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| **This form is not for claiming, service must be documented in a progress note in order to be claimed.** | | | | | | | | | | | | | | | | | | | | | |
| **Client Information** | | | | | | | | | | | | | | | | | | | | | |
| Client: |  | | | | | | |  | | | | | | |  | | | | | | | |
|  | InSyst # | | | | | | | Last Name | | | | | | | First Name | | | | | | | |
| Location: | | | |  | | | | | | | | | | | Episode Opening Date: | | | | |  | | | |
| Agency: | | |  | | | | | | | | | | | | | | RU: | |  | | | | | |
| Services were provided in: | | | | |  | | | | | | | | | by  interpreter or  clinician | | | | | | | | | |
|  | | | | | |  | | | | | | | |  | | | | | | | | | |
| **Initial Medical Necessity** | | | | | | | | | | | | | | | | | | | | | |
| A Licensed Professional of the Healing Arts (LPHA) (Physician; Nurse Practitioner (NPs); Physician Assistants (PAs); Registered Nurses (RNs); Registered Pharmacists (RPs); Licensed Clinical Psychologists (LCPs); Licensed Clinical Social Workers (LCSWs); Licensed Professional Clinical Counselors (LPCCs); Licensed Marriage and Family Therapists (LMFTs); and License-Eligible Practitioners working under the supervision of licensed clinicians) 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. When an unlicensed LPHA establishes medical necessity, a licensed LPHA must review and co-sign this document (within 15 days or when medical necessity is due, whichever is sooner). | | | | | | | | | | | | | | | | | | | | | |
| **The Initial Medical Necessity determination:** For an individual to receive a DMC-ODS benefit, the initial medical necessity determination shall be performed through a face-to-face review or telehealth by a Medical Director, licensed physician or an LPHA. This “face-to-face” interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. It would be allowable to include the beneficiary in this “face-to-face” interaction. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary. After establishing a diagnosis and documenting the basis for diagnosis, the American Society of Addiction Medicine (ASAM) Criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services. The service provider shall Authorize DMC-ODS services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved state Medi-Cal Plan. | | | | | | | | | | | | | | | | | | | | | |
| LPHA completing IMN Form, must check the appropriate box below: | | | | | | | | | | | | | | | | | | | | | |
| LPHA met face-to-face with the beneficiary | | | | | | | | | | | | | | | | | | | | | |
| LPHA met face-to-face with the SUD counselor that conducted the intake | | | | | | | | | | | | | | | | | | | | | |
| Primary Included SUD ICD-10 Code: | | | | | |  | | | | | | | | | | | | | | | |
| Primary Included SUD DSM-5 Name: | | | | | | | | |  | | | | | | | | | | | | |
| Additional Diagnosis ICD-10 Code: | | | | | | |  | | | | | | | | | | | | | | |
| Additional Diagnosis DSM-5/ICD-10 Name: | | | | | | | | | |  | | | | | | | | | | | |
| General Medical Codes: | | | | | | | | | |  | | | | | | | | | | | |
| Written Basis for Diagnosis (Must be completed by LPHA & include specific criteria of Medi-Cal included primary SUD diagnosis): | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Indicate all ASAM Levels of Care recommended: | | | | | | | | | | | | | | | | | | | | | |
| LPHA determined ASAM Level of Care: | | | | | | |  | | | | | | | | | | | | | | |
| LPHA determined ASAM Level of Care: | | | | | | |  | | | | | | | | | | | | | | |
| LPHA determined ASAM Level of Care: | | | | | | |  | | | | | | | | | | | | | | |
| Is this level of care recommendation different than the previously assessed ALOC?  Yes  No  Explain if yes: | | | | | | | | | | | | | | | | | | | | | |
| Client Information that has been considered includes the following:  • The beneficiary’s personal, medical and substance use history; review of information with the client and/or LPHA  • \*Physical Exam (when available) | | | | | | | | | | | | | | | | | | | | | |
| Medical Necessity is determined by the following factors (Medical necessity is not established if all are not *yes*):  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.  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…”  c) The basis for the diagnosis is documented in the client’s individual client record.  d) DSM diagnostic criteria for each diagnosis that is a focus of treatment is identified above  e) Evidence based treatment is known to improve health outcomes and will be provided in accordance with generally accepted practices.  (f) LPHA has considered LPHA/SUD Counselor recommendation | | | | | | | | | | | | | | | | | | | | | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  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. | | | | | | | | | | | | | | | | | | | | | |
| Medical Director, licensed physician or LPHA **Must Initial** one of the Following:  1. After in-person review of the above information with the SUD counselor, I have determined there are no known physical or mental disorders or conditions that would place the beneficiary at excess risk in the treatment program planned, and that the beneficiary 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. | | | | | | | | | | | | | | | | | | | | | |
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| Unlicensed LPHA Signature (if completing form) | | | | | | | | | | | | Printed Name/Credentials | | | | | | | | Date | |
|  | | | | | | | | | | |  | | | | | |  | | | | |
| Licensed LPHA Signature (required) | | | | | | | | | | | | Printed Name/Credentials | | | | | | | | Date | |