Subtitle 44 BOARD OF DENTAL EXAMINERS

10.44.12 Anesthesia and Sedation

Authority: Health Occupations Article, §4-205 Annotated Code of Maryland

Notice of Final Action

[15-088-F]

On April 16, 2015, the Secretary of Health and Mental Hygiene adopted amendments to Regulations **.03**, **.04**, **.08**, **.09**, and **.11**, new Regulations **.12** and **.35**, the recodification of Regulations **.12—.15**, **.17**, **.18**, **.21—.25**, **.27**, **.29**, **.33**, **.35—.37** to be Regulations **.13—.16**, **.18**, **.19**, **.22—.26**, **.28**, **.30**, **.34**, and **.37—.39**, respectively, and amendments and the recodification of Regulations **.16**, **.19**, **.20**, **.26**, **.28**, **.30—.32**, and **.34** to be Regulations **.17**, **.20**, **.21**, **.27**, **.29**, **.31—.33**, and **.36**, respectively, under **COMAR 10.44.12 Anesthesia and Sedation**. This action, which was proposed for adoption in 42:3 Md. R. 383—387 (February 6, 2015), has been adopted with the nonsubstantive changes shown below.

Effective Date: May 11, 2015.

Attorney General's Certification

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

Regulation .03B(6)(b) and (c): The amendments are non-substantive in that they clarify that in order for the second dose of medication for the purpose of anesthesia to be considered an "anxiolytic", it must be the same drug as was initially dispensed. It also clarifies the point that a second drug that is not dispensed for the purpose of anesthesia does not fall within the purview of the regulation. The amendments do not expand the scope of the proposed regulation. The amendments are foreseeable non-substantive additions to the regulation. The changes do not impose additional duties on licensees. Instead, they clarify the proposed regulation.

Regulation .04B: The amendment to this regulation, although not originally proposed, is required to further explain the changes being made to Regulation .03B(6).

.03 Definitions.

A. (proposed text unchanged)

B. Terms Defined.

*(1)—(5) (*proposed text unchanged)

(6) Anxiolysis.

(a) (proposed text unchanged)

(b) "Anxiolysis" includes a single dose of one sedative, narcotic, class of drugs, or medication prescribed by the treating dentist and taken the evening before a procedure or the morning of a procedure, or both, provided that the dosage complies with the definition of anxiolysis under §B(5)(a) of this regulation.

(c) "Anxiolysis" does not include the administering, prescribing, or dispensing of any other **[[***drug***]]** *sedative, narcotic, class of drugs, or medication for the purpose of anesthesia by a dentist to a patient to be used for anesthesia or sedation, to be taken the evening before a procedure or the morning of a procedure.*

(7)—(26) (proposed text unchanged)

.04 Anxiolysis.

A. (text unchanged)

B. The administering, prescribing, or dispensing of more than one type of sedative, narcotic, class of drug, or medication for the purpose of anesthesia to be taken the evening before a procedure, or the morning of a procedure, is not anxiolysis and shall require the appropriate anesthesia or sedation permit.

[[B.**]]** *C.*—**[[**E.**]]** *F.* (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

31.10.21 Private Review Agents

Authority: Insurance Article, §§2-109(a)(1) and 15-10B-03(h), Annotated Code of Maryland

Notice of Final Action

[15-076-F]

On April 10, 2015, the Insurance Commissioner adopted amendments to Regulation **.02-1** under **COMAR 31.10.21 Private Review Agents**. This action, which was proposed for adoption in 42:2 Md. R. 271—272 (January 23, 2015), has been adopted with the nonsubstantive changes shown below.

Effective Date: May 11, 2015.

Attorney General's Certification

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

Regulation .02-1H: The time of the initial date of treatment for a condition is being removed from the uniform treatment plan form. The change is being made because the time of the initial encounter is unnecessary to determine the date of the initial encounter. The change is nonsubstantive since the change does not alter the needed information, which is the date of the initial encounter.

.02-1 Uniform Treatment Plan.

A.—G. (proposed text unchanged)

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

Note: The revised form appears at the end of the Final Action on Regulations section of this issue of the Maryland Register.

I. (proposed text unchanged)

ALFRED W. REDMER, JR.
Insurance Commissioner

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Today's Date _____

Carrier or Appropriate Recipient:

PATIENT INFORMATION

PATIENT'S FIRST NAME | PATIENT'S DATE OF BIRTH ☐☐ / ☐☐ / ☐☐☐☐

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID | PHONE NUMBER

PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE

_____

Date**[**/Time**]** Patient First Seen For
This Episode Of Treatment __/__/____**[[**@____:_____am/pm**]]**

Level of care being requested: Please specify benefit type:

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

Primary Dx Code: _____ **Secondary Dx Code(s):** _____

Current Treatment Modalities: **(check all that apply)**

Psychotherapy: ☐ Behavioral ☐ CBT ☐ DBT ☐ Exposure ☐ Supportive Therapy ☐ Problem Focused ☐ Interpersonal ☐ Psychodynamic ☐ EMDR ☐ Group ☐ Couples ☐ Family ☐ Other_____

☐ **Medical Evaluation and Management**

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

☐ Antipsychotic ☐ Anxiolytic ☐ Antidepressant ☐ Stimulant ☐ Injectables ☐ Hypnotic ☐ Non-psychotropic ☐ Mood Stabilizer ☐Other _____

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

	Current Ideation	Current Plan	Prior Attempt	None
Suicidal	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐

Symptoms/ Functional Impairments	None	Mild	Moderate	Severe
Self-Injurious Behavior	☐	☐	☐	☐
Substance Use Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Agitated/aggressive Behavior	☐	☐	☐	☐
Mood Instability	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Cognitive Impairment	☐	☐	☐	☐
Eating Disorder Symptoms	☐	☐	☐	☐
Social/ Familial/School/WorkProblems	☐	☐	☐	☐
ADL Problems	☐	☐	☐	☐

If requesting additional outpatient care for a patient, why does the patient require further outpatient care: ☐ Maintenance treatment for a chronic condition ☐ Consolidate treatment gains ☐ Continued impairment in functioning ☐ Significant regression ☐ New symptoms and/or impairments ☐ Supportive treatment due to other treatment plan changes ☐ complex psychiatric and medical co-morbidity ☐ Complex Psychiatric and Substance abuse Co-morbidity

☐ other_____

Signature of Practitioner: _____ Date: _____/_____/_____

My signature attests that I have a current valid license in the state to provide the requested services.

***Complete the following if the request is for ECT or rTMS*:** Provide clinical rationale including medical suitability and history of failed treatments:

_____

_____

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

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

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

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

1. _____
2. _____
3. _____

Date of Evaluation by MD/DO: _____

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

_____

_____

_____

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

1._____
2._____
3._____

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Psychological Testing:

Symptoms/Impairment related to need for testing:

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

Purpose of Psychological Testing:

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

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

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

□ Depressed mood	□ Vegetative Symptom	□ Processing speed	□ Performance Anxiety	□ Expressive/ Receptive Communication Difficulties
□ Low frustration tolerance	□ Suspected or Confirmed grapho-motor deficits	□ Physical Symptoms or Conditions such as:_____ _____	□ Other:_____ _____ _____	

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Biofeedback:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Telehealth:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Patient Membership Number_____

Complete for Higher Level of Care Requests (e.g. inpatient, residential, intensive outpatient and partial hospitalization):

Primary reason for request or admission: (check one) □ Self/Other Lethality Issues □ Violent, unpredictable/uncontrolled behavior
□ Safety issues □ Eating Disorder □ Detox/withdrawal symptoms □ Substance Use □Psychosis □ Mania □ Depression
□ Other _____

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

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

Barriers to Compliance or Adherence: _____

Prior Treatment in past 6 months:
□ Mental Health □ Substance Use Disorder □ Inpatient □ Residential □ Partial □ Intensive Outpatient □ Outpatient

Relevant Medical issues (if any): _____
_____

Support System/Home Environment: _____
_____
_____

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

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

Why does member continue to need level of care_____
_____
_____

Discharge Plan (including anticipated discharge date)_____
_____
_____

Complete the following if substance use is present for higher level of care requests:
Type of substance use disorder _____
Onset: □ Recent □ Past 12 Months □ More than 12 months ago
Frequency: □ Daily □ Few Times Per Week □ Few Times Per Month □ Binge Pattern
Last Used: □ Past Week □ Past Month □ Past 3 Months □ Past Year □ More than one year ago
Consequences of relapse: □ Medical □ Social □ Housing □ Work/School □ Legal □ Other _____
Urine Drug Screen: □ Yes □ No Vital Signs: _____
Current Withdrawal Score: (CIWA_____ COWS_____) or Symptoms (□ check if not applicable) _____
_____
History of: □ Seizures □ DT's □ Blackouts □Other □ Not Applicable

Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests:
Height: _____ Weight:_____ % of NBW_____
Highest weight_____ Lowest weight_____ Weight change over time (e.g. lbs lost in 1 month) _____
If purging, type and frequency _____ Potassium _____ Sodium _____ Vital signs _____
Abnormal EKG_____ Medical Evaluation □ Yes □ No

Please identify current symptoms, behaviors and diagnosis of any Eating Disorder issues: _____
_____
Please include any current medical/physiological pathologic manifestations: _____
_____
_____