

Stay Review Justification Instructions

REQUIRED FORM:

This form is a required document in client file for outpatient and residential treatment services.

WHEN:

This form must be completed no sooner than five (5) months and no later than six (6) months from client's admission to the program, or after the completion date of the most recent justification for continuing services. The SUD counselor or LPHA shall review the client's progress and eligibility to continue to receive treatment services, and recommend whether the client should or should not continue to receive treatment services at the same level of care. The Medical Director or LPHA shall determine and document the medical necessity for continued services.

COMPLETED BY:

Authorized agency representative and LPHA or Medical Director.

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Admission Date:** Complete the date of admission.
- **Client ID Number:** Complete the client ID number as determined by agency guidelines.
- **Client's progress in treatment during the past six months (detailed & descriptive):** Complete a detailed and descriptive summary of client's progress in treatment during the past six months.
- **Medical/psychological reasons to continue treatment** Document medical/psychological reasons that client should continue treatment including criteria for specific substance use disorder(s).
- **Consequences of discontinuing treatment:** Complete consequences that may occur if client discontinues treatment. (e.g., recidivism, relapse).
- **Client Name:** Re-enter client's full name.
- **Admission Date:** Re-enter the date of admission.
- **Client ID Number:** Re-enter the client ID number as determined by agency guidelines.
- **Target date for client to complete treatment:** Complete the expected target date client will complete treatment.
- **What is expected to be achieved during continued treatment (MUST include client's prognosis):** Mark the appropriate box for client's prognosis (good, fair, poor) and explain below. Complete a summary of what client is expected to achieve during continued treatment.
- **Counselor or LPHA Name (printed):** Legibly print the counselor's name.
- **Counselor or LPHA Signature and Date:** Counselor or LPHA completing the above-mentioned sections of the form must hand-sign and date.

- **Continued services are medically necessary and the following have been considered:** LPHA or Medical Director completes this section by marking boxes that have been considered when determining if client continues to meet medical necessity.
- **Continuing services for the client is not medically necessary, the client must be discharged from treatment:** LPHA or Medical Director marks this box if client does not meet medical necessity for continued services. The client must be discharged from treatment and referral to appropriate level of treatment services shall be made. ***Please note:** Justice override clients may not be discharged from treatment for not meeting medical necessity; however, these services may not be billed to DMC.
- **LPHA or MD Name (printed):** Legibly print the LPHA or Medical Director's name.
- **LPHA or MD Signature and Date:** LPHA or Medical Director reviewing this form to determine the need for continuing services must hand-sign and date.

NOTES:

- If Stay Review Justification to continue services is missing from client's file, all Medi-Cal billings submitted after the date the justification was due (within six months from admission date) will be disallowed.