(b) School transportation vehicles either owned by or contracted for by the local school system for the purposes of pupil transportation.

.04 Notification.  
A. A local school system experiencing a critical, life-threatening incident shall notify MCSS of the incident as soon as practicable, but no later than 24 hours after the local school system learns of the incident.  
B. The local school system shall hold the after-action meeting and review required pursuant to Education Article, §7-1510(g)(2)(ii), Annotated Code of Maryland, within 45 days of the occurrence of the incident.  
C. The local school system shall file the report required by Education Article, §7-1510(g)(2)(iii), Annotated Code of Maryland, within 60 days of the completion of the after-action meeting set forth in §8 of this regulation.

KATE HESSION  
Executive Director

Title 18  
DEPARTMENT OF ASSESSMENTS AND TAXATION  
Subtitle 15 GROUND RENTS  
18.15.01 Redemption  
Authority: Real Property Article, §8-804; Tax-Property Article, §2-201; Annotated Code of Maryland  
Notice of Proposed Action  
[19-250-P]  
The Director of the Department of Assessments and Taxation proposes to amend Regulations .02 and .06 under COMAR 18.15.01 Redemption.

Statement of Purpose  
The purpose of this action is to require an affidavit from ground lease tenants proving good faith efforts to investigate and discover the identity of ground lease landlords when attempting to redeem a ground rent and to relieve a government or subdivision of a government of the burden of paying redemption amounts by certified check.

Comparison to Federal Standards  
There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact  
The proposed action has no economic impact.

Economic Impact on Small Businesses  
The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities  
The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment  
Comments may be sent to Jason Davidson, Director of Public Affairs, Department of Assessments and Taxation, 300 W. Preston Street, Suite 605, Baltimore, MD 21201, or call 410-767-5754, or email to jason.davidson2@maryland.gov, or fax to N/A. Comments will be accepted through January 7, 2020. A public hearing has not been scheduled.

.02 Documentation of Lease by Tenant.  
To redeem a reversion in a lease under Real Property Article, §8-804, Annotated Code of Maryland, a tenant shall file with the Department of Assessments and Taxation:  
A.—C. (text unchanged)  
D. If the identity of the landlord is unknown, an affidavit setting forth the tenant’s good faith efforts to investigate and discover the identity of the landlord;  
[D.] E. (text unchanged)  
[E.] F. If there is no last known address of the landlord[.];  
(1) [an] An affidavit that the Department’s prescribed notice has been posted in a conspicuous place on the property for 30 days; and  
(2) An affidavit setting forth the tenant’s good faith efforts to investigate and discover the last known address of the landlord; and  
[F.] G. (text unchanged)

.06 Payment Methods.  
A. The tenant shall pay the redemption amount to the Department either by certified check or money order unless the tenant is a government or subdivision of a government.  
B. (text unchanged)

MICHAEL HIGGS  
Director

Title 31  
MARYLAND INSURANCE ADMINISTRATION  
Subtitle 10 HEALTH INSURANCE — GENERAL  
31.10.21 Private Review Agents  
Authority: Insurance Article, §§2-109(a)(1) and §15-108-03(b), and 15-802(b)(3), Annotated Code of Maryland  
Notice of Proposed Action  
[19-248-P]  
The Maryland Insurance Commissioner proposes to amend Regulation .02-1 under COMAR 31.10.21 Private Review Agents.

Statement of Purpose  
The purpose of this action is to amend COMAR 31.10.21.2-1 to update the Uniform Treatment Plan Form to require certain carriers, providers, and private review agents to use the most recent treatment criteria developed by the American Society of Addiction Medicine for addictive, substance-related, and co-occurring conditions for all medical necessity and utilization management determinations for substance use disorder benefits.

Comparison to Federal Standards  
There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact  
The proposed action has no economic impact.

Economic Impact on Small Businesses  
The proposed action has minimal or no economic impact on small businesses.

MARYLAND REGISTER, VOLUME 46, ISSUE 25, FRIDAY, DECEMBER 6, 2019
PROPOSED ACTION ON REGULATIONS

Impact on Individuals with Disabilities
The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment
Comments may be sent to Lisa Larson, Regulations Manager, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, or call 410-468-2007, or email to insuranceregview.mia@maryland.gov, or fax to 410-468-2020. Comments will be accepted through January 6, 2020. A public hearing has not been scheduled.

.02-1 Uniform Treatment Plan.
A.—G. (text unchanged)
H. The uniform treatment plan form required by this regulation shall read as follows:
  Note: The revised form appears on the following three pages.
I. (text unchanged)

ALFRED W. REDMER, JR.
Insurance Commissioner
# Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

## Today's Date

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>PATIENT'S FIRST NAME</th>
<th>PATIENT'S DATE OF BIRTH</th>
</tr>
</thead>
</table>

| MEMBERSHIP NUMBER |

| AUTHORIZATION NUMBER (If Applicable) |

### PRACTITIONER INFORMATION

<table>
<thead>
<tr>
<th>PRACTITIONER ID#/ or TAX ID</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
</table>

| PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE |

Date Patient First Seen For This Episode Of Treatment: / / / 

### Level of care being requested:

- [ ] 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)

- [ ] Psychotherapy: □ Behavioral □ CBT □ DBT □ Exposure □ Supportive Therapy □ Problem Focused □ Interpersonal
- [ ] 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>Symptoms/ Functional Impairments</th>
<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>
<td></td>
</tr>
<tr>
<td>Homicidal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Injurious Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agitated/aggressive Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood Instability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder Symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social/Familial/School/WorkProblems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADL Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 medical 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/HCPC/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):**

- **Supervising BCBA Name**
- Has Autism Spectrum Disorder been validated by MD/DO or Psychologist? □ Yes □ No

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, ABLLS, 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/HCPC/CPT Code(s)</th>
<th>Number of Units for each</th>
</tr>
</thead>
</table>

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

- □ Acute change in functioning from the individual's previous level
- □ Personality problems
- □ Peculiar behaviors and/or thought process
- □ School problems
- □ Symptoms of psychosis
- □ Family issues
- □ Attention problems
- □ Cognitive impairment
- □ Development delay
- □ Mood Related Issues
- □ Learning difficulties
- □ Neurological difficulties
- □ Emotional problems
- □ Physical/medical signs
- □ Relationship issues
- □ Other:

**Purpose of Psychological Testing:**

- □ Differential diagnostic clarification
- □ Help formulate/reframe 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?

<table>
<thead>
<tr>
<th>□ Depressed mood</th>
<th>□ Vegetative Symptom</th>
<th>□ Processing speed</th>
<th>□ Performance Anxiety</th>
<th>□ Expressive/Receptive Communication Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low frustration tolerance</td>
<td>□ Suspected or Confirmed grapho-motor deficits</td>
<td>□ Physical Symptoms or Conditions such as:</td>
<td>□ Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requested Revenue/HCPC/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/HCPC/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/HCPC/CPT Code(s)</th>
<th>Number of Units for each</th>
</tr>
</thead>
</table>
**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 status on these conditions, if applicable**

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

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  

---

**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:**

<table>
<thead>
<tr>
<th>Height: _____</th>
<th>Weight: _____</th>
<th>% of NBW: _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest weight: _____</td>
<td>Lowest weight: _____</td>
<td>Weight change over time (e.g. lbs lost in 1 month): _____</td>
</tr>
<tr>
<td>If purging, type and frequency: _____</td>
<td>Potassium: _____</td>
<td>Sodium: _____</td>
</tr>
<tr>
<td>Abnormal EKG: _____</td>
<td>Medical Evaluation: □ Yes  □ No</td>
<td></td>
</tr>
</tbody>
</table>

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

---

Please include any current medical/physiological pathologic manifestations:

---