Provider Enrollment Checklist for Provider Type 89

Community Health Workers

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

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.

Enrollment for out-of-state and out-of-catchment is not allowed; refer to the Provider Enrollment Information Booklet for catchment areas.

Attachments

- ☐ Community Health Worker certificate from the Nevada Certification Board
- ☐ Supervisor's valid Nevada board license
- ☐ Collaborative Supervision Agreement (attached)

Resources:

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

You do not need to submit this checklist with your enrollment or revalidation.

Collaborative Supervision Agreement
of Community Health Workers in Community Settings

Prior to performing any of the services authorized for Community Health Workers (CHWs) under Medicaid Services Manual (MSM) Chapter 600 – Physician Services, a CHW must enter into a written Collaborative Supervision Agreement with a Nevada Medicaid enrolled Physician, Advanced Practice Registered Nurse (APRN) or Physician's Assistant (PA). A collaborating Physician, APRN or PA is limited to entering into a collaborative agreement with no more than 20 CHWs at any given time. The supervising Physician, APRN or PA of a CHW must be located in the State of Nevada and/or within the neighboring states' catchment areas (https://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf) and be in the same medical group and/or affiliates as the CHW.

The services to be provided by the CHW in community settings must conform with Nevada Revised Statutes Chapter 449 and MSM Chapter 600.

Collaborative Practice Protocols

The collaborative agreement will be reviewed annually by the supervising Physician, APRN, PA and the respective CHW. An updated signed copy of the collaborative agreement will be required upon Nevada Medicaid revalidation.

1. It is essential that the supervisor has sufficient time to dedicate to CHW supervision which can improve CHW motivation and engagement. A supervisor's role is to be regularly available, provide ongoing support, prioritize safety, and offer mentoring and coaching to CHWs. Supervisory tools, such as guides, logs, and checklists, can facilitate supervision.

   In rural areas, it may be necessary to conduct supervision meetings via phone or video conference.

2. Adequate documentation is essential to ensure accurate billing and reimbursement. The supervisor will provide the CHW guidance on their business practice documentation requirements.

   HIPPA compliant documentation is required for each day the service is delivered, must be legible, must be housed in the recipient's medical file, and should include the following information:

   a. The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated;
   b. The place of service and modality;
   c. The date the service was delivered;
   d. The actual beginning and ending times the service was delivered;
   e. The name of the CHW who delivered the service and their title;
   f. The resources/education that were provided during the time the services were rendered; and
   g. Ongoing assessment of the recipient's progress.

   Refer to MSM Chapter 100 for recipient record retention and the safeguarding of confidential information, including notes or documentation, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

COLLABORATIVE AGREEMENT

Collaborative Agreement Supervisor Name: (Print) _____

Supervisor Professional Title: _____

Supervisor NPI: _____

Supervisor License Number: _____

Primary Practice Name: _____

Primary Practice Address: _____

Email: _____ Phone: _____

Supervisors must have written policies and procedures in place to document the process to ensure supervision is performed on a regular basis. Supervisors must evaluate the effectiveness of the CHW's supportive roll to address the recipient's needs including CHW documentation review.

I, the CHW supervisor, understand the scope of service and service limitations criteria detailed in MSM Chapter 600 – Physician Services, Community Health Worker Services. I also agree to indirectly supervise this CHW and agree to maintain written policies and procedures in accordance with this Collaborative agreement. Additionally, I will ensure that the CHW referenced in this Collaborative Agreement will maintain an active Nevada Certification Board Community Health Worker certificate.

Signature: _____Date: _____

Collaborative Agreement CHW Name: (Print) _____

CHW NPI: _____

CHW Certificate Number: _____

Primary Practice Name: _____

Primary Practice Address: _____

Email: _____ Phone: _____

I, the CHW, understand that it is my responsibility to notify Nevada Medicaid if there is a change in supervision. I will notify Nevada Medicaid within 5 business days by completing an Update Application and attaching a new Collaborative Supervision Agreement with the new CHW supervisor.

Signature: _____Date: _____

Collaborative Practice Settings Served Through this Collaborative Agreement:
(attach a separate sheet to include additional settings, if applicable)

Organization/Community Setting Name: i.e., school name, health care facility name, etc.

_____

Address: _____

Email: _____ Phone: _____

Population being served in this setting: i.e., age, community group, non-profit, etc.

_____

Organization/Community Setting Name: i.e., school name, health care facility name, etc.

_____

Address: _____

Email: _____ Phone: _____

Population being served in this setting: i.e., age, community group, non-profit, etc.

_____

Policy Declaration

I hereby declare that as of this date, I have read and understand the current Medicaid Services Manual (MSM) Chapters 100 – Medicaid Providers, 600 – Physician Services, and 3300 – Program Integrity, which can be found by going to https://dhcfp.nv.gov and selecting "Medicaid Services Manual" from the Index box. I attest that I understand these policies and how they relate to my scope of practice. 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 and service limitations criteria detailed in MSM Chapter 600 – Physician Services, Community Health Worker Services.

Applicant Signature: _____ Date: _____

Information Changes

If your information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within five working days. Per MSM Chapter 100, this includes any change in address or any other information pertinent to the receipt of Medicaid funds. All changes may 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.

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: _____

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 or completing the form on the DHCFP website at: http://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/.

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.

Applicant Signature: _____ Date: _____

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 Collaborative Agreement.

Applicant Signature: _____ Date: _____