Provider Enrollment Checklist for Behavioral Health Rehabilitative Treatment

Provider Type 82: Specialty 882, 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 NPI: _____

Please check one. 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 of this document.

Attachments

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

_____ SS-4 or CP575 showing Employer Identification Number

_____ Business License

Policy acknowledgement

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

_____ **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 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:

a. Provide medically necessary services.
b. Adhere to the regulations prescribed in Medicaid Services Manual (MSM) Chapter 400 and all applicable MSM chapters.
c. Provide only those services within the scope of [the provider's] practice and expertise.
d. Ensure care coordination to recipients with higher intensity of needs.
e. Comply with recipient confidentiality laws and HIPAA.
f. Maintain required records and documentation for a period of six years.
g. Comply with requests from the Quality Improvement Organization (QIO)-like vendor (Nevada Medicaid's fiscal agent).
h. Ensure client's (recipient's) rights.
i. Cooperate with the Division of Health Care Financing and Policy's (DHCFP's) review process.

_____ **Rehabilitative Mental Health Services (MSM Chapter 400)**

a. Qualified Mental Health Professionals (QMHPs) may provide Basic Skills Training (BST), Peer-to-Peer Support, Psychosocial Rehabilitative (PSR) and Crisis Intervention (CI) services.

b. Qualified Mental Health Associates (QMHAs) may provide BST, Peer-to-Peer Support, and PSR services under the clinical supervision of a QMHP.

c. 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 (MSM Chapter 400)**

Clinical Supervisors must assure the following:

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

b. 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).

c. A comprehensive and progressive treatment plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP.

d. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive, and age and developmentally appropriate.

e. 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 Plan(s), and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment plan.

f. 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.

g. Only qualified providers provide prescribed services within scope of their practice under state law.

h. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

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

Direct Supervisors must document the following activities:

a. Their (the Direct Supervisor's) face-to-face and/or telephonic meetings with Clinical Supervisors:

   1. These meetings must occur before treatment begins and periodically thereafter.

   2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance.

   3. This supervision may occur in a group and/or individual setting.

b. Their (the Direct Supervisor's) face-to-face and/or telephonic meetings with the servicing provider(s):

   1. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter.

   2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance.

   3. This supervision may occur in group and/or individual settings.

c. Assist the Clinical Supervisor with treatment plan reviews and evaluations

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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. *(If more than one, attach additional sheet, include all information and reference this Supervisors section.)*

Primary Clinical Supervisor Name: _____

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

NPI: _____ Contact Phone: _____

Primary 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

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

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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

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. 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

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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 to Medicaid Information

If your Clinical Supervisor 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 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:** _____

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) 684-3648.

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 or Director Signature: _____ **Date:** _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

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For_____ _____

Facility/Provider Name NPI

_____

Signature of notarial officer Notary Stamp