Provider Enrollment Checklist for Behavioral Health Community Network

Provider Type 14: Specialty 814, Entity/Agency/Group

This checklist must be completed and submitted with the attachments listed below. If you have any questions regarding this form, please contact the Nevada Medicaid Provider Enrollment Unit at (877) 638-3472.

Entity/agency/group name: _____ Date: _____

Entity/agency/group National Provider Identifier (NPI): _____

Please check one of the following boxes. **Updates** to Clinical and Direct Supervisors are reported using this form.

☐ New Enrollment: Complete all sections. Include a copy of all documents in the Attachments section below.

☐ Clinical Supervisor Update: Complete the first four items in the Supervisors section of this document.

☐ Direct Supervisor Update: Complete the last four items in the Supervisors section of this document.

☐ Revalidation: Complete all sections and provide updated Quality Assurance (QA) Program.

DISCLOSURES

Person(s) authorized to make changes (must **match** application). (*If more than one, attach additional sheet, include all information and reference this Disclosures section.)*

Name: _____

Title/Postion held within the entity/agency/group:_____

SSN:_____ DOB_____

Direct Phone Number:_____

Ownership Interest_____

Billing:

Please disclose your biller's information.

Name:_____

SSN:_____ DOB_____

Direct Phone Number:_____

Primary Address:_____

Is this person employed solely by the entity/agency/group? ☐ Yes ☐ No

If No, please provide the name of the entity/agency/group who employs this individual.

Entity/agency/group name:_____

Entity/Agency/Group Structure:

Please disclose the name of any investors/contractors/consultants associated with the entity/agency/group. (*If more than one, attach additional sheet, include all information and reference this Entity/Agency/Group Structure section.)* Please provide a copy of the legal contract (all pages).

Name:_____

Address: _____

Phone Number:_____

Primary Contact Person:_____

Provider Type 14: Specialty 814, Entity/Agency/Group

Attachments

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

_____ SS-4 or CP575 showing Employer Identification Number.

_____ Business license.

_____ Clinical Supervisor's professional license.

_____ Clinical Supervision policy (Clinical Supervision policy must detail how the entity/agency/group will 1) monitor and evaluate the quality/effectiveness of the services provided, 2) ensure medical services are appropriate and necessary, 3) ensure that providers operate under Clinical Supervision, 4) ensure that Clinical Supervisors operate within the scope of their licensure and expertise, and 5) ensure that all services are clinically appropriate.

_____ Quality Assurance (QA) program (QA program must detail how the entity/agency/group will perform internal monitoring and evaluation to improve quality of care. A Behavioral Health Community Network (BHCN) that is accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission, 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 in Medicaid Services Manual (MSM) Chapter 400 Section 403.2.B.6. Accreditation must be specific to a BHCN delivery model.) The QA program will be forwarded to the Division of Health Care Financing and Policy (DHCFP) for review. The DHCFP will send a separate notification once the documentation has been reviewed. Approved enrollment does not guarantee QA Program approval.

_____ When applicable, the BHCN must include its Intensive Outpatient Program (IOP) description and schedule as part of the behavioral health services with evidence-based practices listed in the QA program; these documents will be forwarded to the Division of Health Care Financing and Policy (DHCFP) for review.

_____ When applicable, the BHCN must include its contract to provide Partial Hospitalization Program (PHP), which specifically outlines the roles and responsibilities of both parties (hospital or Federally Qualified Health Center (FQHC) **and** BHCN) in providing this program. The BHCN must also include the program description in the behavioral health services with evidence-based practices listed in the QA program; these documents will be forwarded to the Division of Health Care Financing and Policy (DHCFP) for review.

_____ Provider enrollment application and contract *(original document/signatures required).*

Required Policies *(to be initialed by the Clinical Supervisor)*

As the Clinical Supervisor, I have reviewed and approved the following policies for this entity/agency/group:

_____ Clinical Supervision Policy

_____ Quality Assurance Policy

Required Services (to be initialed by the Clinical Supervisor)

A Behavioral Health Community Network (BHCN) entity/agency/group must offer the following services directly or through a written agreement with other qualified providers. (Nevada Medicaid is not responsible for reimbursement to employees and/or contracted providers of the entity/agency/group.)

As the Clinical Supervisor, I acknowledge that this entity/agency/group offers the following services:

_____ Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services such as assessments, therapy and testing

Provider Type 14: Specialty 814, Entity/Agency/Group

_____ Medication management and medication training & support (by medical professionals practicing under the scope and experience of their licensure in the State of Nevada, as identified on the QA Program, including the Organizational Chart)

_____ 24-hour per day emergency response for recipients

_____ Screening for recipients under consideration for admission to inpatient facilities

_____ Access to psychiatric services, when medically appropriate

_____ Case management

Clinical Supervisor Attestation (to be completed by the Clinical Supervisor)

As the Clinical Supervisor for the Behavioral Health Community Network (BHCN) entity named below, I hereby pledge to ensure that the BHCN works on behalf of recipients to ensure effective care coordination with other providers.

I acknowledge that I am licensed to practice in the State of Nevada, that I am enrolled as an Independent Professional with Nevada Medicaid, that I am practicing under the scope of my licensure, and that I have the competency to oversee and evaluate a comprehensive mental health treatment program.

Behavioral Health Community Network entity/agency/group name: _____

Clinical Supervisor name (print or type): _____

Clincal Supervisor professional title: _____

Clinical Supervisor NPI: _____ Contact phone: _____

Clinical Supervisor signature: _____ Date: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____
Facility/Provider Name NPI

_____
Signature of notarial officer Notary Stamp

Policy Acknowledgement *(to be completed by the owner or director)*

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

_____ Service Delivery Models (MSM Chapter 400)

A BHCN is a public or private entity that provides or contracts with an entity that provides:

1. Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services, such as assessments, therapy, testing, and medication management (by medical professionals practicing under the scope and experience of their licensure in the State of Nevada), including specialized

services for Nevada Medicaid recipients who are experiencing symptoms relating to a Diagnostic and Statistical Manual (DSM) Axis I 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 treatment 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 MSM Chapter 400 and may make payment directly to the qualified provider of each service. BHCNs must coordinate care with mental health rehabilitation providers.

_____ **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 Qualified Improvement Organization (QIO)-like vendor [Nevada Medicaid's fiscal agent];
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)**

1. Qualified Mental Health Professionals (QMPs) may provide Basic Skills Training (BST), Day Treatment, peer-to-peer support, Psychosocial Rehabilitation (PSR) 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 and/or the QIO-like vendor. Day Treatment services are not reimbursable to individuals enrolled as a Provider Type 14 with specialties 300, 305, 306 and 307.
2. Qualified Mental Health Associates (QMHAs) may provide BST, peer-to-peer support, and PSR services under the Clinical Supervision of a QMHP.
3. Qualified Behavioral Aides (QBAs) may provide BST services under the Clinical Supervision of a QMHP and [under] the Direct Supervision of a QMHP/QMHA. QBAs may provide peer-to-peer support services under the clinical/direct supervision of a QMHP.

_____ **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; and
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); and

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, LCSW, LMFT, CPC; and
4. Goals and objectives are time specific, measurable (observable), achievable, realistic, time limited, outcome driven, individualized, progressive, and age and developmentally appropriate; and
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; and
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; and
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.

_____ **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 plans, reviews and evaluations.

Supervisors (to be completed by the owner or director)

I understand that proper Clinical and Direct Supervision must be provided when services are rendered to Nevada Medicaid recipients. The name, title, contact phone and signature of the current, primary Clinical and Direct Supervisors are provided below.

Primary Clinical Supervisor name: _____

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

NPI:_____ Contact phone: _____

Primary Clinical Supervisor signature: _____

State of Nevada

County of _____

Provider Type 14: Specialty 814, Entity/Agency/Group

Signed and sworn before me on _____ by _____

For_____ _____
Facility/Provider Name NPI

_____
Signature of notarial officer Notary Stamp

Additional Clinical Supervisor name (as applicable) _____

Additional Clinical Supervisor Professional title (attach copy of credentials/license): _____

NPI:_____ Contact phone: _____

Additional Clinical Supervisor signature: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____
Facility/Provider Name NPI

_____
Signature of notarial officer Notary Stamp

Primary Direct Supervisor name: _____

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

NPI:_____ Contact phone: _____

Primary Direct Supervisor signature: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____
Facility/Provider Name NPI

_____
Signature of notarial officer Notary Stamp

Provider Type 14: Specialty 814, Entity/Agency/Group

Additional Direct Supervisor name (as applicable): _____

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

NPI:_____ Contact phone: _____

Additional Direct Supervisor signature: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____
Facility/Provider Name NPI

_____
Signature of notarial officer Notary Stamp

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. This entity meets all provider qualifications outlined in MSM Chapters 100 and 400. I also understand that I am responsible for ensuring that all owners, administrators, managing employees, and all other employees providing direct services have a fingerprint-based criminal background check through the Department of Public Safety and Federal Bureau of Investigation. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement and/or termination from the Medicaid program.

Owner or director signature: _____ **Date:** _____

Changes in Medicaid Information

If your Clinical Supervisor changes 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. Changes or additions in Clinical or Direct Supervision may be reported using this form. Changes in business ownership must be reported by resubmitting a new enrollment application and indicating ownership change. All ownership changes must include documentation of the purchase agreement. All other changes must be reported by using the Provider Web Portal at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx. After logging in, click on the "Revalidate – Update Provider" link under Provider Services. The Online Provider Enrollment User Manual Chapter 3 Revalidation and Updates on the Provider Enrollment webpage at https://www.medicaid.nv.gov provides instructions on navigating the Update Provider tool.

(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:

Owner or director signature: _____ **Date**: _____

Provider Type 14: Specialty 814, Entity/Agency/Group

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

Owner or director signature: _____ **Date:** _____

Owner/Director Attestation

I certify under penalty of perjury under the laws of the State of Nevada, that the information I have provided is true and correct and that I have read, understood, and agree to comply with all parts of this Provider Enrollment Checklist.

Owner/Director signature: _____ **Date:** _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____
Facility/Provider Name NPI

_____
Signature of notarial officer Notary Stamp