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

Please refer to the Provider Enrollment Information Booklet for guidance and to the applicable Medicaid Services Manual (MSM) Chapter for enrollment requirements. In addition, the following are required for your provider type and specialty. In the online application, upload specified documents where prompted and additional documents in the Miscellaneous Attachment section.

If you have any questions, please call the Gainwell Technologies Contact Center at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Pacific Time Monday through Friday.

Submit the following with the online application:

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

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

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

☐ 3. 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.

☐ 4. 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.
- 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.

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☐ 5. 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

☐ 6. 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.

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: _____

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

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☐ 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): _____	