Medicaid

EPSDT Prior Authorization & Certificate of Medical Necessity

Requests for Additional Services – Early Periodic Screening, Diagnosis and Treatment

If a child (**up to the age of 21**), needs *medically necessary* services through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, it can be approved on a case by case basis. EPSDT prior authorization requests may 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.

A Request for Additional Services (Prior Authorization) must be completed by the providers before Medicaid can Review or approve payment for the treatment/service as outlined below:

- Request for Additional Services EPSDT form. **The service provider AND ordering provider sections MUST be completed.**
- Required documentation by type of service (listed below) **MUST** be submitted with request. Incomplete requests cannot be reviewed.

After the required documents are received, staff serving as experts for the types of services requested will review the information. Within two weeks, the provider will receive a decision from the Department. If the request is denied, the member, or their parent/guardian, will be notified and may appeal the decision.

REQUIRED DOCUMENTATION	
Of note: Orders/Prescriptions must be dated & signed, include diagnosis, quantity, length of need, and Medical Necessity. Each request will be considered on a case by case basis.	
Durable Medical Equipment (DME): ☐ Order/Prescription with amount requested ☐ HCPCS code and description, and amount needed <u>monthly</u> of non-covered, over-the limit, or does not meet criteria (please specify) ☐ Supporting documentation (ex: progress notes, H&P, diagnostic results, or other relevant records)	**Nutrition:** ☐ Order/Prescription with type, calories, amount, 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 (ex: progress notes, H&P, diagnostic results, or other relevant records)	**Other Services:** ☐ Name and amount of service requested ☐ Supporting documentation (ex: progress notes, H&P, diagnostic results, or other relevant records)

Medical Necessity definition:
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.

Montana Medicaid
Request for Additional Services

Please complete entire form and submit ALL required documentation listed in instructions.

Medicaid Participant Information		
First Name:	Last Name:	
Medicaid ID:	Birthdate:	Phone:

Medicaid Provider Information (providing requested service)		
Provider Name:		NPI/Provider #:
Date:	Phone:	Fax:
I hereby declare that the above named child needs additional services. The additional services will be provided according to the current treatment plan. The services will not be provided for cosmetic purposes or for the convenience or comfort of the child, parent/guardian, or provider.		Signature:

Requesting Provider Information		
Provider Name:		NPI/Provider #:
Contact Person:	Phone:	Fax:
I am the primary care provider or specialist for the above named child. I examined this child or reviewed his/her medical record on:_____. I agree that the additional services being 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:

Please Identify Requested Services by HCPCS or CPT code and description	
DME:	**Nutrition:**
Surgical Services:	**Other Services:**

Statement of Medical Necessity
Why does child need the requested additional service(s)?
How will the requested service(s) maintain, correct or improve child's condition?
Describe what specific goals/objectives can't be met without additional services:

(Department Use Only) Please do not write in area below		
Received Date:	Authorized: Y☐ N☐	PA Number: