# Provider Type 14 and Provider Type 82: Qualified Mental Health Associate (QMHA), Specialty 301

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 a copy of the specified item is attached.*

_____ SS-4, CP575 or W-9 form showing Taxpayer 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)

_____ Professional license or qualifying degree (official transcript required)

_____ Relevant work experience or resume, if applicable

_____ 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 400, Section 403.6A.1b and a summary/outline of all course content

_____ 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 practice. 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 agree to abide by the scope of service, provider qualifications, service limitations and admission criteria detailed in sections:

☐ "Outpatient Mental Health (OMH) Services" and

☐ "Rehabilitative Mental Health (RMH) Services."

**QMHA Signature: _____ Date: _____**

**Provider Type 14 and Provider Type 82:**
**Qualified Mental Health Associate (QMHA), Specialty 301**

## Policy Acknowledgement

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

**_____ Service Delivery Models (MSM Chapter)**

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)**

QMHPs may provide Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), peer-to-peer support, Psychosocial Rehabilitation (PSR) services and Crisis Intervention (CI) services. Day Treatment services may be requested and reimbursed for Provider Type 14 groups who are enrolled with Specialty 308 and have a Day Treatment Model approved by DHCFP. Day Treatment may not be performed or reimbursed by individuals enrolled as a Provider Type 14 with specialties 300, 305, 306 and 307.

**_____ Direct Supervision (MSM Chapter 400)**

Direct supervisors must document the following activities:

1. Their [the direct supervisor's] face-to-face and/or telephonic meetings with Clinical supervisors.
   a. These meetings must occur before treatment begins and periodically thereafter;
   b. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and
   c. This supervision may occur in a group and/or individual setting.
2. Their [the direct supervisor's] face-to-face and/or telephonic meetings with the servicing providers.

a. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter;
b. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and
c. This supervision may occur in group and/or individual settings.

3. Assist the Clinical Supervisor with Treatment and/or Rehabilitation Plan(s), reviews and evaluations.

## Qualifications (MSM Chapter 400)

*Initial the appropriate QMHA qualification that applies to you.*

*If utilizing an option that includes credits in accepted areas of study, you must provide transcripts, a list of courses that meet the accepted areas and a valid course catalog description of each course. Applicant will demonstrate four years of full-time relevant professional experience. Documentation will include agency or group name, number of weekly hours worked, and dates of employment.* **Accepted list:** Accepted degrees/areas of study from an accredited college or university are: Psychology, Sociology, Community Health Sciences, Health Ecology, Public Health, Social Work, Human Development and Family Studies, Early Childhood Education, Nursing, Speech Pathology and Anthropology.

_____ Licensure as a Registered Nurse (RN) in the State of Nevada; or

_____ Bachelor's Degree from accepted list above with additional understanding of Rehabilitative Mental Health (RMH) treatment services and documentation requirements; or

_____ Bachelor's Degree, not on the accepted list above, with a minimum of 30 credits in the accepted areas of study with additional understanding of RMH treatment services and documentation requirements; or

_____ Bachelor's or Associate's Degree, not on the accepted list above, with a minimum of 15 credits in the accepted areas of study and four years of full-time relevant professional experience. Experience must include providing direct service to individuals with mental health disorders with additional understanding of RMH treatment services and documentation requirements.

I have read, understand and meet the qualifications as outlined in MSM chapters 100 and 400.

**QMHA Signature: _____ Date: _____**

## Supervisors

I understand that I must have clinical and direct supervision when providing services to Nevada Medicaid recipients. I have read, understand and meet the qualifications as outlined in MSM Chapter 400, Provider Qualifications for a QMHP. 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: _____**

**Provider Type 14 and Provider Type 82:**
**Qualified Mental Health Associate (QMHA), Specialty 301**

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 http://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:

**QMHA Signature: _____ Date: _____**

## 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:

**QMHA Signature: _____ Date: _____**