Day Treatment Model (Specialty 308)

Day Treatment services will only be reimbursable for those Provider Type (PT) 14 Behavioral Health Community Network (BHCN) groups which have a Day Treatment Model approved by the Division of Health Care Financing and Policy (DHCFP). Providers who do not have an approved model will not be reimbursed for Day Treatment services. Requests for review for prior authorization for this service are to be submitted through the Provider Web Portal.

Providers, please be advised that if the information provided is incomplete, illegible or does not clearly articulate the information requested, the provider's Day Treatment Model may be rejected. This enrollment document is specific to Day Treatment services (H2012) only and will not impact any other services under the PT 14 delivery model.

Provider Group Name: _____ Date: _____

Group National Provider Identifier (NPI): _____

1. Identify the following providers in your provider group:

   Clinical Supervisor Name and NPI:_____

   Signature of Clinical Supervisor:_____

   Direct Supervisor Name and NPI: _____

   Signature of Direct Supervisor:_____

2. Identify the *onsite* Qualified Mental Health Professional(s) (QMHP) providing services in your provider group and identify who provides Direct Supervision. *Attach additional sheet if necessary and reference this question number.*

   Name and NPI of QMHP: _____

   Name and NPI of QMHP: _____

3. If services are being performed by a Qualified Mental Health Associate(s) (QMHA), identify the QMHA(s) in your provider group. *Attach additional sheet if necessary and reference this question number.*

   Name and NPI of QMHA: _____

   Name and NPI of QMHA: _____

4. Is your Day Treatment program located in a home-based or home-like setting, which includes campus/institutions that furnish in single or multiple areas, food, shelter and some treatment/services to four or more persons unrelated to the proprietor?

   ☐ Yes ☐ No

5. Indicate the staff-to-recipient ratio for each age group you work with (*put "NA" next to groups you do not work with*):

   3-6_____ 7-18_____ 19 & Older_____

6. Indicate the maximum group size per age group (*put "NA" next to groups you do not work with*):

   3-6_____ 7-18_____ 19 & Older_____

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7. Attach a separate document(s) for your responses to the questions/requests below and be sure to identify the question. Initial next to each request below indicating your response is attached. Identify the applicable age groups if practices differ.
   (DHCFP may request additional information on evidence based model if needed and the provider's documentation should not exceed 3 pages)

   _____ a. What combination of services does your Day Treatment program provide?

   _____ b. What types of emotional, cognitive and behavioral problems does your Day Treatment program target?

   _____ c. How does your programmatic model ensure the active participation of the recipient and family/legal guardian's in Day Treatment and in outpatient treatment services such as family counseling/therapy?

   _____ d. Describe the therapeutic milieu design and how your Day Treatment program restores recipients to their highest level of functioning and prepares them for re-integration back into home and community based settings.

   _____ e. Identify the evidence-based practice(s) you are utilizing for each category (emotional, cognitive and behavioral skills) and provide an abbreviated or condensed curriculum. At a minimum this would address restoration of emotional, cognitive and behavioral skills.

   _____ f. Provide a schedule of your curriculum(s) and identify age groups they are associated to.

8. Provider's Clinical Supervisor must self attest that the following policies and procedures specific to the Day Treatment program, at a minimum, address the following (Clinical Supervisor must initial):

   _____ Clinical and Direct Supervision; and

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

   _____ Service provision and documentation; and

   _____ Admission and discharge criteria and process

Clinical Supervisor's Name and NPI: _____

Signature: _____ Date: _____

Note:

The provider is advised that the Day Treatment Model may be rejected and sent back to the provider without review if the information submitted is illegible or does not provide concise, direct or clearly articulated information.

Request for Review:

Once enrolled with the Day Treatment specialty, the provider is advised that requests for review for Day Treatment must be submitted electronically through the Provider Web Portal. Providers who are enrolled with the Day Treatment specialty must therefore be registered to use the Provider Web Portal to submit their requests for review. Providers may register by using the Nevada Medicaid website (www.medicaid.nv.gov); select the "EVS" tab and the "Provider Login (EVS)" option.