Title 31
MARYLAND INSURANCE ADMINISTRATION
Subtitle 10 HEALTH INSURANCE—GENERAL

31.10.21 Private Review Agents

Authority: Insurance Article, §§2-109(a)(1), 15-802(d)(3), and 15-108-03(h), Annotated Code of Maryland

Notice of Final Action
[19-248-F]

On February 3, 2020, the Maryland Insurance Commissioner adopted amendments to Regulation .02-1 under COMAR 31.10.21 Private Review Agents. This action, which was proposed for adoption in 46:25 Md. R. 1146—1147 (December 6, 2019), has been adopted with the nonsubstantive changes shown below.

Effective Date: February 24, 2020.

Attorney General's Certification

In accordance with State Government Article, §10-113, Annotated Code of Maryland, the Attorney General certifies that the following changes do not differ substantively from the proposed text. The nature of the changes and the basis for this conclusion are as follows:

Regulation .02H: Two changes have been made to page three of the Uniform Treatment Plan Form. The first amends the wording of the instructions for the low-medium-high American Society of Addiction Medicine (ASAM) grid that was added to the form. In addition, space has been added after the grid in the form of an empty text block so that additional details can be provided by the medical provider who fills out the ASAM grid to explain the provider’s rating of the patient for each factor. These changes are not substantive and, rather, clarify the lead-in and add additional space for the provider to include additional details if they wish. There are no changes to the requirements of the form.

.02-1 Uniform Treatment Plan.

A.—G. (proposed text unchanged)

H. The uniform treatment plan form required by this regulation shall read as follows:

Note: The revised form appears on the following four pages.

I. (proposed text unchanged)

ALFRED W. REDMER, JR.
Insurance Commissioner
Uniform Treatment Plan Form
(For Purposes of Treatment Authorization)

Today's Date ____________________________

Carrier or Appropriate Recipient: ____________________________

PATIENT INFORMATION
PATIENT'S FIRST NAME ____________________
PATIENT'S DATE OF BIRTH ___/___/____

MEMBERSHIP NUMBER ______________________

AUTHORIZATION NUMBER (If Applicable) ________________________

PRACTITIONER INFORMATION
PRACTITIONER ID# or TAX ID ______________________
PHONE NUMBER ____________________________

PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE ____________________________

Level of care being requested: Please specify benefit type:

☐ Mental Health  ☐ Substance Use Disorder  ☐ Outpatient  ☐ Intensive Outpatient Program  ☐ Partial Hospitalization Program
☐ Acute IP  ☐ IP Rehab  ☐ Acute IP Detox  ☐ Residential  ☐ ECT  ☐ rTMS  ☐ Applied Behavior Analysis (ABA)  ☐ Psychological Testing  ☐ BioFeedback  ☐ Telehealth  ☐ Other ____________________________

Primary Dx Code: ____________________________  Secondary Dx Code(s): ____________________________

Current Treatment Modalities: (check all that apply)

Psychodynamic  ☐ EMDR  ☐ Group  ☐ Couples  ☐ Family  ☐ Other ____________________________

Medical Evaluation and Management ____________________________

Type of Medications (if not applicable, no response is required):

☐ Antipsychotic  ☐ Anxiolytic  ☐ Antidepressant  ☐ Stimulant  ☐ Injectable  ☐ Hypnotic  ☐ Non-psychotropic  ☐ Mood Stabilizer  ☐ Other ____________________________

Current Symptoms and Functional Impairments: Rate the patient’s current status on these symptoms/functional impairments, if applicable.

<table>
<thead>
<tr>
<th>Current Ideation</th>
<th>Current Plan</th>
<th>Prior Attempt</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicidal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Symptoms/ Functional Impairments

Self-Injurious Behavior  ☐  ☐
Substance Use Problems  ☐  ☐
Depression  ☐  ☐
Agnitiated/aggressive Behavior  ☐  ☐
Mood Instability  ☐  ☐
Psychosis  ☐  ☐
Anxiety  ☐  ☐
Cognitive Impairment  ☐  ☐
Eating Disorder Symptoms  ☐  ☐
Social/Familial/School/Work Problems  ☐  ☐
ADL Problems  ☐  ☐

If requesting additional outpatient care for a patient, why does the patient require further outpatient care:

☐ Maintenance treatment for a chronic condition  ☐ Consolidate treatment gains  ☐ Continued impairment in functioning  ☐ Significant regression  ☐ New symptoms and/or impairments  ☐ Supportive treatment due to other treatment plan changes  ☐ Complex psychiatric and substance co-morbidity  ☐ Complex Psychiatric and Substance abuse Co-morbidity  ☐ Other ____________________________

Signature of Practitioner: ____________________________  Date: ___/___/____

My signature attests that I have a current valid license in the state to provide the requested services.
**Complete the following if the request is for ECT or rTMS:** Provide clinical rationale including medical suitability and history of failed treatments:

<table>
<thead>
<tr>
<th>Requested Revenue/HCP/CPT Code(s)</th>
<th>Number of Units for each</th>
</tr>
</thead>
</table>

**Complete the following for Applied Behavior Analysis (ABA) Requests (if the carrier classifies ABA as a mental health benefit):**

<table>
<thead>
<tr>
<th>Supervising BCBA Name</th>
<th>Has Autism Spectrum Disorder been validated by MD/DO or Psychologist?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

For initial requests, what are specific ABA treatment goals for the patient?

1. 
2. 
3. 

Date of Evaluation by MD/DO: 

For continuing requests, assessment of functioning (observed via FBA, ABLIS, VB-MAPP, etc.) related to ASD including progress over the last year:


For continuing requests, what are the treatment goals and targeted behaviors, indicating new or continued, with documentation of progress and child’s response to treatment:

1. 
2. 
3. 

<table>
<thead>
<tr>
<th>Requested Revenue/HCP/CPT Code(s)</th>
<th>Number of Units for each</th>
</tr>
</thead>
</table>

**Complete the following if the request is for Psychological Testing:**

<table>
<thead>
<tr>
<th>Symptoms/Impairment related to need for testing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Acute change in functioning from the individual’s previous level</td>
</tr>
<tr>
<td>☐ Personality problems</td>
</tr>
<tr>
<td>☐ Peculiar behaviors and/or thought process</td>
</tr>
<tr>
<td>☐ School problems</td>
</tr>
<tr>
<td>☐ Symptoms of psychosis</td>
</tr>
<tr>
<td>☐ Family issues</td>
</tr>
<tr>
<td>☐ Attention problems</td>
</tr>
<tr>
<td>☐ Cognitive impairment</td>
</tr>
<tr>
<td>☐ Development delay</td>
</tr>
<tr>
<td>☐ Mood Related Issues</td>
</tr>
<tr>
<td>☐ Learning difficulties</td>
</tr>
<tr>
<td>☐ Neurological difficulties</td>
</tr>
<tr>
<td>☐ Emotional problems</td>
</tr>
<tr>
<td>☐ Physical/medical signs</td>
</tr>
<tr>
<td>☐ Relationship issues</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
</tbody>
</table>

**Purpose of Psychological Testing:**

| ☐ Differential diagnostic clarification |
| ☐ Help formulate/reformulate effective treatment plan. |
| ☐ Therapeutic response is significantly different from that expected based on the treatment plan. |
| ☐ Evaluation of functional ability to participate in health care treatment. |
| ☐ Other: (describe) |

Substance use in last 30 days: ☐ Yes ☐ No 
Diagnostic Assessment Completed: ☐ Yes Date________/______/______ ☐ No 
Patient substance free for last ten days: ☐ Yes ☐ No 
Has the patient had known prior testing of this type within the past 12 months? ☐ Yes ☐ No 
If so, why necessary now? ☐ Unexpected change in symptoms ☐ Evaluate response to treatment ☐ Assess functioning ☐ Other 
Names and Number of Hours of each requested test:

If appropriate, complete this section: Reason(s) why assessment will require more time relative to test standardization samples:

| ☐ Depressed mood |
| ☐ Vegetative Symptom |
| ☐ Processing speed |
| ☐ Performance Anxiety |
| ☐ Expressive/Receptive Communication Difficulties |
| ☐ Low frustration tolerance |
| ☐ Suspected or Confirmed graphomotor deficits |
| ☐ Physical Symptoms or Conditions such as: |

| ☐ Other: |

<table>
<thead>
<tr>
<th>Requested Revenue/HCP/CPT Code(s)</th>
<th>Number of Units for each</th>
</tr>
</thead>
</table>

**Complete the following if the request is for Biofeedback:**

<table>
<thead>
<tr>
<th>Requested Revenue/HCP/CPT Code(s)</th>
<th>Number of Units for each</th>
</tr>
</thead>
</table>

**Complete the following if the request is for Telehealth:**

<table>
<thead>
<tr>
<th>Requested Revenue/HCP/CPT Code(s)</th>
<th>Number of Units for each</th>
</tr>
</thead>
</table>

Patient Membership Number

**Complete for Higher Level of Care Requests (e.g. inpatient, residential, intensive outpatient and partial hospitalization):**
Primary reason for request or admission: (check one)  □ Self/Other Lethality Issues  □ Violent, unpredictable/uncontrolled behavior  □ Safety issues  □ Eating Disorder  □ Detox/withdrawal symptoms  □ Substance Use  □ Psychosis  □ Mania  □ Depression  □ Other ______________________________________________

Why does this patient require this higher level of care at this time? (Please provide frequency, intensity, duration of impairing behaviors and symptoms): _____________________________________________________________

Medication adjustments (medication name and dose) during level of care: _____________________________________________________________

Barriers to Compliance or Adherence: _____________________________________________________________

Prior Treatment in past 6 months:

□ Mental Health  □ Substance Use Disorder  □ Inpatient Residential  □ Partial Intensive Outpatient  □ Outpatient Relevant Medical issues (if any): _____________________________________________________________

Support System/Home Environment: _____________________________________________________________

Treatment Plan (include objectives, goals and interventions): _____________________________________________________________

If Concurrent Review—What progress has been made since the last review

Why does member continue to need level of care

Discharge Plan (including anticipated discharge date) _____________________________________________________________

Complete the following if the request is Substance Use related: rate the patient’s current severity/risk and current need for treatment services intensity on these Dimensions:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to charge
5. Relapse, continued use, or continued problem potential
6. Recovery/living environment

<table>
<thead>
<tr>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add details or explanation needed for each dimension

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**Complete the following if substance use is present for higher level of care requests:**

Type of substance use disorder: ____________________________________________

Onset: Recent Past 12 Months More than 12 months ago

Frequency: Daily Few Times Per Week Few Times Per Month Binge Pattern

Last Used: Past Week Past Month Past 3 Months Past Year More than one year ago

Consequences of relapse: Medical Social Housing Work/School Legal Other __________________________ Urine Drug Screen: Yes No Vital Signs: __________________________ Current Withdrawal Score: (CIWA_________ COWS__________) or Symptoms (check if not applicable) __________________________

History of: Seizures DT's Blackouts Other Not Applicable

**Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests:**

Height: ______ Weight: ______ % of NBW _________

Highest weight: ______ Lowest weight: _______ Weight change over time (e.g. lbs lost in 1 month): ____________

If purging, type and frequency: ________ Potassium: ________ Sodium: ________ Vital signs: ____________

Abnormal EKG: _______ Medical Evaluation: □ Yes □ No

Please identify current symptoms, behaviors and diagnosis of any Eating Disorder issues: ________________________________________________________________

Please include any current medical/physiological pathologic manifestations: ________________________________________________________________

_________________________________________________________________________________