



**Qualified Mental Health Professional (QMHP), Specialty 300**

This checklist must be completed and submitted with the attachments listed below. If you have any questions, please contact the 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 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)

\_\_\_\_ Professional license

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

**Policy Declaration**

I hereby declare that I have read the current MSM Chapters 100, 400 and 3300 as of the date above and understand this policy and how it relates to my scope of practice. I acknowledge that, as a Nevada Medicaid-contracted provider, I am responsible for complying with the MSM, with any updates to this policy as may occur from time to time and with applicable state and federal laws.

**QMHP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Policy Acknowledgement**

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

\_\_\_\_ **Rehabilitative Mental Health Services (MSM 403.6B.3a)**

QMHPs may provide BST, Program for Assertive Community Treatment (PACT), day treatment, peer-to-peer support, PSR and crisis intervention (CI) services.

\_\_\_\_ **Service Delivery Models (MSM 403.1c)**

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.



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**Provider Standards (MSM 403.2A)**

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 Qualified Improvement Organization (QIO)-like vendor [HP Enterprise Services];
8. Ensure client's [recipient's] rights; and
9. Cooperate with Division of Health Care Financing and Policy's (DHCFP's) review process.

**Direct Supervision (Addendum – MSM Definitions)**

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 Plans, reviews and evaluations.



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**Clinical Supervision (Addendum - MSM Definitions)**

Clinical supervisors must assure the following:

1. An up to date (within 30 days) case record is maintained on the recipient;
2. 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);
3. A comprehensive and progressive treatment plan and/or rehabilitation plan is developed and approved by the clinical supervisor and/or a direct supervisor, who is a QMHP;
4. Goals and objectives are time specific, measurable (observable), achievable, realistic, time limited, outcome driven, individualized, progressive, and age and developmentally appropriate;
5. 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 plans, and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment and/or rehabilitation plans;
6. 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;
7. Only qualified providers provide prescribed services within scope of their practice under state law; and
8. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

**Qualifications**

I have read, understand and meet the qualifications as outlined in MSM Section 403.3B, Provider Qualifications for a QMHP.

**QMHP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Supervisor**

If I do not have a medical supervisor, I understand that I am only allowed to provide rehabilitation services and must be enrolled as a provider type 82.

The name, title, contact phone and signature of my current medical supervisor is provided below. (Check the box, "I do not have a medical supervisor," if applicable.)

Medical Supervisor Name: \_\_\_\_\_

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

NPI: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

**Medical Supervisor Signature:** \_\_\_\_\_

I do not have a medical supervisor.



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**Changes to Medicaid Information**

If your medical supervisor or employer changes or any other pertinent information changes from what is presented above and on your enrollment application, you are required to notify HP Enterprise Services 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 HP Enterprise Services.

*(Per MSM Chapter 100, Section 103.3 dated December 2008: 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 agree to abide by Nevada Medicaid’s change notification requirements:

**QMHP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reporting Fraud**

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, Section 3303.1B.1). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300, Section 3303.1A.2. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405.

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.

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

**QMHP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_