Provider Enrollment Checklist for Applied Behavior Analysis (ABA) Provider

Provider Type 85: Specialty 885, 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 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 only the above entity/agency/group information and the Clinical Supervisor Attestation section of this document (see below), and submit this page to the Nevada Medicaid Provider Enrollment Unit.

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 as a Psychologist under Nevada Revised Statute (NRS) 641.170 from the Nevada Board of Psychological Examiners or professional license as a Behavior Analyst (BCBA) under NRS 437.205 from the Nevada Board of Applied Behavior Analysis through the State of Nevada Aging and Disability Services Division

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

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

As the clinical supervisor for the applied behavior analysis treatment entity named below, I hereby pledge to ensure that the entity 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 individual provider with Nevada Medicaid, that I have the licensure and competency to oversee Applied Behavior Analysis treatment services.

ABA treatment entity/agency/group name: _____

Clinical supervisor name (print or type): _____

Clinical supervisor professional title: _____

Clinical supervisor NPI: _____ Contact phone: _____

Clinical supervisor signature: _____ Date: _____

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

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

_____ Provider Standards (MSM Chapter 3700)

All providers must:

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1. Provide medically necessary services;
2. Adhere to the regulations prescribed in Chapter 3700 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 [DXC Technology, which is referred to as Nevada Medicaid];
8. Ensure client's [recipient's] rights; and
9. Cooperate with Division of Health Care Financing and Policy's (DHCFP's) review process.

_____ Clinical Supervision (MSM 3700):

Clinical Supervision as established by NRS 437.110, which 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, 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.

Clinical supervisors must assure the following:

1. An up-to-date (within 30 days) case record is maintained on the recipient;
2. A comprehensive assessment and diagnosis is accomplished prior to providing ABA services;
3. A focused or comprehensive treatment plan is developed and approved by the clinical supervisor;
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 plans, and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment 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 ABA services in a safe and efficient manner.

Supervisors (to be completed by the owner or director)

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

Primary clinical supervisor name: _____

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

NPI:_____Contact phone: _____

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Policy Declaration

I hereby declare that I have read the current MSM Chapters 100, 3300 and 3700 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 3700. 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 in clinical supervision may be reported using this form. 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 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 online at http://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/ or 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/Applicant 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/Applicant Signature:_____ **Date:**_____