Trillium
HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

PRIOR APPROVAL
Non-Covered State Medicaid Plan
Services Request Form for Recipients *under* 21 Years Old

About EPSDT

The **Early and Periodic Screening, Diagnosis and Treatment** (EPSDT) entitles Medicaid beneficiaries under the age of 21 to medically necessary screening, diagnostic and treatment services within the scope of Social Security Act that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions," regardless of whether the requested service is covered in the NC State Plan for Medical Assistance. This means that children under 21 years of age can receive services in excess of benefit limits, or even if the service is no longer covered or not covered under the State Plan. To request a service that is not covered by the State Plan but covered under 1905(a) of the Social Security Act, please email Non-Covered State Medicaid Plan Services Request Form for Recipients Under the Age of 21 to UM@TrilliumNC.org.

According to CMS, "ameliorate" means to improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Basic EPSDT criteria are that the service must be covered under 1905(a) of the Social Security Act, and that it must be safe, effective, generally recognized as an accepted method of medical practice or treatment, and cannot be experimental or investigational (which means that most clinical trials cannot be covered).

All requests for MH/IDD/SA services for Medicaid-eligible children under the age of 21 are reviewed using EPSDT criteria. Requests for NC Innovations Waiver services are reviewed under EPSDT if the request is both a waiver and an EPSDT service. Most NC Innovations Waiver services are not covered under the Social Security Act (i.e. respite, home modifications and all habilitative services).

Definitions of the Federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170.

Trillium requires Prior Approval for EPSDT services. Please use the form starting on page 2.

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Please submit the completed form using secure email to the Trillium Health Resources UM Department, at UM@TrilliumNC.org. You may use additional sheets to supply any other information you think would be helpful. **Include evidence-based literature, if available.**

1. **Recipient Information: This must be completed by a physician, licensed clinician, or other provider.**

Name: ______________________________

Date of Birth:________________*(mm/dd/yyyy)* Medicaid ID Number:______________________

Address:

2. **Medical Necessity:** All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name: ______________________ Requestor Name: ______________________
NPI: ______________________ NPI: ______________________
Address: ______________________ Address: ______________________
Telephone: ____________Fax: ____________ Telephone: ____________Fax: ____________

Requested procedure, product or service: ______________________ CPT/HCPCS code: ____________

3. **In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.)**

4. **What is the recipient's health history?**

5. **What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.)**

6. **What treatment has been given for the diagnosis(es) above?** (Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).)

7. **Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem.)** This description *must* include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Is this request for an experimental or investigational treatment? If yes, provide name and protocol number ______________________ Yes No

8. **Is the requested product, service or procedure effective?** Yes No

If no, please explain

9. Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? Yes No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available

10. What is the expected duration of treatment?

Requestor's Signature & Credentials

Date