**Accessing Medicaid Services through EPSDT**

Letters of Medical Necessity MUST contain the following information:

* 1. **Diagnoses** (***ALL diagnoses*** even if you do not think it is relevant)
* For example, the child may have autism as well as a seizure disorder-be sure that both diagnoses are listed.
* For incontinence products:
	+ 1. Enuresis: bladder incontinence must be physician diagnosed
		2. Encopresis: bowel incontinence must be physician diagnosed

\*\*\*If needed, you can pull diagnoses codes from your child’s psychological evaluation (look at the section with the 5 axis listed) or talk with your pediatrician!)

* 1. **Prognoses** (be sure to explain the prognosis of all diagnoses)
	2. The **service** being prescribed as medically necessary to “correct and/or ameliorate the child’s condition”
		1. This does NOT mean CURE! Ameliorate means to “become better”; however, it is understood that some conditions related to disabilities will never “become better” but you are working to stop regression or maintain the child’s current level of medical need.
	3. **Amount, Scope and Duration**
		1. Ex: *I am* *prescribing* ***4 hours*** *of Speech Therapy* ***each week*** *for the* ***next 90 days*** *at which time I will re-evaluate the child’s conditions to determine if services are still necessary at the prescribed amount, scope and duration.*
		2. For diapers, the letter of medical necessity must be very detailed and specific in order for the request to be legitimate:
			1. For example: “I am prescribing 5 incontinence products per day for the next 90 days at which time I will re-evaluate the child’s condition to determine if supplies are still medically necessary at the current prescribed amount, scope and duration”

Next step: find a Durable Medical Equipment (DME) provider as you will need the DME to run the prescription on your child’s Medicaid number to get either a denial or approval. You may have to convince them that Medicaid will cover the cost as many have been told “no” by Medicaid in the past!

This is a process and you should anticipate being denied. Be sure the DME provides you with the denial letter as you only have 30 days from the date on the letter to appeal IN WRITING! Your first appeal request is considered a “reconsideration”- if you are denied again, you should WRITE a request for an “administrative hearing” which is your opportunity to take the denial before a administrative law judge.

**Be sure the DME takes Georgia Medicaid!!!**