MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 28, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health and Alcohol/Substance Abuse Services are being proposed to remove Medical Supervision from the Behavioral Health Community Network (BHCN) and clarify the roles of Clinical and Direct Supervision within the BHCN.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change may affect Medicaid-enrolled providers delivering Medical Supervision to BHCNs. Those provider types include, but are not limited to, Physician, M.D., Osteopath, D.O., Provider Type (PT) 20.

Financial Impact on Local Government: unknown at this time.

These changes are effective April 29, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
OL 03/13/20 Chapter 400 – Mental Health and Alcohol/Substance Abuse Services	MTL 03/17, MTL 14/19, MTL 19/18 Chapter 400 – Mental Health and Alcohol/Substance Abuse Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.1A	**Outpatient Service Delivery Models – Behavioral Health Community Networks (BHCN)**	Clarified Outpatient Mental Health (OMH). Clarified of Rehabilitative Mental Health (RMH).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.2(B)(2)	**Provider Standards**	Removed medical supervision and replaced with Clinical Supervision.
403.2(B)(6)(b)		Removed medical supervisor, replaced qualified mental health professionals and qualified mental health associates with mental health professional(s) and paraprofessionals.
403.2©(1)(a)		Removed "and/or rehabilitation plan."
403.2A(1)	**Supervision Standards**	Removed language for Medical Supervision. Added clarifying language that Clinical Supervision provides documented oversight of medically necessary and clinically appropriate service delivery within the BHCN, and Clinical Supervision is intended to be rendered on-site. Added clarifying language that Individual RMH providers, including interns, may not function as Clinical Supervisors over OMH assessments, therapy, testing and medication management.
403.2A(1)(c)	**Supervision Standards – Clinical Supervision**	Clarified language that Clinical Supervisors must assure all Subsections a. – h. Removed language for rehabilitation plan.
403.2A(1)(e)		Added language to include LCSW, LMFT, and CPC. Removed language for rehabilitation plan.
403.2A(3)		Added clarifying language that Direct Supervisors may be Independent Professionals who may coordinate OMH and/or RMH services. Removed language for rehabilitation plan.
403.2A(3)(c)		Remove "rehabilitation plan."
Attachment A – Policy #4-01	**Day Treatment Ages 3-6**	Removed language for Medical Supervision.
Attachment A - Policy #4-02	**Day Treatment Ages 7-18**	Added clarifying language that services are provided by a QMHP or by a QMHA under the Direct Supervision of a QMHP.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed language for Medical Supervision.
Attachment A - Policy #4-03	**Day Treatment Ages 19 and Older**	Added clarifying language that services are provided by a QMHP or by a QMHA under the Direct Supervision of a QMHP. Removed language for Medical Supervision.

403 POLICY

403.1 OUTPATIENT SERVICE DELIVERY MODELS

Nevada Medicaid reimburses for outpatient mental health and/or mental health rehabilitative services under the following service delivery models:

A. Behavioral Health Community Networks (BHCN)

Public or private entities that provides or contracts with an entity that provides:

1. Outpatient Mental Health (OMH) services, such as assessments, therapy, testing and medication management, including specialized services for Nevada Medicaid recipients who are experiencing symptoms relating to a covered, current International Classification of Diseases (ICD) diagnosis or who are individuals with a mental illness and residents of its mental health service area who have been discharged from inpatient treatment;

2. 24-hour per day emergency response for recipients; and

3. Screening for recipients under consideration for admission to inpatient facilities.

BHCNs are a service delivery model and are not dependent on the physical structure of a clinic. BHCNs can be reimbursed for all services covered in this chapter and may make payment directly to the qualified provider of each service. BHCNs must coordinate care with Rehabilitative ~~m~~Mental ~~h~~Health (RMH) rehabilitation providers.

B. Independent Professionals – State of Nevada licensed: psychiatrists, psychologists, clinical social workers, marriage and family therapists and clinical professional counselors. These providers are directly reimbursed for the professional services they deliver to Medicaid-eligible recipients in accordance with their scope of practice, state licensure requirements and expertise.

C. Individual Rehabilitative Mental Health (RMH) providers must meet the provider qualifications for the specific service. If they cannot independently provide Clinical and Direct Supervision, they must arrange for Clinical and Direct Supervision through a contractual agreement with a BHCN or qualified ~~i~~Independent ~~p~~Professional. These providers may directly bill Nevada Medicaid or may contract with a BHCN.

403.2 PROVIDER STANDARDS

A. All providers must:

1. Provide medically necessary services;

2. Adhere to the regulations prescribed in this chapter and all applicable Division chapters;

3. Provide only those services within the scope of their practice and expertise;

4. Ensure care coordination to recipients with higher intensity of needs;

5. Comply with recipient confidentiality laws and Health Insurance Portability and Accountability Act (HIPAA);

6. Maintain required records and documentation;

7. Comply with requests from the Qualified Improvement Organization (QIO)-like vendor;

8. Ensure client's rights; and

9. Cooperate with the Division of Health Care Financing and Policy's (DHCFP's) review process.

B. BHCN providers must also:

1. Have written policies and procedures to ensure the medical appropriateness of the services provided;

2. Operate under ~~medical~~ Clinical supervision and ensure ~~medical~~ Clinical supervisors operate within the scope of their license and expertise and have written policies and procedures to document the prescribed process;

3. Ensure access to psychiatric services, when medically appropriate, through a current written agreement, job description or similar type of binding document;

4. Utilize ~~c~~Clinical ~~s~~Supervision as prescribed in this chapter and have written policies and procedures to document the process to ensure ~~c~~Clinical ~~s~~Supervision is performed on a regular, routine basis at least monthly and the effectiveness of the mental health treatment program is evaluated at least annually;

5. Work on behalf of recipient's in their care to ensure effective care coordination within the state system of care among other community mental health providers and other agencies servicing a joint recipient;

6. Implement and maintain a Quality Assurance (QA) program which continually assesses quality measures and seeks to improve services on an ongoing basis. A QA program description must be submitted upon enrollment and updated annually

on the anniversary of the BHCN enrollment month. The BHCN's QA program description and report must include the following:

a. A list of behavioral health services and evidence-based practices that the BHCN provides to recipients.

1. Identify the goals and objectives of the services and methods which will be used to restore recipient's highest level of functioning.

b. An organization chart that outlines the BHCN's supervisory structure and the employees and positions within the agency. The organizational chart must identify the ~~medical supervisor, c~~Clinical ~~s~~Supervisor(s), ~~d~~Direct ~~s~~Supervisor(s), affiliated ~~qualified~~ mental health professional(s) and ~~qualified mental health associate(s) including~~paraprofessionals names and National Provider Identifier (NPI) numbers for each.

c. Document how clinical and supervisory trainings are conducted and how they support standards to ensure compliance with regulations prescribed within MSM Chapter 400. Provide a brief description of material covered, date, frequency and duration of training, location, names of employees that attended and the name of the instructor.

d. Demonstration of effectiveness of care, access/availability of care and satisfaction of care. The BHCN must adhere to the QIO-like vendor's billing manual for further instructions concerning the required quality measures below. The following quality measures are required:

1. Effectiveness of care:

a. Identify the percentage of recipients demonstrating stable or improved functioning.

b. Develop assessment tool to review treatment and/or rehabilitation plans and report results of assessment.

2. Access and availability to care:

a. Measure timeliness of appointment scheduling between initial contact and rendered face to face services.

3. Satisfaction of care:

a. Conduct a recipient and/or family satisfaction survey(s) and

provide results.

b. Submit a detail grievance policy and procedure.

e. The DHCFP may require the BHCN to submit a DHCFP approved Corrective Action Plan (CAP) if the BHCN's QA report has adverse findings. The BHCN's CAP shall contain the following and must be provided within 30 days from the date of notice:

1. The type(s) of corrective action to be taken for improvement;

2. The goals of the corrective action;

3. The timetable for action;

4. The identified changes in processes, structure, internal/external education;

5. The type of follow-up monitoring, evaluation and improvement.

f. QA Programs must be individualized to the BHCN delivery model and services provided. Duplication of QA documentation between BHCNs may be cause for rejection without review.

Failure to submit QA Program documentation or failure to meet standards of the QA Program and/or Corrective Action Plan (CAP) as required in MSM 403.B.6 within designated timeframes will result in the imposition of sanctions including, but not limited to, partial suspension and/or termination of the BHCN provider contract. Further clarification of the QA Program requirements may be found in the billing manual.

A BHCN that is accredited through the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or Council of Accreditation (COA) may substitute a copy of the documented QA program and report required for the certification in lieu of the requirements of MSM 403.2B.6. Accreditation must be specific to a BHCN delivery model.

C. Recipient and Family Participation and Responsibilities

1. Recipients or their legal guardians and their families (when applicable) must:

a. Participate in the development and implementation of their individualized treatment plan ~~and/or rehabilitation plan~~;

b. Keep all scheduled appointments; and

c. Inform their Medicaid providers of any changes to their Medicaid eligibility.

403.2A SUPERVISION STANDARDS

~~1. Medical Supervision – The documented oversight which determines the medical appropriateness of the mental health program and services covered in this chapter. Medical supervision must be documented at least annually and at all times when determined medically appropriate based on review of circumstance. Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication. Medical supervision may be secured through a current written agreement, job description or similar type of binding document. Behavioral Health Community Networks and all inpatient mental health services are required to have medical supervision.~~

~~2.~~1. Clinical Supervision – The documented oversight by a Clinical Supervisor to assure the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided, under ethical standards and professional values set forth by state licensure, certification, and best practice. Clinical Supervision is intended to be rendered on-site and Clinical Supervisors must be available to consult with all clinical staff. Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Clinical Professional Counselors (CPC) and Qualified Mental Health Professionals (QMHP~~s~~), excluding Interns, operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials and licensure to coordinate and oversee an array of mental and behavioral health services. ~~Clinical Supervisors must assure that the mental and/or behavioral health services provided are medically necessary and clinically appropriate.~~ Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided by clinical staff, including Independent Professionals, QMHPs, and Individual RMH providers, including Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). Clinical Supervisors can supervise other LCSWs, LMFTs, CPCs, QMHPs, ~~Qualified Mental Health Associates (~~QMHA~~)~~ and ~~Qualified Behavioral Aides (~~QBAs~~)~~. Clinical Supervisors may also function as Direct Supervisors.

Individual RMH providers, who are LCSWs, LMFTs, CPCs, and QMHPs, excluding Interns, may function as Clinical Supervisors over RMH services. However, ~~Independent~~ Individual RMH providers, who are QMHPs, including interns, may not function as Clinical Supervisors over ~~Outpatient Mental Health~~OMH ~~assessments or therapies~~ services, such as assessments, therapy, testing and medication management. Clinical Supervisors must assure the following:

a. An up to date (within 30 days) case record is maintained on the recipient; and

b. A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services); and

c. A comprehensive and progressive treatment plan ~~and/or rehabilitation plan~~ is developed and approved by the ~~c~~Clinical ~~s~~Supervisor and/or a ~~d~~Direct ~~s~~Supervisor, who is a QMHP, LCSW, LMFT or CPC; and

d. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive and age and developmentally appropriate; and

e. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, ~~that~~ the recipient and their family/legal guardian (in the case of legal minors) sign the treatment ~~and/or rehabilitation~~ plan~~(s)~~ and ~~that~~ the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment ~~and/or rehabilitation~~ plan(s); and

f. The recipient and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing; and

g. Only qualified providers provide prescribed services within scope of their practice under state law; and

h. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

~~3~~2. Direct Supervision – Independent Professionals, QMHPs and/or QMHAs may function as ~~d~~Direct ~~s~~Supervisors. Direct ~~s~~Supervisors must have the practice-~~-~~specific education, experience, training, credentials, and/or licensure to coordinate an array of ~~mental and/or behavioral~~ OMH and/or RMH ~~health~~ services. Direct ~~s~~Supervisors assure servicing providers provide services in compliance with the established treatment~~/rehabilitation~~ plan(s). Direct ~~s~~Supervision is limited to the delivery of services and does not include treatment and~~/or rehabilitation~~ plan(s) modification and/or approval. If qualified, ~~d~~Direct ~~s~~Supervisors may also function as ~~c~~Clinical ~~s~~Supervisors. Direct ~~s~~Supervisors must document the following activities:

a. Their face-to-face and/or telephonic meetings with ~~c~~Clinical ~~s~~Supervisors.

1. These meetings must occur before treatment begins and periodically thereafter;

2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

3. This supervision may occur in a group and/or individual settings.

b. Their face-to-face and/or telephonic meetings with the servicing provider(s).

1. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter;

2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

3. This supervision may occur in group and/or individual settings;

c. Assist the ~~c~~Clinical ~~s~~Supervisor with ~~t~~Treatment ~~and/or rehabilitation p~~Plan~~(s)~~ reviews and evaluations.

403.2B DOCUMENTATION

1. Individualized Treatment Plan

a. A written individualized treatment plan, referred to as Treatment Plan, is a comprehensive, progressive, personalized plan that includes all prescribed Behavioral Health (BH) services, to include Rehabilitative Mental Health (RMH) and Outpatient Mental Health (OMH) services. A Treatment Plan is person-centered, rehabilitative and recovery oriented. The treatment plan addresses individualized goals and objectives. The objective is to reduce the duration and intensity of BH services to the least intrusive level possible while sustaining overall health. BH services are designed to improve the recipient's functional level based on achievable goals and objectives as determined in the Treatment Plan that identifies the amount and duration of services. The Treatment Plan must consist of services designed to achieve the maximum reduction of the BH services required to restore the recipient to a functional level of independence.

b. Each prescribed BH service within the Treatment Plan must meet medical necessity criteria, be clinically appropriate and must utilize evidence-based practices.

c. The prescribed services within the plan must support the recipient's restoration of functioning consistent with the individualized goals and objectives.

d. A Treatment Plan must be integrated and coordinated with other components of overall health care.

e. The person-centered treatment plan must establish strength-based goals and

2. NON-COVERED SERVICES

a. Transportation or services delivered in transit.

b. Facilities licensed as a daycare.

c. Club house, recreational, vocational, afterschool or mentorship programs.

d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

e. Routine supervision, monitoring or respite.

f. Non-evidenced based models.

g. Non milieu models.

h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement day treatment programs must be separately enrolled with the DHCFP. Program Criteria:

1. Services not to exceed three hours per day, five days per week;

2. Parental/caregiver involvement and participation in the day treatment program;

3. Ongoing participation in family counseling/therapy;

4. Minimum staff to recipient ratio is 1:3;

5. Maximum group size is six;

6. Therapeutic milieu design;

7. Services must be provided by a Qualified Mental Health Professional (QMHP) or by a Qualified Mental Health Associates (QMHA) under the ~~d~~Direct ~~s~~Supervision of an onsite QMHP;

8. Evidence based programmatic model with established curriculum and schedule;

9. Program admission, service continuation and discharge criteria; and

10. Policies and procedures specific to the day treatment program which at a minimum address the following:

a. ~~Medical, c~~Clinical~~,~~ and ~~d~~Direct ~~s~~Supervision;

b. Health Insurance Portability and Accountability Act (HIPAA) and client's rights;

c. Service provision and documentation; and

d. Admission and discharge criteria and process.

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor website.

A. DESCRIPTION

Day treatment services are interventions performed in a therapeutic milieu designed to provide evidence-based strategies to reduce emotional, cognitive and behavioral problems. Day treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community-based settings.

B. POLICY

Day treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day treatment services must:

1. Have goals and objectives that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and RMH services; and
3. Provided under a BHCN medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

a. CASII score of III or higher;

b. A primary covered, current ICD diagnosis;

c. Determined SED;

d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. Adequate social support system available to provide the stability necessary for maintenance in the program; and

g. Emotional, cognitive and behavioral health issues which:

1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;

2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, school and/ or home placements.

Service Limitations	Ages 7-18: CASII
Levels I & II	No Services Authorized
Level III	Maximum of four hours per day
Level IV	Maximum of five hours per day
Levels V & VI	Maximum of six hours per day

2. NON-COVERED SERVICES

a. Transportation or services delivered in transit.

b. Facilities licensed as a daycare.

c. Club house, recreational, vocational, afterschool or mentorship programs.

d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

e. Routine supervision, monitoring or respite.

f. Non-evidenced based models.

g. Non milieu models.

h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement day treatment programs must be separately enrolled with the DHCFP.

1. Program Criteria:

a. Services not to exceed six hours per day, five days per week;

b. Parental/caregiver involvement and participation in the day treatment program;

c. Ongoing participation in individual therapy (not reimbursed under day treatment model);

d. Minimum staff to recipient ratio is 1:5;

e. Maximum group size is 10;

f. Therapeutic milieu design;

g. Services must be provided by a QMHP or by a QMHA under the ~~d~~Direct ~~and c~~Clinical ~~s~~Supervision of an onsite QMHP;

h. Evidence based programmatic model with established curriculum and schedule;

i. Program admission, service continuation and discharge criteria; and

j. Policies and procedures specific to the day treatment program which at a minimum address the following:

1. ~~Medical, c~~Clinical~~,~~ and ~~d~~Direct ~~s~~Supervision;

2. HIPAA and client's rights;

3. Service provision and documentation; and

4 Admission and discharge criteria and process.

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor website.

A. DESCRIPTION

Day treatment services are RMH interventions performed in a therapeutic milieu to provide evidence-based strategies to restore and/or retain psychiatric stability, social integration skills and/or independent living competencies to function as independently as possible. Services provide recipients the opportunity to implement and expand upon what was previously learned from other mental or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to prepare recipients for reintegration back into home and community-based settings, prevent hospitalizations and ensure stability.

B. POLICY

Day treatment coverage and reimbursement is limited to medically necessary services and are covered at an hourly rate.

Day treatment services must:

1. Have goals and objective that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Must involve the recipient and family or other individuals, as appropriate, and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based, out of home services.
2. A fluid combination of all the RMH services.
3. Provided under a BHCN medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate that the recipient meets all of the following criteria:

a. Must have Level of Care Utilization System for Adults (LOCUS) score of IV, V or VI;

b. A primary covered, current ICD diagnosis;

c. Determined as Serious Mental Illness (SMI);

d. Requires and benefits from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. The recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. An adequate social support system is available to provide the stability necessary for maintenance in the program; and

g. Recipient's emotional, cognitive and behavioral issues which:

1. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

2. are incapacitating, interfere with daily activities or place others in danger to the point that it causes anguish or suffering.

Service Limitations	Ages 19 and older: LOCUS
Levels I & II	
Level III	
Level IV	Maximum of five hours per day
Levels V & VI	Maximum of six hours per day

2. NON-COVERED SERVICES

a. Transportation or services in transit.

b. Facilities licensed as adult daycare may not provide day treatment services.

c. Recreational, mentorship or club house programs.

d. Services in a home based or home like settings, including campus/institutions that furnish in single or multiple areas, food, shelter and some treatment/services to four or more persons unrelated to the proprietor.

e. Non-evidenced based models.

f. Non milieu models.

g. Programs restricted to only those recipients residing at the same location.

E. PROVIDER REQUIREMENTS

1. Program Criteria:

a. Day Treatment services must be provided by a QMHP or by a QMHA under the ~~d~~Direct ~~s~~Supervision of an onsite QMHP;

b. Services not to exceed a maximum of six hours a day, five days a week;

c. Must involve the recipient and family or other individuals, as appropriate in the day treatment program and family counseling/therapy;

d. Minimum staff to recipient ratio is 1:5;

e. Maximum group size is 10;

f. Therapeutic milieu design;

g. Evidence based programmatic model with established curriculum and schedule;

h. Program admission, service continuation and discharge criteria in place; and

i. Policies and procedures specific to the day treatment program which as a minimum address the following:

1. ~~Medical, c~~Clinical and ~~d~~Direct ~~s~~Supervision;

2. HIPAA and client's rights;

3. Service provision and documentation; and

4. Admission and discharge criteria and process

Day treatment services will only be reimbursable to those programs which have been approved and enrolled to serve as Day Treatment Program service providers