Provider Enrollment Checklist for Provider Type 54

Targeted Case Management

The following is a list of required enrollment documents for this provider type. A copy of each document listed below and this completed checklist must be included with your provider enrollment or revalidation application. PT 54 is limited to governmental agencies that meet the provider qualifications outlined in Medicaid Services Manual (MSM) Chapter 2500.

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.

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9).
- ☐ Signed Business Associate Addendum (NMH-3820) if your business is NOT a HIPAA "covered entity." The Addendum is available at www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

  NOTE: Your business is a HIPAA-covered entity if you furnish, bill and receive payment for medical services as a licensed medical professional (as defined by Social Security 42 USC 1395X(s)). A business that does not furnish medical care is called a Business Associate and must sign the Business Associate Addendum. Business Associates may be entities such as providers of waiver services, providers of personal care services (assistance with ADLs and IADLs), homemaker/chore services and non-emergency transportation.
- ☐ Please identify one of the following agency affiliations below and identify the agency's name:
  - ☐ State Agency Name:_____
  - ☐ County Agency Name:_____
  - ☐ Private Community Agency Name:_____
- ☐ Service Agreements: If case management services are provided by a private community agency, please provide a copy of the service agreement with the State or County agency for which you perform services.

Please check the target group(s) you are requesting to serve:
(Providers must meet qualifications according to the targeted population the agency intends to serve.)

- ☐ Adults with a Non-Serious Mental Illness (Non-SMI)
- ☐ Adults with a Serious Mental Illness (SMI)
- ☐ Children and Adolescents with a Non-Severe Emotional Disturbance (Non-SED)
- ☐ Children and Adolescents with a Severe Emotional Disturbance (SED)
- ☐ Child Protective Services
- ☐ Juvenile Parole Services
- ☐ Juvenile Probation Services
- ☐ Infants and Toddlers Developmentally Delayed Under Age 3
- ☐ Persons with Intellectual Disabilities or Related Conditions

Policy Acknowledgement *(to be completed by the agent, business owner or managing employee)*

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

_____ Case Management (CM) Services (MSM 2502.10)

Case management services are services which assist an individual in gaining access to needed medical, social, educational, and other supportive services and must include the following components:

a. Assessment of the eligible individual to determine service needs.

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b. Development of a person-centered care plan.
c. Referral and related activities to help the individual obtain needed services.
d. Monitoring and follow-up.

Case management services involve the following activities to assist the eligible recipient in obtaining needed services:

1. Assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. The assessment activities include the following:
   a. Taking client history.
   b. Identifying the needs of the individual and completing related documentation.
   c. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible recipient.
2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
   a. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible recipient.
   b. Includes activities such as ensuring the active participation of the eligible recipient and working with the recipient (or the individual's authorized health care decision maker) and others to develop those goals.
   c. Identifies a course of action to respond to the assessed needs of the eligible recipient.
3. Referral and related activities (such as scheduling appointments for the recipient) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
4. Monitoring and follow-up; activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately address the needs of the eligible individual and may be with the individual, family members, service provider or other entities or individuals. The monitoring should be conducted as frequently as necessary, and include at least one annual monitoring, to help determine whether the following conditions are met:
   a. Services are being furnished in accordance with the individual's care plan.
   b. Services in the care plan are adequate.
   c. There are changes in the needs or status of the eligible recipient.

   Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Monitoring may involve either face-to-face or telephone contact, at least annually.

_____ Case Record Documentation (MSM 2502.10A)

A case record documentation shall be maintained for each recipient and shall contain the following items:

a. The name of the individual receiving services, the dates of case management services, the name of the provider agency and person chosen by the recipient to provide services.
b. The nature, content and units of case management services received.
c. Whether the goals specified in the care plan have been achieved.
d. If an individual declines services listed in the care plan, this must be documented in the individual's case record.
e. Timelines for providing services and reassessment.
f. The need for and occurrences of coordination with case managers of other programs.

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The case manager shall make available to Nevada Medicaid or Medicaid's Quality Improvement Organization (QIO-like vendor), upon request, copies of the medical record, progress notes, care plan, case record or summary documents which reflect the ongoing need for case management services and support any additional services requested.

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.

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.

Name (Print) _____

Signature _____ **Date** _____

Title: ☐ Agent ☐ Business Owner ☐ Managing Employee