DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

# EPSDT Prior Authorization and Certification of Medical Necessity

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are offered to children up to and through the age of 20. Each submission will be reviewed for on a case-by-case basis. Prior authorization for EPSDT services should be submitted by a child's primary care provider or medical specialist within their scope of practice, when additional treatment, services, or supplies are needed for a primary health condition.

## Member Information

| First Name | Middle Initial | Last Name |
|---|---|---|
| | | |

| Medicaid ID | Date of Birth | Telephone |
|---|---|---|
| | | |

## Required Documentation

Orders/prescriptions must be dated and signed, include diagnostic results, specify quantity and length of need, and meet medical necessity as defined in Administrative Rules of Montana 37.82.102.

### 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 and 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 older than 1 year)
- ☐ Growth charts for children under 18
- ☐ Breast milk only: Must include health care provider documentation of infant growth chart, documentation of infant's failure to thrive, formula failure, breastfeeding failure, number of ounces required per day, and how many days, any other documentation that supports the need for human donor milk. (In the case of formula shortage, documentation that WIC does not have the formula in stock.)

### 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)

### Outpatient Drug and Physician Administered Drug (PAD)

- ☐ Name of drug and amount of service requested **OR** copy of prescription
- ☐ If PAD, please include HCPCS Code if applicable
- ☐ Supporting documentation (e.g., progress notes, H&P, diagnostic results, or other relevant records)

## Information and Clinical Documentation

Requests must include the following information and clinical documentation.
Attach extra pages if necessary.

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

2. How will the requests service(s) ameliorate the child's condition?

3. What specific goals/objectives cannot be met without these additional services?

## Attestation and Signature

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.

**NPI** **Date**

**Signature** _____

I am the primary care provider or specialist for this child. I examined this child or reviewed their 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.

**NPI** **Date**

**Signature**

| **Contact Person** | **Contact Telephone** | **Contact Fax** |
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## Submission Information

**Outpatient Drug EPSDT Requests (Pharmacy and PADs)**

- Submit via fax to (406) 444-1861
- Attention Medicaid Pharmacist

Requests for outpatient drug EPSDT will be reviewed by the Medicaid Pharmacist and **must** be submitted via fax. **Attach supporting documentation when faxing the request.**

**All Other EPSDT Requests**

- Submit to Mountain Pacific through the Mountain Pacific Provider Portal.

Requests for EPSDT services will be reviewed by Mountain Pacific and **must** be submitted electronically through the Mountain Pacific Provider Portal. Under the coverage panel, please mark **Yes** for the EPSDT Indicator. When attaching documentation, select EPSDT PA form as the Category.