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BULLETIN 06-5

To: **Private Review Agents**

Re: **Amendment to Uniform Treatment Plan Form Regulations COMAR 31.10.21**

Date: **March 27, 2006**

Purpose and Applicability

The purpose of this Bulletin is to announce that the Uniform Treatment Plan Form required to be used by COMAR 31.10.21.02-1H has been amended. The Uniform Treatment Plan Form is the form that health care providers use when seeking approval to provide treatment for a mental illness, an emotional disorder or a substance abuse disorder. After consultation with representatives of the insurance and health care industry, the new form was developed to improve and streamline the provision of essential information by health care providers to Private Review Agents.

The notice of final action on the amended Regulation and new Uniform Treatment Plan Form were published in the January 20, 2006 issue of the Maryland Register with an effective date of January 30, 2006. Health care providers may begin submitting health care treatment plan information and Private Review Agents must accept the new Uniform Treatment Plan Form as of that date.

Background

A Private Review Agent, as defined by Title 15, Subtitle 10B "Private Review Agents" of the Insurance Article, is required by Title 15, Subtitle 10B to accept the State of Maryland Uniform Treatment Plan Form to conduct utilization review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder. The uniform treatment plan form does not apply to a person or entity that uses a treatment plan form solely for internal purposes.

Code of Maryland Regulations ("COMAR") 31.10.21 "Private Review Agents" provides additional instruction on form use and completion. For your convenience, a copy of the new Uniform Treatment Plan Form is attached to this Bulletin. An electronic version of the form is available on the MIA's website at www.mdinsurance.state.md.us and is accessible by selecting *Insurer Services* then *Other Related Services* then the *Health Care Provider Page.*

Questions about this bulletin may be directed to Thomas Marshall at (410) 468-2217.

R. STEVEN ORR
INSURANCE COMMISSIONER

Signature on file with original

By: P. Todd Cioni, Associate Commissioner
Compliance and Enforcement
Maryland Insurance Administration

State of Maryland

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Carrier or Appropriate Recipient:

PATIENT INFORMATION | ***PRACTITIONER INFORMATION***

PATIENT'S FIRST NAME | PATIENT'S DATE OF BIRTH (__/__/____) | PRACTITIONER ID# or TAX ID | PHONE NUMBER

MEMBERSHIP NUMBER | PRACTITIONER NAME, ADDRESS & PHONE

AUTHORIZATION NUMBER (If Applicable)

Date Patient First Seen For This Episode Of Treatment __/__/____

Have you communicated with the PCP/other relevant health care practitioners about treatment? ○ Yes ○ No

DSM-IV MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE ALL FIVE AXES)

AXIS I Dx Code ___.__ Dx Code ___.__

AXIS II Dx Code ___.__

AXIS III Does the patient have a current general medical condition that is potentially relevant to the understanding or management of the condition(s) noted in Axis I or II? ○ No ○ Yes

AXIS IV Severity of current psychosocial stressors ○ None ○ Mild ○ Moderate ○ Severe

AXIS V: GAF Score Highest Past Year ___ At first Session ___ Current ___

Current Medications (if not applicable, no response is required)

○ Anti-psychotic ○ Anti-anxiety ○ Anti-depressant ○ Psycho-stimulant ○ Injectables
○ Hypnotic ○ Non-psychotropic ○ Mood stabilizer/Anti-convulsant ○ Other

Symptoms

Please rate the patient's current status on these symptoms, if applicable. **If not applicable, no response is required.**

	Ideation	Plan	Prior Attempt	None		Present	Absent
Suicidal ideation	○	○	○	○	Self-injurious behavior	○	○
Homicidal ideation	○	○	○	○	Substance use problems	○	○

Authorization Request Details

CPT Code _____ Number of Units ___

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: _____/_____/_____

Complete this section only if a second CPT is needed.

CPT Code _____ Number of Units ___

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: _____/_____/_____

Signature of practitioner: _____ __/__/____ Date

My signature attests that I have a current valid license in the state to provide the requested services.