

**Provider Type 85:  
Certified Autism Behavior Interventionist (CABI), Specialty 313**

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 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)
- \_\_\_\_\_ Proof of Certification from Nevada Board of Psychological Examiners
- \_\_\_\_\_ 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, 1500 and 3300 as of the date above and understand the policies and how they apply to my scope of service. 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 will abide by the scope of service, provider qualifications, service limitations and admission criteria detailed in MSM Chapter 1500.

I meet all provider qualifications outlined in MSM Chapters 100 and 1500.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Supervision Acknowledgement**

I understand that I must be under the supervision of a Physician, Psychologist or Board Certified Behavior Analyst (Masters or Doctorate) when providing services to Nevada Medicaid recipients. I have read, understand and meet the qualifications as outlined in MSM Chapter 1500 for a Certified Autism Behavior Interventionist. The name, title, contact phone and signature of my current clinical supervisor is provided below.

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

Professional Title: \_\_\_\_\_

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

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

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**Policy Acknowledgement**

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

\_\_\_\_\_ **Service Delivery Models (MSM Chapter 1500)**

There are two types of ABA treatment delivery models recognized by DHCFP, Focused and Comprehensive. Based upon the Behavior Analyst Certification Board, Inc. (2014) within each of the two delivery models there are key characteristics which must be demonstrated throughout the assessment and treatment.

\_\_\_\_\_ **Supervision Standards (MSM Chapter 1500)**

Clinical supervision as established by NRS 641.100 includes: program development, ongoing assessment and treatment oversight, report writing, demonstration with the individual, observation, interventionist and parent/guardian training/education, and oversight of transition and discharge plans. All supervision must be overseen by a Licensed Psychologist, BCBA/D or BCBA who has experience in the treatment of autism within the scope of practice, although the actual supervision may be provided by a BCaBA at their direction. The amount of supervision must be responsive to individual needs and within the general standards of care and may temporarily increase to meet the individual needs at a specific period in treatment.

\_\_\_\_\_ **Provider Responsibility (MSM Chapter 1500)**

- a. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.
- b. Once an approved prior authorization request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.
- c. Ensure services are consistent with applicable professional standards and guidelines relating to the practice of ABA as well as state Medicaid laws and regulations and state licensure laws and regulations.
- d. Ensure caseload size is within the professional standards and guidelines relating to the practice of ABA.

**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 Hewlett Packard Enterprise 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 Hewlett Packard Enterprise.

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:

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**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:

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_