| Addendum/Maintenance Form

IHCP PRTF Attestation Letter/Maintenance Form

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Overview

An attestation letter must be completed by all psychiatric residential treatment facilities (PRTFs) and submitted with the provider application packet.

Providers enrolling or revalidating as **PRTFs must read this important notice and submit an attestation letter** (see example below) **along with the signed Indiana Health Coverage Programs (IHCP) Provider Agreement. Providers are required to provide an updated attestation letter annually or when a new person takes over the position of facility director.**

Indiana Medicaid rules at *405 IAC 5-20-3.1* stipulate the following requirements for psychiatric residential treatment facility (PRTF) providers:

(1) The facility must be licensed as a private secure care institution under *470 IAC 3-13*.

(2) The facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, or the Council on Accreditation of Services for Families and Children.

(3) The facility must comply with all requirements in *42 CFR 483, Subpart G,* governing the use of restraint and seclusion.

Pursuant to *405 IAC 5-20-3.1(3)*, PRTFs participating in Indiana Medicaid must comply with federal requirements in *42 CFR Part 483, Subpart G,* governing the use of restraint and seclusion, and where the requirements differ from Indiana residential licensing rules at *470 IAC 3-13,* the federal requirements take precedence over Indiana licensing rule requirements governing the use of restraint and seclusion.

Background

An interim final rule establishing standards for the use of restraint and seclusion in PRTFs providing inpatient psychiatric services for individuals under age 21 (the *Psych Under 21* rule) was published on January 22, 2001, by the Centers for Medicare & Medicaid Services (CMS). The rule established a definition of a PRTF that is not a hospital and that may furnish covered inpatient psychiatric services for individuals under age 21. The rule also established a Condition of Participation (CoP) for the use of restraint and seclusion that PRTFs must meet to provide, or continue to provide, this Medicaid inpatient benefit. The CoP specifies requirements designed to protect residents against the improper use of restraint and seclusion. The Medicaid Program *Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21* final rule is available at ***Federal Register Vol. 66 No. 14*** at *CFR Part 483*, *Subpart G*, sections 483.350-483.37.

Reporting

Under the *Psych Under 21* rule, each PRTF is required to report a resident's death, a resident's serious injury, and a resident's suicide attempt to the state Medicaid agency and the state-designated protection and advocacy system. *Section 42 CFR 483.374(c)* requires: "In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office. Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS regional office."

Required Attestation

Section 483.374(a) of the rule requires a facility enrolling or revalidating as a Medicaid provider of PRTF services to meet the requirements of the *Psych Under 21* rule at the time the facility executes a provider agreement with the Medicaid agency and submits an attestation of compliance at that time. Thereafter, annual attestations are required by July 21, or by the next business day if July 21 falls on a weekend or holiday. **The attestation must be signed by an individual who has the legal authority to obligate the facility (facility director)**. A new attestation must be submitted whenever a new person takes over the position of facility director.

A model attestation letter is provided in this packet for you to use in preparing and submitting the required attestation with your signed IHCP Provider Agreement. If you do not use the model attestation letter, **the attestation must include the following required information and be signed by an individual who has the legal authority to obligate the facility**. A delegated administrator may not sign this form.

- Name of the PRTF
- PRTF address, city, state, and ZIP Code
- PRTF telephone number
- PRTF fax number (if applicable)
- PRTF IHCP Provider ID
- PRTF ID number for state survey agency tracking purposes: 15L _ _ _ (this number is assigned on completion of the PRTF's IHCP provider enrollment/revalidation)
- Number of beds in the facility
- Number of individuals currently served in the PRTF who are receiving Indiana Medicaid *Psych Under 21* (PRTF) benefits
- Number of individuals, if any, whose PRTF services are being paid for by a state Medicaid agency other than Indiana Medicaid.

Provider Attestation Letter

Facility name: _____

Address: _____

City, state, ZIP Code: _____

Telephone number: _____ Fax: _____ Email: _____

Description	Required Information
IHCP Provider ID, if currently enrolled	
National Provider Identifier (NPI)	
State survey number	
Number of beds in facility	
Number of individuals currently served in the PRTF who are receiving Indiana Medicaid *Psych Under 21* (PRTF) benefits	
Number of individuals, if any, whose PRTF services are being paid for by a state Medicaid agency other than Indiana Medicaid	

Dear Indiana Health Coverage Programs:

After conducting a reasonable investigation of the subject facility under my control, I make the following certification. Based upon my personal knowledge and belief, I attest that the (Name of Facility)

_____ hereby complies with all the requirements set forth in the interim final rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (*Psych Under 21* rule).

I understand that the Centers for Medicare & Medicaid Services (CMS), the State Medicaid Agency, or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at *431.610*, have the right to validate that (Name of Facility)

_____ is in compliance with the requirements set forth in the *Psych Under 21* rule and to investigate serious occurrences as defined under this rule.

(Name of Facility) _____ will submit a new attestation of compliance by July 21 of each year (or by the next business day if July 21 falls on a weekend or holiday).

In addition, I will notify the Indiana Family and Social Services Administration immediately if I vacate this position, so that an attestation can be submitted by my successor. I will also notify the State Medicaid Agency if it is my belief that

(Name of Facility) _____ is out of compliance with the requirements set forth in the *Psych Under 21* rule.

Signature _____Title _____

Printed name _____ Date _____