



Provider Enrollment Checklist for Behavioral Health Direct Service Provider

**Provider Type 14:  
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 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.*

- \_\_\_\_\_ Qualified Mental Health Professional Enrollment Checklist with original wet signatures and initials required; and
- \_\_\_\_\_ Certificate of Licensure of Clinical Supervisor with Agency/Entity/Group, if not enrolling to provide Clinical Supervision; and
- \_\_\_\_\_ Certificate of Professional licensure in the State of Nevada as a/an:
  - \_\_\_\_\_ Physician, Physician’s Assistant, Psychologist, Advanced Practitioner of Nursing (APN), Independent Nurse Practitioner (INP), Clinical Social Worker (LCSW), Marriage and Family Therapist (LMFT), or Clinical Professional Counselor (LCPC); or
  - \_\_\_\_\_ Master Social Worker (LMSW) with a current clinical post-graduate internship number and current letter of internship issued by the State of Nevada Board of Examiners (BOE) for Social Workers (Nevada Revised Statute (NRS) 641B); or
  - \_\_\_\_\_ Marriage and Family Therapist (LMFT) Post-Graduate Intern issued by the State of Nevada BOE for MFT & CPC (NRS 641A); or
  - \_\_\_\_\_ Clinical Professional Counselor (LCPC) Post-Graduate Intern issued by the State of Nevada BOE for MFT & CPC (NRS 641A)

**Policy Declaration**

I hereby declare that I have read the current Medicaid Services Manual (MSM) Chapters 100, 400 and 3300 as of the date below 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 Chapters, 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 bolded items below, I agree to conform to these policy requirements.*



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#### Service Delivery Models (MSM Chapter 400)

Individual Rehabilitative Mental Health (RMH) providers 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).

#### Provider Standards (MSM Chapter 400)

All providers must:

1. Provide medically necessary Medicaid covered 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 [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.

#### Outpatient Mental Health Services (MSM Chapter 400)

These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services. For case management services, refer to MSM Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications and document requirements.

#### Rehabilitative Mental Health Services (MSM Chapter 400)

Qualified Mental Health Professionals (QMHPs) may provide Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer support, Psychosocial Rehabilitation (PSR) and Crisis Intervention (CI) services. [Day Treatment services may be requested and reimbursed by Provider Type 14 Agency/Entity/Groups who are also enrolled with Specialty 308 and have a [Day Treatment Model](#) approved by the DHCFP. See Attachment A.]

RMH services are goal-oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the recipient to their best possible mental and/or behavioral health functioning. RMH services must be coordinated in a manner that is in the best interest of the recipient. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the recipient's overall health. RMH services must be directly and medically necessary.

#### Clinical Supervision (MSM Chapter 400)

Clinical Supervisors must assure the following:

1. An up to date (within 30 days) case record is maintained on the recipient; and



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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 is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP, LCSW, LMFT or 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 plan, and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment plan; 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.

**Note:** Interns/Psychological Assistants are excluded from functioning as Clinical Supervisors.

#### 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 plans, reviews and evaluations.

#### **Clinical Supervisor**

The name, title, contact phone and signature of my current Clinical Supervisor is provided below.

Clinical Supervisor Name: \_\_\_\_\_

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

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

**Clinical Supervisor Signature:** \_\_\_\_\_



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**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/revalidation application, you are required to notify Nevada Medicaid within five working days. All 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 agree to abide by Nevada Medicaid’s change notification requirements:

**QMHP 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 DHCFP any suspicion of fraud, waste or abuse in the Medicaid and Nevada Check Up (NCU) programs, including fraud, waste 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, waste, abuse or improper payment may be reported online at <http://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/> or by calling (775) 687-8405.

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

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

**Qualifications**

I have read, understand and meet the qualifications as outlined in MSM Chapter 400, Section 403.3(B) Provider Qualifications for a QMHP.

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