

OFFICE OF RISK MANAGEMENT

NOTICE OF FINAL RULEMAKING

The Director of the Office of Risk Management (ORM), Executive Office of the Mayor, pursuant to the authority set forth in section 2344 of the District of Columbia Government Merit Personnel Act of 1978 (CMPA), effective March 3, 1979, D.C. Law 2-139, D.C. Official Code § 1-623.44 (2001); section 7 of Reorganization Plan No. 1 of 2003 for the Office of Risk Management, effective December 15, 2003, and Mayor’s Order 2004-198 (December 14, 2004), hereby gives notice of the adoption of the following amendments to Chapters 1 and 31 to Title 7 of the District of Columbia Municipal Regulations (DCMR). The amendments are necessary to comply with amendments to the CMPA made by sections 1061 and 1062 of the Disability Compensation Amendment Act of 2010, effective September 24, 2010 (D.C. Law 18-223; D.C. Official Code § 1-623.01 *passim*). These amendments will conform rules governing compensation hearings with the changes made by D.C. Law 18-223, as well as other statutory changes made since the disability compensation program has been put under the authority of the Office of Risk Management.

The same rules were adopted on an emergency basis on September 30, 2010, and became effective on October 4, 2010. Notice of the emergency rules and the Director’s intent to adopt them as final in not less than thirty (30) days following the publication of the notice was published in the *D.C. Register* on October 8, 2010, at 57 DCR 9540.

ORM did not receive any comments to the rules adopted on an emergency basis, and no substantive changes have been made since they were published as emergency and proposed. These rules will go into effect upon publication of this notice in the *D.C. Register*.

Title 7, EMPLOYEE BENEFITS, of the DCMR is amended as follows:

Chapter 1, DISABILITY COMPENSATION, is repealed and replaced with:

Chapter 1, PUBLIC SECTOR WORKERS’ COMPENSATION BENEFITS

Sections 101 to 109, 111-116, 119-120, and 199 are amended to read as follows:

101 FORMS

101.1 Any notices, claims, requests, applications or certificates that the Act or this chapter requires to be made shall be on approved forms.

101.2 All approved forms shall be obtained from the Program and completed by the supervisor and claimant, as directed by the Program.

102 REPORT OF INJURY

102.1 In accordance with § 2320 of the Act, the official superior of any employee shall immediately report by telephone to the Program any injury which results in that employee's death or probable disability. All information requested by the Program shall be supplied by the official superior of the employee.

102.2 The immediate superior shall make supplemental reports and the employees shall provide additional reports and information when required by the Program and agreed upon by the head of the employing agency.

102.3 In accordance with § 2303 of the Act, the official superior of any employee shall execute a certificate of medical expenses upon request by the Program if the employing agency accepts that the injury is properly compensable under the Act.

103 NOTICE OF INJURY OR DEATH

103.1 Notice of injury or death by an employee or someone on the employee's behalf shall be given to the Program by writing or by telephone within thirty (30) days of the injury or death, and all information that is required by § 2319 of the Act shall be supplied within that period. The employee shall be asked whether he or she wishes to claim continuation of pay pursuant to § 2318 of the Act.

103.2 The Program shall forward by first class mail or deliver in person the initially completed notice form to the employee or someone on the employee's behalf for review, revision, and execution. The Program shall enclose a medical release form for execution by the employee.

103.3 The completed form shall be returned to the Program within thirty (30) days of the injury or death or within fifteen (15) days of the date from which it was mailed or delivered to the individual giving notice, whichever is later.

103.4 The employee shall supply copies of the completed form to the immediate superior.

104 CONTINUATION OF PAY

104.1 When the Program is informed that an employee wishes to claim continuation of pay pursuant to § 2318 of the Act, it shall forward by mail or delivery in person the initially completed claim forms for continuation of pay to the employee.

- 104.2 The completed form shall be forwarded by the employee to the immediate superior within five (5) days of the date upon which it was mailed or delivered to the employee.
- 104.3 Upon receipt of a claim for continuing compensation, the immediate superior shall arrange to have the employee's pay continued. Within five (5) days of receipt of the claim, the immediate superior shall forward a copy of the claim to the Program.
- 104.4 Continuation of pay shall be furnished as follows:
- (a) To employees hired before January 1, 1980 for a period of forty-five (45) days; and
 - (b) To all other employees for twenty-one (21) days or until the Program has either upheld or denied the employee's right to continuation of pay or issued its determination upon a claim for compensation in accordance with § 106.1, whichever occurs first.
- 104.5 Claims for continuation of pay may be controverted by the Program in the following situations:
- (a) When the injury occurred off the employing agency's premises and the employee was not in the course of employment;
 - (b) When the injury was caused by the employee's willful misconduct, when the employee intended to bring about the injury or death on himself or herself or another person, or when the employee's intoxication was the direct cause of the injury;
 - (c) When the injury is not disabling;
 - (d) When the employee is not in active pay status, i.e., in the case of leave without pay (LWOP) or absence without official leave (AWOL);
 - (e) Occupational disease or illnesses;
 - (f) When the stoppage of work first occurs six (6) months or more after the date of injury; or
 - (g) When the employee initially reports the injury after termination of employment.

104.6 If payments to continuation of pay have been made to a claimant whose right thereto is subsequently and finally denied, the Program shall forward to the claimant a form for the claimant to elect whether the payments made shall be charged to the claimant's sick or annual leave or shall be deemed overpayment of pay, in accordance with § 2318(c) of the Act.

105 CLAIMS FOR BENEFITS

105.1 Any individual seeking benefits provided for by the Act shall file a claim with the Program within two (2) years as specified by § 2322 of the Act except as follows:

- (a) When the official superior has actual knowledge within thirty (30) days of the injury or death;
- (b) Where the employee becomes aware of the relationship between the injury and his or her employment after the exercise of reasonable diligence, the time begins to run from the date of awareness;
- (c) In the case of minors, the time does not run until the minor reaches twenty-one (21) years of age or has a legal representative;
- (d) In the case of incompetents, the time does not begin to run until a legal representative is appointed;
- (e) Where exceptional circumstances justify the filing of a claim; and
- (f) A disability claim for injury timely filed will satisfy notice requirements for a death claim in the event that the injury results in death.

105.2 The Program shall forward by first class mail or deliver in person the appropriate initially completed claim or request form to the individual for review, revision, and execution.

105.3 The Program shall enclose the approved certificate form for execution by the employee's physician, except in cases of death.

105.4 The executed form shall be returned to the Program within the time period specified by § 2322 of the Act or within fifteen (15) days of the date which it was mailed or delivered to the employee, whichever is later.

105.5 No claim shall be deemed to have been filed until the executed form has been received by the Program.

106 REQUEST FOR HEARING

- 106.1 In accordance with the § 2324 of the Act, the Program shall notify the individual claiming benefits, in writing, of its determination upon the claim submitted and its findings of fact upon which the determination is based as soon as practicable.
- 106.2 A form for requesting a hearing pursuant to § 2324(b) of the Act shall accompany the notice of determination.
- 106.3 If the individual claiming benefits under the Act wishes to request a hearing pursuant to § 2324 (b) of the Act, that individual shall sign the request for hearing which was forwarded to him or her pursuant to § 106.1 of this Chapter and return it to the Office of Hearings and Adjudication within thirty (30) days of the issuance of the determination.

107 HEARING PROCEDURES

- 107.1 Hearings pursuant to §2324(b) of the Act shall be conducted by an Office of Hearings and Adjudication Administrative Law Judge (ALJ) who has been duly designated by the Mayor.
- 107.2 The ALJ shall set the time and place of the hearing, and shall mail or deliver in person written notices to the claimant and the OAG at least ten (10) days prior to the hearing.
- 107.3 The hearing shall, when practicable, be set at a time and place convenient for the claimant and the OAG.
- 107.4 The ALJ may, and when so requested by the claimant or the OAG, afford the parties a prehearing conference to clarify the issues involved in the claim and, when necessary, shall postpone the hearing for this purpose.
- 107.5 A hearing may be postponed or cancelled upon the oral or written request of the claimant and the OAG if the request is received by the ALJ assigned to conduct the hearing at least forty-eight (48) hours prior to the time of the hearing or at the option of the ALJ.
- 107.6 In conducting a hearing, evidence may be presented orally or in the form of written statements and exhibits.
- 107.7 All evidence available to the claimant and the OAG on the date of the hearing shall be presented to the ALJ at the time of the hearing.
- 107.8 The ALJ, in his or her discretion, may leave the record open for a reasonable period subsequent to the hearing to receive any evidence prior to making a decision.

- 107.9 The hearing shall be recorded, and if transcribed, the original of the complete transcript shall be made a part of the claims record. Upon request, a copy of the complete transcript shall be provided to all interested parties at cost as established by the Office of Hearings and Adjudication.
- 107.10 If the claimant fails to appear at the time and place set for the hearing and does not, within ten (10) days after the time set for the hearing, show good cause for the failure to appear, the official record shall be closed.
- 107.11 The ALJ shall fix the time within which he or she will receive evidence to reflect findings of fact and conclusions of law.
- 107.12 The ALJ shall then issue an order to reverse, modify, affirm, or remand a determination rendered by the claims examiner.
- 107.13 The final decision shall be rendered within thirty (30) days after the hearing ends or the record closes, and then mailed or delivered to the claimant and the OAG at their last known address.
- 107.14 The final decision shall put the claimant and the OAG on notice of their right to file an appeal from the ALJ's final decision.

108 REPRESENTATION

- 108.1 Any claimant who wishes to be represented in any proceeding before an ALJ under the Act shall submit a written appointment of the individual who he or she is authorizing to undertake the representation to the Office of Hearings and Adjudication or shall make the appointment on the record at a hearing.
- 108.2 A duly appointed representative may make or give, on behalf of the claimant he or she represents, any request or notice relative to any proceeding before the Office of Hearings and Adjudication under the Act, including formal hearing and review.
- 108.3 A representative shall be entitled to present or elicit evidence and make allegations as to facts and law in any proceeding affecting the claimant he or she represents and to obtain information with respect to the claim of the claimant.
- 108.4 Notice to any claimant of any administrative action, determination, or decision or request to any party for the production of evidence shall be sent to the representative of the claimant, and the notice or request shall have the same force and effect as if it had been sent to the claimant.

109 CLAIMS FOR FEES FOR REPRESENTATION

- 109.1 Claims for fees for representation of a claimant shall be submitted in writing to the ALJ, if a hearing has been requested, within thirty (30) days of the issuance of a decision under §107.12 of this chapter.
- 109.2 A copy of the claim shall be simultaneously forwarded by the representative to the claimant who was represented.
- 109.3 All claims shall include an itemized statement describing the services rendered. The itemization shall contain at least the following information:
- (a) The dates that services began and ended and all dates on which conferences were held, documents or letters prepared, telephone calls made, etc.;
 - (b) A description of each service rendered with the amount of time spent on each type of service;
 - (c) The amount of the fee which the representative desires for services performed;
 - (d) The amount of fees requested, charged, or received for services rendered on behalf of the claimant before any State or Federal court or agency, in a similar or related matter; and
 - (e) A statement explaining the basis for the amount of the fee requested.
- 109.4 No claim shall be approved by the ALJ pursuant to §2327(b) of the Act unless the representative submitting the claim was duly appointed by the claimant in accordance with §108.1 of this chapter.
- 109.5 In determining whether to approve a claim, the ALJ shall consider at least the following factors:
- (a) The nature and complexity of the claim;
 - (b) The actual time spent on development and presentation of the claim;
 - (c) The amount of compensation accrued and potential future payments;
 - (d) Customary local charges for similar services; and

(e) Professional qualifications of the representative.

109.6 The decision approving or disapproving a claim shall be forwarded to the representative and to the claimant who was represented.

111 ORDERS FOR PHYSICAL EXAMINATION

111.1 In accordance with § 2323(a) of the Act, the Program may issue an order, in writing, directing any employee who is seeking or has been awarded compensation to submit to a medical examination.

111.2 Any claim or expenses incident to an examination shall be submitted and processed in the same manner provided by this chapter for any other claims for compensation.

111.3 The Program may require updated information or additional medical examinations to award further compensation.

112 INCREASES, DECREASES, SUSPENSION, OR FORFEITURE OF AWARDS

112.1 Whenever the claimant or the OAG has requested a review of an award pursuant to § 2328 of the Act, the parties shall be notified of the determination of the ALJ in the manner provided for notifications in §§ 105, 106, and 107.

112.2 If the Program increases, decreases, suspends, or declares a forfeiture of an award of compensation pursuant to §§ 2306, 2313, 2323 or 2329 of the Act, it shall immediately notify the beneficiary of the award of that action in the same manner specified by §§ 105.2 to 105.5 of this chapter for notification of determination upon claims or requests for benefits.

112.3 Any claimant whose award has been increased, decreased, suspended or forfeited may request a hearing on the determination. Any claimant or the OAG may appeal the decision of the ALJ pursuant to § 2328 of the Act.

113 REPORT OF EARNINGS

113.1 In accordance with § 2306(b) of the Act, the Program may require a partially disabled claimant to file with it a report of the employee's earnings by notifying the employee in writing that a report is required.

113.2 Reports of earnings may be required of a claimant whenever the Program, in its discretion, determines that a report is needed.

113.3 Reports shall be required to be filed with the Program within fifteen (15) days of the date of notification of the request.

114 SUBROGATION

114.1 Whenever the Program believes that a person or entity other than the District of Columbia Government may be legally liable for the injury or death for which benefits are payable, it shall forward a form to the beneficiary for assignment of the beneficiary's rights to the District of Columbia in accordance with § 2331 of the Act.

115 ELECTION OF COMPENSATION

115.1 Whenever the Program determines that a beneficiary may be entitled to other benefits such as those described in § 2316(b) of the Act, it shall forward to the beneficiary a form for the election of which compensation the beneficiary wishes to receive.

116 NOTICE OF RETURN TO WORK

116.1 In all cases reported to the Program, the official superior shall be required to notify the Program immediately when the injured employee returns to work or when the disability ceases.

116.2 The official superior shall notify the Program if, after the employee returns to work, the same injury causes the employee to stop work again.

119 UTILIZATION REVIEW

119.1 Any medical care or service furnished or scheduled to be furnished under the Act shall be subject to utilization review. The review may be performed before, during, or after the medical care or service is provided.

119.2 A utilization review organization or individual used pursuant to the Act shall be certified by the Utilization Review Accreditation Commission.

119.3 The employee or the Program may initiate review where it appears that the necessity, character, or sufficiency of medical services is improper or clarification is needed on medical service that is scheduled to be provided.

119.4 The report of the review shall specify the medical records considered and shall set forth rational medical evidence to support each finding. The report shall be authenticated or attested to by the utilization review individual or by an officer of the utilization review organization. The report shall be provided to the employee and the Program.

- 119.5 A utilization review report which conforms to the provisions of § 119.4 of this chapter may be admissible in all proceedings with respect to any claim to determine whether medical care or service was, is, or may be necessary and appropriate to the diagnosis of the claimant's injury or disability.
- 119.6 If the medical care provider disagrees with the opinion of the utilization review organization or individual, the medical care provider may submit a written request to the utilization review organization or individual for reconsideration of the opinion. The request shall contain reasonable medical justification for the request and shall be made within sixty (60) calendar days from actual receipt of the utilization review report.
- 119.7 If a dispute arises between the medical care provider, and the employee, or the Program on the issue of necessity, character, or sufficiency of the medical care or service or fees charged to the medical provider, the dispute shall be resolved by the Director of the Department of Employment Services upon application for a hearing. The decision of the Director may be reviewed by the Superior Court of the District of Columbia without appeal to the Employees' Compensation Appeals Board.
- 119.8 The cost of a utilization review shall be paid by the District of Columbia government, if the employee seeks the review and is the prevailing party.

120 MEDICAL SERVICES AND SUPPLIES

- 120.1 Under § 2303(a) of the Act (D.C. Official Code § 1-624.03(a)), the District government shall furnish to an employee who is injured while in the performance of duty the services, appliances, and supplies prescribed or recommended by a qualified physician, which the Program on considers likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of the monthly compensation.
- 120.2 An injured employee may initially select a physician to provide medical services, appliances and supplies.
- 120.3 If there is a need for immediate medical treatment and, due to the nature of an injury, the injured employee is unable to contact a physician, the injured employee may seek treatment at an emergency care facility.
- 120.4 Once a physician is selected to provide treatment under the Act, an injured employee shall not change to another physician or hospital without authorization of the Program, except in an emergency. Notice of the provision of emergency care shall be provided to the Program within thirty (30) days after the care is rendered.

- 120.5 The physician shall file a comprehensive medical report, with the Program containing a diagnosis of physical findings or examination, a statement concerning relationship to employment, treatment plan, if any, and prognosis within ten (10) working days of an examination of the injured employee.
- 120.6 Any physician who continues to treat an injured employee shall, at no cost, provide periodic progress reports, treatment records, and bills to the Program, in compliance with § 120.5.
- 120.7 In no event shall a physician attempt to collect a disputed payment for medical services provided in connection with a compensable claim under the Act from the injured employee or beneficiary.
- 120.8 All medical providers shall include in each medical report and bill for services rendered under the Act, the code, as published by the American Medical Association (AMA) in the most current edition of the Physicians Current Procedural Terminology (CPT Codes), for detailing the billing of all medical procedures and the codes established by the most recent edition of the International Classification of Diagnosis (ICD) code, as published by the U.S. Department of Health and Human Services, for diagnosing the conditions.
- 120.9 The Program shall require a medical report from a medical care provider to substantiate payment of bills. The report shall be typewritten on the physician's letterhead, signed and dated by the attending physician.
- 120.10 If the injured employee is not satisfied with the medical care provided by his chosen physician, a request for change shall be submitted, in writing, with justification to the Program. The Program may order a change where it is found to be in the best interest of the injured employee.
- 120.11 Fees and other charges for treatment or medical services shall be limited to those that are reasonable and customary charges prevailing in the local medical community as determined by the Program.
- 120.12 The Program may require an injured employee to submit to physical examinations at times and places reasonably convenient for the employee.
- 120.13 The cost of physical examinations ordered by the Program shall be paid by the Program.

Section 199 is amended to read as follows:

199 DEFINITIONS

199.1

The definitions set forth in § 2301 of Title 23 (Disability Compensation) of the District of Columbia Government Comprehensive Merit Personnel Act of 1978 (D.C. Law 2-139) shall apply to this chapter. In addition, for purposes of this chapter, the following definitions shall apply and have the meaning ascribed:

Act - the District of Columbia Comprehensive Merit Personnel Act of 1978 (D.C. Law 2-139), Title 23, as amended and as it may be hereafter amended.

Administrative Law Judge or ALJ – a hearing officer of the Office of Hearings and Adjudication in the Administrative Hearings Division of the Department of Employment Services.

Beneficiary - an individual who is entitled to receive benefits under the Act.

Claim - an assertion properly filed and otherwise made in accordance with the provisions of this chapter that an individual is entitled to benefits under the Act.

Claimant - an individual who files a claim for entitlement from the Program for benefits under the Act or who is receiving those benefits.

Employment Agency - the agency or instrumentality of the District of Columbia Government which employs an individual who is defined as an employee by the Act.

Mayor - the Mayor of the District of Columbia or a person designated to perform his or her function under the Act.

Office of Hearings and Adjudication – the office in the Administrative Hearings Division of the Department of Employment Services where Administrative Law Judges adjudicate workers’ compensation claims, including public sector workers’ compensation claims under D.C. Official Code § 1-623.01, *et seq.*

Official Superior - officers and employees having responsibility for the supervision, direction or control of employees.

Program – the Public Sector Workers’ Compensation Program of the Office of Risk Management.

Title 7, EMPLOYMENT BENEFITS, of the DCMR is amended as follows:

Chapter 31, OFFICE OF RISK MANAGEMENT TERMINATION, SUSPENSION OR REDUCTION OF PUBLIC SECTOR WORKERS' COMPENSATION BENEFITS FOR DISTRICT EMPLOYEES, is repealed and replaced with:

Chapter 31, OFFICE OF RISK MANAGEMENT TERMINATION, SUSPENSION OR REDUCTION OF DISABILITY COMPENSATION BENEFITS FOR DISTRICT EMPLOYEES

Section 3100 is amended by amending subsections 3100.1 and 3100.2 to read as follows:

- 3100.1 The provisions of Chapter 31 are applicable to the District of Columbia's (District) Public Sector Workers' Compensation Program (Program), administered by the Office of Risk Management (ORM). To the extent that there is a conflict between the rules set forth herein and other rules in Chapter 1 of this title, the rules in Chapter 31 shall control with respect to any matter that is within the jurisdiction of the ORM.
- 3100.2 ORM has oversight and administrative responsibility for the Program, including all Initial Determinations (IDs) and Eligibility Determinations (EDs) rendered by the ORM.

Section 3131 is amended by amending subsections 3131.12 -and 3131.16 to read as follows:

- 3131.12 The employee shall submit proper medical documentation as requested by the ORM to support the employee's ongoing injury and absence from work. These documents shall include, but are not be limited to the following:
- (a) Statements and medical documentation regarding any similar injury that occurred prior to the alleged injury;
 - (b) Statements and medical documentation regarding any other injury or accident of a similar character; and
 - (c) A written statement showing why there was a delay in seeking medical care.
- 3131.16 The ID is effective unless the employee succeeds on a request for hearing as provided in Chapter 1.

Section 3132 is amended to read as follows:

3132 PROCEDURES FOR EXISTING CLAIMS

- 3132.1 The Program shall review EDs for compensation benefits, including decisions to terminate, suspend, or modify benefits.
- 3132.2 The Program shall adjust a claim using information from the treating physician who provides medical treatment to the employee for an injury or disability and from any Additional Medical Examination (AME) report. An AME shall consist of a case file review, and/or an in-person assessment or examination, by a qualified health professional other than the treating physician.
- 3132.3 An AME report shall be conclusive and responsive to the requests from the Program as part of a complete professional evaluation. Prior to any determination of coverage based upon the recommendation(s) of an AME, the injured employee's treating physician shall have thirty (30) days from receipt of a copy of the AME to submit written comments to the Program regarding the AME finding(s).
- 3132.4 Upon a request from the Program, the employee and the treating physician shall provide copies of all the employee's medical records regardless of the source of the record(s) or the medical condition(s) addressed in the records. The Program shall take appropriate steps to ensure that the medical records provided to it are maintained in a confidential manner.
- 3132.5 An employee who is receiving benefits under the Program shall not be the subject of an ED unless and until there is sufficient evidence to support the issuance of an ED pursuant to the Act and this section.
- 3132.6 An ED may be based, in whole or in part, upon the following factors:
- (a) The death of the employee;
 - (b) The clear evidence that employee has returned to work;
 - (c) The employee's conviction of fraud in connection with the claim;
 - (d) The employee's failure to participate in vocational rehabilitation or to cooperate with the Program's request for a physical examination;
 - (e) The cessation or lessening of a compensable injury;
 - (f) The condition is no longer causally related to the employment;
 - (g) The condition has changed from a total disability to a partial disability;

- (h) The employee has returned to work on a full-time or part-time basis notwithstanding individuals directed to undergo vocational rehabilitation under section 2304 of the Act;
- (i) The Program determines based upon strong compelling evidence that the ID was in error; and
- (j) Any other ground demonstrating that the Act requires the employee's benefits to be modified, such as abandonment of the claim, retirement of the employee, or clear evidence that the employee has knowingly and willfully received benefits to which he or she was not entitled under the Act.

3132.7 With the exception of the factors set forth in subsection 3132.6 (a)--(d), compensation benefits subject to an ED shall not be modified until the period for requesting reconsideration set forth in section 3134 has elapsed with no Request for Reconsideration being received by the ORM, or until a timely Request for Reconsideration has been decided by the ORM, whichever is earlier.

3132.8 A claim shall be deemed abandoned or subject to modification for non-cooperation when the employee fails to return required forms for an existing claim, the Program has made at least two (2) attempts to contact the employee and request such forms, and at least fourteen (14) calendar days prior to the issuance of the notice, the Program sends the employee a warning letter explaining why the Program believes the employee is not cooperating or has abandoned the claim, what the employee must do in order to comply, and describing the consequences of failing to cooperate or abandonment.

3132.9 In making its determinations regarding whether a claim should be the subject of an ED, the Program shall consider all relevant evidence in the claim file, including all relevant medical evidence.

3132.10 The ED is effective unless the employee succeeds on a request for reconsideration under section 3134 or the Program revises the ED.

3132.11 Medical reports used in connection with an ED shall meet the requirements of section 3160.

Section 3161 is amended by amending subsection 3161.1 to read as follows:

3161.1 An employee and his or her attorney shall have access to the Program's file pertaining to his or her claim. The Program's files pertaining to Public Sector Workers' Compensation are District of Columbia property.

Section 3162 is amended to read as follows:

3162 PAYMENT OF COMPENSATION BENEFITS ON REMAND FROM APPEAL

3162.1 The Program shall pay compensation to the employee pursuant to an order of an ALJ, provided the employee, within fifteen (15) days of the Order, has submitted:

- (a) Verification of the injury for the period specified in the Order;
- (b) Verification of lost wages for the period specified in the Order, including but not limited to, all wage documentation for the period (i.e., pay stubs, W-2 or 1099 income tax forms, and/or other related income earnings statements).

Section 3199 is amended to read as follows

3199 DEFINITIONS

3199.1 When used in this chapter, the following terms shall have the following meanings:

Act -- Title XXIII of the District of Columbia Comprehensive Merit Personnel Act of 1978, effective March 3, 1979, D.C. Law 2-139, D.C. Official Code § 1-623.01, *et seq.* (2001).

Best practices -- practices that reflect well-established methods of adjustment for weighing evidence, consulting industry reference materials, seeking advice from medical consultants, and engaging in the other steps of adjustment commonly known in the Public Sector Workers' compensation field.

Claim File -- all program documents, materials, and information, written and electronic, pertaining to a claim, excluding that which is privileged or confidential by law or custom within the Public Sector Workers' Compensation industry.

Controversion -- holding a claim in abeyance due to insufficient information to either accept or deny.

Eligibility Determination (ED) -- a decision concerning, or that results in, the termination, suspension or reduction of a claimant's existing Public Sector Workers' compensation benefits, excluding de minimus modifications and corrections of technical errors that affect five percent (5%) or less of the claimant's monetary benefits.

Good Cause -- "excusable neglect," as defined in the Federal Rules of Civil Procedure, Rule 6(b)(2) and interpretive case law.

Initial Determination (ID) -- a decision regarding initial eligibility for benefits under the Act, including decisions to accept, deny, or controvert new claims, pursuant to this subchapter.

Medical opinion-- a statement from a physician, psychiatrist, psychologist or other acceptable medical source that reflects judgments about the nature and severity of an impairment, including: symptoms, diagnosis and prognosis, physical or mental restrictions, and what the employee is capable of doing despite his or her impairments.

Office of Risk Management (ORM) -- the agency within the Government of the District of Columbia that is responsible for the District of Columbia's Public Sector Workers' Compensation Program or its designee.

Qualified health professional-- includes a surgeon, podiatrist, dentist, clinical psychologist, optometrist, orthopedist, neurologist, psychiatrist, chiropractor or osteopathic practicing within the scope of their practice as defined by state law. The term includes a chiropractor only to the extent that reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the Mayor.

Treating physician-- the physician, psychiatrist, psychologist, or other medical source who provided the greatest amount of treatment and who had the most quantitative and qualitative interaction with the employee.