Early Periodic Screening, Diagnosis and Treatment (EPSDT) Prior Authorization & Certificate of Medical Necessity Cover Sheet

EPSDT requests are submitted according to provider type:

- **Dental EPSDT Requests**
  Attention: Dental Program Officer
  Submit via fax to: (406) 444-1861

  Requests for Dental EPSDT Services will be reviewed by the Dental Program Officer and MUST be submitted via fax. Attach the following page with the supporting documentation when faxing the request.

- **Outpatient Drug EPSDT Requests (Pharmacy and Physician Administered Drugs)**
  Attention: Medicaid Pharmacist
  Submit via fax to: (406) 444-1861

  Requests for Outpatient Drug EPSDT Requests will be reviewed by the Medicaid Pharmacist and MUST be submitted via fax. Attach the following page with the supporting documentation when faxing the request.

- **All Other EPSDT Requests**
  Submit via Qualitrac Web Portal
  https://www.mpqhf.org/corporate/medicaid-portal-home

  Requests for EPSDT Services will be reviewed by Mountain-Pacific Quality Health and MUST be submitted electronically through the Qualitrac Portal. Under the coverage panel, please mark YES for the EPSDT Indicator and under documentation, select EPSDT PA form as the Category when attaching documentation.

Medicaid

Early Periodic Screening, Diagnosis and Treatment (EPSDT)
Prior Authorization & Certificate of Medical Necessity

Services provided through the EPSDT benefit to children under the age of 21 will be reviewed for medical necessity on a case-by-case basis. Prior authorization of EPSDT services should be submitted by a child's primary care provider or medical specialist, within their scope of practice, who determines the child needs additional treatment, services, or supplies for a primary health condition.

MEDICAID MEMBER INFORMATION

First Name: **Last Name:**

Medicaid ID: **Birth Date:** **Phone:**

REQUIRED DOCUMENTATION

Orders/prescriptions must be dated/signed and include diagnostic results, quantity, length of need, and medical necessity.

Durable Medical Equipment (DME):
- ☐ Order/prescription with detailed written order to include monthly requested amounts
- ☐ HCPCS code, description, product or manufacturer number. Also include the amount of non-covered, over the limit, or does not meet criteria (please specify).
- ☐ Supporting documentation (e.g., progress notes, History & Physical (H&P), formula, supplies, diagnostic results, or other relevant records)
- ☐ MSRP pricing

Nutrition:
- ☐ Order/prescription with type, calories, amount, and length of time
- ☐ Supporting documentation (registered dietician, nutritionist, or specialist for children >1 year)
- ☐ Growth charts for children under 18
- ☐ Breastmilk only: Must include lactation documentation, types of formula attempted, and relevant diagnosis for consideration.

Medical or Surgical Services:
- ☐ CPT code for non-covered or does not meet criteria
- ☐ Supporting documentation (e.g., progress notes, H&P, diagnostic results, or other relevant records)

Other Services:
- ☐ HCPCS or CPT code
- ☐ Name and amount of service requested
- ☐ Supporting documentation (e.g., progress notes, H&P, diagnostic results, or other relevant records)

REQUESTS MUST INCLUDE THE FOLLOWING INFORMATION & SUPPORTING CLINICAL DOCUMENTATION

Why does child need the requested additional service(s)?

How will the requested service(s) maintain, correct, or improve the child's condition?

Describe what specific goals/objectives can't be met without additional services.

Medical necessity definition based on Administrative Rules of Montana (ARM) 37.82.102

(18) "Medically necessary service" means a service or item reimbursable under the Montana Medicaid program, as provided in these rules:

(a) Which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:
  (i) endanger life;
  (ii) cause suffering or pain;
  (iii) result in illness or infirmity;
  (iv) threaten to cause or aggravate a handicap; or
  (v) cause physical deformity or malfunction.

(b) A service or item is not medically necessary if there is another service or item for the recipient that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all.

(c) Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of the Montana Medicaid program.
  (i) Experimental services are procedures and items, including prescribed drugs, considered experimental or investigational by the U.S. Department of Health and Human Services, including the Medicare program, or the department's designated review organization or procedures and items approved by the U.S. Department of Health and Human Services for use only in controlled studies to determine the effectiveness of such services.

I attest this child needs additional services that will be provided according to the current treatment plan. The services are not provided for cosmetic purposes or for the convenience or comfort for the child, parent/guardian, or provider.

Signature: _____

NPI: **Date:**

I am the primary care provider or specialist for this child. I examined this child or reviewed his/her medical record on: _____. I agree the additional services requested are necessary to correct or ameliorate defects of physical or mental illness. There is no other equally effective course of treatment available or suitable for the child.

Signature: _____

NPI: **Date:**

Contact Person: **Phone:** **Fax:**