Provider Type 14 and Provider Type 82: Qualified Behavioral Aide (QBA), Specialty 302

This checklist must be completed and submitted with the attachments listed below. If you have any questions, please contact the Nevada Medicaid Provider Enrollment Unit at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Provider Name: _____ Date: _____

National Provider Identifier (NPI): _____

Attachments

Initial each space below to signify that the specified item is attached.

_____ SS-4, CP575 or W-9 form showing tax payer identification number (this may be the employer's tax ID; individual providers do not need their own tax ID if they are an employee of an entity/agency/group with a tax ID)

_____ High School Diploma or General Education Development (GED) equivalent

_____ Tuberculosis (TB) test with negative results or medical clearance as outlined in NAC 441.A375

_____ Documentation showing that the provider completed the initial 16-hour competency and in-services training program as described in Nevada Medicaid Services Manual (MSM) Chapter 400and a summary/outline of all course content

_____ Copy of current cardio pulmonary resuscitation (CPR) certification

_____ Provider Enrollment Application and Contract *(original document/signatures required)*

_____ National Provider Identifier (NPI) validation: Printed page from the NPPES NPI Registry displaying the provider's NPI or a printed copy of the email confirmation showing the provider's NPI

Policy Declaration

I hereby declare that I have read the current MSM Chapters 100, 400 and 3300 as of the date above and understand the policies and how they apply to my scope of service. I acknowledge that, as a Nevada Medicaid-contracted provider, I am responsible for complying with the MSM, and with any updates that may occur to these policies as applicable by state and federal laws.

Based on this understanding, I will abide by the scope of service, provider qualifications, service limitations and admission criteria detailed in MSM Chapter 400, Basic Skills Training (BST) and Peer to Peer Support Services.

I meet all provider qualifications outlined in MSM Chapters 100 and 400.

QBA Signature: _____ Date: _____

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Policy Acknowledgement

By initialing each of the four bolded items below, I agree to conform to these policy requirements.

_____ Service Delivery Models (MSM Chapter 400)

Individual rehabilitative mental health providers (RMH) 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 Behavioral Health Community Network (BHCN) or qualified independent professional. These providers may directly bill Nevada Medicaid or may contract with a BHCN.

_____ Provider Standards (MSM Chapter 400)

All providers must:

1. Provide medically necessary services;
2. Adhere to the regulations prescribed in Chapter 400 and all applicable Division chapters;
3. Provide only those services within the scope of their [the provider's] 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 Quality Improvement Organization (QIO)-like vendor [DXC Technology, which is referred to as Nevada Medicaid];
8. Ensure client's [recipient's] rights; and
9. Cooperate with Division of Health Care Financing and Policy's (DHCFP's) review process.

_____ Rehabilitative Mental Health Services (MSM Chapter 400)

QBAs may provide Basic Skills Training (BST) services under the clinical supervision of a Qualified Mental Health Professional (QMHP) and the direct supervision of a QMHP or a Qualified Mental Health Associate (QMHA). Peer-to-peer support services must be provided under the clinical and direct supervision of a QMHP.

_____ Competency and In-services Training (MSM Chapter 400)

QBAs must successfully complete an initial 16-hour training program before enrolling as Medicaid providers. This training must be interactive, not solely based on self-study guides or videotapes, and should ensure the QBA will be able to interact appropriately with individuals with mental health disorders. At a minimum, this training must include the following core competencies:

a. Case file documentation;

b. Recipient's rights;

c. Client confidentiality pursuant to state and federal regulations;

d. Communication skills;

e. Problem solving and conflict resolution skills;

f. Communication techniques for individuals with communication or sensory impairments;

g. Cardio Pulmonary Resuscitation (CPR) certification (certification may be obtained outside the agency); and

h. Understanding the components of a Rehabilitation Plan.

Clinical and Direct Supervisors

I understand that I must have clinical and direct supervision when providing services to Nevada Medicaid recipients. The name, title, contact phone and signature of my current clinical and direct supervisors are provided below.

Clinical Supervisor Name: _____

Professional Title (attach a copy of credentials/license): _____

NPI:_____ Contact Phone: _____

Clinical Supervisor Signature: _____

Direct Supervisor Name: _____

Professional Title (attach a copy of credentials/license): _____

NPI:_____ Contact Phone: _____

Direct Supervisor Signature: _____

Changes to Medicaid Information

If your direct supervisor, clinical supervisor or employer change or any other pertinent information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within five working days. To comply with this notification requirement, complete the relevant sections of form FA-33 (which is online at https://www.medicaid.nv.gov/) and submit the form to Nevada Medicaid.

Per MSM Chapter 100 Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, **any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds**. Failure to do so may result in termination of the contract at the time of discovery.

I hereby accept Nevada Medicaid's change notification requirements:

QBA Provider Signature: _____ Date: _____

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Reporting Fraud

I understand that Nevada Medicaid payments are made from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

Providers have an obligation to report to the Division of Health Care Financing and Policy (DHCFP) any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers (MSM Chapter 3300). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405.

I hereby agree to abide by Nevada Medicaid's fraud reporting requirements:

QBA Provider Signature: _____ Date: _____