- Physical abuse
- Verbal abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Parent or caretaker that abuses substances
- Parent or caretaker that is the victim of domestic violence
- Parent or caretaker that has a mental health diagnosis
- The loss of a parent or caretaker to divorce, abandonment, or death
- A parent or caretaker that is incarcerated
- A traumatic event that is significantly impacting the stability of the family or members of the family unit.

FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Quality Professional's effective practice. FCT is one of few home- based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

Clinical Indications

Utilization Management:

- No Prior Authorization (PA) for first 6 months of service.
- Initial authorization for services is one unit per month and may not exceed six units.
- Service Authorization Request (SAR) Notification only is required within 7 days of starting service.
- Reauthorization may not exceed 60 days.

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Eligibility Criteria: The member is eligible for this service when all the following are met:

a. There is a mental health or substance use disorder diagnosis (as defined by the DSM5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability.

b. The member has a caregiver who is available to participate with service providers for the duration of the treatment.

c. There are aspects of family functioning that are likely to impede the ability of the member to remain in the home (e.g., problem solving, communication, role performance, affective responsiveness and involvement and behavioral control) identified in clinical assessment.

d. A Comprehensive Clinical Assessment determines that FCT is an appropriate intervention.

e. Outpatient treatment services were considered or previously attempted but were found to be inappropriate or not effective.

f. The member has current symptoms or behaviors that increase the likelihood of crisis intervention including suicidal or homicidal ideation, physical aggression toward others, behaviors related to trauma, self-injurious behavior, serious risk-taking behavior (e.g., running away, sexual aggression, sexually reactive behavior or substance use).

g. The member’s symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the member’s mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions.

h. The member is at increased or imminent risk of out-of-home placement or is currently in an out-of-home placement and a return home is imminent; and

i. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Continued Stay Criteria:

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The member is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the member's Person-Centered Plan; or the member continues to be at risk for out-of-home placement, based on current clinical assessment, history and the tenuous nature of the functional gains.

a. The member/family is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person-Centered Plan.
b. The member/family is making some progress, but the specific interventions in the Person-Centered Plan need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible; or
c. The member/family has yet to make progress or demonstrates regression in meeting goals through the interventions outlined in the Person-Centered Plan. 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.

Discharge Criteria

The member meets the criteria for discharge if support systems for the family have been put into place, and any one of the following applies:

a. The member has achieved goals and no longer meets eligibility criteria for FCT services.
b. The member's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care.
c. 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.
d. The member or legally responsible person no longer wishes to receive FCT services.
e. The member, based on presentation and demonstration of little or no improvement despite modifications in the Person-Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Service Documentation Requirements

- A Comprehensive Clinical Assessment (CCA) or addendum that demonstrates medical necessity shall be completed prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning and contains all the required

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elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be utilized as a part of the current comprehensive clinical assessment or addendum.

- A signed service order shall be completed by a physician, licensed psychologist, physician's assistant, or nurse practitioner according to his or her scope of practice. Each service order shall be signed and dated by the authorizing professional and shall indicate the date on which the service was ordered. A service order shall be in place prior to or on the first day that the service is provided. The service order is valid for one year from the date of the original service order. Service orders may not be revised or backdated. The service order shall be based on a comprehensive clinical assessment of the member's needs.

- Each individual receiving FCT services is required to have a Person-Centered Plan (PCP) that is fully complete prior to or on the first date of service. The PCP must meet all the requirements, including an enhanced crisis plan, as outlined in the NC PCP Instruction Manual. The amount, duration, and frequency of the service must be included in the PCP Crisis plan.

Providers of FCT are expected to:

- Demonstrate the ability to submit FCT fidelity and adherence documentation for all families in receipt of FCT.

- Ensure that a minimum threshold, as set by FCT Board given stage of implementation, of all active and discharged FCT families have fidelity documentation completed and submitted for last phase of treatment completed.

- Services shall be documented in accordance with this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement. The services requires a full-service note, which includes Items 1 through 12, under Contents of a Service Note, Chapter 7 of the RMDM.

Continued authorization requests must include an updated Person-Centered Plan. Services are based upon a finding of medical necessity, must be directly related to the member's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals detailed in the member's Person-Centered Plan.

Limitations on Coverage:

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- FCT will not be reimbursed for dates of service when members are receiving psychiatric inpatient services but may facilitate coordination of discharge plans if admission occurs (core payment cannot happen same day as psychiatric inpatient).

Service Exclusions:

Family Centered Treatment cannot be provided during the same authorization period as:

- Outpatient Therapy Services
- Outpatient Plus
- In-Home Therapy
- Intensive In-Home Services (IIHS)
- Multisystemic Therapy (MST)
- Intercept
- Child and Adolescent Day Treatment
- Child ACT
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Residential Services may be authorized concurrently during transitions in and out of home placements. Typically, no more than 90 days based on acuity of need and clinical justification.

CFSP Care Management is allowed concurrently. Since this service includes a case management component, providers must clearly outline on the member's care plan how they will collaborate with CFSP Care Management to ensure there is no duplication of services. The case management function of this service is to support the treatment being done within the program to ensure progress and decrease the need for a higher level of care for the service.

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from

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worsening or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, Qualified Professional or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. That is unsafe, ineffective, experimental or investigational.
2. That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

1. If the service, product or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide and on the EPSDT provider page. The web addresses are specified below.

NC Tracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page:
http://www.ncdhhs.gov/dma/epsdt/

Program Requirements

FCT providers must meet the provider qualification policies, procedures and standards established by the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C, and any competencies

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specified by the NC Medicaid/DHB.

Provider must ensure clinicians and staff that provide FCT meet the requirements to deliver FCT. Clinicians performing FCT must be enrolled in the FCT online training system and must complete the first 4 units of training before they can begin seeing families. The clinicians are expected to achieve full FCT certification within their first year of hire/enrollment into the training system.

Provider must be accredited through a national accrediting body or achieve national accreditation within 1 year of contract with the CFSP/HBCT or request a waiver to extend the timeframe to get this completed.

The provider agency must maintain FCT licensure through the FCT Foundation, and all staff must maintain the required certification, which includes all recertification requirements and field observations. The FCT Foundation, monitors and tracks staff training and certification development. Upon successful passing grade completion of the three training components including the Wheels of Change online audio/visual training course, field-based practice of the required FCT core skills and field-based performance evaluation to assess competency, FCT Foundation will issue certification as an FCT clinician to the staff member. Provider organizations are required to maintain all other FCT Foundation licensure standards as outlined in a licensure agreement.

FCT Qualified Professionals are provided with numerous hours of supervision every week, encompassing peer supervision, individual supervision, field supervision, and on-call supervision support. The minimum requirement for such supervision is two hours per week as per FCT guidelines, but it commonly reaches an average of five combination hours or more. Peer supervision is performed within FCT teams that convene no less than once a week for conducting clinical case supervision and management. When applicable, FCT Trainers work with FCT Qualified Professionals to ensure adherence to the fidelity of the model and assure quality services with field observation. In addition, the trainers model the skill and provides practice experiences to teach and coach Qualified Professionals. They also observe Qualified Professionals in the field or via videotape to assess competency in the core required FCT skills. FCT Trainers are expected to

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undergo a specific process, overseen by the FCT Foundation, to verify Trainer status.

The FCT certification program, including Wheels of Change© (WOC), ensures that each FCT qualified professional is trained in the principles of youth-guided, family-driven empowerment and can identify and assess child abuse/neglect, domestic violence, and substance use and substance use disorders, as well as how to assist families affected by past trauma in times of crisis. WOC is a component of a structured certification process that utilizes the five aspects of training modalities: teaching, observing, performing the
required task or skill, being observed with checklists to assess competence, and
evaluation. Successful completion results in certification in FCT by the FCT Foundation.

FCT Qualified Professionals undertake and successfully complete an intensive competency-based, standardized training/certification process. This knowledge-based portion of the certification process includes testing of knowledge, audio visual learning, discussion boards, and videos of core skills in practice. FCT staff are trained in direct mental health services, long- and short-term mental health interventions designed to maintain family stability, individual and family assessments, community-based partnerships, cultural competency, individual, family, and group counseling, individualized service planning, 24-hour crisis intervention and stabilization, skills training, service coordination and monitoring, referrals to community resources, follow-up tracking, and coordination with local stakeholders.

Trauma Focused Training:
Because all families are assessed for trauma at the onset of services, all FCT qualified professionals must maintain a level of competency in this area. In order to demonstrate the skills necessary to assess trauma, staff must undergo comprehensive trauma-based training. These skills include recognizing the presence of trauma through interactions and assessment tools and developing personalized interventions to address trauma as identified.

Field-based practice of the required core skills and supervision occurs simultaneously as trainees take the online course. Additionally, it is best practice to cite and address trauma and trauma impact in safety plans, when/where applicable.

FCT supervisors must be qualified professionals and have either completed the FCT Supervision Certification or are enrolled in the FCT Supervisors Certification course. A non-associate or fully licensed FCT supervisor will have access to an associate or fully licensed clinician or other

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licensed professional (psychologist, psychiatrist etc.,) who will provide case consultation as needed. The FCT supervisor or other FCT directors/trainers or authorized licensed personnel conduct individual supervision or consultation. The FCT supervisor is readily available for on-call support to each employee and can also refer them to other FCT directors/trainers for consultation as needed. Every supervision session, whether carried out in the field, an office, or over the phone (on-call), is noted by the FCT qualified professionals on a specific form that records the direction given. This form is signed by both the qualified professional and the individual who provided the supervision. It is then added to the qualified professional's personnel file.

FCT's management and supervisory components are integral to the model fidelity and client outcomes that are achieved. Therefore, all direct supervisors of frontline staff are required to complete the FCT Supervisory Certification Course which includes an experiential practice-based component.

The requirements for the FCT Management and Supervisory Course also include the successful completion of the online training curriculum as well as the assignments associated with each unit. There are eight units in the online curriculum and FCT Supervisor Certification is overseen by the FCT Foundation. The FCT Supervision curriculum consists of learning key concepts on how to guide staff in delivering each phase of treatment effectively. There are supervisory documents that help guide the process to ensure that supervisors are adhering to and producing high fidelity to the model.

Coding			
Procedure Code	**Service Description**	**Rate**	**Billing Frequency**
H2022 U5-U1 H2022 U5-U2 H2022 U5-U3 H2022 U5-U4	FCT: H2022-U5-U1 Per month= 6 units FCT Outcome: H2022-U5-U3 Per 3 months = 1 unit FCT Outcome H2022-U5-U4 Per 6 months = 1 unit	Based on Fee Schedule or Contract	1 Unit = 30 Days

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Discussion/General Information

Reason the service is needed/Gap service intends to fill:
FCT has been a structured, manualized model since 2004, and the model achieved evidence-based status in 2010. FCT is an alternative model to IIH that is grounded in the use of treatment components that are sound and research based. FCT is comprehensive and designed to address the causes of family system breakdown. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement, and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Quality Professional's effective practice. FCT is one of few home- based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost-effective and stabilizes youth at risk and their families.

This model not only focuses on changing negative behaviors—it also emphasizes the value of positive change so that families are more likely to sustain improvements in family functioning after treatment. FCT Qualified Professionals are available to families 24/7.

Data will be uploaded to the state by CFSP at the frequency required by CMS. Monthly payment, outcome payments and encounter data are kept for all services. FCT oversees and consistently performs program evaluation through data analysis (data is given to FCT Foundation on a quarterly basis for evaluation). Healthy Blue Care Together intends to receive copies of the external fidelity reviews regularly. Healthy Blue Care Together will conduct post service review to ensure eligibility for outcome payments as they are requested.

Expected Outcome as identified by the Family Centered Treatment Foundation

- Decrease in trauma symptomology.
- Decrease in psychiatric or substance use disorder symptoms.
- Reduction of hurtful and harmful behaviors affecting family functioning.
- Improved family functioning.
- Improved functioning in the home, school, and community setting
- Increased utilization of learned coping skills and social skills.

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- Increased utilization of natural supports in the community.
- Increased capacity to monitor and manage the individual's behavior.
- Increased connection to community services and resources.
- Increased family engagement in treatment (85%).
- Increased rates of permanency (80% of members will remain in their home, reunite with their family, live independently or have a planned placement upon discharge).

Expected Outcomes Measured by Healthy Blue Care Together

- Decrease in crisis episodes and psychiatric inpatient stays.
- Decrease in the length of stay in inpatient, crisis facilities, PRTFs and other Residential Placements.
- Decrease in the number of Emergency Department (ED) visits.
- Maintenance of low recidivism rate (target = less than 10% of clients will require future FCT services minimally six months post discharge because of an increase in sustainability and stability due to focus on family functioning).

Eligibility For Outcome Payments Dependent Upon The Following Criteria

- No inpatient, Facility Based Crisis admissions.
- No residential Level II or higher from discharge (planned or unplanned).
- No return to FCT, admission to IIH, MST, Intercept, or comparable Adult Services.

Targeted Length of Service

FCT's anticipated length of stay is six months or 6 monthly units. Outcome payments for three and six months are eligible for FCT recipients who are discharged from episode duration of one to six months.

a. National target standards are 6 months, with the national average at 6.4 months (n=>2,000 families).
b. It is important to note that in scenarios where reunification or 'unknown' reunification is the objective the national benchmarks for 6 months of service differs. When permanency

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or reunification is in question, additional time to work with the family/caregivers/child is often warranted, extending the treatment time to 9-11 months. The rationale for this includes the following:

i. Additional time is often needed to assess safety and permanency needs in the early months.
ii. Frequently systems (courts) exceed 6 months to make a ruling surrounding permanency. iii. The underlying complex dynamics of the systems involved: extreme distrust of the agencies and resistance to intervention and treatment require much longer treatment times for developing trust necessary for effective engagement and adjustments that often occur to the permanency plan.

Definitions

In Lieu of Services (ILOS): Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.

Acronyms

ILOS: In Lieu of Services
CCP: Clinical Coverage Policy
EPSDT: Early and Periodic Screening, Diagnostic and Treatment

References

Centers for Medicare & Medicaid Services. (n.d.). *In Lieu of Services and Settings (ILOS).* Federal guidance pursuant to 42 C.F.R. § 438.3(e)(2) and 42 C.F.R. § 438.6.NC

NC Medicaid/DHHS Clinical Coverage Policy 8A — Enhanced Mental Health and Substance Abuse Services (Amended Jan 1, 2025).

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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(DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C

DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) Items 1 through 12, under Contents of a Service Note, Chapter 7 of the RMDM.

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act].

Glickman, S., Fuller-Holden, J., Wood, T., Painter, B., Schenk, K., Cunningham, P., McDuffie, J., and Boyd, l. The Family Centered Treatment (FCT): At-A-Glance. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Websites for Additional Information

Family Centered Treatment Foundation:

familycenteredtreatment.org/

NC Tracks Provider Claims and Billing Assistance Guide:
nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: ncdhhs.gov/dma/epsdt

History

Status	Date	Action
Draft	11/21/2025	Revised
Approved	02/10/2026	Approved by Medical Operation Committee (MOC)

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