DIAGNOSIS DETERMINATION NOTE

Client Name _____ Primary Counselor _____

Client ID: _____

DATE OF SERVICE	*SERVICE CODE	Determination of Diagnosis Documentation must include DSM criteria for a Substance Use Disorder, and Perinatal/EPSDT eligibility, if applicable: **Please note a beneficiary with sobriety for more than 365 days may continue to meet medical necessity based on Title 22 CCR 51303. Document client specific potential risks for relapse and/or review DSM specifier of In a Controlled Environment (See Instruction Sheet for further details).**

Diagnostic Impression: _____

Counselor Signature: _____ **Date:** _____

Counselor Printed Name: _____

Therapist, PA, NP, or MD Complete Below

☐ **SERVICES FOR THE BENEFICIARY ARE NOT MEDICALLY NECESSARY. THE BENEFICIARY MUST BE DISCHARGED.**

The following have been considered:

☐ Client's personal, medical, and substance use history ☐ Documentation of client's most recent physical examination

☐ Client's progress notes and treatment plan goals ☐ Therapist or Counselor recommendation ☐ Client's prognosis

Diagnosis, including DSM label and ICD-10 Code(s): _____

Basis for Diagnosis:** _____

_____

_____

Therapist, PA, NP, or MD Printed Name: _____

Therapist, PA, NP, or MD Signature: _____ **Date:** _____

***Service Codes:** 2 = Individual Counseling – Intake; 3 = Individual Counseling – Planning; 4 = Individual Counseling – Crisis Intervention; 18 = File Review/M.D.

**A Therapist, Physician Assistant, or Nurse Practitioner, acting within their scope of practice, or a Medical Doctor must complete