Exhibit -mta-mobility-app- SEE PG 7.pdf
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Position: FAV

MARYLAND DEPARTMENT OF TRANSPORTATION
MARYLAND TRANSIT ADMINISTRATION

Larry Hogan
Governor
Boyd K. Rutherford
Lt. Governor
Gregory Slater
Secretary
Kevin B. Quinn, Jr.
Administrator

Important Notice to Applicants Regarding COVID-19 Modified Procedures

Dear Applicant,

During the COVID-19 State of Emergency, MobilityLink will not be receiving customers for appointments in our office. Applications should be sent to the MTA Mobility Office using one of the below options. Our team will contact you to schedule a phone interview, once we received your completed application (Part A & B). Original Signatures are not required at this time.

Option 1: Once completed, please mail to: ATTN: MobilityLink Certification Office 1st Floor, 4201 Patterson Avenue, Baltimore, MD 21215

Option 2: Please fax your completed application to (410) 764-7526.

Option 3: Please email your completed application to MTACertification@mdot.maryland.gov.

If you would like to register to vote electronically in person at the Mobility Certification Office, please contact the number below and transportation can be provided to the Certification Office after the state of emergency has concluded.

We apologize for any inconvenience this change may cause, and we look forward to serving you in person when it is safe to do so. If you have any questions or concerns, please contact the MobilityLink Certification Office at 410-764-8181 Option 6.

Thank you,

MTA MobilityLink Certification Office

Application for MTA Mobility

If you need help understanding this information or assistance in completing or understanding Mobility forms or policies, wish to request a reasonable accommodation or modification, or need a copy of this document in an alternative format, please contact Mobility Information at 410-764-8181 or MD Relay 711. You may also contact the Office of Equal Opportunity Compliance Programs at 410-764-8507 or 410-767-3944.

MTA Mobility

Is provided in accordance with the Americans with Disabilities Act (ADA). The ADA requires transit systems that operate fixed route buses/trains to offer complementary paratransit service to people with disabilities who cannot use the fixed route buses/trains for some or all of their trips. MTA Mobility is an origin-to-destination, shared ride, advanced reservation public transit system that is comparable to MTA's fixed route system in terms of service area and service characteristics.

The MTA Mobility eligibility process looks at each individual's functional abilities and their ability to utilize MTA's buses and trains to determine level of eligibility for the program.

The MTA Mobility application process consists of a completed application, completed Healthcare Professional Verification, an interview, and if needed, a functional assessment.

Application Process

1. Complete Part A of the application
2. Have a Healthcare Professional, who can speak to your disability or health condition, complete Part B
    a. Ensure your Healthcare Professional has fully completed Part B, including original signature, license number, and ICD code(s)
3. Once Part A and Part B are completed, return the application to the MTA by one of the following methods:

    Option 1: Once completed, please mail to: ATTN: MobilityLink Certification Office 1st Floor, 4201 Patterson Ave., Baltimore, MD 21215

    Option 2: Please fax your completed application to (410) 764-7526

    Option 3: Please email your completed application to: MTACertification@mdot.maryland.gov

Please note: Applicant interview must take place within 60 days of the completion of Part B.

In order to better serve applicants, MTA Mobility will consider additional forms of identification in lieu of a government approved photo identification if you do not have government approved identification available. MTA Mobility will consider alternative form(s) of identification on a case-by-case basis. If you are unsure about appropriate identification, you may call 410-764-8181, option 6.

MTA has up to 21 days to make a determination. You will receive an eligibility determination letter in the mail that outlines the determination. If your determination is not made within 21 days, you will qualify for Mobility services until such time as an eligibility decision is made. You may contact the reservation center at 410-764-8181, option 1 to schedule a ride until a determination is made.

You have the right to appeal the determination if you do not agree. Information on how to request an appeal will be included with the eligibility determination letter.

Part A: Applicant Information *(please print)*

This section to be completed by the applicant, the applicant's caregiver, or another individual familiar with the applicant's disability. Please attach supplemental documentation if additional space is required to thoroughly answer all questions.

☐ New Application ☐ Recertification If Recertification, Mobility #: _____

Demographic Information

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Email Address: _____

Emergency Contact Information

Last Name: _____ First Name: _____

Phone Number: _____ Relationship: _____

Transit Usage

1. Have you used MTA buses and trains? ☐ Yes ☐ No ☐ Sometimes
2. Are you able to reach the MTA bus/train stop/station nearest your home? ☐ Yes ☐ No ☐ Sometimes

   If you answered no or sometimes, please explain: _____

3. What best describes your ability to use MTA's fixed route service?
   - ☐ I can use the MTA buses and trains for most trips
   - ☐ I can use the MTA buses and trains, but it would be difficult
   - ☐ I can use the MTA buses and trains, but only for specific trips or destinations
   - ☐ I have never tried to use the MTA buses and trains
   - ☐ I cannot use the MTA buses and trains without a personal care attendant
   - ☐ I cannot use the MTA buses and trains at all because: _____

Disability/Health Condition Information

1. What is the primary disability or health condition that prevents you from being able to use MTA's buses and trains? Please be specific. _____

   _____

   _____

   _____

   Date of diagnosis or onset: _____

2. Do you have other disabilities or health conditions that limit your ability to use MTA's buses and trains? ☐ Yes ☐ No
   If yes, please explain: _____

3. Do the effects of your disability or health condition vary from day to day? ☐ Yes ☐ No
   If yes, please explain: _____

4. Is your disability or health condition: ☐ Permanent ☐ Temporary
   If temporary, please explain: _____

Mobility Aids

1. Check any and all mobility equipment that you expect to use while traveling:

   ☐ Cane ☐ Braces ☐ Crutches ☐ Walker
   ☐ White Cane ☐ Manual Wheelchair ☐ Motorized Wheelchair ☐ Service Animal
   ☐ Scooter ☐ Respirator/Oxygen ☐ Other:

2. If you use a wheelchair or scooter, what is the width and length?

   Width: _____ inches Length: _____ inches

3. Do you require a personal care attendant (PCA) with you to provide assistance during travel or at your destination? ☐ Always ☐ Sometimes ☐ Never

   If always or sometimes, how does a PCA assist you?

   _____

   _____

   _____

   _____

   _____

Functional Skills

The following questions will give us more information about your functional abilities. Please select Always (A), Sometimes (S), or Never (N) in response to the following questions.

Without the help of someone else, can you:

1. Ask for and understand written or spoken instructions? ☐ A ☐ S ☐ N
   If Sometimes or Never, please explain: _____
2. Cross the street? ☐ A ☐ S ☐ N
   If Sometimes or Never, please explain: _____
3. Stand for 20 minutes if there is no place to sit? ☐ A ☐ S ☐ N
   If Sometimes or Never, please explain: _____
4. Step on and off a sidewalk from a curb? ☐ A ☐ S ☐ N
   If Sometimes or Never, please explain: _____
5. Walk on uneven surfaces? ☐ A ☐ S ☐ N
   If Never, please explain: _____
6. Stand on a moving bus or train if there is a handrail? ☐ A ☐ S ☐ N
   If Never, please explain: _____
7. Transfer from one bus or train to another? ☐ A ☐ S ☐ N
   If Never, please explain: _____
8. What is the farthest that you can travel outdoors (using your mobility aid if you use one) without the aid of another person? ☐ < 1 block ☐ 1-4 blocks ☐ > 4 blocks

Please provide any other information about your disability or health condition that would help us better understand your travel abilities: _____

_____

_____

_____

Travel Training

1. Have you ever had travel training to learn how to travel around the community or how to use MTA buses and trains? ☐ Yes ☐ No
2. Would you like information about travel training to use MTA's bus/train service? ☐ Yes ☐ No

Voter Registration

1. Would you like to register to vote? ☐ Yes ☐ No

Certification

I understand that the purpose of this application is to determine if there are times when I cannot use MTA Fixed Route buses, subway, and light rail and I will require paratransit services. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I hereby certify, under penalty of perjury, that the information submitted is true and correct. I understand that providing any false information on this application may constitute a crime punishable under the law. Further, I understand that providing false or misleading information could result in the denial of my application or termination of my eligibility.

I give permission for MTA Mobility Certification staff to contact the professional who has filled out this application or given supplemental verification of my condition.

Applicant Signature: _____ Date: _____

If someone other than the applicant has completed this form, please provide the following information:

Print Name: _____ Relationship to Applicant: _____

Agency *(if applicable)*: _____

Phone Number: _____ Other Phone Number: _____

Signature: _____ Date: _____

Part B: Healthcare Professional Certification *(please print)*

Licensed or certified healthcare professionals authorized to fill out this certification include, but are not limited to the following:

- Vocational Rehabilitation Counselor
- Physician
- Licensed Clinical Social Worker
- Physician's Assistant
- Respiratory Therapist
- Nurse Practitioner
- Occupational Therapist
- Psychiatrist/Psychiatric Social Worker
- Physical Therapist
- Ophthalmologist
- Audiologist
- Optometrist
- Independent Living Specialist
- Psychologist
- Speech and Language Pathologist

The Americans with Disabilities Act (ADA) requires transit systems that operate fixed route service to offer complementary paratransit to people with disabilities who cannot use the MTA fixed route service. In accordance with the ADA, the MTA offers MTA Mobility, a door-to-door, shared ride service for those who cannot use the fixed route service because of their disability.

The following factors do not, by themselves, qualify a person for ADA paratransit:

- Diagnosis
- Age
- Distance to bus stop
- Inconvenience
- Lack of bus service
- Personal finances
- Inability to drive
- Discomfort

Please be advised that all of MTA's buses and rail services are lift/ramp equipped, have wheelchair securement areas, priority seating areas for people with disabilities, and provide audio route and stop announcements.

MTA bases eligibility determinations on the information provided by the applicant in the application and in the interview, observations made during the functional assessment, if used, and information provided by the healthcare professional.

An incomplete application will be returned to the applicant and may delay processing. Every question **must** be answered and must be legible. Please attach supplemental documentation if additional space is required to thoroughly answer all questions.

Applicant Name: _____ Applicant Sex: ☐ Male ☐ Female

Healthcare Professional Name: _____

Title: _____

License Number: _____ State Issued: _____

Institution/Facility/Agency: _____

Street Address: _____

City/State/Zip Code: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

In the following questions, please focus on the applicant's functional abilities.

1. Written diagnosis(es) and ICD-10 and/or DSM Code(s): _____

2. How long have you been treating the applicant? _____

3. When was the last time you saw the patient? _____

4. What is the expected duration of the disability? ☐ Short Term ☐ Long Term
   Short Term: Conditions likely to improve within one year
   Long Term: Conditions with little expectation of improvement

5. How does the disability or health condition impact the applicant's ability to travel independently on MTA fixed route services? _____

6. Check all of the mobility devices that the applicant requires:
   ☐ Cane ☐ Braces ☐ Crutches ☐ Walker
   ☐ Manual Wheelchair ☐ Motorized Wheelchair
   ☐ White Cane ☐ Service Animal
   ☐ Scooter ☐ Respirator/Oxygen _____

7. Is the applicant currently on any medications with side effects that may significantly reduce/hinder their ability to independently ride the accessible MTA fixed route service?

☐ Yes ☐ No *If yes, please list the medications:* _____

8. Does the applicant have a seizure disorder? ☐ Y ☐ N ☐ N/A
9. Are the seizures controlled with medication? ☐ Y ☐ N ☐ N/A
10. Date of the last seizure: _____
11. Does the applicant have a cognitive impairment? ☐ Y ☐ N ☐ N/A

Please explain: _____

For the following questions (12-27), check Yes (Y), No (N), or Sometimes (S). If you answer yes or sometimes, please explain how it prevents the applicant from using accessible MTA buses and trains.

12. Does the applicant have any challenges with memory? ☐ Y ☐ N ☐ S
    Please explain: _____
13. Would the applicant be able to recognize and avoid dangers when traveling alone in the community? ☐ Y ☐ N ☐ S
    Please explain: _____
14. Would the applicant be able to independently seek assistance if they were lost in the community? ☐ Y ☐ N ☐ S
    Please explain: _____
15. Would temperature extremes affect the applicant's ability to ride transit? ☐ Y ☐ N ☐ S
    Please explain: _____
16. Would ice and/or snow affect the applicant's ability to ride transit? ☐ Y ☐ N ☐ S
    Please explain: _____
17. Would poor air quality affect the applicant's ability to ride transit? ☐ Y ☐ N ☐ S
    Please explain: _____
18. Does the applicant have any challenges with balance? ☐ Y ☐ N ☐ S
    Please explain: _____

19. Does the applicant have a psychiatric condition that may impact functional ability? ☐ Y ☐ N ☐ S
    Please explain: _____
20. Does the applicant have any challenges with breathing? ☐ Y ☐ N ☐ S
    Please explain: _____
21. Does the applicant have any challenges with strength and endurance? ☐ Y ☐ N ☐ S
    Please explain: _____
22. Does the applicant have any challenges with ambulating on hills? ☐ Y ☐ N ☐ S
    Please explain: _____
23. Are there any visual impairments that would affect this applicant's ability to ride transit? ☐ Y ☐ N ☐ S
    Please explain: _____
24. Are there any hearing impairments that would affect this applicant's ability to ride transit? ☐ Y ☐ N ☐ S
    Please explain: _____
25. Does the applicant exhibit any inappropriate social behaviors? ☐ Y ☐ N ☐ S
    Please explain: _____
26. Do you have safety concerns for this applicant in using the fixed route service independently? ☐ Y ☐ N ☐ S
    Please explain: _____
27. Does the applicant require a Personal Care Attendant while traveling or at their destination? ☐ Y ☐ N ☐ S
    Please explain: _____
28. In your medical opinion, what other factors related to the applicant's disability(ies) affect their ability? to ride MTA fixed route service? _____

Certification

I certify that I am licensed/certified and am currently treating _____.
I certify that all information provided in this application is a fair representation of the applicant's disability(ies) or health condition(s) and is true and correct.

I understand that the information provided will be used for the purpose of determining the applicant's eligibility for ADA paratransit service.

I agree that MTA and its eligibility contractor may contact me for clarification of any information I have provided and that I will reply with good faith.

This page to be completed by health care provider only

Signature: _____ Date: _____

Please Note:

- Applicant interview must take place within 60 days of the completion of Part B.
- Applicants must present the original form in person at their interview appointment. Please do not mail this form to Certification.

October 23, 2019 Mobility Customer ID: 15694

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote? If you do not check either box, you will be considered to have decided not to register to vote at this time.

☐ Yes ☐ No

You can register online at www.vote.org/register-to-vote/maryland/ or in person in our Certification Office.

If your answer is yes, a voter registration application is enclosed with the MTA MobilityLink Application. You may complete the enclosed voter registration application and send it to MTA MobilityLink. MTA will transmit it to the appropriate election board. You may also send the voter registration form to the appropriate State election official yourself. You can also register online at www.vote.org/register-to-vote/maryland/ or in person at the MTA MobilityLink Certification Office. If you would like to register to vote electronically in person at the Moblity Certification Office, please contact the number below and transportation can be provided to the Certification Office after the State of Emergency has concluded.

When you complete a voter registration application, if you do not select a political party affiliation, you will be designated as not affiliated with a political party and will be unable to vote in a party primary election.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by MTA. If you would like help in filling out the voter registration application form, MTA will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact MTA MobilityLink at (410) 764-8181 Option 6 for assistance with voter registration.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the State Board of Elections.

Maryland State Board of Elections
P.O. Box 6468
Annapolis, Maryland 21401-0486
800-222-8683

Your application for MTA MobilityLink services may not be completed until you have indicated whether you wish to register to vote. Therefore, please indicate whether you would like to register to vote or decline to register above.

AFTER THIS FORM IS FILLED OUT, YOU MUST SIGN AND MAIL IT TO YOUR COUNTY BOARD OF ELECTIONS. IT CANNOT BE PROCESSED IF IT IS FAXED OR E-MAILED, BECAUSE IT REQUIRES AN ORIGINAL SIGNATURE.

MARYLAND VOTER REGISTRATION APPLICATION

TO REGISTER, YOU MUST

- Be a U.S. citizen;
- Be a Maryland resident;
- Be at least 16 years old*;
- Not be under guardianship for mental disability or if you are, you have not been found by a court to be unable to communicate a desire to vote;
- Not have been convicted of buying or selling votes;
- Not have been convicted of a felony, or if you have, you have completed serving a court-ordered sentence of imprisonment.

*You may register to vote if you are at least 16 years old but cannot vote unless you will be at least 18 years old by the next general election.

DEADLINE INFORMATION

- This application must be postmarked no later than 21 days before an election.
- If your application is complete and you are found to be qualified, a Voter Notification Card will be mailed to you.
- The submission of this form to an individual other than an official, employee, or agent of a County Board of Elections does not assure that the form will be submitted or filed in a timely manner.

YOU CAN USE THIS FORM TO

- Register to vote in federal, state, county, and municipal elections in Maryland.
- Change your name, address, or party affiliation.

INSTRUCTIONS

- If you do not have a current, valid Maryland driver's license or MVA ID card, you must enter the last 4 digits of your social security number. The statutory authority allowing officials to request the last 4 digits of your social security number is Election Law Article, § 3-202. The number will only be used for registration and other administrative purposes. It will be kept confidential.
- Complete Items 1–11 in Voter Registration Application. Sign and date Item 12. If you are registered to vote in another Maryland county or another state, you must complete Items A–B in Last Voter Registration.
- You must register with a party if you want to take part in that party's primary election, caucus or convention. Check one box only.
- Detach this panel at the perforation.
- Address and mail the application to your County Board of Elections, using the list on the back panel.

WARNING

Giving false information on an application for voter registration is perjury, punishable by imprisonment for up to 10 years, and a violation of the election laws, punishable by a fine of up to $1,000, or by imprisonment for up to 5 years, or both.

PERSONAL RECORDS NOTICE/CONFIDENTIALITY

This form collects personal information for voter registration purposes. If you are not registered to vote and you refuse to provide this information, you will not be allowed to vote in Maryland. You may update your voter registration at any time at your County Board of Elections. Except for items specified as confidential, voter registration records are generally available for public inspection; they may also be shared with jury commissioners/clerks or other government agencies as provided by law. The law prohibits use of voter registration records for commercial solicitation purposes. If you decline to register to vote, that fact will remain confidential and will be used only for voter registration purposes.

If you register to vote, the identity of the office at which the application is submitted will remain confidential and will be used only for voter registration purposes.

The Maryland Safe at Home Address Confidentiality Program (ACP) is administered by the Office of the Secretary of State and provides an important service to victims of domestic violence and human trafficking. For more information about this Program please call 1-800-633-9657, ext. 3875.

QUESTIONS

Visit the State Board of Elections website at www.elections.maryland.gov to verify your registration, find your polling place, and find out other important information. If you have any questions, call your County Board of Elections or the State Board of Elections at the numbers listed on the back of the application.

Large type Voter Registration Applications available upon request to your County Board of Elections or the State Board of Elections.

Detach this panel before mailing.

VOTER REGISTRATION APPLICATION

PLEASE COMPLETE IN BLACK INK – DETACH FORM AND FOLD WHERE INDICATED TO MAIL

Maryland State Board of Elections SBE 03-202-1 Rev 04/20 VRA

1 *Are you at least 16 years old?* ☐ *Yes* ☐ *No*
ARE YOU A U.S. CITIZEN? ☐ *Yes* ☐ *No*
If you answer NO to either question, do not complete this form.

2 *Check boxes that apply and complete Items 3–12.*
☐ *New Registration* ☐ *Name Change* ☐ *Party Affiliation Change* ☐ *Address Change*

3 *Last Name* | *First Name* | *Middle* | *Suffix*

4 *Gender:* ☐ *Male* ☐ *Female* ☐ *Unspecified or Other*

5 *Birth Date:* *Month* / *Date* / *Year*

6a **MARYLAND** *Driver's License or MVA ID Number* **MANDATORY** *(If you have neither see instructions)*

6b *Social Security Number (last 4 digits)*

6c ☐ *Check here if you do not have either a current, valid Maryland driver's license / MVA ID card or a Social Security Number*

7 *Maryland Residence Address:* *Street Number* | *Street Name* | *Apt. No.* | *City or Town* | *Zip Code* | *County*
☐ *Check here if you reside in Baltimore City.*

8 *Mailing Address (if different from Item 7)*

9 *You must register with a political party if you want to take part in the political party's primary election, caucus, or convention. Check one box only.*
Party (check one): ☐ *Democratic Party* ☐ *Republican Party* ☐ *Bread and Roses Party* ☐ *Working Class Party*
☐ *Unaffiliated (independent of any party)* ☐ *Other – Specify* _____

10 **CONTACT INFORMATION**
Daytime Phone: *Email (optional):*

11 ☐ *Check here if you need help voting.*
☐ *Check here if you would like to be an election judge.*

12 *Under penalty of perjury, I hereby swear or affirm: I am a U.S. citizen. ■ I am a Maryland resident. ■ I am at least 16 years old. ■ I have not been convicted of buying or selling votes. ■ I have not been convicted of a felony, or if I have, I have completed serving a court-ordered sentence of imprisonment. The information in this application is true to the best of my knowledge, information and belief.*
Signature (required) X _____ *Date* _____

LAST VOTER REGISTRATION INFORMATION (if applicable)

A *Name on Last Registration:* *Last Name* | *Title (Jr., Sr., etc.)* | *First Name* | *Middle Name* | *Date of Birth*

B *Address on Last Registration:* *Street Number* | *Street Name* | *Apt. No.* | *City or Town* | *Zip Code* | *State*

State Board of Elections • P.O. Box 6486 • Annapolis, MD 21401-0486 • www.elections.maryland.gov • 800-222-8683 • MD Relay Service (800) 735-2258

Applicant's Return Address

_____

_____

_____

Place Stamp Here

County Board of Elections

_____

_____

_____

Fold here and close with adhesive strip to mail.

County Board of Elections

Allegany County
701 Kelly Road, Suite 231
Cumberland, MD 21502-2887
301-777-5931

Anne Arundel County
P.O. Box 490
Glen Burnie, MD 21060-0490
410-222-6600

Baltimore City
Charles L. Benton Bldg.
417 E. Fayette Street, Rm. 129
Baltimore, MD 21202-3432
410-396-5550

Baltimore County
P.O. Box 798
Cockeysville, MD 21030-0798
410-887-5700

Calvert County
P.O. Box 798
Prince Frederick, MD 20678-0798
410-535-2214

Caroline County
Health & Public Services Bldg.
403 S. Seventh Street, Suite 247
Denton, MD 21629-1378
410-479-8145

Carroll County
300 S. Center Street, Rm. 212
Westminster, MD 21157-5366
410-386-2080

Cecil County
200 Chesapeake Blvd.
Suite 1900
Elkton, MD 21921-6395
410-996-5310

Charles County
P.O. Box 908
La Plata, MD 20646-0908
301-934-8972
301-870-3167

Dorchester County
501 Court Lane, Room 105
P.O. Box 414
Cambridge, MD 21613-0414
410-228-2560

Frederick County
340A Montevue Lane
Frederick, MD 21702
301-600-VOTE (8683)

Garrett County
Public Service Center
2008 Maryland Highway, Suite 1
Mountain Lake Park, MD 21550-6349
301-334-6985

Harford County
133 Industry Lane
Forest Hill, MD 21050-1621
410-638-3565

Howard County
9770 Patuxent Woods Drive, Suite 200
Columbia, MD 21046
410-313-5820

Kent County
135 Dixon Drive
Chestertown, MD 21620-1141
410-778-0038

Montgomery County
P.O. Box 4333
Rockville, MD 20849-4333
240-777-VOTE (8683)
TDD 800-735-2258

Prince George's County
1100 Mercantile Lane, Suite 115A
Largo, MD 20774
301-341-7300

Queen Anne's County
110 Vincit St, Suite 102
Centreville, MD 21617-0274
410-758-0832

St. Mary's County
P.O. Box 197
Leonardtown, MD 20650-0197
301-475-4200 ext. *1625

Somerset County
P.O. Box 96
Princess Anne, MD 21853-0096
410-651-0767

Talbot County
P.O. Box 353
Easton, MD 21601-0353
410-770-8099

Washington County
P.O. Box 3147
Hagerstown, MD 21741-3147
240-313-2050

Wicomico County
P.O. Box 4091
Salisbury, MD 21803-4091
410-548-4830

Worcester County
201 Belt Street
Suite C
Snow Hill, MD 21863-1300
410-632-1320

State Board of Elections • P.O. Box 6486 • Annapolis, MD 21401-0486 • www.elections.maryland.gov • 800-222-8683 • MD Relay Service (800) 735-2258

Maryland State Board of Elections SBE 03-202-1 Rev 04/20 VRA

To:

County Board of Elections

OPEN HERE

OPEN HERE

OFFICIAL ELECTION MAIL

Authorized by the U.S. Postal Service

Exhibit 1-Testimony HB-1210 Workers Compensation-E

Uploaded by: arthur flax

Position: FAV

February 15, 2025
Senator Pamela Beidle, Committee Chair
Senator Antonio Hayes, Committee Vice Chair
Maryland General Assembly
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401
Cc: Delegate Susan McComas

RE: **HB-1210** - Workers' Compensation - Evaluation of Permanent Impairments -Licensed Certified Social Worker-Clinical (LCSW-C)

POSITION: **FAVORABLE- STRONGLY SUPPORT**

Dear Senators Pamela Beidle, Chair, Vice Chair Antonio Hayes, and Members of the Senate Finance Committee:

Disclaimer: Although I consult closely with the below listed entities, the opinions concerning HB-1210 are my own and do not in any way, shape, form, or matter represent those of any other person, individual (LLC, S-Corp., etc.), Governmental agency, for or not for Profit Corporation, or Organization.

Please note, this **legislation only applies to the Licensed Certified Social Worker-Clinical (LCSW-C) and no other classification of Social Worker license. The LCSW-C license is an advanced clinical license.** I reviewed the requirements for Workers Compensation-Evaluation of Permanent Impairments. I initiated and prepared the initial draft for HB-1210. I am registered with the WCC number (G0235). I can provide a full range of services to the injured worker, but not render my opinion as to my evaluative findings affecting permanent impairment.

In 2005, Psychologists were included in Sec. 9-721(HB-384-SB-264-yr. 2005). Psychologists are not physicians. Licensed Certified Social Workers-Clinical and psychologists are both medical health care/health care providers. **Since 2005, the Scope of Practice of the LCSW-C has greatly expanded to include equal diagnostic, evaluative, and treatment authority to a licensed psychologist.**

For an individual licensed as a certified social worker–clinical, "practice social work" also includes: (i) Supervision of other social workers; (ii) Evaluation, diagnosis, and treatment of biopsychosocial conditions, mental and emotional conditions and impairments, and behavioral health disorders, including substance use disorders, addictive disorders, and mental disorders, as defined in § 7.5–101 of the Health – General Article; (Exhibit 2), and is qualified to testify as an expert witness (See AG Advice of Counsel(s) dated 01/30/2004 (Exhibit 3), and AG Advice of Counsel dated 01/25/2024 (Exhibit 3a). . The Labor and Employment Article, Title 14, Independent Agencies, Subtitle 09, Workers Compensation Commission, Chapter 08 Guide to Medical and Surgical Fees, recognizes the Scope of Practice of the LCSW-C (Exhibit 4).

There is a severe shortage and need for qualified mental health practitioners who are experienced, and qualified in the evaluation, diagnosis, treatment, and collaboration with other health care providers,

agencies, and resources to provide this service for the injured worker though the Workers Compensation Commission. This includes the evaluation, diagnosis, and treatment including determinations of impairment, if a handicap exists related to the impairment, further treatment and coordination with other sources, and recommendations for reasonable accommodations under EEOC. The LCSW-C is legally defined as a medical provider and more broadly as a health care provider who incorporates social work values. **Further, HB-1210 requires the LCSW-C "shall comply with all regulations of the Commission". This allows for the adoption of regulations, if deemed necessary, as to specific experience or training.**

The Scope of Practice of the LCSW-C has expanded over the last 20 years as noted above (HO 19-101, n, (5) (ii) referencing HG-Sec. 7.5-101 (1) (2)) and in several other State and Federal statutes and CFR (Exhibit 5). The LCSW-C is authorized to independently provide a range of full services to Medicaid, Medicare, and commercial insurance to patients same as a psychologist (Exhibit 5).

Texts books, including the AMA Comprehensive Textbook of Psychiatry, and the AMA Guides to the Evaluation of Permanent Impairment, Ch.14, (does not restrict usage to only physicians and psychologists (Exhibit 6), and is incorporated into the learning process for the LCSW-C. The Diagnostic and Statistical Manual of Mental Disorders 4th Ed. (DSM), and later editions are standard diagnostic references, as is the International Classification of Diseases, 10th Ed. (ICD), and the use of CPT codes that define services provided. In addition the Global Assessment of Function (GAF) incorporated into the DSM4th.Ed. is utilized, as are other assessment instruments to conduct functional capacity evaluations-mental (FCE-M) (also referred to as ADL's) standing alone, or in conjunction with physical injury or illness. (Exhibit 6)

Section 9-721 of the L&E Article was enacted many years ago, before the LCSW-C license was enacted and since amended. Note, a Physician (Psychiatrist) or Psychologist, without any training, or experience in impairment determinations of injured workers is accepted to evaluate and testify on Permanent Impairment. While the qualified LCSW-C is arbitrarily disallowed to engage is this function within their Scope of Practice. This appears to be a restraint of trade (HB-1615 (2018)) deleted physician (Exhibit 7a).

In support of this amendment I submit the following documentation:

Sincerely,

Arthur Flax, LCSW-C, DCSW, WCC # G-0235
6126 D Greenmeadow Parkway
Baltimore, Maryland 21209-3349; 410-653-6300;
flaxcps@gmail.com

Attachments:

EXHIBIT 1. HB-1210 TESTIMONY; House Bill 1210 passed the House of Delegates and is now scheduled in the Senate Finance Committee on 3/20/2025 at 1:00 PM.

EXHIBIT 2.

HEALTH OCCUPATIONS TITLE 19. SOCIAL WORKERS SUBTITLE 1 DEFINITIONS; GENERAL PROVISIONS § 19-101. Definitions

1. (5) For an individual licensed as a certified social worker–clinical, "practice social work" also includes: (i) Supervision of other social workers; (ii) Evaluation, diagnosis, and treatment of biopsychosocial conditions, mental and emotional **conditions and impairments**, and behavioral health disorders, including substance use disorders, addictive disorders, and mental disorders, as defined in § 7.5–101 of the Health – General Article; (a) "Clinical social work" means the professional application of social work knowledge, skills, values, theories, and methods for the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional disorders, mental disorders, and substance use disorders with individuals, groups, and families.

EXHIBIT 3. Attorney General Advice of Counsel – Ultimate Issue AG Advice of Counsel; on January 30, 2004.

EXHIBIT 3a. Attorney General Advice of Counsel – Ultimate Issue -01-25-2024

EXHIBIT 4. LABOR AND EMPLOYMENT -Title 14-09 Ch. 08; LCSW-C included as a medical provider.

EXHIBIT 5. CMS FINAL RULE 2024 INCLUDES LCSW-C

EXHIBIT 6. AMA GUIDES TO THE EVALUATION OF PERMANENT INPAIRMENT CHAPTER 14 does not limit usage to physicians and psychologists

EXHIBIT 7. DHR FIA ACTION TRANSMITTAL 3/3/2015; addresses restraint of trade;

Exhibit 7a. House Bill-1615 (2018), **Pg.6 line 3 deleted physician and inserted "by a licensed health care provider" with independent diagnostic authority, to render an opinion on the ultimate issue of permanent impairment (DHR /FIA Form 500)).**

EXHIBIT 2- Social Work Title 19-101.pdf
Uploaded by: arthur flax
Position: FAV

HEALTH OCCUPATIONS
TITLE 19. SOCIAL WORKERS

SUBTITLE 1 DEFINITIONS; GENERAL PROVISIONS

§ 19-101. Definitions

(a) In this title the following words have the meanings indicated.

(b) "Board" means the State Board of Social Work Examiners.

(c) "Certified" means having demonstrated to the satisfaction of the Board that the individual has completed 2 years of supervised social work practice as defined in § 19–302(d) or (e) of this title.

(d) "Independent practice" means to practice bachelor social work or master social work without the requirement of supervision by another social worker.

(e) "License" means, unless the context requires otherwise, one of four categories of licenses issued by the Board authorizing an individual to practice:

(1) Bachelor social work;

(2) Master social work;

(3) Certified social work; or

(4) Certified social work–clinical.

(f) "Licensed bachelor social worker" means an individual licensed by the Board to practice bachelor social work.

(g) "Licensed certified social worker" means an individual licensed by the Board, on or before December 31, 2023, to practice certified social work.

(h) "Licensed certified social worker–clinical" means an individual licensed by the Board to practice clinical social work.

(i) "Licensed master social worker" means an individual licensed by the Board to practice master social work.

(j) "Practice bachelor social work" means to use the education and training required under § 19–302(b) of this title to:

(1) Practice social work under the supervision of a licensed certified social worker, licensed certified social worker–clinical, licensed master social worker, or licensed bachelor social worker who meets the conditions specified in regulations; or

(2) If approved by the Board in accordance with § 19–302(f) of this title, engage in independent practice.

(k) "Practice certified social work" means to use the education, training, and experience required under § 19–302(d) of this title to practice social work.

(l) "Practice clinical social work" means to use the specialized education, training, and experience required under § 19–302(e) of this title to practice social work.

(m) "Practice master social work" means to use the education and training required under § 19–302(c) of this title to:

(1) Practice social work under the supervision of a licensed certified social worker, licensed certified social worker–clinical, or licensed master social worker who meets the conditions specified in regulations; or

(2) If approved by the Board in accordance with § 19–302(f) of this title, engage in independent practice.

(n) (1) "Practice social work" means to apply the theories, knowledge, procedures, methods, and ethics derived from receiving a baccalaureate or master's degree from a program in social work that is accredited by or a candidate for accreditation by the Council on Social Work Education, or an equivalent organization approved by the Council on Social Work Education, to restore or enhance social functioning of individuals, couples, families, groups, organizations, or communities through:

(i) Assessment;

(ii) Planning;

(iii) Intervention;

(iv) Evaluation of intervention plans;

(v) Case management;

(vi) Information and referral;

(vii) Counseling that does not include diagnosis or treatment of behavioral health disorders;

(viii) Advocacy;

(ix) Consultation;

(x) Education;

(xi) Research;

(xii) Community organization;

(xiii) Development, implementation, and administration of policies, programs, and activities; or

(xiv) Supervision of other social workers as set forth in regulations.

(2) "Practice social work" includes:

(i) Counseling for alcohol and drug use and addictive behavior; and

(ii) Using technology as set forth in regulations.

(3) For an individual licensed as a master social worker, "practice social work" also includes:

(i) Supervision of other social workers if the master social worker meets the requirements set out in regulations;

(ii) Formulating a diagnosis, under the supervision of a licensed certified social worker–clinical;

(iii) Treatment of biopsychosocial conditions, under the supervision of a licensed certified social worker–clinical; and

(iv) Treatment of behavioral health disorders, including substance use disorders, addictive disorders, and mental disorders, and the provision of psychotherapy under the supervision of a licensed certified social worker–clinical.

(4) For an individual licensed as a certified social worker, "practice social work" also includes:

(i) Supervision of other social workers;

(ii) Formulating a diagnosis, under the supervision of a licensed certified social worker–clinical;

(iii) Treatment of biopsychosocial conditions, under the supervision of a licensed certified social worker–clinical; and

(iv) Treatment of behavioral health disorders, including substance use disorders, addictive disorders, and mental disorders, and the provision of psychotherapy under the supervision of a licensed certified social worker–clinical.

(5) For an individual licensed as a certified social worker–clinical, "practice social work" also includes:

(i) Supervision of other social workers;

(ii) Evaluation, diagnosis, and treatment of biopsychosocial conditions, mental and emotional conditions and impairments, and behavioral health disorders, including substance use disorders, addictive disorders, and mental disorders, as defined in § 7.5–101 of the Health – General Article;

(iii) Petitioning for emergency evaluation under Title 10, Subtitle 6 of the Health –

General Article; and

(iv) The provision of psychotherapy.

(o) "Private practice" means the provision of psychotherapy by a licensed certified social worker–clinical who assumes responsibility and accountability for the nature and quality of the services provided to a client:

(1) In exchange for direct payment or third–party reimbursement; or

(2) On a pro bono basis as determined in regulations adopted by the Board.

(p) "Psychotherapy" means the assessment and treatment of mental disorders and behavioral health disorders.

(q) "Reactivation" means the process of obtaining a license less than 5 years after the Board placed an individual on inactive status.

(r) "Reinstatement" means the process of obtaining a license less than 5 years after the Board placed an individual on nonrenewed status.

(s) "Reissuance" means the process of obtaining a license more than 5 years after the Board placed an individual on inactive or nonrenewed status.

(t) "Supervision" means a formalized professional relationship between a supervisor and a supervisee that:

(1) Provides evaluation and direction of the supervisee; and

(2) Promotes continued development of the supervisee's knowledge, skills, and abilities to provide social work services in an ethical and competent manner.

§ 19-102. Legislative policy

(a) The General Assembly finds that the profession of social work profoundly affects the lives, health, safety, and welfare of the people of this State.

(b) The purpose of this title is to protect the public by:

(1) Setting minimum qualification, education, training, and experience standards for the licensing of individuals to practice social work; and

(2) Promoting and maintaining high professional standards for the practice of social work.

§ 19-103. Scope of title

This title does not limit the right of an individual to practice a health occupation that the individual is authorized to practice under this article.

EXHIBIT 3-AG ADVICE OF COUNSEL 1-25-2024 EXPERT W

Uploaded by: arthur flax

Position: FAV

CANDACE MCLAREN LANHAM
Chief Deputy Attorney General

CAROLYN A. QUATTROCKI
Deputy Attorney General

LEONARD J. HOWIE III
Deputy Attorney General

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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

Exhibit 4-WCC TITLE 14 CH 08 LCSW-C MED PROVIDER.
Uploaded by: arthur flax
Position: FAV

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.

EXHIBIT 5- CMS Final Rule 2024 LCSW-C physical hea

Uploaded by: arthur flax

Position: FAV

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

Exhibit 6- AMA_Guides to the Eval of Permanent Imp

Uploaded by: arthur flax

Position: FAV

14.1 Principles of Assessment

14.1a Initial Considerations

Before using the information in this chapter, the *Guides'* user should become familiar with Chapters 1 and 2 and the Glossary, Chapters 1 and 2 discuss the *Guides'* purpose, applications, and methods for performing and reporting impairment evaluations in general. The Glossary provides definitions of common terms used by many specialties in impairment evaluations. It should be emphasized that the presence of a diagnosis does not necessarily suggest the patient is impaired.

Clinicians who use this chapter will generally be trained in psychiatry or psychology. Other users of this chapter should have:

- Expertise in the utilization of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.
- Expertise in the psychiatric or psychological evaluation of patients.
- Expertise in the diagnosis and treatment of mental and behavioral disorders.

14.1b Diagnosis

The goal of this chapter is to provide ratings for permanent impairment relating to M&BD. The first critical step is to make a definitive diagnosis, which should be based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, commonly known as *DSM-IV*.[1] This manual is the widely accepted classification system for mental disorders. In general, the history, signs, and symptoms of mental disorder should justify and confirm the diagnosis, which should be made according to *DSM-IV*- criteria. The diagnosis (with the associated factors of prognosis and course) will form the basis by which one assesses the severity and predicts the probable duration of the impairment.

The criteria for mental disorders include a wide range of signs, symptoms, and impairments. The *DSM-IV* calls for a multiaxial evaluation, as summarized in Table 14-1. Each of 5 axes refers to a different class of information. The first 3 axes constitute the major diagnostic categories. These include the major clinical syndromes and the conditions that are the focus of treatment (Axis I), the personality and developmental disorders (Axis II), and the physical disorders and conditions that may be relevant to understanding and managing the care of the individual (Axis III). Axis IV refers to psychosocial stressors. Axis V refers to global functional capacity and reflects the effects of the psychiatric impairments.

TABLE 14-1
Multiaxial System of the *DSM-IV-TR*[a]

Axis	Condition
I	Clinical disorders
	Other conditions that may be a focus of clinical attention
II	Personality disorders
	Mental retardation
III	General medical conditions
IV	Psychosocial and environmental problems
V	Global assessment of functioning

[a] *DSM-IV* indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*

14.1c Diagnostic Categories

Although the *DSM-IV* remains the bedrock of diagnosis in mental illness, psychiatrists and psychologists are continuously reconsidering and refining how to classify the conditions they treat. Proponents for reliable diagnostic criteria prompted contributors to the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* ***(DSM-III)*** to include specific criteria for diagnosis.[2] These criteria needed to be observable and clearly defined so they could be readily recognized by different practitioners. The criteria were then subjected to field trials. The result was a standardized diagnostic nomenclature that mental health professionals could apply to the patients they treated.

Over time the *DSM* has swelled to nearly 300 mental and behavioral disorders, and there is significant debate regarding the validity and interrater reliability of many *DSM-IV* disorders, as well as the multiaxial approach in general. One patient may meet criteria for several different disorders, and many dissimilar patients may meet criteria for the same disorder.[3] In contrast, the validity and interrater reliability of the the major mental illnesses/disorders—depression, mania, and schizophrenia—are well established.

The rapid expansion of *DSM* diagnoses has blurred the boundary where mental health ends and illness begins. According to the National Comorbidity Survey Replication, one half of Americans will meet the criteria for a *DSM-IV* disorder sometime in their life.[4] Proponents of expanding the number of *DSM* diagnoses suggest that definitions should be broad enough to include milder conditions that can cause distress or lead to more severe problems later. Others disagree, arguing that criteria should be tightened: (1) to ensure that limited resources go to those with more serious illness and (2) to avoid alienating a skeptical public who is dubious whether such a large proportion of the population truly suffers from a mental illness.[3] A useful analogy might be found in the paradigm of persons experiencing low back pain. Nearly all persons will suffer low back pain over the course of a lifetime. The vast majority of these episodes will be self-limited, will not herald ongoing low back impairment, will improve regardless of treatment, and will adapt to any intermittent or continuing symptoms.[5]

It is not the purpose of this chapter to rate impairment in all persons who may fit a *DSM-IV* diagnosis. It is understood that many conditions are common in the general population, and whether or not they are included in the *DSM-IV*, they do not require an impairment rating (eg, brief adjustment disorder, normal grief reactions).[5] Patients with severe mental illness may have a greater role impairment than a patient with a severe physical ailment.

Because the *Guides* is generally used in medicolegal settings (eg, Worker's Compensation), impairment rating in the Sixth Edition will be limited to 1 of the following diagnoses:

- *Mood* disorders, including major depressive disorder and bipolar affective disorder.
- *Anxiety* disorders, including generalized anxiety disorder, panic disorder, phobias, posttraumatic stress disorder, and obsessive compulsive disorder.
- *Psychotic* disorders, including schizophrenia.

When mental illness is profound, occupational impairment is obvious. It is more difficult to assess occupational impairment when mental illness is more subtle, complicated by the legal setting, and combined with preexisting personality factors.

Disorders that are *not* ratable in this chapter include:

- Psychiatric reaction to pain: It is inherent in the AMA *Guides* that the impairment rating for a physical condition provides for the pain associated with that impairment. *The psychological distress associated with a physical impairment is similarly included within the rating.*
- Somatoform disorders.
- Dissociative disorders.
- Personality disorders.
- Psychosexual disorders.
- Factitious disorders.
- Substance use disorders: Affective or other mental disorders due to substance abuse are *not* rated.
- Sleep disorders: Primary sleep disorders are covered in Chapter 13, the Central and Peripheral Nervous System. Many M&BD are associated with disordered sleep and should be considered as a feature of the M&BD impairment rating in this chapter.
- Dementia and delirium (covered in Chapter 13).
- Mental retardation.
- Psychiatric manifestations of traumatic brain injury (covered in Chapter 13).

The rules for using this chapter would include:

- In the presence of a mental and behavioral disorder without a physical impairment or pain impairment, utilize the methodology outlined in this chapter;
- In the event of a mental and behavioral disorder that is judged *independently compensable by the jurisdiction involved*, the mental and behavioral disorder impairment is combined with the physical impairment;
- Whenever it is specifically required by a compensation system;
- In most cases of a mental and behavioral disorder accompanying a physical impairment, the psychological issues are encompassed within the rating for the physical impairment, and the mental and behavioral disorder chapter should not be used.

14.2 Psychiatric/Psychological Evaluation

The general psychiatric or psychological evaluation involves eliciting a history, review of appropriate records, and a mental status examination. An outline of the mental status examination is summarized in Table 14-2.[6] Readers are referred to standard psychiatric textbooks for details.

There may be adjunctive psychological, neuroradiological, or laboratory testing as well. Neuroradiologic imaging is discussed further in Chapter 13, The Central and Peripheral Nervous System.

TABLE 14-2
Mental Status Examination[a]

- Appearance
- Activity
- Mood and affect; anxiety
- Speech and language
- Thought content and organization
- Perceptual disturbances
- Insight and judgment
- Neuropsychiatric functions

[a] Adapted from Leon et al.[6]

EXHIBIT 7-DHR FIA ACTION TRANSMITTAL 3-3-2015.pdf
Uploaded by: arthur flax
Position: FAV

Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**Family Investment Administration** **ACTION TRANSMITTAL**
Control Number: 15-21	**Effective Date: UPON RECEIPT** **Issuance Date: March 3, 2015**

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND CASE MANAGERS

FROM: ROSEMARY MALONE, EXECUTIVE DIRECTOR

RE: NEW MEDICAL REPORT FORM DHR/FIA 500

PROGRAMS AFFECTED: FOOD SUPPLEMENT PROGRAM (FSP), TEMPORARY CASH ASSISTANCE (TCA), REFUGEE CASH ASSISTANCE (RCA), TEMPORARY DISABILITY ASSISTANCE PROGRAM (TDAP) AND CHILD CARE SUBSIDY (CCS)

ORIGINATING OFFICE: OFFICE OF PROGRAMS

Background:

We have revised the form DHR/FIA 500 medical report, effective immediately. We have also revised the signature requirements: we will no longer make a distinction between a "health provider" and a "medical provider." Specifically, we no longer will require a medical doctor to sign the form when a licensed medical provider completes it. Another reason for the change in signature requirements is because we are no longer required to send medical reports to State Review Team to establish disability for Medical Assistance.

The revised form incorporates all information case managers need when determining disability for TCA, RCA, TDAP, and CCS applicants or recipients.

While we have streamlined the procedures for processing this form, our intent is that providers who are familiar with the clients complete the form. Additionally, while we respect the diagnoses and opinions of the professionals who complete forms, guidelines for questionable verification remain applicable. For example, a case manager may ask for follow up information if a mental health provider bases a work program exemption solely on a physical injury.

Exhibit 7a House bill 1615 (2018).pdf
Uploaded by: arthur flax
Position: FAV

HOUSE BILL 1615

O1 (8lr0539)

ENROLLED BILL

— Appropriations/Finance —

Introduced by **Delegates Valentino–Smith, Reznik, Gutierrez, Haynes, Hettleman, Jones, Krimm, Lam, Lierman, and McIntosh**

Read and Examined by Proofreaders:

_____

Proofreader.

_____

Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____M.

_____

Speaker.

CHAPTER _____

AN ACT concerning

Human Services – Temporary Disability Assistance Program

FOR the purpose of establishing the Temporary Disability Assistance Program in the Department of Human Services; requiring the Family Investment Administration to be the central coordinating and directing agency of the Program; establishing the primary purpose of the Program; requiring the Program to be administered by the local departments of social services in a certain manner; specifying the requirements for ~~eligibility for~~ entitlement to assistance under the Program; requiring an application for assistance under the Program to be made in a certain manner and include a certain medical ~~report~~ form; requiring a local department to verify that certain requirements are met~~,~~ and notify applicants of certain determinations~~, and record certain information~~; requiring local departments to determine eligibility periods for recipients based on certain information; establishing certain restrictions on the length of eligibility periods under certain circumstances; authorizing a local

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.
Italics indicate opposite chamber/conference committee amendments.

department to establish certain additional eligibility periods under certain circumstances; requiring a local department to adjust the eligibility period under certain circumstances; providing for the automatic end of a recipient's eligibility for assistance; ~~requiring local departments to determine the amount and timing of assistance in accordance with certain regulations;~~ requiring assistance to be paid to an applicant in a certain manner; requiring the monthly allowable assistance under the Program to equal a certain amount in a certain fiscal year; requiring the monthly allowable assistance under the Program to equal at least certain percentages of a certain benefit in certain fiscal years; ~~authorizing an applicant or recipient to appeal certain actions of local departments to the Administration in certain circumstances; requiring the Administration to provide certain notice and an opportunity for a hearing in certain circumstances; authorizing the Administration to initiate certain reviews and make certain investigations; requiring the Administration to make certain decisions; requiring a local department to comply with a certain decision;~~ requiring the Administration to supervise the administration of the Program~~,~~ and adopt certain regulations~~, prescribe certain forms, and take certain other actions~~; stating the intent of the General Assembly; defining certain terms; and generally relating to the Temporary Disability Assistance Program.

BY repealing and reenacting, without amendments,
Article – Human Services
Section 5–201
Annotated Code of Maryland
(2007 Volume and 2017 Supplement)

BY repealing and reenacting, with amendments,
Article – Human Services
Section 5–205(a)
Annotated Code of Maryland
(2007 Volume and 2017 Supplement)

BY adding to
Article – Human Services
Section 5–5B–01 through ~~5–5B–12~~ 5–5B–09 to be under the new subtitle "Subtitle 5B. Temporary Disability Assistance Program"
Annotated Code of Maryland
(2007 Volume and 2017 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Human Services

5–201.

There is a Family Investment Administration in the Department.

5–205.

(a) The Administration shall be the central coordinating and directing agency of all public assistance programs in the State, including:

(1) the Family Investment Program and related cash benefit programs;

(2) public assistance to adults;

(3) emergency assistance;

(4) food stamps;

(5) medical assistance eligibility determinations;

(6) the Energy Assistance Program; **[**and**]**

(7) THE TEMPORARY DISABILITY ASSISTANCE PROGRAM; AND

[(7)**] (8)** any other public assistance activities financed wholly or partly by the Administration.

SUBTITLE 5B. TEMPORARY DISABILITY ASSISTANCE PROGRAM.

5–5B–01.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "APPLICANT" MEANS AN INDIVIDUAL WHO APPLIES FOR ASSISTANCE UNDER THIS SUBTITLE.

(C) "ASSISTANCE" MEANS CASH PAYMENTS MADE TO A RECIPIENT.

(D) "ELIGIBILITY PERIOD" MEANS THE PERIOD OF TIME AN INDIVIDUAL IS ELIGIBLE FOR ASSISTANCE UNDER THIS SUBTITLE.

(E) "IMPAIRMENT" MEANS A MEDICALLY VERIFIED MENTAL OR PHYSICAL CONDITION THAT RENDERS AN INDIVIDUAL UNABLE TO WORK AT ANY OCCUPATION.

(F) "PROGRAM" MEANS THE TEMPORARY DISABILITY ASSISTANCE PROGRAM.

(G) "RECIPIENT" MEANS AN INDIVIDUAL WHO RECEIVES, OR HAS RECEIVED, ASSISTANCE UNDER THIS SUBTITLE.

5–5B–02.

(A) THERE IS A STATE–FUNDED TEMPORARY DISABILITY ASSISTANCE PROGRAM IN THE DEPARTMENT.

(B) THE PRIMARY PURPOSE OF THE PROGRAM IS TO PROVIDE ASSISTANCE TO LOW–INCOME DISABLED ADULTS WHO ARE INELIGIBLE FOR OTHER CATEGORIES OF ASSISTANCE.

(C) THE PROGRAM SHALL BE:

(1) IN EFFECT IN EACH COUNTY; AND

(2) ADMINISTERED BY THE LOCAL DEPARTMENTS IN ACCORDANCE WITH REGULATIONS THAT THE ADMINISTRATION ADOPTS.

5–5B–03.

~~(A)~~ **SUBJECT TO § 5–5B–04 OF THIS SUBTITLE, AN APPLICANT IS** ~~**ELIGIBLE FOR**~~ **ENTITLED TO ASSISTANCE UNDER THIS SUBTITLE IF THE APPLICANT IS:**

(1) A CITIZEN OF THE UNITED STATES OR A QUALIFIED ALIEN AS DETERMINED BY THE ADMINISTRATION;

(2) A RESIDENT OF THE STATE AND THE JURISDICTION SERVED BY THE LOCAL DEPARTMENT AT THE TIME OF APPLICATION;

(3) UNEMPLOYED;

(4) NOT RECEIVING ANY OTHER MEANS–TESTED CASH ASSISTANCE; AND

(5) DETERMINED, BASED ON THE MEDICAL ~~**FINDINGS**~~ **FORM REQUIRED UNDER § 5–5B–05 OF THIS SUBTITLE, TO HAVE AN IMPAIRMENT** ~~**THAT RENDERS THE APPLICANT UNABLE TO WORK FOR**~~ **THAT IS EXPECTED TO LAST AT LEAST 3 MONTHS.**

~~**(B) AN APPLICANT MAY BE ELIGIBLE FOR ASSISTANCE UNDER THIS SUBTITLE IF THE APPLICANT HAS APPLIED FOR SOCIAL SECURITY DISABILITY INSURANCE OR SUPPLEMENTAL SECURITY INSURANCE DURING THE PERIOD WHEN THE APPLICATION IS BEING PROCESSED.**~~

5–5B–04.

(A) IF AN APPLICANT HAS AN IMPAIRMENT THAT IS EXPECTED TO ~~RENDER THE APPLICANT UNABLE TO WORK FOR~~ LAST AT LEAST 12 MONTHS, THE APPLICANT SHALL:

(1) PURSUE SUPPLEMENTAL SECURITY ~~INSURANCE~~ INCOME; AND

(2) SIGN AN INTERIM PAYMENT REIMBURSEMENT AUTHORIZATION THAT:

~~1.~~ (I) GIVES THE SOCIAL SECURITY ADMINISTRATION AUTHORITY TO MAIL THE APPLICANT'S PAYMENTS TO THE DEPARTMENT OR THE LOCAL DEPARTMENT; AND

~~2.~~ (II) AUTHORIZES THE DEPARTMENT OR LOCAL DEPARTMENT TO DEDUCT FROM THE PAYMENTS AN AMOUNT EQUAL TO THE ASSISTANCE GRANTED THE APPLICANT UNDER THIS SUBTITLE.

(B) A RECIPIENT WHO IS OTHERWISE ELIGIBLE UNDER THIS SUBTITLE MAY NOT RECEIVE ASSISTANCE FOR MORE THAN 9 MONTHS IN A 36–MONTH PERIOD, UNLESS THE RECIPIENT:

(1) HAS BEEN CERTIFIED AS MEDICALLY DISABLED BY A LICENSED HEALTH CARE PROVIDER ~~IN A MANNER PRESCRIBED BY THE ADMINISTRATION~~ ON THE MEDICAL FORM REQUIRED UNDER § 5–5B–05 OF THIS SUBTITLE; AND

(2) HAS A PENDING APPLICATION FOR SUPPLEMENTAL SECURITY ~~INSURANCE~~ INCOME THAT HAS NOT BEEN WITHDRAWN OR FINALLY DENIED.

5–5B–05.

(A) AN APPLICATION FOR ASSISTANCE UNDER THIS SUBTITLE SHALL BE MADE:

(1) TO THE LOCAL DEPARTMENT OF THE COUNTY WHERE THE APPLICANT RESIDES; AND

(2) IN THE FORM AND MANNER THAT THE ADMINISTRATION REQUIRES.

(B) AN APPLICATION FOR ASSISTANCE UNDER THIS SUBTITLE SHALL INCLUDE A MEDICAL ~~REPORT~~ FORM THAT:

(1) CONTAINS ~~A STATEMENT ON THE NATURE~~ THE NAME AND ESTIMATED DURATION OF THE APPLICANT'S IMPAIRMENT; AND

(2) IS SIGNED BY ~~AN EXAMINING PHYSICIAN~~ A LICENSED HEALTH CARE PROVIDER.

5–5B–06.

(A) IN DETERMINING ~~THAT~~ WHETHER AN APPLICANT QUALIFIES FOR ASSISTANCE UNDER THIS SUBTITLE, THE LOCAL DEPARTMENT SHALL ~~VERIFY THAT:~~

~~(1) THE APPLICANT'S MEDICAL REPORT INDICATES THE APPLICANT HAS AN IMPAIRMENT PREVENTING THE APPLICANT FROM WORKING FOR AT LEAST 3 MONTHS; AND~~

~~(2)~~ EVALUATE WHETHER THE APPLICANT MEETS THE ~~OTHER~~ CRITERIA LISTED UNDER § 5–5B–03 OF THIS SUBTITLE.

(B) THE LOCAL DEPARTMENT SHALL NOTIFY THE APPLICANT OF ITS DETERMINATION UNDER SUBSECTION (A) OF THIS SECTION.

~~(C) ON RECEIPT OF AN APPLICATION FOR ASSISTANCE UNDER THIS SUBTITLE, THE LOCAL DEPARTMENT SHALL MAKE A RECORD OF:~~

~~(1) THE CIRCUMSTANCES OF THE APPLICANT;~~

~~(2) THE FACTS SUPPORTING THE APPLICATION; AND~~

~~(3) ANY OTHER INFORMATION THAT THE ADMINISTRATION REQUIRES BY REGULATION.~~

5–5B–07.

(A) THE LOCAL DEPARTMENT SHALL DETERMINE AN ELIGIBILITY PERIOD FOR A RECIPIENT BASED ON THE ESTIMATED DURATION OF THE IMPAIRMENT INDICATED IN THE MEDICAL ~~REPORT PROVIDED~~ FORM REQUIRED UNDER § 5–5B–05 OF THIS SUBTITLE.

(B) THE ELIGIBILITY PERIOD DETERMINED BY THE LOCAL DEPARTMENT:

(1) MAY BE LESS THAN THE ESTIMATED RECOVERY TIME INDICATED ~~IN~~ ON THE MEDICAL ~~REPORT~~ FORM; AND

(2) MAY NOT EXCEED THE ESTIMATED RECOVERY TIME INDICATED ~~IN~~ ON THE MEDICAL ~~REPORT~~ FORM.

(C) IF A LOCAL DEPARTMENT DETERMINES THAT A RECIPIENT'S ELIGIBILITY PERIOD IS AT LEAST 3 MONTHS, BUT LESS THAN 12 MONTHS, THE RECIPIENT SHALL BE ELIGIBLE FOR ASSISTANCE FOR NOT MORE THAN 9 MONTHS IN A 36–MONTH PERIOD.

(D) (1) IF THE LOCAL DEPARTMENT DETERMINES THAT A RECIPIENT IS UNLIKELY TO RECOVER IN LESS THAN 12 MONTHS, THE RECIPIENT SHALL BE ELIGIBLE FOR ASSISTANCE FOR NOT MORE THAN 12 MONTHS IF THE RECIPIENT:

(I) PURSUES SUPPLEMENTAL SECURITY ~~INSURANCE~~ INCOME; AND

(II) OTHERWISE REMAINS ELIGIBLE FOR ASSISTANCE UNDER THIS SUBTITLE.

(2) THE LOCAL DEPARTMENT MAY ESTABLISH ADDITIONAL ELIGIBILITY PERIODS, EACH NOT EXCEEDING12 MONTHS, IF THE RECIPIENT:

(I) REAPPLIES FOR ASSISTANCE UNDER THIS SUBTITLE;

(II) MAINTAINS ELIGIBILITY; AND

(III) CONTINUES TO PURSUE A SUPPLEMENTAL SECURITY ~~INSURANCE~~ INCOME CLAIM.

(3) THE LOCAL DEPARTMENT SHALL ADJUST THE ELIGIBILITY PERIOD FOR A RECIPIENT TO BE NOT MORE THAN 9 MONTHS IN A 36–MONTH PERIOD IF THE RECIPIENT:

(I) WITHDRAWS THE RECIPIENT'S APPLICATION FOR SUPPLEMENTAL SECURITY ~~INSURANCE~~ INCOME; OR

(II) IS DENIED THE SUPPLEMENTAL SECURITY ~~INSURANCE~~ INCOME CLAIM.

(E) UNLESS A RECIPIENT REAPPLIES FOR ASSISTANCE AND THE LOCAL DEPARTMENT ESTABLISHES AN ADDITIONAL ELIGIBILITY PERIOD, A RECIPIENT'S ELIGIBILITY FOR ASSISTANCE UNDER THIS SUBTITLE WILL AUTOMATICALLY END AT THE END OF THE ELIGIBILITY PERIOD ESTABLISHED BY THE LOCAL DEPARTMENT.

(F) IF A RECIPIENT IS ELIGIBLE FOR ANY PORTION OF A MONTH, THE RECIPIENT SHALL BE ELIGIBLE FOR THE ENTIRE MONTH.

5–5B–08.

~~**(A) THE LOCAL DEPARTMENT SHALL, IN ACCORDANCE WITH REGULATIONS THAT THE ADMINISTRATION ADOPTS, DETERMINE THE AMOUNT OF ASSISTANCE AND THE DATE ON WHICH THE ASSISTANCE WILL BEGIN.**~~

~~**(B) ASSISTANCE SHALL BE PAID TO THE APPLICANT MONTHLY OR AS THE ADMINISTRATION OTHERWISE DETERMINES.**~~

~~**5–5B–09.**~~

(A) THE GOVERNOR SHALL PROVIDE SUFFICIENT FUNDS IN THE BUDGET TO ENSURE THAT THE VALUE OF THE MAXIMUM MONTHLY ALLOWABLE ASSISTANCE UNDER THE PROGRAM IS EQUAL TO AT LEAST:

(1) FOR FISCAL YEAR 2020, ~~EQUAL TO 75% OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2020~~ $215;

(2) FOR FISCAL YEAR 2021, ~~EQUAL TO 85%~~ ~~72%~~ *74%* OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2021; ~~AND~~

(3) FOR FISCAL YEAR 2022 ~~AND EACH FISCAL YEAR THEREAFTER, EQUAL TO, 75%~~ *78%* OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN ~~THAT FISCAL YEAR~~ FISCAL YEAR 2022;

(4) FOR FISCAL YEAR 2023, ~~78%~~ *82%* OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2023;

(5) FOR FISCAL YEAR 2024, ~~81%~~ *86%* OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2024;

(6) FOR FISCAL YEAR 2025, ~~84%~~ *90%* OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2025;

(7) FOR FISCAL YEAR 2026, ~~87%~~ *94%* OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2026; *AND*

(8) FOR FISCAL YEAR 2027 *AND EACH YEAR THEREAFTER*, ~~90%~~ *100%* OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM ~~IN FISCAL YEAR 2027;~~ *FOR THAT FISCAL YEAR.*

~~**(9) FOR FISCAL YEAR 2028, 93% OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2028;**~~

~~**(10) FOR FISCAL YEAR 2029, 96% OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM IN FISCAL YEAR 2029; AND**~~

~~**(11) FOR FISCAL YEAR 2030 AND EACH YEAR THEREAFTER, 100% OF THE MONTHLY ALLOWABLE BENEFIT FOR A ONE–PERSON HOUSEHOLD RECEIVING TEMPORARY CASH ASSISTANCE THROUGH THE FAMILY INVESTMENT PROGRAM FOR THAT FISCAL YEAR.**~~

(B) ASSISTANCE SHALL BE PAID TO THE APPLICANT MONTHLY.

~~**5–5B–10.**~~

~~**(A) AN APPLICANT OR A RECIPIENT MAY APPEAL TO THE ADMINISTRATION IF THE LOCAL DEPARTMENT:**~~

~~**(1) DOES NOT ACT ON AN APPLICATION WITHIN A REASONABLE TIME;**~~

~~**(2) DENIES AN APPLICATION WHOLLY OR PARTLY; OR**~~

~~**(3) MODIFIES OR CANCELS A GRANT OF ASSISTANCE.**~~

~~**(B) (1) THE APPEAL SHALL BE FILED IN THE MANNER AND FORM THAT THE ADMINISTRATION REQUIRES.**~~

~~**(2) THE ADMINISTRATION SHALL GIVE THE APPLICANT OR RECIPIENT REASONABLE NOTICE AND AN OPPORTUNITY FOR A HEARING ON THE APPEAL.**~~

~~(C) (1) ON ITS OWN MOTION, THE ADMINISTRATION MAY:~~

~~(I) REVIEW ANY DECISION OF A LOCAL DEPARTMENT; AND~~

~~(II) CONSIDER AN APPLICATION ON WHICH THE LOCAL DEPARTMENT HAS NOT MADE A DECISION WITHIN A REASONABLE TIME.~~

~~(2) THE ADMINISTRATION:~~

~~(I) MAY MAKE ANY ADDITIONAL INVESTIGATION IT CONSIDERS NECESSARY; AND~~

~~(II) SHALL MAKE ANY DECISION ON THE GRANTING OF ASSISTANCE AND THE AMOUNT OF ASSISTANCE IT CONSIDERS JUSTIFIED IN ACCORDANCE WITH THIS SUBTITLE.~~

~~(3) ON REQUEST, THE ADMINISTRATION SHALL GIVE AN APPLICANT OR RECIPIENT AFFECTED BY A DECISION MADE UNDER PARAGRAPH (2) OF THIS SUBSECTION REASONABLE NOTICE AND AN OPPORTUNITY FOR A HEARING.~~

~~(D) (1) A DECISION OF THE ADMINISTRATION UNDER THIS SECTION IS FINAL AND BINDING ON THE LOCAL DEPARTMENT.~~

~~(2) THE LOCAL DEPARTMENT SHALL COMPLY WITH A DECISION OF THE ADMINISTRATION UNDER THIS SECTION.~~

~~5–5B–11.~~ **5–5B–09.**

THE ADMINISTRATION SHALL:

(1) SUPERVISE THE ADMINISTRATION OF THE PROGRAM UNDER THIS SUBTITLE BY THE LOCAL DEPARTMENTS; AND

(2) ADOPT REGULATIONS NECESSARY OR DESIRABLE TO CARRY OUT THIS SUBTITLE~~, INCLUDING REGULATIONS TO ESTABLISH ELIGIBILITY REQUIREMENTS AND ANY OTHER REQUIREMENTS NOT SET FORTH IN THIS SUBTITLE;~~

~~(3) PRESCRIBE THE FORM OF AND SUPPLY TO THE LOCAL DEPARTMENTS ANY FORMS THE ADMINISTRATION CONSIDERS NECESSARY OR DESIRABLE; AND~~

~~(4) TAKE ANY OTHER ACTION NECESSARY OR DESIRABLE TO CARRY OUT THIS SUBTITLE.~~

~~5–5B–12.~~

~~EACH LOCAL DEPARTMENT SHALL:~~

~~(1) ADMINISTER THIS SUBTITLE IN ITS COUNTY IN ACCORDANCE WITH THE REGULATIONS THE ADMINISTRATION ADOPTS; AND~~

~~(2) REPORT TO THE ADMINISTRATION AS THE ADMINISTRATION DIRECTS~~.

SECTION 2. AND BE IT FURTHER ENACTED, That it is the intent of the General Assembly that the eligibility requirements for the Temporary Disability Assistance Program, codified under Section 1 of this Act and previously established under COMAR 07.03.05, are not made more restrictive than at the time this Act is enacted.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2018.

Approved:

_____

Governor.

_____

Speaker of the House of Delegates.

_____

President of the Senate.

Exhibit 8-blue cross testing.pdf
Uploaded by: arthur flax
Position: FAV

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

HB1210 - Senate_FAV_GWSCSW_Workers' Comp - Eval. o

Uploaded by: Christine Krone

Position: FAV

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

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Chief Deputy Attorney General

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LEONARD J. HOWIE III
Deputy Attorney General

CHRISTIAN E. BARRERA
Chief Operating Officer

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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

HB1210 Testimony.pdf
Uploaded by: Darlyn McLaughlin
Position: FAV

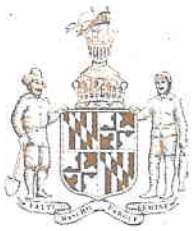
SUSAN K. MCCOMAS
Legislative District 34B
Harford County

DEPUTY MINORITY WHIP

Appropriations Committee
Subcommittees
Public Safety and Administration
Oversight Committee on Pensions

Joint Committees
Administrative, Executive, and Legislative Review
Legislative Ethics

Past President
Women Legislators of Maryland



Annapolis Office
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The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

HB1210 – Worker's Compensation – Evaluation of Permanent Impairments – Licensed Certified Social Worker – Clinical

Currently only a licensed psychologist or qualified physician may perform the required evaluations and generate the related report that must occur in connection with a Worker's Compensation claim that involves permanent impairments to behavior and mental disorders. HB 1210 authorizes a licensed certified social worker-clinical (LCSW-C) to perform these evaluations and provide the related comprehensive report to the Worker's Compensation Commission. In doing so the licensed certified social worker-clinical must comply with the requirements of expert witnesses as set forth by the Worker's Compensation Commission.

HB1210 expands the practice area of these highly qualified and trained mental health providers, LCSW-C, allowing them to evaluate only those injuries that are related to mental and behavior health issues. Certified social workers have completed two years of supervised social work practice. A licensed certified social worker-clinical (LCSW-C) is an individual licensed by the State Board of Social Work Examiners to practice clinical social work. Practicing social work means to apply the theories, knowledge, procedures, methods, and ethics obtained through the completion of a bachelor's or master's degree from an accredited program in social work or the equivalent approved by the Council on Social Work Education.

Through the passing of HB 1210, these professionals are enabled to enhance social functioning of individuals suffering permanent mental or behavioral impairments.

PLEASE ENTER A FAVORABLE REPORT FOR HB1210.

NASW Maryland - 2025 HB 1210 FAV - Social Workers-
Uploaded by: Karessa Proctor
Position: FAV

5750 Executive Drive, Suite 100, Baltimore, MD 21228
410.788.1066 » nasw-md.org

NASW MARYLAND CHAPTER
National Association of Social Workers

Senate Finance Committee
March 20, 2025

House Bill 1210
Workers' Compensation - Evaluation of Permanent Impairments –
Licensed Certified Social Worker-Clinical

***** Support*****

Dear Chair Wilson, Vice Chair Crosby, and Members of the Committee,

The Maryland Chapter of the National Association of Social Workers (NASW-MD) represents over 2,700 social workers across the state. We are writing to express our strong support for House Bill 1210, which pertains to the evaluation of permanent impairments under the Workers' Compensation system.

This legislation specifically addresses the role of the Licensed Certified Social Worker-Clinical (LCSW-C) in evaluating, diagnosing, and treating mental and emotional disorders, including substance use disorders and behavioral health conditions, as part of the Workers' Compensation process.

The Health Occupations Article, Title 19-101, Section (5)(ii), authorizes the LCSW-C to independently evaluate and diagnose mental health conditions and impairments, provide treatment, and serve as an expert witness in legal proceedings. Additionally, the Labor and Employment Article and COMAR Title 14, Subtitle 09, Chapter 08 acknowledge the full scope of practice of the LCSW-C, including the authority to conduct evaluations, **make impairment determinations,** and provide medical case management.

In Maryland, there is a shortage of qualified mental health professionals capable of conducting comprehensive evaluations and providing appropriate care for injured workers. **LCSW-Cs are well-trained to address mental and emotional impairments,** and their role in medical case management ensures effective collaboration with other healthcare providers. Furthermore, LCSW-Cs are recognized as healthcare providers under both state and federal statutes, and their qualifications include the authority to authorize sick leave and determine Temporary Total Disability for injured workers.

(over)

5750 Executive Drive, Suite 100, Baltimore, MD 21228
410.788.1066 » nasw-md.org

NASW MARYLAND CHAPTER
National Association of Social Workers

Given the critical role that LCSW-Cs play in supporting the mental health needs of injured workers, NASW-MD fully supports the inclusion of the LCSW-C in Section 9-721(c) as an expert witness, in accordance with Workers' Compensation Commission regulations.

We urge the Committee to give a favorable report to HB 1210.

Sincerely,

Karessa Proctor, BSW, MSW

Executive Director
National Association of Social Workers - Maryland Chapter

HB 1210 - FIN - BSWE - support.docx.pdf
Uploaded by: Maryland Department of Health /Office of Governmen oga
Position: FAV

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Ryan Moran, DrPH, MHSA, Acting Secretary

Maryland Board of Social Work Examiners
4201 Patterson Ave
Baltimore, MD 21215

March 20, 2025

The Honorable Pamela Beidle
Chair, Finance Committee
3 East Senate Miller Office Building
11 Bladen Street
Annapolis, MD 21401-1991

RE: HB 1210 Workers Compensation – Evaluation of Permanent Impairment- Licensed Certified Social Worker-Clinical – Letter of Support

Dear Chair Beidle and Committee Members:

The Board of Social Work Examiners (BSWE) is writing this letter in support of HB 1210. The Licensed Certified Social Worker – Clinical (LCSW-C) is the highest independent level of clinical social work licensure in Maryland. The scope of practice for an LCSW-C includes the ability to *evaluate, diagnose and treat biopsychosocial conditions, mental and emotional conditions and impairments, and mental disorders as defined in Health-General Article, §10-101(f), Annotated Code of Maryland.*

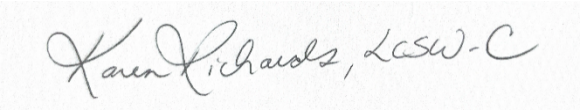
Currently, the LCSW-C is authorized to evaluate and treat the injured worker as a part of the treatment process in a Workers Compensation case. However, they have not been able to render an opinion on "permanent impairment." This legislation would give LCSW-Cs the opportunity to be qualified as an "Expert Witness" in conducting evaluations and rendering a decision of permanent impairment in the case of Mental or Emotional Disorders, Conditions, or Impairments.

Enacting this legislation will encourage LCSW-Cs to engage in additional training and certifications to expand their scope of practice to not only treat injured workers but to also serve

as expert witnesses. This will elevate their status as evaluators of individuals who have suffered permanent mental health impairments. Due to the shortage of qualified mental health care practitioners, this legislation would benefit both social workers and the stakeholders involved in the Workers Compensation field.

For these reasons, the Board of Social Work Examiners requests a favorable vote on HB 1210. If you would like to discuss this further, please contact me at 410-740-4722 or at karen.richards2@maryland.gov.

Respectfully,



Karen Richards, LCSW-C
Executive Director

The opinion of the Board expressed in this document do not necessarily reflect that of the Department of Health or the Administration.

HB1210_MAJ_FAV
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Position: FAV

2025 POSITION PAPER

HB 1210

WORKERS' COMPENSATION – EVALUATION OF PERMANENT IMPAIRMENTS – LICENSED CERTIFIED SOCIAL WORKER - CLINICAL

FAVORABLE

Currently, only licensed psychiatrists or psychologists are authorized to conduct the necessary evaluations and generate the requisite reports in support of an injured worker's claim for permanent behavioral or mental disorder disability benefits. In the context of permanent mental health impairments, the Maryland Association of Justice (MAJ) supports the expansion of this authority to include Licensed Certified Social Workers—Clinical (LCSW-Cs), recognizing their professional qualifications and ability to contribute meaningfully to the evaluation process.

In order to pursue a claim for permanent disability benefits, whether arising from physical or mental injury, an injured worker is required to undergo a formal impairment evaluation. Specifically for mental health impairment evaluations, workers are currently required to seek assessments from a licensed psychiatrist or psychologist, despite a significant shortage of available providers. These evaluations, which are necessary before the declaration of a permanent injury, are vital to ensure that injured workers receive fair and timely determinations of their permanent impairment. Expanding the scope of eligible evaluators to include LCSW-Cs, who are already trained and qualified to conduct impairment evaluations, would dramatically increase the pool of providers, thereby enhancing access to necessary services for injured workers across the state. This expansion is both a pragmatic and equitable solution to meet the growing demand for qualified mental health evaluators, ultimately benefiting injured workers, employers, and the broader community.

The Maryland Association for Justice urges a FAVORABLE Report on HB1210

About Maryland Association for Justice

The Maryland Association for Justice (MAJ) represents over 1,250 trial attorneys throughout the state of Maryland. MAJ advocates for the preservation of the civil justice system, the protection of the rights of consumers and the education and professional development of its members.

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HB 1210_Senate Hearing_Chesapeake-IWIF Testimony_s
Uploaded by: Lyndsey Meninger
Position: UNF

Senate Finance Committee
March 20, 2025

Testimony of Chesapeake Employers' Insurance Company and Injured Workers' Insurance Fund in Opposition to House Bill 1210, being heard in the Senate Finance Committee

House Bill 1210, being heard in the Senate Finance Committee, proposes to authorize a licensed certified social worker–clinical to provide evaluation services for workers' compensation claims related to permanent impairments involving a behavioral or mental disorder under Labor and Employment, § 9-721.

Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund have significant concerns regarding the proposal for licensed certified social workers–clinical to provide evaluation services currently performed exclusively by physicians, psychologists, and psychiatrists.

Under Labor and Employment § 9-721, only physicians or psychologists are authorized to provide permanent impairment ratings for workers' compensation evaluations. Additionally, COMAR 14.09.09.03 extends psychiatric impairment evaluations to psychiatrists. Given the long-standing practice of having only physicians, psychologists, or psychiatrists perform these ratings, Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund are averse to allowing non-physicians, psychologists, or psychiatrists to conduct these evaluations. These evaluations must adhere to the standards set forth by the American Medical Association's "Guide to the Evaluations of Permanent Impairment," which have traditionally been completed by the aforementioned professionals.

Of particular importance, allowing non-doctors to provide permanent impairment ratings establishes a precedent that could potentially compromise the quality and consistency of these critical evaluations. Additionally, should House Bill 1210 pass, although Labor and Employment § 9-721 may permit a licensed certified social worker–clinical to perform ratings, it is likely that these ratings would not be upheld at the appellate level for various reasons, including potential questions about the evaluator's qualifications and the consistency of the evaluations with established medical standards.

Due to this significant departure from established law and practice, Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund respectfully oppose House Bill 1210, as being heard in the Senate Finance Committee.

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Position: UNF

American Property Casualty Insurance Association
INSURING AMERICA apci.org

Testimony of

American Property Casualty Insurance Association (APCIA)

Senate Finance Committee

House Bill 1210 - Workers' Compensation –Evaluation of Permanent Impairments– Licensed Social Workers

March 20,2025

Unfavorable

The American Property Casualty Insurance Association (APCIA) is a national trade organization whose members write approximately 67% of the U.S. property and casualty insurance market, including 90% percent of Maryland's workers' compensation market. APCIA appreciates the opportunity to provide written comments in opposition to House Bill 1210.

While APCIA does not object to permitting certain licensed social workers to provide vocational rehabilitation services under the workers' compensation law. APCIA **does object** to authorizing a licensed certified social worker-clinical to evaluate the mental or behavioral portion of a permanent impairment involving a behavioral or mental disorder. Consistent with current law in Maryland and other states, it is widely accepted that this type of evaluation should only be conducted by **licensed psychologists and qualified physicians**.

For instance, legislation enacted in California in 2022 – which otherwise authorizes licensed clinical social workers (LCSWs) to furnish certain types of *treatment* to workers' compensation claimants – pointedly **"does not authorize"** LCSWs to **"determine disability"** for either those claimants or unemployment claimants. See Section 3209.11 of the California Labor Code

For these reasons, APCIA urges the Committee to provide an unfavorable report on House Bill 1210.

Nancy J. Egan,

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