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**NOTICE OF FINAL RULEMAKING**

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The Director of the Department of Health, pursuant to the authority set forth under § 302(14) of the District of Columbia Health Occupations Revision Act of 1985 ("Act"), effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1203.02 (14)), and Mayor's Order 98-140, dated August 20, 1998, hereby gives notice of the adoption of the following amendments to Chapter 42 of Title 17 of the District of Columbia Municipal Regulations (DCMR).

The purpose of the amendments is to clarify that a dentist may not refuse to provide copies of a patient's records upon proper request in accordance with law, based upon the patient owing a balance and to require dentists to maintain patient dental records for a minimum of three (3) years after last seeing the patient or the patient reaching age eighteen (18).

Proposed rulemaking was published April 21, 2006 at 53 DCR 3275. No written comments were received from the public in connection with that notice during the comment period. These final rules will be effective upon publication of this notice in the D.C. Register.

17 DCMR Chapter 42, DENTISTRY, is amended to read as follows:

**Section 4213.4 is added to read as follows:**

4213.4 A dentist shall maintain a record for each patient that accurately reflects the evaluation and treatment of the patient. These records shall be kept for three (3) years after last seeing the patient or three (3) years after a minor patient reaches eighteen (18) years of age.

**Section 4213.5 is added to read as follows:**

4213.5 Upon request of a patient or the patient's representative, a dentist shall make available to the patient or the patient's representative a copy of the patient's record in accordance with the following:

- (a) A dentist shall provide to a patient or the patient's representative a copy of the patient's record within thirty (30) days of the request; and
- (b) A dentist may charge a reasonable fee for duplicating records and the fee may be required prior to providing the records in non-emergency situations, but a dentist shall not refuse to provide the records on the basis of the patient owing payment for dental services.

**NOTICE OF FINAL RULEMAKING**

The Director of the Department of Health pursuant to the authority set forth under § 302(14) of the District of Columbia Health Occupations Revision Act of 1985 ("Act"), effective March 25, 1986 (D.C. Law 6-99: D.C. Official Code § 3-1203.02(14)), and Mayor's Order 98-140, dated August 20, 1998, hereby gives notice of his intent to adopt the following amendments to Chapter 46 of Title 17 of the District of Columbia Municipal Regulations (DCMR). The proposed amendments establish continuing education requirements for physicians who are actively practicing medicine by adding two new sections 4614 and 4615. In addition, the continuing education requirements for physicians who are not actively practicing medicine are clarified by repealing sections 4606.2 and 4606.3. These amendments were first published in the D.C. Register on April 28, 2006 at 53 DCR 3488. No comments were received; no changes have been made. This rulemaking will become effective upon publication of this notice in the D.C. Register.

**Chapter 46 (Medicine) of Title 17 DCMR (Business, Occupations & Professions) (May 1990) is amended to read as follows:**

**Sections 4606.2 and 4606.3 are repealed.**

**New sections 4614 and 4615 are added to read as follows:**

**4614 CONTINUING EDUCATION REQUIREMENTS FOR PRACTICING PHYSICIANS**

- 4614.1 Subject to § 4614.2, this section shall apply to actively practicing applicants for the renewal or reinstatement of a license for a term expiring December 31, 2006, and for subsequent terms.
- 4614.2 Physicians actively practicing medicine in the District of Columbia shall submit proof of having completed fifty (50) American Medical Association Physician Recognition Award (AMA/PRA) Category I hours of Board of Medicine approved continuing education credit during the two-year period preceding the date the license expires.
- 4614.3 For purposes of this section, a physician is actively practicing medicine if each calendar year the physician meets the following requirements:
- (a) Maintains a practice of one thousand (1,000) patient-visits per year;
  - (b) Is employed full-time in medical teaching, research, or administration; or

- (c) Is employed part-time in medical teaching, research, or administration and maintains a practice of five-hundred (500) patient-visits per year.

4614.4 An applicant under this section shall prove completion of required continuing education credits by submitting with the application the following information:

- (a) The name of the program, its location, and a description of the subject matter covered;
- (b) The dates on which the applicant attended the program;
- (c) The hours of credit claimed; and
- (d) Verification of completion of the credits by signature or stamp of the sponsor.

4614.5 This section shall not apply to applicants for an initial license by national examination, reciprocity, or endorsement, nor shall it apply to applicants for the first renewal of a license granted by examination. Neither shall the requirement for continuing education apply to physicians specifically exempted due to:

- (a) Hardship;
- (b) Disability;
- (c) Serious illness;
- (d) Service in the United States Congress;
- (e) Military service or other circumstances as the Board deems appropriate if supported by adequate documentation acceptable to the Board; and
- (f) Postgraduate training pursuant to § 4611.

4614.6 Physicians seeking such an exemption shall submit a written request with appropriate documentation including a description of circumstances sufficient to justify such an exemption.

4614.7 A request for an exemption shall be submitted to the Board in a sufficient time period prior to the expiration of the license to receive a determination from the Board as to whether an exemption shall be granted.

4614.8 A physician suspended for disciplinary reasons shall not be exempt from from the requirements of this section.

**4615 APPROVED CONTINUING EDUCATION PROGRAMS AND ACTIVITIES**

4615.1 Pursuant to §§ 4607.2, 4607.3, and 4607.5 the Board may, in its discretion, approve Category I continuing education programs and activities that contribute to the knowledge, skills, and professional performance and relationships that a physician uses to provide services to patients, the public or the profession and which meet the other requirements of this section.

4615.2 The Board shall periodically conduct a random audit of at least one percent (1%) of its active licensees to determine compliance. The physicians selected for the audit shall provide a completed Continuing Education Compliance Audit Form and all supporting documentation to the Board within thirty (30) days of receiving notification of the audit.

4615.3 Failure to comply with these continuing medical education requirements may subject the licensee to disciplinary action by the Board.

**4699 DEFINITIONS**

4699.1 When used in this chapter, the following terms and phrases shall have the meanings ascribed:

**Category I** – structured activities receiving an American Medical Association Physicians Recognition Award (AMA/PRA) that are designated by an organization approved by the Accreditation Council for Continuing Medical Education (ACCME) or the American Osteopathic Association (AOA).

## DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth under § 302 (14) of the District of Columbia Health Occupations Revision Act of 1985 (Act), effective March 15, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1203.02(14), and Mayor's Order 98-140, dated August 20, 1998, hereby gives notice of his intent to adopt the following amendments to Title 17 (Business, Occupations & Professions) (May 1990) of the District of Columbia Municipal Regulations (DCMR). The purpose of the amendments is to establish licensure and practice regulations for naturopathic medicine. This profession was established by enactment of the Practice of Naturopathic Medicine Licensing Amendment Act of 2003, effective July 8, 2004 (D.C. Law 15-172; D.C. Official Code § 3-1201.02(7A)). These amendments were first published in the D.C. Register on April 14, 2006 at 53 DCR 3068. No comments were received; no substantive changes were made. This rulemaking will become effective upon publication of this notice in the D.C. Register.

**Title 17 (Business, Occupations & Professions) (May 1990) is amended as follows:**

**I. The table of contents is amended as follows:**

**A. A new Chapter heading for Chapter 52 is added to read as follows:**

**CHAPTER 52 NATUROPATHIC MEDICINE**

**B. Section headings for Chapter 52 are added to read as follows:**

5200	GENERAL PROVISION
5201	TERM OF LICENSE
5202	EDUCATIONAL REQUIREMENTS
5203	[RESERVED]
5204	[RESERVED]
5205	NATIONAL EXAMINATION
5206	CONTINUING EDUCATION REQUIREMENTS
5207	APPROVED CONTINUING EDUCATION PROGRAMS AND ACTIVITIES
5208	[RESERVED]

- 5209 [RESERVED]
- 5210 LAWFUL PRACTICE
- 5211 [RESERVED]
- 5212 STANDARDS OF CONDUCT
- 5299 DEFINITIONS

**II. A new Chapter 52 is added to read as follows:**

**CHAPTER 52 NATUROPATHIC MEDICINE**

**5200 GENERAL PROVISIONS**

- 5200.1 This chapter shall apply to applicants for and holders of a license to practice naturopathic medicine.
- 5200.2 Chapters 40 (Health Occupations: General Rules) and 41 (Health Occupations: Administrative Procedures) of this title shall supplement this chapter.
- 5200.3 An applicant for a license to practice naturopathic medicine shall furnish proof that the applicant is a District resident or has an office or location of practice involved in the practice of naturopathic medicine in the District of Columbia. A post office box shall not be proof of residency nor shall it demonstrate that an applicant either has an office or location of practice in the District.

**5201 TERM OF LICENSE**

- 5201.1 Subject to § 5201.2, a license issued pursuant to this chapter shall expire at twelve o'clock midnight of December 31<sup>st</sup> of each even-numbered year.
- 5201.2 If the Director changes the renewal system pursuant to § 4006.3 of chapter 40 of this title, a license issued pursuant to this chapter shall expire at twelve o'clock midnight of the last day of the month of the birthdate of the holder of the license, or other date as established by the Director.
- 5201.3 An applicant for renewal of a license who fails to renew the license by the date the license expires may renew the license for up to sixty (60) days after the date of expiration by completing the application, submitting the required supporting documents, and paying the required late fee. Upon renewal, the applicant shall be deemed to have possessed a valid license

during the period between the expiration of the license and the renewal thereof.

5201.4 If a licensee applying for a renewal of a license fails to renew the license and pay the late fee within the sixty (60) days after the expiration of the applicant's license, the license shall be considered to have lapsed on the date of expiration and the health care professional shall thereafter be required to apply for reinstatement of an expired license and meet all requirements and fees for reinstatement.

5201.5 The Board may, in its discretion, grant an extension of the sixty (60) day period, up to a maximum of one (1) year, to renew after expiration if the applicant's failure to renew was for good cause. As used in this section, "good cause" includes the following:

(a) Serious and protracted illness of the applicant; or

(b) The death or serious and protracted illness of a member of the applicant's immediate family.

5201.6 An extension granted under this section shall not exempt a licensee from complying with the continuing education requirements pursuant to § 5206.

**5202 EDUCATIONAL REQUIREMENTS**

5202.1 An applicant shall furnish proof satisfactory to the Board in accordance with § 504(e-1)(1) of the Act, (D.C. Official Code § 3-1205.04(e-1)(1) (2001)), that the applicant has:

(a) Earned a degree of doctor of naturopathic medicine from a college or university which at the time of the awarding of the degree was accredited by or a candidate for accreditation with:

(1) The Council of Naturopathic Medicine Education (CNME), so long as the CNME maintains recognition from the United States Department of Education; or

(2) Any other accrediting agency recognized by the United States Department of Education.

5202.2 The Board of Medicine shall not waive the educational requirements for licensure to practice naturopathic medicine for person registered to practice naturopathy or naturopathic healing.

**5203 – 5204 [RESERVED]**

**5205 NATIONAL EXAMINATION**

- 5205.1 Except as otherwise provided in this subtitle, an applicant shall receive a passing score on the required level of the examination sponsored by the Naturopathic Physicians Licensing Examination (NPLEX) basic science examination and clinical science examination sections administered by the North American Board of Naturopathic Examiners (NABNE), or other examination approved by the Board of Medicine or the Mayor.
- 5205.2 A passing score on the Part I series of the basic science examination shall be a minimum converted score of seventy-five (75) of each of the five (5) parts.
- 5205.3 An applicant who does not achieve a score of at least sixty (60) on each of the failed parts shall be required to retake the entire Part I series.
- 5205.4 An applicant shall take and pass Part II of the clinical science examination within ten (10) years of taking Part I of the basic science examination. Failure to take and pass Part II within the ten (10) year period shall result in the applicant retaking Part I again.

**5206 CONTINUING EDUCATION REQUIREMENTS**

- 5206.1 Subject to § 5206.2, this section shall apply to applicants for the renewal, reactivation, or reinstatement of a license for a term expiring February 28, 2008.
- 5206.2 This section shall not apply to applicants for an initial license by examination, reciprocity, or endorsement, nor shall it apply to applicants for the first renewal of a license granted by examination.
- 5206.3 A continuing education credit shall be valid only if it is part of a program or activity approved by the Board in accordance with § 5207.
- 5206.4 An applicant for renewal of a license shall:
- (a) Have completed thirty (30) hours of approved continuing education credit during the two (2) year period preceding the date the license expires;
  - (b) Attest to completion of the required continuing education credit on the renewal application form; and
  - (c) Be subject to a random audit.
- 5206.5 To qualify for a license a person in inactive status within the meaning of

§ 511 of the Act, D.C. Official Code § 3-1205.11 (2001) for five (5) years who submits an application to reactivate a license shall submit proof pursuant to § 5206.8 of having completed fifteen (15) hours of approved continuing education credit in the year immediately preceding the date of the application.

5206.6 To qualify for a license, a person in inactive status within the meaning of § 511 of the Act, D.C. Official Code § 3-1205.11 (2001) for more than five (5) years who submits an application to reactivate a license shall submit proof pursuant to § 5206.8 of having completed approved continuing education credit in the year immediately preceding the date of the application as follows:

- (a) Thirty (30) hours of approved continuing education credit; and
- (b) One hundred sixty (160) hours within a sixty (60) day period of professional practice under the supervision of a naturopathic physician.

5206.7 To qualify for a license, an applicant for reinstatement of a license shall submit proof pursuant to § 5206.8 of having completed approved continuing education credit in the year immediately preceding the date of the application as follows:

- (a) Thirty (30) hours of approved continuing education credit; and
- (b) One hundred sixty (160) hours within a sixty (60) day period of professional practice under the supervision of a naturopathic physician.

5206.8 Except as provided in § 5206.10, an applicant under this section shall prove completion of required continuing education credits by submitting with the application the following information with respect to each program:

- (a) The name and address of the sponsor of the program;
- (b) The name of the program, its location, a description of the subject matter covered, and the names of the instructors;
- (c) The dates on which the applicant attended the program;
- (d) The hours of credit claimed; and
- (e) Verification by the sponsor of completion, by signature or stamp.

5206.9 Beginning with the 2008 renewal period, the Board shall conduct a random audit of continuing education credits at the completion of each renewal period.

5206.10 Applicants for renewal of a license shall only be required to prove completion of the required continuing education credit by submitting proof pursuant to § 5206.8 if requested to do so as part of the random audit, or if otherwise requested to do so by the Board.

**5207 APPROVED CONTINUING EDUCATION PROGRAMS AND ACTIVITIES**

5207.1 The Board may, in its discretion, approve continuing education programs and activities designed to maintain, develop, or increase the knowledge, skills, and professional performance of persons licensed to practice as naturopathic physicians and which meet the other requirements of this section.

5207.2 The Board may approve the following types of continuing education programs, if the programs meet the requirements of § 5207.3:

- (a) An undergraduate or graduate course given at an accredited college or university;
- (b) A seminar or workshop;
- (c) An educational program given at a conference; and
- (d) In-service training.

5207.3 To qualify for approval by the Board, a continuing education program or activity shall do the following:

- (a) Be current in its subject matter;
- (b) Be developed and taught by qualified individuals; and
- (c) Meet one of the following requirements:
  - (1) Be administered or approved by a recognized national, state, or local naturopathic medicine organization; health care organization; accredited health care facility; or an accredited college or university; or
  - (2) Be submitted by the program sponsors to the Board for review no less than sixty (60) days prior to the date of the presentation and

be approved by the Board.

5207.4 The Board may issue and update a list of approved continuing education programs.

5207.5 An applicant shall have the burden of verifying whether a program is approved by the Board pursuant to this section prior to attending the program.

**5208 [RESERVED]**

**5209 [RESERVED]**

**5210 LAWFUL PRACTICE**

5210.1 An individual licensed to practice naturopathic medicine under the Act may use the titles "Doctor of Naturopathic Medicine," "Naturopathic Physician," "Licensed Naturopath," "Naturopathic Doctor," "Doctor of Naturopathy," "Naturopath," or the initials "ND."

5210.2 An individual licensed to practice naturopathic medicine may:

- (a) Administer or provide for preventive and therapeutic purposes natural medicines by their appropriate route of administration the following:
  - (1) Natural remedies;
  - (2) Topical medicine;
  - (3) Counseling;
  - (4) Hypnotherapy;
  - (5) Dietary therapy;
  - (6) Naturopathic physical medicine;
  - (7) Therapeutic devices; and
  - (8) Barrier devices for contraception.
- (b) Review and interpret the results of diagnostic procedures commonly used by physicians in general practice, including:

- (1) Physical and official examinations;
- (2) Electrocardiograms;
- (3) Diagnostic imaging techniques;
- (4) Phlebotomy;
- (5) Clinical laboratory test and examinations; and
- (6) Physiological function tests.

5210.4

An individual licensed to practice naturopathic medicine under this Act shall not:

- (a) Prescribe, dispense, or administer any controlled substances, except those natural medicine authorized by this Act;
- (b) Perform surgical procedures, except for minor office procedures, as defined by rule;
- (c) Use for therapeutic purposes, any device regulated by the United States Food and Drug Administration (FDA) that has not been approved by the FDA;
- (d) Participate in naturopathic childbirth, unless the naturopathic physician:
  - (1) Passes a specialty examination in obstetrics or natural childbirth approved by the Advisory Committee on Naturopathic Medicine, the Board of Medicine, or the Mayor, such as the American College of Nurse Midwives Written Examination or an equivalent national examination;
  - (2) Has a minimum of 100 hours of course work, internship, or preceptorship in obstetrics of natural childbirth approved by the Advisory Committee on Naturopathic Medicine;
  - (3) Files with the Department of Health and maintains a written collaboration agreement with a licensed obstetrician who is qualified to perform obstetrical surgery; and
  - (4) Has assisted in a minimum of fifty (50) supervised births, including prenatal and postnatal care, under the direct supervision of a licensed naturopathic, medical, or osteopathic physician with

training in obstetrics or natural childbirth, at least twenty-five (25) of which document the naturopathic physician as the primary birth attendant.

**5211 STANDARDS OF CONDUCT**

5211.1 Any holder of a license under this chapter to practice as a naturopathic physician shall comply with the standards of ethical and professional conduct established by the American Association of Naturopathic Physicians as they may be amended or republished from time to time.

**5299 DEFINITIONS**

5299.1 As used in this chapter, the following terms have the meanings ascribed:

**Applicant** – a person applying for a license to practice naturopathic medicine under this chapter.

**Board** – the Board of Medicine, established by § 203(a) of the Act, D.C. Official Code § 3-1202.03 (1985).

**Naturopathic physical medicine** – the use of the physical agents of air, water, heat, cold, sound, and light, and the physical modalities of electrotherapy, biofeedback, diathermy, ultraviolet light, ultrasound, hydrotherapy, and exercise, includes naturopathic manipulation and mobilization therapy.

5299.2 The definitions in § 4099 of chapter 40 of this title are incorporated by reference into and are applicable to this chapter.

## DEPARTMENT OF HEALTH

**NOTICE OF FINAL RULEMAKING**

The Director of the State Health Planning and Development Agency with the Department of Health ("Director"), pursuant to the authority set forth in § 22 of the Health Services Planning Program Re-establishment Act of 1996 (Act), effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-421 (2001)), hereby gives notice that she took final action to adopt the following amendments to Chapter 44 of Title 22 of the District of Columbia Municipal Regulations (DCMR) on June 7, 2006. The purpose of the final rule is to revise the requirements for health care facilities for providing uncompensated care to persons who cannot afford health services consistent with re-establishment of the Health Services Planning Program and changes implemented through the Health Services Planning and Development Amendment Act of 2004, effective April 22, 2004 (D.C. Law 15-149). The proposed rule was published September 2, 2005, at 52 DCR 8258. The Director received two (2) sets of comments in response to the notice of proposed rulemaking. The Director considered both sets of comments and decided not to change the proposed rules.

Pursuant to § 22 of the Act, the proposed rules were transmitted to the Council of the District of Columbia, for a forty-five (45) day period of Council review. The proposed rule was deemed approved without Council action on May 18, 2006, by Resolution 16-650. This rule will be effective upon publication of a notice of final rulemaking in the *D.C. Register*.

**Chapter 44 of Title 22 DCMR (Public Health & Medicine) (August 1986) is amended by striking Chapter 44 in its entirety and replacing it with a new Chapter 44 to read as follows:**

**CHAPTER 44 PROVISION OF UNCOMPENSATED CARE****4400 GENERAL PROVISIONS**

- 4400.1 This chapter implements the requirements of the District of Columbia Health Services Planning Program Re-Establishment Act of 1996 (Act), effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-401 *et seq.*), for the provision by health care facilities of uncompensated care as a condition of holding a Certificate of Need (CON).
- 4400.2 As a condition for issuance of a CON to a health care facility or health service that operates on a payment for services rendered basis, the health care facility or health service shall provide uncompensated care in an amount not less than three percent (3%) of the health care facility's or health service's annual operating expenses, less the amount of reimbursements it receives from Titles XVIII and XIX of the Social Security Act (Medicaid and Medicare), without regard for contractual allowances. In addition, the health care facility or health service shall comply with any uncompensated care obligations required pursuant to the Act in a previous CON.
- 4400.3 The State Health Planning and Development Agency (SHPDA) may require each health care facility or health service subject to an uncompensated care obligation through a CON to submit data to verify compliance with the uncompensated care obligation.

- 4400.4 Each health care facility or health service subject to an uncompensated care obligation shall provide uncompensated care at the annual compliance level required by § 4400.2, for each fiscal year, or any part thereof, in which it is subject to the uncompensated care obligation.
- 4400.5 Each health care facility or health service that has an uncompensated care obligation shall make uncompensated care available to the extent of that obligation to all eligible persons, without discrimination on the grounds of race, color, creed, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or any other grounds unrelated to an individual's need for the service or the availability of the needed service.
- 4401 RESERVED**
- 4402 CERTIFICATE OF NEED HOLDER PARTICIPATION IN THIRD PARTY PAYER PROGRAMS**
- 4402.1 Each CON holder may make arrangements, if eligible to do so, for reimbursement for services from:
- (a) Those principal District and state third party payers that provide reimbursement for services; and
  - (b) Federal governmental third-party programs, including Medicare and Medicaid.
- 4402.2 Each CON holder shall take all actions necessary to ensure that admission to and receipt of its services are available to beneficiaries of the governmental programs specified in § 4402.1, without discrimination or preference because they are beneficiaries of those programs.
- 4403 PROHIBITION OF EXCLUSIONARY ADMISSIONS POLICIES**
- 4403.1 A CON holder shall be out of compliance with § 4400.4, if it uses an admissions practice that has the effect of excluding persons who are eligible for uncompensated care under § 4406.
- 4403.2 Prohibited admissions practices include the following:
- (a) Limiting admission to patients who are referred by physicians with staff privileges at the CON holder's facility (or facilities);
  - (b) Maintaining an operational structure that includes few or no physicians with staff privileges who will treat persons who are eligible for uncompensated care; or
  - (c) Requiring advance deposits (pre-admission or pre-service deposits) from

persons who qualify or appear to qualify for uncompensated care before admitting or serving these persons.

- 4403.3 A CON holder may have in effect a policy or practice described in § 4403.2(a) and still comply with this chapter if the CON holder makes alternative arrangements to treat those persons who would otherwise be unable to gain admission to, or obtain services available from, the CON holder. Alternative arrangements may include the following:
- (a) Authorizing the individual's physician, if licensed and otherwise qualified, to treat the patient at the facility even though the physician does not have staff privileges at the facility;
  - (b) Obtaining the voluntary agreement of physicians with staff privileges at the facility to accept referrals regularly of patients who do not have a physician (e.g. rotating referrals to the physicians with staff privileges);
  - (c) Requiring acceptance of referrals of patients who do not have a physician as a condition of obtaining or renewing staff privileges;
  - (d) Establishing a hospital-based primary care clinic through which patients needing hospitalization may be admitted; or
  - (e) Hiring or contracting with qualified physicians to treat patients who do not have private physicians.
- 4403.4 A CON holder need not require all its staff physicians to accept Medicaid or Medicare patients to remedy a violation of § 4403.2(b). If the Department of Health, Medical Assistance Administration, determines that a CON holder or CON applicant is out of compliance with Medicaid or Medicare obligations, the CON applicant or CON holder shall be deemed out of compliance with admissions and service requirements until the CON applicant or CON holder takes steps to ensure that Medicaid and Medicare program beneficiaries have full access to all of the CON applicant's or CON holder's available services.
- 4403.5 A CON holder that engages in a practice prohibited by § 4403.2(c) is not required to forego the use of a deposit policy in all situations. The CON holder can remedy this violation by making alternative arrangements to ensure that persons who probably can pay for services are not denied them simply because they do not have the available cash at the time services are requested. A CON holder shall not deny admission or a service to a person who probably can pay because of the person's inability to pay a deposit at the time the person requests admission or a service.
- 4404 UNCOMPENSATED CARE COMPLIANCE REQUIREMENTS**
- 4404.1 Each CON holder shall provide uncompensated care pursuant to § 4400.2 to eligible persons. The uncompensated care to be provided shall be based upon these rules or contractual obligations between the health care provider and the District of Columbia

Government, whichever standard provides the higher dollar value.

- 4404.2 If, during any fiscal year, a CON holder fails to meet its annual uncompensated care obligation, the CON holder shall, during a subsequent fiscal year, provide uncompensated care in a dollar value sufficient to remediate that deficit, pursuant to a compliance plan under § 4413 approved by the SHPDA. The compliance plan shall include the following:
- (a) The conditions or circumstances that caused or contributed to the deficit;
  - (b) Specific actions the CON holder plans to take to remediate the deficit;
  - (c) Specific actions the CON holder plans to take to prevent further deficits;
  - (d) The name of a staff person who will be responsible for administering the compliance plan; and
  - (e) The dates on which the compliance plan will begin and is expected to be completed.
- 4404.3 A deficit incurred during any fiscal year shall be made up within not more than three (3) fiscal years after the end of the fiscal year during which the deficit occurred.
- 4404.4 A CON holder shall begin to make up a deficit during the fiscal year immediately following the fiscal year during which it incurred the deficit.
- 4404.5 The SHPDA shall complete its review of the compliance plan within forty-five (45) days of receipt from the CON holder. The compliance plan shall expire after the CON holder remedies the deficit for which it submitted the compliance plan.
- 4404.6 The Director may extend the period of time within which a CON holder may make up a deficit.
- 4404.7 The amount of an uncompensated care deficit for any fiscal year shall be the difference between a CON holder's annual compliance level for that fiscal year and the amount of uncompensated care provided during that fiscal year.
- 4404.8 If a CON holder provides uncompensated care during a fiscal year in an amount exceeding its annual compliance level, the CON holder may request that the Director apply the excess amount as a credit towards an existing deficit or its annual compliance level for any subsequent fiscal year. To be eligible for a credit, the excess dollar value above the annual compliance level must have been provided pursuant to the requirements of this chapter.
- 4405 NOTICE OF AVAILABILITY OF UNCOMPENSATED CARE**
- 4405.1 Each CON holder shall publish, in a newspaper of general circulation within the

District of Columbia, and submit to the Director before the beginning of the CON holder's fiscal year, a notice of its uncompensated care obligation. The notice shall include:

- (a) The dollar value of uncompensated care that the CON holder intends to make available during the fiscal year or a statement that the CON holder will provide uncompensated care to all persons unable to pay for treatment who request uncompensated care;
- (b) An explanation of the difference between the amount of uncompensated care the CON holder proposes to make available and the annual compliance level for the CON holder, if any; and
- (c) A statement whether the CON holder has satisfied all outstanding uncompensated care obligations from previous reporting periods, or a statement indicating that it will, during a specified period, satisfy any outstanding obligations.

4405.2 The CON holder shall post the following notice:

"Under District of Columbia law, this health care provider must make its services available to all people in the community. This health care provider is not allowed to discriminate against a person because of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or place of residence or business, or because a person is covered by a program such as Medicare or Medicaid.

"This health care provider is also required to provide a reasonable volume of services without charge or at a reduced charge to persons unable to pay. Ask the staff if you are eligible to receive services either without charge or at a reduced charge. If you believe that you have been denied services or consideration for treatment without charge or at a reduced charge without a good reason, contact the Admissions or Business Office of this health care provider, and call the State Health Planning and Development Agency through the Citywide Call Center at 202-727-1000.

"If you want to file a complaint, forms are available from the State Health Planning and Development Agency."

4405.3 The notice required by § 4405.2 shall also include the CON holder's eligibility criteria for uncompensated care.

4405.4 The CON holder shall post the notice required by § 4405.2 in plain view in areas of the CON holder's facility or service that are easily accessible to the public. Those areas shall include the admissions areas, the business office, and the emergency room.

4405.5 The notice required by § 4405.2 shall be printed in the following languages:

- (a) English;
- (b) Spanish; and
- (c) Any other language that is the usual language of households of ten percent (10%) or more of the population of the District of Columbia, according to the most recent figures published by the Bureau of Census.

4405.6 Each CON holder shall communicate the contents of the posted notice to any person who the CON holder has reason to believe cannot read the notice.

4405.7 During any period of a fiscal year when uncompensated care is available in the CON holder's facility or service, the CON holder shall provide written notice of the availability of the services to each person who seeks services from the CON holder, whether on his or her own behalf or on behalf of another. The written notice of availability shall include the following:

- (a) The information set out in the notice in § 4405.2.
- (b) The location in the CON holder's facility or service where any person seeking uncompensated care may request it; and
- (c) A statement that the CON holder is required to make a written determination whether the person will receive uncompensated care; and
- (d) The date by, or period within which, the determination will be made.

4405.8 Each CON holder shall provide the written notice required by § 4405.7 before providing services, except where the emergency nature of the services makes prior notice impractical. In emergency situations, the CON holder shall provide the written notice to the patient as soon as practical, or to the next of kin. The CON holder shall give the notice not later than when presenting the first bill for services.

#### **4406 UNCOMPENSATED CARE ELIGIBILITY CRITERIA**

4406.1 A person is eligible to receive uncompensated care if the person is unable to pay for health services and satisfies the following additional requirements:

- (a) Is not covered, or receives services that are not covered, under a third-party insurer or governmental program;
- (b) Has an annual individual or family income that is not greater than two hundred percent (200%) of the federal poverty level; and
- (c) Requests services.

4406.2 Financial eligibility for uncompensated care shall be calculated by either of the following methods:

- (a) Multiplying by four (4) the person's individual or family income, as applicable, for the three (3) months preceding the request for uncompensated care; or
- (b) Using the person's or family's actual income, as applicable, for the twelve (12) months preceding the request for uncompensated care.

4406.3 For purpose of determining income eligibility for uncompensated care pursuant to § 4406.1(b), revisions to the federal poverty level used to calculate eligibility shall be effective sixty (60) days after the date of publication in the *Federal Register*.

4407 **RESERVED**

4408 **WRITTEN DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED CARE**

4408.1 Each CON holder shall give written notice of its determination of eligibility for uncompensated care in response to each request for uncompensated care to the person requesting care. The CON holder shall give notice in person at the time uncompensated care is requested or by regular mail to the address the person requesting services provided. If the person requesting care has not provided an address and is not available to receive notice in person, the CON holder may post at the facility, in a conspicuous place such as the admissions office or the emergency services department, a notice that the person's eligibility status is available in the administrative office within that facility.

4408.2 Each CON holder shall communicate the contents of the written determination to any person requesting uncompensated care that the CON holder has reason to believe cannot read the determination.

4408.3 Each determination of eligibility for uncompensated care shall include the following statements:

- (a) That the CON holder will, will with conditions, or will not provide uncompensated care;
- (b) That there will be no charge for uncompensated care;
- (c) The date on which the person requested care;
- (d) The date on which the CON holder made the determination;
- (e) The annual individual or family income, as applicable, and family size of the person who requested uncompensated care;
- (f) The date on which services were, or will be, provided; and

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(g) The reason for denial, if applicable.

4408.4 As a condition of providing uncompensated care, a CON holder may:

- (a) Require the person requesting uncompensated care to furnish any information that is reasonably necessary to substantiate eligibility; and
- (b) Require each person requesting uncompensated care to apply for any benefits under third party insurer or governmental programs to which the person requesting uncompensated care is, or could be, entitled upon application.

4408.5 A conditional eligibility determination shall state the conditions that the person requesting uncompensated care must satisfy to be eligible.

4408.6 CON holders shall make eligibility determinations as follows:

- (a) Each hospital shall make an eligibility determination for uncompensated care within five (5) business days of a request for an outpatient service or before discharge for an inpatient service;
- (b) Each ambulatory surgical facility shall make an eligibility determination for uncompensated care within five (5) business days of a request for an outpatient service; and
- (c) Any other CON holder shall make a determination of eligibility for uncompensated care within ten (10) business days following the date of admission or delivery of services.

**4409 RESERVED**

**4410 UNCOMPENSATED CARE REPORTING REQUIREMENTS**

4410.1 Each CON holder shall submit an annual report to the SHPDA on uncompensated care. The report shall be on a schedule prescribed by the SHPDA. The report shall be submitted within one hundred and twenty (120) days after the close of the CON holder's fiscal year. The report shall include:

- (a) The dollar value of uncompensated care that the CON holder was required to provide;
- (b) The dollar value of uncompensated care the CON holder actually provided, with the dollar value of charity care and bad debt reported separately;
- (c) A copy of the CON holder's audited financial statement for that fiscal year;
- (d) Other documentation SHPDA may require to determine if a CON holder has met its annual compliance level for the period covered by the report;

- (e) The dollar value of services and care provided to District residents;
- (f) A copy of the notice required by § 4405.1, including the date the notice was published and the name of the newspaper that printed the notice;
- (g) If the CON holder failed to provide the required annual level of uncompensated care, the reason and any documentation that supports its reason for failing to meet the annual compliance level;-and
- (h) Any other documentation the Director may request.

4410.2 The Director may require a CON holder to submit the report required by § 4410.1 more frequently when:

- (a) The Director determines that during the preceding fiscal year the CON holder did not provide uncompensated care at its required annual compliance level; or
- (b) The Director notifies the CON holder, in writing, that additional reports are needed for proper administration of the CON program.

4410.3 If the Director requests additional reports pursuant to § 4410.2, the CON holder shall submit the report within ninety (90) days after receiving the request or within ninety (90) days after the close of the fiscal year, whichever is later. The Director may, for good cause shown, extend the time within which the CON holder must submit the report.

4410.4 Not later than ten (10) days after being served with a summons or complaint regarding uncompensated care or any other activity relating to the CON, each CON holder shall notify the Director of any legal action brought against it that alleges that it has failed to comply with the requirements of this chapter.

#### **4411 UNCOMPENSATED CARE RECORDS MAINTENANCE REQUIREMENTS**

4411.1 Each CON holder shall maintain and provide to the Director, upon request, any records necessary to document the CON holder's compliance with the requirements of this chapter. Each CON holder shall make available for public inspection the records it maintains to document its compliance. Patient identifying information shall be removed from records provided for public inspection.

4411.2 The CON holder shall maintain uncompensated care records, including the following:

- (a) Any documents from which the information required to be reported under § 4410 was obtained;
- (b) Documents that clearly segregate uncompensated care from other accounts;

- (c) Copies of written determinations of eligibility under § 4408; and
- (d) Documentation that verifies compliance with the requirements of this chapter during any fiscal year, including documents from which information required to be reported under § 4410.1 was obtained.

4411.3 Each CON holder shall retain records to document its compliance with this chapter for five (5) years from the date of the last entry for a particular fiscal year. The Director may require a CON holder to maintain the records for a longer period.

#### 4412 INVESTIGATION AND CERTIFICATION OF COMPLIANCE

4412.1 Any person may file a complaint with the Director that a CON holder is not complying with the requirements of this chapter.

4412.2 Each complaint shall include the following information:

- (a) The name and address of the complainant;
- (b) The name and address of the CON holder;
- (c) The date or approximate date on which the event or incident being complained of occurred; and
- (d) A statement describing the event or incident that the complainant believes violates the requirements of this chapter.

4412.3 The filing date of a complaint shall be the date of receipt by the SHPDA.

4412.4 The Director shall provide a copy of the complaint to the CON holder named in the complaint within ten (10) business days after receiving the complaint.

4412.5 The Director shall initiate an investigation of each complaint filed pursuant to the provisions of this section within thirty (30) business days of its receipt.

4412.6 The CON holder shall provide the Director with documents, records, or other requested information that may assist in investigating the complaint.

4412.7 A CON holder shall be out of compliance with its uncompensated care obligations if it fails to provide documentation the Director requests to determine the CON holder's compliance with this chapter.

4412.8 The Director shall determine the merit of a complaint based on:

- (a) Information contained in the complaint;
- (b) Documents the CON holder provides; and

(c) Other credible information the Director receives.

- 4412.9 If the Director determines that a complaint is not substantiated, the Director shall dismiss the complaint.
- 4412.10 The Director shall make periodic reviews of the uncompensated care requirements and activities of each CON holder to determine whether a CON holder is complying with its obligations.
- 4412.11 The Director shall conduct audits to determine each CON holder's compliance with its uncompensated care obligation according to standard audit procedures.
- 4412.12 After completing the audit the Director may certify that a CON holder has substantially complied with its uncompensated care obligation for a specific fiscal year or years. The certification shall confirm that the CON holder has provided the uncompensated care stated for the period covered by the certification.
- 4412.13 The Director shall base each certification of substantial compliance on the amount of uncompensated care properly claimed by the CON holder, using procedures and reviewing individual account data the Director determines to be sufficient to establish that the CON holder has substantially complied with its uncompensated care obligation for the period covered by the certification.
- 4412.14 The Director may certify substantial compliance when he or she determines that, for the period covered by the certification, the CON holder provided uncompensated care to eligible persons who had equal opportunity to apply for uncompensated care.
- 4412.15 To determine whether a CON holder has substantially complied with its obligations, the SHPDA shall consider each of the following in descending order of importance:
- (a) Whether the CON holder took corrective action prescribed pursuant to § 4413;
  - (b) Whether the CON holder's noncompliance with its uncompensated care obligation may be remedied by corrective action under § 4413; and
  - (c) Whether the CON holder had procedures in place that complied with the applicable notice, eligibility, and record keeping requirements of §§ 4405, 4406, 4408, 4410, and 4411, and systematically and correctly followed the procedures.
- 4412.16 The Director shall determine and certify the amount of creditable service required by each CON holder for the three (3) fiscal years ending prior to the effective date of these rules. The Director shall base the determination on information necessary to establish the CON holder's substantial compliance with its uncompensated care obligation during the period being reviewed.
- 4412.17 To determine creditable service during the three (3) fiscal years ending prior to the

effective date of these rules, each CON holder shall submit to the Director for each fiscal year the following:

- (a) The number of persons to whom it provided care without charge or below its normal and customary charge;
- (b) The total dollar amount of uncompensated care it provided in each fiscal year and the method used to determine that dollar amount; and
- (c) A description of the eligibility criteria it used for providing uncompensated care.

#### 4413 UNCOMPENSATED CARE ENFORCEMENT

4413.1 If the Director finds, based on an investigation, review, or audit under § 4412, that a CON holder has not complied with the requirements of this chapter, the Director may take any action authorized by law to secure compliance, including:

- (a) Voluntary agreement;
- (b) Judicial enforcement of the obligations under this chapter; and
- (c) Denial or withdrawal of a CON.

4413.2 Each CON holder that has denied uncompensated care to any person because it failed to comply with its uncompensated care obligation shall be out of compliance until it takes the actions necessary to remedy fully the noncompliance, including:

- (a) Providing uncompensated care to applicants improperly denied;
- (b) Repaying amounts improperly collected from persons eligible to receive uncompensated care; and
- (c) Other corrective action the Director may prescribe.

4413.3 The Director may disallow all of the uncompensated care claimed in a fiscal year if the Director finds that a CON holder was in substantial noncompliance with its uncompensated care obligation because it failed to do any of the following:

- (a) Have a system for providing notices to eligible persons as required by § 4405;
- (b) Comply with the applicable reporting requirements of § 4410;
- (c) Have a system for maintaining records of uncompensated care provided;
- (d) Take corrective action pursuant to § 4413.2;

(e) Comply with the applicable eligibility standards in § 4406; or

(f) Comply with the written determination procedures in § 4408.

4413.4 If the Director determines, based on investigation, audit, or review under § 4412, that a CON holder has limited its services in violation of its uncompensated care obligation, the Director may require the CON holder to establish a compliance plan to ensure that the CON holder's services are available according to the requirements of this chapter.

4413.5 In the absence of a finding of noncompliance in any fiscal year, the Director may disallow uncompensated care claimed by a CON holder in the fiscal year to the extent that the services are not documented as uncompensated care according to this chapter.

4414 **RESERVED**

4499 **DEFINITIONS**

4499.1 The provisions of § 4099 of Chapter 40 of this title and the definitions set forth in that section shall apply to this chapter.

4499.2 When used in this chapter, the following terms and phrases shall have the meaning ascribed below:

**Act** - the Health Services Planning Program Re-establishment Act of 1996, effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-401 *et seq.*).

**Certificate of Need or CON** – authorization for a health care facility or health service to develop a new institutional health service, purchase major medical equipment, or obligate a capital expenditure to obtain an asset worth more than two million five hundred thousand dollars (\$2,500,000).

**Certificate of Need applicant or CON applicant** - a person who applies for a CON.

**Certificate of Need holder or CON holder** - a person who has applied for and received a Certificate of Need pursuant to this chapter. For the purpose of this chapter, a person continues to be a CON holder after the completion of the project for which the CON was obtained.

**Compliance plan** - the means by which a CON holder that violates this chapter or is out of compliance with its uncompensated care obligations proposes to remedy the violations or other noncompliance.

**Director**--Director of the District of Columbia State Health Planning and Development Agency, Department of Health.

**Health care facility**--a private general hospital, psychiatric hospital, other specialty hospital, rehabilitation facility, skilled nursing facility, intermediate care facility, ambulatory care center or

clinic, ambulatory surgical facility, kidney disease treatment center, freestanding hemodialysis facility, diagnostic health care facility, home health agency, hospice, or other comparable health care facility that has an annual operating budget of at least \$500,000. This term shall not include Christian Science sanitariums operated, listed, and certified by the First Church of Christ Scientist, Boston, Massachusetts; the private office facilities of a health professional or group of health professionals, where the health professional or group of health professionals provides conventional office services limited to medical consultation, general non-invasive examination, and minor treatment, or a health care facility licensed or to be licensed as a community residence facility, or an Assisted Living Residence as defined by § 102.01(4) of the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; 44-102.01(4)).

**Health service** - any medical or clinical related service, including services that are diagnostic, curative, or rehabilitative, as well as those related to alcohol abuse, inpatient mental health services, home health care, hospice care, medically supervised day care, and renal dialysis. This term shall not include those services provided by physicians, dentists, HMOs, and other individual providers in individual or group practice.

**Request for uncompensated care** - any indication by or on behalf of an individual seeking health care from a CON holder of the individual's inability to pay for the services that is made at any time, including following institution of a collection action against the individual.

**SHPDA** - State Health Planning and Development Agency, Department of Health.

**DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING**

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**NOTICE OF FINAL RULEMAKING**

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The Commissioner of the Department of Insurance, Securities and Banking ("Commissioner"), pursuant to the authority set forth in section 8 of the Prompt Payment Act of 2002 (Act), effective July 23, 2002, D.C. Law 14-176, D.C. Official Code § 31-3137, hereby gives final notice of his intent to add a new Chapter 88, entitled Health Benefit Plans Prompt Payment, to Title 26 of the D.C. Municipal Regulations (Insurance). The purpose of this new chapter is to establish a uniform medical claims form to be accepted by health insurers and used by providers when a health insurer requests a treatment plan in order to adjudicate a medical health claim for mental health services provided by a provider. Notice of Proposed Rulemaking was published on April 14, 2006 in 53 DCR 3134. No comments were received on the proposed rules. These final rules will become effective upon publication of this notice in the *D.C. Register*.

Title 26 DCMR (Insurance) is amended by adding a new Chapter 88, Health Benefit Plans Prompt Payment to read as follows:

**Chapter 88 HEALTH BENEFIT PLANS PROMPT PAYMENT**

**8800 CLAIM FORM FOR MENTAL HEALTH SERVICES**

8800.1 When a health insurer requests a treatment plan from a provider who provides mental health services, the health insurer shall require the provider to submit the information on the "Release of Mental Health Information for Outpatient Mental Health Treatment" form (See the Appendix).

**8899 DEFINITIONS**

8899.1 "Health benefits plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage;

coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

8899.2 "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

8899.3 "Provider" means any hospital or health professional licensed, or authorized by reciprocity or endorsement, to practice a health occupation by the District pursuant to Chapter 12 of Title 3, or any state.



PUBLIC SERVICE COMMISSION OF THE DISTRICT OF COLUMBIA  
1333 H STREET, N.W., SUITE 200, WEST TOWER  
WASHINGTON, DC 20005

NOTICE OF FINAL RULEMAKING

GAS TARIFF 00-2, IN THE MATTER OF WASHINGTON GAS LIGHT  
COMPANY'S RIGHTS-OF-WAY SURCHARGE GENERAL REGULATIONS  
TARIFF, P.S.C.-D.C. No. 3

1. The Public Service Commission of the District of Columbia ("Commission") hereby gives notice, pursuant to Section 2-505 of the District of Columbia Code,<sup>1</sup> of its final rulemaking action taken in the above-captioned proceeding. On June 8, 2006, the Commission released Order No. 13965, approving Washington Gas Light Company's ("WGL")<sup>2</sup> Application for an updated Rights-of-Way Surcharge Rider ("ROW").

2. Pursuant to D.C. Code Section 10-1141.6,<sup>3</sup> WGL filed with the Commission an updated ROW on March 24, 2006.<sup>4</sup> On March 30, 2006, WGL amended its tariff filing by including additional information on the proposed revision.<sup>5</sup> In the tariff filing, WGL shows the process to be used to recover from its customers the D.C. Public Rights-of-Way fees paid by WGL to the District Columbia Government. Specifically, WGL proposes to amend the following tariff page:

**GENERAL SERVICES TARIFF, P.S.C.-D.C. No. 3**  
**Section 22**  
**2<sup>nd</sup> Revised Page 56**

<sup>1</sup> D. C. Code § 2-505 (2005 Supp.).

<sup>2</sup> *GT00-2, In The Matter Of Washington Gas Light Company's Rights-Of-Way Surcharge General Regulations Tariff, P.S.C.-D.C. No. 3, ("GT00-2"), Surcharge Filing of Washington Gas Light Company, ("Surcharge Filing"), filed March 24, 2006.*

<sup>3</sup> D.C. Code, 2001 Ed. § 10-1141.06, states that "Each public utility company regulated by the Public Service Commission shall recover from its utility customers all lease payments which it pays to the District of Columbia pursuant to this title through a surcharge mechanism applied to each unit of sale and the surcharge amount shall be separately stated on each customer's monthly billing statement."

<sup>4</sup> Surcharge Filing at 1.

<sup>5</sup> *GT00-2, WGL Rights-of-Way Surcharge Factor Amended Filing P.S.C. of D.C. No. 3, Section 22, Second Revised Page No. 56 Pursuant to Commission Order No. 13767 ("Amended Filing"), filed March 30, 2006.*

3. In its amended filing, WGL states that its proposed ROW Surcharge Factor is consistent with Commission Order No. 13767.<sup>6</sup> In addition, WGL asserts that the ROW Surcharge Factor will become effective with the April 2006 billing cycle.<sup>7</sup>

4. A Notice of Proposed Rulemaking was published in the *D.C. Register* on April 21, 2006.<sup>8</sup> No comments were filed in response to the filing. Subsequently, the Commission approved WGL's surcharge filing by Order No. 13965. WGL's Rights-of-Way Surcharge Rider will become effective upon the date of publication of this Notice of Final Rulemaking in the *D.C. Register*.

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<sup>6</sup> *Id.*

<sup>7</sup> *Id.* at 1, which has an assumed typographical error stating that the effective date was within the April 2005 billing cycle rather than the April 2006 billing cycle.

<sup>8</sup> 53 D.C. Reg. 3295-3296 (April 21, 2006).