



Psych Under 21 Form Packet

Dear Service Provider:

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 reimbursement from Medicaid 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 return the completed, signed forms, copies of licenses and certificates, the separately attached Disclosure Statement and any other information with your signed contract via email, fax, or mail:

You can email to:	<a href="mailto:charlotte.martin@state.de.us">charlotte.martin@state.de.us</a>
Or, You can fax to: (Must use all 10 digits)	302.661.7224
Or, You can mail to	STATE OF DELAWARE DSCYF-DMSS-N301 COST RECOVERY UNIT (ATTN: CHARLOTTE MARTIN) 1825 FAULKLAND ROAD, WILMINGTON, DE 19805

We are requesting the following:

1. **Required: FORMS** – These are standard forms that we require all of our providers to complete and sign annually (**including mental health subcontractors**).
  - **Rate Certification Form** - Please provide the “**usual and customary rate**” that you charge to the general public 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 Certification Form**
  - **Accreditation Status Form**
  - **Seclusion and Restraint Attestation Form**
  - **Psych Under 21 / PRTF Form**
  - **Information on Treating Physicians Form**
  - **Disclosure of Ownership and Control Interest Statement (separate attachment)**
2. **Required: Copies of Licenses, Certificates, Accreditations, and NPI Letter**
  - **Professional Licenses:** If you are a clinician in private practice, please send a copy of your current professional license.
  - **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.
  - **State Medicaid Letter:** Please provide a copy of your State's Medicaid agency letter showing your Medicaid enrollment and rate(s).
3. **Other Information:**
  - Any additional program or rate information that will help us in our Medicaid recovery efforts would be greatly appreciated.

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,

Charlotte Martin, Management Analyst II  
DSCYF-DMSS-N301  
Cost Recovery Unit  
Phone: 302.892.4567 | Fax: 302.661.7224 | E-mail: [charlotte.martin@state.de.us](mailto:charlotte.martin@state.de.us)

Enclosures: 6



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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.

Contract ID # (found on your DSCYF Contract)		
Contract Period	<b>From:</b>	<b>To:</b>
Program Funded	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do children in your residential program receive public education through a 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

Facility / Program Name	Service Description	Procedure Billing Code (Medicaid if applies)	Procedure Modifier (as needed)	DSCYF Contract Rate	Usual and Customary Education Rate	Usual and Customary Total Rate	Your State’s Medicaid Rate (MCO or FFS)
<i>e.g. Seashell Treatment Center</i>	<i>Psychiatric Residential Treatment Service for children adolescents without education cost</i>	<i>0154</i>		<i>\$350.00</i>	<i>Educ. billed separately</i>	<i>\$430.00</i>	

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

Signature of Authorized Representative	
Title of Authorized Representative	
Printed Name of Authorized Representative	
Agency Name	
Date	
Phone	
Email	

Please provide a copy of your State’s Medicaid letter showing your enrollment and your rate(s).



**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.

As an authorized representative of this agency, I certify that the following is true regarding sanctions by the Centers for Medicare & Medicaid Services (CMS), formerly HCFA.

- This agency or individuals working for it have never been sanctioned by CMS.
- This agency or individuals working for it were sanctioned by CMS. The agency or individuals were sanctioned on (date) \_\_\_\_\_. Please select one option below.
  - The sanctions have not been removed.
  - The sanctions were removed on (date) \_\_\_\_\_. Please provide supporting documentation.

Signature of Authorized representative	
Printed Name	
Date	
Title	
Phone Number	
Email Address	
Agency Name	
Agency Address	
Agency City, State, Zip	

You may attach supporting documentation if necessary.



**ACCREDITATION STATUS FORM**

- This agency is not accredited.
- This agency is accredited. Documents confirming accreditation such as certificates are attached.

Agency Name	
Accrediting Organization(s), i.e. JCAHO, CARF, COA, etc.	
Period of Accreditation START Date	
Period of Accreditation END Date	

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, if applicable, included in the survey within each service area.

Signature of Person Completing Form	
Printed Name of Person Completing Form	
Date	
Phone Number	
Email address	

Please provide copies of accreditation certificate(s).



### **Seclusion and Restraint Attestation Form**

- This facility does not use seclusion and restraint (skip to Seclusion and Restraint Form signature space).
- This facility does use seclusion and restraint, and this form is completed as requested.

The Department of Services for Children, Youth, and Their Families (DSCYF) is the exclusive provider of behavioral health services to Medicaid eligible children in Delaware. As a service provider within DSCYF's behavioral healthcare network, services purchased under our contract with you may ultimately be claimed to Medicaid by the department under a contract between DSCYF and Delaware Medicaid.

On January 22, 2001, Centers for Medicare and Medicaid Services (CMS), published regulations in the Federal Register governing the use of **seclusion and restraint** in Psychiatric Residential Treatment Facilities (PRTF's), a new category of facilities which was also created in this regulation. This new category of provider includes accredited, non-hospital providers which meet the requirements for providing the Medicaid benefit for Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs ("Psych Under 21") at 42 CFR 441 Subpart D. Our records indicate that at least some of the facilities with which we contract fall within this regulatory definition.

These regulations mandate certain levels of staffing, additional staff competencies and procedures in the above facilities. They were subsequently amended on May 22, 2001 to change the type of staff that will enable facilities to comply with the regulations. These regulations became effective May 22, 2001.

As a condition of continued participation in the Medicaid program for the provision of the psych under 21 benefit, the CMS is mandating that all applicable facilities for which the Medicaid psych under 21 benefit is being billed certify in writing to the applicable state Medicaid agency that they are in compliance with the regulations.

The below attestation must be signed by the facility director. While your facility is not directly enrolled with Delaware Medicaid, DSCYF is bound to these requirements and must certify to Medicaid that any facilities with which we contract to provide services under the psych under 21 benefit meet the conditions. Please send the attached attestation form to Leslie Boyd, Cost Recovery Administrator, within 14 days of receipt of this letter.

Please review the cited regulations and indicate on the attached form whether the services we are purchasing under this contract either are or are not in compliance with the regulations or whether you plan to be in compliance by some future date. If you have more than one location/service we are purchasing under this contract, please identify which services this attestation applies to. Failure to respond to this request or to be in compliance with the regulations may result in DSCYF terminating its contract with you, as your services for which we contract may no longer be Medicaid reimbursable. We request that you sign and return the enclosed attestation form as soon as possible for each facility within your organization in which a DSCYF client could be placed as a result of this contract.

Thank you in advance for your cooperation and your expeditious handling of this request.



**Seclusion and Restraint Attestation Form**

Parent Organization Name	
Parent Organization Address	
Campus Name	
Campus Address	
Campus Phone Number	

Building / Facility Name	NPI Number	License Number	Number of Beds

Please list below all states in which you are certified by the state Medicaid agency to provide MA Psych Under 21 Services and provide contact information to verify your status.

State Name	Contact Information (Name, Title, Phone)	Education included in MA rate? (Yes/No)

I hereby confirm that I have read all of the federal requirements at 42 CFR Part 483, subpart G §483.350 through §483.376, §441.150 through §441.156, and all state requirements.

I [printed name of facility director] \_\_\_\_\_, attest that the policies and procedures of [printed name of facility] \_\_\_\_\_ regarding the use of **seclusion and restraint** are in compliance with state and federal requirements. In addition, I will notify the Delaware Department of Services for Children Youth and Their Families (DSCYF) Cost Recovery Unit if at any time in the future it is my belief that one of the above facilities is no longer in compliance with the requirements set forth in the state and federal requirements.

I am attaching a copy of the written material used to inform residents and responsible parents or legal guardians of the facility's policy on the use of restrictive procedures.

I understand that the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agency, or their agents may rely on this attestation in determining whether the facility qualifies for payment for its services and, pursuant to Medicaid regulations at 42 CFR §431.610, have the right to validate that the facility is in compliance with the requirements set forth in the cited regulations, and to investigate serious occurrences as defined under those regulations.

In addition, I agree that this facility will submit a new attestation of compliance annually to the DSCYF Cost Recovery Administrator.

Signature of Facility Director	
Printed Name of Facility Director	
Date	



Psych Under 21 Form Packet

**Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (Psych Under 21)**

The purpose of this form is to determine whether your facility is certified by one or more state Medicaid agencies to provide Psych Under 21 services to Medicaid recipients as described in 42 CFR 441 Subpart D and related regulatory references. This form will assist DSCYF in setting up an appropriate mechanism for claiming services purchased by DSCYF from your facility for Delaware Medicaid children.

Link to CMS memorandum "**Psychiatric Residential Treatment Facilities (PRTF) Clarification**" can be viewed at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-15.pdf>

Facility Name	
Facility Address	
Facility City, State, Postal Code	

- The facility identified above IS NOT certified to provide Psych Under 21 services as a Psychiatric Hospital or as a PRTF. **You do not need to complete the table below.**
- The facility identified above IS certified to provide Psych Under 21 services as a Psychiatric Hospital or as a PRTF. **Please complete the table below.**

Please list all states in which you are certified by the state Medicaid agency to provide MA Psych Under 21 Services and provide contact information in each state where we may contact to verify your status. Please also indicate for each state whether education costs are included in your facility's Medicaid rate, consistent with 42 CFR 441.13 (b) which allows educational costs to be claimed *if they are part of active treatment* as defined at 441.154.

State	State Medicaid Agency Contact Information: Name, Title, Phone Number	Procedure Code Billed	Education Included in Medicaid Rate? (Yes/No)

Please provide copies of correspondence from state Medicaid agencies certifying the above facility is authorized to provide Psych Under 21 services.

For the 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 Part 441**-Services: Requirements and Limits Applicable to Specific Services.  
Subpart D-Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs
- **42 CFR Part 483**--Requirements For States And Long Term Care Facilities 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

Signature of Authorized Representative	
Printed Name of Authorized Representative	
Title of Authorized Representative	
Phone number	
Date	



### 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 Social Security number and Provider Taxonomy of the treating physician for services provided in hospitals such as yours. The Provider Taxonomy is a unique alphanumeric code, ten characters in length. The code list is structured into three distinct levels including Provider Type, Classification, and Area of Specialization.

**Please provide the information regarding the physicians treating DSCYF children or the physicians eligible to treat our children.** The most commonly used Health Care Provider Taxonomies used by providers who treat DSCYF children are listed below. A complete list can be found at <http://www.wpc-edi.com/codes/taxonomy>

<b>2084P0800X</b> - Psychiatry & Neurology: Psychiatry	<b>2084P0802X</b> - Psychiatry & Neurology: Addiction Psychiatry	<b>2084P0804X</b> - Psychiatry & Neurology: Child & Adolescent Psychiatry
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The Administrative Simplification provisions of HIPAA mandate the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique **National Provider Identifier (NPI)**. **NPI application forms can be found at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>**

Last Name	First Name	National Provider Identifier	Physician Taxonomy

Facility Name	Contact Name	Contact Phone Number	Date