Residential Treatment Center (RTC)

To enroll/revalidate as a Nevada Medicaid and Nevada Check Up Residential Treatment Center (RTC), all providers (in-state and out-of-state) must complete the provider enrollment application using the Online Provider Enrollment tool and attach all four pages of this Enrollment Checklist and a copy of the documents listed below.

If you have any questions, please contact Provider Customer Service at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Resources:

- The Provider Enrollment webpage provides instruction materials that will assist providers with enrolling in Nevada Medicaid.
- Medicaid Services Manual (MSM) Chapter 400 Mental Health and Alcohol and Substance Abuse Services

Medical Director

Attestation (to be completed by the Medical Director)

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

Residential Treatment Center (RTC) entity/agency/group name: _____

Medical Director Name (print): _____

Medical Director Signature: _____

Medical Director NPI: _____ 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 (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):_____

Owner or Person with Five Percent or More Interest Signature: _____

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: RTC, PRTF or BHCQC license equivalent from home state

      Submitted License Expiration Date: _____

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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. Letter of Attestation in compliance with 42 CFR Subpart G 483.350 – 483.376 which confirms the facility is in compliance with Centers for Medicare & Medicaid Services (CMS) standards governing the use of restraint and seclusion specifically from the "individual having legal authority to do so (i.e., facility director, owner, Administrator)."
6. This Enrollment Checklist with the following questions completed and the required initials and signature below:

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

   ☐ Yes ☐ No

   Is this RTC 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

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 Disorder	☐ Complex Medical Issues
☐ Co-Occurring Disorders	☐ Deaf or Hard of Hearing	☐ Dual Diagnosis
☐ Eating Disorders	☐ Fetal Alcohol Syndrome	☐ General Psychiatric
☐ IQ Between 48 And 80 or Borderline IQ	☐ Neurological Disorders	☐ Pervasive Developmental Disorder
☐ Post Traumatic Stress Disorder	☐ Sexual Offenders	☐ Sexually Reactive Disorders
☐ Substance Abuse	☐ Traumatic Brain Injuries	☐ Other (please specify): _____

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

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

_____ Residential Treatment Center (RTC) Services (MSM Chapter 400 Section 403.8B) Provider Responsibilities

a) RTC provider will adhere to MSM 403.8B Provider Responsibilities and report Critical Events within 48 hours of occurrence.

b) The RTC must have a QA/Quality Improvement program in place at the time of enrollment and a process to submit an annual QA report to DHCFP upon request.

c) Quarterly Family Visits are based on clinical appropriateness and are utilized to support person- and family-centered treatment planning. It is the responsibility of out-of-state and in-state RTCs, as part of the all-inclusive daily rate, to bring up to two family members to the facility on a quarterly basis when the family resides 200 miles or more from the RTC. This includes the RTC providing travel, lodging and meals, to the family.

d) For Medicaid-eligible recipients in the custody of a public child welfare agency, prior to arranging the visit, the RTC must consult with and obtain approval from the agency's clinical representative pertaining to the appropriateness of such a visit.

e) RTCs must ensure the following is provided to the legal representative upon discharge of a Medicaid-eligible recipient:

   i. Supply or access to current prescribed medications;
   ii. The recipient's Medicaid-eligibility status;
   iii. All pertinent medical records and post discharge plans to ensure coordination of and continuity of care.

_____ Clinical Requirements

a) The RTC must have a Medical Director who has overall medical responsibility for the RTC program. The Medical Director must be a board-certified/board eligible psychiatrist with specific experience in child and adolescent psychiatry.

b) Psychiatric/Medical Services

   i. Medicaid-eligible children and adolescents must receive, at a minimum, two monthly face-to-face/one-on-one sessions with a child and adolescent psychiatrist.
   ii. The RTC must provide routine medical oversight to effectively coordinate all treatment, manage medication trials and/or adjustments to minimize serious side effects and provide medical management of all psychiatric and medical issues.

c) 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.

_____ Patient Rights

a) RTCs must protect and promote Patient's Rights in accordance with all applicable Federal and State regulations.

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_____ Federal Requirements

a) RTCs must comply with all Federal and State Admission 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.

_____ Reporting Fraud or Abuse

a) 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, Section 3303.1B.1). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300, Section 3303.1A.2. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405 or completing the form on the DHCFP website at http://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/.

b) 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.

c) I hereby agree to abide by Nevada Medicaid's fraud reporting requirements.

Name (Print):_____

Signature:_____Date: _____

Title: ☐ Agent ☐ Business Owner ☐ Managing Employee

Contact telephone number:_____

Facility name:_____

National Provider Identifier (NPI):_____