HP Enterprise Services - Nevada Medicaid and Nevada Check Up

Policy Acknowledgement and Supervisor Information

For Behavior Health provider types 14 and 82

Provider Name: _____ Date: _____

NPI/API: _____

I hereby certify that I have read the current Nevada Medicaid Services Manual (MSM) Chapters 400 and 100 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 Nevada MSM and with any updates to this policy as may occur from time to time.

Based on this, I acknowledge understanding of the following (provider initials are required next to each item):

____ Service Delivery Models *(MSM 403.1 (3))*

"Individual" Rehabilitative Mental Health providers (RMH) 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 403.2 (1))*

All providers must:

a. Provide medically necessary services
b. Adhere to the regulations prescribed in this chapter (Chapter 400) and all applicable Division (Nevada 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
g. Comply with requests from the QIO-like vendor (HP Enterprise Services)
h. Ensure client's (recipient's) rights
i. Cooperate with DHCFP's review process

____ Clinical Supervision *(MSM 402.7)*

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 and/or Rehabilitation 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 Plans, and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the Treatment and/or Rehabilitation Plans

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 402.11)*

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 providers.

   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 and/or Rehabilitation Plan reviews and evaluations

_____ Provider Qualifications (for Rehabilitative Mental Health Services) *(MSM 403.6B (2))*

a. Qualified Mental Health Professionals (QMHP): QMHPs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR and CI services

b. Qualified Mental Health Associates (QMHA): QMHAs may provide BST, PACT, Peer-to-Peer Support, and PSR services under the Clinical Supervision of a QMHP

c. Qualified Behavioral Aides (QBA): 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

For QMHP's only

If I do not have a Medical Supervisor, I understand that I am only allowed to provide rehabilitation services. I acknowledge that I am responsible for notifying HP Enterprise Services within five working days if there is a change to the information presented below.

Medical Supervisor name: _____

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

Contact phone: _____

Medical Supervisor signature: _____

☐ I do not have a Medical Supervisor.

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 (per Medicaid Services Manual, Chapter 100, section 103.3, December 2008).

Provider signature: _____ **Date:** _____

For QMHAs and QBAs only

I understand that I must have clinical and direct supervision when providing services to Nevada Medicaid recipients. I acknowledge that I am responsible for notifying HP Enterprise Services within five working days if there is a change to the information presented noted below.

Clinical Supervisor name: _____

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

Contact phone: _____

Clinical Supervisor signature: _____

Direct Supervisor name: _____

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

Contact phone: _____

Direct Supervisor signature: _____

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 (per Medicaid Services Manual, Chapter 100, section 103.3, December 2008).

Provider signature: _____ **Date:** _____