

# INITIAL MEDICAL NECESSITY – SUD ADMISSION CRITERIA

**(Registered or Certified Counselor does NOT complete this form)**

A licensed physician is REQUIRED to review each beneficiary’s personal, medical and substance use history within thirty (30) calendar days of the beneficiary’s admission to treatment date.

Agency Name:

Client Name:	Date:
--------------	-------

Admission to Treatment Date:	Client ID:
------------------------------	------------

**Substance Use Disorder Evaluation:**  
 A physician, licensed/registered “**therapist**” with BBS & CA Board of Psychology, physician assistant, or nurse practitioner, acting within their respective practice, shall evaluate each beneficiary, within thirty-(30) calendar days of the patient’s admission to treatment, to diagnose whether the beneficiary has a substance use disorder. Beneficiary must meet DSM-5 SUD diagnostic criteria and a “written basis” for the diagnosis must be documented in client’s record. For SUD diagnoses conducted by a therapist, PA, or NP, the physician must review the diagnosis and document approval by signing this form and the beneficiary’s treatment plan. *LPHA conducting diagnostic assessment must evaluate the client during a face-to-face session.*

<b>PRIMARY DSM-5 CODE, NAME:</b>	<b>SECONDARY DSM-5 CODE, NAME:</b>
----------------------------------	------------------------------------

**Written Basis for Diagnosis (Must be completed by therapist or MD & include specific criteria of Medi-Cal included primary SUD diagnosis):**

**Patient Information that has been considered includes the following:**

- The beneficiary’s personal, medical and substance use history; and
- \*Physical Exam (when available);

**Medical Necessity is determined by the following factors:**

- a) The client has a primary Medi-Cal Included SUD diagnosis from the Diagnostic and Statistical Manual (DSM-5) that is substantiated by chart documentation:  Yes  No
- b) SUD Health Care Services are medically necessary and consistent with 22 CCR Section 51303: “...which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury...”  Yes  No
- c) The basis for the diagnosis is documented in the client’s individual client record.  Yes  No
- d) DSM diagnostic criteria for each diagnosis that is a focus of treatment is identified above  Yes  No
- e) Evidence based treatment is known to improve health outcomes and will be provided in accordance with generally accepted practices.  Yes  No

- **Physical Exam Requirement:** 1) M.D. conducts physical exam or client provides copy 2) Client *will* provide copy of recent physical exam (within 12 months) or 3) The client must schedule an exam. Options 2 & 3 must be added to client tx plan.
- **Physical Examination generally includes vital signs; head, face, ear, throat, & nose; evaluation of organs for infectious disease; and neurological assessment conducted by a qualified physician.**

**Physician Must Initial One of the Following:**

1. \_\_\_\_\_ After review of the above information, I have determined there are not physical or mental disorders or conditions that would place the patient at excess risk in the treatment program planned, and that the patient is receiving appropriate and beneficial treatment that can reasonably be expected to improve the diagnosed condition.
2. \_\_\_\_\_ After review of the above named information, I have determined that continued treatment is not medically necessary and the beneficiary should be discharged from treatment.

**Therapist Signature, Credentials (If applicable)	**Print Name, Title	**Date
**Physician Signature, Credentials (REQUIRED)	**Print Name, Title	**Date

**\*\*COMPLETE SIGNATURE REQUIRES LEGIBLY PRINTED NAME, SIGNATURE & DATE**