INITIAL MEDICAL NECESSITY – SUD ADMISSION CRITERIA

The physician shall 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:

Physician Evaluation:

The physician or "**therapist"** (includes registered BBS & CA Board of Psychology (CBP) interns), or 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 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. The physician shall document approval of the diagnosis that is performed by signing *and dating this form* and the beneficiary's treatment plan. *Therapist, PA or NP must evaluate the client during a face to face session.*

PRIMARY DSM CODE, NAME:	**SECONDARY DSM CODE, NAME:**

Physician or "Therapist" Note:

MUST State Specific Criteria for the DSM Medi-Cal Included Primary 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) that is substantiated by chart documentation: □ Yes □ No

b) SUD Health Care Services are medically necessary consistent with 22 CCR Section 51303. "…reasonable and necessary to: **1.** Protect life, **2.** To prevent significant illness, or **3.** Significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury which are covered by the Medi-Cal program." □ 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.

**Physician or Authorized LPHA Signature	**Print Name and Title	**Date
**If "Therapist" Signed, Physician Must Co-Sign	**Print Name and Title	**Date

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

CCR Section § 51341.1 (h) (1) (v) of Title 22: Diagnosis Requirements