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 August 2, 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.

The emergency rules will remain in effect for a period of one hundred twenty (120) days from adoption, until November 30, 2018, or until the publication of a Notice of Final Rulemaking, whichever occurs first.

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 An employee or an employee's representative shall give notice of an employee's death, to the employee's immediate supervisor or the Program within thirty (30) days of the injury, recurrence of disability, or death pursuant to Section 2319 of the Act and this chapter.

104.2 Notice shall be effected upon:

(a) Electronic submission of a workers' compensation incident report and completed Form 4 and IRS Form 4506-T, through the designated web portal found on the Office of Risk Management's Website; or

(b) The immediate supervisor's or Program's receipt of a completed Form 1, Form 4, and IRS Form 4506-T within thirty (30) days of the injury, recurrence of disability or death, or within such greater period permitted under Section 2319 of the Act or § 104.6 of this chapter.

104.3 The workers' compensation incident report and Form 1 shall be in writing and be signed by and contain the electronic mail and physical mailing address of the individual giving notice.

104.4 The employee or employee's representative shall designate an e-mail address to receive notices and correspondence from the Program. All employees and employee representatives will be responsible for checking the designated e-mail account for notices and correspondence from the Program. While correspondence may be mailed to the mailing address, unless returned, any notice or correspondence sent to the designated e-mail address will be presumed received for the purpose of 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, the immediate supervisor, shall report any injury which results in an employee's death, bodily harm or probable disability to the Program by telephone or through the Program's online portal, as designated on Office of Risk Management's website.

105.2 The immediate supervisor shall make an initial report of injury to the Program through the designated online portal found on ORM's website within twenty-four (24) hours of learning of the incident, injury, death, or notice by employee, whichever occurs earlier, preferably before the shift's end.

105.3 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 portal through the grant access link and complete and submit the requested information online. If an immediate supervisor receives Form 1 from the employee, the immediate supervisor shall immediately report the incident in accordance with §105.1 of this chapter.

105.4 The immediate supervisor shall supply all information requested by the Program and upload all available supporting documentation through the online portal at the time an incident/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 Upon notice of an employee's injury or death reported by the Employing Agency, the Program shall notify the employee that a report of injury has been received for the employee and provide the employee or employee's representative with instructions on how to file a claim for workers' compensation. The Program's failure to provide claimant with 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 – 108.2 are amended to read as follows:

108.1 To file a claim for COP, the employee or employee's representative must comply with § 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 and

(a) Submit notice of injury pursuant to § 104 of this chapter and submit Forms 3, 3A, 4, and IRS Form 4506-T to the Program or immediate supervisor through the Program's designated online portal or by mail or fax;

(b) 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 workers' compensation coordinator and the Program within ten (10) calendar days after filing the claim for COP;

(c) Cooperate with the Program and workers' compensation coordinator in developing the claim;

(d) Ensure that the treating physician specifies work limitations and provides the information to the immediate supervisor, workers' compensation coordinator, and the Program within ten (10) calendar days after filing the claim for COP; and

108.2 An employee's COP status shall not be construed to preclude the employee from filing a claim for compensation pursuant to § 115 of this chapter. COP payments shall terminate upon acceptance or denial of a 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 Once the employing agency learns of a traumatic injury sustained by an employee, it shall:

(a) Refer the employee to ORM's Pubic Sector Workers' Compensation Website;

(b) Advise the employee of the right to receive COP;

(c) Inform the employee of any decision to controvert COP, and the basis for doing so; and

(d) Review and respond to the employee's claim for COP by completing the COP determination section of the Program's online form and upload all relevant documents, and Forms, along with all other available pertinent information, (including the basis for any controversion), to the Program 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.

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; and

(b) No claim for 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:

Subsections 115.5 and 115.9 are repealed and 115.2, 115.4, 115.7 – 115.8, 115.10 - 115.11, and 115.13 are amended to read as follows:

115.2 A claim for disability compensation is deemed filed only upon 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 by filing Form CA7, Part A, and the Program's receipt of the following completed documents:

(a) Repealed.

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

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

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

(e) IRS Form 4506 T – Request for Transcript of Tax Return

115.4 At the time the employee submits a claim, an e-mail and physical mailing address must be provided for the employee and if applicable the representative, for the purpose of receiving Program notices and correspondence. Any correspondence sent to the designated e-mail or physical mailing address will be presumed received, unless returned, and any applicable deadlines shall take effect based on the date of the electronic transmission or correspondence. In the case of the death

of an employee, the employee's representative shall also provide documentation establishing the 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.

115.5 Repealed.

115.7 The employee or employee's representative 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 disability, identify the time, date, circumstance and location of the accident, the parties involved, the disposition of any subsequent trial or legal action(s), any injuries relating from the previous accident(s), and the hospital, medical facilities, doctors, physicians, dentists, or any other individual that treated any injury;

(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 employee has been absent from employment due to illnesses or injuries, including the nature and dates of such injuries or illnesses. The employee or employee's representative shall specify the date and time for all absence from employment due to injury claimed; and

(e) Describe any similar condition, disability, 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 employee or employee'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, 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 accident of a similar character; and

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

115.9 Repealed.

115.10 The employee or employee'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 An employee seeking to supplement his or her original claim to add additional disabilities or conditions arising out of the same incident, but not already reported, shall:

(a) File a supplement to his or her claim;

(b) Include a signed statement under penalty of perjury explaining the cause for delay in reporting the additional disability or condition; and

(c) Report the additional disability or condition within two (2) years of the original injury. The Program may consider a supplemental claim reported over two (2) years from the date of injury provided that the employee shows good cause for why the supplemental claim should be allowed.

115.13 Claims for latent disability shall be filed pursuant to Section 2322 of the Act and §§ 115.1 through 115.10 of this chapter within two (2) years of the earlier of:

(a) The date on which the employee first sought medical attention for the employee'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 employee ceased work; or

(b) The date on which the employee 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.

Section 122, MEDICAL BENEFITS AND SERVICES; GENERAL, is amended as follows: Subsection 122.1 is amended and subsection 122.2 is added to read as follows:

122.1 Pursuant to Section 2303(a) of the Act, the District government shall furnish to an employee who is injured while in the performance of duty the services, appliances, and supplies prescribed or recommended by a qualified healthcare provider, whom the Program has admitted into its Panel of Healthcare Providers.

122.2 Payment for medical benefits, services or supplies pursuant to Section 2303 of the Act shall only be made, where the medical benefits, services 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 member of the Program's Panel of Healthcare Providers pursuant to the rules prescribed at §124, subject to utilization review.

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

Subsections 122.1 – 123.5 are amended to read as follows:

123.1 When a claimant is first injured and before a claim is filed or accepted, the claimant may select a non-panel healthcare provider to provide reasonably necessary emergency medical care for an injury sustained in the performance of duty, provided that notice of such medical treatment is given to the Program no later than thirty (30) days after the care is rendered. All non-emergency medical care must be pre-authorized by the Program.

123.2 In order for the Program to pay for the services provided by a healthcare provider, the provider must be a member of the Program's Panel of Healthcare Providers, except as provided in § 123.3.123.3 The Program's reimbursement for any medical expenses incurred for medical care or services provided pursuant to Section 2303 of the Act shall be limited by the fee schedule prescribed in this chapter.

123.4 Once an employee or claimant selects a healthcare provider from the Program's Panel of Healthcare Providers, he or she cannot receive care from another provider without authorization of the Program, except in an emergency.

123.5 An employee or claimant, who is not satisfied with medical services provided by the selected panel healthcare provider, must complete and return Form M3 to change the provider, with justification in support of the request to the Program. The Program shall permit a change where the Program finds the change to be in the best interest of the claimant.

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

Subsections 124.1 – 124.5 are amended and subsections 124.6 – 124.12 are added to read as follows:

124.1 There shall be established a Program Panel of Healthcare Providers (hereinafter the "panel") to furnish medical services, appliances, and 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 The Program shall select members of the panel based on the physicians' ability to cure, give relief, reduce the degree or length of injury, or aid in lessening the amount of the monthly compensation. The Program may add and remove physicians from the panel at its discretion.

124.3 If the Program decides to remove a healthcare provider from the Panel, the Program shall give all of the claimants currently being treated by that healthcare provider notice of the decision, as well as a list of up to three (3) alternative panel healthcare providers, thirty (30) days before the healthcare provider 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 an injured claimant to submit to physical examinations as frequently as may be reasonably required to investigate an employee's initial and continued eligibility for benefits under the Act, as provided at § 136 of this chapter.

124.6 Any decision by the Program to remove a member from the panel shall be final.

124.7 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) healthcare providers from the panel and inform the employee or claimant of the requirements in § 123 of this chapter.

124.8 Within thirty (30) days of receipt of a written request for prior authorization for any medical care, supply, or service, the Program shall provide the claimant and healthcare provider written notice approving, denying or disputing the request

124.9 When disputing or denying a request for prior authorization by a treating physician pursuant to §124.9 because the Program believes the necessity, character, or sufficiency of medical care or service to be improper, the Program shall:

(a) Initiate utilization review;

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

(c) Ensure that the written notice of denial is accompanied by information about the employee's rights to initiate utilization review and the employee and the treating physician's right to request a hearing before the Chief Risk Officer.

124.10 When denying a request for prior authorization for medical care or service pursuant to § 124.9 for any reason other than for a dispute as to the necessity, character or sufficiency of medical care, the Program's written notice of denial shall be accompanied by information about the employee's rights to appeal the decision to the Chief Risk Officer pursuant to § 156.

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

124.12 The Program's reimbursement to an employee or claimant for any medical expenses incurred for medical care or services shall be limited by the fee schedule prescribed in this chapter.

124.13 The Program may execute a Provider Agreement with a healthcare provider that sets forth the terms and conditions of this Chapter and such 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.

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

The title to Section 125 is amended to read as follows:

125 MEDICAL BENEFITS AND SERVICES; HEALTHCARE PROVIDER RESPONSIBILITY

Subsections 125.1 – 125.8 are amended and subsections 125.9 – 125.14 are added to read as follows:

125.1 Any healthcare provider who provides medical care, supply or service to an injured employee or claimant must comply with the provisions in this chapter.

125.2 Unless otherwise authorized by the Program, within seven (7) business days of an initial examination of the injured employee or claimant, healthcare providers shall transmit Form 3 or other Program approved medical report(s) containing information required under § 125.4 to the Program electronically or by fax to the e-mail or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management Website.

125.3 Unless otherwise authorized by the Program, panel healthcare providers shall, within five (5) business days of any medical care or service provided after 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 to the Program electronically or by fax to the e-mail or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management Website.

125.4 Unless otherwise directed or required by the Program, the following information shall be included in Form 3, Form 3S, Form 3RC or other Program approved medical report(s) submitted from healthcare providers:

(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;

(i) Course of treatment, if any;

(j) 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;

(k) Treatment given, if any

(l) Treatment plan recommended for the claimed injury or recurrence of disability to bring about maximum medical improvement, if any;

(m) Physician's opinion, with medical reasons and bases, as to the probable cause and mechanism of injury;

(n) In the case of a claimed recurrence of disability, the physician'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);

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

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

(q) All other material findings.

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

125.6 All healthcare providers 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 Physicians Current Procedural Terminology (CPT Codes), for detailing the billing of all medical procedures and the codes established by the most recent edition of the International Classification of Diagnosis (ICD) code, as published by the U.S. Department of Health and Human Services, for diagnosing the conditions. For those where there are no standard CPT codes, refer to the Program's fee schedule as published on the ORM website.

125.7 Any healthcare provider who provides medical care, supplies or services to a employee or claimant, who is injured, while in the performance of duty must be a member of the Program's Panel of Healthcare Providers, unless:

(a) The procedure is needed for emergency care; or

(b) The healthcare provider belongs to a network of healthcare providers to which the Program has secured access to care for claimants through license or similar agreement and such healthcare provider applies for admission to the Program's Panel of Healthcare Providers within one hundred twenty (120) days after first treating an injured District government employee or claimant as a healthcare provider participating within such network (and then only for so long as the application is pending);

(c) Otherwise permitted by law.

125.8 Healthcare providers must apply to be members of the Program's Panel of Healthcare Providers to provide medical care, supplies or services to an employee or claimant, who is injured while in the performance of duty, except as provided in §125.6.

125.9 Healthcare providers selected to be members of the Program's Panel of Healthcare Providers shall:

(a) Submit documentation pertaining to the jurisdiction in which the provider is licensed, license number, Board Name, the state in which it is certified, and any sanctions the provider may have received since certification upon the Program's request;

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

(c) Notify the Program of any 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) setting forth terms and conditions of payment and provision of services for injured employees and claimants.

125.10 Any healthcare provider who provides medical care, supplies or services to a District government employee or claimant, who is injured while in the performance of duty agrees to the medical billing rules prescribed at §126 of this chapter as a condition for payment of services rendered.

125.11 Unless the medical care, supplies or services are needed for emergency care or the service to be rendered is limited to an office or clinic visit, healthcare providers shall seek prior authorization from the Program.

125.12 To seek prior authorization, all healthcare providers 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 Any healthcare provider who provides medical care, supplies or services 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 disputed payment for medical services from the employee or claimant.

Section 126, MEDICAL BILLS, is amended as follows:

Subsections 126.1 – 126.6 are amended and subsections 126.7 – 126.13 are added to read as follows:

126.1 Medical care, supplies (including prescription drugs), or services shall be billed at a rate not to exceed the medical fee schedule adopted by the Program. This fee schedule shall be based on one hundred-thirteen percent (113%) of Medicare's reimbursement amounts or, for medical care, supplies or services (including prescription drugs) not scheduled for Medicare reimbursement, the Program’s fee schedule as published on the Healthcare Provider Information Page of the Office of Risk Management Website. If not reflected in the Program’s fee schedule, fees shall be limited to those that are reasonable and customary charges prevailing in the local medical community, as the Program determines. Dispensing fees shall not exceed five dollars ($5.00) per prescription.

126.2 Where a health care provider intends to bill for medical care, supplies or services where prior authorization is required, that provider must request such prior authorization from the Program before rendering service. All medical bills submitted to the Program lacking required prior authorization will be automatically denied.

126.3 All bills for medical care, supplies, or services rendered under the Act must:

(a) Include the code, as published by the American Medical Association (AMA) in the most current edition of the Physicians Current Procedural Terminology (CPT Codes) for detailing the billing of all medical procedures and the codes established by the most recent edition of the International Classification of Diagnosis (ICD) code, as published by the U.S. Department of Health and Human Services, for diagnosing the conditions. For those where there are no standard CPT codes, refer to the Program’s fee schedule;

(b) Include the “From” and “Through” dates with the appropriate units for each CPT code billed when billing for services over a period of time;

(c) Include the name, address, telephone number, date and signature of the healthcare provider, who rendered service;

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

(e) Be supported by medical evidence as provided in § 125 or as requested by the Program.

126.4 The Program may withhold payment for services until bills are submitted in accordance with § 126.3 of this chapter.

126.5 All medical evidence or report submitted in support of a bill shall be typewritten on the medical provider's letterhead and signed and dated by the attending physician and include information required under § 125 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 e-mail address or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management Website.

126.7 No bill will be paid for expenses incurred if the bill is submitted:

(a) More than one year beyond the end of the calendar year in which the expense was incurred or the medical care, service or supply was provided; or

(b) More than one year beyond the end of the calendar year in which the claim was first accepted as compensable by the Program, whichever is later.

126.8 Within thirty (30) days of receipt of a bill for medical care, supplies or services submitted pursuant to the requirements of this section, the Program shall provide the claimant and healthcare provider with written notice approving, denying, adjusting or disputing the bill. If the Program denies the bill because it disputes the necessity, character or sufficiency of medical care or service furnished, or scheduled to be furnished, or fees charged by the medical provider, the notice shall be accompanied by an explanation of review and information regarding the healthcare provider and employee's right to seek reconsideration of the denial by the Program or request a hearing before the Chief Risk Officer, unless the Program has:

(a) Initiated utilization review;

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

(c) Denied the bill because the medical care or service was rendered for a condition that was not accepted by the Program as being compensable under the Act.

126.9 When denying a bill for any reason other than for a dispute as to the necessity, character or sufficiency of medical care furnished or to be furnished or fees charged by the medical provider, the Program's written notice of denial shall be accompanied by information about the healthcare provider and employee's rights to appeal the decision to the Chief Risk Officer pursuant to § 156.

126.10 If the Program fails to respond to a bill from a treating physician in accordance with section 2303(f) of the Act, the Program shall be deemed to have authorized payment of the bill.

126.11 To seek reconsideration, all healthcare providers shall complete and electronically submit Form 9R to the e-mail address or fax number designated on the Healthcare Provider Information Page of the Office of Risk Management Website within 30 days of the date of the denial.

126.12 Requests for hearings to the Chief Risk Officer pursuant to Section 2323 of the Act shall be submitted by filing Form 9H with the Office of Risk Management within 30 days of the date of the denial or final decision on reconsideration, whichever is later.

126.13 Nothing in this section shall be construed to allow for payment on any medical care, supply or service rendered 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, 127.3 – 127.13 are amended and subsections 127.15 – 127.17 are added to read as follows:

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

(a) Medical care, supplies, or services performed, where prior authorization is not required, shall be subject to utilization review.

127.3 The claimant, the Program, or Chief Risk Officer's Hearing Representative may initiate utilization review where it appears that the necessity, character, or sufficiency of medical care, supplies, or services is improper or clarification is needed on medical service that is scheduled to be provided.

127.4 The necessity, character or sufficiency of medical care, supplies, or services should only be reviewed for treatment of condition(s) that the Program has accepted as being compensable under the Act.

127.5 If a review of medical care, supplies, or services is initiated under this section, the utilization review organization or individual must make a decision no later than sixty (60) days after the utilization review is requested. If the utilization review is not completed within one hundred-twenty (120) days of the initiation, the care or service under review shall be deemed approved for medical care, supplies, or services for conditions that the Program has accepted as being compensable under the Act, subject to the following:

(a) Deemed approved medical services, appliances or supplies must be provided by a member of the Program's Panel of Healthcare Providers.

127.6 The report of the review 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 and the Program.

127.7 Any decision issued by the utilization review organization or individual under this section shall inform the claimant of his or her right to reconsideration before the utilization review organization or individual or to a hearing before the Chief Risk Officer.

127.8 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 medical care, supply, or service was, is, or may be necessary and appropriate to treat the condition that has been accepted by the Program as being compensable under the Act.

127.9 If the healthcare provider or claimant disagrees with the opinion of the utilization review organization or individual, the healthcare provider 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;

(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 of the claimant's receipt of the utilization review report if the claimant is requesting reconsideration, or

within sixty (60) calendar days of the healthcare provider's receipt of the utilization review report, if the healthcare provider is requesting reconsideration.

127.11 Disputes pursuant to Section 2323(a-2)(4) of the Act may be resolved upon an application for a hearing before the Chief Risk Officer pursuant to §157 within thirty (30) calendar days of the date of

(a) The Program's decision denying authorization for medical, supplies, or services,

(b) The utilization review report; or

(c) The reconsideration decision, whichever is later.

127.12 Requests for a hearing pursuant to § 127.12 of this chapter may be made by the Program, healthcare provider, or claimant.

127.13 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.

127.14 The District of Columbia government shall pay the cost of a utilization review if the claimant seeks the review and is the prevailing party.

127.15 The Program may deny a request by a treating physician for authorization for medical care, supplies, or services furnished, or scheduled to be furnished, where insufficient information has been provided to initiate utilization review.

127.16 Where the Program makes payment for medical care, supplies, 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.

127.17 The Program may enter into Provider Agreements with utilization review organizations or individuals authorized under this section to provide such services in order to ensure that the necessity, character and sufficiency of medical services afforded claimants is appropriate and effective. The Provider Agreement shall set forth terms and conditions as determined by the Program to be reasonable and necessary to ensure appropriate care, including fee and payment guidelines. Any bill for payment for utilization services shall be tendered and adjudicated in the same manner as a medical bill under § 126.

Section 130, COMPUTATION OF WAGE INDEMNITY; PARTIAL DISABILITY, is amended as follows:

Subsections 130.7 – 130.10 are repealed to read as follows:

130.7 Repealed.

130.8 Repealed.

130.9 Repealed.

130.10 Repealed.

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 Provider Agreements with AME physicians and organizations authorized under this section to provide AME services in order to ensure that the medical services afforded claimants is appropriate and effective. The Provider Agreement shall set forth terms and conditions as determined by the Program to be reasonable and necessary to ensure appropriate care, including fee and payment guidelines. Any bill for payment for AME services shall be tendered and adjudicated in the same manner as a medical bill under § 126.

Section 141, VOCATIONAL REHABILITATION, is amended as follows:

Subsection 141.7 is added to read as follows:

141.7 The Program may enter into Provider Agreements with vocational counselors and organizations to provide vocational rehabilitation services to claimants. The Provider Agreement shall set forth terms and conditions as determined by the Program to be reasonable and necessary to ensure appropriate service, including fee and payment guidelines. Any bill for payment for vocational rehabilitation services shall be tendered and adjudicated in the same manner as a medical bill under § 126.

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

Subsection 144.11 is added to read as follows:

144.11 Resumption of compensation benefits that have been subject to suspension or forfeiture shall occur on a prospective basis. Benefits may be restored on a retroactive basis where a good cause determination has been made, pursuant to §148, for reversal of the suspension or forfeiture decision. Periods of forfeiture

shall be counted toward the 500-week limitation in Section 2306a of the Act.

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

Subsection 145.3 is repealed and subsections 145.1 and 145.7 are amended to read as follows:

145.1 Except as provided in §§ 145.3, 145.4, and 145.5 of this chapter, the Program will provide the claimant with prior written notice of the proposed action 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 either modified or terminated 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) 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.

145.3 Repealed.

145.7 The Program shall provide a written Notice of Benefits, where there are adjustments in wage loss benefits or corrections of technical errors that result in greater than five percent (5%) change to the claimant's monetary benefits, with rights of appeal to the Chief Risk Officer. Any changes to wage loss benefits that are five percent (5%) or less shall constitute de minimus changes andshall be documented in claimant's PSWCP file.

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

Subsection 149.4 is added to read as follows:

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

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

Subsection 153.1 is amended to read as follows:

153.1 A claimant who believes that the Program has incorrectly calculated his or her wage loss 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 wage loss compensation benefits were not terminated more than three (3) years prior to the date of the Form A-1 request.

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; and

(b) Modification of awarded benefits pursuant to Section 2324(d) of the Act.

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

Subsections 156.3 – 156.4 are amended and subsections 156.6 – 156.7 are added to read as follows

156 OFFICE OF RISK MANAGEMENT, JURISDICTION

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 or the Program's decision may be affirmed, modified, revised 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 of the Program's receipt of the appeal. If no decision is issued within those thirty (30) days, the Program's decision shall be deemed the final decision of the agency for appeal to the Superior Court of the District of Columbia, unless the Chief Risk Officer issues a decision prior to the date on which the appeal to Superior Court is filed.

156.6 Disputes arising under Section 2323 of the Act between a healthcare provider, claimant, or the Program on the issue of necessity, character, or sufficiency of the medical care or service furnished, or scheduled to be furnished, decisions issued by utilization review organizations or individuals, or the fees charged by the

healthcare provider shall be resolved by the Chief Risk Officer upon application for a hearing by the Program, claimant, or healthcare provider, in accordance to the applicable hearing rules provided at § 157 of this chapter.

156.7 The decision of the Chief Risk Officer pursuant to § 156.6 may be reviewed by the Superior Court of the District of Columbia. The decision may be affirmed, modified, revised, or remanded in the discretion of the court. The decision shall be affirmed if supported by substantial competent evidence on the record pursuant to the District of Columbia Superior Court Rules of Civil Procedure Agency Review.

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 157.3 is amended and subsection 157.4 is added to read as follows:

157.3 The rules shall govern the conduct of hearing of cases filed pursuant to Section 2324 of the Act, 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.

157.4 Hearings before the Chief Risk Officer requested pursuant to Section 2323 of the Act shall be conducted under the following rules:

(a) Employees, Claimants, healthcare providers, or the Program may request an oral hearing or a review of the written record and shall so indicate on Form 9H within fifteen (15) days of the Program's initial decision or decision on reconsideration, whichever is later.

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

(c) If the Program is requesting the hearing pursuant to Section 2323 of the Act, the District shall mail a copy of the hearing request to all parties involved. The other parties shall have 15 days to file a written response with supporting evidence to the Program hearing request with the hearing representative.

(d) If requested by any party, the hearing representative shall schedule the oral hearing and determine, at his or her discretion, whether the oral hearing will be conducted in person, by teleconference, videoconference or other

electronic means. The hearing representative retains complete discretion to set the time, place and method of the hearing. The notice shall provide reasonable notice of the date and time for the hearing.

(e) Once the oral hearing is scheduled and the hearing representative has transmitted appropriate written notice to the parties, the hearing representative may, upon submission of proper written documentation of unavoidable serious scheduling conflicts (such as court-ordered appearances/trials, jury duty or previously scheduled outpatient procedures), entertain requests from any party for rescheduling, as long as the hearing can be rescheduled in no more than 30 days after the originally scheduled time. When a request to postpone a scheduled hearing by the hearing proponent cannot be accommodated under this subsection, no further opportunity for an oral hearing will be provided. Instead, the hearing will take the form of a review of the written record and a decision issued accordingly.

(f) 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 prevents attendance at the hearing, the hearing representative will, upon submission of proper documentation, grant a postponement beyond the period prescribed at § 157.4(e).

(g) Decisions regarding rescheduling under paragraphs (c) through (e) of this subsection are within the sole discretion of the hearing representative.

(h) 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 issued accordingly.

(i) Prior to the date of the oral hearing, the hearing representative may change the format 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 a hearing to a review of the written record is up to the discretion of the hearing representative.

(j) Requests for reasonable accommodations by individuals with disabilities shall be made through the procedure described in the initial acknowledgement letter.

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

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

(m) 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.

(n) The hearing representative determines the conduct of the oral hearing. Oral hearings are limited to 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 proceeding and direct the parties to address matters that come up during the hearing.

(o) Argument at oral hearings, including those conducted by teleconference, videoconference or other electronic means, is recorded, and placed in the record. The transcript of the hearing is the official record of the hearing.

(p) 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.

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

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

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

(t) When conducting hearings regarding the necessity, character, or sufficiency of medical services or supplies furnisher, or scheduled to be furnished, the hearing representative may initiate utilization review pursuant to Section 2323 of the Act and issue notice to all parties to stay the decision, pending completion of utilization review (provided that utilization review has not already been undertaken).

(u) The proponent of the hearing may withdraw the hearing request at any time up to and including the day the hearing is held, or the decision issued.

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

Subsections 159.2 and 159.4 are amended and subsections 159.5 – 159.6 are added to read as follows:

159.2 Burden of Proof, Termination or Modification of Award. If the Agency seeks to terminate or modify an award, it must present substantial evidence that the Program had reason to believe

(a) The claimant's medical condition has sufficiently changed to warrant modification or termination of benefits,

(b) The claimant has been convicted of fraud in connection with the claim, or

(c) The initial decision was in error.

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

159.4 Burden of Proof, Permanent Disability. The claimant has 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.

159.5 Burden of Proof, Necessity, Character, Sufficiency of Medical Care or Service. 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 sought is:

(a) Proper to treat a condition that has been accepted by the Program as compensable under the Act,

(b) Improper to treat a condition that has been accepted by the Program as compensable under the Act, or

(c) Sought to 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 has 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 160.2 and 160.4 are amended and subsection 160.6 is added to read as follows:

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 from the date the decision becomes final.

160.4 Claimants may dispute the Program's benefits calculations by appealing the Notice of Benefits or Program Certification of Compensation to the Chief Risk Officer pursuant to §156.

160.6 Decisions issued on hearings filed pursuant to Section 2324 and 2328 of the Act shall be 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 type 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 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.

(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.

(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, 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

(1) 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;

(2) 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

(3) 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 a person who has graduated from an accredited program for physicians, advance practice nurses, physician assistants, clinical psychologist, physical therapy, and is licensed to practice in the jurisdiction where care is provided or an organization comprised of such persons.

(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 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.

(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.

(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 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.

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

(z) **Occupational disease or infection** – a disease or infection contracted as a result of exposure to risk factors arising from work activity or environment, or that arise as a direct result of a traumatic work injury. See also latent disability.

(aa) **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, 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.

(bb) **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 , and rules set forth in this chapter.

(cc) **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).

(dd) **Panel physician –** means a physician approved by the Program pursuant to § 124.2 of this chapter to provide medical treatment to persons covered by the Act.

(ee) **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 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.

(ff) **Permanent Disability** -- 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 the body or disfigurement pursuant to Section 2307 of the Act and § 139.3 of this chapter.

(gg) **Permanent total disability payment (PTD)** -- schedule award indemnity 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.

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

(ii) **Provider Agreement** – a working agreement developed by the Program in accordance with Section 2302b of the Act with healthcare provider(s) or other public and private organizations to facilitate the provision to claimants of medical and other services authorized under the Act,

(jj) **Qualified health professional or qualified physician** -- 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 regulation by the Mayor.

(kk) **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 injury or illness without an intervening injury or new exposure to the work environment that caused the illness.

(ll) **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.

(mm) **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.

(nn) **Temporary partial disability payment (TPD)** -- indemnity 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 and § 130 of this chapter.

(oo) **Temporary total disability payment (TTD)** -- indemnity 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 and § 129 of this chapter.

(pp) **Treating physician** -- the physician, as defined in Section 2301 of the Act, who provided the greatest amount of treatment and who had the most quantitative and qualitative interaction with the employee or claimant.