

EXHIBIT 1 AG Advice of Counsel 4-22-2024 EXPERT WI

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Position: FAV

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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).

January 25, 2024

Page 2

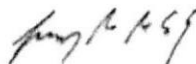
Maryland Rule 5-702 addresses the admissibility of expert testimony in State court proceedings. The rule allows a trial court to admit expert testimony “in the form of an opinion or otherwise, if the court determines that the testimony will assist the trier of fact to understand the evidence or to determine 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

OP: H: 1/25/24 @ CAG. State MD. ^{US} ~~MD~~

Exhibit 3- CMS Final Rule 2024 LCSW-C physical hea

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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.

~~X~~ 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 ~~X~~ 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 4- (OTHER) AMA 4TH ED GUIDES TO THE EVALU

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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*

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

* 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 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.⁵ 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. It is understood that many conditions are common to 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).⁶ 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 14-2.⁷ Readers are referred to standard psychiatric textbooks for details.

There may be adjunctive psychological, neuro-radiological, or laboratory testing as well. Neuro-radiologic imaging is discussed further in Chapter 13, The Central and Peripheral Nervous System.

TABLE 14-2
Mental Status Examination*

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

* Adapted from Leon et al.⁷

21 TH ED



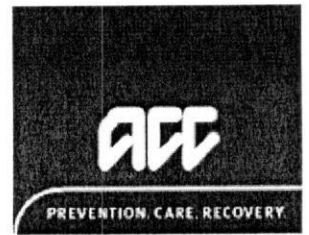
Chapter 14

Chapter 14

EXHIBIT 5 -ACC GUIDES TO THE EVAL OF PERMANENT IMP

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Position: FAV



The ACC User Handbook to the AMA "Guides to the Evaluation of Permanent Impairment" 4th Edition

Also known as "The ACC User Handbook to AMA4"

Mental and behavioural

ACC policy

The Accident Insurance Act 1998 describes mental injury as a clinically significant behavioural, cognitive, or psychological dysfunction.

ACC covers mental injury in the following situations:

- ♦ Sexual abuse⁴ from which mental injury has arisen; and
- ♦ Cases where mental injury arises from physical injury. (To be covered, the mental injury must arise from the physical injury itself, not the circumstances within which the injury was sustained.)

When a claimant with mental injury cover seeks entitlement, ACC's policy is to confirm by psychiatric assessment that the claimant is suffering a mental injury as diagnosable by DSM IV (chapter 14).

Note: Mental injury assessments are only to be done by specially trained assessors.

General approach

For independence allowance and lump sums, assessment of mental injury is based on the four functional categories set out in AMA4, which are:

- Activities of daily living
- Social functioning
- Concentration, persistence, and pace
- Adaptation, decompensation

Notes:

- ♦ As with physical injuries, the focus of the impairment rating is on impairment of the individual's independence.
- ♦ For assistance with range finding within a class, see page 9 of this document and the examples starting on pages 56. For assistance with apportionment, see page 10.

As AMA4 doesn't provide a specific assessment tool or rating system, use the method described below. (Don't use chapter 4 of AMA4.)

Assessment process

The assessment process for mental injury is as follows:

Step	Description	Where documented
1	Interview the claimant	Page 34 of this document
2	Rate the functional categories (as listed above)	Page 36 of this document
3	Rate the overall impairment	Page 40 of this document

In addition, the report format is discussed on page 41 of this document.

4. Note that ACC prefers the term "sensitive issue".

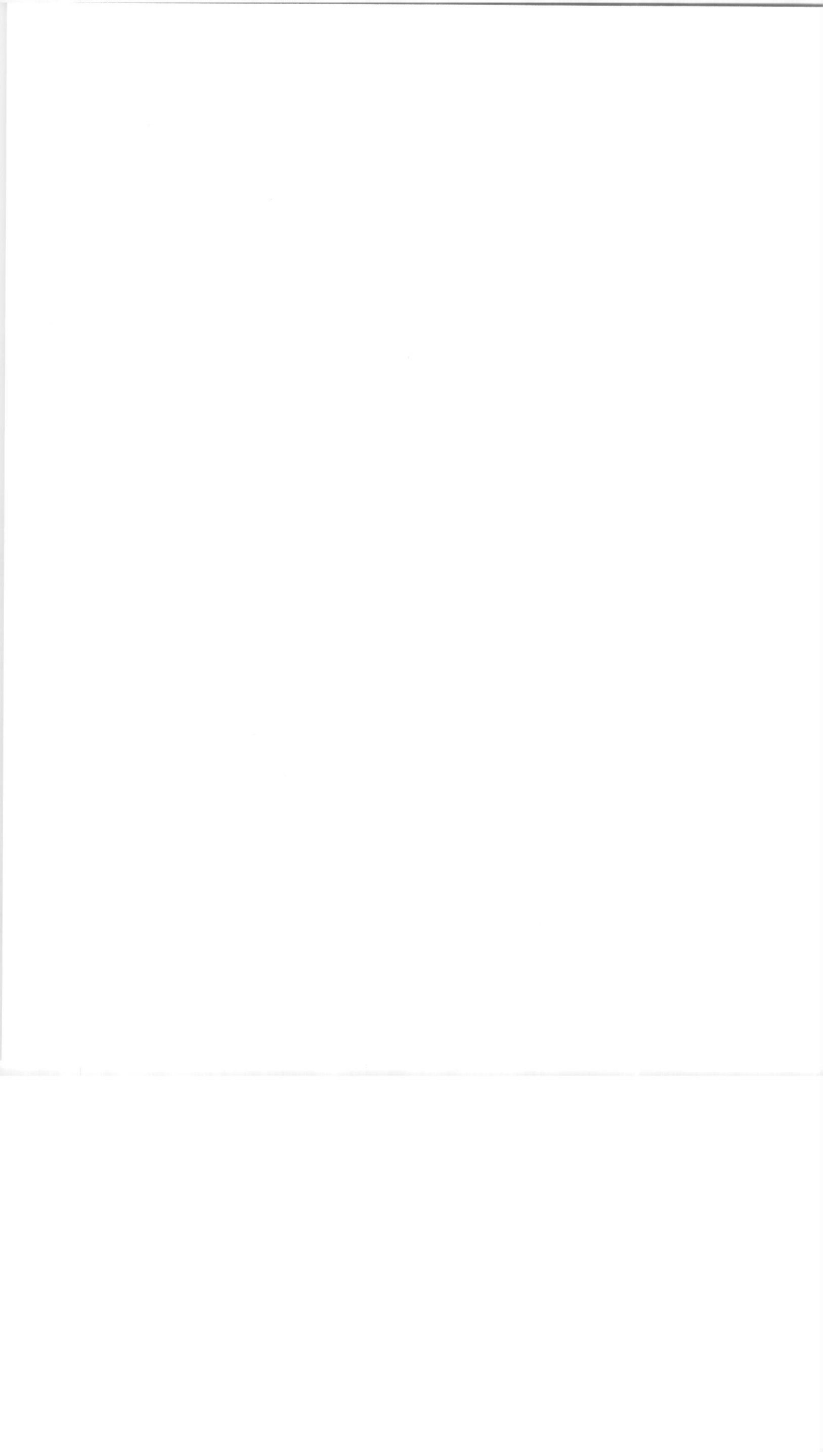
Interview the claimant

Topic	Checklist
Current personal circumstances	<ul style="list-style-type: none"> ♦ Marital status ♦ Living arrangement ♦ Partner (including their occupation) ♦ Children ♦ Occupation (or, how they fill in the day) ♦ Finances (security, in debt?)
Personal history	<ul style="list-style-type: none"> ♦ Childhood ♦ Milestones ♦ Parents (relationship, occupation, treatment of children) ♦ School and work history (self, siblings, parents) ♦ Relationships
Medical history	<ul style="list-style-type: none"> ♦ Current medication ♦ Psychiatric history ♦ Drugs, alcohol, forensic ♦ Significant medical conditions (hospital, prolonged medication)
Mental status examination	<ul style="list-style-type: none"> ♦ Appearance ♦ Behaviour (normal, agitated, retarded, cooperative, appropriate) ♦ Attitude (rapport, eye contact, frank, friendly, hostile, guarded) ♦ Talk (monotone, limited, verbose, pressured, derail, circumlocution) ♦ Thought (psychotic, manic, depressed) ♦ Affect ♦ Mood (manic, depressed, angry, anxious, suspicious, euthymic, irritability, panic attacks, suicide, confidence, self esteem)
Activities for daily living (ADL)	<ul style="list-style-type: none"> ♦ Self care ♦ Communication ♦ Travel (able to drive car or use public transport) ♦ Sexual ♦ Development and maintenance of close relationship ♦ Shopping (memory, handling money, need assistance) ♦ Eating ♦ Sleep ♦ Maintain residence ♦ Hobbies, music, video, TV, reading, handicraft, garden
Social functioning	<ul style="list-style-type: none"> ♦ Able to maintain social norms. Disinhibition. ♦ Gets on with neighbours, shopkeepers, co-workers, etc ♦ Circle of friends (visit them, have visitors) ♦ Initiates social contacts ♦ Goes out to social functions ♦ Groups (sports, church, etc) ♦ Cooperative and considerate ♦ Socially responsible (care for others) ♦ Negotiation and compromise

Topic	Checklist																
Concentration, persistence, and pace	<ul style="list-style-type: none"> ♦ Task completion at home or work ♦ Planning and organising ♦ Decisions ♦ Judgement ♦ Bank account, budget ♦ Concentration ♦ Folstein's (see below). Only use if suspected decrease in cognition. 																
	Folstein's mini mental-status exam																
	Orientation	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Year, season, date, day, month</td> <td style="width: 50%; text-align: right;">5</td> </tr> <tr> <td>Country, city, suburb, PM, deputy PM</td> <td style="text-align: right;">5</td> </tr> </table>	Year, season, date, day, month	5	Country, city, suburb, PM, deputy PM	5											
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	Registration	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Ball, flag, Tree</td> <td style="width: 50%; text-align: right;">3</td> </tr> <tr> <td colspan="2">Get to repeat once (tests attention and registration)</td> </tr> </table>	Ball, flag, Tree	3	Get to repeat once (tests attention and registration)												
	Ball, flag, Tree	3															
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	Calculation	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">100-7=93, 86, 79, 72, 65</td> <td style="width: 50%; text-align: right;">5</td> </tr> <tr> <td colspan="2">OR: Spell "world" backwards (= "dlrow")</td> </tr> <tr> <td colspan="2">Tests attention and concentration</td> </tr> </table>	100-7=93, 86, 79, 72, 65	5	OR: Spell "world" backwards (= "dlrow")		Tests attention and concentration										
	100-7=93, 86, 79, 72, 65	5															
	OR: Spell "world" backwards (= "dlrow")																
	Tests attention and concentration																
	Recall	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Ball, flag, tree (up to 6 tries)</td> <td style="width: 50%; text-align: right;">3</td> </tr> <tr> <td colspan="2">Tests short-term memory</td> </tr> </table>	Ball, flag, tree (up to 6 tries)	3	Tests short-term memory												
	Ball, flag, tree (up to 6 tries)	3															
	Tests short-term memory																
Language	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Name simple objects (pencil, watch)</td> <td style="width: 50%; text-align: right;">2</td> </tr> <tr> <td colspan="2">Repeat (no ifs, ands, or buts). One try.</td> </tr> <tr> <td colspan="2">"Take paper in right hand, fold in half, and place on desk" (Tests ability to follow simple three-step instruction)</td> </tr> <tr> <td colspan="2">Read, "close your eyes", and follow instruction</td> </tr> <tr> <td colspan="2">Write a sentence (with verb and noun)</td> </tr> <tr> <td colspan="2">Copy design (intersecting pentagons)</td> </tr> <tr> <td colspan="2">Must have all five angles present</td> </tr> <tr> <td colspan="2">TOTAL</td> </tr> </table>	Name simple objects (pencil, watch)	2	Repeat (no ifs, ands, or buts). One try.		"Take paper in right hand, fold in half, and place on desk" (Tests ability to follow simple three-step instruction)		Read, "close your eyes", and follow instruction		Write a sentence (with verb and noun)		Copy design (intersecting pentagons)		Must have all five angles present		TOTAL	
	Name simple objects (pencil, watch)	2															
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	Write a sentence (with verb and noun)																
	Copy design (intersecting pentagons)																
Must have all five angles present																	
TOTAL																	
Score = 22/30: Suspect cognitive impairment																	
Score = 17/30: Definite cognitive impairment																	
For further information, see:																	
<ul style="list-style-type: none"> ▫ Folstein, Folstein & McHugh, Journal of Psychiatric Research 1975 Vol 12 pp 189-198 ▫ International Psychogeriatrics 1997 Vol 9, Supplement 1 pp 87-94 																	
Adaption /decomposition	<ul style="list-style-type: none"> ♦ What causes stress? <ul style="list-style-type: none"> ▫ Unexpected change in routine ▫ Conflict ▫ Dealing with authority figures (bank, ACC, employer) ▫ Major life change (death, divorce, changing jobs) ♦ How does stress manifest? <ul style="list-style-type: none"> ▫ Nil noticeable response ▫ Withdraw socially ▫ Impairment of home role ▫ Impairment of work role (still attending?) ▫ Mood change (irritable, angry, depressed, anxious) ♦ How is it managed? <ul style="list-style-type: none"> ▫ Take in stride (that is, adapts to stress) ▫ Walk, bath, music (that is, copes with stress) ▫ Alcohol, drugs ▫ Counsellor, help line, friend ▫ Doctor, medication ▫ Psychiatric help <p>EFFECTS: "I've nearly finished with the questions I want to ask, and we've covered a lot of ground. But I'd like you to tell me how you think the sexual abuse you suffered still affects you today."</p>																

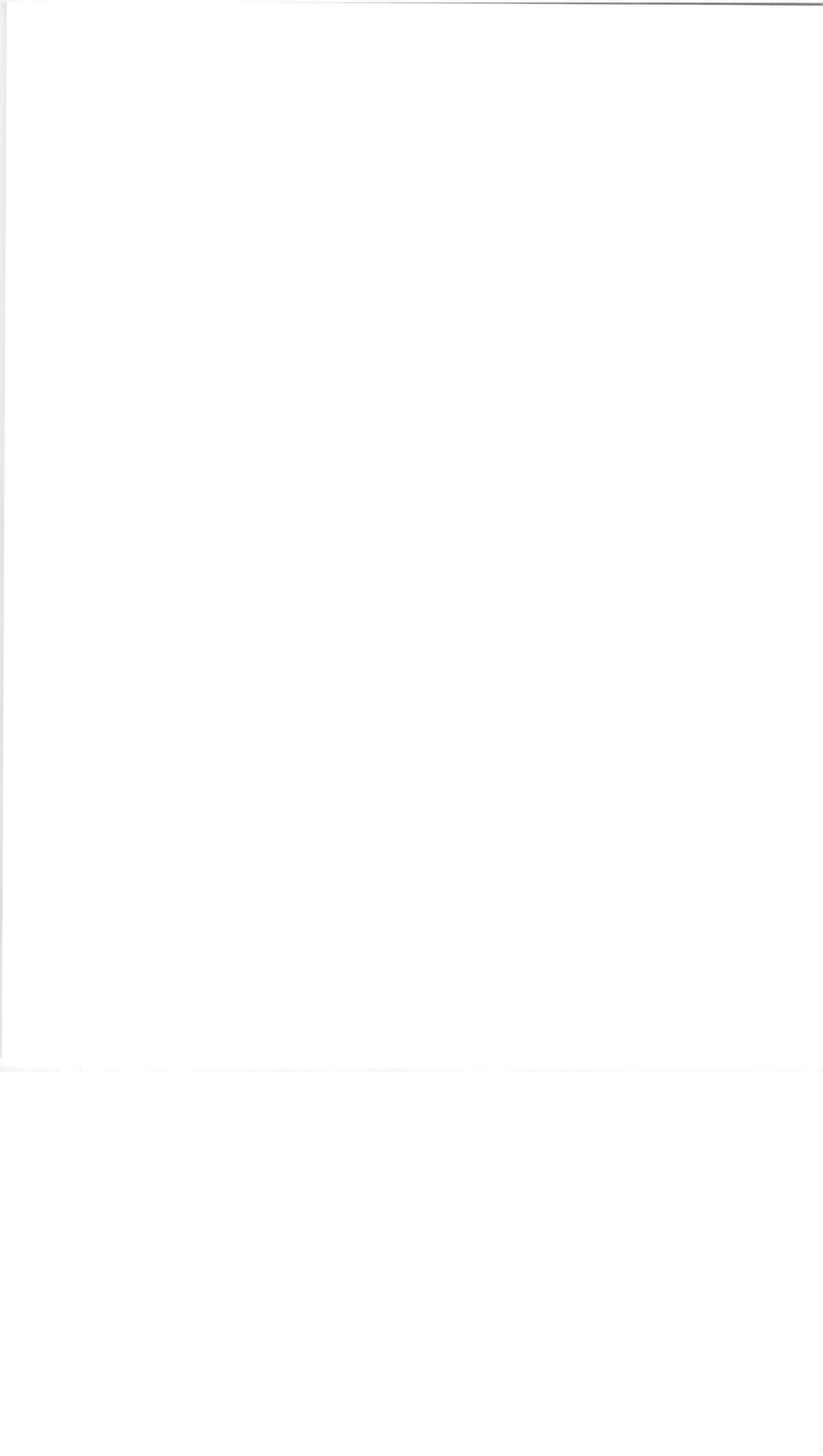
Rate the functional categories (activities of daily living)

Class	Impairment	Comments	Rating
General comments:			
<ul style="list-style-type: none"> ♦ This refers to activities confined to the immediate home environment. ♦ Judge the quality of these activities by independence, effectiveness, appropriateness, and sustainability. ♦ Read AMA4 page 300 section 14.7 on evaluating psychiatric impairment. 			
I	Nil / minimal	<ul style="list-style-type: none"> ♦ Able to be effectively independent most of the time. ♦ Any minor deficit of function could reasonably be attributed to normal variation within the general population. ♦ Examples: <ul style="list-style-type: none"> ▫ Copes adequately with everyday problems. ▫ Possibly mild impairment (such as anxiety) in situations requiring high self esteem. ▫ May occasionally look unkempt or miss a meal. 	0-9%
II	Mild	<ul style="list-style-type: none"> ♦ Independent, but in some areas functioning is not particularly effective. ♦ Impairment levels compatible with some (but not all) useful functioning. ♦ Examples: <ul style="list-style-type: none"> ▫ Can cook and clean. ▫ Can hold down a job or run a household. ▫ May have difficulty with relationships, travel, recreation. ▫ May be difficult to live with. 	10-35%
III	Moderate	<ul style="list-style-type: none"> ♦ Independent, but not effective in all or many areas of function. ♦ Impairment levels significantly impede useful functioning. ♦ Examples: <ul style="list-style-type: none"> ▫ Can cook and clean. ▫ Fearful of leaving home even for doctor's appointments, shopping, etc. ▫ May not answer telephone or door. ▫ Unable to develop or maintain intimate relationships. 	36-60%
IV	Marked	<ul style="list-style-type: none"> ♦ Is only able to live independently with some sort of regular or intermittent support. ♦ Impairment levels significantly impede useful function. ♦ Examples: <ul style="list-style-type: none"> ▫ Needs prompting to shower regularly and to wear clean clothes. ▫ Struggles to prepare own meals or frequently misses meals. 	61-79%
V	Extreme	<ul style="list-style-type: none"> ♦ Complete dependence on another person at all times. ♦ Analogous with institutional living (for example, permanent patient in a psychiatric hospital). 	80-100%



Rate the functional categories (social functioning)

Class	Impairment	Comments	Rating
General comments: <ul style="list-style-type: none"> ♦ This relates to the claimant's effective and appropriate interaction with the general public and society at large. ♦ Is the claimant able to maintain society's norms? Has there been a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation? ♦ Read AMA4 page 300 section 14.7 on evaluating psychiatric impairment. 			
I	Nil / minimal	<ul style="list-style-type: none"> ♦ Able to be effectively independent most of the time. ♦ Any minor deficit of function could reasonably be attributed to normal variation within the general population. ♦ Examples: <ul style="list-style-type: none"> ▫ Anxiety in certain situations, such as a job interview. 	0-9%
II	Mild	<ul style="list-style-type: none"> ♦ Independent, but in some areas functioning is not particularly effective. ♦ Impairment levels compatible with some (but not all) useful functioning. ♦ Examples: <ul style="list-style-type: none"> ▫ May have difficulty relating to certain groups. ▫ May become irritable. ▫ Rarely goes to social events and may need prompting to do so. ▫ Tendency to social isolation. ▫ Previously established relationships may be severely strained (for example, with periods of separation or domestic violence). 	10-35%
III	Moderate	<ul style="list-style-type: none"> ♦ Independent, but not effective in all or many areas of function. ♦ Impairment levels significantly impede useful functioning. ♦ Examples: <ul style="list-style-type: none"> ▫ Loathe to leave home and will usually only go out with a support person. ▫ Socially isolated. ▫ Avoids actively engaging with society at large. ▫ May tolerate the company of a family member or close friend but go to a different room when others come to visit family or flatmates. ▫ Struggles to maintain social norms. 	36-60%
IV	Marked	<ul style="list-style-type: none"> ♦ Is only able to live independently with some sort of regular or intermittent support. ♦ Impairment levels significantly impede useful function. ♦ Examples: <ul style="list-style-type: none"> ▫ Violates social norms. ▫ May never leave place of residence. ▫ Unable to be socially responsible (for example, take care of others). 	61-79%
V	Extreme	<ul style="list-style-type: none"> ♦ Complete dependence on another person at all times. ♦ Analogous with institutional living (for example, permanent patient in a psychiatric hospital). 	80-100%



Rate the functional categories (concentration, persistence, and pace)

Class	Impairment	Comments	Rating
General comments:			
<ul style="list-style-type: none"> ♦ This refers to the ability to plan, organise, and complete tasks. ♦ Read AMA4 page 300 section 14.7 on evaluating psychiatric impairment. 			
I	Nil/minimal	<ul style="list-style-type: none"> ♦ Able to be effectively independent most of the time. ♦ Any minor deficit of function could reasonably be attributed to normal variation within the general population. (For example, anxiety in certain situations, such as a job interview.) ♦ Examples: <ul style="list-style-type: none"> ▫ Able to sustain focused attention long enough to permit timely completion of tasks in the home and workplace without supervision. ▫ Able to work full time. Duties and performance are consistent with the claimant's education and training. 	0-9%
II	Mild	<ul style="list-style-type: none"> ♦ Independent, but in some areas functioning is not particularly effective. ♦ Impairment levels compatible with some (but not all) useful functioning. ♦ Examples: <ul style="list-style-type: none"> ▫ Can undertake basic training. But may have difficulty concentrating on complicated instructions. ▫ Can focus intellectually on demanding tasks, but possibly only for a limited time. ▫ Usually employed, but may have erratic work history marked with periods of unemployment. ▫ May need some assistance with such things as decision making and finances. 	10-35%
III	Moderate	<ul style="list-style-type: none"> ♦ Independent, but not effective in all or many areas of function. ♦ Unable to sustain employment. ♦ Impairment levels significantly impede useful functioning. ♦ Examples: <ul style="list-style-type: none"> ▫ Marked difficulty in completing tasks in a timely manner. ▫ Marked difficulty in following instructions. 	36-60%
IV	Marked	<ul style="list-style-type: none"> ♦ Is only able to live independently with some sort of regular or intermittent support. ♦ Impairment levels significantly impede useful function. ♦ Examples: <ul style="list-style-type: none"> ▫ Unable to perform tasks without intensive support and supervision. ▫ Concentration deficits obvious even during brief conversation. ▫ Can only read a few lines before losing concentration. 	61-79%
V	Extreme	<ul style="list-style-type: none"> ♦ Complete dependence on another person at all times. ♦ Analogous with institutional living (for example, permanent patient in a psychiatric hospital). ♦ Requires constant supervision and assistance. ♦ All useful functioning precluded. ♦ Can't attend to conversation or any productive task at all. ♦ Examples: <ul style="list-style-type: none"> ▫ Acute confusional state. ▫ Complete loss of short term memory. ▫ Intractable psychotic state. ▫ Intractable depression. 	80-100%

Rate the functional categories (adaptation/decompensation)

Class	Impairment	Comments	Rating
General comments:			
♦ This deals with the claimant's reaction to stress.			
♦ Read AMA4 page 300 section 14.7 on evaluating psychiatric impairment.			
I	Nil / minimal	<ul style="list-style-type: none"> ♦ Able to be effectively independent most of the time. ♦ Any minor deficit of function could reasonably be attributed to normal variation within the general population. ♦ Well able to adapt to the challenge of new stresses, or may experience minimal decompensation with stress. ♦ Examples: <ul style="list-style-type: none"> ▫ Mood changes or anxiety around emotional triggers (like the anniversary of a loved one's death). 	0-9%
II	Mild	<ul style="list-style-type: none"> ♦ Mild decompensation with stress such that: <ul style="list-style-type: none"> ▫ Can still complete tasks at home and work; but ▫ Standard of function is impaired (for example, pace reduced), or may actively seek a less stressful environment. 	10-35%
III	Moderate	<ul style="list-style-type: none"> ♦ Decompensation with stress is such that claimant may not be able to meet usual commitments of home and work. ♦ Averages no more than two episodes a year of decompensation (for example, depressive episodes) and loss of adaptive functioning requiring support (medication, psychiatric input, hospitalisation). ♦ Examples: <ul style="list-style-type: none"> ▫ Doesn't attend work, or attendance is erratic. ▫ Becomes depressed. ▫ Seeks treatment from a counsellor or GP. ▫ Abuses drugs or alcohol as a reaction to stress. 	36-60%
IV	Marked	<ul style="list-style-type: none"> ♦ Decompensation with stress is such that claimant may not be able to meet usual commitments of home and work. ♦ Averages three or more episodes a year of decompensation (for example, depressive episodes) and loss of adaptive functioning requiring support (medication, psychiatric input, hospitalisation). ♦ Each episode lasts two or more weeks. 	61-79%
V	Extreme	<ul style="list-style-type: none"> ♦ Extreme impairment precluding all useful function. ♦ Analogous with institutional living (for example, permanent patient in a psychiatric hospital). ♦ Can't tolerate any change of routine or of environment. ♦ Can't function, or decompensates, when schedules changes in an otherwise structured environment. ♦ Examples: <ul style="list-style-type: none"> ▫ May have a psychotic episode if meal not served on time ▫ May have a panic attack if left without a companion. 	80-100%

Rate the overall impairment

The figures taken from the above four categories are not added, averaged or combined. The figures are to assist the assessor, in conjunction with clinical judgement, to arrive at a whole-person impairment rating based on the claimant's current level of functioning, and expressed as a single percentage.

Guidelines:

- ♦ An EXTREME rating in one category implies that the individual is highly unlikely to perform satisfactorily in any of the categories.
- ♦ A MARKED rating in two categories implies that the individual is unlikely to be able to perform any complex task without support or assistance.
- ♦ A MODERATE rating in four categories should be considered to be moderate overall. (That is, they aren't additive.)

The final whole-person impairment rating is not expected to be:

- ♦ Less than the lowest of the figures selected to represent impairment in the four categories of function; or
- ♦ Higher than the highest of the figures.

Bear in mind the following summary when selecting a final whole person impairment:

Impairment	Rating	Comments
Nil / minimal	0-9%	♦ Effectively independent.
Mild	10-35%	♦ Independence not fully effective or sustainable in some areas of function.
Moderate	36-60%	♦ Independence not fully effective or sustainable in all areas of function.
Marked	61-79%	♦ Independent only with support.
Extreme	80-100%	♦ Unable to live independently.

Finally:

- ♦ Always justify the final whole-person impairment rating.
- ♦ The majority of cases require some apportionment for the impact of non-covered factors. For assistance with apportionment, see page 10.

Report format: Mental injury

Use the following format for your report. Each element must be present, and in the order specified.

Topic	Comments	
Background	Assessor details	♦ Your name and contact details.
	Title of report	♦ Either: Lump sum report; or Independence allowance assessment report ♦ Indicate in the title if the report is amended.
	Address to referring case manager	
	Appointment details	♦ Date, time, and duration of appointment. ♦ Date assessment requested by ACC.
	Claimant details	♦ Name and DOB.
	Injuries	♦ List injuries for which ACC has requested assessment: Date Injury Claim number
	Documentation	♦ List documents received and reviewed: Date Source or author ♦ Don't summarise the content of the document in this list.
History	♦ Brief history of abuse ♦ Brief summary of treatment received (for example, counselling) ♦ Current impact of the covered mental injury (as described by the claimant) ♦ Current personal circumstances ♦ Personal history ♦ Medical history ♦ Mental status examination	
Assessment	♦ Activities of daily living ♦ Social functioning ♦ Concentration, persistence, and pace ♦ Adaptation/decompensation	
Impairment rating	♦ Report separately for the following, justifying the rating: Activities of daily living Social functioning Concentration, persistence, and pace Adaptation/decompensation	
Estimated WPI		
Apportionment	Make sure you justify this	
Final WPI		
Discussion	Comment on permanence ⁵ and stability ⁶	
Conclusion	Final whole-person rating (for ALL conditions)	
	Signature	♦ Sign after proof reading.
	Attachments	♦ Note how many attachments are enclosed at the foot of the report.

Notes:

- Make sure you number the pages of the report.
- Don't use names of people, places, schools, etc. That is, avoid using unnecessary identifying data.

5. Permanent impairment means:

"A loss, loss of use, or derangement of any body part, organ system, or organ function, that is well established and unlikely to change substantially in the next year, with or without further medical treatment."

6. Stability means:

"Unlikely to improve in the next twelve months."

EXHIBIT 6-WCC TITLE 14.09.08.01(B)(2)(m) LCSW-C M

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 7- A-COMAR 14.09.09.03(C) MENTAL RATING EX

Uploaded by: arthur flax

Position: FAV

- LII > State Regulations > Maryland Code of Regulations
- > Title 14 - INDEPENDENT AGENCIES
- > Subtitle 09 - WORKERS' COMPENSATION COMMISSION
- > Md. Code Regs. tit. 14, subtit. 09, ch. 14.09.09 - Guide for Evaluation of Permanent Disability;
- > **Md. Code Regs. 14.09.09.03 - Evaluation of Permanent Impairment**

Md. Code Regs. 14.09.09.03 - Evaluation of Permanent Impairment

State Regulations Compare

A. Written Evaluation Required. As evidence of permanent impairment, a party shall submit:

- (1) A written evaluation of permanent impairment prepared by a physician; or
- (2) In claims where the issue concerns psychiatric impairment, a written evaluation of permanent psychiatric impairment prepared by a licensed psychologist or psychiatrist.

B. When preparing an evaluation of permanent impairment, a physician, psychologist or psychiatrist shall:

- (1) Generally conform the evaluation with the format set forth in §2.2 ("Reports") of the American Medical Association's "Guides to the Evaluation of Permanent Impairment";
- (2) Use the numerical ratings for the impairment set forth in the American Medical Association's "Guides to the Evaluation of Permanent Impairment",

provided that a physician, psychologist or psychiatrist is not required to use the inclinometer evaluation technique specified in § 3.3, but instead may use the goniometer technique specified in the "Addendum to Chapter 3";

(3) Include the items listed under the heading "Comparison of the results of analysis with the impairment criteria . . ." in §2.2 ("Reports") of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"; and

(4) Include information on the items required by Labor and Employment Article, § 9-721, Annotated Code of Maryland:

(a) Loss of function, endurance, and range of motion; and

(b) Pain, weakness, and atrophy.

C. Numerical Ratings.

(1) A physician, psychologist or psychiatrist preparing an evaluation of permanent impairment may include numerical ratings not set forth in the American Medical Association's "Guides to the Evaluation of Permanent Impairment" for the items listed in §B(4) of this regulation.

(2) If the physician, psychologist or psychiatrist uses other numerical ratings the physician shall include in the evaluation the detailed findings that support those numerical ratings.

D. When reviewing an evaluation for permanent impairment, the Commission shall consider all the items listed in §B of this regulation.

E. The Commission may not approve payment of a physician's, psychologist's or psychiatrist's fee for an evaluation that does not comply with this regulation.

F. This regulation shall apply to all evaluations prepared on or after July 1, 1990.

Notes

Md. Code Regs. 14.09.09.03

Regulations .03, Public Information Act Requests, recodified from COMAR 14.09.09 to COMAR 14.09.16, Public Information Act Requests, effective 41:4 Md. R. 305, eff.3/3/2014

Flax SB-522 Testimony.pdf

Uploaded by: arthur flax

Position: FAV

Arthur Flax's
COMPREHENSIVE PSYCHOSOCIAL SERVICES, INC.
 P.O. Box 15021
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March 5, 2026

Maryland General Assembly
 Senate Finance Committee
 3 East Miller Senate Office Building
 Annapolis, Maryland 21401

RE: SB-522 Workers' Compensation- Evaluation of Permanent Impairments-Licensed Social Worker-Clinical
 Position: Favorable-Support

Dear Senator Beidle, Chair and Members of the Committee:

Disclaimer: The opinions expressed are my own and do not represent any other person, corporation, organization public or private, or governmental agency.

Personal Qualifications:

I am a Licensed Certified Social Worker-Clinical, the only distinct separate classification license authorizing the licensee to independently render a formal diagnosis (Health General Article;(HO 19-101 (5) (ii) referencing HG-Sec. 7.5-101 (1) (2) . The LCSW-C is legally defined as a medical provider and more broadly as a health care provider who incorporates social work values. Please, do not confuse the LCSW-C licensee with other Social Work categories of licensees. I am also registered with the WCC (G0235). I provided services including evaluations, including assessment of Permanent Impairment, until it was determined to not be authorized. I advocate based upon my personal experience for legislation to authorize the LCSW-C, who is qualified as an evaluator and registered with the Workers Compensation Commission, to conduct Evaluation of Permanent Impairment of Mental and Behavioral Disorders. I performed Evaluations of Permanent Impairment and other evaluations of the injured worker before the Commission. I was referred clients by both defense attorneys' and claimant's attorneys. I evaluated persons' referred to me by the Workers Compensation Commission to review discrepancies in ratings. Two of these were major cases; one for the defense attorney, the other for the claimant's attorney.

In a case, the claimant's counsel raised this issue, after agreeing to settle the case based upon my evaluation. He stated an LCSW-C was not included, but not excluded; in the Labor and Employment Article 9-721, (only a physician, psychiatrist, or psychologist is specifically included). It was the defense attorney associated with S. B. S. who strongly encouraged me to advocate for inclusion of the LCSW-C. (Subsequently an AG advice of counsel was requested. The Scope of Practice of the LCSW-C has expanded since 2005, per HO-19-101(5) (ii).

Reason for this Legislation:

1. There is a severe need for experienced qualified psychiatrists and psychologists fully serve the injured worker who are qualified to provide Workers Compensation evaluations which include diagnosis, review of treatment, and collaborate with other health care providers, agencies, and resources to make objective determinations of the severity of impairment, if a handicap is relevant to the work related injury/impairment, need for further treatment or referral, and recommendations for reasonable accommodations. Attorneys' who litigate Workers Compensation have specialized training, so should health care practitioners who evaluate claimants.
2. Licensed Health Care Practitioners' should be utilized within their Scope of Practice based upon training and experience for the "public good", especially when there are insufficient resources available.
3. An attorney and or the Court will not present a health care practitioner as an expert witness, who is not qualified per the legal process.

Supportive Documentation:

Licensed Certified Social Worker-Clinical (LCSW-C) Qualifications

Scope of Practice:

The Licensed Certified Social Worker-Clinical licensee is authorized to engage in the: 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;(HO 19-101 (5) (ii) referencing HG-Sec. 7.5-101 (1) (2) and testify as an expert witness (See AG Advice of Counsel(s) dated 01/30/2004, and 01/25/2024. The LCSW-C may engage in various psychological assessments and testing based upon individual qualifications. (The term "psychological" is a broad term not limited to use only by licensed psychologists). Evaluation of Permanent Impairment is not limited to a physician, psychiatrist, or psychologist:

The Guides to the Evaluation of Permanent Impairments, Ch. 14, Emotional and Behavioral Disorders, does not restrict the evaluator to a physician, psychiatrist, or psychologist. Chapter 14, pg. 348, includes "other" 14.1 Principles of Assessment. Under the Annotated Code of Maryland and COMAR, the LCSW-C is authorized to render ultimate decisions on impairments of mental disorders, as it may affect an individual's functional capacity.

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). In addition the Global Assessment of Function (GAF) incorporated into the DSM 4th.Ed. is utilized, as are other assessment instruments (see attachment) to evaluate functional capacity-mental (FCE-M) standing alone, or in conjunction with physical injury or illness (Psychologists do not evaluate physical conditions). (ACC Prevention Care Recovery User Handbook to the AMA "Guides to the Evaluation of Permanent Impairment" 4th Ed.).

The Licensed Certified Social Worker-Clinical (LCSW-C) may be an Expert Witness, subject to the legal process and render an opinion on ultimate issues per AG Advice of Counsel 1-30-2004 and subsequent AG Advice of Counsel). An Expert Witness may incorporate and reference documentation to support the testimony rendered. Therefore, if the injured worker is also seen for treatment by a physician or psychologist, that information may be included in the evaluation/testimony rendered by the Expert Witness.

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.

1. This proposed legislation specifically requires the LCSW-C to be registered with the Workers Compensation Commission, Rehabilitation Division, and qualified to perform evaluations of the injured worker (COMAR 14.09.04, et.al.). This includes specific requirements and continuing

education. Just as attorneys who represent clients in Workers Compensation cases should have expertise, so should evaluators.

Attachments : Testimony and Exhibits 1 to 7;

Sincerely,



Arthur Flax, LCSW-C; Evaluator for the Workers Compensation Commission (G-0235)
State of Maryland Licensed Certified Social Worker- Clinical; Licensed Clinical Alcohol Drug Counselor, DHMH;
Evaluator for the Workers Compensation Commission (G-0235); Licensed Health Care Provider, HG-8-403 (HB-1510
enrolled bill -2014) in compliance with DHMH Behavioral Health Integration enacted statutes and regulations.
Direct Pay Non-Attorney Advocate approved by the Social Security Administration.

SB0522_FAV_GWSCSW_Workers' Comp. - Eval. Permanent

Uploaded by: Christine Krone

Position: FAV



Greater Washington Society for Clinical Social Work

Senate Finance Committee

March 10, 2026

Senate Bill 522 – *Workers’ Compensation – Evaluation of Permanent Impairments – Licensed 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 the Maryland Legislative and Advocacy Committee of the GWSCSW, we strongly support Senate Bill 522.

The bill would amend Maryland’s workers’ compensation law to authorize qualified LCSW-Cs to perform and report evaluations of permanent impairments involving behavioral or mental disorders. This bill modernizes and clarifies the role of LCSW-Cs in evaluating mental and emotional injury in the workers’ compensation system and ensures that injured workers have access to the full range of qualified health professionals capable of providing expert assessments.

LCSW-Cs are highly trained, licensed healthcare professionals whose scope of practice includes *evaluating, diagnosing, and treating biopsychosocial conditions, mental and emotional impairments, and behavioral health disorders*. Under current law, only licensed psychologists or qualified physicians may conduct evaluations of permanent impairments involving behavioral or mental health conditions. This restricts the pool of qualified evaluators despite the critical role LCSW-Cs already play in the comprehensive assessment and treatment of these conditions. Senate Bill 522 appropriately expands Section 9-721 of the Labor and Employment Article to include LCSW-Cs who meet specified experience and credentialing requirements, ensuring they are authorized to conduct these evaluations and report their findings to the Workers’ Compensation Commission.

This bill will help address the shortage of qualified evaluators for mental and behavioral health permanent impairment determinations and ensure injured workers receive timely, expert assessments grounded in clinical expertise. For the sake of fairness, evidence-based practice, and improved outcomes for injured workers, we respectfully urge a **favorable report and passage of Senate Bill 522**.

Greater Washington Society for Clinical Social Work: www.gwscsw.org

Contacts: Director, Legislation & Advocacy Program: Judy Gallant, LCSW-C; email: judy.gallant@verizon.net; mobile (301) 717-1004

Legislative Consultants: Christine K. Krone and Danna L. Kauffman, Schwartz, Metz, Wise & Kauffman, PA, 20 West Street, Annapolis, MD 21401

Email: ckrone@smwpa.com; mobile (410) 940-9165 ; dkauffman@smwpa.com; mobile (410) 294-7759

SB522 Workers' Compensation - Evaluation of Perman

Uploaded by: Dean Judy Postmus

Position: FAV

Testimony for SB 522
Workers' Compensation – Evaluation of Permanent Impairments – Licensed Social Worker–Clinical
March 10, 2026
Support

Thank you, Chair Beidle, Vice Chair Hayes, and members of the Finance Committee for addressing this critical issue and therefore recognizing the vital role of social work. The School of Social Work appreciates the opportunity to provide testimony in favor of SB 522. This bill would permit clinical social workers to perform an evaluation for the Workers' Compensation Commission if a permanent impairment involves a behavioral or mental disorder.

Current law restricts the professionals who may perform an evaluation to a licensed psychologist or physician. The changes proposed in SB 522 better reflect that the far majority of behavioral health services are delivered by licensed social workers and they have the expertise to assess, evaluate, and treat individuals with behavior health conditions. We support the language in the bill that limits these tasks to only include a licensed social worker at the highest level of licensing, the LCSW-C, and not the other social work entry level licenses (LBSW or LMSW.) The requirements to earn this highest level of licensure include the following steps which take a minimum of over a four-year process before earning the LCSW-C.

Here is a description of the minimum requirements: (1) earn a master's degree from an accredited program; (2) successfully complete two placement practicums/professional internships – two full-days their foundation year of the master's program and three full-days in their advanced year; (3) practice social work competencies in both placements under the supervision of a licensed and experienced social worker; (4) pass all the clinical coursework which is required for the LCSW-C; (5) pass the first (of two) national licensing test administered through the National Association of Social Work Boards (ASWB) or the Masters exam; (6) complete additional application requirements to earn the LMSW license; (7) work with their LMSW license for a minimum of 3,000 hours of social work experience under the supervision of a LCSW-C; (8) the work experience must be "clinical social work experience" which is defined to include: completing assessments; formulating diagnostic impressions or a diagnosis; treating mental disorders and other conditions; treating behavioral health disorders including substance use disorders, addictive disorders and other conditions; and providing psychotherapy; (9) pass the second national licensing test administered through the National Association of Social Work Boards (ASWB) which tests their clinical knowledge or Clinical exam; and (10) complete a minimum of 40 hours of continuing education in social work practice every two-year period.

I share these details to highlight that the steps along the social work licensing pathway for the LCSW-C has more than screened and prepared them to provide comprehensive evaluations concerning Workers' Compensation matters.

I respectfully request a favorable committee report on SB 522.

Respectfully submitted by,



Judy L. Postmus, Ph.D., ACSW, Dean & Professor

Cc: Senator Mary Washington

NASW Maryland - 2026 SB 522 FAV - Workers' Compens

Uploaded by: Karessa Proctor

Position: FAV



**Testimony before the Senate Finance Committee
March 10, 2026**

**Senate Bill 522 - Workers' Compensation - Evaluation of Permanent Impairments -
Licensed Social Worker-Clinical
SUPPORT**

On behalf of the Maryland Chapter of the National Association of Social Workers (NASW-MD) Chapter, I respectfully submit this testimony in strong support of Senate Bill 522 - Workers' Compensation - Evaluation of Permanent Impairments - Licensed Social Worker-Clinical.

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.

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.

For these reasons, we ask for your favorable report on Senate Bill 522.

Respectfully,

Karessa Proctor, BSW, MSW
Executive Director, NASW-MD

SB522-Workers Comp LCSW- FAV NAMI.pdf

Uploaded by: Morgan Mills

Position: FAV

March 10, 2026

Chair Beidle, Vice Chair Hayes, and distinguished members of the Finance Committee,

NAMI Maryland and our 11 local affiliates across the state represent a network of more than 60,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families, and the wider community.

SB522 acknowledges the essential role clinical social workers play in our healthcare infrastructure and ensures they can practice to the full extent of their specialized training. By allowing LCSW-C to perform permanent impairment evaluations for workers compensation claims involving behavioral or mental disorders, we are recognizing the expertise these professionals bring to the mental health field.

LCSW are uniquely trained to evaluate, diagnosis, and treat these conditions. Incorporating LCSW-C into the worker's compensation into the worker's compensation process, we are ensuring injured workers can receive timely evaluations from qualified experts who understand the complexity of their mental health challenges in a clinical context.

For these reasons, we urge a favorable report.

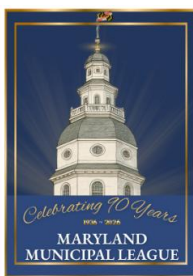
Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills-DiEnno
Compass Government Relations
Mmills@compassadvocacy.com

SB 522 - MML - UNF.pdf

Uploaded by: Bill Jorch

Position: UNF



TESTIMONY

COMMITTEE: Senate Finance

DATE: March 10, 2026

POSITION: Unfavorable

BILL: SB 522

The Maryland Municipal League (MML) opposes Senate Bill 522, Workers' Compensation - Evaluation of Permanent Impairments - Licensed Social Worker-Clinical.

SB 522 adds “licensed certified social worker-clinical” to the list of people who are authorized to conduct evaluation services for workers’ compensation claims related to permanent impairments involving a behavioral or mental disorder. While the intent to increase the supply of available professionals to perform this type of evaluation, this bill takes a stark departure from past precedent.

Behavioral and mental evaluations involving workers compensation claims must adhere to certain American Medical Association standards traditionally done by currently authorized medical professionals. There is concern that by allowing non-doctors to conduct these evaluations the quality and consistency of the ratings may suffer. Additionally, introducing non-doctor evaluations of this type may lead to their findings to face significant challenges in the court system.

For these reasons, the League respectfully requests that the committee provide Senate Bill 522 with an unfavorable report.

For more information relating to this piece of testimony, please contact:

Bill Jorch: Managing Director, Advocacy and Public Policy, billj@mdmunicipal.org

Municipalities in Maryland support 42,000 jobs and provide \$5.2 billion in employee compensation.

SB 552_Chesapeake-IWIF Testimony_social worker_per

Uploaded by: Lyndsey Meninger

Position: UNF



Senate Finance Committee
March 10, 2026

Testimony of Chesapeake Employers' Insurance Company and Injured Workers' Insurance Fund in Opposition to Senate Bill 522

Senate Bill 522 proposes to authorize a licensed certified social worker–clinical, with certain specified requirements, 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 other disciplines 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 concern is the disconnect between administrative authorization and judicial admissibility. While the Workers' Compensation Commission operates under more of a relaxed evidentiary framework, Maryland Courts require expert medical opinions, particularly those stated to a reasonable degree of medical certainty, to be offered by witnesses qualified under Maryland Rule 5-702. Expanding Labor and Employment, § 9-721 to include licensed certified social workers–clinical does not alter the Rules of Evidence or appellate standards governing expert medical testimony, creating uncertainty and increased litigation risk on appeal.

Due to this significant departure from established law and practice, Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund respectfully oppose Senate Bill 522.

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SB 522 Social Worker UNF APICA 03102026.pdf

Uploaded by: Nancy Egan

Position: UNF



Testimony of

American Property Casualty Insurance Association (APCIA)

Senate Finance Committee

Senate Bill 522 - Workers' Compensation –Evaluation of Permanent Impairments– Licensed Social Workers

March 10, 2026

Unfavorable

The American Property Casualty Insurance Association (APCIA) is a national trade organization whose members write approximately 71% of the U.S. property and casualty insurance market, including 89.1% percent of Maryland’s workers’ compensation market. APCIA appreciates the opportunity to provide written comments in opposition to Senate Bill 522.

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, psychiatrists 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 Senate Bill 522.

Nancy J. Egan,

State Government Relations Counsel, DC, DE, MD, VA, WV

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