Greater Washington Society for Clinical Social Work

Senate Finance Committee
March 20, 2025
House Bill 1210 – *Workers' Compensation – Evaluation of Permanent Impairments – Licensed Certified Social Worker-Clinical*
POSITION: SUPPORT

The Greater Washington Society for Clinical Social Work (GWSCSW) was established in 1975 to promote and advance the specialization of clinical practice within the social work profession. Through our lobbying, education, community building, and social justice activities, we affirm our commitment to the needs of those in our profession, their clients, and the community at large. On behalf of GWSCSW, we support House Bill 1210.

The Licensed Certified Social Worker-Clinical (LCSW-C) licensee is authorized to independently evaluate, diagnose, treat mental and emotional disorders, conditions, and impairments and testify as an expert witness. (HO 19-101 Et. Seq.). There is a severe need for qualified mental health practitioners to fully serve the injured worker who are experienced, and qualified in the evaluation, diagnosis, and treatment of mental and emotional disorders, conditions, and impairments as well as medical case management and collaboration with other health care providers, agencies, and resources. LCSW-Cs perform evaluations, diagnosis, and treatment objectively not based upon advocacy for the patient or referral sources.

GWSCSW supports amending Sec. 9-721 (c) to include the LCSW-C who is qualified as an expert witness. House Bill 1210 limits the LCSW-C to only those practitioners who are trained and qualified though the Expert Witness procedural process on an individual basis. However, a Physician (Psychiatrist) or Psychologist, without any training, experience or oversight by their licensing Board in impairment determinations of Workers Compensation is automatically accepted to testify on Permanent Impairment. This appears to be a restraint of trade; arbitrarily disallowing qualified LCSW-Cs to engage in this function within their scope of practice, while permitting other health practitioners with no specified qualifications to engage in this function.

For these reasons we urge a favorable vote.

Please see the attachments.

For more information call:
Christine K. Krone
Danna L. Kauffman
410-244-7000

Title 14 INDEPENDENT AGENCIES

Subtitle 09 WORKERS' COMPENSATION COMMISSION

Chapter 08 Guide of Medical and Surgical Fees (Effective as of February 24, 2020)

Authority: Labor and Employment Article, §§9-309, 9-663, and 9-731, Annotated Code of Maryland

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Ambulatory surgical center (ASC)" means any center, service, office facility, or other entity that:

(a) Operates primarily for the purpose of providing surgical services to patients requiring a period of postoperative observation but not requiring overnight hospitalization; and

(b) Seeks reimbursement from payers as an ambulatory surgery center.

(2) "Authorized provider" means:

(a) A licensed physician's assistant (P.A.), providing services on or after March 24, 2008;

(b) A licensed acupuncturist;

(c) A medical doctor (M.D.);

(d) A doctor of osteopathy (D.O.);

(e) A doctor of chiropractic (D.C.), for services provided within the scope of Health Occupations Article, Title 3, Annotated Code of Maryland;

(f) Podiatrist (D.P.M.);

(g) An optometrist (O.D.);

(h) A certified registered nurse anesthetist (C.R.N.A.);

(i) An occupational therapist (O.T.);

(j) A pharmacist (R. Ph.);

(k) A licensed physical therapist (P.T.);

(l) A psychologist (Ph.D.);

(m) A licensed clinical social worker (L.C.S.W.);

(n) A licensed audiologist;

(16) "Resource based relative value scale (RBRVS)" means the system by which medical providers are reimbursed based on the resource costs needed to provide a given service. Under the RBRVS, CMS assigns each medical procedure a relative value quantifying the relative work (work), practice expense (PE), and malpractice costs (MP) for each service.

(17) "RBRVS relative value unit (RVU)" means the uniform value assigned by CMS to each medical procedure and service identified by CPT/HCPCS code quantifying the work (work), practice expense (PE), and malpractice costs (MP) for each service.

(18) "Time Unit" means a measure of each 15-minute interval, or fraction thereof, during which anesthesiology services are performed.

.02 Incorporation by Reference.

A. The "Official Maryland Workers' Compensation Medical Fee Guide" (1995) is incorporated by reference.

B. Health Services Cost Review Commission. In accordance with Health-General Article, §19-211, Annotated Code of Maryland, in the case of a discrepancy between a rate for a hospital service set by the Health Services Cost Review Commission and that set by the Workers' Compensation Commission, the rate set by the Health Services Cost Review Commission shall prevail.

(3) The facility MRA shall be calculated by multiplying each RBRVS RVU by each corresponding GPCI, adding those sums, and then multiplying that total by the MSCF as follows: Facility MRA = ((Work RVU × Work GPCI) + (Transitioned Facility PE RVU × PE GPCI) + (MP RVU × MP GPCI)) × MSCF.

(4) For anesthesiology services, the MRA shall be calculated by adding the Time Units and Base Units and multiplying that sum by the MSCF: MRA = (Time Units + Base Units) × MSCF.

(5) In calculating the MRA, the following MSCFs apply:

(a) For anesthesiology services, the MSCF is $19.39;

(b) For orthopedic and neurological surgical procedures, MSCF is $53.77; and

(c) For all other medical services and treatment, except as otherwise provided, the MSCF is $40.70.

F. Ambulatory Surgical Centers.

(1) For medical services and treatment provided at an ASC between September 1, 2004, and January 31, 2006, the MRA is calculated by multiplying the CMS 2004 ASC group payment rate by 109 percent.

(2) For medical services and treatment provided at an ASC between February 1, 2006, and March 24, 2008, the MRA is calculated by multiplying the 2004 CMS ASC group payment rate by 125 percent.

(3) For medical services and treatment provided at an ASC on, or after, March 24, 2008, the MRA is calculated by multiplying the current calendar year ASC MRR by 125 percent.

G. MSCF Annual Adjustment.

(1) Beginning January 1, 2009, an adjustment shall be made to the prior year's MSCFs and percentage multiplier (for ASCs).

(2) The MSCFs for the following year shall be calculated by multiplying the MSCFs in effect on November 1 of the current year by the percentage change in the first quarter MEI of the current year, as published on November 1 of the current year, and adding that amount to the current year's MSCFs.

(3) The percentage multiplier for the following year shall be calculated by multiplying the percentage multiplier in effect on November 1 of the current year by the percentage change in the first quarter MEI of the current year, as published on November 1 of the current year, and adding that amount to the current year's percentage multiplier.

(4) The resulting figures shall be utilized as the new MSCF and percentage multiplier for the following year for the purpose of calculating the MRA under §§E and F of this regulation.

(5) The Commission shall post the new MSCFs and percentage multiplier on its website by December 1.

(6) The resulting new MSCFs and percentage multiplier shall be effective January 1 of the following year.

(7) The Commission shall review the annual adjustment process every 5 years to assure that reimbursement rates are neither inadequate nor excessive.

.06 Reimbursement Procedures.

A. To obtain reimbursement under this chapter, an authorized provider shall:

(1) Complete Form CMS-1500 in accordance with the written instructions posted on the Commission's website; and

(2) Within the time provided in §H of this regulation, submit to the employer or insurer the completed Form CMS-1500, which shall include:

(a) An itemized list of each service;

(b) The diagnosis relative to each service;

(c) The medical records related to the service being billed;

(d) The appropriate CPT/HCPCS code with CPT modifiers, if any, for each service;

(e) The date of each service;

(f) The specific fee charged for each service;

(g) The tax ID number of the provider;

(h) The professional license number of the provider; and

(i) The National Provider Identifier (NPI) of the provider.

B. Modifiers.

(1) Modifying circumstances may be identified by use of the relevant CPT modifier in effect when the medical service or treatment was provided.

(2) The identification of modifying circumstances does not imply or guarantee that a provider will receive reimbursement as billed.

C. Time for Reimbursement. Reimbursement by the employer or insurer shall be made within 45 days of the date on which the Form CMS-1500 was received by the employer or insurer, unless the claim for treatment or services is denied in full or in part under §G of this regulation.

D. Untimely Reimbursement. If an employer or insurer does not pay the fee calculated under this chapter or file a notice of denial of reimbursement, within 45 days of receipt of the CMS-1500, the Commission may assess a fine against the employer or its insurer, and award interest to the provider in accordance with Labor and Employment Article, §§9-663 and 9-664, Annotated Code of Maryland, and COMAR 14.09.06.02.

E. Denial of Reimbursement.

(1) If an employer or insurer denies, in full or in part, a claim for treatment or services, the employer or insurer shall:

(a) Notify the provider of the reasons for the denial in writing; and

.07 Medical Records.

A. Medical records are the basis for determining whether a particular treatment or service is medically necessary and, therefore, reimbursable.

B. Each health care provider is responsible for creating and maintaining legible medical records documenting the employee's course of treatment.

C. Employee medical records shall include the:

(1) History of the patient;

(2) Results of a physical examination performed in conformity with the standard of practice of similar health care providers, with similar training, in the same or similar communities;

(3) Progress, clinical, or office notes that reflect:

(a) Subjective patient complaints;

(b) Objective findings of the provider;

(c) Assessment of the presenting problem;

(d) Any plan or plans of care or recommendations for treatment; and

(e) Updated assessments of patient's medical status and response to therapy;

(4) Copies of lab, x-ray, or other diagnostic tests, if any, that reflect the current progress of the patient and response to therapy; and

(5) Hospital inpatient and outpatient records, if any, including:

(a) Operation reports;

(b) Test results;

(c) Consultation reports;

(d) Discharge summaries; and

(e) Other dictated reports.

D. Writing, Maintaining, and Submitting Medical Records.

(1) Employee medical records shall be submitted to the employer or insurer, or, upon request, to the Commission.

(2) The cost of maintaining medical records is included in the treatment and service fees established by the Official Maryland Workers' Compensation Medical Fee Guide (1995) and this chapter. A provider may not submit a separate fee for writing or maintaining medical records.

(3) Additional Medical Report Fees.

DEPARTMENT OF
BUDGET & MANAGEMENT

OFFICE OF PERSONNEL SERVICES AND BENEFITS

SICK LEAVE GUIDELINES

1. Eligibility

In accordance with State law, employees are entitled to sick leave with pay:

a. for illness or disability of the employee;
b. for death, illness, or disability of a member of the employee's immediate family;
c. following the birth of the employee's child;
d. when a child is placed with the employee for adoption; or
e. for a medical appointment of the employee or a member of the employee's immediate family.

“Immediate family" is defined as: the employee’s spouse; the employee’s children (including foster and stepchildren); parents, stepparents, or foster parents of the employee or spouse, or others who took the place of parents; legal guardians of the employee or spouse; brothers and sisters of the employee or spouse; grandparents and grandchildren of the employee or spouse; and other relatives living as members of the employee’s household.

2. Notification

When an employee is unable to work due to circumstances provided in Section 1, the employee or employee's designee will notify his/her immediate supervisor or designee at the work site at a time as established by existing agency policy/practice, unless extenuating circumstances preclude this notification. When an employee calls in accordance with established practice or policy, he/she shall leave a message if the supervisor or supervisor's designee is unavailable, or the Employer may instruct an employee to call a secondary number, and the employee will not be required to call back.

The employee or designee must call each day of absence until the employee notifies the Employer of a date he/she will return to duty. The Employer shall not ask the employee to provide information as to his/her diagnosis or condition except as permitted by applicable law.

3. Certificate of Illness for Absences for Five (5) or More Consecutive Days

The Employer shall require an employee to provide an original certificate of illness or disability only in cases where an absence is for five (5) or more consecutive workdays or in accordance

with the procedures described in Section 4 below. The certificate required by this Section shall be signed by one of the following:

A. A medical doctor who is authorized to practice medicine or surgery by the state in which the doctor practices;

B. If authorized to practice in a state and performing within the scope of that authority:
   1. a chiropractor;
   2. a clinical psychologist;
   3. a dentist;
   4. a licensed certified social worker – clinical;
   5. a nurse midwife;
   6. a nurse practitioner;
   7. an oral surgeon;
   8. an optometrist;
   9. a physical therapist; or
   10. a podiatrist;

C. An accredited Christian Science practitioner; or

D. A health care provider as defined by the federal Family Medical Leave Act.

4. Certificate of Illness for Absences of Less Than Five (5) Consecutive Days

The Employer may require an employee to submit documentation of sick leave use on the following conditions:

A. When an employee has a consistent pattern of maintaining a zero or near zero sick leave balance without documentation of the need for such relatively high utilization; or

B. When an employee has six (6) or more occurrences of undocumented sick leave usage within a twelve (12) month period. Sick leave use that is certified in accordance with this policy shall not be considered as an occurrence.

Note that after the first instance of an employee being absent for more than four (4) consecutive days without documentation, the Employer may place the employee on notice that future absences of more than three (3) days, within a rolling twelve (12) month period, will require documentation.

5. Procedures for Certification Requirement

Prior to imposing a requirement on an employee for documentation of sick leave use, the Employer shall orally counsel the employee that future undocumented absences may trigger a requirement for certification of future instances of sick leave.

If the employee has another undocumented absence after such counseling, the Employer may then put the employee on written notice that he/she must certify all sick leave usage for the next six (6) months if the undocumented absences accumulate in accordance with Section 4.

At the conclusion of the six (6) months, the certification requirement will be rescinded provided the employee has complied with the requirement. If the employee has not complied, the requirement shall be extended for six (6) months from the date of the lack of compliance with the requirement.

Although a requirement for certification is not a disciplinary action, an employee may grieve allegations of misapplication of this procedure.

6. Chronic Conditions

Employees who suffer from chronic or recurring illnesses or disabling conditions that do not require a visit to a health care provider each time the condition is manifested, shall not be required to provide certification for each absence, provided that a general certification is provided, unless the absence is for five (5) or more consecutive days. Such frequent absences also shall not be used as the basis for a certification requirement.

Unless the employee has a condition identified as a permanent disabling condition, the Employer may require certification and follow-up reports from a health care provider no more frequently than every six (6) months of the continued existence of the chronic condition.

7. Acceptable Documentation

For the purposes of absences of less than five (5) consecutive days, acceptable documentation shall consist of the following:

A. A certificate from a health care provider that the employee (or member of the employee's immediate family) visited the office and/or the employee was unavailable for duty for the reasons specified in Section 1 on the day or dates of absence. For absences of four (4) hours or less, at the employee's option, he or she may submit a copy of the universal health insurance claim form or similar document from the health care provider's office showing the name of the provider, the date of treatment and address and telephone number of the provider.

B. An employee who works less than his/her full work day due to having to provide care to the employee's child or member of his/her immediate family shall not be required to provide certification from an acceptable health care provider unless management has a basis to believe sick leave is being used for a purpose other than described in Section 1 above. Sick leave use in such circumstances shall not count as an occurrence under Section 4.

8. Disciplinary Actions

The Employer may take appropriate disciplinary action against an employee for using sick leave for purposes other than described in law, regulation, this policy, or an applicable MOU; for failing to properly notify the Employer of the use of sick leave; or for failure to provide appropriate documentation when properly required to do so.

The Employer may not penalize an employee with regard to scheduling, overtime eligibility, performance evaluations or other right or benefit for sick leave usage for being subject to a documentation requirement.

This does not preclude appropriate disciplinary action for use of sick leave for purposes other than described in Section 1.

RELEASED: _____ 10/31/08

Cynthia A. Kollner
Executive Director
Office of Personnel Services and Benefits
Maryland Department of Budget and Management

Date

2005 Federal Employee Program Benefit Changes

Below are the Federal Employee Program (FEP) benefit changes to the Blue Cross and Blue Shield Service Benefit Plan, effective January 1, 2005.

Change to both Basic and Standard Options

- Benefits will be provided for inpatient and outpatient nutritional counseling for the treatment of anorexia and bulimia when rendered by any covered provider, including dieticians and nutritionists.

Basic Option Changes
Benefits will be at 100% of the Plan Allowance for:

- **neurological/ psychological testing. testing by providers, such as psychiatrists, psychologists, clinical social workers and psychiatric nurses is subject to a $20 copay. testing by a specialist is subject to a $30 copay.**
- Professional maternity care delivery. The $100 copay for these services will be eliminated.
- Laboratory services billed separately from an office visit. The $20 copay for these services will be eliminated.
- Radiological services and diagnostic tests billed separately from an office visit. The $20 copay for these services will be eliminated.

2/20/2006

CANDACE MCLAREN LANHAM
Chief Deputy Attorney General

CAROLYN A. QUATTROCKI
Deputy Attorney General

LEONARD J. HOWIE III
Deputy Attorney General

CHRISTIAN E. BARRERA
Chief Operating Officer

ZENITA WICKHAM HURLEY
Chief, Equity, Policy, and Engagement

PETER V. BERNS
General Counsel

ANTHONY G. BROWN
Attorney General

SANDRA BENSON BRANTLEY
Counsel to the General Assembly

DAVID W. STAMPER
Deputy Counsel

SHAUNEE L. HARRISON
Assistant Attorney General

JEREMY M. MCCOY
Assistant Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
OFFICE OF COUNSEL TO THE GENERAL ASSEMBLY

January 25, 2024

The Honorable Susan K. McComas
Maryland House of Delegates
411 Lowe House Office Building
Annapolis, Maryland 21401
Via email

Dear Delegate McComas:

You have inquired whether a licensed certified social worker-clinical ("LCSW-C") may be qualified to testify as a witness on ultimate issues regarding matters within the scope of practice for clinical social work. As earlier advised by this office, (*see* Letter of Advice to the Honorable Samuel I. Rosenberg from Asst. Atty. Gen. Kathryn M. Rowe (Jan. 30, 2004) ("Rosenberg Letter")), a LCSW-C may be qualified to testify on matters within the scope of practice for clinical social work by a LCSW-C.

A LCSW-C is an individual licensed by the State Board of Social Work Examiners to practice clinical social work. Md. Code Ann., Health Occupations Article ("HO"), § 19-101(h). "Practice clinical social work" means to use the specialized education, training, and experience required under HO § 19-302(e) to practice social work. HO § 19-101(l). "Practice social work" is defined under HO § 19-101(n)(1), and specifically for a LCSW-C, the "practice of social work" also includes the: (1) supervision of other social workers; (2) "[e]valuation, diagnosis, and treatment of biopsychosocial conditions, mental and emotional conditions and impairments, and behavioral health disorders, including substance abuse disorders, addictive disorders, and mental disorders, as defined in § 7.5-101 of the Health-General Article;" (3) petitioning for emergency evaluation under Title 10, Subtitle 6 of the Health-General Article; and (4) provision of psychotherapy. HO § 19-101(n)(1) and (5).

Maryland Rule 5-702 addresses the admissibility of expert testimony in State court proceedings. The rule allows a trial court to admit expert testimony "in the form of an opinion or otherwise, if the court determines that the testimony will assist the trier of fact to understand the evidence or to determine a fact in issue." Md. Rule 5-702. In making the determination, the rule requires a court to examine three factors: "(1) whether the witness is qualified as an expert by knowledge, skill, experience, training, or education[;] (2) the appropriateness of the expert testimony on the particular subject[;] and (3) whether a sufficient factual basis exists to support the expert testimony." *Id.*

In *In re Adoption/Guardianship No. CCJ14746, in the Circuit Court for Washington County*, 360 Md. 634 (2000), the Maryland Supreme Court held that the trial court in that case did not abuse its discretion in finding a licensed clinical social worker qualified as an expert and in admitting his opinion on the respondent's mental disorders. The Court relied on the then-existing statutory definition of the practice of social work under then HO § 19-101(f), which included "rendering a diagnosis based on a recognized manual of mental and emotional disorders[,]" as well as the advanced educational standards required for licensed clinical social workers. *Id.* at 642-43. Subsequent to the Court's opinion in that case, the General Assembly enacted Chapter 554 of the Acts of 2000, which modified the language of the scope of practice under former HO § 19-101(f), and added the scope of practice language for LCSW-Cs that is similar to the scope of practice language under existing HO § 19-101(n)(1) and (5). As this office has previously advised, "[t]his change provides [LCSW-Cs] with at least as broad diagnostic authority as the former law, and thus, does not alter the conclusions in *Adoption No. CCJ14746*." Rosenberg Letter at 2. *See also In re Yve S.*, 373 Md. 551, 615 (2003) ("A witness may not testify to the effect of making a diagnosis concerning mental illness unless he or she is a physician qualified to make such a diagnosis or prognosis, or unless they are otherwise authorized by statute to make such diagnosis.").

For these reasons, subject to the discretion of a trial court to determine the admissibility of expert testimony under Maryland Rule 5-702, a LCSW-C may be qualified to testify on matters within the scope of practice for clinical social work by a LCSW-C.

I hope this is responsive to your request. If you have any questions or need any additional information, please feel free to contact me.

Sincerely,

Jeremy M. McCoy
Assistant Attorney General

OPINIONS@OAG.State MD. US

Behavioral Health Services

For CY 2024, we are implementing Section 4121 of the CAA, 2023, which provides for Medicare Part B coverage and payment under the Medicare Physician Fee Schedule for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. Additionally, we are finalizing our proposal to allow addiction counselors or drug and alcohol counselors who meet the applicable requirements to be an MHC to enroll in Medicare as MHCs. MFTs and MHCs will be able to begin submitting Medicare enrollment applications after the CY 2024 Physician Fee Schedule final rule is issued, and they will be able to bill Medicare for services starting January 1, 2024, consistent with statute. (See link here for enrollment information). We are also making corresponding changes to Behavioral Health Integration codes to allow MFTs and MHCs to bill for these services.

We are also implementing Section 4123 of the CAA, 2023, which requires the Secretary to establish new HCPCS codes under the PFS for psychotherapy for crisis services that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit) furnished on or after January 1, 2024. Section 4123 of the CAA, 2023 specifies that the payment amount for psychotherapy for crisis services shall be equal to 150% of the fee schedule amount for non-facility sites of service for each year for the services identified (as of January 1, 2022) by HCPCS codes 90839 (*Psychotherapy for crisis; first 60 minutes*) and 90840 (*Psychotherapy for crisis; each additional 30 minutes — List separately in addition to code for primary service*), and any succeeding codes.

Additionally, we are finalizing our proposal to allow the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists. Health Behavior Assessment and Intervention codes are used to identify the psychological, behavioral, emotional, cognitive, and social factors included in the treatment of physical health problems. Allowing a wider range of practitioner types to furnish these services will allow for better integration of physical and behavioral health care, particularly

given that there are so many behavioral health ramifications of physical health illness.

We are also finalizing an increase in the valuation for timed behavioral health services under the PFS. Specifically, we are finalizing our proposal to apply an adjustment to the work RVUs for psychotherapy codes payable under the PFS, which we are implementing over a four-year transition. In response to public comments, we are also finalizing the application of this adjustment to psychotherapy codes that are billed with an E/M visit and to the HBAI codes. We believe that these finalized changes will begin to address distortions that have occurred in valuing time-based behavioral health services over many years.

Section 4121(b) of the CAA, 2023 also established that the hospice interdisciplinary group is required to include at least one social worker, MFT, or MHC. Therefore, CMS is finalizing its proposal to modify the requirements for the hospice Conditions of Participation (CoPs) to allow social workers, MHCs or MFTs to serve as members of the interdisciplinary group (IDG) and removing the proposed language requiring that the determination regarding whether a social worker, MFT or MHC serve as a member of the IDG *depending on the preferences and needs of the patient.*

Additionally, Section 4121(b) of the CAA 2023 allows MFTs and MHCs to furnish services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). CMS is finalizing the requirements for the RHC and FQHC Conditions for Certification and Conditions for Coverage (CfCs) to allow MFTs and MHCs to provide additional behavioral health services in these facilities. CMS is also finalizing, as proposed, revising the definitions of several health care professionals who are already eligible to provide services at RHCs and FQHCs, including nurse practitioners. The revised definition for nurse practitioners includes the removal of the requirement that they be certified in primary care to provide care in these facilities. CMS believes that removing this requirement will aid in addressing staffing shortages that healthcare facilities are experiencing in underserved and rural communities by increasing the number of nurse practitioners eligible to provide care in RHCs and FQHCs.

In the proposed rule, we also sought comment on ways we can continue to expand access to behavioral health services and requested