Substance Use Treatment: Group Specialty 704, Residential Substance Use Treatment in an Institution for Mental Disease (IMD)

The following is a list of required enrollment documents for this provider type. A copy of each document listed below must be included, along with this completed checklist, with your enrollment or revalidation application.

Original signatures and initials are required on this form.

If you are linking an intern to your group, a copy of the intern's Supervisor Agreement for **EACH INTERN** is required to be attached to this checklist (Provider Types 93/703, 93/705, 14/300 and 82/300).

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.

Group Name: _____ Date: _____

National Provider Identifier (NPI): _____

Please check one of the following boxes. Updates to Clinical Supervisors of the agency are reported using this form and the appropriate change application.

- ☐ New Enrollment
- ☐ Re-enrollment
- ☐ Revalidation
- ☐ Change of Ownership
- ☐ Clinical Supervisor of the agency Update

Attachments (please check the box indicating that a copy of the specified item is attached):

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9).
- ☐ Current Substance Abuse Prevention and Treatment Agency (SAPTA) certificate/endorsement as a Co-Occurring Capable or Co-Occurring Enhanced Program.
- ☐ Current SAPTA certificate/endorsement showing certified American Society of Addiction Medicine (ASAM) Levels of Care.
- ☐ Please list your bed count to ensure that you do qualify as an Institution for Mental Disease (IMD) (group specialty 704). _____. Groups with bed counts of 16 or less most likely do not qualify as an IMD and should enroll accordingly.

  NOTE: If your bed count for performing ASAM level 1, 2.1, or 2.5 outpatient SUD services is 16 or less, you must obtain a separate type 2 NPI and enroll as a Substance Use Treatment Clinic (PT 93/707) for these services.
- ☐ Attestation on business letterhead from the owner, signed and dated, that the bed count is more than 16 beds and more than 50% of care is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, and also provides for medical attention, nursing care and related services.
- ☐ Nevada Secretary of State Business License.
- ☐ Appropriate Clinical Laboratories Improvement Act (CLIA) certification for the level of testing performed, as applicable.

Substance Use Treatment: Group Specialty 704, Residential Substance Use Treatment in an Institution for Mental Disease (IMD)

- ☐ Associated Providers List with original provider signature(s).
- ☐ Current copy of the license for the Clinical Supervisor of the agency.
- ☐ Electronic Funds Transfer (EFT) form and voided check/bank letter.

Select all subspecialties (ASAM levels of care that you are SAPTA certified to provide) for which you are enrolling:

- ☐ 713 (ASAM Level 3 Residential)

  Note: *Groups who are certified as ASAM Level 3.1, 3.5 or 3.7WM should select 713.

Clinical Supervisor

Clinical Supervisor of the agency name: _____

Professional Title: _____

NPI: _____ Phone: _____

Clinical Supervisor Signature: _____ Date:_____

Policy Declaration

I hereby declare that I have read the current MSM Chapters 100, 400, 3300 and 4100 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 4100. 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 the time frame established in MSM Chapter 100, Section 103.3(A). 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.

Substance Use Treatment: Group Specialty 704, Residential Substance Use Treatment in an Institution for Mental Disease (IMD)

(Per MSM Chapter 100, Medicaid providers, and any pending contract approval, are required to report, in writing within the time frame established in MSM Chapter 100, Section 103.3(A), 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) 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: _____

Resources:

The Provider Enrollment webpage provides instruction materials that will assist providers with enrolling in Nevada Medicaid.