Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Requests
for Medicaid Autism Treatment Services

- Medicaid EPSDT Prior Authorization & Certificate of Medical Necessity Form
  - https://dphhs.mt.gov/MontanaHealthcarePrograms/WellChild
  - Medicaid Participant Information: Member Name, Medicaid ID, DOB, Phone #
  - Medicaid Provider Information (providing requested service)
    - Completed and signed by MT Medicaid Enrolled Board Certified Behavior Analyst (Provider Type #76)
  - Requesting Provider Information
    - Completed and signed by primary health care provider, generally pediatrician or psychiatrist
  - Please Identify Requested Services by HCPCS or CPT code and description
    - Specify CPT codes, descriptions, and number of units requested
  - Guardian(s) name and address also needs to be included

- Supporting documentation (must be included with EPSDT Form)
  - Any evaluation supporting ASD diagnosis and level of need, any available speech, OT, PT assessments, and current IEP/school evaluations

- EPSDT Form and supporting documentation are faxed to Health Resources Division (HRD)/EPSDT (406-444-1861) and then forwarded to the Developmental Disabilities Program (DDP) via ePass

- Once a completed form and sufficient documentation is received, a Vineland-II by state staff is scheduled and administered with the guardian while the member is present (independent and in-person)

- Desk review and recommendation for services by DDP psychiatrist or HRD physician

- If the member meets medical necessity criteria for either low or high intensity level services, a prior authorization is entered into MMIS

- Letter of eligibility (high intensity services or low intensity services) or denial is mailed to guardian and emailed to BCBA

- Medical Necessity Reviews are to be conducted every 6 months to determine continued eligibility