Centers for Medicare & Medicaid Services (CMS) Psychiatric Residential Treatment Facilities (PRTF) Attestation Form

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Health Facilities Licensing & Certification
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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)**. Providers are required to provide an updated attestation letter every year on or before July 21 and when a new person takes over the position of facility director.**

PRTFs participating in Alaska Medicaid must comply with federal requirements in 42 CFR Part 483, Subpart G, 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 483.350-483.376.

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 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. 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 State Provider ID/license number
- National Provider ID (NPI)
- PRTF CMS Certification (CCN) ID number for state survey agency tracking purposes: The certification numbers for PRTFs will have five digits and one letter. The first two digits identify the State in which the PRTF facility is located.(this number is assigned on completion of the PRTF's Alaska Medicaid provider enrollment/revalidation)
- Number of beds in the facility
- Number of individuals currently served in the PRTF who are receiving Medicaid Inpatient Psychiatric Services for Individuals Under age 21 (*Psych Under 21)* PRTF benefits
- Number of individuals, if any, whose PRTF services are being paid for by a state Medicaid agency other than Alaska
- List of all states from whom the facility has ever received Medicaid payment for the provision of the Psych under 21 benefit
- The signature of the facility director (individual who has the legal authority to obligate the facility)
- The date the attestation was signed
- A statement certifying that the PRTF currently meets all the requirements of Part 483, Subpart G governing the use of restraint and seclusion
- A statement acknowledging the right of the Survey Agency, State Medicaid 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
- A statement that the facility will submit a new attestation of compliance annually by July 21st, or the following business day following the weekend or holiday, and in the event a new facility director is appointed
- A statement that the State Medicaid Agency will be notified if there is a belief the facility is out of compliance with the requirements set forth in the Psych under 21 rule

Attestation Letter of Compliance with 42 CFR 483.350-483.376 Condition of Participation for the use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities (PRTF)

Facility name:

Address:

City, State, ZIP Code:

Telephone number: Fax: Email:

Description	**Required Information**
Alaska Medicaid Provider ID, if currently enrolled	
State License Number (if applicable)	
National Provider Identifier (NPI)	
CCN# (if applicable)	
Number of beds in facility	
Number of individuals currently served in the PRTF who are receiving 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 Alaska Medicaid	
List of all states from whom the facility has ever received Medicaid payment for the provision of the Psych under 21 benefit	

Dear Alaska Medicaid:

After conducting a reasonable investigation of the subject facility under my control, I make the following certification. Based upon my personal knowledge, information, belief, reasonable interpretation and understanding of 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 attest that (Name of Facility) _____ hereby complies with all the requirements and meets the Conditions of Participation found in 42 CFR Part 483 Subpart G governing the use of restraint and seclusion and that all residents meet the certification of need requirements for PRTFs.

I understand that the Centers for Medicare & Medicaid Services (CMS), the Survey Agency, 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 have the right to validate that (Name of Facility) _____ is in compliance with the requirements set forth in the *Psych Under 21* rules and to investigate serious occurrences as defined under this. I acknowledge the right of the surveying agency and, if necessary, CMS to conduct an onsite survey at any time to validate the facility's compliance with the requirements of the rule, examine complaints lodged against the facility, or investigate serious occurrences.

On behalf of (Name of Facility) I 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) and in the event a new facility director is appointed. I will notify the State Medicaid Agency 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