POLICY: The Division of Mental Health and Developmental Services and its mental health agencies will ensure Medicaid's Provider Enrollment requirements are met and monitored for compliance.

PURPOSE: Federal and State Medicaid requirements mandate mental health providers, including hospitals and centers/clinics, as well as the individual mental health professionals they employ, to be Medicaid enrolled as Qualified Mental Health Professionals (QMHP), Qualified Mental Health Associations (QMHA) and Qualified Behavioral Aides (QBAs).

PROCEDURES:

This Policy pertains only to the following MHDS Mental Health Agencies – Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS) and Rural Services – Mental Health (RS-MH). This policy does not pertain to any of MHDS' Developmental Services agencies.

I. Medicaid Individual Provider Enrollment

A. Within 30 days upon hire, and annually, the MHDS mental health agencies - Southern Nevada Adult Mental Health Services (SNAMHS), Northern Nevada Adult Mental Health Services (NNAMHS) and Rural Services – Mental Health (RS – MH) will report to Medicaid, in Excel Spreadsheet format, the following data information, with respect to individual mental health professionals employed by the MHDS mental health hospital or clinic/center:

1. Begin Date as employee
2. End Date (if and when applicable)
3. Professional Discipline title (e.g., MD, PhD, LCSW, etc.)
4. Last Name
5. First Name
6. NPI number
7. Date NPI Status Verified
8. National Provider Identifier (NPI) status verified By
9. Taxonomy Code
10. Office of Inspector General (OIG) Validation Date
11. Individual Provider Classification (QMHP, QMHA or QBA)
12. Date Classification Validated

B. An updated Excel spreadsheet shall be submitted to Medicaid no later than the first day of each calendar month when 1) there is a new MHDS mental health agency hire or a QMHP, QMHA or QBA and 2) a QMHP, QMHA or QBA leaves employment from an MHDS mental health agency. This includes both state employees and contractors who are QMHPs, QMHAs and QBAs. All activity should be done with a color coding to identify the changes in the entire spreadsheet for that submission. (For example, new hires or additions might be color coded in blue and deleted might be color coded in red).

C. Each MHDS Mental Health Agency – SNAMHS, NNAMHS and RS – MH shall designate at least two contact persons (primary and backup) responsible for reporting this data to Medicaid.

D. The Personnel Department at each of MHDS' three mental health agencies shall notify their respective contact persons at their agencies of new hires and staff leaving employment within ten (10) days of becoming aware of these activities.

E. Lake's Crossing Center is not a Medicaid Provider and therefore is not required to perform these functions as addressed in this policy.

F. Data element requirements addressed in #1 above are subject to change, based on Medicaid requirements.

II. Bi-Annual MHDS Quality Assurance (QA) Medicaid Enrollment Compliance Review/Audit

A. The MHDS Central Office Medicaid Liaison Program Specialist and MHDS Central Office Fiscal/Revenue Supervisor shall complete at least one MHDS Medicaid QA Provider Enrollment Compliance Review/Audit at least every two years (bi-annually), to include a formal report outlining the QA Reviews/Audits' Findings, Recommendations and if required, Corrective Action Plan.

B. MHDS QA Medicaid Provider Enrollment Review/Audit tools shall be developed and utilized for purposes of conducting the review/audit (Attachment A).

C. The MHDS QA Medicaid Provider Enrollment Review/Audit shall be conducted at the following MHDS agencies:

1. SNAMHS
2. NNAMHS
3. RS-MH

III. MHDS Medicaid Enrollment Educational In-Service

A. As needed, based on the MHDS' review/audit findings, the Medicaid MHDS Central Office Liaison and Fiscal/Revenue Supervisor shall conduct an educational in-service at each of the following MHDS agencies - NNAMHS, SNAMHS and RS-MH.

B. Components of the educational in-service will include, but not be limited to:

1. Provider Enrollment procedure and process requirements.
2. Changes or updates in Medicaid requirements or expectations.
3. Clinical, Direct and Medical Supervision documentation requirements and assurances.
4. Prior and Continuing Stay Authorization Requirements.

The curricula will be flexible and applicable to the needs of specific agency staff.

IV. Each MHDS Mental Health Agency (SNAMHS, NNAMHS and RS-MH) shall develop their own agency policy for purposes of addressing compliance and specific practices and procedures with this policy and Medicaid's Provider Enrollment requirements.

ADMINISTRATOR

ATTACHMENTS:

Attachment A: Qualified Mental Health Professional (QMHP) Review/Audit Form
Attachment B: Qualified Mental Health Associate (QMHA) Review/Audit Form
Attachment C: Qualified Behavioral Aide (QBA) Review/Audit Form
Attachment D: Entity/Agency/Group Review/Audit Form

EFFECTIVE DATE: 03/16/2012
DATE REVISED: N/A
SUPERSEDES: New
APPROVED BY MHDS ADMINISTRATOR: 03/16/2012
APPROVED BY MHDS COMMISSION: 03/16/2012

Attachment A

NEVADA DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

MEDICAID PROVIDER ENROLLMENT QA REVIEW FORM

QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)

Individual Provider Name: _____

MHDS Mental Health Agency: _____

Individual Provider Start Date with Agency: _____

Professional Licensure (e.g. MD, RN, LCSW, etc.): _____

Taxonomy Code: _____

	REQUIRED FUNCTION	**YES**	**NO**
1.	Professional License	____	____
2.	SS-4, CP575 or W-9 form showing Tax payer Identification Number	____	____
3.	National Provider Number (NPI) If yes, date verified: _____	____	____
4.	Office of Inspector General (OIG) If yes, date verified: _____	____	____
5.	QMHP status verified If yes, date verified: _____	____	____
6.	Officially Reported to Medicaid in required spreadsheet format	____	____
7.	Does individual provider meet d Medicaid enrollment requirements?	____	____

Comments (include Findings during Review/Audit and if a Corrective Action Plan is required): _____

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MHDS Reviewer Signature Date

Attachment B

NEVADA DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

MEDICAID PROVIDER ENROLLMENT QA REVIEW FORM

QUALIFIED MENTAL HEALTH ASSOCIATE (QMHA)

Individual Provider Name: _____

MHDS Mental Health Agency: _____

Individual Provider Start Date with Agency: _____

Professional Licensure (e.g. RN, etc.): _____

Taxonomy Code: _____

REQUIRED FUNCTION	**YES**	**NO**
1. Professional License or Qualifying degree	_____	_____
_____Bachelor's Degree (accepted List of study)		
_____ Bachelor's Degree (not from Accepted list of study, but With required 30 credits in) Accepted areas of study)		
_____ Bachelor's or Associates Degree (with a minimum of 15 credits in accepted area of study and four years of relevant professional exper.)		
2. SS-4, CP575 or W-9 form showing Tax payer Identification Number	_____	_____
3. National Provider Number (NPI)	_____	_____
If yes, date verified: _____		
4. Office of Inspector General (OIG)	_____	_____
If yes, date verified: _____		

REQUIRED FUNCTION (continued)		YES	NO
5.	QMHP status verified	____	____
	If yes, date verified: _____		
6.	Relevant work experience or Resume, if applicable	____	____
7.	Verification that the provider Completed the initial 16 hour Competency and in-services Training required by Medicaid	____	____
	a. Includes summary outline of of all course content?	_____	_____
8.	FBI criminal background check Within the past six months (new Enrollments) or last five years (re-enrollments)	_____	_____
9.	Officially Reported to Medicaid in required spreadsheet format	_____	_____
10.	Does individual provider meet Medicaid enrollment requirements?	____	_____

Comments (include Findings during Review/Audit and if a Corrective Action Plan is required): _____

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MHDS Reviewer Signature Date

Attachment C

NEVADA DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

MEDICAID PROVIDER ENROLLMENT QA REVIEW FORM

QUALIFIED BEHAVIORAL AIDE (QBA)

Individual Provider Name: _____

MHDS Mental Health Agency: _____

Individual Provider Start Date with Agency: _____

Professional Licensure (e.g. MD, RN, LCSW, etc.): _____

Taxonomy Code: _____

	REQUIRED FUNCTION	**YES**	**NO**
1.	SS-4, CP575 or W-9 form showing Tax payer Identification Number	_____	_____
2.	High School Diploma or General Education Development (GED)	_____	_____
3.	TB Test with negative results or medical clearance	_____	_____
4.	Verification that the provider Completed the initial 16 hour Competency and in-services Training required by Medicaid	_____	_____
	a. Includes summary outline of of all course content?	_____	_____
5.	Copy of current CPR certification	_____	_____
6.	Copy of FBI criminal background check	_____	_____
9.	Officially Reported to Medicaid in required spreadsheet format	_____	_____
10.	Does individual provider meet d Medicaid enrollment requirements?	_____	___

Comments (include Findings during Review/Audit and if a Corrective Action Plan is required): _____

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MHDS Reviewer Signature Date

Attachment D

NEVADA DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

MEDICAID PROVIDER ENROLLMENT QA REVIEW FORM

ENTITY/AGENCY/GROUP

MHDS Agency Provider Name: _____

MHDS Agency Provider NPI number: _____

REQUIRED FUNCTION		**YES**	**NO**
1.	SS-4, CP575 or W-9 form showing Tax payer Identification Number	_____	_____
2.	Medical Supervisor's Professional License	_____	_____
3.	Medical Supervision Policy	_____	_____
	Demonstrates how the agency will:		
	a. monitor and evaluate the quality and effectiveness of services provided;	_____	_____
	b. ensure medical appropriateness of services provided;	_____	_____
	c. ensure that providers operate under medical supervision; and	_____	_____
	d. ensure that medical supervisors operate within the scope of their license and expertise	_____	_____
4.	Clinical Supervision Policy	_____	_____
	Demonstrates how the agency will ensure that all services are medically necessary and clinically appropriate (see MSM, chapter 400, section 402.7)	_____	_____

REQUIRED FUNCTION (continued)	YES	NO
5. Quality Assurance Policy: QA policy must detail how the Agency will perform internal monitoring and evaluation to Improve quality of care (see MSM Chapter 400, section 402.33 and 403.2.2).	____	____

Comments (include Findings during Review/Audit and if a Corrective Action Plan is required): _____

_____ _____

MHDS Reviewer Signature