Provider Type 63/Specialty 963: Psychiatric Residential Treatment Facility (PRTF)

Please refer to the Provider Enrollment Information Booklet for enrollment guidance and to the applicable Medicaid Services Manual (MSM) Chapter for your provider type and enrollment requirements. In addition, the following are required for your provider type and specialty.

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. Pacific Time Monday through Friday.

Original signatures and initials are required on this form.

☐ 1. Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9).

☐ 2. Bureau of Health Care Quality and Compliance (BHCQC) License (for in-state providers): Psychiatric Residential Treatment Facility (PRTF) License.

Submitted BHCQC License Expiration Date: _____

a. For out-of-state providers: PRTF or BHCQC license equivalent from home state.

Submitted License Expiration Date: _____

☐ 3. Nevada Secretary of State Business License for in-state providers, or equivalent for out-of-state providers, if applicable.

☐ 4. Accreditation from the Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA).

Submitted Document's Expiration Date:_____

☐ 5. Centers for Medicare & Medicaid Services (CMS) PRTF certification per requirements from the Quality, Safety and Oversight Group (QSOG) State Operating Manual (SOM), 100-01, Chapter 2 which can be received from BHCQC for in-state providers or appropriate Survey Agency (SA) for out-of-state providers.

☐ 6. The PRTF must comply with 42 CFR Subpart G 483.374(a) and submit a Letter of Attestation with their Nevada Medicaid enrollment application. The attestation must be signed by the facility director, which confirms the facility is in compliance with CMS standards governing the use of restraint and seclusion (42 CFR Subpart G 483.350-483.376). A facility enrolling as a Medicaid provider must meet this requirement upon initial enrollment.

Thereafter, attestations must be submitted annually and are due on July 21st of each fiscal year. However, if July 21st occurs on a weekend or holiday, the attestation is due on the first business day following the weekend or holiday.

Attestations must include the following information:

- Facility General Characteristics: name, address, telephone number of the facility, and a state provider identification number;
- Facility Specific Characteristics:
  - Bed count;
  - Number of individuals currently served within the PRTF who are provided services based on their eligibility for the Medicaid Inpatient Psychiatric Services for Individuals Under age 21 Benefit (Psych under 21);
  - Number of individuals, if any, whose Medicaid Inpatient Psychiatric Services Under 21 Benefit is paid for by any State other than the State of the PRTF identified in this attestation letter; and
  - List all States from which the PRTF has ever received Medicaid payment for the provision of Psych under 21 services.

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- The signature of the facility director;
- The date the attestation was signed;
- A statement certifying that the facility currently meets all of the requirements of Part 483, Subpart G governing the use of restraint and seclusion;
- A statement acknowledging the right of the Survey Agency (or its agents) and, if necessary, CMS to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences; and
- A statement that the facility will submit a new attestation of compliance annually and in the event a new facility director is appointed.

☐ 7. This Enrollment Checklist with the following questions completed and the required initials and signature below:

Are PRTF services at this facility provided in a secure, self-contained environment that can be locked if needed?

☐ Yes ☐ No

Is this PRTF providing 24-hour inpatient care with observation and supervision by mental health professionals?

☐ Yes ☐ No

Is a psychiatrist available 24 hours a day?

☐ Yes ☐ No

☐ 8. If providing Applied Behavior Analysis (ABA) services, please enroll as a PT 85 (ABA) to bill for these services separately. Must have a separate NPI for PT 85.

☐ 9. Complete and submit to Nevada Medicaid the following forms. These forms do not need to be included with your enrollment packet. The return email and mailing address to Nevada Medicaid are provided at the bottom of each form. The forms are available by clicking on the links below and are also available on the Provider Enrollment webpage under "Required Enrollment Documents."

- Advance Directives Compliance Self-Evaluation & Certification (NMH-3827)
- Civil Rights Compliance Self-Evaluation & Certification (NMH-3828)

For out-of-state facilities: Please provide the following information:

Licensing Agency name: _____

Licensing Agency contact information: _____

Disability and Advocacy Agency name: _____

Disability and Advocacy contact information: _____

Child Protective Services Agency name: _____

Child Protective Services Agency contact information: _____

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Facility Specialty:

What is this facility's bed count? _____

What age groups does your facility treat?_____

What gender does your facility treat?

☐ Female ☐ Male

Please check the box for each specialty your facility treats:

☐ Asperger's or Autism Spectrum Disorder	☐ Attention Deficit or Hyperactivity Disorder	☐ Bipolar Disorder
☐ Complex Medical Issues	☐ Conduct Disorder	☐ Co-Occurring Disorders
☐ Developmental Disabilities	☐ Dual Diagnosis	☐ Eating Disorders
☐ Fetal Alcohol Syndrome	☐ General Psychiatric	☐ Intermittent Explosive Disorder
☐ IQ Between 48 And 80 or Borderline IQ	☐ Mood Dysregulation Disorder	☐ Neurological Disorders
☐ Oppositional Defiant Disorder	☐ Pervasive Developmental Disorder	☐ Post Traumatic Stress Disorder
☐ Reactive Attachment Disorder	☐ Schizophrenia	☐ Sexually Exploited
☐ Sexual Offenders	☐ Sexually Reactive Disorders	☐ Substance Use
☐ Traumatic Brain Injuries	☐ Other (please specify): _____	

Policy Acknowledgement *(to be completed by the business owner or director)*

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

_____ Psychiatric Residential Treatment Facility (PRTF) Services (Medicaid Services Manual (MSM) Chapter 400 Section 403.7E) Provider Responsibilities

- PRTFs will provide an on-ground educational component tailored to the recipient's grade level. PRTFs will utilize strength-based, evidence-based strategies and active family engagement to improve the recipient's condition. This includes parental involvement services to enhance parenting skills and maintain or modify parent-recipient relationships when necessary. PRTFs will also provide all essential medical, dental, psychological, social, behavioral, and developmental care.

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- PRTFs will adhere to Critical Events/Serious Occurrences incident submission requirements and will, no later than close of business on the next business day after the event or occurrence, notify the appropriate state entities including:
    - State Medicaid Agency (Nevada Medicaid for recipients);
    - State designated Protection and Advocacy agency;
    - Child Protective Services (CPS) if the event or occurrence involved any confirmed or suspected incidents of recipient abuse and/or neglect; and
    - Appropriate state licensing entity
- The PRTF must have an ongoing quality assurance (QA) program to review and monitor facility services and individual recipient care, ensuring high service quality, problem resolution, and expected outcomes. The PRTF will cooperate with authorized external review bodies, including the state licensing agency and Nevada Medicaid. The QA plan must be readily available for Nevada Medicaid review upon request.
- Family Visits are based on clinical appropriateness and are utilized to support person- and family-centered treatment planning. PRTFs, as part of the all-inclusive daily rate, must bring up to two family members to the facility quarterly, covering travel, lodging, and meals, if the family lives 200 miles or more away.
    - For Medicaid-eligible recipients in public child welfare custody, the PRTF must consult and obtain approval from the agency's clinical representative before arranging a visit.

_____ Patient Rights

- PRTFs must protect and promote Patient's Rights in accordance with all applicable Federal and State regulations.

_____ Federal and State Requirements

- PRTFs must comply with all Federal and State Requirements. Federal Regulations 42 CFR 441.151 to 441.156 address certification of need, individual plan of care, active treatment and composition of the team developing the individual plan of care. In addition, 42 CFR 441.184 addresses emergency preparedness. To protect recipients' safety a thorough Fingerprint-Based Background Check and review is required. Reference MSM Chapter 100 for further details regarding Provider Conditions of Participation.

_____ Clinical Requirements/Staff Qualifications

- The PRTF must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate residential supervision 24 hours a day, seven days a week. The team of professional staff must be appropriately licensed, trained, and experienced in providing mental health psychiatric residential treatment.
- The PRTF must have a Medical Director who has overall medical responsibility for the PRTF program. The Medical Director must be a board-certified/board eligible psychiatrist with specific experience in child and adolescent psychiatry and must be available on a regularly scheduled basis to support the program and conduct regular onsite, in-person visits at the PRTF to assess the overall quality of care being provided at the PRTF.
- The PRTF must have an Interdisciplinary team of physicians and other personnel who are employed by, or provide services to recipients in, the PRTF in accordance with 42 CFR 441.156.
- Recipients must receive at least two monthly one-on-one sessions with a child and adolescent psychiatrist or board-certified Psychiatric/Mental Health APRN, who must also be available 24 hours a day.

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- Clinical psychotherapy (Individual, Group or Family Therapy) must be provided by a licensed QMHP. All Rehabilitative Mental Health (RMH) services may also be provided by a QMHP, a QMHA or a QBA within the scope of their practice under state law and expertise. Consultation by a licensed clinical psychologist must be available when determined medically necessary.

_____ Staff Training

- The PRTF must ensure that qualified personnel meet or exceed the requirements for training with respect to facility objectives, policies, services, community resources, state and federal policies, and best practice standards.
- All full and part-time clinical and direct care staff shall be trained in the following de-escalation and CPR training guidance in accordance with 42 CFR 483.376 including but not limited to:
    - The use of non-physical and non-restraining intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations; and
    - Safe and appropriate restraint and seclusion techniques, including the ability to respond to signs of physical distress in beneficiaries who are being restrained or in seclusion, including adult and child cardiopulmonary resuscitation (CPR). Competency of certification in CPR shall be demonstrated and documented annually.

_____ Discharge Requirements

- In accordance with MSM Section 403.7D(4), PRTFs must prioritize community permanency and stability in discharge planning, actively involving families/guardians in treatment plan development, progress updates, and case conferences. Services will be designed to strengthen family/guardian relationships and empower them to fulfill their roles.
- PRTFs must develop a treatment plan in accordance with 42 CFR 441.155 that is updated at least every 30 days in collaboration with the recipient and family/guardian.
- PRTFs must ensure the following is provided to the legal representative upon discharge of a Medicaid-eligible recipient:
    - Supply or access to currently prescribed medications equal to the amount already stocked for the recipient with instructions for use;
    - Written prescriptions for all prescribed medications as needed;
    - Written information about the recipient's Medicaid-eligibility status;
    - Provide all relevant medical records and post-discharge information for the recipient, including their safety plan, community provider referrals, emergency contact details, and a list of upcoming appointments to ensure coordinated and continuous care upon discharge.

Name (Print):_____

Owner or Director Signature:_____ Date: _____

Contact telephone number:_____

Facility name:_____

Facility NPI number:_____

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Medical Director

Attestation (to be completed by the Medical Director)

As the Medical Director for the Psychiatric Residential Treatment Facility (PRTF) entity named below, I hereby acknowledge that I have the overall medical responsibility for the below named PRTF, and I am, and shall be for the duration of my position with this PRTF, a board-certified/board-eligible psychiatrist with specific experience in child and adolescent psychiatry.

Psychiatric Residential Treatment Facility (PRTF) entity/agency/group name:

_____

I understand if I leave my position as Medical Director of (group's name)_____, I will report this change to Nevada Medicaid within the time required by policy found in the Medicaid Services Manual (MSM) Chapter 100, Section 103.

Medical Director Name (print): _____

Medical Director Signature: _____

Medical Director National Provider Identifier (NPI) number: _____

Contact phone:_____ Date: _____

Attestation (to be completed by an Owner or Person with Five Percent or More Interest):

I attest to the knowledge and understanding that should a new Medical Director be hired, contracted, or otherwise added, notification to Nevada Medicaid will be made in accordance with the Medicaid Services Manual Chapter 100 policy, Section 103 (https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/) regarding reporting requirements and through the method found in the Provider Enrollment Information Booklet (https://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf).

Name of Owner or person with five percent or more interest (print): _____

Signature of Owner or person with five percent or more interest: _____

I understand if the Medical Director of (group's name) _____ leaves or resigns as Medical Director, I will notify Nevada Medicaid of the replacement Medical Director within the time required by policy found in the Medicaid Services Manual (MSM) Chapter 100, Section 103.

Owner or Director signature: _____ Date: _____

Changes in Medicaid Information

If 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 Medical Director 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

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Updates on the Provider Enrollment webpage at https://www.medicaid.nv.gov provides instructions on navigating the Update Provider tool.

(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: _____

Policy Declaration

I hereby declare that I have read the current MSM Chapters 100 and 400 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 1800. 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: _____

Reporting Fraud

Providers have an obligation to report to Nevada Medicaid any suspicion of fraud or abuse in Nevada Medicaid 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.