



Cost Recovery Documentation

Dear Colleague:

Under an agreement between DSCYF and Delaware Medicaid, DSCYF is the exclusive provider of Medicaid behavioral health and substance abuse services to children in Delaware.

In order for DSCYF's Cost Recovery Unit to pursue Medicaid reimbursement for services we provide to Delaware children through a third party such as your organization, we must obtain certain documentation from you annually. In your Contract or Statement of Agreement (Article I, Section B.5) with DSCYF you agree to provide this information.

Please provide us with the items checked below:

1. **Required: 3 GREEN FORMS** – These are standard forms that we require all of our providers to complete and sign annually.
 - Rate Certification Form P21** - Please provide the “**usual and customary rate**” that you charge for the services you have contracted with DSCYF. These rates *may be different from the* DSCYF Contracted Rates. Per Federal Regulations, DSCYF can only receive Medicaid reimbursements at or below the **usual and customary rate that is charged to the general public.** (*42 CFR 447.271 - Upper Limits Based on Customary Charges*)
NOTE: If you have rate information already prepared and do not want to handwrite your rates on this form, please attach your rate information to the **signed** Rate Certification Form.
 - CMS Sanctions Form**
 - Accreditation Status Form**
2. **Required: Copies of Licenses, Certificates, Accreditations, and NPI Letter**
 - Facility Licenses:** Different states use different wording for each type of license. Examples of facility licenses and/or certificates we need include, but are not limited to: Alcohol & Drug, Child & Youth Agency, Child Caring Institution, Child Placing Agency, Day Treatment, Foster Care, Group Home, Hospital, Outdoor Program, Private Child & Youth Agency, Psychiatric Hospital, Residential Services, Residential Treatment, and Residential Childcare.
 - Accreditations:** Please send a copy of any accreditation you may have. For JCAHO accreditation, send a copy of the JCAHO certificate and a copy of the JCAHO letter that specifies the effective month, day, and year of the accreditation.
 - NPI Letter:** Please send a copy of your NPI assignment letter or NPI assignment email.
3. **Required:**
 - Disclosure of Ownership and Control Interest Statement – New requirement**
 - Psych Under 21 Facility** – Please note that this questionnaire also covers inpatient facilities that provide treatment for *alcoholism and other chemical dependency syndromes* if treatment follows a psychiatric model and is performed by medically trained and licensed personnel.
 - Attending Physician Form** – Required Under HIPAA
4. **Other Information:**
 - Any additional program or rate information that will help us in our Medicaid recovery efforts would be greatly appreciated.
 - Please return the completed, signed, GREEN FORMS (originals), copies of licenses and certificates, Psych Under 21 Facility, Attending Physician Form and any other information with your signed contract.

State of Delaware



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Division of Management Support Services – Cost Recovery Unit (CRU)*

Or, you can mail them directly to:

State of Delaware
DSCYF - DMSS
Cost Recovery Unit
1825 Faulkland Road
Wilmington, DE 19805
Attn: Charlotte Martin, MA II

If you expect a delay of more than two weeks in your response, or if you have any questions, please contact me.

The funds we recover from Medicaid allow us to provide more services, through you, to the children of Delaware.

Thank you for your cooperation.

Sincerely yours,

Charlotte Martin, Management Analyst II
DSCYF-DMSS
Cost Recovery Unit
Phone: 302-892-4567
Fax: 302-661-7224
E-mail: charlotte.martin@state.de.us

Enclosures: 5

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**RATE CERTIFICATION FORM – Psych Under 21 Services
Usual and Customary Charges to the General Public**

Complete a separate form for each location for which services are contracted by DSCYF. A campus consisting of closely located cottages is considered one location. Please list both your “**Usual and Customary**” rate and the “**DSCYF Contracted**” rate for all services. If you operate an on-site education program as part of the treatment program, list the residential and therapeutic education rates separately. If the children attend public school, it is not necessary to list the public education cost.

Contracting Division	
Contract ID (found on your DSCYF Contract)	
Contract Period	
Program Funded	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section I

Do children in your residential program receive public education through your state’s public school system?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Where is the education provided?	<input type="checkbox"/> On-Site	<input type="checkbox"/> Off-Site

Section II

Program Name\Service Description	Healthcare Procedure Billing Code	Contracted DSCYF Rate	Usual & Customary Therapeutic Education Rate	Usual & Customary Residential Rate	Usual & Customary Total Rate

Section III

Is your facility enrolled with Medicaid?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, which States?	

Section IV

Agency Name	
Name of Authorized Representative	
Title of Authorized Representative	
Signature of Authorized Representative	
Date	
Phone	
E-mail	

Please complete, sign, and return to charlotte.martin@state.de.us, fax 302.661.7224, phone 302.892.4567, or mail to: DSCYF/DMSS/CRU, 1825 Faulkland Rd, Wilmington, DE 19805



CMS SANCTIONS CERTIFICATION FORM

Per the SOCIAL SECURITY ACT, SEC. 1128, 42 USC Sec. 1320a-7 “Exclusion of certain individuals and entities from participation in Medicare and State health care programs,” the Secretary of U.S. Department of Health and Human Services may exclude individuals and entities from participation in any Federal health care program, including Medicaid and Medicare, or any State health care program.

I, the undersigned, as an authorized representative of this agency, certify that this agency has never been sanctioned by the Centers for Medicare & Medicaid Services (CMS), formerly HCFA, or had a license revoked.

Date

Authorized Signature

Printed Name

Title

Agency

Street Address

City, State, Zip

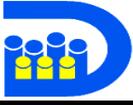
Phone Number

Email address

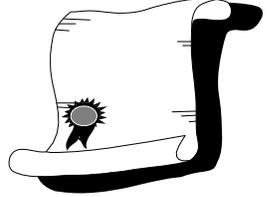
If your agency has ever been sanctioned, please provide details including date of reinstatement.

SEND ORIGINAL (NOT PHOTOCOPIED) SIGNATURE ONLY.

Return with contract or mail to: Cost Recovery Unit/DMSS/DSCYF
1825 Faulkland Road, BMP 2120
Wilmington, DE 19805
302-892-4567 or 302-892- 4565



ACCREDITATION STATUS FORM



- This organization is not accredited.
- This organization is accredited.

_____ From: _____ To: _____
 Accrediting Organization(s) Period of Accreditation mm/dd/yy

Please detail which parts of your organization are covered by the accreditation standards (If your entire organization is accredited, it is only necessary to indicate “All” instead of providing a comprehensive list). In addition, please specify facility or campus names included in the survey (if applicable) within each service area.

PLEASE PROVIDE A COPY OF THE ACCREDITATION CERTIFICATE FOR OUR FILE

Date

Name of person completing form (please print)

Phone number

Agency

Email address



Survey of Medicaid Compliance Psychiatric Under 21 Services Facility Review

Alcoholism and other chemical dependency syndromes are classified as mental health disorders per the ICD-9-CM system. Treatment for chemical dependency is considered medical treatment of a mental health disease if it follows a psychiatric model and is performed by medically trained and licensed staff.

	Yes	No
I. Certification		
A. <i>Facility Accreditation</i>		
Is the center a		
a. Psychiatric hospital or inpatient psychiatric program in a hospital, accredited by JCAHO?	<input type="checkbox"/>	<input type="checkbox"/>
OR		
b. Psychiatric facility accredited by JCAHO, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or any other accrediting organization with comparable standards recognized by the State?	<input type="checkbox"/>	<input type="checkbox"/>
Name of Accrediting Org: _____		
B. <i>Seclusion Room Requirements</i>		
1. Does the room allow staff full view of the resident in the entire room?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the room free of potentially hazardous conditions (unprotected light fixtures, electrical outlets, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
II. Staffing		
A. <i>Physician Directed Services</i>		
Are services provided under the direction of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
B. <i>Certification that services are necessary in setting provided</i>		
Is this certification of services performed by an independent team, which includes a physician?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Active Treatment & Independent Plan of Care</i>		
3. Is the IPC based on a diagnostic evaluation and developed by an interdisciplinary team of physicians and other staff?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does this interdisciplinary team include:		
i) a Board-eligible or -certified psychiatrist;	<input type="checkbox"/>	<input type="checkbox"/>
ii) a clinical psychologist with a doctoral degree; and		
iii) a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>

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	OR i) a licensed physician trained in the diagnosis and treatment of mental diseases; and ii) a master’s level clinical psychologist certified by the State of the State psychological association?		
5.	Does the interdisciplinary team also include: i) a psychiatric social worker; ii) a registered nurse with experience/training in treating mentally ill people; and iii) a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Does the written IPC include: i) a diagnostic evaluation that indicates the need for admission? ii) treatment objectives? iii) specific orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the child’s health and safety? iv) plans for continuing care, including review and modification to the IPC? v) at the appropriate time, plans for discharge, including post-discharge plans and coordination inpatient and related community services to ensure continuity of care with the child’s family, school, and community?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
7.	Is the IPC implemented within 14 days of admission?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Is the IPC designed to achieve the recipient’s discharge from inpatient status at the earliest possible time?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Is the IPC reviewed by the team every 30 days to determine that inpatient services are/were required and to recommend changes in the plan?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Are there progress reports/notes that describe the services being provided and their relationship to the treatment plan (<i>i.e.</i> , therapeutic interventions are aligned with the treatment plan)?	<input type="checkbox"/>	<input type="checkbox"/>
<i>C. 24-hour care</i>			
1.	Is 24-hour care available from a registered nurse or other licensed staff such as a licensed practical nurse?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is the clinical staff trained in emergency interventions?	<input type="checkbox"/>	<input type="checkbox"/>
<i>D. On-call Care</i>			
1.	Is on-call care available from a physician or other licensed practitioner permitted by the State and facility to order restraint and seclusion and trained in emergency safety interventions?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are orders for restraint or seclusion the least restrictive intervention that is most likely to be effective in resolving the	<input type="checkbox"/>	<input type="checkbox"/>

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emergency safety situation based on consultation with staff and limited to no longer than the duration of the emergency safety situation?		
3. Are the time limits for restraint or seclusion consistent with the July 1999 hospital interim final rule? (No more than 4 hours for residents aged 18 to 21, 2 hours for residents aged to 9 to 17, and 1 hour for residents under 9.)	<input type="checkbox"/>	<input type="checkbox"/>
III. Staff Training		
A. Education/Training		
1. Does the Center’s staff receive ongoing restraint and seclusion training which includes CPR certification?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is this training performed by individuals qualified by education, training, and experience?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do staff personnel records document that this training was successfully completed and are staff required to demonstrate their competencies on a semi-annual basis?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the Center make all training programs and material available for review by CMS, the State Medicaid agency, and the State survey agency?	<input type="checkbox"/>	<input type="checkbox"/>
IV. Facility Reporting and Record Keeping		
A. Parental Notification		
1. Does the Center inform incoming residents and their parents/legal guardians of the restraint and seclusion policy?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the Center obtain written acknowledgement from the resident or parents/legal guardians stating that they are aware of the facility policy?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the written policy include contact information for the State Protection and Advocacy organization?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the Center document restraint and seclusion activity in the resident’s record?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the Center notify parents/legal guardians of restraint and seclusion incidents?	<input type="checkbox"/>	<input type="checkbox"/>
B. Communication within Facility		
1. Is there communication with the resident’s treatment team physician?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are there debriefings among staff and residents involved in restraint and seclusion incidents? (Debriefings may also involve parents/legal guardians and must be conducted in a language understood by the resident and parents/legal guardians.)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are there separate debriefings of staff involved in emergency safety intervention and review by appropriate supervisory and administrative staff of the situation that required the use of restraint and seclusion?	<input type="checkbox"/>	<input type="checkbox"/>

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<i>C. Reports to Public Agencies</i>			
1.	Is there attestation of Medicaid compliance with CMS standards (under the State plan)? List attestation # _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is there reporting of serious incidents to the resident's parents/legal guardians within 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is there reporting of resident deaths to the State Medicaid agency and the State designated P&A system (no later than the close of business the following day)?	<input type="checkbox"/>	<input type="checkbox"/>
<i>V. Seclusion & Restraint</i>			
<i>A. Seclusion & Restraint Policies</i>			
1.	Does the facility have written policies?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is parental/guardian acknowledgement of notification of such policies retained in the resident's record?	<input type="checkbox"/>	<input type="checkbox"/>
<i>B. Seclusion & Restraint Orders</i>			
1.	Are orders for restraint/seclusion ordered by an MD or other licensed practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is that person trained in emergency safety interventions?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is the resident's treatment team physician available to give the order, and is he/she the only one to do so?	<input type="checkbox"/>	<input type="checkbox"/>
4.	If the order is verbal, is it taken by an RN or LPN?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is the person who ordered it available at least by phone throughout the intervention?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Does an MD or other licensed practitioner do a face-to-face assessment of physical and psychological well-being within 1 hour of the intervention?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Are clinical staff trained in the use of emergency safety interventions physically present in, or immediately outside, the seclusion room continually assessing, monitoring and evaluating the physical and psychological well-being of the resident in seclusion? <i>(Video monitoring does NOT meet this requirement.)</i>	<input type="checkbox"/>	<input type="checkbox"/>
8.	If the intervention lasts longer than ordered, does an RN or other licensed practitioner call back for further instructions?	<input type="checkbox"/>	<input type="checkbox"/>

If facility is NOT certified to provide Psych Under 21 Services in any state of jurisdiction, check here _____

If facility is certified by any State Medicaid agencies to provide Medicaid Psych Under 21 Services, please complete the following. Please indicate for each state whether education costs are included in your facility's Medicaid rate, consistent with 42 CFR 441.13 (b), which allows education costs to be claimed if they are a part of the active treatment as defined at 441.154.

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State	Contact Information: Name, Title, and Phone # of Medicaid Agency Representative	Education included in Medicaid rate?
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO

Name of Agency/Facility: _____
Please Print

Name of Person Completing Survey: _____
Please Print

Signature of Person Completing Survey: _____
Signature

Title of Person Completing Survey: _____
Please Print

Date: _____

Please return completed survey with your signed contract or mail to:

DSCYF
Division of Management Support Services
Cost Recovery Unit
1825 Faulkland Road
Wilmington, DE 19805
Attn: Charlotte Martin

For the actual regulatory citations for the Medicaid Psych Under 21 benefit and related conditions of participation, please refer to the following sections of the Code of Federal Regulations (CFR):
42 CFR 441 Subpart D – Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs
42 CFR 456 Subpart G – Admission and Plan of Care Requirements
42 CFR 483 Subpart G – Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities providing Inpatient Psychiatric Services for Individuals Under Age 21

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Division of Management Support Services – Cost Recovery Unit (CRU)

Information on Treating Physician Required Under HIPAA

The Delaware Department of Services for Children Youth, and Their Families (DSCYF), Division of Child Mental Health Services, operates as a Managed Care Behavioral Health entity for Medicaid children in Delaware. We have a contract with Delaware Medicaid that allows us to provide public behavioral health services and to purchase services from private entities that meet our standards. We then bill Medicaid for those services.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health care claims be submitted on one of two acceptable formats. One of those formats, the 837 Institutional which is used for billing hospital and psych under 21 services, requires that we provide the National Physician Identifier and Physician Taxonomy of the treating physician for services provided in hospitals such as yours. The Physician Taxonomy is a unique alphanumeric code, ten characters in length. The code list is structured into three distinct levels including Physician Type, Classification, and Area of Specialization.

Please provide information for the physicians treating DSCYF children and physicians eligible to treat our children. The most commonly used Health Care Physician Taxonomies used by physicians who treat DSCYF children are listed below. Complete list can be found at http://www.wpc-edi.com/codes/taxonomy

Table with 3 columns: 2084P0800X - Psychiatry & Neurology: Psychiatry, 2084P0802X - Psychiatry & Neurology: Addiction Psychiatry, 2084P0804X - Psychiatry & Neurology: Child & Adolescent Psychiatry

The Administrative Simplification provisions of HIPAA mandate the adoption of a standard unique identifier for health care physicians. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care physicians and assigns each a unique National Physician Identifier (NPI). NPI application forms can be found at https://nppes.cms.hhs.gov/NPPES/Welcome.do

Table with 4 columns: LAST NAME, FIRST NAME, NATIONAL PHYSICIAN IDENTIFIER, PHYSICIAN TAXONOMY

Please complete, sign, and return this form to Charlotte.Martin@state.de.us, fax 302.661.7224, phone 302.892.4567, or mail to: DSCYF\DMSS\CRU 1825 Faulkland Rd, BMP 2120, Wilmington, DE 19805. Thank you in advance for your assistance in this matter.

Facility Name Contact Name Phone Number Date