DEPARTMENT OF MENTAL HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Mental Health, pursuant to the authority set forth in sections 104 and 105 of the Department of Mental Health Establishment Amendment Act of 2001, effective December 18, 2001 (D.C. Law 14-56; D.C. Official Code § 7-1131.04 and § 7-1131.05) (Act), hereby gives notice of adoption on an emergency basis of the following new Chapter 22 of Title 22A of the D.C. Code of Municipal Regulations, entitled Standards for Supported Housing for DMH Consumers.

Chapter 22, Title 22A, DCMR establishes minimum requirements for all housing (other than licensed community residence facilities) that receives support from the Department of Mental Health (DMH), including access to housing support services for consumers, financial support for housing (whether directly paid for by DMH or through a fiscal intermediary), and related support services. These minimum requirements include physical plant requirements, access to transportation, monitoring, and other provisions.

These emergency rules will: (1) address supported housing for children and youth and the required involvement of parents or guardians; (2) clarify that submission of the quarterly Safety/Quality Checklists to DMH is based on fiscal year quarters beginning October 1 and not on calendar year quarters, and require that a summary cover sheet be sent with the Checklists; (3) require documentation in a consumer's record of the assistance provided to a consumer in contacting the landlord to arrange for needed repairs; (4) change the percentage of random oversight inspections performed by DMH of consumer occupied housing from 25% to a sampling; (5) revise the definition of consumer to include child and youth; (6) add a definition of quarterly reporting to the section on definitions; and (7) increase the maximum number of blocks that housing must be near public transportation to 6 blocks from 4 blocks.

These rules are published as emergency to comply with the requirements of the Act. The Act was enacted to comply with the Consent Order in *Dixon et al. v. Anthony A. Williams, et. al* (Consent Order). The Consent Order governs the process for transitioning DMH back to the District of Columbia Government. The Act requires that DMH enact rules governing mental health services and mental health supports, including housing services. In addition, DMH is required to meet certain exit criteria established by the parties to Dixon et al. v. Anthony A. Williams, et al. and adopted by the U.S. District Court in its order dated December 12, 2003 (Dixon Exit Criteria). The Dixon Exit Criteria require DMH to establish rules and regulations for housing supports provided to persons with mental illness. The emergency rules are necessary to preserve the welfare, peace, health and safety of the public.

The emergency rules were adopted on May 25, 2005, and will become effective on their publication in the D.C. Register. The emergency rules will expire 120 days after their effective date.

The Director also gives notice of her intent to take final rulemaking action to adopt the proposed rules in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

Title 22A DCMR is amended by adding the following new Chapter 22:

CHAPTER 22

STANDARDS FOR SUPPORTED HOUSING FOR CONSUMERS

2200 PURPOSE AND APPLICATION

2200.1 These rules establish the minimum requirements for all providers who support Department of Mental Health (DMH) consumers in housing, excluding private family homes and licensed community residence facilities.

2200.2 These supported housing rules are applicable to homeless adults, children and youth enrolled in DMH. The parents or guardians of children and youth shall act on their behalf for housing issues, as needed and appropriate.

2200.3 Housing support may occur as follows:

(a) A Core Services Agency (CSA) may provide housing to a consumer directly or through a specialty or subprovider;

(b) DMH, a CSA, or another government agency may provide a monetary subsidy for rent either directly to a consumer or payable to a landlord for the benefit of a consumer;

(c) A CSA, either directly or through a specialty or subprovider, may assist a consumer with locating or arranging for the residence;

(d) A CSA or other provider may provide mental health services and supports in the consumer's home (other than a private family home or licensed community residence facility) to assist with developing and improving activities of daily living; or

(e) DMH or another government agency may provide funds to a business entity to develop or provide housing for consumers enrolled with DMH.

2200.4 Each consumer seeking support from DMH to obtain supported housing or maintain supported housing in the District of Columbia shall be enrolled with a CSA.

2200.5 Each business entity seeking support from DMH to provide housing or housing supports in the District of Columbia shall be a DMH-certified CSA or be

affiliated with a CSA or DMH. Affiliation with a CSA or DMH shall mean that the business entity has a written agreement with a CSA or DMH that describes each party's responsibilities specific to housing.

2201 GENERAL PROVISIONS

2201.1 Each consumer who is receiving services from DMH through a CSA and is in need of housing or resources to secure housing shall be given choice in the type of housing (i.e., independent, congregate). The CSA with whom the consumer is enrolled shall provide supports as identified through the individualized recovery planning process to assist the consumer as needed in whatever type of housing is chosen by the consumer.

2201.2 If a consumer chooses to enroll with a CSA other than the CSA providing the housing to the consumer, the consumer shall not be required to move from any housing associated with the previous CSA if that previous CSA receives housing support funding from DMH as described in § 2200.3(e). The CSA providing the housing shall not require the consumer to choose it as the consumer's CSA for MHRS or Medicaid services.

2201.3 Each CSA providing housing support, either directly or through a specialty or subprovider, shall notify, in writing, each consumer receiving housing support of the need for the CSA to conduct initial, and thereafter quarterly, inspections in compliance with the requirements of this rule. This notification must include provision of a copy of the DMH provided Housing Safety/Quality Checklist that is used to evaluate housing. Other housing inspection forms, such as those required for subsidy programs, may be substituted at the sole discretion of DMH.

2201.4 Each CSA shall maintain and keep current, at all times, a log that lists all consumers residing in each of the CSA's DMH supported housing as defined by these rules. This information shall be available to DMH upon request.

2201.5 For purposes of these rules, mental health services and supports include, but are not limited to, services that address clinical, environmental, and therapeutic needs identified by the consumer and the treatment team. These services include community support in the consumer's living environment (i.e., training in life skill activities, home management, and community services), crisis intervention, and assistance with self-advocacy. Support is provided through a comprehensive continuum of care that is individualized, flexible, and recovery based.

2202 FINANCIAL SUPPORT

2202.1 Any housing for which a financial subsidy is provided shall meet the standards established in all applicable federal and District laws and regulations including, but not limited to, 14 DCMR, Subtitle A, Chapters 1-12.

2202.2 Nothing in this rule is intended to nullify the obligation that the CSA has to comply with all inspection and documentation requirements of the applicable subsidy program for any housing for which financial subsidy is provided.

2203 PHYSICAL PLANT REQUIREMENTS

2203.1 All housing covered under these rules shall be in compliance with all applicable governmental regulations including, but not limited to, 14 DCMR, Subtitle A, Chapters 1-12.

2203.2 All housing and its furnishings shall be clean, safe, in sanitary condition, in good repair, and free from rodents and vermin.

2203.3 Each facility, utility, and fixture shall be properly and safely installed and shall be maintained in a safe and good working condition.

2203.4 Each facility for cooking, storage, or refrigeration of food shall be maintained in a sanitary, safe, and good working condition.

2203.5 Each kitchen sink, lavatory, and bathing facility shall be properly connected with both hot and cold water lines.

2203.6 Adequate facilities for heating, ventilation, and lighting shall be provided.

2203.7 Each consumer shall be provided with an adequate lock and key for each door used or capable of being used as an entrance to or exit from the housing.

2203.8 Each lock shall be kept in good repair and shall be capable of being locked from inside and outside the housing.

2203.9 Required fire extinguishing equipment shall be present in a conspicuous, accessible location and in an operable condition.

2203.10 All emergency exit doors shall be operable at all times.

2203.11 All fire escapes, stairways, and other egress facilities shall be maintained in a good state of repair and shall be free from obstruction.

2203.12 Basic amenities in all housing covered by this rule shall include: refrigerator, stove, oven, hot water, whole house heating (central, base board, or radiator), oscillating fan if no central air conditioning, secure door locks, basic furniture (bed, pillow, dresser, chair/couch, dining table, and chairs), basic kitchen set-up (plates, glasses, utensils, pots, and pans), and basic linens (bath towels, hand towels, wash cloths, sheets, blankets, pillowcases, and dish towels).

2204 ACCESS TO TRANSPORTATON

2204.1 Any housing for which support is provided by DMH or providers certified or licensed by DMH shall be located within a reasonable walking distance, which is six (6) blocks or less, from public transportation

2205 TRAINING

2205.1 DMH shall provide training to persons who are responsible for completing the DMH Housing Safety/Quality Checklist.

2205.2 Each person who completes the checklist shall attend mandatory DMH Housing Safety/Quality Training prior to monitoring housing and shall attend annual refresher training.

2206 DMH INSPECTIONS OF HOUSING BUILT OR RENOVATED USING DMH FUNDS

2206.1 DMH shall conduct annual inspections of one hundred percent (100%) of the residences that meet both descriptions below by using the DMH Housing Safety/Quality Checklist:

(a) The housing was built or renovated using DMH funds through the provision of a loan, grant or other financial supports in excess of $49,999; and

(b) No DMH enrolled consumers reside in the housing.

2206.2 If structural or environmental deficiencies exist that are the responsibility of the owner, DMH shall issue a Corrective Measure Plan (CMP) to the fiscal intermediary, individual, or business entity who received the loan, grant, or other financial support, and the owner of the residence within ten (10) business days of an inspection. For purposes of this section, the term "fiscal intermediary" refers to an organization that has a grant from or contract with DMH that allows it to develop housing or to finance housing.

2206.3 Within ten (10) business days of notice of the violation(s), the fiscal intermediary, individual, or business entity who received the loan, grant, or other financial support, and the owner of the residence shall each submit to DMH a Plan of Correction to address cited deficiencies.

2206.4 Thirty (30) calendar days after the approval of the Plan of Correction, DMH shall reinspect to determine if deficiencies have been corrected.

2206.5 If violations have not been corrected at the time DMH reinspects, DMH shall pursue any recourse available under the grant agreement or contract with the fiscal intermediary, individual, or business entity.

2207 HOME INSPECTIONS BY CORE SERVICES AGENCIES

2207.1 The CSA with which the consumer is enrolled for individual recovery planning shall evaluate all DMH supported housing by using the DMH Housing Safety/Quality Checklist before the consumer enters into the lease. If the consumer enters a lease prior to the CSA's knowledge, the CSA shall evaluate the housing as soon as it becomes aware that the consumer has entered a lease. The consumer (or parent or guardian for children and youth as appropriate) shall hold the lease for housing that receives DMH subsidized rents for any type of housing arrangement covered by these rules.

2207.2 Conversion to consumer held leases as new consumers are housed and as leases come up for renewal shall commence within six (6) months of adoption of these rules.

2207.3 Each CSA with which the consumer is enrolled shall complete the Housing Safety/Quality Checklist at least quarterly (every ninety (90) days) beginning from the date that the lease is secured, or the date that mental health housing supports are initiated for a consumer already in housing, and on an as needed basis.

2207.4 Each quarter is based on the fiscal year which begins on October 1. Depending on when the lease is secured or housing supports begin, the first Housing Safety/Quality Checklist may not cover a full quarter, but must be submitted for the period covered. Each successive reporting period shall cover a full quarter.

2207.5 Each CSA, in order to assist with developing and improving activities of daily living, shall monitor the housing of its enrolled consumers who live in housing directly provided by the CSA, receive a rental subsidy, receive assistance from the CSA in locating or arranging for the residence, receive community supports from or through the CSA in the consumer's home (other than a private family home or licensed community residence facility) or live in housing developed or provided by DMH funding.

2207.6 The completed Housing Safety/Quality Checklists shall be filed in the consumer's clinical record at the CSA.

2207.7 Each CSA shall submit copies of all completed Housing Safety/Quality Checklists along with a brief summary cover sheet to the DMH Office of Accountability no later than fifteen (15) business days following the end of each quarter. Each quarter is based on the fiscal year which begins on October 1.

2208 CORE SERVICES AGENCY ACTIONS TO CORRECT HOUSING PROBLEMS

2208.1 If housing problems exist that are the responsibility of the landlord, the CSA with which the consumer is enrolled for individual recovery planning shall assist the consumer with contacting the landlord to arrange for needed repairs and maintenance. Assistance provided to the consumer shall be documented in the consumer's clinical record.

2208.2 If the deficiencies put the consumer in imminent danger, the consumer, with assistance from the CSA if needed, shall request that the landlord correct them immediately. If the deficiencies cannot be corrected immediately, the CSA shall provide the consumer, within twenty-four (24) hours, the opportunity and assistance to move to appropriate housing. If the consumer refuses to move, documented efforts by the CSA should continue as described in § 2208.4, and the CSA shall assist the consumer in immediately notifying the housing authority described in § 2208.3.

2208.3 If the situation is not life threatening and the landlord does not provide needed repairs and maintenance within fifteen (15) days from the date the request was made, the CSA shall assist the consumer with contacting the Housing Regulations Administration of the Department of Consumer and Regulatory Affairs (DCRA/HRA) to file a formal complaint.

2208.4 If the above actions do not result in amelioration of the problems within sixty (60) days from the date the request was made, or if the consumer refuses to pursue the above actions, the CSA shall provide information to the consumer concerning his/her rights and options regarding housing. This shall include efforts by the CSA to show the consumer other available housing that meets all applicable governmental regulations. Documented efforts by the CSA should continue over time until the consumer secures housing that is in compliance with these rules.

2208.5 If problems exist that are the responsibility of the consumer, the CSA shall provide additional supports as identified through the individualized recovery planning process to assist the consumer in taking responsibility for correcting these problems, and shall document the offered services in the consumer's clinical record.

2208.6 Each CSA shall report unusual incidents in accordance with DMH unusual incident reporting procedures.

2209 OVERSIGHT AND MONITORING BY DMH

2209.1 The DMH Office of Accountability has the primary responsibility for overseeing compliance with this rule and shall provide the Housing Safety/Quality Checklists and summary cover sheet to providers for use.

2209.2 Oversight shall include monitoring of CSA consumer clinical records, as needed, to ensure that the Housing Safety/Quality Checklist is completed as required prior to securing housing for the consumer and quarterly thereafter.

2209.3 Oversight shall include annual random inspections of a sampling of the supported housing as defined in § 2200.3. Increased levels of inspections may occur for housing that is subsidized or provided through a contractual arrangement with DMH. These inspections refer to housing that is occupied by DMH enrolled consumer(s).

2209.4 DMH may perform additional inspections of supported housing based upon complaints from consumers, families, or other interested parties regarding the safety or quality of the supported housing.

2210 DMH ACTIONS TO CORRECT HOUSING AND/OR HOUSING MONITORING PROBLEMS

2210.1 When consumers are in imminent danger as a result of housing conditions, the DMH Office of Accountability shall issue a Corrective Measure Plan (CMP) and direct the CSA to take action to correct the situation immediately, and shall notify the Director of DMH immediately.

2210.2 If deficiencies are life threatening and cannot be corrected immediately, the DMH Office of Accountability shall direct the CSA to provide consumers, within twenty-four (24) hours, the opportunity and assistance to move to appropriate housing.

2210.3 When serious environmental deficiencies are found in supported housing that is supported by a contract with DMH, DMH shall pursue the actions identified in §§ 2210 and 2212 against the organization that has the contract with the DMH.

2210.4 When deficiencies are not life threatening, the DMH Office of Accountability shall notify the CSA by issuing a CMP indicating any violation of these rules within ten (10) business days of an inspection.

2210.5 Within ten (10) business days of notice of the violation(s), the CSA shall submit a Plan of Correction to address cited deficiencies to the DMH Office of Accountability.

2210.6 Thirty (30) calendar days after the approval of the Plan of Correction, the DMH Office of Accountability shall reinspect to determine if deficiencies have been corrected.

2211 COMPLAINTS

2211.1 A consumer or someone acting on behalf of a consumer may file a grievance in accordance with 22A DCMR Chapter 3. The consumer may contact the DMH Office of Consumer and Family Affairs at the Mental Health Authority regarding the DMH grievance process.

2212 LEVYING OF SANCTIONS

2212.1 If violations have not been corrected at the time of the reinspection by DMH, DMH may pursue any or all of the following actions:

(a) Impose civil fines issued pursuant to 16 DCMR, section 3502, based on violation of MHRS standards related to requirements of this rule.

(b) Impose sanctions provided for in contractual arrangements with the DMH; and/or

(c) Decertification of the CSA and its affiliates, as applicable.

2212.2 A CSA that is sanctioned under these rules may seek review by the Director of the DMH.

2299 DEFINITIONS

2299.1 When used in this chapter, the following terms and phrases shall have the meanings ascribed:

"Affiliation" – means there is a written agreement between a business entity and a CSA or DMH that describes each party's responsibilities specific to housing.

"Business Entity" – any entity that has responsibilities specific to housing or who is involved in activities related to provision of housing for DMH consumers and who is either a DMH certified CSA or has a written agreement with a CSA or DMH.

"Community Residence Facility" – a licensed residence which provides 24-hour on-site supervision, lodging, and meals in a supportive, homelike environment for individuals who require supervision within a structured environment that can include specialized services such as medical, psychiatric, nursing, behavioral, vocational, social, or recreational services.

"Community Support" – rehabilitation and environmental supports considered essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer.

"Congregate" – a living setting where more than one individual with mental illness lives and which provides on-site staff supervision.

"Consumer" – as used in this chapter, an adult, child or youth who seeks or receives mental health services or mental health supports funded or regulated by the Department of Mental Health.

"Contract" – the written agreement that may be used for the procurement of housing, education or special education, health, human or social services, or other assistance, to be provided directly to individuals who are disabled, disadvantaged, displaced, elderly, indigent, mentally ill, physically ill, unemployed, or minors in custody of the District of Columbia. Contracts include Human Care Agreements for purposes of this rule.

"Core Services Agency" (CSA) – a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS.

"Corrective Measure Plan (CMP)" - the CMP is a written statement of non-compliance that describes the areas of non-compliance, suggests actions needed to bring the situation or violation into compliance with the standards, and sets forth a timeframe for submitting a written plan of correction.

"DMH" – the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental Health Services.

"Fiscal Intermediary" - an organization that has a grant from or contract with DMH that allows it to develop housing or to finance housing.

"Housing" – the dwelling where a person resides, either alone or with others, which is not a private family home, a licensed community residence facility, a crisis bed, a shelter, a residential treatment center, or St. Elizabeths Hospital.

"Imminent danger" - imminent danger is a situation in which the provider's non-compliance with one or more DMH standards has caused, or is likely to cause, serious injury, harm, impairment, or death to a consumer. Imminent danger is interpreted as a crisis situation in which the health and safety of consumers are at risk.

"Independent" – a living setting where an individual with mental illness lives alone or with roommates of choice which does not provide on-site staff supervision.

"Mental Health Rehabilitation Services" (MHRS) - mental health rehabilitative or palliative services provided by a DMH-certified community mental health

provider to consumers in accordance with the District of Columbia State Medicaid Plan, the MAA/DMH Interagency Agreement, and this chapter.

"Mental health services and supports"- means the services and supports funded or regulated by the Department for the purpose of addressing mental illness or mental health problems.

"Plan of Correction" - the provider's written plan of correction that describes the actions to be taken and the timeframe for correcting the areas of non-compliance with standards in response to the Corrective Measure Plan issued by DMH.

"Private family home" – a residence with one (1) or more persons related by blood, marriage, or adoption, or not more than six (6) persons who are not so related, living together as a single house-keeping unit and which is not provided under a Human Care Agreement with the DMH.

"Provider" - (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports, or (b) any individual or entity, public or private, that has entered into an agreement with DMH or a certified CSA to provide mental health services or mental health supports.

"Quarterly Reporting" – Copies of all completed Housing Safety/Quality Checklists along with a brief summary cover sheet are submitted by each CSA to the DMH Office of Accountability no later than fifteen (15) business days following the end of each quarter. Each quarter is based on the fiscal year which begins on October 1 and not on calendar year quarters.

"Subsidy Program" – This category includes these programs: Home First II, Shelter Plus Care, DMH Rental Subsidy Program, Section 8, and any other rental subsidy program developed by DMH.

"Utility" – water, electricity, gas or other fuels, sewer or refuse service.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty (30) days after the date of publication of this notice in the Register. Comments should be filed with Anne M. Sturtz, General Counsel, Department of Mental Health, 64 New York Ave, N.E., Fourth Floor, Washington, D.C. 20002 or anne.sturtz@dc.gov. Additional copies of these rules are available from the Office of the General Counsel, Department of Mental Health.

OFFICE OF RISK MANAGEMENT

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Office or Risk Management (ORM), Executive Office of the Mayor, pursuant to the authority set forth in section 7 of Reorganization Plan No.1 of 2003 for the Office of Risk Management, effective December 15, 2003, and Mayor's Order 2004-198 (December 14, 2004), hereby gives notice of the adoption, on an emergency basis, of the following new Chapter 31 to Title 7 of the *D.C. Municipal Regulations*. The new Chapter 31, entitled Termination, Suspension or Reduction of Disability Compensation Benefits for District Employees, sets forth the rules regarding notice requirements and other processes attendant to the termination, suspension, or reduction of disability compensation benefits being paid, by ORM or its designee, to District employees (including employees of instrumentalities of the District government and District government employees serving on petit or grand juries) from the District's Disability Compensation Program (Program).

The emergency rulemaking is necessary for the immediate preservation of the public peace, health and welfare in order to comply with the court's order in *Lightfoot, et al. v. District of Columbia, et al.* (No. 01-1484 (CKK)) (September 24, 2004) (*Lightfoot*) under which the District has been directed to publish rules concerning the termination, suspension or reduction of disability compensation benefits for District employees. The current rulemaking in 7 DCMR Chapter 1 was promulgated by the Department of Employment Services (DOES) when the disability compensation program was entirely under DOES's jurisdiction. While the DOES still has jurisdiction with respect to the adjudication of disability compensation appeals, the Program itself is under the jurisdiction of the ORM. The District government is appealing the court's order in *Lightfoot.* Therefore, while some of the current rules may be applicable to matters now within the jurisdiction of ORM, it was determined that, for purposes of this mandated rulemaking, a new Chapter 31 would be created to distinguish the subject rules from the rules currently published in 7 DCMR Chapter 1. At a future time, the DOES and the ORM may consider revising 7 DCMR Chapter 1 in its entirety by promulgating joint rulemaking pursuant to their respective jurisdictions, or, the ORM may publish more comprehensive rulemaking concerning the Program. However, the subject rulemaking is limited to addressing only those aspects of the Program as are required by the *Lightfoot* decision and other matters that must be addressed as a result of the promulgation of these rules. This rulemaking incorporates certain concepts embodied in the Disability Compensation Effective Administration Amendment Act of 2004, effective April 5, 2005 (D.C. Law 15-290). However, this rulemaking is not the rulemaking required by that act.

The emergency rules were adopted on February 18, 2005, and became effective immediately. The emergency rules will expire on June 18, 2005 (120 days after the effective date), or upon publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever occurs first.

The Director also hereby gives notice of her intent to take final rulemaking action to adopt the proposed rules in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

A new Chapter 31 is added to 7 DCMR, as follows:

Chapter 31

Office of Risk Management

Termination, Suspension or Reduction of Disability Compensation Benefits for District Employees

3100 Applicability

3100.1 The provisions of this subchapter are applicable to the District's Disability Compensation Program (Program), administered by the Office of Risk Management (ORM). To the extent that there is a conflict between the rules set forth in this subchapter and other rules in Chapter 1 of this title that are not part of this subchapter, the rules in this subchapter shall control with respect to any matter that is within the jurisdiction of the ORM.

3100.2 ORM has oversight and administrative responsibility for the Program, including decisions on requests for reconsideration of Initial Determinations (IDs) and Eligibility Determinations (EDs) rendered by the ORM or its designee. (When the term ORM is used in this subchapter, it is understood that the activity referenced may in fact be performed by the ORM's designee. A responsibility of the Program described in this subchapter may be carried out by the ORM or its designee, as the ORM may determine from time-to-time).

3100.3 All employees, contractors, sub-contractors, and agents, acting for or on behalf of the District of Columbia, to implement the Program pursuant to the Act, including third party administrators, shall comply with these rules.

3100.4 Nothing in these rules, or any instructions or attachments related thereto, shall be interpreted as:

(a) Creating an entitlement or property interest in any employee, contractor, sub-contractor, or agent to whom these rules are applicable;

(b) Making any person or entity a third-party beneficiary to any contract with the District or with any of its contractors or sub-contractors;

(c) Establishing a standard of care; or

(d) Limiting the District's ability to amend, modify, or rescind these rules, consistent with any applicable law, including the Act and the District of Columbia Administrative Procedure Act, approved October 21, 1968, 82 Stat. 1203, D.C. Official Code § 2-551 *et seq.* (2001), binding case law, government contract provisions and modifications, and applicable judgments or settlements.

3101 through 3130 Reserved

3131 Procedures for New Claims

3131.1 The Program shall render IDs concerning new claims for compensation benefits, including decisions to accept or deny new claims, pursuant to this subchapter.

3131.2 The District government is responsible for receiving first reports of injuries, administering claims and making compensability and continued eligibility determinations. The ORM may delegate some or all of these responsibilities to a third party administrator.

3131.3 Claims properly and timely reported by employees that meet the requirements of the Act shall be covered by the Program.

3131.4 The employer shall report the claim to ORM, or its designee, by telephone and in writing, using Form 1, the Employer and Employee First Report of Injury or Occupational Disease, and Form 2, Supervisor's Report.

3131.5 Form 1 shall contain the following information:

(a) The name and address of the employer;

(b) The name and address of the employee;

(c) The year, month, day and hour when the injury or death occurred;

(d) The name and telephone number of the employee's supervisor;

(e) The employee's occupation at the time of the injury or death;

(f) The employee's wage/base salary information;

(g) The length of employee's employment;

(h) The location of the accident; and

(i) A description of the events which resulted in the injury or disease, type of injury, and the body parts affected.

3131.6 Form 2 shall contain the following information:

(a) Whether the supervisor witnessed the accident;

(b) Whether the employee reported the accident or injury, and to whom;

(c) Whether an incident report was prepared in connection with the injury;

(d) The nature of the injuries the employee complained of;

(e) Whether the employee has been placed on Continuation of Pay (COP);

(f) Whether the employee was in the performance of duty at the time of injury;

(g) A description of the events which resulted in the injury or disease; and

(h) An attached copy of the employee's position description and all incident reports.

3131.7 The Employer shall complete and submit supplemental reports to the ORM as requested. Said reports shall contain:

(a) Statements from witnesses confirming or refuting the employee's allegations concerning the accident or injury;

(b) Statements, where requested, to give additional details of the accident or incident;

(c) Statements regarding whether the employee had a similar disability prior to the alleged injury, and, if so, full details of the prior disability or incident and associated medical reports; and

(d) Statements of other injuries or accidents of a similar character and the full details.

3131.8 The Employer shall complete Form CA-3, Report of Return to Duty.

3131.9 The Employee shall complete Form CA-7, Claim for Compensation, Part A, Employee Statement or another notice which shall:

(a) Be in writing;

(b) State the name and address of the employee;

(c) State the year, month, day, and hour when and the particular locality where the injury or death occurred;

(d) State the cause and nature of the injury, or in the case of death, the employment factors believed to be the cause;

(e) State the employee's official job title, grade/step, and number of hours scheduled to work per day;

(f) State the employee's health benefit plan and code;

(g) State whether the employee has optional life insurance;

(h) State whether a claim has been made against a third party as a result of the injury or illness;

(i) State the names, relationship, and birth dates of employee's dependents, and/or the amount of support paid for dependents not living with the employee;

(j) Be signed by, and contain the address of, the individual giving the notice;

(k) Attach proof of dependency, for example, birth certificates and court orders; and

(l) Attach a copy of the employee's last pay stub.

3131.10 The employee shall complete a Medical Authorization and Release of Confidential Information Form as provided by ORM.

3131.11 The employee shall have his physician complete and return to the ORM, a Form 3, Physician's Report of Employee's Injury and Disability.

3131.12 The employee shall submit proper medical documentation as requested by the ORM to support the employee's ongoing disability and absence from work. These documents shall include, but not be limited to the following:

(a) Statements and medical documentation regarding any similar disability which occurred prior to the alleged injury;

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

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

3131.13 ID benefits may be based, in whole or in part, upon the following factors:

(a) The claimant's lack of a compensable injury;

(b) The claimant's abandonment of the claim;

(c) The claimant's failure to cooperate with treatment or rehabilitation recommendations, or with Program requirements for providing information;

(d) Any other grounds, such as fraud, that reasonably demonstrate that the claimant is not entitled to benefits under the Act.

3131.14 A new claim shall be denied as controverted when a claimant fails to cooperate, by following the procedures set forth in this subchapter.

3131.15 Within 30 days after the Program receives a new claim for compensation benefits compensable under the Act, the Program shall issue an ID providing notice to the claimant furnishing or authorizing payment for services, appliances, supplies, reasonable transportation, and expenses incidental thereto. Within 30 days after the Program receives a new claim for compensation benefits that is not compensable under the Act, the Program shall issue an ID providing notice to the claimant denying such claim.

3131.16 The ID is effective unless the claimant succeeds on a request for reconsideration as provided in section 134 of this subchapter, or the Program revises the ID.

3131.17 Medical reports used in connection with an ID shall meet the requirements of section 160 of this subchapter.

3132 Procedures for Existing Claims

3132.1 The Program shall render EDs, concerning existing claims for compensation benefits, including decisions to terminate, suspend, or modify benefits, pursuant to this subchapter.

3132.2 The Program shall adjust a claim using information from the treating physician who provides medical treatment to the claimant for an injury or disability and from any Additional Medical Examination (AME) report. An AME shall consist of a case file review, and/or an in-person assessment or

examination, by a qualified health professional other than the treating physician.

3132.3 An AME report shall be conclusive and responsive to the requests from the Program as part of a complete professional evaluation.

3132.4 Upon a request from the Program, the claimant and the treating physician shall provide copies of all the claimant's medical records regardless of the source of the record(s) or the medical condition(s) addressed in the records. The Program shall take appropriate steps to ensure that the medical records provided to it are maintained in a confidential manner.

3132.5 A claimant who is receiving benefits under the Program shall not be the subject of an ED unless and until there is sufficient evidence to support the issuance of an ED pursuant to the Act and this subchapter.

3132.6 An ED may be based, in whole or in part, upon the following factors:

(a) The death of the claimant;

(b) The clear evidence that claimant has returned to work;

(c) The claimant's conviction of fraud in connection with the claim;

(d) Suspension of the payment of compensation due to the claimant's failure to participate in vocational rehabilitation or cooperation with the Program's request for a physical examination;

(e) The cessation or lessening of a compensable injury;

(f) The condition is no longer causally related to the employment;

(g) The condition has changed from a total disability to a partial disability;

(h) The employee has returned to work on a full-time or part-time basis notwithstanding individuals directed to undergo vocational rehabilitation under section 2304 of the Act;

(i) The Program determines based upon strong compelling evidence that the ID was in error; and

(j) Any other ground demonstrating that the Act requires the claimant's benefits to be modified, such as abandonment of the claim, retirement of the claimant, or clear evidence that the claimant has knowingly and willfully received benefits to which he or she was not entitled under the Act.

3132.7 With the exception of the factors set forth in section 132.6 (a)-(d) of this subchapter, compensation benefits subject to an ED shall not be modified until the period for requesting reconsideration set forth in section 134 of this subchapter has elapsed with no Request for Reconsideration being received by the ORM, or until a timely Request for Reconsideration has been decided by the ORM, whichever is earlier.

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

3132.9 In making its determinations regarding whether a claim should be the subject of an ED, the Program shall consider all relevant evidence in the claim file, including all relevant medical evidence. In weighing medical evidence, the Program shall give great weight to the opinion(s) of the treating physician, unless there are compelling reasons for rejecting such opinions, in which case, the opinion(s) of another physician may be given greater weight. Such reasons may include:

(a) Sketchiness, vagueness, and imprecision in the reports of the treating physician;

(b) The fact that the opinion of the treating physician is not supported by medically acceptable clinical and laboratory diagnostic techniques;

(c) The fact that the opinion of the treating physician is inconsistent with the other substantial evidence of record; or

(d) The existence of an AME report from a physician with superior, relevant, professional knowledge, who examined the claimant personally and reviewed all relevant, available medical records, and diagnostic studies.

3132.10 An AME report shall be considered to the extent permitted by section 132.9 of this subchapter, where the report was provided by a physician with superior, relevant, professional knowledge, who examined the claimant personally and reviewed all relevant, available medical records, and diagnostic studies.

3132.11 If, pursuant to section 132.9, the Program does not give great weight to the opinions of a treating physician, the notice required by section 133 of this

subchapter, informing the claimant of the ED, shall explain why the Program took such action in connection with its decision.

3132.12 The ED is effective unless the claimant succeeds on a request for reconsideration under section 134 of this subchapter or the Program revises the ED.

3132.13 Medical reports used in connection with an ED shall meet the requirements of section 160 of this subchapter.

3133 Program Notices of Initial Determinations and Eligibility Determinations

3133.1 The Program shall issue a notice regarding each ID and ED pursuant to this subchapter. A notice of an ID or ED shall be issued using a standard form developed by the Program that informs the claimant of the right to request reconsideration. Sample notices shall be published in the *District's Personnel Manual*.

3133.2 A notice shall contain a narrative description of the rationale for the decision, shall cite relevant portions of the supporting documentation or claim file, and shall be accompanied by supportive documentation.

3133.3 A notice shall be sent to the claimant's last known address by first class U.S. mail. A certificate of service shall be executed by the Program at the time of mailing.

3134 Reconsiderations of Initial Determinations and Eligibility Determinations

3134.1 A claimant who is dissatisfied with an ID or ED may either submit a request for reconsideration to the ORM, or, appeal the ID or ED as provided in the Act, but not both. Reconsideration shall be optional and in addition to an appeal under the Act.

3134.2 A claimant shall be entitled to receive continued benefits pending a decision on a request for reconsideration unless:

(a) The claimant has died;

(b) The claimant has returned to work;

(c) The claim has been controverted;

(d) The claimant's compensation benefits have been suspended for non-cooperation;

(e) The claimant is no longer entitled to augmented compensation pursuant to the Act;

(f) The claimant has voluntarily retired and been awarded retirement benefits in lieu of disability compensation benefits;

(g) The claimant knowingly and willfully received benefits to which he or she was not entitled under the Act; and

(h) The claim has been abandoned, as defined in section 132.8 of this subchapter.

3134.3 If a request for reconsideration is properly and timely submitted pursuant to this section, the ORM may affirm, modify, vacate, or remand the ID or ED for further examination by claims examiners within the Program, in full, or in part.

3134.4 A request for reconsideration shall be written and shall contain medical, vocational, or factual justification.

3134.5 A Request for Reconsideration shall be delivered to the ORM by hand, or by United States Mail, within 30 days of the date of issuance of the ID or ED that is the subject of the Request for Reconsideration. If a Request for Reconsideration is hand-delivered, the ORM shall provide the claimant with a dated receipt. Requests for Reconsideration shall not be accepted by facsimile or email.

3134.6 The deadline for filing a Request for Reconsideration shall be strictly enforced. If, by the 31st day following the date of issuance of the ID or ED, the ORM has not received a Request for Reconsideration, it shall implement the decision if it has not already done so consistent with sections 132.6 and 132.7 of this subchapter. If the ORM receives a Request for Reconsideration after the 30th day following the issuance of the ID or ED, then it shall deny the Request for Reconsideration as untimely without ruling on the merits.

3134.7 If the deadline for a Request for Reconsideration falls on a Sunday, a holiday, or a day that is normally a business day but on which the District government is otherwise closed, such as for snow or other emergency, then the request for reconsideration shall be timely if it is received by ORM on the next business day.

3134.8 The ORM shall permit a claimant to request a waiver of the filing deadline in section 134.6 of this subchapter on the grounds that good cause existed during the 30 days following the ID or ED decision sufficient to justify the

ORM's late receipt of the Request for Reconsideration. The claimant shall provide factual justification and any documentation required by ORM to support the request for the waiver. In no event shall a request for a waiver of the deadline be considered after 180 days from the date of issuance of an ID or ED.

3134.9 The ORM shall make its ruling on the merits of a Request for Reconsideration upon a preponderance of the evidence, based on the Act, best practices, and applicable case law. If the ORM's decision on the Request for Reconsideration is based in whole or in part on medical information, the ORM shall, in making its ruling, adhere to the requirements of section 132.9 of this subchapter.

3134.10 If the ORM rules favorably upon a Request for Reconsideration and the claimant has been receiving continued benefits during the pendency of the ORM's decision, such benefits shall continue without interruption. If the ORM rules favorably upon a Request for Reconsideration and the claimant has not been receiving benefits during the pendency of the ORM's decision, all current and any retroactive benefits due to the claimant shall be paid.

3134.11 If the ORM does not rule favorably upon a Request for Reconsideration, the ORM shall, using a standard form developed by the ORM, provide a brief explanation of its decision. On such form, the ORM shall either direct the Program to issue a new ID or ED from which the claimant shall have thirty (30) calendar days from the date of the ORM's reconsideration decision to appeal to the Department of Employment Services (DOES), or shall adjust the date of the existing ID or ED so the claimant has thirty (30) calendar days from the date of the ORM's reconsideration decision to appeal to the DOES.

3134.12 The decision rendered by the ORM upon a Request for Reconsideration shall not be binding upon an Administrative Law Judge. If a claimant files a Request for Reconsideration of an ID or ED with the ORM, any subsequent appeal following the ORM's decision on the Request for Reconsideration to the DOES shall be from the existing or new ID or ED that is in effect following the ORM's decision on the Request for Reconsideration, and not from the ID itself.

3135 through 3159 Reserved

3160 Required Contents of Medical Reports from Physicians

3160.1 The following information shall be included in a medical report from a physician that is used by the Program in connection with an ID, ED, or other Program decision affecting claimant benefits:

(a) Date(s) of examination and treatment;

(b) History given by the employee;

(c) Physical findings;

(d) Results of diagnostic tests;

(e) Diagnosis;

(f) Course of treatment

(g) Description of any other conditions found but not due to the claimed injury;

(h) Treatment given or recommended for the claimed injury;

(i) Physician's opinion, with medical reasons, as to causal relationship between the diagnosed condition(s) and the factors or conditions of the employment;

(j) Extent of disability affecting the employee's ability to work due to the injury;

(k) Prognosis for recovery; and

(l) All other material findings.

3160.2 Medical reports that fail to meet the requirements of this section may be deemed to be invalid and compensation claims based thereon may be denied.

3161 Claimant and Attorney Access to Program Claims Files

3161.1 A claimant and his or her attorney shall have access to the Program's file pertaining to his or her claim. The Program's files pertaining to disability compensation claims are District of Columbia property.

3161.2 A claimant and his or her attorney may contact the Program to request an appointment to review the Program's file and make one copy of the documents at the claimant's expense at reasonable rates set by the Program. The Program shall schedule an appointment to be held at a mutually convenient time within five (5) business days of receiving the claimant's request.

3162 Payment of Compensation Benefits on Remand from Appeal

3162.1 The Program shall pay compensation to the claimant pursuant to an Order of an Administrative Law Judge (ALJ), and provided the claimant, within fifteen (15) days of the Order, has submitted:

(a) Verification of the disability for the period specified in the Order; and

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

3163 through 3197 Reserved

3198 Computation of Time

3198.1 Any days required to be counted pursuant to this subchapter shall be counted commencing with the day after the date referenced in the rule.

3199 Definitions

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

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

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

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

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

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

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

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

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

Comments on the proposed rulemaking should be submitted, in writing, to Kelly L. Valentine, Interim Chief Risk Officer, 441 Fourth Street, N.W., Suite 800S, Washington, DC 20001, within thirty (30) days of the date of publication in the *D.C. Register*. Additional copies of the proposed rules are also available from this same address.