

JUSTIFICATION FOR CONTINUING SUD TREATMENT SERVICES (JCSTS)

For each beneficiary, no sooner than 5 months and no later than 6 months after date of admission or date of last JCSTS shall be completed. DMC SUD Services 22 CCR § 51341.1

Agency Name:

Client Name:

Client ID:

Date:

Admission to Treatment Date:

Date of Most Recent JCSTS:

Counselor Recommendation:

I recommend that the above named client continue to receive treatment services based on review of the beneficiary's progress in treatment and eligibility to continue to receive treatment services.

Counselor Additional Comment (not required):

Counselor Signature

Printed Name & Title

Date

Physician's Statement:

To ensure fulfillment of their role for establishing medical necessity, the physician shall sign a legible "individualized note using DSM Criteria" to document the basis for the DSM-SUD & Other diagnosis in the beneficiary's individual patient record.

PRIMARY DSM DIAGNOSIS:

SECONDARY DSM DIAGNOSIS:

Physician's Note:

Patient Information that has been considered includes the following:

- The beneficiary's personal, medical and substance use history;
- *Physical Exam (when available);
- The beneficiary's progress notes and treatment plan goals;
- The therapist or counselor's recommendation (initial or justification); and
- The beneficiary's prognosis.

***Physical Exam Requirements include vital signs; head, face, ear, throat, & nose; evaluation of organs for infectious disease; and neurological assessment conducted by a qualified physician. Check One of the Following:**

☐ **A.** Within 30 calendar days of beneficiary's admission a physical exam was conducted by the provider's physician or another medical office of the beneficiary's choice.

☐ **B.** Previous physical exam documentation no older than twelve (12) months from the date of beneficiary's admission to treatment.

☐ **C.** The beneficiary has not completed either A. or B. above. The beneficiary and provider have documented efforts to obtain and meet the physical exam requirements. See treatment plan dated _____, which has a plan to obtain the physical exam.

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 reasonable 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.

Physician's Signature

Print Name & Title

Date Signed