OFFICE OF RISK MANAGEMENT

NOTICE OF EMERGENCY RULEMAKING

The Chief Risk Officer 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 (2016 Supp.)); the Office of Administrative Hearings Establishment Act of 2001 (OAH Act), effective March 6, 2002 (D.C. Law 14-76, D.C. Official Code §§ 1-1831.01 *et seq.* (2014 Repl.)); Section 7 of Reorganization Plan No. 1 of 2003 for the Office of Risk Management, December 15, 2003; and Mayor's Order 2004-198, dated December 14, 2004, hereby gives notice of the adoption, on an emergency basis, of the following amendments to Chapters 1 (Public Sector Workers' Compensation Benefits) and 33 (Revised Public Sector Workers' Compensation Benefits) of Title 7 (Employment Benefits) of the District of Columbia Municipal Regulations (DCMR).

The purpose of these rules is to amend portions of the existing rules effective November 30, 2018. The need for these rules to take effect as of that date is for the immediate preservation and promotion of the health, safety, and welfare of the residents of the District by supporting the Program's transition from third-party administration to self-administration of the Public Sector Workers' Compensation Program (Program). The adoption of emergency rules is necessary to support the transition to self-administration by way of establishing: (1) new hearing procedures and standards to be employed by the Chief Risk Officer to resolve disputes between a medical care provider, employee, or the District of Columbia government on the issue of necessity, character, or sufficiency of the medical care or service furnished, or scheduled to be furnished, or the fees charged by the medical care provider under Sections 2323(a-2)(4) of the CMPA; (2) to clarify the type of hearings to be conducted by the Office of Administrative Hearings (OAH) under Sections 2324(b)(1) and (2) and D.C. Official Code § 2-1831.03(b)(1) (2012 Repl.); (3) uniform procedures for electronic claim filing and clarification of benefit calculations to allow for implementation of the Program's electronic system for managing claims and integration of the Program's new claims management system with the District's payroll system, both of which are integral to self-administration of the Program; (4) procedures and rules governing the creation, operation, and oversight of the PSWCP's Healthcare Provider Panel under Section 2303(d)(1) of the CMPA; (5) rules concerning the provision of medical care to injured workers by the Program's Healthcare Provider Panel under Section 2303(d)(1) and 2324 of the CMPA; and (6) rules and procedures to adjudicate bills for medical and other services afforded injured District employees under Subchapter 23 of the CMPA and to develop and maintain Provider Agreements for the provision of such services. All of these aforementioned rules and procedures were previously addressed by the private Third-Party Administrator (TPA) of the Program through the TPA's proprietary electronic claims management systems and contractual arrangements it had by virtue of its network and other agreements with medical providers. The TPA ceased its operations effective August 1, 2018. ORM adopted emergency rules at that time to establish a regulatory framework to substitute for the TPA's systems and contractual network procedures so as to ensure that injured workers would have uninterrupted access to medical care and the Program would have a means to effect payment to medical providers. Through implementation of those rules and administration of the Program, these emergency rules were developed in conjunction with a proposed final rulemaking.

These emergency rules were adopted on December 3, 2018 and will take effect December 3, 2018. The emergency rules will remain in effect for a period of one hundred twenty (120) days from adoption or until the publication of a Notice of Final Rulemaking, whichever occurs first. A Notice of Proposed Rulemaking will be published in conjunction with this Notice of Emergency Rulemaking.

Chapter 1, PUBLIC SECTOR WORKERS' COMPENSATION BENEFITS, of Title 7 DCMR, EMPLOYMENT BENEFITS, is amended as follows:

Section 104, NOTICE OF INJURY; EMPLOYEE OR REPRESENTATIVE ACTION, is amended as follows:

Subsections 104.1 – 104.4 are amended to read as follows:

104.1 Notice of an employee's injury or death shall be given in accordance with Section 2319 of the Act (D.C. Official Code § 1-623.19) or § 104.6 of this chapter. Notice of recurrence of disability or medical condition shall be given in the same manner as a notice of injury.

104.2 The notice required by subsection § 104.1 of this chapter shall be deemed given upon:

(a) Electronic submission of a workers' compensation incident report through the Program's online portal, as designated on the Office of Risk Management's website, or the filing of Form 1 in hard copy with the Program or employee's immediate supervisor; and

(b) The Program or employee's immediate supervisor's receipt of the following completed documents:

(1) Form 4 – Employee Authorization for Release of Medical Records; and

(2) IRS Form 4506-T – Request for Transcript of Tax Return.

104.3 The workers' compensation incident report and Form 1 shall:

(a) Be in writing;

(b) Be signed by the individual giving notice; and

(c) Contain the email and physical mailing address of the individual giving notice.

104.4 (a) When notice is given in accordance with § 104.1 of this chapter, the person giving notice shall designate an email address(es) to receive notices and correspondence from the Program. The person giving notice shall be responsible for checking the designated email account for notices and correspondence from the Program. Anyone who cannot comply with this provision may apply to the Program for a waiver. A waiver shall be granted, where good cause is established.

(b) While the Program may mail notices or correspondence to the designated physical mailing address, any notice or correspondence sent to the designated email address, unless returned, shall be presumed received and the date of issuance shall be used to calculate any deadlines that arise from the notice or correspondence issued.

Section 105, NOTICE OF INJURY, DISEASE OR DEATH; EMPLOYING AGENCY ACTION, is amended as follows:

Subsections 105.1 – 105.5 are amended to read as follows:

105.1 In accordance with Section 2320 of the Act (D.C. Official Code § 1-623.20), the immediate supervisor of an employee shall report any injury to the employee that results in the employee's death, bodily harm, or probable disability to the Program by telephone or through the Program's online portal, as designated on the Office of Risk Management's (ORM) website.

105.2 (a) The immediate supervisor shall make an initial report of injury to the Program through the Program's online portal found on ORM's website within twenty-four (24) hours of learning of the injury, and preferably before the end of the shift during which the supervisor learned of the injury.

(b) No later than three (3) days after receipt of a grant access link requesting additional information from the Program, the immediate supervisor shall log onto the online portal through the grant access link and submit the requested information through the online portal.

105.3 If an immediate supervisor receives Form 1, the immediate supervisor shall report the incident in accordance with §105.2 of this chapter.

105.4 The immediate supervisor shall supply all information identified in the online portal and upload all available supporting documentation through the online portal at the time the report of injury is submitted.

105.5 If an employee elects COP, the employing agency shall respond to the employee's request for COP in accordance with §109 of this chapter.

Section 106, NOTICE OF INJURY; PSWCP ACTION, is amended as follows:

Subsection 106.1 is amended to read as follows:

106.1 (a) Promptly, after receiving notice of an employee's injury or death, the Program shall:

(1) In the event of injury, notify the employee or employee's representative that a report of injury has been received for the employee, if the report was filed by the employing agency;

(2) In the event of an employee's death, notify eligible beneficiaries of record that a report of death of the employee has been received; and

(3) Provide the employee, employee's representative, or eligible beneficiaries, as applicable, with instructions on how to file a claim for workers' compensation.

(b) The Program's failure to provide notification pursuant to this subsection shall not be prima facie evidence of good cause for a delay in submitting a claim.

Section 108, COP, EMPLOYEE'S RESPONSIBILITIES, is amended as follows:

Subsections 108.1 and 108.2 are amended to read as follows:

108.1 To file a claim for COP, the employee or employee's representative shall:

(a) Submit notice of injury pursuant to § 104 of this chapter and complete the indicated portion for COP as soon as possible, but no later than thirty (30) days after the traumatic injury;

(b) Submit Forms 3, 3A, 4, and IRS Form 4506-T to the Program through the Program's designated online portal or by mail or fax or to the employee's immediate supervisor by hand delivery;

(c) Ensure that medical evidence supporting disability resulting from the claimed traumatic injury, including a statement as to when the employee can return to his or her date of injury job, is provided to the employing agency's workers' compensation coordinator and the Program within ten (10) calendar days after the claim for COP is filed;

(d) Cooperate with the Program and the employing agency's workers' compensation coordinator in developing the claim; and

(e) Ensure that the qualified health professional specifies work limitations and that the work limitation information is provided to the employee's immediate supervisor, the employing agency's workers' compensation coordinator, and the Program within ten (10) calendar days after the claim for COP is filed.

108.2 An employee's COP status shall not be construed to preclude the employee from filing a claim for workers' compensation pursuant to § 115 of this chapter. COP payments shall terminate upon the Program's acceptance or denial of the claim for workers' compensation.

Section 109, COP, EMPLOYING AGENCY'S RESPONSIBILITIES, is amended as follows:

Subsections 109.1 - 109.2 are amended to read as follows:

109.1 After the employing agency learns of a work injury sustained by an employee, it shall:

(a) Refer the employee to ORM's Public Sector Workers' Compensation website;

(b) Advise the employee of the right to receive COP for any period of disability;

(c) Review and respond to the employee's claim for COP by completing the COP determination section of the Program's online form and uploading all relevant documents, forms, and pertinent information (including the basis for any controversion) to the Program online portal within three (3) business days after receiving a request for additional information through a grant access link or the employee's completed Form 1, Form 3, Form 3A, Form 4, and Form IRS 4506-T from the employee; and

(d) If controverting employee's claim for COP, inform the employee of the basis for doing so.

109.2 An employing agency that learns of a recurrent disability arising out an injury for which a claim for COP has already been accepted shall place the employee on COP status if:

(a) The employee has any time remaining from the last time the employee was on COP status for the same injury;

(b) No claim for wage-loss compensation has been accepted by the Program; and

(c) The employee submits evidence in support of the recurrence of disability and its causal relation to the original work injury.

Section 112, CALCULATION OF COP, is amended as follows:

Subsection 112.1 is amended to read as follows:

112.1 Once an employee makes a claim for COP, the first three (3) days of leave must be charged to leave without pay, unless the disability:

(a) Exceeds fourteen (14) calendar days; or

(b) Is followed by permanent disability.

Section 115, CLAIM FOR PSWCP BENEFITS; EMPLOYEE OR REPRESENTATIVE ACTION, is amended as follows:

Section 115 is amended to read as follows:

Section 115 CLAIM FOR PSWCP BENEFITS; CLAIMANT OR REPRESENTATIVE ACTION

Subsection 115.2 is amended to read as follows:

115.2 A claim for compensation is deemed filed only upon:

(a) The filing of a claim for workers' compensation through the Program's online portal, as designated on the Office of Risk Management's website, or the filing of Form CA7, Part A in hard copy with the Program; and

(b) The Program's receipt of the following completed documents:

(1) Form 3 – Physician's Report of Employee's Injury;

(2) Form 3A – Employee's Statement of Medical History;

(3) Form 4 – Employee Authorization for Release of Medical Records; and

(4) IRS Form 4506-T – Request for Transcript of Tax Return.

Subsections 115.4 - 115.5 are amended to read as follows:

115.4 At the time the claimant or claimant's representative submits a claim, an email address and physical mailing address must be provided for the claimant and if applicable the claimant's representative, for the purpose of receiving Program notices and correspondence. Any notice or correspondence sent to the designated email address or physical mailing address shall be presumed received, unless returned.

115.5 In the case of the death of an employee, the claimant or claimant's representative shall also provide documentation establishing the claimant's relationship to the deceased. Documentation may include:

(a) A certified copy of a birth certificate;

(b) A certified copy of a marriage license;

(c) Documentation of the executor of the employee's estate; or

(d) Other documentation satisfactory to the Program.

Subsections 115.7 - 115.15 are amended to read as follows:

115.7 The employee shall complete, sign, and return to the Program, Form 3A, Employee's Statement of Medical History, which shall:

(a) Describe any and all accidents the employee was involved in, or physical disability or illness the employee suffered, prior or subsequent to the reported injury;

(b) For each accident, illness, or physical disability, identify the time, date, circumstance, and location of the accident or incident, the parties involved, the disposition of any subsequent trial or legal action(s), any injuries relating from the previous accident(s) or incident(s), and the hospital, medical facilities, doctors, physicians, dentists, or any other individual that treated any injury, illness, or physical disability;

(c) Identify the physician who treated the employee and the approximate dates of such treatments, if employee alleges aggravation of a previous injury or condition;

(d) Describe in detail each instance during the past five (5) years that the employee has been absent from employment due to an illness or injury, including the nature and dates of each such illness or injury. The employee

or employee's representative shall specify the date and time for all absences from employment due to each illness and injury claimed; and

(e) Describe any similar condition, disability, or injury that occurred prior to the alleged injury or any pre-existing condition that may be related to the condition or disability caused by the injury.

115.8 The claimant or claimant's representative shall submit proper medical documentation as requested by the Program to document the employee's ongoing injury and substantiate the employee's absence from work to justify continued payment of wage-loss compensation. These documents shall include, but are not limited to, the following:

(a) Statements and medical documentation regarding any similar condition, disability, or injury that occurred prior to the alleged injury or any pre-existing condition that may be related to the injury;

(b) Statements and medical documentation regarding any other injury or incident of a similar character; and

(c) A written statement showing why there was a delay in seeking medical care, if applicable.

115.9 After a claim is initiated, a claimant who wishes to continue representation by his or her representative must complete and return Form 15 – Declaration of Representative Form to the Program, so the claimant's representative may continue to receive communication and information related to the claim, unless the representative is appointed by a court of law or is the claimant's attorney, and a court order or retainer agreement, respectively, is submitted to the Program in lieu of Form 15. If the claimant is a minor child, documentation establishing legal guardianship may be submitted in lieu of Form 15.

115.10 The claimant or claimant's representative shall file supplemental reports when required by the Program or when there is any change in information provided to the Program.

115.11 A claimant seeking to supplement his or her original claim to add additional disabilities or conditions arising out of the same injury, but not already reported, shall:

(a) File a supplemental claim to add the additional disability or condition within two (2) years after the earlier of:

(1) The date on which the claimant first sought medical attention for the additional disability or condition and was aware or, by the exercise of reasonable diligence should have been aware, of the causal

relationship between the claimant's condition and employment, whether or not the claimant ceased work; or

(2) The date on which the claimant became disabled and was aware or, by the exercise of reasonable diligence should have been aware, of the causal relationship between the claimant's disability and employment.

(b) The supplemental claim shall include a signed statement under penalty of perjury explaining the cause for delay in reporting the additional disability or condition.

115.12 Claims for aggravated injury shall be filed as an original claim for compensation pursuant to Section 2321 of the Act (D.C. Official Code § 1-623.21) and §§ 115.1 through 115.10 of this chapter within two (2) years from the injury that aggravated, worsened or exacerbated the employee's pre-existing disease, illness or condition, unless otherwise authorized by law.

115.13 Claims for latent disability shall be filed pursuant to Section 2322 of the Act (D.C. Official Code § 1-623.22) and §§ 115.1 through 115.10 of this chapter within two (2) years after the earlier of:

(a) The date on which the claimant first sought medical attention for the claimant's condition and was aware or, by the exercise of reasonable diligence should have been aware, of the causal relationship between the claimant's condition and employment, whether or not the claimant ceased work; or

(b) The date on which the claimant became disabled and was aware or, by the exercise of reasonable diligence should have been aware, of the causal relationship between the claimant's disability and employment.

115.14 Claims for the recurrence of disability shall include medical evidence to establish that the recurrence is for the same condition and injury for which the claim was originally accepted and be filed pursuant to §§ 115.1 through 115.10 of this chapter through within one (1) year after the date wage-loss compensation terminates or, if such termination is appealed, within one (1) year after the date of the final order was issued by a judicial entity, unless

(a) The inability to work occurred because a modified duty assignment made specifically to accommodate the employee's physical limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.

115.15 All other original claims for compensation for disability or death arising out of a single injury shall be filed within two (2) years after the injury or death pursuant to Section 2321 of the Act and § 115 of this chapter, except as provided by Section 2322(a) of the Act (D.C. Official Code § 1-623.22(a)).

Section 120, DECISIONS ON ENTITLEMENT TO BENEFITS, is amended as follows:

Subsection 120.10 is added to read as follows:

120.10 The Program shall issue a Notice of Benefits within fourteen (14) days of an ID or DRD granting an award of compensation. The Notice of Benefits shall set forth the calculation of benefits pursuant to the award.

Section 122, MEDICAL BENEFITS AND SERVICES; GENERAL, is amended as follows:

Subsection 122.1 is amended to read as follows:

122.1 Pursuant to Section 2303(a) of the Act (D.C. Official Code § 1-623.03(a)), the District government shall furnish to an employee or claimant who is injured while in the performance of duty the services, appliances, or supplies prescribed or recommended by a qualified health professional whom the Program has admitted into its Panel of Healthcare Providers, except as provided in § 125.7 of this chapter.

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A new subsection 122.2 is added to read as follows:

122.2 Payment for services, appliances, or supplies pursuant to Section 2303 of the Act (D.C. Official Code § 1-623.03(a)) shall only be made, where the services, appliances, or supplies are:

(a) Rendered for treatment of a condition that has been accepted as compensable under the Act by the Program or necessary for the Program to issue a compensability determination, and

(b) Ordered by a District of Columbia government medical officer or hospital, or a qualified health professional pursuant to the rules prescribed at § 124 of this chapter, subject to utilization review.

Section 123, MEDICAL BENEFITS AND SERVICES; EMPLOYEE RESPONSIBILITY, is amended as follows:

Subsections 123.1 – 123.5 are amended to read as follows:

123.1 (a) All medical services, appliances, or supplies provided to an injured employee or claimant must be pre-authorized by the Program in order to be paid or reimbursed by the Program, except as provided in paragraph (b) of this subsection.

(b) If there is a need for emergency treatment the employee or claimant may, without prior authorization by the Program, select a healthcare provider to provide reasonably necessary emergency medical care prescribed by a qualified health professional for an injury sustained in the performance of duty, and such medical services, appliances, or supplies may be paid or reimbursed by the Program, subject to utilization review, if notice of such medical care is given to the Program no later than thirty (30) days after the care is rendered.

123.2 In order for the Program to pay for the medical services, appliances, or supplies provided by a healthcare provider and prescribed by a qualified health professional, the healthcare provider must be a member of the Program's Panel of Healthcare Providers, except as provided in §§ 123.1(b) and 123.4 of this chapter.

123.3 The Program's reimbursement for any expenses incurred for medical services, appliances, or supplies provided pursuant to Section 2303 of the Act (D.C. Official Code § 1-623.03) shall be limited by the fee schedule prescribed in this chapter.

123.4 Once an employee or claimant selects a qualified health professional from the Program's Panel of Healthcare Providers, the Program will not pay for or reimburse the costs of medical care provided or prescribed by another qualified health professional without authorization of the Program, except as provided in § 123.1(b) of this chapter.

123.5 An employee or claimant who is not satisfied with medical services provided by the qualified health professional selected from the Program's Panel of Healthcare Providers shall file Form M3 with the Program to request to change the qualified health professional, with justification in support of the request. The Program shall authorize a change where the Program finds the change is in the best interest of the employee or claimant.

Subsection 123.6 is added to read as follows:

123.6 An employee or claimant may request reimbursement of expenses for medical services, appliances, or supplies that are incurred prior to (i) acceptance of the claim or (ii) reinstatement of the claim pursuant to a compensation order by completing and submitting Form MR with a copy of the bill and medical record to the Program, provided such expenses have not otherwise been paid for by insurance.

(a) If the Program does not respond within thirty (30) days of receipt of a request for reimbursement submitted pursuant to this subsection, the Claimant may file a request for an audit to request review of the reimbursement request by the Chief Risk Officer pursuant to § 153 of this chapter.

Section 124, MEDICAL BENEFITS AND SERVICES; PROGRAM RESPONSIBILITY, is amended as follows:

Subsections 124.1 – 124.5 are amended to read as follows:

124.1 The Program shall establish a Program Panel of Healthcare Providers (hereinafter the "Panel") to furnish medical services, appliances, or supplies to District government employees or claimants who are injured while in the performance of duty, in accordance with the Act and rules and regulations of the Program.

124.2 (a) The Program shall select members of the Panel based on the healthcare provider's ability to cure, give relief, reduce the degree or length of injury, or aid in lessening the amount of the monthly compensation.

(b) A qualified health professional shall apply to be a member of the Panel, pursuant to an application issued by the Program. Any other healthcare provider may be designated a member by the Program without application.

(c) The Program may add and remove healthcare providers from the Panel at its discretion. A decision by the Program to remove a member from the Panel shall be final.

124.3 If the Program decides to remove a qualified health professional from the Panel, the Program shall give all of the claimants currently being treated by that qualified health professional notice of the decision, as well as a list of up to three (3) alternative Panel qualified health professionals, at least thirty (30) days before the qualified health professional is removed from the Panel.

124.4 The Program shall take appropriate steps to ensure that medical records are maintained in a confidential manner.

124.5 The Program may require a claimant to submit to physical examinations as frequently as may be reasonably required to investigate a claimant's initial and continued eligibility for benefits under the Act, as provided at § 136 of this chapter.

Subsections 124.6 – 124.12 are added to read as follows:

124.6 Upon notification of an injury or acceptance of a claim for compensation, the Program shall provide the employee or claimant with a list of up to three (3)

qualified health professionals from the Panel and inform the employee or claimant of the requirements in § 123 of this chapter.

124.7 Within thirty (30) days after receipt of a written request for prior authorization for any medical care, supply, or service, the Program shall provide the claimant and qualified health professional written notice approving, denying, or disputing the request. If no authorization is granted within thirty (30) days the medical care, supply, or service shall be deemed approved, provided the medical care, supply, or service is for a condition that has been accepted as compensable by the Program.

124.8 When the Program disputes or denies a request for prior authorization by a qualified health professional pursuant to § 124.7 of this chapter because the Program believes the necessity, character, or sufficiency of the medical care is improper, the Program shall:

(a) Provide written notice of the dispute or denial to the claimant and qualified health professional; and

(1) Initiate utilization review;

(2) Request a hearing on the matter before the Chief Risk Officer; or

(3) Provide, with the written notice of denial or dispute, information about the claimant's rights to initiate utilization review and the claimant and the qualified health professional's right to request a hearing before the Chief Risk Officer.

124.9 If the Program denies a request for prior authorization for medical care, pursuant to § 124.7 of this chapter on any basis other than the necessity, character, or sufficiency of the medical care, the Program shall:

(a) Provide written notice of the denial to the claimant and qualified health professional; and

(b) Provide, with the written notice of denial to claimant, information about the claimant's right to appeal the decision to the Chief Risk Officer pursuant to § 156 of this chapter.

124.10 The Program shall not reimburse or pay costs incurred for services rendered by a healthcare provider who is not a member of the Program's Panel of Healthcare Providers, unless otherwise authorized by law or regulation or awarded on appeal. Reimbursement for costs incurred for services rendered by non-Panel healthcare providers shall be subject to utilization review and limited by the fee schedule prescribed in this chapter.

124.11 The Program may enter into a provider agreement with a healthcare provider that sets forth the provisions of this Chapter and additional terms and conditions relating to the provision of services to District government employees and claimants, as determined by the Program to be reasonable and necessary to ensure appropriate care, including fee and payment guidelines.

124.12 The Program shall issue a decision on a request for reimbursement of medical services, appliances, or supplies submitted by a claimant pursuant to § 123.6 of this chapter within thirty (30) days of receipt of Form MR and required supporting documentation.. The Program's decision shall include notice of claimant's right to appeal pursuant to § 156 of this chapter.

Section 125, MEDICAL BENEFITS AND SERVICES; TREATING PHYSICIAN RESPONSIBILITY, is amended to read as follows:

125 MEDICAL BENEFITS AND SERVICES; HEALTHCARE PROVIDER RESPONSIBILITY

Subsections 125.1 – 125.8 are amended to read as follows:

125.1 A healthcare provider who provides medical services, appliances, or supplies to an injured employee or claimant must comply with the provisions in this chapter.

125.2 Unless otherwise directed or required by the Program, the following information shall be included in a Form 3, Form 3S, Form 3RC, or other Program-approved medical report(s) submitted by a qualified health professional:

(a) Date(s) of examination and treatment, if any;

(b) History given by the employee;

(c) Physical findings;

(d) Results of diagnostic tests;

(e) Medical records reviewed;

(f) Diagnosis;

(g) Nature of injury;

(h) Manner and mechanism of injury, to include the qualified health professional's opinion, with medical reasons and bases, as to the probable cause and mechanism of injury;

(i) Description of any other conditions found that are not due to the claimed injury, including indications of pre-existing conditions that may be the cause of or contribute to any alleged disabling condition;

(j) Treatment given, if any;

(k) Course of treatment, including treatment plan recommended for the claimed injury or recurrence of disability to bring about maximum medical improvement, if any;

(l) In the case of a claimed recurrence of disability, the qualified health professional's opinion, with medical reasons and bases, as to causal relationship between the diagnosed condition(s) and the original work-place injury and resulting condition(s);

(m) Nature, extent, and expected duration of disability affecting the employee's or claimant's ability to work due to the injury;

(n) Prognosis for recovery, including an estimate regarding when the employee or claimant will be able to return to work; and

(o) All other material findings.

125.3 Unless otherwise authorized by the Program, a qualified health professional shall, within five (5) business days after any medical care is provided following the initial examination of the injured employee or claimant, transmit Form 3S or other Program-approved medical report(s) containing information required under § 125.4 of this chapter to the Program electronically at the email address or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management website.

125.4 Unless otherwise authorized by the Program, within seven (7) business days after an initial examination of the injured employee or claimant, a qualified health professional shall transmit Form 3 or other Program-approved medical report(s) containing information required under § 125.4 of this chapter to the Program electronically at the email address or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management website.

125.5 A healthcare provider who provides medical services, appliances or supplies, to an injured employee or claimant shall, at no cost, provide medical reports and records pertaining to the services, appliances, or supplies rendered no later than ten (10) days after receipt of the Program's request for such reports and records.

125.6 A healthcare provider shall include in each medical report for services rendered under the Act, the code, as published by the American Medical Association (AMA)

in the most current edition of the Current Procedural Terminology (CPT codes), for detailing the billing of each medical procedure provided by the healthcare provider and the diagnosis code established by the most recent edition of the International Classification of Diseases (ICD), as published by the U.S. Department of Health and Human Services, for diagnosing the claimant's condition. If there is no standard CPT code for a procedure provided by the healthcare provider, additional CPT Codes may be prescribed by the Program, as published on the ORM website.

125.7 In order to be paid by the Program for compensable medical services, appliances, or supplies provided to an employee or a claimant, a healthcare provider must be a member of the Program's Panel of Healthcare Providers at the time service is provided, unless:

(a) The medical care is provided pursuant to § 123.1(b) of this chapter;

(b) The healthcare provider belongs to a network of healthcare providers to which the Program has secured access to care for employees or claimants through a license or working agreement and within two hundred and forty (240) days after first treating an injured District government employee or claimant as a healthcare provider participating within such a network:

(1) Is designated a member of the Panel by the Program; or

(2) With respect to a qualified health professional, applies for admission to the Program's Panel of Healthcare Providers (only for so long as the application is pending).

(c) The healthcare provider is a pharmacy or pharmacist licensed in the jurisdiction where medication or prescription drugs are dispensed.

125.8 A qualified health professional must apply to be a member of the Program's Panel of Healthcare Providers to provide or prescribe medical care to a claimant or employee, and any other healthcare provider must be designated a member of the panel by the Program in order to provide services, appliances or supplies, except as provided in §125.7.

Subsections 125.9 – 125.14 are added to read as follows:

125.9 A healthcare provider selected to be a member of the Program's Panel of Healthcare Providers shall:

(a) Submit the following documentation, as applicable, pertaining to the jurisdiction in which the healthcare provider is licensed

(1) License number;

(2) Board name;

(3) The name of the state in which the provider is certified or licensed; and

(4) At the Program's request, information regarding any sanctions the provider may have received since licensure or certification;

(b) Possess and maintain appropriate insurance as determined by the Program;

(c) Notify the Program of any material changes, including changes to licensure, insurance coverage, staff who provide treatment to injured employees or claimants, or certification or history of sanctions or adverse action taken against the provider or staff, within fourteen (14) days of a change;

(d) Comply with the payment guidelines prescribed by the District of Columbia Office of the Chief Financial Officer, published on the Healthcare Provider Information Page of the Office of Risk Management website; and

(e) Comply with the terms and conditions of a Provider Agreement (if any).

125.10 A healthcare provider who provides compensable medical care to a District government employee or claimant shall comply with the medical billing rules prescribed at §126 of this chapter as a condition for payment of services rendered.

125.11 Unless the medical care is needed for emergency care pursuant to § 123.1 of this chapter or the service to be rendered is limited to an office or clinic visit with a qualified health professional, any prescribed medical services, appliances, or supplies requires prior authorization from the Program.

125.12 To seek prior authorization, a qualified health professional shall complete and electronically submit Form 3PA to the Program in the manner prescribed on the Healthcare Provider Information page found at the ORM website.

125.13 The cost of physical examinations ordered by the Program shall be paid by the Program.

125.14 A Panel healthcare provider who provides medical services, appliances, or supplies to a District government employee or claimant for a condition that is accepted by the Program as compensable under the Act shall not attempt to collect payment for such medical services, appliances, or supplies from the employee or claimant.

Section 126, MEDICAL BILLS, is amended as follows:

Subsections 126.1 – 126.6 are amended to read as follows:

126.1 (a) Medical services, appliances, or supplies shall be billed and reimbursed at a rate that does not exceed the rate set forth on the medical fee schedule adopted by the Program.

(b) For medical services, appliances, or supplies included on a Medicare fee schedule, the rate set forth on the Program's fee schedule shall be one hundred-thirteen percent (113%) of Medicare's reimbursement rates. For purposes of this chapter, medical supplies include medication and prescription drugs.

(c) For medical services, appliances, or supplies not included on a Medicare fee schedule, the billing and reimbursement rate shall be the rate set forth for the services, appliances, or supplies on the Program's fee schedule published on the Healthcare Provider Information Page of the Office of Risk Management website.

(d) If a medical service, appliance, or supply is not included on a Medicare fee schedule or the Program's published fee schedule, the billing and reimbursement rates shall be limited to the reasonable and customary charges prevailing in the local medical community, as determined by the Program.

(e) Notwithstanding the foregoing, dispensing fees for prescription drugs shall not exceed five dollars ($5.00) per prescription filled.

126.2 If a healthcare provider intends to bill for medical services, appliances, or supplies, where prior authorization is required, that provider must request or verify the existence of such prior authorization from the Program before providing services, appliances, or supplies. All medical bills submitted to the Program lacking required prior authorization will be automatically denied.

126.3 Unless otherwise authorized by the Program, all bills for medical services, appliances, or supplies rendered under the Act must be submitted on a CMS1500, Health Insurance Claim Form and shall:

(a) Include the code, as published by the American Medical Association (AMA) in the most current edition of the Current Procedural Terminology (CPT codes) for each care, supply, and service rendered and the codes established by the most recent edition of the International Classification of Diseases (ICD), as published by the U.S. Department of Health and Human Services, for diagnosing the claimant's condition. If there is no standard CPT code for a care, supply, or service rendered, the health care provider shall refer to the Program's fee schedule for the procedure code prescribed by the Program;

(b) Include the "From" and "Through" dates with the appropriate units for each CPT code billed, when billing for care, supplies, or services over a period of time;

(c) Include the name, address, telephone number, signature, and date of signature of the healthcare provider who rendered care, supplies, or services;

(d) Be generated and submitted by the healthcare provider; and

(e) Be supported by medical evidence documented on Form 3, 3S, 3RC, or other Program approved forms, as provided in § 125 of this chapter.

126.4 The Program may withhold payment for an authorized service, appliance, or supply until a bill for such service, appliance, or supply is submitted in accordance with § 126.3 of this chapter.

126.5 A medical report or medical evidence that is not on a Program form submitted in support of a bill shall be typewritten on the healthcare provider's letterhead and signed and dated by the healthcare provider and include information required under § 125 of this chapter or as requested by the Program.

126.6 Unless otherwise authorized by the Program, all bills shall be submitted by first-class U.S. mail or electronically to the email address or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management website.

Subsections 126.7 – 126.15 are added to read as follows:

126.7 No bill will be paid for expenses incurred if the bill is received more than one (1) year after the later of:

(a) The end of the calendar year in which the expense was incurred, or the medical service, appliance, or supply was provided; or

(b) The end of the calendar year in which the claim was first accepted as compensable by the Program.

126.8 Within thirty (30) days after receipt of a bill for medical services, appliances, or supplies submitted pursuant to the requirements of this section, the Program shall provide the claimant and healthcare provider with written notice approving, adjusting, denying, or disputing the bill.

126.9 If the Program fails to respond to a bill from a healthcare provider in accordance with this section and section 2303(f) of the Act (D.C. Official Code § 1-623.03(f)),

the Program shall be deemed to have authorized payment of the bill, provided that the medical service, appliance, or supply is:

(a) For a condition that has been accepted as compensable by the Program; and

(b) Prior authorization requirements are met.

126.10 If the Program adjusts, denies, or disputes a bill, the Program shall issue a written Explanation of Review to the claimant and healthcare provider.

126.11 The Explanation of Review shall inform the recipients of the recipients' right to request a hearing before the Chief Risk Officer to dispute the Program's decision, unless the Program has:

(a) Initiated utilization review; or

(b) Requested a hearing on the matter before the Chief Risk Officer.

126.12 A request for a hearing before the Chief Risk Officer to dispute the Program's decision regarding the bill pursuant to section 2323(a-2)(4) of the Act (D.C. Official Code § 1-623.23(a-2)(4)) shall be submitted by filing Form 9H with the Office of Risk Management no later than six (6) months of the later of:

(a) The date of the bill;

(b) The date of initial payment of the bill; or

(c) The date of the initial Explanation of Review.

126.13 Prior to requesting a hearing before the Chief Risk Officer pursuant to § 126.12 of this chapter, a healthcare provider, but not a claimant, may seek reconsideration of the Program's adjustment, denial, or dispute of a bill as follows:

(a) For an Explanation of Review issued by the Program, complete and electronically submit Form 9R by email or fax to the email address or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management website.

(b) For an Explanation of Review prepared by a bill review vendor and issued by the Program, resubmit the bill directly to the vendor or contact the vendor directly to discuss the bill.

126.14 A request for reconsideration does not toll the time to request a hearing as set forth in § 126.12 of this chapter.

126.15 Nothing in this section shall be construed to allow for payment of any medical service, appliance, or supply provided for a condition that is not accepted by the Program as being compensable under the Act.

Section 127, UTILIZATION REVIEW, is amended as follows:

Subsections 127.1 is amended to read as follows:

127.1 Any medical care or service furnished or scheduled to be furnished under the Act shall be subject to utilization review, regardless of whether prior authorization was required for the medical care or service. The utilization review may be performed before, during, or after the medical care or service is provided. Medical care under this section includes medical appliances and supplies.

Subsections 127.3 – 127.14 are amended to read as follows:

127.3 The claimant, the Program, or the Chief Risk Officer's hearing representative may initiate utilization review if it appears that the necessity, character, or sufficiency of medical care or services furnished or scheduled to be furnished is improper or needs to be clarified.

127.4 Utilization review shall be initiated only for medical care or services provided, or scheduled to be provided, for treatment of a condition that the Program has accepted as being compensable under the Act.

127.5 (a) If a utilization review is initiated under this section, the utilization review organization or individual shall make a decision no later than sixty (60) days after the utilization review is requested.

(b) If the utilization review is not completed within one hundred twenty (120) days of the request, the medical care or service under review shall be deemed approved if:

(1) The medical care or service was provided, or is scheduled to be provided to treat a condition that the Program has accepted as being compensable under the Act; and

(2) The medical care or service, is provided, or scheduled to be provided, by a member of the Program's Panel of Healthcare Providers.

127.6 The utilization review report shall specify the medical records considered and shall set forth rational medical evidence and standards 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 claimant, qualified health professional, and the Program.

127.7 A utilization review report which conforms to the provisions of this section shall be admissible in all proceedings with respect to any claim to determine whether a medical care or service was, is, or may be necessary and appropriate to treat a condition that has been accepted by the Program as being compensable under the Act.

127.8 A decision issued by the utilization review organization or individual under this section shall inform the claimant and qualified health professional of their right to reconsideration before the utilization review organization.

127.9 If the qualified health professional or claimant disagrees with the opinion of the utilization review organization or individual, the qualified health professional or claimant may submit a written request to the utilization review organization or individual for reconsideration of the opinion.

127.10 The request for reconsideration shall:

(a) Be in writing;

(b) Contain reasonable medical justification for the reconsideration;

(c) Provide additional information, if the medical care or service was denied because insufficient information was initially provided to the utilization review organization or individual; and

(d) Be made within sixty (60) calendar days after the claimant's receipt of the utilization review report if the claimant is requesting reconsideration, or within sixty (60) calendar days after the qualified health professional's receipt of the utilization review report, if the qualified health professional is requesting reconsideration.

127.11 A decision issued on reconsideration pursuant to Section 2323(a-2)(3) of the Act (D.C. Official Code § 1-623.23(a-2)(3)) is final and not subject to further review on the issue of necessity, character, or sufficiency of the medical care or service provided, or scheduled to be provided.

127.12 Where utilization review has not been initiated, a dispute regarding the issue of necessity, character, or sufficiency of the medical care or service provided, or scheduled to be provided may, pursuant to Section 2323(a-2)(4) of the Act (D.C. Official Code § 1-623.23(a-2)(4)), be resolved upon an application for a hearing before the Chief Risk Officer pursuant to § 157 of this chapter within thirty (30) calendar days after the date of the Program's decision denying authorization for medical care or services.

127.13 A request for a hearing under § 127.12 of this chapter may be made by the Program, qualified health professional, or claimant.

127.14 As provided in Section 2323(a-2)(4) of the Act (D.C. Official Code § 1-623.23(a-2)(4)), the Superior Court of the District of Columbia may review the Chief Risk Officer's decision. The decision may be affirmed, modified, revised, or remanded at the discretion of the court. The decision shall be affirmed if supported by substantial competent evidence of the record, pursuant to the District of Columbia Superior Court Rules of Civil Procedure Agency Review.

Subsections 127.15 – 127.18 are added to read as follows:

127.15 The District of Columbia government shall pay the cost of a utilization review if the claimant seeks the review and is the prevailing party. The claimant shall pay the cost of a utilization review if the claimant seeks the utilization review and the Program is the prevailing party. Utilization review services, if paid by the Program, may be recovered under Section 2329 of the Act (D.C. Official Code § 1-623.29).

127.16 The Program may deny a request by a qualified health professional for authorization for medical care or services furnished, or scheduled to be furnished, where insufficient information has been provided to initiate utilization review.

127.17 If the Program makes payment for medical care or services that are later denied pursuant to utilization review, the Program shall recoup such payment as an overpayment in accordance with Section 2329 of the Act (D.C. Official Code § 1-623.29).

127.18 The Program may enter into a working agreement with a utilization review organization or individual to carry out the utilization reviews authorized under this section. Each such agreement shall set forth terms and conditions to ensure appropriate review, including fee, and payment guidelines.

Section 130, COMPUTATION OF WAGE-LOSS COMPENSATION; PARTIAL DISABILITY, is amended as follows:

Subsections 130.1 – 130.9 are amended to read as follows:

130.1 A disability is partial, when a qualified health professional determines that a claimant can perform work with restrictions, provided that:

(a) The restrictions arise out of a work-related injury;

(b) A claim has been filed for the work-related injury and accepted by the Program; and

(c) The qualified health professional has examined the employee and reviewed his or her medical records.

130.2 If the disability is partial, subject to the limitations in Section 2306a of the Act (D.C. Official Code § 1-623.06a), the claimant's monthly monetary compensation shall be sixty-six and two-thirds percent (66 2/3%) (or seventy-five percent (75%), if an augmented rate of wage-loss compensation is permitted) of the difference between the claimant's monthly pay, as defined at Section 2301(4) of the Act (D.C. Official Code § 1-623.01(4)), and the claimant's monthly wage-earning capacity after the beginning of the partial disability.

130.3 (a) Determination based on actual wages. If the claimant has current or a history of actual earnings which fairly and reasonably represent his or her wage-earning capacity, those earnings shall form the basis for payment of wage-loss compensation for partial disability.

(b) Determination based on labor market survey. If the claimant's actual earnings do not fairly and reasonably represent his or her wage-earning capacity, or if the claimant has no actual earnings, the Program shall perform a labor market survey, using the factors set forth in § 130.5 of this chapter, to select a position that represents his or her wage-earning capacity.

(c) Determination pending labor market survey. If a claimant is released to work in any capacity, the Program may calculate earnings at the highest minimum wage rate in effect within a fifty (50) mile radius of the claimant's residence at the time, taking into account the total hours the claimant is medically authorized to work, to construct a temporary wage-earning capacity until a labor market survey is completed.

130.4 In establishing a wage-earning capacity, the Program is not obligated to secure employment for the claimant in the position selected for establishing a wage-earning capacity.

130.5 The phrase "labor market survey" means a determination of the types of positions that a claimant is capable of doing, based on the following factors, as set forth in Section 2315 of the Act (D.C. Official Code § 1-623.15):

(a) The nature of his or her injury;

(b) The degree of physical impairment;

(c) His or her usual employment;

(d) His or her age;

(e) His or her qualifications for other employment;

(f) The availability of suitable employment; and

(g) Other factors or circumstances which may affect his or her wage-earning capacity as a worker with a disability.

130.6 When conducting a labor market survey, the Program shall identify at least three (3) suitable positions that are available at the time. The claimant's wage-earning capacity shall be calculated based on the annual earnings of the lowest-paid position identified, taking into account the total hours the claimant is medically authorized to work, unless it is reasonable to select a higher-paid position based on the factors set forth in § 130.5 of this chapter.

130.7 The Program shall determine whether the positions selected are reasonably available and vocationally suitable. The fact that a claimant is not successful in securing employment does not establish that the selected positions are not vocationally suitable.

130.8 (a) When calculating wage-earning capacity pursuant to Section 2315 of the Act (D.C. Official Code § 1-623.15) and this section, it is necessary to establish that the selected positions are medically suitable given the claimant's injury-related and pre-existing impairments.

(b) A wage-earning capacity determination must be based on a current or contemporaneous medical evaluation.

(c) Medical conditions not related to the work-related injury or condition that has been accepted as compensable by the Program will not be considered, unless they pre-existed the accepted injury or condition.

(d) Considerations shall be based on well-defined work restrictions in the medical or claim record.

130.9 The positions selected for determining the wage-earning capacity must be reasonably available in the general labor market within fifty (50) miles of the claimant's residence.

Subsection 130.13 is added to read as follows:

130.13 The Program may apply a wage-earning determination retroactively if the evidence shows that partial, rather than total, disability existed. A claimant's receipt of actual earnings shall be deemed to support the retroactive application of a wage-earning

capacity determination to at least the period when wages were first earned. Following the Program's initial determination, a retroactive determination based solely on a labor market survey may not encompass any period during which wage-loss benefits were actually paid.

Section 136, ADDITIONAL MEDICAL EXAMINATIONS, is amended as follows:

Subsection 136.14 is added to read as follows:

136.14 The Program may enter into a working agreement to provide AME services under this section. Each such agreement shall set forth terms and conditions to ensure appropriate evaluations, including fee and payment guidelines.

Section 141, VOCATIONAL REHABILITATION, is amended as follows:

Subsection 141.7 is added to read as follows:

141.7 The Program may enter into a working agreement with vocational counselors and organizations to provide vocational rehabilitation services to claimants. Each such agreement shall set forth terms and conditions necessary to ensure appropriate service, including fee and payment guidelines.

Section 144, MODIFICATION, FORFEITURE, SUSPENSION OR TERMINATION OF BENEFITS, is amended as follows:

The title to Section 144 is amended to read as follows:

Section 144, MODIFICATION OF AWARD OF COMPENSATION

Subsections 144.1 - 144.10 are amended to read as follows:

144.1 The Program may modify an award of compensation if the Program has reason to believe that the claimant's PSWCP file and records establish:

(a) A change of condition has occurred pursuant to section 2324(d)(1) of the Act (D.C. Official Code § 1-623.24(d)(1));

(1) A change of condition means a change to a claimant's accepted medical condition or other circumstance, such as incarceration, vocational or other education studies, that affect the claimant's ability to earn wages; or

(b) A change to the claimant's accepted medical condition has occurred pursuant to section 2324(d)(4) of the Act (D.C. Official Code § 1-

623.24(d)(4)) for one of the following reasons:

(1) The disability for which compensation was paid has ceased or lessened;

(2) The disabling condition is no longer causally related to the accepted work injury;

(3) Claimant's condition has changed from total disability to partial disability;

(4) Claimant has been released to return to work with or without restrictions; or

(5) The Program determines based on compelling evidence that the initial decision was in error.

144.2 An "award of compensation" means a Program determination or Compensation Order issued pursuant to section 2324 of the Act (D.C. Official Code § 1-623.24) and shall not include calculations set forth in a Notice of Benefits or adjustments to benefits made pursuant § 145 of this chapter.

144.3 Except as provided at subsection 144.3(a), the Program will provide the claimant with prior written notice of the proposed action to modify an award of compensation pursuant to § 144 of this chapter and give the claimant thirty (30) days to submit relevant evidence or argument to support entitlement to continued payment of compensation prior to issuance of an Eligibility Determination (ED), where the Program has a reason to believe that compensation should be modified due to a change of condition pursuant to Sections 2324(d)(1) and (4) of the Act. An ED shall be accompanied by information identifying the employee's appeal rights and, for termination of wage loss benefits, claimant's one hundred eighty (180)-day time limitation from the date of the notice to make a claim for permanent disability compensation.

(a) Prior written notice will not be given when:

(1) The claimant dies;

(2) The Program either reduces or terminates compensation upon a claimant's return to work or release to return to work,

(3) The claimant has been convicted of fraud in connection with the claim;

(4) When the award of compensation was for a closed period, which has expired;

(5) The Program issues an initial determination where a claim has been deemed accepted pending such issuance; or

(6) The claimant's benefits are suspended for failure to:

(i) Participate in vocational rehabilitation, if the claimant is hired on or after January 1, 1980;

(ii) Follow prescribed and recommended course of medical treatment from the treating physician; or

(iii) Attend an appointment for Additional Medical Examination (AME), bring medical records under the claimant's possession and control, or any other obstruction of the examination.

144.4 Prior notice provided under this section will include a description of the reasons for the proposed action and a copy of the specific evidence upon which the Program is basing its determination. Payment of compensation will continue until any evidence or argument submitted has been reviewed and an appropriate decision has been issued, or until thirty (30) days have elapsed after the issuance of the notice if no additional evidence or argument is submitted.

144.5 (a) If a claimant timely files his or her response to the Program's prior written notice of proposed modification and identifies additional evidence the claimant wishes to submit, the Program shall allow the claimant additional time to submit evidence, where claimant establishes good cause for the delay in acquiring the evidence

(b) If the claimant submits evidence or argument prior to the issuance of the decision, the Program will evaluate the submission in light of the proposed action and undertake such further development as it may deem appropriate, if any. Evidence or argument that is repetitious, cumulative, or irrelevant will not require any further development. If the claimant does not respond within thirty (30) days of the prior written notice, the Program will issue a decision consistent with its prior written notice. The Program will not grant any request for an extension of this thirty (30) day period.

(c) Evidence or argument that refutes the evidence upon which the proposed action was based will result in the continued payment of compensation. If the claimant submits evidence or argument that fails to refute the evidence upon which the proposed action was based but which requires further development of the evidence and basis for the decision, the Program will not provide the claimant with another notice of its proposed action upon completion of such development. Once any further development of the evidence is completed, the Program will either continue payment or issue a decision consistent with its prior written notice or further developed evidence.

144.6 (a) If substantial evidence in the claimant's Program file establishes that a claimant hired before January 1, 1980, without good cause failed to apply for or undergo vocational rehabilitation, when directed by the Program:

(1) The Program may propose a reduction of wage-loss compensation and present the proposed reduction to the Compensation Review Board (CRB) for review; and

(2) The CRB shall affirm the reduction in benefits, if it determines that there is substantial evidence in the record to show that the wage-earning capacity of the individual would probably have substantially increased, absent the claimant's failure to attend vocational rehabilitation, as directed by the Program.

(b) For the purposes of this subsection, the term "substantially increase" means an increase in wage-earning capacity of fifty percent (50%) or more.

(c) The Program shall compute the claimant's wage-earning capacity by conducting a labor market survey or applying the factors provided at Section 2315 of the Act (D.C. Official Code § 1-623.15) based on the assumption the claimant has enrolled completed in vocational rehabilitation. The claimant's annual wage-earning capacity shall be divided by twelve (12) to arrive at the claimant's monthly wage-earning capacity. The claimant's monthly wage-earning capacity assuming enrollment incompletion of vocational rehabilitation shall be compared against the claimant's wage-earning capacity without enrollment or incompletion of vocational rehabilitation. If the claimant's wage-earning capacity assuming enrollment in completion of vocational rehabilitation exceeds the claimant's wage-earning capacity without vocational rehabilitation by fifty percent (50%) or more, the Program may propose a reduction of wage-loss compensation.

144.7 Failure to apply for or undergo vocational rehabilitation shall include failure to attend meetings with the vocational rehabilitation counselor, failure to apply for jobs that have been identified for the claimant, or failure to otherwise participate in good faith in the job application process.

144.8 In all claims, the claimant is responsible for continual submission, or arranging for the continual submission of, a medical report from the attending physician as evidence supporting the reason for continued payment of compensation under the award of compensation.

144.9 For wage-loss compensation benefits, "reason to believe" that the disability for which compensation was paid has ceased pursuant to §§ 144.1(b)(1) and 144.3(a) of this chapter includes a claimant's failure to provide contemporaneous medical evidence to show that:

(a) The accepted condition remains disabling; and

(b) The nature and extent of the ongoing disability necessitate claimant's continued absence from work or restricts claimant from performing the full scope of pre-injury duties.

144.10 For medical compensation benefits, "reason to believe" that the condition for which compensation was paid has ceased pursuant to § 144.3(a) of this chapter includes a claimant's lack of treatment for the accepted condition for one year or more.

Subsection 144.11 is added to read as follows:

144.11 Compensation benefits that have been suspended under this section may be resumed if a claimant cures the deficiency that gave rise to the suspension, unless benefits have been terminated. Resumption of compensation benefits that have been suspended shall occur on a prospective basis.

Section 145, ADJUSTMENTS AND CHANGES TO BENEFITS, is amended as follows:

The title to Section 145 is amended to read as follows:

Section 145, ADJUSTMENTS TO BENEFITS

Subsections 145.1 – 145.6 are amended to read as follows:

145.1 A claimant's benefits shall be adjusted, where the claimant's PSWCP file and records establish substantial evidence that:

(a) The claimant's benefits shall be forfeited for failure to:

(1) Complete a report of earnings pursuant to § 138 of this chapter; or

(2) Accept a modified duty assignment offered within the time prescribed at §142 of this chapter.

(b) The claimant's benefits shall be terminated because the claimant's compensation benefits have been subject to forfeiture for failure to complete a report of earnings for more than ninety (90) days;

(d) The claimant's eligibility for wage-loss compensation is subject to limitations provided at section 2316 of the Act (D.C. Official Code § 1-623.16) and § 134 of this chapter; or

(d) The claimant is no longer eligible for benefits for reasons not otherwise prescribed at Section 2324(d) of the Act (D.C. Official Code § 1-623.24(d)).

145.2 The Program shall provide a written notice to a claimant when benefits are adjusted pursuant to § 145.1 of this chapter and inform the claimant of his or her right to appeal to the Chief Risk Officer.

145.3 Prior written notifications pursuant to Section 2324(d) of the Act (D.C. Code § 1-623.24(d)) shall not apply to adjustments to benefits issued pursuant to § 145 of this chapter.

145.4 The Program shall provide a written Notice of Benefits to a claimant if there is an adjustment in the claimant's wage-loss compensation benefits or a correction of a technical error that results in a change to the claimant's wage-loss compensation benefits and inform the claimant of his or her right to appeal to the Chief Risk Officer.

145.5 Compensation benefits that have been forfeited under this section may be resumed if a claimant cures the deficiency that gave rise to the forfeiture, unless benefits have been terminated. Resumption of compensation benefits that have been forfeited shall occur on a prospective basis; except, that compensation benefits may be restored on a retroactive basis where a good cause determination has been made, pursuant to § 147 of this chapter, for reversal of the suspension or forfeiture decision.

145.6 Periods of forfeiture shall be counted toward the five hundred (500)-week limitation in Section 2306a of the Act (D.C. Official Code § 1-623.06a).

Subsections 145.7 – 145.9 are repealed and shall read as follows:

145.7 [Repealed]

145.8 [Repealed]

145.9 [Repealed]

Section 149, COMPUTATION OF TIME, is amended as follows:

Subsection 149.4 is added to read as follows:

149.4 For the purposes of the Act and this chapter, a form or required document is deemed timely filed if it is received by the Program by the due date.

Section 153, REQUESTS FOR AUDIT OF INDEMNITY BENEFITS, is amended as follows:

The title to Section 153 is amended to read as follows:

153 REQUESTS FOR AUDIT OF COMPENSATION BENEFITS

Subsection 153.1 is amended to read as follows:

153.1 A claimant who believes that the Program has incorrectly calculated his or her medical compensation, wage-loss compensation, or death benefit may request an audit of the Program's calculation by completing Form A-1 and submitting it to the Chief Risk Officer, provided that the claimant's medical compensation, wage-loss compensation or death benefits were not terminated more than three (3) years before the date of the Form A-1 submission.

Section 155, OFFICE OF ADMINISTRATIVE HEARINGS (OAH), JURISDICTION AND OFFICE OF HEARINGS AND ADJUDICATION (OHA), is amended as follows:

The title to Section 155 is amended to read as follows:

155 OFFICE OF ADMINISTRATIVE HEARINGS (OAH), JURISDICTION

Subsection 155.1 is amended to read as follows

155.1 Beginning December 1, 2016, the following decisions shall be appealed to the Office of Administrative Hearings (OAH):

(a) Initial awards for or against compensation benefits pursuant to Section 2324(b) of the Act (D.C. Official Code § 1-623.24(b)); and

(b) Modification of awarded compensation benefits pursuant to Section 2324(d) of the Act (D.C. Official Code § 1-623.24(d)).

Section 156 OFFICE OF RISK MANAGEMENT, JURISDICTION, is amended as follows:

Subsection 156.1 is amended to read as follows:

156.1 A claimant who is dissatisfied with a decision issued by the Program, other than a decision subject to review by OAH as set forth in § 155 of this chapter, may only appeal the decision to the Chief Risk Officer.

Subsections 156.3 - 156.4 are amended to read as follows:

156.3 The Chief Risk Officer shall affirm the Program's decision if it is supported by substantial evidence in the record. Otherwise, at the discretion of the Chief Risk Officer, the claimant's appeal may be dismissed for failure to state a claim, lack of jurisdiction, procedural errors, or other appropriate reason or the Program's decision may be affirmed, modified, or remanded to the Program with instructions.

156.4 The Chief Risk Officer shall notify the claimant in writing of his or her decision within thirty (30) days after the Program's receipt of the appeal. If no decision is issued within the thirty (30)-day period, the Program's decision shall be deemed the final decision of the agency for appeal to the Superior Court of the District of Columbia as provided in § 156.5 of this chapter, unless the Chief Risk Officer issues a decision before the date on which the appeal to the Superior Court is filed.

Subsections 156.6 - 156.7 are added to read as follows:

156.6 A dispute arising under Section 2323 of the Act (D.C. Official Code § 1-623.23) between a qualified health professional, claimant, or the Program on the issue of necessity, character, or sufficiency of the medical care, supply, or service furnished, or scheduled to be furnished, or the fees charged by the healthcare provider (including a physician or organization providing Additional Medical Examination or utilization review services) shall be resolved by the Chief Risk Officer upon application for a hearing by the Program, claimant, or healthcare provider, in accordance with the applicable hearing rules provided at § 157 of this chapter.

156.7 As provided in Section 2323(a-2)(4) of the Act (D.C. Official Code § 1-623.23(a-2)(4)):

(a) The decision of the Chief Risk Officer pursuant to § 156.6 of this chapter may be reviewed by the Superior Court of the District of Columbia;

(b) The decision may be affirmed, modified, revised, or remanded in the discretion of the court; and

(c) The decision shall be affirmed by the court if supported by substantial competent evidence on the record.

Section 157, OAH AND OHA, HEARING RULES, is amended as follows:

The title to Section 157 is amended to read as follows:

157 HEARING RULES

Subsection 157.1 – 157.3 are amended to read as follows:

157.1 OAH Rules 2950 through 2969 (OAH Rules) shall apply to management of PSWCP cases filed pursuant to Section 2324 of the Act (D.C. Official Code § 1-623.24) with the Department of Employment Services, Office of Hearings and Adjudications (OHA) and Office of Administrative Hearings (OAH).

157.2 If no procedure is specifically prescribed by the OAH Rules, the Superior Court for the District of Columbia Rules may be used as guidance, to the extent practicable.

157.3 The OAH Rules shall govern the conduct of hearing of cases filed pursuant to Section 2324 of the Act (D.C. Official Code § 1-623.24), unless the ALJ determines that their application impairs the ALJ's ability to ascertain the claimant's rights pursuant to Section 2324(b)(2) of the Act (D.C. Official Code § 1-623.24(b)(2)).

Subsection 157.4 is added to read as follows:

157.4 Hearings before the Chief Risk Officer (CRO) requested pursuant to Section 2323 of the Act (D.C. Official Code § 1-623.23) shall be conducted under the following rules (the "ORM Hearing Rules"):

(a) Hearings before the CRO shall be held by a hearing representative appointed by the CRO.

(b) A claimant, healthcare provider, or the Program may request an oral hearing or a hearing on the written record and shall so indicate on Form 9H:

(1) Within thirty (30) calendar days after the date of the Program's decision denying authorization for medical care or services; or

(2) Within six (6) months of the later of the date of the bill, the date of initial payment of the bill, or the date of the initial Explanation of Review.

(c) The party requesting the hearing (hereinafter "hearing proponent") shall submit, with his or her request for a hearing, all evidence or written argument that he or she wants to present to the hearing representative.

(d) If the Program is requesting the hearing pursuant to Section 2323 of the Act (D.C. Official Code § 1-623.23), the Program shall mail a copy of the hearing request to all parties involved. Each other party shall have fifteen (15) days to file a written response with supporting evidence or written argument to the Program hearing request with the hearing representative.

(e) If requested by any party, the hearing representative shall schedule an oral hearing and determine, at his or her discretion, whether the oral hearing will be conducted in person, by teleconference, by videoconference, or by other electronic means. The hearing representative shall have sole discretion to set the time, place, and method of the hearing. The hearing representative shall provide written notice through an acknowledgment letter to each party of the time, place, and method of the hearing. The acknowledgment letter shall be provided within a reasonable period of time prior to, but no less than seven (7) days before, the date and time of the hearing

(f) After the oral hearing has been scheduled and the hearing representative has transmitted appropriate written notice to the parties, the hearing representative may, upon submission of proper written documentation of an unavoidable serious scheduling conflict (such as court-ordered appearance or trial, jury duty, or a previously scheduled medical procedure), grant a request from any party to reschedule the hearing, as long as the hearing can be rescheduled to a date and time that is no more than thirty (30) days after the originally scheduled date and time. When a request to postpone a scheduled hearing by the hearing proponent cannot be accommodated under this paragraph, no further opportunity for an oral hearing shall be provided. Instead, the hearing will take the form of a review of the written record.

(g) Where either party or its representative is hospitalized for a non-elective reason or where the death of the claimant's, healthcare provider's, or representative's parent, spouse, child, or other immediate family member prevents attendance by the party or its representative at the hearing, the hearing representative shall, upon submission of proper documentation, grant a postponement beyond the period prescribed in paragraph (f) of this subsection.

(h) A decision regarding rescheduling under paragraphs (d) through (g) of this subsection shall be in the sole discretion of the hearing representative.

(i) When the proponent of an oral hearing fails to appear at the scheduled hearing, the hearing shall take the form of a review of the written record and a decision shall issue accordingly.

(j) Before the date of the oral hearing, the hearing representative may change the format of the hearing from an oral hearing to a review of the written record upon the hearing proponent's request. The decision to grant or deny a change of format from an oral hearing to a review of the written record shall be in the sole discretion of the hearing representative.

(k) A request for reasonable accommodation by an individual with a disability shall be made through the procedure described in the initial acknowledgement letter.

(l) The hearing shall be an informal process, and the hearing representative shall not be bound by common law or statutory rules of evidence, by technical or formal rules of procedure, or by the Administrative Procedure Act.

(m) During the hearing, the party requesting the hearing shall be given up to thirty (30) minutes to present argument in support of the relief sought; each responding party shall be given up to thirty (30) minutes to present argument in support of its position. The hearing representative may ask questions of those presenting information on behalf of any party.

(n) When conducting the hearing, the hearing representative may review the claim file and any additional evidence submitted by the parties that has already been exchanged between the parties in advance of the hearing.

(o) The hearing representative shall determine the conduct of the oral hearing. Oral hearings shall be limited to no more than ninety (90) minutes. The hearing representative may extend this limitation at his or her discretion or terminate the hearing at any time he or she determines that all relevant evidence has been obtained, or because of misbehavior on the part of the claimant and/or representative. The hearing representative may stay the hearing and direct the parties to address matters that come up during the hearing.

(p) Argument at an oral hearing, including an oral hearing conducted by teleconference, videoconference, or other electronic means, shall be recorded and placed in the record. The transcript of the hearing shall be the official record of the hearing.

(q) The Office of Risk Management shall file a transcript of the oral hearing with the Superior Court as a part of the agency record, upon request for a

review of the hearing representative's decision made pursuant to Section 2323 of the Act (D.C. Official Code § 1-623.23).

(r) The hearing record shall be closed after the hearing is held, unless the hearing representative, in his or her discretion, grants an extension. A request for an extension must be made orally at the hearing or submitted in writing no later than ten (10) days after the hearing is held. Only one (1) such extension may be granted. A copy of the hearing representative's decision on the extension request shall be transmitted to all parties.

(s) When conducting a hearing on the written record, the hearing representative shall issue a decision within forty-five (45) days after receipt of the hearing request.

(t) When conducting an oral hearing, the hearing representative shall issue a decision within thirty (30) days after the date of the oral hearing.

(u) When conducting a hearing regarding the necessity, character, or sufficiency of medical care or service furnished, or scheduled to be furnished, the hearing representative may initiate a utilization review pursuant to Section 2323 of the Act (D.C. Official Code § 1-623.23), and the relevant time periods set forth in paragraphs (s) and (t) of this section shall be stayed pending completion of the utilization review. The hearing representative shall issue a notice to all parties informing the parties that a utilization review has been initiated and that the time period for a decision has been stayed pending completion of utilization review.

(v) The proponent of the hearing may withdraw the hearing request at any time up to the time the decision is issued.

Section 159, HEARINGS, BURDEN OF PROOF, is amended as follows:

Subsection 159.2 is amended to read as follows:

159.2 Burden of Proof, Termination, or Modification of Award.

(a) If the Program seeks to terminate or modify an award, it must present substantial evidence that the Program had reason to believe:

(1) Claimant's accepted medical condition or other circumstance that affects the claimant's ability to earn wages has sufficiently changed to warrant modification or termination of benefits; or

(2) The claimant's medical condition had sufficiently changed to warrant modification or termination of benefits;

(3) The claimant had been convicted of fraud in connection with the claim; or

(4) The initial decision was in error.

(b) Once the Agency presents such evidence, the claimant shall have the burden to prove, by a preponderance of the evidence, the entitlement to ongoing benefits, as well as the nature and extent of disability.

Subsection 159.4 is amended to read as follows:

159.4 Burden of Proof, Permanent Disability. The claimant shall have the burden to prove, by a preponderance of the evidence, that he or she is entitled to an award for permanent disability, when requesting a permanent disability award pursuant to Section 2306a of the Act (D.C. Official Code § 1-623.06a).

Subsections 159.5 - 159.6 are added to read as follows:

159.5 Burden of Proof, Necessity, Character, Sufficiency of Medical Service, Supply, or Care. The party that requests the hearing has the burden to prove, as applicable, by a preponderance of the evidence, that the medical care or service furnished or sought to be furnished:

(a) Is proper to treat a condition that has been accepted by the Program as compensable under the Act;

(b) Is improper to treat a condition that has been accepted by the Program as compensable under the Act; or

(c) Treated or would treat a condition that has not been accepted by the Program as compensable under the Act.

159.6 Burden of Proof, Healthcare Provider Fees. The healthcare provider shall have the burden to prove, by a preponderance of the evidence, that the healthcare provider is entitled to the relief sought.

Section 160, HEARING DECISIONS, COMPLIANCE AND ENFORCEMENT, is amended as follows:

Subsections 160.1 – 160.2 are amended to read as follows:

160.1 The ALJ shall issue an order to reverse, modify, affirm, or remand a determination rendered by the Program within thirty (30) days after the hearing ends or the record closes.

160.2 Unless the OHA or OAH decision is stayed by a reviewing administrative or judicial forum, the Program shall comply with the decision within thirty (30) calendar days after the date the decision becomes final.

Subsection 160.4 is amended to read as follows:

160.4 A claimant may dispute the Program's benefits calculations by appealing the Notice of Benefits to the Chief Risk Officer pursuant to §156 of this chapter.

Subsection 160.6 is added to read as follows:

160.6 A decision issued on an appeal filed pursuant to Section 2324 or 2328 of the Act (D.C. Official Code §§ 1-623.24 or 1-623.28) shall be limited to a decision for or against the payment of compensation. The Program shall calculate and issue a Notice of Benefits in accordance with a compensation order which determines the rate of compensation and period of award.

Section 199, DEFINITIONS, is amended as follows:

Subsection 199.1 is amended to read as follows:

199 DEFINITIONS

199.1 The definitions set forth in Section 2301 of Title 23 (Workers' Compensation) of the District of Columbia Government Comprehensive Merit Personnel Act of 1978, effective March 3, 1979 (D.C. Law 2-139; D.C. Official Code §§ 1-623.01 *et seq.* (2014 Repl. & 2016 Supp.)) shall apply to this chapter. In addition, for purposes of this chapter, the following definitions shall apply and have the meanings ascribed:

(a) **The Act** -- 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.* (2014 Repl. & 2016 Supp.)), as amended and as it may be hereafter amended.

(b) **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 or Administrative Law Judge in the Office of Administrative Hearings.

(c) **Aggravated injury --** The exacerbation, acceleration, or worsening of a pre-existing disability or condition caused by a discrete event or occurrence and resulting in substantially greater disability or death.

(d) **Alive and well check** -- an inquiry by the Program to confirm that a claimant who is receiving benefits still meets the eligibility requirements of

the Program.

(d-1) **Award of Compensation** -- a Program determination or Compensation Order issued pursuant to section 2324 of the Act (D.C. Official Code § 1-623.24) and shall not include calculations set forth in a Notice of Benefits or adjustments to benefits made pursuant § 145 of this chapter.

(e) **Beneficiary** -- an individual who is entitled to receive death benefits under the Act.

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

(g) **Claim file** -- all program documents, materials, and information, written and electronic, pertaining to a claim, excluding that which is privileged or confidential under District of Columbia law.

(h) **Claimant** -- an individual who receives or claims benefits under the Act (D.C. Official Code § 1-623.01 *et seq.*).

(i) **Claimant's Representative** -- means an individual or law firm properly authorized by a claimant of this chapter to act for the claimant in connection with a claim under the Act or this chapter.

(j) **Controversion** -- means to dispute, challenge or deny the validity of a claim for Continuation of Pay.

(k) **Disability** -- means the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total.

(l) **Earnings** -- for the purposes of § 138 of this chapter, any cash, wages, or salary received from self-employment or from any other employment aside from the employment in which the worker was injured. It also includes commissions, bonuses, and cash value of all payments and benefits received in any form other than cash. Commissions and bonuses earned before disability but received during the time the employee is receiving workers' compensation benefits do not constitute earnings that must be reported.

(m) **Eligibility Determination (ED)** -- a decision concerning, or that results in, the termination or modification of a claimant's existing Public Sector Workers' Compensation benefits that is brought about as a result of a change to the claimant's condition.

(n) **Employee** – means

(a) A civil officer or employee in any branch of the District of Columbia government, including an officer or employee of an instrumentality wholly owned by the District of Columbia government, or of a subordinate or independent agency of the District of Columbia government;

(b) An individual rendering personal service to the District of Columbia government similar to the service of a civil officer or employee of the District of Columbia, without pay or for nominal pay, when a statute authorizes the acceptance or use of the service or authorizes payment of travel or other expenses of the individual, but does not include a member of the Metropolitan Police Department or the Fire and Emergency Medical Services Department who has retired or is eligible for retirement pursuant to D.C. Official Code §§ 5-707 through 5-730 (2012 Repl. & 2016 Supp.)). The phrase "personal service to the District of Columbia government" as used for the definition of employee means working directly for a District government agency or instrumentality, having been hired directly by the agency or instrumentality; it does not mean working for a private organization or company that is providing services to the District government or its instrumentalities; and

(c) An individual selected pursuant to federal law and serving as a petit or grand juror and who is otherwise an employee for the purposes of this chapter as defined by paragraphs (i) and (ii) above.

(o) **Employee's Representative** -- means an individual or law firm properly authorized by an employee in writing of this chapter to act for the employee in connection with a request for continuation of pay under the Act or this chapter.

(p) **Employing agency** -- the agency or instrumentality of the District of Columbia government which employs or employed an individual who is defined as an employee by the Act.

(q) **Good cause** -- omissions caused by "excusable" neglect or circumstances beyond the control of the proponent. Inadvertence, ignorance or mistakes construing law, rules and regulations do not constitute "excusable" neglect.

(r) **Healthcare provider** -- means any person or organization who or that renders medical services, appliances or supplies directly to claimants or employees and is licensed to practice or operate in the jurisdiction where care is provided.

(r-1) **Healthcare organization** -- An organization comprised of allied health

professionals, as defined under Section 2301 of the Act (D.C. Official Code § 1-623.01).

(s) **Immediate supervisor** -- the District government officer or employee having responsibility for the supervision, direction, or control of the claimant, or one acting on his or her behalf in such capacity.

(t) **Indemnity --** See Wage-loss Compensation.

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

(v) **Latent disability** -- a condition, disease or disability that arises out of an injury caused by the employee's work environment, over a period longer than one workday or shift and may result from systemic infection, repeated physical stress or strain, exposure to toxins, poisons, fumes or other continuing conditions of the work environment.

(v-1) **Marriage** –both civil marriage, which is represented by a marriage license, and common-law marriage, which must be proved by a preponderance of the evidence based on the law of the applicable jurisdiction.

(w) **Mayor** -- the Mayor of the District of Columbia or a person designated to perform his or her functions under the Act.

(x) **Medical opinion** -- a statement from a physician, as defined in Section 2301 of the Act (D.C. Official Code § 1-623.01) that reflects judgments about the nature and severity of impairment, including symptoms, diagnosis and prognosis, physical or mental restrictions, and what the employee or claimant is capable of doing despite his or her impairments.

(x-1) **Notice of Benefits** -- a notice provided to a claimant that sets forth the Program's calculation of a claimant's benefits as a result of an initial award or subsequent change in benefits.

(y) **Office of Administrative Hearings (OAH)** -- the office where Administrative Law Judges adjudicate public sector workers' compensation claims under Sections 2323(a-2)(4), 2324(b)(1), and (d)(2) of the Act (D.C. Official Code §§ 1-623.23 (a-2)(4), 1-623.24(b)(1) and (d)(2)), pursuant to jurisdiction under D.C. Official Code § 2-1831.03 (b)(1) (2012 Repl.), Section 2306a of the Act, and rules set forth in this chapter.

(z) **Office of Hearings and Adjudication (OHA)** -- 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 Sections 2323(a-2)(4), 2324(b)(1), and (d)(2) of the Act (D.C. Official Code §§ 1-623.23 (a-2)(f), 1-623.24(b)(1) and (d)(2)), and rules set forth in this chapter.

(aa) **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 (PSWCP).

(bb) **Panel physician –** means a physician approved by the Program pursuant to §§ 124 and 125 of this chapter to provide medical treatment to persons covered by the Act.

(cc) **Pay rate for compensation purposes --** means the employee's pay, as determined under Section 2314 of the Act, at the time of injury, the time disability begins, or the time compensable disability recurs if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the District of Columbia government, whichever is greater, except as otherwise determined under Section 2313 of the Act (D.C. Official Code § 1-623.13) with respect to any period. Consideration of additional remuneration in kind for services shall be limited to those expressly authorized under Section 2314(e) of the Act (D.C. Official Code § 1-623.14(e)).

(dd) **Permanent disability compensation** -- schedule award compensation payable when a qualified physician has determined that a claimant has reached maximum medical improvement and has full or partial loss of use of a body part or disfigurement pursuant to Section 2307 of the Act (D.C. Official Code 1-623.07) and § 140 of this chapter.

(ee) **Permanent total disability payment (PTD)** -- schedule award and wage-loss compensation payable to a completely disabled claimant, when a qualified physician has determined that a claimant has reached maximum medical improvement and is unable to work on a permanent basis. PTD has been repealed since February 26, 2015. However, claimants who were awarded PTD prior to the repeal may continue to receive PTD benefits.

(ff) **Program** -- the Public Sector Workers' Compensation Program of the Office of Risk Management, including a third party administrator thereof.

(ff-1) **Provider agreement** – a working agreement developed by the Program in accordance with Section 2302b of the Act (D.C. Official Code § 1-623.02b) with a healthcare provider or other public or private organization comprised of healthcare providers to furnish medical care or services (including transport incident to such care or services) to an employee. Disputes regarding fees or the necessity, character or sufficiency of services pursuant

to such agreements shall be resolved in accordance with Section 2323 of the Act (D.C. Official Code § 1-623.23) and § 156.6 and 156.7 of this chapter.

(gg) **Qualified health professional** – means a physician, as that term is defined by section 2301 of the Act (D.C. Official Code § 1-623.01) and includes a surgeon, podiatrist, dentist, clinical psychologist, optometrist, orthopedist, neurologist, psychiatrist, chiropractor, or osteopath practicing within the scope of his or her 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 guidelines established by the Program. For purposes of initial treatment or emergency care, or with respect to of a managed care organization, as that term is defined by section 2301 of the Act (D.C. Official Code § 1-623.01), the term also includes physician assistants and nurse practitioners who are authorized by the jurisdiction where they practice and who are performing within the scope their practice as defined by said jurisdiction.

(hh) **Recurrence of disability** – means a disability that reoccurs within one (1) year after the date wage-loss compensation terminates or, if such termination is appealed, within one (1) year after the date of the final order issued by a judicial entity, caused by a spontaneous change in a medical condition which had resulted from a previous compensable injury or illness without an intervening injury or new exposure to the work environment that caused the illness.

(ii) **Recurrence of medical condition** -- means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a "need for further medical treatment after release from treatment," nor is an examination without treatment.

(jj) **[Repealed]**

(kk) **Traumatic injury** -- means a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including physical stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected.

(ll) **Temporary partial disability payment (TPD)** – wage-loss compensation payable to a claimant, who has a wage-earning capacity and has not reached maximum medical improvement, calculated pursuant to Section 2306 of the Act (D.C. Official Code § 1-623.06) and § 130 of this chapter.

(mm) **Temporary total disability payment (TTD)** – wage-loss compensation payable to a claimant, who has a complete loss of wage earning capacity and has not reached maximum medical improvement, calculated pursuant to Section 2305 of the Act (D.C. Official Code § 1-623.05) and § 129 of this chapter.

(nn) **Treating physician** -- the physician, as defined in Section 2301 of the Act (D.C. Official Code § 1-623.01), who provided the greatest amount of treatment and who had the most quantitative and qualitative interaction with the employee or claimant.

(oo) **Wage-loss compensation** -- the money allowance paid to a claimant by the Program to compensate for the wage-loss experienced by the claimant as a result of a disability directly arising out of an injury sustained while in the performance of his or her duty, calculated pursuant to the provisions of this chapter.

(pp) **Working agreement** – means a provider agreement or other agreement developed by the Program in accordance with Section 2302b of the Act (D.C. Official Code § 1-623.02b) with: (1) a utilization review organization or individual certified to perform such reviews, as specified in Section 2323 of the Act (D.C. Official Code § 1-623.23); (2) a physician or an organization comprised of physicians, including an organization with a proprietary panel of physicians affiliated exclusively with such organization, who conduct Additional Medical Examinations, as described in § 136 of this chapter; (3) a provider of vocational rehabilitation services; or (4) a physician or other public or private organization to facilitate the functions of the Program. The fees and other conditions contained in such agreements shall be approved by the Chief Risk Officer. Except in the case of a provider agreement, disputes arising under such agreements shall be resolved by the Superior Court for the District of Columbia, or as otherwise provided by law.