

MEDICAL NECESSITY – SUD ADMISSION CRITERIA

For each beneficiary, within 30 days of admission medical necessity shall be completed. DMC SUD Services 22 CCR § 51341.1

Agency Name:

Client Name:

Date:

Admission to Treatment Date:

Client ID:

Physician Evaluation:

The physician shall evaluate each beneficiary, within thirty-(30) calendar days of the patient's admission to treatment date, to diagnose whether the beneficiary has a substance use disorder. The diagnosis shall be based on the applicable diagnostic code from the DSM published by the American Psychiatric Association.

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);

***Physical Examinations generally 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